AN ABSTRACT OF THE DISSERTATION OF

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Title: The Experiences of Licensed Mental Health Professionals Who Have Encountered and Navigated Through Compassion Fatigue

Abstract approved _____
Deborah J. Rubel

The purpose of this dissertation study was to increase understanding of licensed mental health professionals' experiences as they have encountered and navigated through compassion fatigue (CF). CF is a complex construct with an attendant constellation of secondary stress responses. In order to examine the complex and varying factors associated with experiencing CF, the research was conducted using a grounded theory, qualitative approach and methodology. Nine licensed mental health professionals across the disciplines of marriage and family therapy, mental health counseling, professional counseling, psychology, and social work were individually interviewed three times, for a total of at least 180 minutes. All interviews were recorded, transcribed and analyzed. As a result of the analyses, four main categories emerged, *experiencing internal dissonance, recognizing and processing the effects, becoming intentional,* and *creating ongoing changes. Becoming intentional* is the central category because of its central and pivotal relationship to the whole process of participants' experience of encountering and navigating through CF. This fulcrum punctuates participants' experiences leading up to *becoming intentional* and those which came after as delineated in the other three categories of the theory. Prior to becoming intentional, participants experienced internal dissonance, which escalated to distress or crisis. When this distress or crisis reached a point where it became untenable, participants recognized and processed the effects. One

of the effects which participants came to recognize was a loss of internal locus of control. Becoming intentional served as a catalyst for participants to take action and recapture their locus of control. The process of becoming intentional is reflected in three practices, transforming perceptions, developing support, and making professional changes. These findings are applicable to a variety of models of counseling, supervision, counselor education, and clinical practice in either a single or interdisciplinary setting.

The Experiences of Licensed Mental Health Professionals Who Have Encountered and Navigated Through Compassion Fatigue

by
Louise B. Jorgensen

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APPROVED:

Major Professor, representing Counseling

Dean of the College of Education

Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Louise B. Jorgensen, Author

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It would be impossible to go back and specifically acknowledge and name all those individuals, teachers, colleagues, supervisors, and friends who have threaded their way through the warp and weave of the tapestry of my life leading to this point. Completing this dissertation would not have been possible save for these many individuals who have influenced me as they have 'stood at the crossroads.' To them, I give my profound thanks for helping me through this journey.

As I contemplate that journey, I acknowledge the influence of professors and colleagues at Oregon State University. To my dissertation committee members, Dr. Lorie Blackman, Dr. Faline Christensen, Dr. Daniel Stroud, and Dr. Joseph Krause—thank you for your enthusiasm and interest in my dissertation topic. Each of you has influenced me for the good. To Dr. Deborah Rubel, my dissertation Chair, I offer my deep respect and gratitude. You have been a bracing support to me as your steady hand has guided this process. You have deftly taught me how to love qualitative inquiry, while adroitly balancing the tasks of allowing me to struggle, at times, while quietly persisting in your efforts to scaffold my endeavor. Through your example and teaching, you have successfully infused me with greater confidence in my abilities to conduct future qualitative research.

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I thank my clinical and academic colleagues for their encouragement and support. Colleagues and supervisors at the agencies where I conduct clinical practice and fellow faculty at the University where I teach have all been encouraging and responsive.

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Pursuing a doctorate has been a dream of mine since I was a child. My pursuit and love of life-long learning was instilled in me by my parents, Dean and Mary Elen and by their parents, my maternal and paternal grandparents. They all provided unselfish care as they encouraged me to follow my dreams and never give up. I want to thank all my extended family members, especially my sister, Rosie, who has influenced my writing and my thinking and who is the embodiment of compassion.

Completing this dissertation would have been impossible without the support of my beloved husband, David Jorgensen. You have fortified me through every step of the journey. Your commitment kept me grounded during each increment of the doctoral program. You've been more than a partner—you've been my best friend and champion. I also acknowledge my beautiful daughters, Amy, Krista, Bethany, and Meagan and my sons-in-law, John, Stephen, and Brent. Your encouraging words, counsel, prayers, and support have kept me on course. You've all sacrificed family time in order to bring this pursuit to fruition. Krista and Steve, you generously opened your home to me and provided transportation during the two years of course work prior to the dissertation phase of this journey. Thank you. To my grandchildren, Rachel, Seth, Ellie, Jacob, Colin, Lydia, Ethan, Tegan, Savannah, Brooke, Brayden, and

Oliver, the angel who has made it all the way ‘home,’ your love has been a lamp to me and a refreshing balm during the stresses and rigors of the academic process.

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Dedication

To my parents, Dean and Mary Elen, who taught me to be passionate about compassion,
to

David,

who sustained that effort,

and

to our children and grandchildren, who engender a joyful compassion.

CHAPTER I: General Introduction

Dissertation Overview

Practitioners within the mental health disciplines face a wide variety of experiences which present challenges to professional and personal well-being. The mental, physical, and emotional intensity often associated with clinical practice creates the potential for incurring a constellation of responses which some clinicians may find difficult to negotiate. These responses have been studied for some time, in scientific literature, under the topic of compassion fatigue (CF). The purpose of this dissertation is to add to the body of scholarly work on CF through producing a manuscript-style document dissertation. The rationale for using this format, as outlined by the Department of Teacher and Counselor Education Ph.D. Program manual, includes the following goals: an approach to the topic of CF which includes both a breadth and depth of information, and a facilitation of a coherent body of information that provides practical and applicable results to the counseling profession and its related disciplines.

In following the goals of this format, chapter 1 is a general introduction which provides an explanation of the importance of the topic of CF to the counseling profession. Furthermore, Chapter 1 explains how two journal-formatted manuscripts, Chapters 2 and 3 are thematically tied, providing a rationale for further research on the topic. Chapter 2 provides a breadth of information regarding CF as outlined in extant literature. Chapter 3 provides an overview of an in-depth research analysis of the experience of CF. These chapters build toward research conclusions on CF pertinent to the counseling profession. Chapter 2 is a literature review entitled, *A Review of the Literature on Compassion Fatigue and Related Constructs: Implications for Counseling, Counselor Education, and*

Supervision. Chapter 3 presents qualitative research in a manuscript entitled, *Becoming Intentional: A Grounded Theory of Licensed Mental Health Professionals' Experiences as They Have Navigated through Compassion Fatigue.*

The first manuscript (Chapter 2) is a comprehensive literature review that provides the history, background, definition, and theoretical underpinnings of the construct of CF, as well as a discussion of risk factors, prevalence, pre-dispositions, symptoms, postulated etiology, potential consequences, and potential remediation. Moreover, Chapter 2 examines CF in conjunction with a constellation of responses which are reflected in related constructs, some of which are burnout, countertransference, vicarious traumatization, and secondary traumatic stress. Examining these constructs clarifies distinctions and similarities regarding concepts associated with CF, distinctions that have caused some semantic confusion and disparity within the body of scientific literature on CF. Finally, the manuscript provides a platform for discussing trends in the literature towards studying caregiver resilience, professional growth, and personal development.

The second manuscript (Chapter 3) is an overview of the theory which emerged as a result of the qualitative study I conducted surrounding the topic of CF. The purpose of Chapter 3 is to elucidate this grounded theory study which explored the experiences of licensed mental health professionals who had encountered symptoms of CF and navigated through its effects. In this case, licensed mental health professionals were defined as individuals working within the mental health counseling disciplines, Relative to this study, these licensed mental health professionals were licensed clinical mental

health counselors, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, and licensed psychologists.

Importance to the Profession of Counseling

Counselors and other mental health professionals across disciplines work with people who are experiencing stress, suffering, or trauma directly or indirectly. These caregivers run the potential risk for being similarly affected by the same physical, mental, and psychological symptoms as their clients who deal with these crises and this stress. Practitioners, as a result, are experiencing a traumatic secondary or tertiary contagion, similar to primary posttraumatic stress symptomatology (Figley, 2002a; Figley, 2002b; Marriage & Marriage, 2005; Sabin-Farrell, & Turpin, 2003, Sabo, 2011).

Indeed, those caregivers who work with direct or indirect suffering, pain, crisis and/or trauma are at the greatest risk for developing care-giver stress reactions such as compassion stress or CF (Baird & Jenkins, 2003; Cerney, 1995). Often individuals who possess a high degree of empathy, intuitiveness, and caring are drawn to the mental health professions. Any individual who possesses these traits is also at risk for developing some form of CF (Figley, 2002a; Sabo, 2011; Showalter, 2010, Stebnicki, 2008). That risk increases with frequency, intensity, and exposure to individuals' or clients' suffering and traumata, occurring in all fields of counseling (Adams & Riggs, 2008).

Supervision and training. Figley (as cited in ACA, 2010) defines CF as "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Definition section, ¶ 6). The ACA definition further states that CF is the debilitating "emotional residue of exposure to working with the suffering" (Definition section, ¶ 7).

Working with individuals or groups of individuals who are experiencing trauma, suffering, and emotional pain is an expectancy within the mental health milieu and constitutes what researchers have called the profession's cost of caring (Bride & Figley, 2007; Linley & Joseph, 2007)

The apparent universality of risk underscores the need for enhancing CF awareness within the counseling field in general, and counselor education and supervision specifically. Sommer (2008) highlights the need for increased training of both counselor trainees and experienced counselors. She contends that clinical work is not what it was a decade ago, nor were the problems encountered in the current mental health arena prepared for in the training curricula of the past. Others have augmented this pejorative by urging for more specific supervision to enhance counselor resilience through promoting awareness and prevention of secondary traumatic stress reactions and CF among mental health professionals (Gentry, Baggerly, & Baranowsky, 2004; Munroe et al., 1995; Sommer; Sommer & Cox, 2005; Walker, 2004).

Undoubtedly, the challenges that are faced by professional caregivers are complex, varied, and unique depending on context, clients, and personal circumstances. Nevertheless, CF is not unique to one branch of caregivers and "is prevalent across all spectrums of the helping professions and is flourishing" (Showalter, 2010, p. 239).

In this light, the effects of CF on the mental health professions could be enormous for both clinician and client alike, highlighting the need for ongoing clinical training and supervision. Such training and supervision may contribute to the attenuation or prevention of CF among both experienced counselors and counselor trainees. Moreover, training and supervision specific to the CF spectrum could lead to greater professional

growth and higher professional functioning among the mental health professions in general. Such a scenario translates to increased potential for facilitating client well-being and healing.

The ACA (2010) *Taskforce on counselor wellness and impairment* has highlighted the risks for potential counselor impairment inherent in counselors who are untrained or unprepared to deal with the effects of secondary exposure to trauma and suffering in their clients. The APA *Code of Ethics* (2005) also highlights this concern. Other mental health organizations have mirrored the call for additional training and supervision to foster awareness of CF risks, pointing out the commensurate potential for harm to clients and patients (Ackerly, Burnell, Holder, & Kurdek, 1988; Gentry et al., 2002; Stebnicki, 2008). Moreover, The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) guidelines also point to an orientation of counselor wellness and prevention of counselor impairment.

The significance of creating CF awareness cannot be understated. Of equal, or greater, significance however is the trend within the counseling movement towards discovering ways in which to create resilience among mental health practitioners (Linley, 2003; Linley & Joseph, 2007; Seligman, 2003). Heightening awareness of CF provides an opportunity for supervision which emphasizes resilience, positive growth, and personal and professional development. This growth may be achieved as practitioners successfully navigate through CF with the guiding support of appropriate clinical supervision. Considering that the U.S. Department of Labor, Bureau of Labor and Statistics has projected the need for mental health counselors will rise by 37% from 2010

to 2020, promoting counselor wellness is an imperative (U.S. Department of Labor, 2012).

Fostering caregiver awareness. However, the implications and importance of fostering both awareness and training go beyond the realm of counselor education and supervision. The conditions associated with the CF spectrum can affect any caregiver including school counselors, counselor educators, hospital personnel, emergency workers, firefighters, policeman, journalists, lawyers and legal witnesses, members of military families, families with special needs children, and families who care for aging family members (Beaton & Murphy, 1995; Gentry et al., 2004). In addition to the potential value of CF research relative to these groups, the research described in these manuscripts is also relevant to counseling and psychotherapy, social work, psychology, psychiatry, general medicine, and nursing.

Current Trends in Scientific Literature

CF is a complex concept that has been explored in academic literature since Joinson (1992) first introduced the term as a way to explain a caregiver-specific form of burnout she observed among nurses. Since that time, the mental healthcare field has become increasingly aware of the secondary effects that can occur when counselors and other mental health caregivers work with clients who are suffering or are in pain or trauma (Figley, 2002a; Figley, 2002c; Gentry, 2002; Killian, 2008; Kochevar, 2002; Munroe et al., 1995; Stebnicki, 2008; Showalter, 2010). Studying these secondary effects has increased in importance, in light of what theorists and researchers have referred to as a meta-paradigmatic shift related to increased trauma and stress in a post ‘9/11’ world, where global trauma and suffering are displayed in real-time in the media (Columbia

University Center for Journalism and Trauma, 2008; Figley, 2002a; Figley, 2002b, Stebnicki, 2008).

As part of a constellation of caregiver secondary symptoms, the term compassion fatigue is often used interchangeably in literature under the following terms: burnout, secondary traumatic stress, compassion stress, vicarious trauma, secondary traumatization, empathy fatigue, traumatoid states, and traumatic countertransference. The use of these terms, either singularly or synonymously, has been somewhat dependent upon the researcher and the discipline from which the researcher works. This condition has created conceptual and methodological inconsistency and a lack of semantic precision across the research in general (Collins & Long, 2003b; Devilly, Wright, & Varker, 2009; Najjar, David, Beck-Coon, & Doebbeling, 2009; Thomas & Wilson, 2004).

Rationale

While critical thinking and disagreement often enliven the research process, some researchers contend that the lack of unanimity regarding CF has been counterproductive in advancing research on CF across disciplines (Devilly et al., 2009). Further, the majority of peer-reviewed journal articles or scholarly books on CF are theoretical, opinion pieces, while a relatively few number are actually quantitative or qualitative published research (Collins & Long, 2003b; Sabo, 2011). It is no surprise, therefore, that almost all the reviewed literature calls for additional research (Devilly et al.; Figley, 2002a; Figley; 2002b; Figley, 2002c; Lonergan, O'Halloran, & Crane, 2004; Showalter, 2011).

The research exploring CF relative to counselor impairment, is still in its nascence (Stebnicki, 2008). CF as a construct has not yet been crystallized. However, the

multiplicity of anecdotal and illustrative case studies that have been published provide compelling evidence of secondary trauma reactions among mental health caregivers (Fahy, 2007; Bride & Figley, 2007; Collins & Long, 2003a; Stamm, 2005; Stebnicki).

However, the preponderance of scholarly literature exploring CF comes from the nursing and social work professions, while a minority of literature exists within the other mental health counseling disciplines, particularly professional or mental health counseling (Figley, 2002a; Figley, 2002b; Figley, 2002c; McHolm, 2006, Sabo, 2011). To my knowledge, following a thorough search of the literature, only one qualitative research study on the phenomenon of CF across professional mental health disciplines has been published. That particular study was conducted with licensed professionals who worked in a hospital setting only. The study did not include licensed mental health counselors, licensed professional counselors, or licensed marriage and family therapists and was not specific to recovery experiences or the creation of therapeutic resilience (Marriage & Marriage, 2005). Moreover, concerned over the premature loss of practitioners as a result of CF, Bride and Figley (2007) have proposed that additional research on CF ought to focus, not just on the etiology or negative aspects of CF, but also on recovery experiences that exposit strategies to create practitioner resilience. This paucity of literature elucidated in Chapter 2, links the need for the research elucidated in Chapter 3.

Indeed, an in-depth qualitative exploration into the experiences of mental health professionals who have encountered and navigated through CF fills the gap in existing literature. With that aim in mind, the grand research question was “What are the experiences of licensed mental health professionals who have encountered and navigated

through compassion fatigue?" Another rationale for studying a cross-section of these professional caregivers relative to CF is not just to augment the body of literature on CF, but also to provide maximum variation sampling to the qualitative data methodology. Indeed, studying the phenomena associated with CF across disciplines assists in balancing the academic literature elucidating CF.

CF is a complex phenomenon. The exploration of CF is appropriate for a study grounded in the data of individuals' experiences rather than exploring the parameters of terminology. The hope is that this exploratory and descriptive study, guided by the multifaceted and individualized experiences of licensed mental health professionals, will be a valuable addition to academic inquiry.

Organization

This dissertation is organized into two manuscripts (Chapters 2 and 3) which converge on the importance of adding to scientific inquiry through understanding and exploring CF as both an overarching construct as well as an individualized experience. In Chapter 2, a comprehensive literature review, I explore and discuss scholarly work which exists within current scientific literature around the topic of CF and its related constructs.

The second manuscript, Chapter 3, contains a research article. In Chapter 3, I provide a brief description of the qualitative analysis conducted. Chapter 3 also provides an overview of the theory which emerged attendant with the grand research question and the grounded theory analysis.

Chapter 4 provides general conclusions associated with both Chapters 2 and 3. Moreover, Chapter 4 discusses implications for application of the information to

supervision, counselor education, clinical practice, and continuing education models. Finally, Chapter 4 concludes with recommendations for future research.

Two other sections round out the remaining portion of the dissertation. These sections are comprised of a comprehensive bibliography, and a grouping of appendices. In keeping with the qualitative tradition of promoting trustworthiness of the results, the appendices are an ensample of both the broad and in-depth sampling of each part of the research analysis from inception through member checking.

CHAPTER II

A Review of the Literature on Compassion Fatigue and Related Constructs: Implications for Counseling, Counselor Education, and Supervision

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Abstract

The purpose of this manuscript is to explore the academic literature regarding compassion fatigue (CF) and its related constructs. CF is a complex construct associated with caregiver secondary stress reactions brought on by a nexus of factors. These potentially debilitating effects have been studied for some time under the constructs of burnout or countertransference. More recently, however, additional sequelae have been addressed in the broader context of professional literature described in a variety of terms. These terms are often used synonymously, but can vary depending upon the researcher or theorist and the discipline from which they work. As a result of varying terminology, some semantic confusion regarding CF exists within the literature. For the purposes of this content literature review, focusing on the prevailing terms of compassion fatigue, secondary traumatic stress, and vicarious trauma alleviates some confusion of terminology. Compassion fatigue, secondary traumatic stress, and vicarious trauma are often used interchangeably; whereas, countertransference and burnout are seen as both distinct from and yet synergistic with compassion fatigue. These constructs, and the constellation of responses they represent, are explored and synthesized in the review. The final purpose of the review is to identify implications for counselors-in-training, counselor education, supervision, and clinical practice.

Introduction

> For there is nothing heavier than compassion. Not even one's own pain weighs so heavy as the pain one feels for someone, for someone, pain intensified by the imagination and prolonged by a hundred echoes.
>
> (Kundera, 1999, p.31)

Anyone who functions in a caregiving role, either professionally or non-professionally, is at risk for a developing secondary or vicarious caregiver distress, often referred to as compassion fatigue (Boscarino, Figley, & Adams, 2004; Bride & Figley, 2007; Endicott, 2006; Figley, 1995a; Gentry, 2002; Figley, 2003; Figley, 2002a; Radey & Figley, 2007; Rothschild & Rand, 2006; Sabin-Farrell & Turpin, 2003; Showalter, 2011; Showalter, 2010; Stebnicki, 2008; Thompson, 2003; Yassen, 1995; Zimering, Munroe, & Gulliver, 2003). Mental health professionals, particularly, are exposed to parts and pieces of client/patient stories of pain, loss, grief, addiction, trauma, and suffering. These professionals have the risk of absorbing the pain of those with whom they work. This risk increases with professionals and clinicians who possess a high degree of empathic sensitivity, intuitiveness, and engagement (Abendroth & Flannery, 2006; Baker, 2003; Sabo, 2011; Sexton, 1999; Stebnicki, 2000; van Minnen & Keijsers, 2000). Indeed, the process of being compassionate and empathic catalyzes what many theorists and researchers have identified as symptoms that exhibit emotional, physical, mental, social, and spiritual debilitation in both professional and non-professional caregivers exposed to the suffering and trauma of others (Barnett, Baker, Elman, & Shoener, 2007; Becvar, 2003; Bodnar & Keicolt-Glaser, 1994; DiScala, 2008; Ducharme, Knudsen & Roman, 2008; Figley, 1995a; Figley, 1995b; Figley, 2002a). “The cost of caring,” a phrase first coined by Figley, is a description for this phenomenon that other researchers have identified as a potential hazard of being in a helping role. The phenomenon parallels the

signs of primary post-traumatic stress. In the case of counselors and other allied professionals and non-professionals, these signs are secondary or even tertiary responses from working with individuals in primary distress (Adams, Boscarino, & Figley, 2006; Cerney, 1995; Collins & Long, 2003b; Devilly, Wright, & Varker, 2009; Dutton & Rubenstein, 1995).

The therapeutic setting, even with professional boundaries applied, does not insulate the practitioner from these intense emotional effects (Collins & Long, 2003a). Interestingly, individuals with the above described empathic qualities are often attracted to the extensive field of mental health (Figley, 2002a; Figley, 2002b; Killian, 2008; Linley, 2003; Lonergan, O'Halloran, & Crane, 2004). Yet, in an effort to view the world from the perspective of their suffering clients, they may also suffer the effects of such work (Lipsky & Burk, 2009; Stebnicki, 2008). These potentially debilitating effects have been studied for some time under the constructs of burnout or countertransference. More recently, however, additional sequelae have been addressed in the broader context of professional literature under the terms of burnout, countertransference, vicarious trauma, vicarious traumatization, secondary stress, secondary traumatic stress, compassion fatigue, compassion stress, traumatoid states, and empathy fatigue. These terms are often used synonymously, but can vary depending upon the researcher or theorist and the discipline from which they work (Abendroth & Flannery, 2006; Adams et al., 2006; Bober & Regher; 2006; Bride & Figley, 2007; Endicott, 2006; Figley, 1995a; Figley, 2002a; Figley, 2003; Gentry, 2002; Jenkins & Baird, 2002; Radey & Figley, 2007; Rothschild & Rand, 2006; Sabin-Farrell & Turpin, 2003; Showalter, 2010; Showalter, 2011; Stebnicki, 2008; Thompson, 2003; Yassen, 1995; Zimering et al., 2003). This lack

of semantic clarity has caused some confusion and controversy within the research process (Sabo, 2011).

For the purposes of this content literature review, focusing on the prevailing terms of compassion fatigue, secondary traumatic stress, and vicarious trauma alleviates some confusion of terminology. Compassion fatigue, secondary traumatic stress, and vicarious trauma are often used interchangeably; whereas, countertransference and burnout are seen as both distinct from and yet synergistic with compassion fatigue (Figley, 1995a; Collins & Long, 2003a; Stebnicki, 2008). All of these concepts are part of the compassion fatigue spectrum. Regardless of terminology, the majority of theorists and researchers acknowledge that a constellation of professional and lay secondary stress reactions exist that are disquieting. These deleterious signs require attention and attenuation. This attention has concentrated on attempting to determine the identification, causes, and potential amelioration of associated symptoms of the compassion fatigue spectrum, symptoms that may range from mild to severe (Figley, 1995a; Figley, 2002a; Figley 2002b; Figley, 2007 Gentry, Baggerly & Baranowsky, 2004; McHolm, 2006; Najjar, David, Beck-Coon, & Doebbeling, 2009; Showalter, 2010; Showalter, 2011; van Minnen & Keijsers, 2000).

Rationale

Ironically, those professionals who are passionate about their work are inevitably affected by its effects. However, mental health professionals who are able to become aware of potential hazards—compassion fatigue spectrum symptoms—adopting a passionate stance of resilience, professional development, and professional flexibility are less likely to be affected (Barnett et al., 2007; Bonanno, 2004; Collins & Long, 2003b;

Dlugos & Friedlander, 2001; Ducharme, Knudsen, & Roman, 2008; Gentry et al., 2004; Killian, 2008; Lawson & Myers, 2011; Linley, 2003; Linley & Joseph, 2007; Moran, 2002; Munroe et al., 1995; Osborn, 2004; Wicks, 2008). The terms passion and compassion come from the same philological roots and are inextricably linked. Compassion is defined as deep awareness of the suffering of another coupled with the wish to relieve it. Passion is defined as strong and intense emotion for something (Merriam-Webster, 2005).

These definitions are partial descriptions of the work of professional mental health caregiving—a work that is critically important. In truth, the importance of this work is significant, particularly in light of the present day stressors that exist in a 'post 9/11' world where natural disasters, human suffering, social injustice, poverty, abuse, loss of life, and psychological and physical grief appear to be accelerating and are played out in real-time on television, the Internet, and other forms of media (Adams et al., 2006; Adams, Figley, & Boscarino, 2004; Baranowski, 2002; Boscarino et al., 2004; Campbell, 2007; Figley, 2002a; Jenkins & Baird, 2002; Pilar, Gangsei, & Engstrom, 2007; Roberts, Flannelly, Weaver, & Figley, 2003). In fact, many academic theorists and researchers point to a 'post 9/11' world as having experienced a paradigmatic shift into greater perceptions of cultural stress, danger, and trauma (Naturale, 2007; Pulido, 2007; Racanelli, 2005; Stebnicki, 2008, Wee & Meyers, 2002).

A plethora of literature elucidates the phenomenon of compassion fatigue existing among crisis and trauma workers who work directly with primary victims of these traumata. Recently, some authors of extant literature have also suggested that symptoms of secondary traumatic stress, vicarious trauma, and compassion fatigue exist among

practitioners who work with a variety of mental health problems such as depression, anxiety, substance abuse, and relational issues (Benoit, Veach, and LeRoy, 2007; DiScala, 2008; Endicott, 2006; Fahy, 2007; Gentry, Baranowsky, & Dunning, 2002; Linley & Joseph, 2007; McLean, Wade & Encel, 2003; Radey & Figley, 2007; Rothschild & Rand, 2006; Sabo, 2011; Showalter, 2011; Southern, 2007; Stebnicki, 2008; Udipi, Veach, Kao, & LeRoy, 2008). Though research in the area of compassion fatigue as a phenomenon which exists across mental health disciplines is in its nascence, compassion fatigue, as a phenomenon, appears not to be isolated to just those professionals who work in crisis response or with trauma. Perhaps this shift is emerging because of the previously mentioned shift within the culture. Other theorists speculate the shift may be due to increasing work demands upon mental health caregivers as mental health systems move towards managed care and interdisciplinary teams (Sabo, 2011; Showalter, 2011; Stebnicki, 2008).

Undoubtedly, the challenges that are faced by professional caregivers are complex, varied, and unique depending on context, clients, and personal circumstances. However, compassion fatigue is not unique to one branch of caregivers and "is prevalent across all spectrums of the helping professions and is flourishing" (Showalter, 2010, p. 239). In this light, the effects of compassion fatigue on the mental health professions could be critical for both clinician and client alike, highlighting the need for ongoing clinical training and supervision. These issues have led some professional associations to call for identification and training to foster awareness and prevention of compassion fatigue responses. The American Counseling Association (ACA, 2005), which has focused attention on professional well-being and personal growth of counselors, has also

recognized debilitating patterns of compassion fatigue as a form of counselor impairment (ACA, 2010). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) guidelines also point to an orientation of counselor wellness and prevention. Training and supervision may increase this awareness and contribute to the attenuation of compassion fatigue and vicarious trauma. This awareness is important for both experienced counselors and counselor trainees (Sommer, 2008; Sommer & Cox, 2005; Walker, 2004; Yager &Tovar-Blank, 2007). Moreover, training and supervision specific to the compassion fatigue spectrum could lead to greater professional growth and higher professional functioning among the mental health professions in general. Such a scenario translates to increased potential for facilitating client well-being and healing.

Objectives

The purpose of this manuscript is to explore the construct of compassion fatigue and the literature relevant to the experiences of mental health professionals who have encountered, modulated, or recovered from it. Bride and Figley (2007) have lamented the loss of caring and sensitive licensed mental health professionals because of a lack of awareness regarding compassion fatigue, secondary traumatic stress, and vicarious trauma. The hope is that promoting and elucidating ways in which to foster greater awareness of compassion fatigue will assist in creating a broader dialogue across disciplines regarding the risks and implications inherent in the compassion fatigue spectrum. By adding to the body of knowledge on compassion fatigue, greater professional growth and development among licensed mental health professionals may be potentiated. In order to understand this process, the literature review explores the topic of compassion fatigue, addressing research and theoretical concepts, constructs, and

controversies related to it. Exploring the history and trends of all the concepts associated with compassion fatigue will assist in gaining greater understanding of how the research and theory development of secondary fatigue reactions, including compassion fatigue, continue to evolve.

This article reviews the prevalence of compassion fatigue and its associated secondary fatigue reactions. Moreover, the aim of this article is to identify who may be at risk for developing compassion fatigue, highlighting the potential causes, delineating the signs and symptoms, discussing how is it measured, and briefly discoursing on potential strategies for attenuation of and management of it. Additionally, the review confirms the need for counselor education, training, and supervision specific to addressing the problems inherent in the compassion fatigue spectrum. Throughout the review, the thread of historical and directional trends inherent in the theoretical development and research of compassion fatigue are noted.

Search Methodology

In preparing for this review, five electronic databases were utilized for searching academic literature pertinent to the theory and research of compassion fatigue. Three databases were explored first, including ProQuest, PsychArticles, and ERIC, utilizing the following search terms: compassion fatigue, compassion stress, compassion fatigue recovery, compassion fatigue research, burnout, vicarious trauma, vicarious traumatization, countertransference, empathy, compassion satisfaction, resilience, counselor impairment, and counselor wellness. A thorough search of abstracts resulted in a parsing out of approximately 80 journal articles and 18 scholarly books. Searching the following electronic Internet sites provided additional access to articles incorporating the

above delineated search terms: The National Institutes of Health (www.nih.gov), The International Society of Traumatic Stress Studies (www.istss.org), Gift From Within (www.giftfromwithin.org), and The Compassion Fatigue Awareness Project (www.compassionfatigue.org). These sites revealed additional titles for peer-reviewed journal articles salient to the reviewed topic of compassion fatigue and its associated concepts. The fourth database then used was A-Z online journal titles, which generated the abstracts for the additional journal article search. Approximately 60 more journal articles were chosen to review. All the journal articles were cross-referenced and short reports were eliminated. The cross-referencing also enabled an elimination of duplicative or outdated articles, resulting in approximately 80 journal articles and books being annotated. This annotation was deemed necessary in order to flesh out trends and themes within the literature. Finally, the fifth database searched was Digital Dissertations and Theses. This search facilitated a greater understanding of the thrust, amplitude, and trajectory of emerging academic literature on compassion fatigue.

A Review of the Literature

Authors of current literature on compassion fatigue theorize about the etiology of this phenomenon, but defining and delineating the constructs associated with compassion fatigue has been a more difficult process (Devilly et al., 2009; Figley, 2002a; Figley, 2002b; Gentry, 2002; Sabo, 2011; van Minnen & Keijsers, 2000). Moreover, debate in the literature exists as to whether the phenomena of compassion fatigue, the compassion fatigue spectrum, and other associated caregivers' vicarious reactions are singular and separate events or accumulative and concomitant in nature. Some researchers have gone so far as to report that compassion fatigue is not a separate construct from burnout and

that the use of the term represents an iatrogenic tipping point rather than an actual set of symptoms or conditions (Devilly et al., 2009). As a result, the specific terms of countertransference, burnout, secondary traumatic stress, compassion fatigue, empathy fatigue, and vicarious traumatization are often used interchangeably by some researchers and exclusively by others.

A concept review of the most recent literature indicates a trend towards looking at all of these constructs and concepts as a set of secondary fatigue reactions or symptoms, not just as a constellation, but on a continuum with the lesser reactions being transitory and the more extreme reactions creating permanent changes in cognitive schema of the caregiver (McHolm, 2006; Najjar et al., 2009; Sabo, 2011). At the very least, researchers who once posited that each construct described a definite and specific set of symptoms are now suggesting that symptoms overlap with one another and may be a symbiotic constellation of caregiver responses (Collins & Long, 2003b; Gentry, 2002; James, 2008; Salston & Figley, 2003; Showalter, 2010; Showalter, 2011; Sprang, Clark, & Whitt-Woosley, 2007; Stebnicki, 2000). An elucidation of the above mentioned constructs is occurring more fully in existing literature and is salient to this particular review. Although the emphasis of this article is placed on compassion fatigue, overviewing and defining the other aforementioned constructs assists in crystallizing a conceptualization of what compassion fatigue is and is not.

Elucidating Constructs and Concepts Associated With Compassion Fatigue

Countertransference. The concept of countertransference, a form of potential professional impairment, is associated with current discussions of compassion fatigue, is the oldest of the professional caregiver secondary reactions to be addressed in academic

literature. The idea of countertransference began to appear in scientific literature in the early 20th century, particularly in the writings of Jung and Freud. Freud described this concept as an indicator of unresolved cognitions and emotions directly related to specific issues (Corey, 2009). Additionally Jung posited that countertransference could be seen as either helpful or injurious to the therapeutic relationship depending upon the ego strength and clinical expertise of the therapist involved (Salston & Figley, 2003).

Authors of recent scientific literature suggest that a form of countertransference experienced by a counselor or allied professional can imitate the symptomatology of the client. In this sense, the classic view of countertransference is more specifically identified as traumatic or secondary countertransference where the caregiver unconsciously absorbs the client's story and suffering leading to secondary fatigue reactions (Figley, 2002a; Pearlman & Saakvitne,1995a; Salston & Figley; Rothschild & Rand, 2006). This form of countertransference mimics the signs of primary posttraumatic stress disorder (PTSD) (Gentry, 2002; Pearlman & Saakvitne, 1995a). However, some theorists propose that traumatic countertransference has more to do with unresolved issues from the professional than empathic attunement from the professional—a more indicative context for compassion fatigue and secondary stress reactions (Stebnicki, 2008). Others acknowledge, however, that countertransference and traumatic countertransference may be precursors to, or concomitant with, compassion fatigue, vicarious trauma, and burnout (Collins & Long, 2003a; Figley, 2002c; Trippany, White-Kress, & Wilcoxon, 2004). Unlike the other constructs mentioned in this review, traumatic countertransference has not been recently studied as a stand-alone concept, but rather in conjunction with the other secondary fatigue reactions previously discussed (Iliffe, 2000).

Burnout and its relationship to compassion fatigue. Of all the constructs mentioned in this review, burnout has received the greatest attention in academic literature. Thousands of scholarly articles and books have been generated on this topic in the last fifteen years (Bride & Figley, 2007; Gentry, 2002). Within the context of the mental health professions, burnout was first noted in the literature beginning in the late 1970's (Figley, 2002a). Burnout, as such, is a fairly stable topic in the research by definition and etiology and is often measured psychometrically using the *Maslach Burnout Inventory* (Maslach & Jackson, 1981).

Merriam-Webster (2005) defines burnout as the "exhaustion of physical or emotional strength or motivation, usually as a result of prolonged stress or frustration." Others have augmented that definition. For example, in the context of mental health professionals, Figley (2002c) describes burnout as a state of fatigue brought about by a nexus of factors; including temporal issues, monetary compensation, caseload size, organizational problems, paperwork, lack of agency support, and failed expectations. In the ACA (2005) definitions section, burnout is described as "a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations" (¶ 8). Gentry (2002) further defines burnout as a chronic condition in which the mental health professionals' perceptions of demands within the psychotherapeutic milieu outweigh their perceived resources.

Authors of extant literature have conceptualized burnout in several different ways. In their study, Devilly et al. (2009) assert that work overload, limited support systems, and role conflict within the professional realm are burnout's chief prevenients. Much of academic literature distills burnout into three striking elements: emotional and

physical exhaustion, depersonalization, and reduced personal accomplish (Ackerly, Burnell, Holden & Kurdek,1988; Sabo, 2011). Stebnicki (2008) adds that burnout is also mental and spiritual exhaustion, identifying these as antecedents of negative feelings about work and co-workers, clients, and the self of the therapist. Such inter- and intra-psychic dissonance may compromise professional well-being and satisfaction. Perhaps of greater concern is the denouement of clinical effectiveness and objectivity proportionate with burnout, issues that compromise clients' mental health and well-being.

This potential clinical deficit is particularly concerning because some theorists and researchers declare that less experienced mental health professionals are more vulnerable to burnout and more prone to harm clients as a result. Such findings illustrate the need for increasing training among counselor trainees (Collins & Long, 2003a; Collins & Long, 2003b; Frank & Adkison, 2007; McHolm, 2006; Ramey & Leibert, 2011). Weiss (2004) suggests that less experienced mental health professionals begin their work with enthusiasm, idealism, and perceived expectations, but may fall prey to a loss of those expectations due to insufficient supervision and support. Weiss's four other stages of burnout illustrate this continuum in which enthusiasm is replaced by stagnation and an abatement of idealism. This diminution is followed by frustration, anger, and feelings of being overwhelmed or disappointed. Dissatisfaction with a loss of expectations leads to a sense of powerlessness. The final stage of caregiver burnout is described as depersonalization and apathy typified by numbness, becoming robotic, or going through the motions.

Although seasoned mental health professionals can experience burnout as well (Figley, 2002c; Zimering et al., 2003), it is surprising that more studies do not indicate a

greater prevalence of burnout in more experienced clinicians. Authors of relevant literature cite this statistic as the lamentable manifestation of attrition and professional dropout from those untrained or unaware of burnout or compassion fatigue risks and how to avoid them (Collins & Long, 2003b; Figley, 1995a; Figley, 1995b; Figley, 2002a; Figley, 2002b; Figley, 2002c; Frank & Adkinson, 2007). Further, those that are passionate about their work experience less burnout because they have developed resilience and pliability, often because of positive training and supervisory experiences (Barnett et al., 2007; Bonanno, 2004; Collins & Long; Dlugos & Friedlander; 2001; Ducharme et al., 2008; Gentry et al., 2004; Killian, 2008; Lawson & Myers, 2011; Linley, 2003; Linley & Joseph, 2007; Munroe et al., 1995; Osborn, 2004; Wicks, 2008). All of these ideas underscore the need for appropriate and adequate ongoing supervision and training for mental health professionals in general. Indeed, while trainee enthusiasm is important and laudable, several authors contend that counselors and allied professionals in training who are unschooled in the realities of the profession and its potential hazards run the risk of hurting themselves and their clients as they experience burnout indicators on a continuum from a few bad days to de-compensation (Linley & Joseph, 2007; Lipsky & Burk, 2009; Osborn, 2004; Roach & Young, 2007; Rothschild & Rand, 2006).

Highlighting the need for supervision and training. The ability for mental health professionals, in any phase of their professional life, to grow, change, and adapt in order to inoculate against burnout and compassion fatigue, is critical. This ability is fostered through a supportive environment of curiosity, awareness, and ongoing dialogue associated with counselor growth and well-being, clinical support, and continued

supervision and training (Barnett et al., 2007; Bonanno, 2004; Collins & Long, 2003a; Collins & Long, 2003b; Dlugos & Friedlander; 2001; Ducharme et al., 2008; Gentry et al., 2004; Killian, 2008; Lawson & Myers, 2011; Linley, 2003; Linley & Joseph, 2007; Moran, 2002; Munroe et al., 1995; Osborn, 2004; Sommer, 2008; Sommer & Cox, 2005; Wicks, 2008). Such fostered resilience and growth potentiation is important to consider in identifying ways in which burnout coalesces with compassion fatigue, the recovery from which also requires similar professional characteristics of training and supervision (Sommer; Sommer & Cox; Showalter, 2010; Walker, 2004).

Compassion fatigue and burnout as interrelated phenomena. Burnout and compassion fatigue are neither conceptually redundant nor mutually exclusive (Gentry, 2002; Stamm, 2002). Burnout has both distinctions from, and confluence with, compassion fatigue. In fact, one of the distinctions that can be made between burnout and compassion fatigue exists in the context of work (Ackerly et al. 1988; Collins & Long, 2003b). Undoubtedly, burnout can occur in the helping professions due to lack of institutional or agency support, isolation, monetary compensation, boredom, cynicism, or work load (Figley, 2002c). Nevertheless, the three critical elements inherent in burnout, namely, emotional and/or physical exhaustion, depersonalization, and reduced personal accomplishment, are not specifically inherent in the caregiving professions, but can potentiate in any profession (Ducharme et al., 2008). Burnout is related to work circumstances rather than relational interactions, as is the case with compassion fatigue. Although burnout may be considered a part of the constellation of compassion fatigue symptoms, compassion fatigue is also more caregiver specific and is commensurate with empathic attunement and exposure to clients' suffering and trauma (Gentry; Pearlman

and Saakvitne, 1995a). Moreover, burnout is considered a gradual and insidious process that exists on a continuum with each stage of the continuum related to intensity, frequency, and duration of stressors (Ackerly et al. 1988; Wicks, 2008) Whereas, compassion fatigue may be, similarly, accumulative in nature, but can also occur suddenly, even with one clinical case (Figley, 1995b; Figley, 2002a; Figley, 2002b; Maytum, Heiman, & Garwick, 2004). Showalter (2011) describes burnout as the worker developing a dislike for work and a desire not to do the work. Whereas, compassion fatigue exists in an affective and relational plane in which the caregiver enjoys their work, but has reduced mental or emotional energy left to accomplish it.

In light of mental health professionals' susceptibility to both burnout and compassion fatigue, it is important to examine burnout carefully in relation to compassion fatigue. Initially, the former trend in literature was to define compassion fatigue as behaviorally distinct from burnout (Figley, 1995a; Figley, 1995b; Pearlman & Saakvitne, 1995b; Stamm, 2002; Thompson, 2003). While some researchers claim that no difference exists in the constructs of burnout and compassion fatigue (Devilly et al., 2009; van Minnen & Keijsers, 2000), many researchers and theorists contend that burnout may be distinct from compassion fatigue and yet also a precursor to, or outgrowth of, compassion fatigue (Kochevar, 2002; Rupert & Morgan, 2005; Steed & Bicknell, 2001). Recently, theorists and researchers have indicated that compassion fatigue is a caregiver-specific form of burnout with both corresponding and distinctively augmented features related specifically to vicarious stress reactions that are exacerbated by burnout (Figley, 2002c; Showalter, 2011, Zimering et al., 2003). Baird and Jenkins (2003) propose a specific model in which secondary traumatic stress, a secondary

condition similar to PTSD or PTSS, coupled with burnout leads to compassion fatigue. Gentry (2002) goes one step further in indicating that compassion fatigue may be a combination of primary stress, secondary stress, and burnout.

In any case, the prevailing theoretical trends in the literature supports a synergism between burnout, primary and secondary stress of the caregiver, and compassion fatigue with one or more of these phenomena diminishing caregiver resilience (Gentry, 2002; Gentry et al., 2002). A lack of resilience in one or more of the above phenomena evinces a lower threshold for coping with either of the others (Gentry et al.; Kochevar, 2002). Gentry et al. provide some of the only research that goes beyond theorizing, seeking to clarify the relationship between compassion fatigue and burnout. Devilly et al. (2009) and Sabo (2011) emphasize that the dearth of research weakens the ability to understand how any of these secondary stress reactions may be prevented or recovered from.

Some researchers have reported that burnout catalyzes physiological changes in the Autonomic Nervous System (ANS) creating a pattern of sympathetic nervous system dominance in the caregiver . This contention supports the idea that these secondary reactions exist on a continuum, paralleled by ANS responses of fight, flight, or freeze, with fight being more temporary frustration, flight being depersonalization, and freeze pointing to the numbing effects of chronic burnout responses.

In this respect, burnout and compassion fatigue have the strongest convergence. Compassion fatigue also catalyzes ANS sympathetic dominance in much the same way (Gentry, 2011; Killian, 2008; Rothschild & Rand, 2006; Showalter, 2011). However, compassion fatigue also has striking distinctions from burnout having do to with augmented ANS symptomatology associated with hyper-arousal, avoidance, or intrusive

symptoms—symptoms that are more intense than those of burnout . On a positive note, burnout is considered preventable and compassion fatigue remediable (Sabo, 2011). This idea stresses the importance of exploring what professionals across disciplines have experienced, including both affective and physiological changes during the remediation process.

Compassion Fatigue

Authors of studies and published research of compassion fatigue have professed that remediation goal—the attenuation and modulation of compassion fatigue with its associated stress reactions (Figley, 2002a; Figley, 2002b). Researchers and theorists have hoped to accomplish this by defining the phenomenon and exploring its etiology: discovering how to measure it, understanding who is at risk for developing it, and detailing the symptoms of it (Adams et al., 2004; Adams & Riggs, 2008; Baranowsky, 2002; Barnett et al., 2007; Beaton & Murphy, 1995; Bober & Regehr, 2006; Boscarino et al., 2004; Bride & Figley, 2007; Cerney, 1995; Endicott, 2006; Figley,1995a; Gentry et al., 2004; Jenkins & Baird, 2002; Lynch, 1999; McHolm, 2006; Munroe et al., 1995).

Historical and theoretical underpinnings of compassion fatigue. Joinson (1992) was the first researcher to posit that compassion fatigue, a term that she originated, was a caregiver specific phenomenon. Joinson's work came from the field of nursing, the extension of which has been a plethora of subsequent theoretical literature on compassion fatigue generated by the nursing and social work professions (Sabo, 2011). By comparison, research studies have been sporadic and discipline specific with only a few notable exceptions.

The Etiology of Compassion Fatigue. The theoretical underpinning of compassion fatigue comes from the field of traumatology and is an outgrowth of changes to the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III*; American Psychiatric Association, 1980) (APA, 1980) regarding PTSD and secondary traumatic stress. An overarching definition of compassion fatigue is described as a secondary stress reaction from helping, or desiring to help, a person who is suffering (Figley, 2002a). The definition and etiology of compassion fatigue were originally developed through the work of Figley and his associates. Figley first compared the criteria of PTSD with secondary traumatic stress. He posited that secondary traumatic stress reactions can sometimes emerge without advanced notice, creating confusion and a sense of helplessness in the caregiver—similar to PTSD (Figley, 1995a; Gentry, 2002; Rothschild & Rand, 2006). Theorists began to label these reactions as synonymous with compassion fatigue and vicarious trauma (Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). Compassion fatigue is conceptualized as escalating events including exposure to clients' traumata either singularly or over time. Additionally, compassion fatigue is the residual and absorbed stress from the client to the caregiver coupled with the caregivers' past history of personal trauma—catalyzed by uncontrolled empathy (Rothschild & Rand, 2006, Stebnicki, 2008; Sabin-Farrell & Turpin, 2003). Pearlman & McIan (1995) describe this process as a "transformation that occurs with the therapist [or other helping professional] as a result of empathic engagement with clients' trauma," or suffering (p. 558). They further describe this process as absorbing clients' mental and emotional toxicity. Figley (2002a) describes compassion fatigue as a constellation of sequelae associated with empathic ability, primary experiences of the sufferer, and the

inability for the caregiver to find relief or a sense of satisfaction in the helping process. Figley (2002c) enlarged this former etiological model to include empathic ability, empathic concern, exposure to traumata, empathic responsiveness, compassion stress, prolonged exposure, traumatic recollections, and life disruptions—all of which lead to a set of deleterious reactions on the part of the caregiver.

Proponents of compassion fatigue research in the 1990s devised assessment instruments in an effort to measure compassion fatigue symptoms. These instruments include the *Compassion Fatigue Self-Test* (CFST), the *Compassion Satisfaction and Fatigue Test* (CSFT), and the *Compassion Fatigue Scale* (CFS) (Bride, Radey, & Figley, 2007). More recently, Stamm (2005) has devised a manualized instrument, the *Professional Quality of Life Scale* (ProQOL), to measure symptoms of compassion fatigue. The ProQOL, which utilizes a combination of scales incorporating primary and secondary stress as well as apperceptions of quality of life, continues to be developed and used in some quantitative studies (Injeyan et al., 2011). While most researchers applaud the efforts to develop instrumentation to measure compassion fatigue, the concern lingers that individual clinicians during their most heightened distress remain silent regarding their compassion fatigue symptoms (Adams & Riggs, 2008; Boyle, 2011).

Symptoms of compassion fatigue. For some time, the literature evoked disagreement as to whether the onset of compassion fatigue in caregivers occurred suddenly or gradually and accumulatively (Collins & Long, 2003b; Figley, 1995a; Figley, 2002a; Figley, 2002b; Jenkins & Baird, 2002; Salston & Figley, 2003; Stamm, 1999). Presently, researchers opine that the onset can occur either way (Ortlepp & Friedman, 2002; Gentry, 2011;Gentry, 2002; Stebnicki, 2010). Until recently, compassion fatigue

research has mainly been comprised of hundreds of case studies of crisis and trauma therapists. These case studies were mostly reported anecdotally and illustratively, but were instrumental in helping to develop a conceptualization of compassion fatigue signs and symptoms, including the onset of those symptoms (Baranowsky, 2002; Becvar, 2003; Campbell, 2007; Cerney, 1995; Dutton & Rubinstein, 1995; Meyers & Cornille, 2002; Naturale, 2007; Pulido,2007; Simon, Pryce, Roff, & Klemmack, 2006; Smith, 2007; Ward-Griffin, St.-Amant, & Brown, 2011).

Symptoms of compassion fatigue may include the aforementioned symptoms of burnout, augmented by indicators that mirror posttraumatic stress symptomatology (De Vente, Emmelkamp, Kamphuis, Van Amsterdam, & Olff, 2003; Figley, 2002a; Gentry, 2002; Rothschild & Rand, 2006; Showalter, 2011). Arousal symptoms include increased anxiety, increased perception of threats to safety, increased anger, sleep disturbances, and restlessness. Intrusive symptoms include thoughts and images associated with client suffering, obsessive and/or compulsive desires to help certain clients, the inability to disengage with work related issues during leisure time, thoughts of inadequacy, and a sense of ‘specialness’ or ‘giftedness’ in the role of caregiver. Avoidant symptoms include the silencing response to clients, mild to severe anhedonia, depression, loss of energy, a sense of dread, isolation, intimacy problems, a perception of loss of control, and loss of spirituality as an emotional anchor (Becvar, 2003; Devilly et al., 2009; Showalter, 2011; Sabo, 2011; Zimering et al., 2003). Loss of spirituality is indicative of an inability to create meaning from personal or client experiences (Dlugos & Friedlander, 2001; Linley, 2003). This inability to create meaning or meaningfulness within the counseling context heightens the risk of developing compassion fatigue (Sprang, Clark, & Whitt-Woosley,

2007). Conversely, the ability to create meaning out of the ambiguity that often accompanies mental health work may be one of the ways in which compassion fatigue is overcome (Showalter, 2011; Gentry, 2011).

Vicarious trauma symptoms relative to compassion fatigue. Mental health counselors and allied professionals who primarily engage in crisis intervention, or who work with traumatized children, are at the greatest risk for developing some kind of secondary traumatic response (Najjar et al., 2009; Pearlman & Saakvitne, 1995b; Racanelli, 2005; Wee & Meyers, 2002). This group of professional caregivers carries the greatest risk for developing a severe form of secondary traumatic stress responses known as vicarious trauma. Vicarious trauma is part of the compassion fatigue spectrum, but is distinguishable from the other reactions because it creates permanent changes in the cognitive schemata of caregivers. The risk for vicarious trauma increases with intensity, frequency, and duration of traumatic exposure and a lack of adequate trauma training and supervision (Sommer, 2008).

Risk factors for developing compassion fatigue. As specified at the beginning of this review, compassion fatigue risk is inherent in anyone who functions in a caregiving capacity professionally or non-professionally (Ortlepp & Friedman, 2002). The compassion fatigue spectrum is not discriminate. Family members of those individuals who have experienced primary trauma are at risk for secondary traumatic stress or symptoms associated with the compassion fatigue spectrum. Their therapists or other allied professionals are then at risk for a tertiary traumatic response. (Abendroth & Flannery, 2006; Baranowsky, 2002; Bodnar & Kiecolt-Glaser, 1994; Boscarino et al., 2004; Lonergan et al., 2004). In truth, wherever a circumstance arises that adds a

dimension of care to current professional and personal responsibilities, compassion fatigue risk exists (Stebnicki, 2008, Showalter, 2010). Thus far, the research shows no correlation between the development of compassion fatigue and demographics (Stebnicki, 2008; Udipi et al., 2008; Yildirim, 2008).

The risk for developing distress associated with the compassion fatigue spectrum increases with mental health professionals who carry unresolved trauma (Gentry et al., 2004; Macran, Stiles, & Smith, 1999; Meyers & Cornille, 2002). Professionals who have unrealistic expectations, have a tendency towards pragmatic or perfectionistic thinking, or tend to exhibit self-sacrificing behaviors are at risk (Adams & Riggs, 2008). Stebnicki (2008), who has labeled the compassion fatigue spectrum as 'empathy fatigue,' makes an argument that clinicians with a two-person psychology clinical orientation exhibit greater risk factors than clinicians who practice other forms of psychotherapy such as cognitive-behavioral therapy. Similarly, clinicians whose clinical orientation is influenced by transpersonal psychology, which emphasizes empathic attunement and understanding the world of the other, are working in a clinical context associated with risk for secondary traumatic stress and compassion fatigue development (Stebnicki).

Empathy in relation to compassion fatigue. The concept of empathy and its relationship to the compassion fatigue spectrum evinces a paradox (Sabo, 2011). Most theorists and researchers assert that empathy is a necessary component in producing positive therapeutic outcomes, and yet empathy is also the pathway to catalyzing compassion fatigue (Figley, 2002a; Stebnicki, 2008; Showalter, 2011). Sabo contends that empathy ought to be a fulfilling, growth potentiating emotion, yet empathy can also evince a secondary traumatic response that the mental health professional may attempt to

suppress, constituting an empathic failure on the part of the therapist (Adams & Riggs, 2008). Empathic failure then leads to a sense of personal inadequacy and self-criticism, which may in turn catalyze a shame response (Brown, 2009). This response then repeats the potential cycle of avoidance and empathic failure. Rothschild and Rand (2006) illuminate a possible ameliorating solution. Classifying empathy as either automatic and uncontrolled or controlled, Rothschild and Rand argue for the clinical development of controlled empathy as one way to modulate the symptoms associated with the compassion fatigue spectrum. They further discuss that uncontrolled empathy is as dangerous as it is effortless in the unskilled or unaware professional caregiver. On the other hand, controlled empathy requires practice, skill, and the ability to engage with the client during therapy and healthily disengage at its conclusion.

Achieving Professional Growth and Resilience through Overcoming Compassion Fatigue Distress

This process of engaging and disengaging, Rothschild and Rand (2006) conclude, is one of the steps in attenuating compassion fatigue and vicarious trauma, thus fostering therapeutic resilience. Therapeutic resilience, in turn, becomes an antidote to compassion fatigue (Abendroth & Flannery, 2006; Fahy, 2007; Lawson & Myers, 2011; Lonergan et al., 2004; Ortlepp & Friedman, 2002). In fact, Skovholt (2001) emphasizes this point in observing "in counseling, therapy, teaching, and healing, we constantly must first feel for the other, be involved, then separate—being able to feel for, be involved with, and then [healthily] separate from person after person in a highly effective, competent useful way" is the key to healthy engagement and disengagement (p. 13). Thus, part of developing the skill of resilience in professional caregiving is striking a balance between practicing

empathic attunement toward the client in need while maintaining self-awareness and attunement towards one's own intra-psychic and corporeal responses (Gentry, 2011).

These thoughts raise the question of whether mitigation of compassion fatigue is engendered through mental and affective exertion and skill building or through leisure and self-care or through both. Some researchers and theorists suggest that self-care is an antidote for burnout, but not for compassion fatigue (McLean et al., 2003; Yildirim, 2008). Bober and Regehr (2006) give credence to this distinction, citing their study as an example of leisure time and compassion fatigue symptoms having no negative correlation. Osborn (2004) proposes a balance of leisure time and affective resilience as deterrents to both burnout and secondary traumatic stress, further suggesting that this affective resilience may be the most important deterrent to developing caregiver symptoms associated with the compassion fatigue spectrum

Discussion

Authors of literature across professional disciplines have called for additional research to study and identify ways to foster greater understanding of how to recognize and prevent counselor impairment, including the experience of compassion fatigue and its associated secondary fatigue reactions. The rationale for recommending more research seems obvious because much of the assemblage of academic literature elucidating compassion stress, compassion fatigue, vicarious trauma, and similar concepts is theoretical or reflective in nature (DeVilly et al., 2009; Najjar et al., 2009; Sabo, 2011).

Researchers have generated some quantitative studies in order to define the constructs more definitively, honing scaling questionnaires and other assessment tools (Adams et al., 2004; Devilly et al., 2009; Gentry et al., 2002; Bober & Regehr, 2006;

Jenkins & Baird, 2002; Munroe et al., 1995; Stamm, 2002). Moreover, academic authors have written about numerous case studies, but many of these have been reported anecdotally and illustratively rather than qualitatively (Baranowsky, 2002; Becvar, 2003; Campbell, 2007; Cerney, 1995; Dutton & Rubinstein, 1995; Meyers & Cornille, 2002; Naturale, 2007; Pulido, 2007; Simon et al., 2006; Smith, 2007; Ward-Griffin et al., 2011). However, though progress has been made, stabilizing the definition of compassion fatigue is still an evolving process requiring much more quantitative and qualitative data development. Indeed, problems exist with currently published research. In addition to conceptual dissonance, many researchers concede that while burnout is a stable construct, compassion fatigue, secondary traumatic stress, and vicarious trauma have not yet been sufficiently validated through psychometric instrumentation nor adequately explored qualitatively (Devilly et al., 2009; Marriage & Marriage, 2005; Najjar et al., 2009; van Minnen & Keijsers, 2000).

In addition, there is a paucity of qualitative literature reporting methodological rather than anecdotal results. Of note, the predominance of the research has been generated by the social work and nursing disciplines (Figley, 2002a; Figley, 2002b; Figley, 2002c; McHolm, 2006). Moreover, there is a dearth of peer-reviewed journal published research that addresses compassion fatigue, secondary fatigue reactions, or secondary traumatic stress across professional disciplines. While a very small number of qualitative research articles dealing with specific populations exists (Lonergan et al., 2004), a thorough database search rendered only one qualitative study of the compassion fatigue spectrum across disciplines. This study was conducted in a hospital setting and did not include licensed professional counselors or marriage and family therapists

(Marriage & Marriage, 2005). Generally, research is demarcated according to professional discipline margins and is sporadic.

Many of the most current journal authors have recommended that more studies on vicarious trauma, compassion stress, and compassion fatigue be conducted across disciplines (Collins & Long, 2003a; Collins & Long, 2003b; Devilly et al., 2009; Figley, 2002a; Figley, 2002b, Figley, 2002c, Lonergan et al., 2004; Showalter, 2011). Compassion fatigue research across disciplines is noteworthy because it may be applicable to other caregiving professions and members of the lay population who are also at risk; namely, school counselors, counselor educators, hospital personnel, emergency workers, firefighters, policeman, clergy, lawyers and legal witnesses, members of military families, families with special needs, and families who care for aging family members (Beaton & Murphy, 1995; Gentry et al., 2004). All of these (and perhaps other) individuals and groups could hypothetically benefit from a greater understanding of compassion fatigue and other secondary traumatic stress markers, elucidated by additional exploratory research into the phenomena itself.

Conclusion

Perhaps one of the most important factors in favor of doing such research is the idea that promoting discussion and exploration creates an atmosphere of understanding (Bride & Figley, 2007). This understanding fosters communication and awareness, breaking the silence and shame that often surround compassion fatigue and empathic failure among professionals and the lay population (Bride & Figley, 2007; Brown, 2006; Brown, 2009; Figley, 2002b). Many professionals who experience varying degrees of these debilitating symptoms avoid speaking up because of agency culture or fear of being

labeled or pathologized (Zimering et al., 2003). Conversely, professionals and lay caregivers alike who have experienced compassion fatigue and are willing to discuss their experiences report feeling bereft and alone (Baker, 2003; Becvar, 2003; Bober & Regehr, 2006; Cerney, 1995; Figley, 2002a; Zimering et al.). Normalizing these reactions is one of the first steps to attenuating them.

Some theorists and researchers who have studied compassion fatigue are calling for a paradigmatic change in professional caregiver training, supervision, and clinical practice that stresses openness about the burnout and the compassion fatigue spectrum across mental health disciplines (Barnett et al., 2007; Bonanno, 2004; Figley, 2002c; Endicott, 2006; Showalter, 2010; Showalter, 2011; Seligman & Csikszentmihalyi, 2000). Ideally, additional research into management and recovery of the compassion fatigue spectrum across disciplines will foster a greater understanding of how the caregiving professions as a whole are affected by its effects. Engendering new research may foster dialogue and enhance training of new counselors and allied professionals. Heightening awareness provides an opportunity for a paradigmatic change in supervision, training, and clinical practice that emphasizes resilience, self-acceptance, and positive growth and development in regard to management and/or prevention of compassion fatigue and its associated spectrum (Seligman, 2003).

Compassion fatigue, as a concept, is still relatively new, and much more research can be done to define and understand it (Joinson, 1992; Figley,1995a; Pearlman & Saakvitne, 1995b, Figley, 2007, Stebnicki, 2010). However, the concept that engaging with individuals who are suffering extracts a toll on the caregiver is not new. Native American tradition holds that a healer must experience woundedness personally in order

to facilitate healing in others (Tafoya & Kouris, 2003). For centuries, the Cherokee tribe has taught that each time an individual heals someone else, a piece of that person is given away until the healer requires healing also (Stebnicki, 2008). Traditionally, these wounds are often kept concealed by the healer. Similarly, counselors and other allied professionals in the mental health field often keep their unseen compassion fatigue 'wounds' hidden, partly because of a lack of knowledge regarding what they are experiencing or how it originated. Native American tradition also teaches that this unseen wound in a healer must eventually manifest (Tafoya & Kouris, 2003). Ironically, it is the process of healing the wound that fortifies and strengthens the healer. Similarly, Collins & Long (2003a) and Linley (2003) suggest that working through the struggle of compassion fatigue, or its associated secondary stress experiences, has the potential to create strength in the caregiver not previously known. Such a professional course of action can only serve to enhance the mental health professions in general.

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CHAPTER III

Becoming Intentional: A Grounded Theory of Licensed Mental Health Professionals' Experiences as They Have Navigated through Compassion Fatigue

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Abstract

The purpose of this article is to enhance understanding of licensed mental health professionals' encounter and navigation through compassion fatigue (CF) across clinical mental health disciplines. Nine licensed mental health professionals participated in the study, and each participated in three individual, qualitative interviews over a period of five months. These professionals included two licensed clinical mental health counselors, two licensed clinical social workers, one licensed marriage and family therapist, one licensed professional counselor, two licensed psychologists, and one individual who held a triadic licensure of licensed clinical psychologist, licensed marriage and family therapist, and licensed clinical social worker. A grounded theory analysis elicited the emergence of four main categories including *experiencing internal dissonance, recognizing and processing the effects, becoming intentional,* and *creating ongoing changes. Becoming intentional* is the central category because of its central and pivotal relationship to the whole process of participants' experience of encountering and navigating through CF. This fulcrum punctuates participants' experiences leading up to *becoming intentional* and those which came after as delineated in the other three categories of the theory. This study provides a qualitative view into both the subjectivity and universality of licensed mental health professionals' experiences of CF across disciplines. Implications for utilizing the study results in a variety of models of counseling, supervision, clinical practice, and education are discussed.

Introduction

> Compassionate action involves working with ourselves as much as working with others.
> (Chodron, 1994, p.144)

An inquisitive researcher, wanting to understand the particular experience of caregiver burnout in her profession, postulated a unique and synergistic relationship between burnout, secondary caregiver stress, and trauma within the caregiving context. She described this phenomenon as Compassion Fatigue (Joinson, 1992). Since that time, the mental healthcare field has become increasingly aware of Compassion Fatigue (CF) as a distinct affective, physical, mental, and spiritual sequela which occurs among caregivers, including many mental health professionals (Bride, Radey, & Figley, 2007; Gentry, 2011; Hamilton, 2008; Killian, 2008; Kochevar, 2002; Showalter, 2010).

Initially, CF was thought to be a phenomenon which existed predominantly among those who worked specifically within trauma or crisis contexts (Beaton & Murphy, 1995; Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995; van Minnen & Keijsers, 2000). More recently, however, some theorists and researchers have opined that anyone who functions in a mental health caregiving role is at risk for developing some form of CF (Bride & Figley, 2007; Endicott, 2006; Gentry, 2011; Marriage & Marriage, 2005; Rothschild & Rand, 2006; Showalter, 2011; Stebnicki, 2008; Thompson, 2003; Yager & Tovar-Blank, 2007; Zimering, Munroe, & Gulliver, 2003). Moreover, this risk may intensify when caregivers demonstrate a high degree of empathic sensitivity and client/therapist engagement (Abendroth & Flannery, 2006; Baker, 2003; Sabo, 2011, Stebnicki, 2008).

As theorists and researchers have attempted to define CF, some have used a variety of terms such as burnout, empathy fatigue, secondary traumatic stress, traumatic

countertransference, and vicarious trauma. These terms are often used interchangeably, synonymously, and in tandem with the term compassion fatigue, causing a lack of conceptual clarity and some semantic and theoretical confusion (Collins & Long, 2003; Najjar, David, Beck-Coon, & Doebbeling, 2009; Sabo, 2011). Moreover, some researchers are definitive in their contention that CF is a valid construct with psychometric support (Gentry, Baggerly, & Baranowski, 2004; Gentry, Baranowski, & Dunning, 2002; Jenkins & Baird, 2002; Salston & Figley, 2003; Stamm, 2005). Others contend that CF is conceptually redundant with burnout and doesn't exist separately from burnout except as an iatrogenic response to changes in the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III*; American Psychiatric Association, 1980) related to post traumatic stress disorder (PTSD) (Devilly, Wright, & Varker, 2009; van Minnen & Keijsers, 2000).

While these controversies continue to evince disagreement regarding terminology and definition, CF theorists and researchers largely concur that the above named conditions overlap. Indeed, most agree that conditions associated with caregiver sequelae may be circumscribed into a constellation of secondary stress or CF responses that influence each other and range from mild to severe (Figley, 2002a; Figley, 2002b, Gentry, 2011; Gentry, et al., 2004; Kanno, 2010; McHolm, 2006; Sabo, 2011).

The probable effects of developing CF or some form of a secondary traumatic response across mental health disciplines underscores the need for developing and increasing understanding in what experiencing CF is like and how mental health caregivers have mitigated it. Analogously, CF and its associated conditions may be the antecedents to a loss of professional functioning and commensurate client well-being

(Linley & Joseph, 2007). Inversely, navigating through the deleterious effects of the CF spectrum may assist in fostering resilience and professional growth and development, contributing to client well-being and functioning as well. (Linley, 2003).

Purpose of the Study

Rather than focusing on the confounding nature of the aforementioned semantic confusion, it may be of equal or greater value to explore the process of experiencing CF. Indeed, paradigmatic confusion and controversy is fertile ground for qualitative inquiry that explores and illuminates individual experiences (Lincoln, Lynham, & Guba, 2011). Individual caregivers' experiences are varied and unique. Yet, CF is not unique to one branch of caregivers and "is prevalent across all spectrums of the helping professions and is flourishing" (Showalter, 2010, p. 239). With the previous ideas in mind, the purpose of this current study was not to define CF, but rather to increase understanding of how CF is experienced by mental health professionals across a variety of disciplines. The grand research question was: "What are the experiences of licensed mental health professionals who have encountered and navigated through Compassion Fatigue?"

Current research on CF has been sporadic and mixed with most of the theory and research coming from the nursing and social work fields. The majority of the early research associated with CF consisted of anecdotal and illustrative case studies (Collins & Long, 2003; Sabo, 2011). Following a thorough search of current literature, to my knowledge only a handful of isolated qualitative studies on CF exist and none of those studies are across mental health disciplines, nor are based on a grounded theory methodology. Rather, extant literature elucidating CF is dominated by reviews and theoretical opinion articles. In comparison, a paucity of published research exists (Collins

& Long, 2003; Najjar et al., 2009; Sabo, 2011). The hope is that the dynamic and fluid process essential to qualitative inquiry will foster discussion on ways to enhance awareness and attenuation of CF while addressing deficits in the literature. This current study was considered with those aims in mind.

Methodology

Corbin and Strauss (2008) designed their refined grounded theory to facilitate an understanding of participants' experience. Their prescribed approach was used to explore the experience of licensed mental health professionals who have encountered and navigated through CF. Grounded theory is a qualitative method, grounded in the data, that enables researchers to 'go deep' into the data of the client's world, thus providing a progressive process for theoretical development through the systematic gathering and analysis of data (Charmaz, 2006). Indeed, utilizing grounded theory was appropriate in order to evoke, explicate, and interpret a meaningful pattern from the discursive interactions of participants' intersecting data.

The construct of CF is complex, suggesting both an individualized as well as recursive phenomenon (Gentry, 2011; Sabo, 2011). The goal was not to eschew this complexity, but rather to embrace it by capturing and analyzing the thick, rich data commensurate with participants' narratives. Using this discovery orientation, I approached the research by privileging participants' stories while considering participants to be the greatest experts of their own reality. This orientation and approach created space for a structure to inductively emerge (Charmaz, 2006; Corbin & Strauss, 2008).

Epistemological Underpinnings

A constructivist epistemology undergirded this qualitative inquiry, adhering to the idea that multiple realities exist within situational contexts. These realities include the perceptions and apperceptions of the researcher and the participants, as well as the social context of the research (Charmaz, 2006). A constructivist approach fosters developmental and experiential learning, centered around making meaning through the amalgamation of experiences and ideas, accommodating new ways of being and doing in the process (Creswell, 2007). Furthermore, considering a constructivist approach elicits a co-creation of meaning between researcher and participants (Corbin & Strauss, 2008; Ponterotto, 2005). Constructivism frames this co-construction as a feedback loop which is managed through researcher reflexivity. This reflexivity is essential in order to avoid the consequences of intractability or obfuscation of potential conceptualizations due to researcher bias (Charmaz).

Symbolic Interactionism Theory, braced by constructivism, also informed this study and was used as a theoretical guideline (Blumer, 1969). This theory is constructed on how individuals develop life meaning assuming "that individuals are active, creative, and reflective and that social life consists of processes" (Charmaz, 2006, p. 189).

Participants and Setting

Participants were selected for this study through purposeful sampling, which facilitated a predefined selection of individuals with the qualities of experience attendant with the grand research question and purpose of the research. Participants were licensed mental health professionals who had encountered and navigated through CF. Relative to this research, CF was defined as a form of care-giver burn-out and/or secondary trauma

which creates a state of tension and preoccupation with the suffering of those for whom an individual is providing care. This preoccupation may cause a degree of traumatization to the helping professional which exhibits as intrusive, avoidant, or hyperarousal effects. The traumatization comes through the professional helper's effort to exhibit empathy and compassion. CF symptoms are similar to those of posttraumatic stress. These symptoms may also manifest as mental, emotional, physical, and/or spiritual fatigue (Figley, 2007; Gentry, 2002). In addition, allowing for alternative and augmented meanings elicited from participants and co-constructed from the interaction of researcher and participant was an important consideration (Ponterotto, 2005).

In the context of this study, licensed mental health professionals were individuals working within the counseling field or one of its associated disciplines. Participants were chosen partly based on their ability and desire to recall and articulate their experiences in enough detail to provide rich, thick data. Nine licensed mental health professionals volunteered to participate in the study. These professionals were two licensed clinical mental health counselors, two licensed clinical social workers, one licensed marriage and family therapist, one licensed professional counselor, two licensed psychologists, and one participant who holds a triadic licensure of licensed psychologist, licensed marriage and family therapist, and licensed clinical social worker. Six participants were female and three male. Eight participants were Caucasian American and one participant was Hispanic American. Participants lived and worked in various parts of the United States. Years of experience working in the mental health field varied among the participants from two years to over thirty years.

In order to gain access to participants who met the criteria of the study, I contacted publically available list-serves associated with licensed mental health professional organizations. I also contacted supervisors within regional and national private and public mental health agencies. All of these contacts were provided with a study description, selection criteria, and researcher contact information. Potential participants were encouraged and instructed to contact me via phone or email, in the event they met the criteria and had a desire to participate. When a potential participant and I made contact, and it was determined that they met the criteria for the study, I then provided the participant with details of the study, including a review of the informed consent document, and answered any questions they had about the study.

Data Collection

All contact with potential participants and, ultimately, study participants was conducted in a manner that encouraged and respected the privacy of participants and the sensitive nature of the topic. Once participant eligibility was determined and an informed consent was obtained, a 60 minute, first round interview was conducted at a location chosen by each participant. In order to thoroughly protect confidentiality, the participant's name was only included on the informed consent document and the demographic questionnaire. From that point on, each participant was assigned a number and a chosen pseudonym used as identifiers throughout the analysis.

After obtaining the informed consent, participants filled out a demographic questionnaire (See Appendix D), immediately followed by the first round, face-to-face, semi-structured interview. This interview contained structured and open-ended questions. First-round interview questions were reflective of the topic of encountering and

navigating through CF and included the following: (a) Could you briefly tell me about your clinical work as a mental health professional?; (b) Could you tell me about the time and the circumstances surrounding your experience with CF?; (c) Using as much detail as you feel that you can, could you please give a narrative of your experience with CF?; (d) Can you describe the experience from the point of view of negotiating or navigating through CF?; (e) Is there anything else which you feel is important about your experience with CF?; and (f) Is there a metaphor which would be meaningful for you that describes your experience with CF?

Two additional rounds of interviews were conducted in a similar manner and were similar in length to the initial interview. These interviews were followed by a fourth and final member checking interview. Each of the aforementioned interviews was audiotaped.

The purpose of multiple interviews was to promote rich data and thick descriptions which would engender a theory developed through theoretical sampling. This theoretical sampling allowed for analysis of previous interviews to inform additional interview questions in order to reach a point where all the categories, subcategories, properties, and dimensions of the structure emerged and were defined (Corbin & Strauss, 2008). During the data collecting process, each interview increased in specificity, contributing to the development and emergence of a theoretical structure. Three rounds of interviews were ample to arrive at a satisfactory point of data saturation.

Data Analysis

Methodological procedures outlined by Corbin and Strauss (2008) guided the data analysis. This analysis included the use of constant comparison (Charmaz, 2006). The data collection and analyses were conducted simultaneously, promoting theoretical

sampling of the data, while conceptualizing and developing concepts in terms of categories, subcategories, properties, and dimensions (Corbin & Strauss). This systematic process utilized three stages of data analysis: open coding, axial coding, and selective coding. The goal was to allow the data to progress to greater levels of conceptualization and abstraction (Charmaz). Analysis took place in the following sequence using gerunds throughout the process in order to create semantic uniformity within the data wherever possible.

Open coding. Open coding involved interfacing with the transcript data to define emerging meanings within the data. This open coding included assigning micro codes to small chunks of lined data located in each transcript. Wherever possible, the use of *in vivo codes* during the open-coding process "serve[d] as symbolic markers of participants speech and meanings" (Charmaz, 2006, p. 55). Throughout, I memoed the emerging revelations and questions which occurred while mentally interfacing with the data (Corbin & Strauss, 2008). Memoing served as both an audit trail and a procedural strategy. Moreover, memoing enhanced the continuity and integrity of the interpretive decisions while engendering theoretical sensitivity. Importantly, the memos facilitated a way make the leap between open coding and the next and concurrent phase of analysis.

Axial coding. Employing axial coding concurrently moved the process into developing an analytic structure which related categories to subcategories while specifying the properties and dimensions of each subcategory. Axial coding allowed for describing participants' experiences at a higher level of commonality and abstraction, thus, engendering the inclusion of data which fragmented during initial coding. Every piece of data was considered important as axial coding facilitated identification of

relational patterns within and between the transcripts (Charmaz, 2006).

Selective coding. The final stages of coding included the development of a sorted spreadsheet after each round of interviews. This sorted spreadsheet served two functions: first, to determine whether or not a specified category and subcategory was robust; and second, to facilitate the elevation of some properties and subcategories and the collapsing of others. This was the point at which parsimonious categories were filled in through subsequent interview questions while burgeoning categories and subcategories were restructured within the overall structure (Corbin & Strauss, 2008).

Simultaneously, the data was synthesized by using selective coding to assist in explaining larger segments of data and to sift through data which lacked clarity (Charmaz, 2006). Selective coding also included the development of integrated memos relative to each of the participant interviews. These memos partly facilitated the promotion of one core category, highlighting the ways in which all the other categories related to each other and to the central category. During the analysis of the data, the memos, the three spreadsheets from each round, and the evolution of participants' responses through the interview process were all tools used in determining the identification of this central category. Connecting logical relationships in the other categories through the dimensions of each of the properties served to explain any variability in the data and to strengthen connections between the categories (Charmaz).

Measures To Ensure Trustworthiness of Results

Engendering trustworthiness and confidence is imperative for qualitative researchers. The criteria for trustworthiness include credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility refers to the

congruence of analytical findings while assuring an accurate capturing of participants' experience. The specific strategies of prolonged engagement, triangulation, and peer debriefing served to increase the probability that the conceptualization and interpretation of the structure were accurate (Lincoln & Guba).

The first strategy of prolonged engagement required a sufficient amount of time to become immersed in the data. This immersion facilitated an understanding of the worldview of the participants while establishing a milieu of mutual trust. Interfacing with participants' data through the interviews and transcription process promoted confidence in the conceptualization. An equally beneficial byproduct was identifying any inconsistencies that needed to be clarified in later rounds.

Increasing credibility through triangulation was achieved by an ongoing review of the literature and continuously attending to reflexive journaling, field notes, and memos. Additionally, the responses provided in the final two rounds of analysis, helped to confirm accuracy of the emerging structure. When appropriate, participants were asked to verify that the transcripts of their interviews matched what they had intended. The formal member checking interview at the end of the analyses provided an opportunity for participants to confirm, correct, or provide information in reference to the data analysis.

The final technique I used for achieving credibly was peer debriefing which allowed for further scrutiny of the data and analysis (Lincoln & Guba, 1985). Allowing this type of interface with the data assisted in a cooling off from the data to increase data detachment and decrease researcher bias.

Transferability is related to the applicability of the research to other settings. To accomplish this, I ensured adequate descriptions and explanations of the data. These

descriptions ought to enable future scrutiny of interpretations regarding the validity of the study and its transferability to other contextualized settings (Lincoln & Guba, 1985)

Dependability refers to reliability of results over time. The objectivity of the study is related to confirmability of the study (Lincoln & Guba, 1985). By using a variety of tools within a systematic audit trail, dependability and confirmability were addressed. This audit trail included generating all information into a systematic format that was reliable and organized. The research material will be retained in the event that further examination is warranted or desired.

Challenges to credibility may also be related to the interpretive lens of the researcher (Charmaz, 2006). Inasmuch as researcher bias is a potential threat to credibility, Creswell (2007) recommends the identification and clarification of any potential biases in order to diminish assumptions during the data collection and analysis processes. To help identify and clarify my biases, I discussed my own CF experiences with mentors and trusted colleagues. My experiences included feeling overwhelmed, hyper-aroused and anxious. On several occasions, I experienced secondary trauma which led to some sleep disruption, exhaustion, and thought perseveration regarding clients' suffering and outcomes. These responses were attenuated by drawing on support from family and supervisors and gaining greater knowledge regarding the topic of CF.

Generating a content-based literature review assisted me to see areas in which I needed to focus on greater awareness of CF. Gaining greater recognition and awareness of the signs of CF has been empowering in that many of the feelings I experienced associated with CF were normalized for me. Sharing that awareness has been a way to practice providing support to other professionals in the mental health field. Throughout

the data collection and analysis, I maintained a reflexive attunement to these experienced feelings in order to mitigate and bracket potential biases during each phase of the analysis.

Results

> I kind of picture [encountering and navigating through CF] as a metaphor. . .I want to get to that mountain over there; that's a great mountain, and I want to climb it and see what I can see. You walk out to start your journey and the whole land in front of you is just muck. It's messy and briars and rocks and "do I go across that to go to my mountain or do I go back in the house? I've got to figure out somehow to get out of this muck, so I can get there to the mountain." I think that I was in the muck for a while, and now I'm a little closer to the mountain actually. . .the muck's important. . .it's part of the journey.
>
> —Andrew

The very nature of the phrase *encountering and navigating through compassion fatigue* connotes a process along a continuum of experience. Employing the systematic analysis outlined by Corbin and Strauss (2008) served to evoke a theoretical structure which evinced the 'humanness' and dimensionality of this process reflective of both the discursive and recursive experiences which occurred among all the participants. The data may thus be conceptualized as both individual and universal, based on the applicability of the categories, subcategories, properties, and dimensions concomitant with the grounded theory analysis. This manuscript provides a synopsis of the emergent theory developed through the aforementioned analysis and grounded theory enquiry.

The prescribed analysis (Corbin & Strauss, 2008) elicited the emergence of four main categories including *experiencing internal dissonance, recognizing and processing the effects, becoming intentional,* and *creating ongoing changes. Becoming intentional* is the central category because of its central and pivotal relationship to the whole process of participants' experience of encountering and navigating through CF. This central category is not the foundation of participants' experiences, but rather, the fulcrum which facilitated an intentional change. This fulcrum punctuates participants' experiences

leading up to *becoming intentional* and those which came after as delineated in the other three categories of the theory.

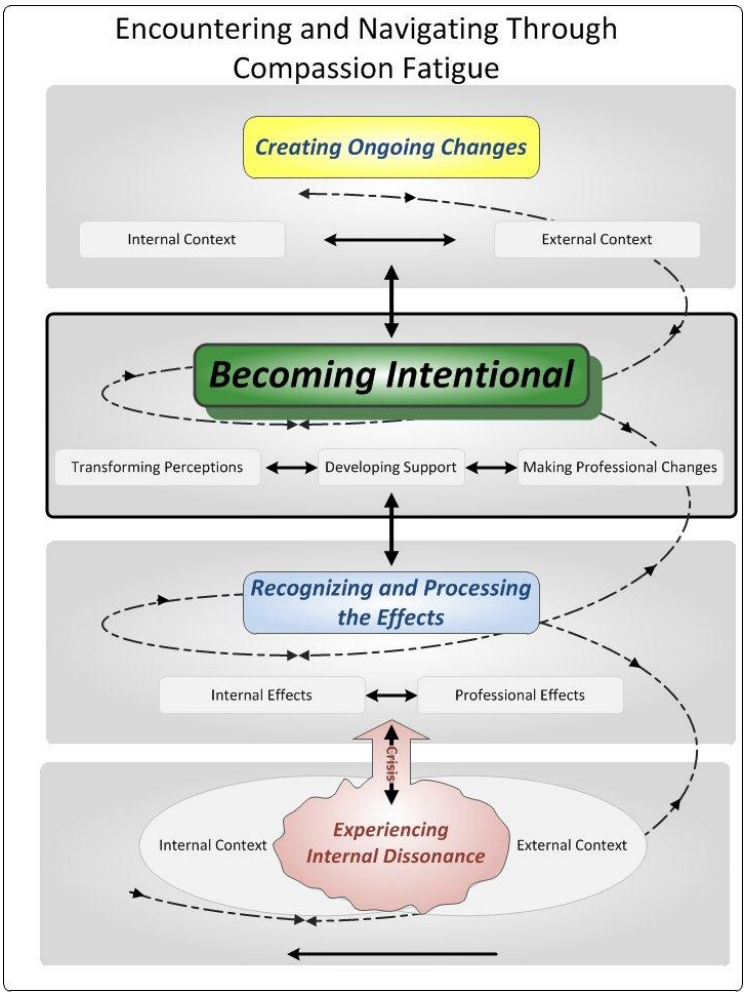

Figure 1. Licensed Mental Health Professionals' Experiences as They Have Navigated through Compassion Fatigue

An analysis of the data revealed that this central category is influenced by, or influences, the other categories and subcategories with respect to the theory. Indeed, each participant moved to a place of *becoming intentional* while negotiating CF as illustrated in Figure 1. This diagram highlights the main categories and subcategories relative to each other. The arrows and spiral in the diagram represent both a linear and non-linear

experience characterized by a concurrent, recurrent, or circular dynamic escalating or de-escalating depending on the nature of each participant's narrative.

The diagram (Figure 1) is constructed to flow from bottom to top, illustrating the foundational category as *experiencing internal dissonance*. This foundational category represents the underpinnings of distress which provoked participants' encounter with CF.

Experiencing Internal Dissonance

> . . . I felt completely divided. . .[CF] felt like a downright crisis; that sense of crisis and loss of identity and lack of capacity that I believed I had to continue doing this [professional work].
>
> —Phil

As they encountered CF, participants experienced internal dissonance characterized as a loss of internal balance and replaced by a state of disharmony or conflict. For some, the dissonance was more "subtle" as was the case with Jane; for others, it elevated to a state of distress or crisis, suddenly or over time. For example, Mary's CF was catalyzed by escalating dissonance followed by a sudden traumatic event which created the crisis. Conversely, John's work gradually became "aversive" until there was "some kind of, discord or dissonance . . . an empathic resonance that all of a sudden there's dissonance, so just a sense where there used to be connection and flow, all of a sudden it's jarring."

The framework undergirding *experiencing internal dissonance* consists of two subcategories, *internal* and *external contexts.* The interface of these two contexts created the spark which ignited the distress of encountering CF. *Internal context* refers to an individual's state of mind and body—the internal terrain. Conversely, *external context* refers to external settings or circumstances. Participants affirmed having a range of dichotomous *beliefs about the self* and *beliefs about the profession* within the *internal context.* Some participants reported these conflicting beliefs as innate and inherent; others

reported the perceptions were either triggered or exacerbated by circumstances and settings reflected within participants' *external context.*

Internal context. Counseling theories propose that individuals develop a set of perceptions based on personality, experience, and learning (Corey, 2009). Although most participants reported feeling effective and adequate much of the time, they also manifested contradictory self-perceptions of both an idealized sense of self and an inadequate and/or vulnerable sense of self. These perceptions were both personal and professional. This perceptual dialectic was conceptualized as contributory to the dissonance associated with CF. Modulating the dialectic likewise modulated CF.

The majority of participants described themselves as having innate empathic giftedness. These perceptions ranged from feelings of possessing "extreme amounts of compassion," "extra sensitiv[ity]," or "extreme empathy" to feeling "weak," "vulnerable," or "inadequate." These contrasting states were often experienced by participants simultaneously as a strength and weakness. For instance, Jane professed extra-sensitivity and an "intuitive ability to discern" and feel others' energy: "The problem with that level of sensitivity is that even though it can be a real blessing. . .it's a 'double-edged sword.'"

Correspondent to *beliefs about the self*, participants also experienced conflicting *beliefs about the (mental health) profession*; this in turn influenced their professional identity. These beliefs ranged on a continuum from idealistic to cynical. Several participants described themselves as being "perfectionistic" or professionally "idealistic," particularly at the beginning of their careers. Jane opined "initially you think you can do it all or. . .you have to do it all." Almost all participants implied this sense of neophyte

idealism at some point—a perception which was altered over time as they navigated through CF. This idealism created an ecology in which participants had three responses: distress over an inability to consistently relieve pain and suffering, distress due to the extremity of the work environment, or distress over the quality of social relationships. All three of these responses link the *internal* and *external contexts* within this category. Such was the case for Roxy who, new in her career, had a goal to be fully present and effective with every client. Against the backdrop of a pending divorce, she came to a place where she no longer felt "competent," questioning if she "should be doing the job at all." Jennifer had similar sentiments, expressing a neophyte excitement as a new intern. Initially, she drew upon her "nature" as a "fixer," but later as she experienced CF, she questioned, at times, whether she herself was "crazy. . .the one who had the problem."

Particular participants developed strong dichotomous feelings about the profession specifically. In turn, these feelings created a conflict of personal and professional identity, in which several participants declared a love/hate relationship with the profession. Andrew's words reflect that feeling: [It's] the golden handcuffs thing. . .You're locked into something wonderful, but you're locked in." Mary also "loved" the profession, but stated, "What I didn't like is how it affected me physically, personally, and maybe even, I've been told, a change in personality."

External context. Dichotomous beliefs were also connected to, and modulated by, triggers from the *external context,* constituting the seedbed of encountering CF. Participants' narratives point to three specific properties represented in the *external context*. These properties are *professional environment, quality of social relationships,* and *exposure to suffering and/or pain.* Moreover, these properties are representative of

circumstances which altered, shaped, or broadened the dissonance or crisis participants were experiencing.

Professional environment does not refer to clinical population, but rather to systemic and self-expectancies related to professional practice. These expectancies included temporal, monetary, and administrative issues. Additional professional and personal expectancies correlated with professional and psychological preparedness.

Indeed, most participants expressed, in hindsight, that they expected more of themselves than was realistic, expressing a lack of preparedness for the extremity of their professional environment, particularly as new clinicians. They reported their experience symbolically as being "thrown into the fire" or "thrown into the deep end." Roxy described this phenomenon as providing "no room for being human." She labeled her experience with CF as feeling "robotic." She, A.J., Andrew, John, and Phil all faced expectancies, either systemically or personally, of having to "suck it up" despite having heavy caseloads, working in more than one job, providing long clinical hours, or working in extreme clinical environments. Elizabeth actually pushed her self-expectancy by choosing an extreme professional environment early on in her career where she could "face [her] fear." Like some other participants, her narrative includes contending with personal trauma and speaks to how the properties in the *external context* intersect.

Participants' contact with pain and suffering, both past and present, included exposure to personal as well as clients' suffering. Exposure to client suffering, for certain participants, catalyzed temporary secondary trauma. This secondary trauma was experienced within a variety of clinical milieu including work with addiction, mood disorders, trauma, and relational problems. The participants' *quality of social*

relationships, either functional or dysfunctional buffered their distress or aggravated it. Reciprocally, the *quality of social relationships* was affected by participants' CF.

Recognizing and Processing the Effects

> It was really disappointing to have the miscarriage…Right during the same time, I'm working in the burn unit . . . One morning when I came in and went to [the patient's] crib and he wasn't there, so I grabbed one of the nurses and I said, "Did they take [him] back to bathe him?" She said, "Oh no, he died last night. Hey, there is this patient over here we really need your help with." . . . A complete surprise. And he had been getting better… I hadn't had this experience of getting that attached to a patient . . .I thought, "Okay, we don't acknowledge it…we just move on…" I just kind of swallowed it.
>
> It [was] really those extremes of emptiness, numbness… feeling nothing and at the same time being in great distress.
>
> —A.J.

As participants negotiated CF, they continually weaved within and between their *internal* and *external contexts* relative to the dissonance they were feeling. In all cases the dissonance surged to distress or even crisis, what A.J. termed an "existential crisis." All participants arrived at a state where these effects of CF became untenable and could not be ignored. This tipping point occurred with the participants' realization of what was transpiring both inter-psychically and intra-psychically. As awareness increased, participants began to process through the *internal* and *professional effects* of CF.

Internal effects. Most participants came to that awareness in hindsight or when the effects of experiencing CF began to hamper their ability to function optimally both personally and professionally. The properties of *internal effects* are conceptualized as *emotional responses* and *corporeal responses.*

All participants experienced *emotional responses* as dimensions from extreme isolation and numbness to extreme reactivity. These emotions may be characterized as avoidant, intrusive, or hyper-aroused. Among emotions described were feeling raw,

crazy, dread, numb, hyper-vigilant, heavy, angry, ambivalent, dirty, pressured, shame, trapped, hopeless, frightened, and flooded.

For some participants, their emotions and compassion felt drained or tapped out. Inverse to feeling drained, several participants dealt with emotional reactivity which included experiencing nightmares and feelings of hyper-vigilance. As Jane experienced nightmares she felt "almost as though I had been a victim myself." Phil, who experienced feelings of cynicism, resentment, and paranoia, shared "an incident where I went home, and I couldn't control my own shaking. . .the story I heard, it scared me to death." All their accounts assist in linking *emotional responses* and *corporeal responses.*

The property of *corporeal responses* refers to the physical body and its functioning and to cognitive processes associated with mental functioning. Participants became aware of feeling fatigue, bodily pain, a loss of body control, muscle tension, physical exhaustion, nausea, and sensory sensitivity. Andrew recounted, " I didn't sleep well in general . . .a lot of tension." Some participants were challenged by a lack of focus, lack of concentration, memory problems, distractibility, and confusion. Mary, who "started forgetting appointments," highlighted her physical challenges by asserting that the client/therapist symbiosis she experienced somatically had exacerbated her auto-immune disorder. Jane, Jennifer, and Elizabeth felt clients' problems as a physical weight or physical pain. "I could feel that energy coming off of them . . . and that's where the fatigue comes in," "That's when I start noticing the [CF] is I'll feel the weight of other people's stuff," and "Physical pain. I know all about it. Too many times to count."

Linked to their *emotional responses* in an internal feedback loop, participants also became aware of, and began to process their *professional responses.* The subcategory of

professional responses is defined by the following properties: *burnout*, *client/therapist relationship,* and *countertransference,* all of which qualitatively correlate with the prior designated properties within the *external context* associated with participants' dissonance.

Professional effects. In their accounts of navigating through CF, all participants experienced burnout as a professional effect of CF. Burnout closely linked with both *emotional* and *corporeal responses* and the extremity or expectations within the work environment. At times, participants experienced those expectancies as exceeding their personal resources to meet the demands which were placed upon them, either by their work environment, or their own self-driven expectations.

For example, Andrew experienced burnout as emotional and physical exhaustion that was "killing [him]." Roxy experienced burnout as a form of de-personalization and reduced personal accomplishment, feeling like she was an "automaton." She said, "I try to think of [burnout] as a step beyond compassion fatigue. I had compassion fatigue, then it went one stage further to kind of crispy fried burnout." John's described his struggle with burnout and CF: "You're like a cage fighter. . .and for that 45 minutes you're just alone with that person's depression or their addiction or their marital distress . . ." He further expressed both ruminating over and, at times, concurrently disengaging from client outcomes. His narrative points to another *professional effect* of CF, namely, issues within the *client/therapist relationship*.

Multiple participants noticed becoming either over-invested or disengaged from client outcomes, often as a direct result of *exposure to clients' suffering.* Several participants described themselves ruminating over client problems and suffering. At one point, as Jennifer recognized and processed the effects of CF, she noticed being both

over-engaged and disengaged, first becoming "sucked into the vortex of clients' confusion," and second, "los[ing] the ability to be as engaged with clients as [she] wanted to be." Jennifer attributes part of her disengagement to *countertransference*. Similarly, other participants cited *countertransference* as an effect of CF and contributory to CF in a synergistic loop of dissonance and distress.

Elizabeth's narrative points to this feedback loop as well, connecting the properties within the category of *recognizing and processing the effects.* While concurrently experiencing personal partner relationship problems, she became increasingly aware as she became emotionally "flooded" during sessions. She described a "racing heart" and "sweaty palms" during moments of *countertransference* and, associatively, as part of her overall experience with CF.

Participants' accounts manifest a growing awareness of the effects of CF. This increased awareness allowed participants to continue to process and mitigate the internal dissonance associated with the properties of CF over time. Indeed, awareness served as a catalyst to participants' adjusted perceptions surrounding their dichotomous beliefs, their circumstances, and their responses consequential to the effects of CF.

Becoming Intentional

> "[CF] felt like I was drowning and…like I was being pulled under by some force and being pushed down by [my boss] when I was reaching out to like, a life preserver here. 'I need some support to get me out of this place where I feel like I'm drowning,' and nope! And so, it was kind of a long process of deciding, 'eh, nobody's saving me or helping me here, so I'm going to start swimming sideways and swim to shore.'"
>
> "I was in a place for a while where I felt victimized…But, humans are survivors and there is only so long that you can take [it]. If you're not dead, you have to do something …so I had to keep kind of struggling to find some way to get through [CF] and I think eventually I took ownership. . ."
>
> —Roxy

Data analysis revealed adjusting perceptions as an integral part of the concept of *becoming intentional*, the central category on which the process of encountering and

navigating through the effects of CF pivots. All of the categories in the theory may be connected in some measure to this central category. Becoming intentional, for participants, was behaving purposefully and deliberately toward changing outcomes as they moved towards a more growth oriented perspective on CF.

This change often occurred gradually as participants tried different coping strategies. Jane found that the practice of intentionality was learned by degrees and through benchmarks within her professional cycles with CF. In hindsight, she saw the accumulative effect of her experience provided "definite points" where she became aware of a need to become intentional about change: "I've got significant points during my career and my life . . . something happens that's pretty major that is a wake-up call."

As participants processed the effects of encountering CF, *becoming intentional* reflected a series of steps wherein they made a decision, took action, or recaptured their locus of control. Sometimes that intentionality manifested by moving forward with intensity and purpose. Other times becoming intentional meant stepping back or purposefully allowing for the easing of circumstances. Shifting from being acted upon to acting, or becoming purposeful, was what one participant referred to as "the tail wagging the dog, back to the dog wagging the tail."

An examination of the data suggests that not all participants became intentional in the same way or in equal degrees. However, a comparison of all the data indicates an emergence of three main themes or subcategories associated with *becoming intentional*: *making perceptual changes, developing support* and *making professional changes.* These three subcategories are interrelated and ubiquitously define participants' experience.

Transforming perceptions. Participants' narratives highlight that each, unique to

their circumstances, was looking for a modicum of hope as a result of their struggle with CF. Hope increased as they adjusted their perceptions. In some cases this adjustment included moving from feeling helpless or somewhat victimized to a renewal of the belief in their own capacity. For others the perceptual change was a purposeful acceptance or "surrender." *Transforming perceptions* took place as participants' employed three strategies, represented by the properties of *practicing internal awareness, adjusting perceptions about the self,* and *adjusting perceptions about the profession.*

The process of *becoming intentional* constituted, in and of itself, a perceptual change. All the participants had perceived some lack of control over what they were experiencing. Inner attunement assisted in changing perceptions. In this regard, becoming attuned connects directly back to the category of *recognizing and processing the effects*. Not only did participants increase awareness of the signs of CF, they also became attuned to the potential for cycling through CF. Participants reported cycling through CF several times, each time with less severity than their initial experience.

Jane's statement mirrors this idea: "If we didn't have pain, we wouldn't know that something is wrong that we need to take care of. . .you get stronger each time and you don't have to keep learning the same lesson." Jennifer continues to notice and be attuned to the following potential warning signs of CF: "I don't have as much energy. I want to isolate more. . . I feel it in my body . . . that kind of weight on me."

Becoming more aware of the nature and signs of compassion fatigue, participants were also able to modulate their former dissonance and the effects of CF as they specifically adjusted perceptions about the self and the profession. These adjustments helped to mitigate the dichotomous *beliefs about the self* and *beliefs about the profession*

which participants had experienced as reflected in the foundational category of the theory, *experiencing internal dissonance*. For example, A.J. adjusted her perceptions about her own innate sensitivity: "I came to the conclusion that if I had a choice, I would want to be an empathic person." She further stated, "And if that comes with some risk for [CF], that's ok, because the alternative is worse." That eschewed alternative was the loss of compassion and professional efficacy—an unacceptable option for participants.

The loss of compassion, with an attendant crisis of professional identity had been one of the seedbeds of the original distress for several participants. Adjusting perceptions about those beliefs was a large part of the perceptual transformation which aided participants in negotiating CF. In Phil's case, he adjusted his dichotomous perceptions about the profession by making a purposeful choice to trust others professionally. "I had to start exercising [trust] again almost like a weak muscle. . .I had to start practicing it." Phil had experienced a toxic supervisorial environment at the apex of his experience with CF. Learning to trust again was a monumental step in *becoming intentional* as he, like other participants, worked towards *developing support* along a number of fronts.

Developing support. All participants described the development of support as a primary factor in navigating through their experience of CF. The subcategory of *developing support* is defined by the properties of *professional support, outside support, spiritual support,* and *self-support.*

Some participants described feeling invalidated and disregarded by their supervisors. Several participants referred to this phenomenon as "toxic" support. On the other hand, most participants received either neutral or positive professional support. Jennifer said, "one of the things that's helped me with [CF] is I had people to staff it with.

. . they could see the chaos and the lack of balance." Indeed, participants pointed to the benefits of having other professionals see what they were not always able to see themselves. Furthermore, developing support assisted participants in normalizing their experience with CF. A.J. discussed her supervisor in that vein: "She gave me that support and connection of somebody to talk to, normalize [CF] and diffuse some of my feelings."

Mary and Jane echoed these sentiments: "I think that all therapists need to have an outlet or another therapist that can listen to them without judgment." "Therapists need therapists . . . believing people when they talk to you. That will save you, but you have to have people you trust. I learned you have to find safe people." Safety was also important within the context of outside support which refers to social support and therapeutic support. Several participants sought professional therapeutic help as a way to modulate the effects of CF, citing this endeavor as a very helpful component in the process.

While some participants did not emphasize spirituality, others became intentional about developing spiritual support, drawing on their belief in a "higher power." Some participants alluded to feeling metaphysical support as was the case with Jennifer: "I feel like I have help . . . spiritual help. . .and had some amazing spiritual experiences."

Participants' narratives point to the connectedness of developing all aspects of support, including self-support as a means to ameliorating the effects of CF. As participants became self-supportive they allowed for time and space to heal from CF as they created more internal balance. Phil's statement is an example: "I slowly started building up, getting some faith, getting some faith in myself and some faith in something higher than myself to guide me out of this crud." With the support of his wife and others, he "had a whole lot more control over [his] own direction, [his] own choices as well as

[his] own outcome." This support and internal control allowed him to be intentional about *making professional changes*—an essential step in participants' navigation through CF.

Making professional changes. As a result of *becoming intentional* through both *transforming perceptions* and *developing support*, participants were able to make professional changes as well. For example, almost all the participants, at some point, felt that their professional context was beyond their control. Yet, when they began to make internal adjustments, they were empowered through support to make professional adjustments, in turn creating a different contextual ecology, internally and externally.

The concept of *making professional changes* is defined through properties of *adjusting professionally, seeking learning and skill development,* and *changing the client/therapist relationship.* This adjusting included finding a new work environment, changing workload, or changing clinical contexts. All of these actions may be represented by the dimensional concepts of stepping forward or stepping back professionally along a continuum. Some of the participants purposefully tried both actions.

Similarly, various participants purposefully sought formal and informal learning and skill development as a means to navigating through CF. This was the case with A.J. who said continual learning was a "powerful intervention" against CF. Other participants were like John, who "eased off" of professional learning in order to provide time and space to heal from CF. He said, "It might be the reverse for me; that there's sort of an easing off from doing as much reading and trying to back away from that if anything."

Stepping back from client outcomes was also an aspect of participants' efforts to make professional changes. Participants intentionally practiced and are continuing to practice creating boundaries. These actions directly modulated the client/therapist

relational effects previously mentioned as participants' over-investiture or disengagement. This separation may also be defined as movement towards healthier compassion and a perceptual maturation which attenuated previous unrealistic expectations or idealism.

Creating Ongoing Changes

> [Experiencing CF] . . .that's how we grow . . . but we're going to get it from a different perspective because I believe that when we look at things, when we don't have experience, we don't even understand all the different angles of what we're looking at. We can only look at it through the eyes and the experience that we've had up to that point. . . But those things change, because as you gain experience, like the little baby, you learn to crawl and then you learn to walk and then you learn how to say more than two word sentences . . . you grow and that's how it is in this profession, or in life. We continue to add to what we have internally to look at our world and as we do that, and we actually experience things, we can become better and better equipped at being able to see more angles and more things coming from different directions and how to maneuver into an internal [and external] world that keeps changing. But when I started out, I didn't see all the things that I see now. And [CF] changed who I am . . . It changed who I am because if I hadn't navigated well through those things, I would be stuck and I would keep looking at stuff in the exact same way . . . if we can't [change] as clinicians, how can we expect our clients to be able to change?
>
> —Jane

The movement towards developing healthier compassion, for themselves and their clients, was part of participants' experience of *creating ongoing changes* as they built internal and external fortifications against CF. Participants' *internal* and *external contexts,* or framework, remained similar to the framework in which they had experienced the dissonance and/or crisis. However, now participants were creating ongoing changes within that framework, resulting in a protection of the core self and a more balanced response to inter-psychic and intra-psychic pressures and processes. Developing this balance came through accommodating new experiences of growth during the process of *experiencing internal dissonance* and/or crisis, *recognizing and processing the effects* of the distress, and *becoming intentional* about navigating through CF.

Internal context. Participants created ongoing internal balance as epitomized by

the properties of *processing emotions*, *creating positive cognitions*, *creating meaning*, and *creating healthy compassion.* Linked back to the subcategories of *developing support*, and *transforming perceptions*, participants processed their emotions both verbally and non-verbally by sharing their emotions with a trusted other, or practicing internal rituals of divesting their negative emotions. Several participants, including Elizabeth, cited participation in this study as a modulator in verbally processing the emotions associated with their story of CF. She also underscored the importance of non-verbal processing of emotions, in her case, through personal practice of guided imagery: "I was trying to play tough girl again . . . [guided imagery] helped me release a lot that I was holding in and that's what helped me push through, I think, to ask for help."

Several participants discussed the role of positive cognitions in creating an ongoing milieu of CF fortification, using purposeful positive self-talk and taking a stance of personal non-judgment as forms of self-support and self-care. This internal positive stance assisted participants in creating meaning around the experience of CF. Being able to perceive CF in a larger context of growth and development was cited as a significant perceptual event which was freeing to several participants, helping to create resilience.

External context. This growth and development was manifest externally as many participants continue to create changes in their external professional environment by providing support to themselves through self-care, and support to others, avoiding systemic CF in the process. The two properties of this context are therefore, *creating changes in the professional context* and *creating self-care.*

When participants were experiencing the dissonance associated with CF, circumstances within their *external context* were triggers which exacerbated their

dissonance. As participants worked to *create ongoing changes*, their *external context* served as a catalyst for increasing resilience and healthy compassion. A.J., who has developed a program for assisting other professionals to learn self-care strategies while moving towards resilience, provided a metaphor which embodies both efforts of self-care and providing support to other professionals:

> So I see myself on one of those [balance boards] and it's like, "Okay I'm going to stay in balance, I'm going to keep my arms locked with this whole line of, you know, connections with others," and then I have . . . this shield in front of me and I'm going to be prepared and aware that [CF] could happen [to me or to them].

A.J.'s excerpt also highlights the need for increasing dialogue regarding CF on a more systemic level. Although every mental health professional may experience CF unique to their own circumstances, certain universalities of experience appear to exist. As those universal phenomena are normalized, they may render greater inoculation of CF both individually and within a larger systemic arena.

Discussion

A desire for understanding CF from an experiential perspective was part of the aim of this dissertation study. Furthermore, the goal was to understand participants' data both singularly and universally. Participants' stories attest to the strength of the human spirit and to the courage of many individuals who work across mental health disciplines. Attempting to place the experiences of encountering and navigating through compassion fatigue into a grounded theory, while still honoring the individual narratives, was

daunting and challenging. Nevertheless, an analysis of the data has rendered the structure in such a way as to, hopefully, give profundity and meaning to the experiences.

This analysis gave rise to a grounded theory which placed emphasis on the central category of *becoming intentional.* Within the context of CF, intentionality, exposited by some researchers as a significant modulator of CF, may be defined as behaving purposefully and deliberately toward changing outcomes, while moving toward a positive, growth oriented, and favorable conclusion (Gentry, 2011).

This category was deemed central to participants' process because it represented the fulcrum of participants' experience in regards to the following connection between the categories in the theory: As participants encountered CF, they did so within an internal and external framework which catalyzed internal dissonance, distress, and/or crisis. When the effects of that dissonance escalated to a point where they became untenable, participants became aware of, and began to process those effects. The effects were experienced internally and manifested professionally and personally. Attendant to the effects, participants ubiquitously affirmed that while experiencing CF, at some juncture and for varying periods, they felt a loss of control regarding what they were experiencing. Feeling that loss of control exacerbated the dissonance. *Becoming intentional* served as an internal scaffold from which participants could recapture their locus of control while accommodating new growth, resilience, and healthy compassion.

The idea of regaining an internal locus of control, relative to CF, has recently been explored within the context of some research literature (Injeyan et al., 2011).

Such a movement is reflective of growth which may occur as individual participants transitioned from assimilation to accommodation which occurred through creating a new paradigm of ongoing changes both internally and externally (Feldman, 2003).

Navigating through CF, in light of this research, involves a 'change process.' This change process comprises a series of linear, concurrent, and recurrent steps (see Figure 1). Participants' change processes relate, in part, to the *Trans-theoretical Model of Change* (Prochaska & Norcross, 2007). Five stages of change are posited in this model: pre-contemplation, contemplation, preparation, action, and maintenance. Correspondent to these stages, participants first experienced an environment of dissonance which began with a subtlety, as in a stage of pre-contemplation. Participants' dissonance escalated to distress or crisis in which contemplation and preparation for change was engendered through growing awareness. Each participant then took purposeful and deliberate action to evoke a change in their conditions. Moreover, each participant worked and continues to work to maintain these changes. Most participants have cycled through the process multiple times, typically in an upward spiral of growth and enhanced resilience.

Thus, participants' navigation through CF may be viewed from the perspective of inoculation against subsequent CF. Increased awareness of the effects of CF engenders greater potential to avoid the deleterious effects of CF in the future. A parallel example would be the introduction of pathogens into the body. The first time this occurs, the individual may become very ill. Due to the buildup of antibodies, the next time the pathogen is introduced, the body senses it and is resilient against it.

Implications

This study provides detailed descriptions of participants' experiences with encountering and navigating through CF (See appendices G-I). The findings of this study are relevant to supervision, counselor education, and clinical practice. Moreover, the findings may foster a discussion on developing strategies within both micro and macro contexts as personal and systemic expectancies within the mental health profession are explored.

The role of support, including supervisory support, in assisting counselors through CF cannot be understated. Discussions about self-care may be relevant within the supervisory context. However, self-care discussions may not be a substitute for 'scaffolding' a supervisee through the process associated with the inevitability of experiencing some form of a secondary stress reaction within the constellation of CF responses (James, Milne, & Morse, 2008; Ladany, Ellis, & Friedlander, 1999). John's comments about receiving support are applicable to the need for sensitive and supportive supervision: "To suffer is inevitable but to suffer it alone is unbearable. . . had I not had someone who was willing to empathize and be there with me and nurture me emotionally through that. . .I felt in a very regressed state, very in need."

The supervisory arena may also foster an environment of increased dialogue among licensed mental health professionals across disciplines, particularly since CF flourishes within a variety of clinical contexts and is not discipline specific. Relative to supervision, participants cited the importance of sharing narratives with other professionals as a way to inoculate against CF or navigate through CF. Indeed, research indicates the efficacy of sharing narratives as a healing tool associated with meaning

making and normalizing (Lindahl, 2012). Elizabeth's comments apply: "I think we can all develop our own perception of what [CF] is and it can almost sound shameful and . . . I like that I've had a chance to talk to a professional that this is normal; it's okay."

This study may also inform counselor education strategies. As a counselor educator, Andrew expressed a need for increasing awareness within the counselor education context, not just in an ethics class: "I don't think we talk about [CF] enough in graduate school, in prepping students. . . I have struggled teaching grad students who, of course, are coming in with stars in their eyes." Additionally, Roxy suggested a need for additional dialogue and training regarding CF, burnout, and counselor impairment. "But I didn't have a clue as to what is normal or ok or expected with the industry standards. Like were employers taking advantage of me or is that just normal?" Roxy's comments underscore the need for continuing education and avoidance of the systemic CF which some participants experienced (Roach & Young, 2007). This avoidance may be fostered as individual clinicians amend the silence which often accompanies the experience of CF (Showalter, 2011). Opening up such dialogue can only serve to ameliorate systemic effects.

The upside of increasing the dialogue regarding CF is that despite mounting evidence of the toll which is exacted on licensed mental health professionals, many professionals, including the participants, maintain a professional passion about their work (Bride et al., 2007). Participants' narratives underscore the reality that CF exists, but that it can exist concurrently with finding satisfaction, motivation, and even positive effects from working in the mental health profession. This idea is part of Elizabeth's growth narrative in which she, like other participants, positioned herself and her experience with

CF within a larger context. Her metaphor resonates with other participants' narratives: "It's the pebble in the pond with the ripple." This thought evinces the idea that change comes through learning to grow into professionally sustaining behaviors, a move which can only serve to enhance both clinician and client well-being singularly and in a "ripple effect," collectively.

Addressing Limitations

Within the milieu of qualitative research there is a variance of interpretation. Participants themselves may prove to be the best authority regarding the validity of the analysis and concomitant theory attendant to their experiences (Charmaz, 2006). This concept emphasizes the role of member-checking as a form of ensuring trustworthiness relative to the emerging theory. As such, member checking was the final step in the data analysis. However, one of the limits to member checking is the potential for collective member bias (Lincoln & Guba, 1985). These biases were attenuated by conducting individual, in depth interviews where the spirit of open dialogue could be developed.

The constructivist viewpoint acknowledges multiple realities as to research results co-constructed between researcher and participant (Corbin & Strauss, 2008). Glaser (1985) suggested this constructivist epistemology may be a shortcoming because of the potential for researcher bias. I monitored these potential biases and assumptions through reflexivity, an audit trail, peer de-briefing, and an ongoing review of the literature. Prior to conducting the research, I generated a comprehensive literature review on CF and its related constructs. This endeavor could be perceived as a limiting factor which influenced my analysis. As a mitigating factor, I set aside the review for a protracted period, while reviewing literature which subsequently emerged.

Conclusion

Such literature points to the need for additional and ongoing research regarding CF. CF is a complex phenomenon which incorporates a constellation of primary and secondary reactions brought on by a nexus of factors. This idea points to the suitability of experiential inquiry. This study provides a qualitative view into the universality of licensed mental health professionals' experiences of CF across disciplines where a paucity of literature now exists. An important factor in favor of more research is the development of increased dialogue and understanding across these disciplines where all professional caregivers are at risk for incurring CF and its commensurate struggles. This risk crosses demographic lines and mental health disciplines (Stebnicki, 2008; Udipi, Veach, Kao, & LeRoy, 2008; Yildirim, 2008). As a result, valued and caring professionals may be leaving the mental health professions prematurely. Conversely, additional research may engender understanding and the normalization of CF as an attenuable phenomenon from which growth, resilience, and development are achievable.

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CHAPTER IV: General Conclusions

This dissertation study resulted in the creation of two manuscripts, Chapter 2 and Chapter 3, which are thematically linked. Both manuscripts examine the phenomenon of compassion fatigue (CF). The first manuscript is a broad, content literature review which focuses on CF and its related constructs. The second manuscript is an in-depth exposition of grounded theory research examining licensed mental health professionals' experiences as they have navigated through compassion fatigue.

The literature review, Chapter 2, lays the groundwork for understanding the complexity of concepts and constructs related to CF by exploring the historical background of CF. Additionally the definition and theoretical underpinning of CF along with a discussion of risk factors, prevalence, etiology, and remediation are discussed. The goal of the exposition attendant with the literature review is also to clarify distinctions and similarities regarding CF, while elucidating related constructs in terms of a spectrum of CF secondary responses. This elucidation, therefore, is an attempt to simplify and deconstruct each of the attendant terms associated with CF.

The literature review is important because first, it is a comprehensive synthesis of prevailing literature in the mental health counseling field related to CF, both theoretical and analytical. Second, it serves to engender greater understanding of the prevailing professional conversation regarding variation in terminology and semantics relative to CF within extant literature. And third, it provides a rationale for research based on a paucity of qualitative literature on CF, particularly within the context of grounded theory methodology.

CF is a concept within the literature which has been explored for three decades. However, much of the research literature on CF has come from the nursing and social work disciplines. Yet, existing literature also postulates that CF is a phenomenon that exists within all the helping professions, particularly the mental health professions. Any caregiver capable of empathy is also at risk for CF (Stebnicki, 2008; Showalter, 2010). Indeed, the quality of exercising empathy and compassion in a caregiving role has the potential to catalyze secondary responses which exhibit emotional, physical, mental, social, and spiritual fatigue as caregivers are exposed to suffering and pain. These secondary responses, from mild to severe, may result in mental health professionals' loss of therapeutic effectiveness. More significantly, some professionals may leave the profession prematurely due to a lack of knowledge about what they are experiencing. This issue punctuates the imperative for greater understanding about the experience of CF and how to attenuate it.

Professional literature, counselor education textbooks, and professional organizations attest to CF as a phenomenon of which mental health professionals ought to be aware. The primary, secondary, and tertiary responses associated with caregiver stress and CF were originally studied under the concepts of burnout and/or countertransference. More recently, however, additional sequelae have been addressed. These terms associated with compassion fatigue, including burnout, vicarious trauma, and secondary traumatic stress, have been used interchangeably causing some confusion of terminology. While burnout is a phenomenon that has been extensively explored in literature, CF is still a relatively new construct. In a content search of the literature, only one qualitative study addressed experiences of CF across disciplines and the context of that study was a

hospital setting. Additionally the study was not specific to recovery experiences (Marriage & Marriage, 2005). Extant literature expositing CF is dominated by theoretical or opinion publications. Almost all professional publications call for additional research.

To my knowledge no research, using a grounded theory methodology, addresses the phenomenon of CF across mental health disciplines and clinical contexts. Further, the aforementioned paradigmatic confusion which often accompanies explications of CF in the literature warrants qualitative research inquiry which explores the complexities and potential multiple meanings of experience.

Addressing that complexity, the grand research question of this study was "What are the experiences of licensed mental health professionals who have encountered and navigated through Compassion Fatigue?" This research question was the central focus of data collection and analysis relative to the second manuscript. The second manuscript, Chapter 3, is an overview of the research analysis findings attendant with the grand research question. This manuscript contains detailed and specific data correspondent to the experiences of licensed mental health professionals who have encountered and navigated through CF.

Relative to this research, CF was defined as a form of care-giver burnout and/or secondary trauma which creates a state of tension and preoccupation with the suffering of those for whom an individual is providing care. This preoccupation may cause a degree of traumatization to the helping professional which exhibits as intrusive, avoidant, or hyperarousal effects. The traumatization comes through the professional helper's effort to exhibit empathy and compassion. CF symptoms are similar to those of posttraumatic stress. These symptoms may also manifest as mental, emotional, physical, and/or spiritual

fatigue (Figley, 2007; Gentry, 2002). In addition, allowing for, and being open to, alternative and augmented meanings elicited from participants and co-constructed from the interaction of researcher and participant was an important consideration (Ponterotto, 2005).

The research used a qualitative, grounded theory methodology (Corbin & Strauss, 2008). This approach was specifically designed to facilitate an understanding of experience. Grounded theory is a qualitative method, grounded in the data, which enables a systematic and progressional approach to data collection and analysis (Charmaz, 2006).

Participants were selected for this study through purposeful sampling, which facilitated a predefined selection of individuals with the qualities of experience attendant with the grand research question and purpose of the research. Participants were licensed mental health professionals who had encountered and navigated through CF.

Data was collected through three rounds of interviews with individual participants, using a semi-structured format with both structured and open-ended questions. These questions were specifically designed to promote comprehensive and detailed responses through the collection of thick, rich data from participants. Each interview was recorded and transcribed. Following the transcription of each round's interviews, the data was analyzed using the methodological procedures of open, axial, and selective coding. Memos and sorted spreadsheets were generated as part of the analysis process and as a method of managing and tracking the data. During the data collecting process, each interview increased in specificity, contributing to the development and emergence of a theoretical structure. Participants validated this structure as a result of their responses during the member checking interview.

As each round of interviews progressed this theoretical structure crystallized into a solid, yet flexible structure which included dimensionality reflective of both the recursive and discursive nature of participants' experiences. The data may thus be conceptualized as both individual and universal, based on the applicability of the categories, subcategories, properties, and dimensions concomitant with the grounded theory analysis. This manuscript provides a synopsis of the emergent theory developed through the aforementioned analysis and grounded theory enquiry.

The data analysis culminated in a conceptualized structure which elucidated participants' experiences within categories, subcategories, properties and dimensions. The four main categories of that structure are as follows: *1) experiencing internal dissonance, 2)recognizing and processing the effects, 3) becoming intentional, and 4)creating ongoing changes.*

Becoming intentional was identified as the central category of the structure because it represents the fulcrum of participants' experience and the pivot on which participants turned from encountering CF to navigating through CF. Each of the categories, in some measure, is directly linked to this central category of *becoming intentional.* A diagram was generated which highlights the centrality of this category relative to the other categories characterized by a concurrent, recurrent, or circular dynamic escalating or de-escalating depending on the nature of each participant's narrative.

Recommendations and Implications for Future Research

The grounded theory study, detailed within the second manuscript of this dissertation, facilitated an in-depth exploration and examination of the experiences of

licensed mental health professionals as they have encountered and navigated through CF. The qualitative methodology associated with grounded theory provided detailed and rich descriptions. The detailed and rich descriptions given by participants provides a fruitful narrative of data which adds to the body of qualitative inquiry associated with CF. The analysis and concomitant findings of the research may be incorporated into supervision, counselor education, clinical practice, and continuing educations contexts. Because the research involved mental health professionals across disciplines, the findings are applicable to both specific and interdisciplinary professional settings. Incorporating these findings into future research regarding CF is appropriate to multiple settings and contexts.

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Appendices

Appendix A

Recruitment letter of introduction to professional liaisons—listserv moderators, mental health public and private agency supervisors

Dear

My name is Louise Jorgensen. I am a doctoral candidate in Counselor Education and Supervision at Oregon State University. This study is being conducted in accordance with the dissertation/thesis qualifications as set forth by Oregon State University. I am under the supervision of Deborah Rubel, Ph.D, Associate Professor. I am in the process of recruiting participants for an exploratory study of the experiences of licensed mental health professionals who have encountered and navigated through compassion fatigue. The prevailing definition of compassion fatiuge is classified as a form of burn-out and/or secondary trauma which creates a state of tension and preoccupation with the suffering of those for whom an individual is providing care. This preoccupation may cause a degree of traumatization to the helping professional which exhibits as intrusive, avoidant, or hyperarousal symptomatology. The traumatization comes through the professional helper's effort to exhibit empathy and compassion. Compassion fatigue symptoms are similar to those of posttraumatic stress. These symptoms may also manifest as mental, emotional, physical, and/or spiritual fatigue.

Due to your level of expertise, and your ability to publicly access the above specified licensed mental health professionals within your organization, I would like to ask for your help in the recruitment of participants for my research study. The criteria for participation are licensed mental health professionals who identify as previously experiencing compassion fatigue. These professionals are still working, or have previously worked in private practice, school, substance abuse or mental health agency programs for at least two years post licensure, and are able to speak about their experiences in encountering and navigating through compassion fatigue. For purposes of this study, these mental health professionals will hold the following licensure: licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed (Ph.D) psychologist. If you know licensed therapists who meet these criteria, I would appreciate it if you would give them the information I have attached. This information includes a letter of introduction and a participant consent form further explaining the research study. Please indicate to the prospective participant that participation is strictly voluntary, and if interested he or she may contact me directly. By contacting me directly, participants will be assured of confidentiality and that no other individual will have knowledge of their participation in the research study. My email address is: jorgenlo@onid.orst.edu. Participants may also contact the principle investigator, Deborah Rubel, Ph.D. at deborah.rubel@oregonstate.edu

The research design for this investigation is a qualitative, grounded theory methodology. The study will include three 45-60 minute taped in-person interviews with participants,

approximately one per month over the course of four months. A fourth and final 30 minute follow-up interview will conclude the study. Total time commitment for participants will be approximately three hours.

I appreciate your help with this research which will add to the body of extant literature related to experiencing compassion fatigue. Moreover, my hope is that this study will expand the knowledge of how mental health professionals may encounter and navigate through compassion fatigue to achieve greater wellness and professional efficacy.

Thank you in advance for your support and assistance.

Appendix B

Recruitment email to potential participants

To Professional Organization Members and/or licensed mental health professionals (licensed clinical social workers, licensed marriage and family therapists, licensed Ph.D. psychologists, and licensed professional counselors).

Study title: An Exploration of the Experiences of Licensed Mental Health Professionals as They Encounter and Navigate through Compassion Fatigue

A doctoral research study on compassion fatigue is being conducted with licensed mental health professionals, in this context, licensed clinical social workers, licensed marriage and family therapists, licensed psychologists, and licensed professional counselors. You may be eligible to participate, if you choose. Participating in this research study is strictly voluntary and, if you qualify, it is up to you to decide if you would like to participate. This research is in no way related to your employment or affiliation with any professional organization. No information regarding your participation will be shared with any individual, organization, or employer.

If you believe you qualify and desire to be a part of this study, please contact the student researcher directly.

Documents are attached that explain participation requirements, a consent form for your review.

Briefly, to be eligible for this study you:

- Must be a licensed mental health professional who has worked in one of the above specified mental health disciplines for a minimum of two years.
- Must have experienced and navigated through symptoms associated with caregiver burnout, known as compassion fatigue. In this context, compassion fatigue is classified as a form of burn-out and/or secondary trauma which creates a state of tension and preoccupation with the suffering of those for whom an individual is providing care. This preoccupation may cause a degree of traumatization to the helping professional which exhibits as intrusive, avoidant, or hyperarousal symptomatology. The traumatization comes through the professional helper's effort to exhibit empathy and compassion. Compassion fatigue symptoms are similar to those of posttraumatic stress. These symptoms may also manifest as mental, emotional, physical, and/or spiritual fatigue.

- Must be able to recall your encounter with compassion fatigue and navigation through compassion fatigue, and be able to reflect on and articulate your experience.

- Must be willing to participate in a maximum of four interviews in which you will be asked to recall and reflect upon your encounter with and navigation through compassion fatigue. The first three interviews will be 45-60 minutes in length. These interviews will be conducted face-to-face between you and the researcher in a mutually agreed upon private location. The interviews will be audio-recorded.

If you are interested, please review the attached documents carefully. As stated previously, participation is strictly voluntary and if you are interested you may contact the student researcher, Louise B. Jorgensen, MS, LPC, directly via email at jorgenlo@onid.orst.edu or by calling me at my direct phone number: xxx-xxx-xxxx. Please include phone contact information so that I might contact you to set up an initial screening interview. You may also contact the principle investigator, Deborah Rubel, Ph.D. at deborah.rubel@oregonstate.edu or by direct phone at 541-737-5973.

Thank you,

Appendix C

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Participant Consent Form

Project Title: An Exploration of the Experiences of Mental Health Professionals As They Encounter and Navigate through Compassion Fatigue

Principal Investigator: Deborah J. Rubel, Ph.D.

Student Researcher: Louise B. Jorgensen MS, LPC

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to explore the experiences of licensed mental health professionals who have encountered and navigated through compassion fatigue. In this context, compassion fatigue is defined as a degree or state of tension and preoccupation with the suffering of those for whom an individual is providing care. This preoccupation may cause a degree of traumatization to the helping professional which exhibits as intrusive, avoidant, or hyperarousal symptomatology. The traumatization comes through the professional helper's effort to exhibit empathy and compassion. Compassion fatigue symptoms are similar to those of posttraumatic stress.

This research may be used for the student researcher's dissertation, for publication in professional manuscript journals, or for presentations at professional conferences and/or workshops. No identifying information regarding participants will be included in any form of publication, dissertation, or presentation. Information from this research study could be used to inform counselor, counselor education, supervision, and counseling agency practices to prevent or mitigate compassion fatigue. The researcher wants to know if counselor education programs, as well as agencies that employ counselors and other licensed mental health professionals, can do more to support the counseling and related fields in avoiding compassion fatigue.

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WHAT IS THE PURPOSE OF THIS FORM?

This consent form gives you the information you will need to help you decide whether you wish to participate in this research study or not. Please read the form carefully. You may ask any questions about the research, the possible risks and benefits, your rights as a volunteer, and anything else that is not clear.

WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

Because of experience and insight you may be able to share, you are being invited to take part in this study. You have self-identified as a person who may have experienced and navigated through compassion fatigue. You have also self-identified as having two or more years of experience post licensure in the state in which you reside.

WHAT WILL HAPPEN DURING THIS STUDY AND HOW LONG WILL IT TAKE?

As a participant in this study you will be asked to participate in a maximum of four , with the first three in-person interviews lasting between 45 and 60 minutes, and a final follow-up interview lasting 30 minutes. At the first interview, you will be asked to sign this Participant Consent Form and to provide the completed Licensed Mental Health Professional Participant Information Form. All interviews will be conducted at a mutually agreed upon location, and audio-recorded to ensure the accuracy of the data. No provision will be made for taking written notes during these interviews. If you do not wish to be audio-recorded you should not enroll in the study. After the data has been analyzed following each interview, you will be asked to review the results in subsequent interviews in order to ensure that they accurately describe your experiences. If you agree to take part in this study, your involvement will consist of approximately three total hours, over the span of approximately four months.

WHAT ARE THE RISKS OF THIS STUDY?

The interviews associated with this investigation pose minimal risk to participants economically and physically. The interviews are confidential and the data generated from the interviews will be reported in such a way as to avoid participant identification, posing minimal social or professional risk. Though every precaution will be taken to ensure confidentiality, there is a chance that we could accidentally

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disclose information that could identify you. The use of the Internet poses potential risks in that email transmissions cannot be guaranteed to be secured or error-free. The greatest potential risk may be psychological. Participants will be asked to discuss their experience of encountering and navigating through compassion fatigue.

While the interview questions are not intended to be threatening, they do require a level of introspection and reflection. Such reflection may evoke emotional reactions in participants. In the unlikely event that very strong emotional reactions occur, you will be asked if you wish to continue the interview. If you wish, the interview will be terminated. At the point of termination, the tape recorder will be turned off and no further data will be collected. The researcher is a Licensed Professional Counselor and is trained to process strong emotional reactions as they arise in order to ensure participant stability. If necessary, the participant will be referred to a professional counselor or therapist in her area. However, this level of emotional distress is highly unlikely. The interview questions are designed to be broad and biographical, and as such are not likely to cause distress.

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WHAT ARE THE BENEFITS OF THIS STUDY?

There are no known direct benefits to participating in this investigation. The indirect benefits to participation include contributing to the professions of counseling, counselor education and supervision, and to informing both individual counselors and professional organizations what benefits there are to reducing burnout among counselors.

WILL I BE PAID FOR PARTICIPANTING?

You will not be paid for participating in this research study.

WHO WILL SEE THE INFORMATION I GIVE?

No information regarding your participation in the study will be shared with any individual, participant, organization, or employer. The information you provide during this research study will be kept confidential to the extent permitted by law. The confidentiality of participants will be protected throughout the sampling, data collection, analysis, and writing procedures. An audio recorder will be used during the interviews to record the verbal data shared by participants. You will be asked not to reveal any identifying information regarding clients. Once the interviews are transcribed and checked for accuracy, the audio-recordings will be destroyed. All other data, such as the transcription of tapes will be labeled only with the participant's assigned number. No other individuals will have access to participant names or corresponding numbers. All forms and data from the study will be stored separately and securely in a locked file cabinet in the offices of the Department of Teacher and Counselor Education at Oregon State University for a minimum of three years. Only the researchers will have access to the data. If the results of this project are published your identity will not be made public. Other than the researchers, no other individual, organization, or employer will know of your participation in this study.

DO I HAVE A CHOICE TO BE IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

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You will not be treated differently if you decide to stop taking part in the study. If at any time you do not wish to answer a question or if you want to stop an interview, you are free to do so. If you choose to withdraw from this project before it ends, the researchers may keep information collected about you and this information may be included in study reports.

WHAT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact: Louise B. Jorgensen, LPC, PhD candidate at xxx-xxx-xxxx. Email: jorgenlo@onid.orst.edu . You may also contact the principle investigator, Deborah Rubel, Ph.D. at deborah.rubel@oregonstate .edu or by direct phone at 541-737-5973.

If you have questions about your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office, at (541) 737-8008 or by email at IRB@oregonstate.edu.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

_____

Participant's Name (printed)

_____

(Signature of Participant) (Date)

Appendix D

Licensed Mental Health Professional Participant Information Form

Name: _____ Age: ____ Email: _____

Mailing Address: _____

_____

Phone:_____ Okay to leave a message? Yes ☐ No ☐

Gender: Male ☐ Female ☐ Transgendered ☐

African-American or African descent ☐

Asian/Pacific Islander ☐

Hispanic/Latino(a) ☐

Native American/Alaskan Native ☐

Multiracial/Bi-racial ☐

White/Euro-American ☐

Other (please specify):

PhD Licensed Psychologist ☐ LPC ☐ LMFT ☐ LCSW ☐

Years of experience as a practicing therapist: _____

Appendix E

First Round Interviews

Introduction

The initial data set for this grounded theory study was collected from first round, face-to-face, semi-structured interviews with nine licensed mental health professionals. These professionals were two licensed clinical mental health counselors, two licensed clinical social workers, one licensed marriage and family therapist, one licensed professional counselor, two licensed psychologists, and one participant who holds a triadic licensure of licensed psychologist, licensed marriage and family therapist, and licensed clinical social worker. Six participants were female and three male. Eight participants were Caucasian American and one participant was Hispanic American. Participants were from the Western United States, the Intermountain Western United States, and the Southern United States. Years of experience working as licensed mental health professionals in the field varied among the participants from two years to over thirty years. The initial interview questions were as follows:

1. Could you briefly tell me about your clinical work as a mental health professional?
2. Could you tell me about the time and the circumstances surrounding your experience with compassion fatigue?
3. Using as much detail as you feel that you can, could you please give a narrative of your experience with compassion fatigue?
4. Can you describe the experience from the point of view of negotiating or navigating through compassion fatigue?
5. Is there anything else which you feel is important about your experience with compassion fatigue?

6. Is there a metaphor which would be meaningful for you that describes your experience with compassion fatigue?

The interviews were audio-recorded and then transcribed within a few days of each interview. After transcribing the interviews, I reviewed the recordings and transcripts several times to ensure for accuracy of the data. I first analyzed each transcript separately using a process of grounded theory methodology of open coding. Where possible, I used *in vivo* codes with the expectancy that each participant ought to be considered an authority on their own narrative. During this phase of analysis, I immersed myself in the data while asking theoretical questions to determine a structure—questions such as "What is this participant trying to say?", "How does this participant's experiences relate to or compare to the other participant's experiences?", or "How might I define this portion of the data?" In addition I looked for symbolic interaction taking place within and between the transcripts. In doing so I employed constant comparison of the data as I moved from open coding to axial coding. By using these procedures, along with both constant comparison and memoing, the emergence of themes, properties, and categories was inductively engendered from the data. Creating connections between concepts and categories allowed for the nascence of theoretical conceptualizations regarding the participants' experience of encountering and navigating through compassion fatigue.

Three broad categories or themes became apparent as a result of the analysis of participants' narratives and experiences as described in the data. Under each of these categories, I delineated nine subcategories with associated properties and their dimensions. The dimensions of these properties illuminated connections between categories and properties. During the conceptualization of the analyses of categories,

properties, and their dimensions, I generated several color-coded outlines to ensure that each category and property was fully explored within the context of all nine transcripts. These outlines developed as I returned to each of the transcripts several times, producing transcript-specific memos which elucidated and documented the development of more abstract conceptualizations of the data. I then generated integrated memos to further deepen the comparison between participants' data. This process continued to ensure I was utilizing constant comparison as I moved within and between transcripts many times in order to discover relational patterns between the concepts and categories. Additionally, each axial coded transcript was coalesced into a sorted table in which all nine transcripts were grouped together under categories, subcategories and properties. In this way, I was able to determine whether or not a category was robust enough to maintain its status, or if it needed to be downgraded to become a property of another category. Inversely, if a property was too large, with multiple dimensions, it was elevated to the level of a subcategory.

The three thematic categories and nine subcategories which emerged from the analyses are structured in the following way: first, *EXPERIENCING DISSONANCE AND INTERFERENCE IN THE EXISTING FRAMEWORK*, with the subcategories of *Internal Context* and *External Context*; second, PROCESSING THE DISTURBANCE, with the subcategories *of Becoming Aware of the Effects, Recognizing A Need for Change,* and *Developing Support*; and third, MAKING CHANGES TO THE EXISTING FRAMEWORK, with the subcategories of *Internal Context, Professional Context, Client/Therapist Relationship Context*, and *Contextual Changes Outside of the*

Profession. These categories and subcategories are connected through their corresponding properties and dimensions.

Experiencing Dissonance and Interference in the Existing Framework

The very nature of encountering and, particularly, navigating through compassion fatigue connotes a process, not merely a singular phenomenon. The first category of this process emerged AS *EXPERIENCING DISSONANCE AND INTERFERENCE IN THE EXISTING FRAMEWORK.* From this perspective, the existing framework represents the context in which the dissonance and interference occurs. Dissonance within the framework refers to a disharmony which occurred internally and externally with participants because of the interference/distress associated with encountering compassion fatigue. Interference is classified, in this situation, as a disturbance in the homeostasis of the participant and his or her environment. The existing framework may be defined as the self of the therapist or licensed mental health professional. With the self of the therapist in mind, the two subcategories of this category emerged as *Internal Context* and *External Context.*

Internal Context

The nine participants, from whom the data was collected, shared that as they encountered compassion fatigue, they experienced interference and dissonance within the internal context in varying dimensions of intensity, frequency, and duration. In this setting, the *internal context* refers to an individual's state of mind and body—in short, the internal terrain. The data analysis elicited three properties within the subcategory of *Internal Context* which represent how and where the dissonance and interference was

experienced—*1) emotional responses, 2) corporeal responses, and 3) dichotomous beliefs about the self.*

Emotional Responses. Describing their experience of encountering compassion fatigue, all the participants recalled feeling multiple dimensions of emotional responses from shutting down emotionally to experiencing extreme emotional reactivity. Some of the emotions they felt were dread, numbness, avoidance, hyper-vigilance, paranoia and fear. One participant described feeling heavy, while others felt more serious, troubled, ambivalent, guilty, apprehensive, pressured, stressed, dirty, and different. Some felt weak, burdened, and hopeless. Others felt a loss of humor, trapped, angry, frustrated, pressured, and stressed. Roxy describes feeling an emotional shut down occurring as she felt she became robotic and had "no room to be human."

> Roxy I sucked it up and kept going at, you know, and try to adapt to where I was with the burnout and compassion fatigue, like I knew I couldn't give my clients what I would like to give my clients.

A.J., who had recently experienced a miscarriage at the time of encountering compassion fatigue, echoes this same sentiment regarding her emotions shutting down—having to swallow "any emotion." She assisted with caring for an infant patient in a burn unit who had suddenly died.

> A.J. One morning when I came in and went to his crib and he wasn't there and so I grabbed one of the nurses and I said, "Did they take [the patient] back to bathe him?" She said, "Oh no, he died last night. Hey, there is this patient over here we really need your help with will you come on over here?" A complete surprise. . . And he had been getting better and so I didn't think that was going to happen. And I had seen a few patients die already, but they had maybe been admitted for a day or two, and then they had passed away. I hadn't had this experience of getting attached to a patient. It really, getting some kind of relationship with him, and then to

> have him suddenly pass away…. So, I sucked it up and that's what I did, 'cause I thought, "Ok, we don't acknowledge it, we don't talk about it. We just move on and take care of other folks." I just kind of swallowed it. . . I shed a few tears that night then I thought, "This is what you're supposed to do, just suck it up and act like nothing happened" So that's what I did.

Elizabeth also felt that she couldn't release or verbalize her internal emotional responses while doing some clinical work with clients, while Jane and Mary experienced their emotions as being drained out:

Elizabeth	I would have an immediate moment of getting flooded with numerous feelings, 'cause again, I felt that connection with that [client] on a deeper level and for a moment and when I say a moment, I would say maybe for a couple minutes, maybe 5 minutes. I would go through a period of being flooded with these emotions and I would tear up and things like that. I don't have any problem showing them my emotions. I wanted them to know I cared and that I could relate. . . Rather than let it drain me to the point of oh, I can't go back to work, oh, and even though I did feel that way sometimes, because I think I was being flooded from every direction, there's no question I had days I just can't do this today. I'm just too tired. . . .and that's where it became difficult for me. Because I couldn't let out any of my pain.
Jane	[I was] drained of emotion I think at different levels. I remember there was another time when I had a baby that was a severely handicapped baby. . . and the mother couldn't deal with the death. We were in the ER for hours. We couldn't get her to give the baby up so . . . I remember emotionally just doing that for, I mean, you can do a lot in short periods of time, but when it goes on for hours, you are just . . . your own ability to have that kind of compassion is tapped out.
Mary	And their stories, their narratives about fathers sexually abusing them in several situation and the guilt that they had and how that affected their personal lives now I would notice it became heavy on me and kind of burdensome and I would try not to think about it. . . What I did notice in myself I was becoming more serious

> through the counseling. Maybe not so much diagnosing other people but becoming serious because having a bit of a heavy heart. And when I really noticed it was when I went to see a doctor who was a kinesiologist, and I was just completely fatigued energy drained and really tired. He told me I needed to be careful that it was literally draining my energy taking on people's problems.

Mary also felt embarrassed because of experiencing compassion fatigue.

> Mary But sometimes as a therapist it's very difficult to go to another therapist because of the embarrassment . . . I thought that maybe because I felt compassion and sympathy for other clients, that maybe I was weak.

Inverse to feeling emotionally drained or numb, several participants experienced emotional reactivity associated with the dissonance and interference connected with encountering compassion fatigue. For example Roxy became frightened by her own reactivity:

> Roxy It started to get scary and just distressing, like you don't feel good about yourself when you can't do the kind of work you take pride in, but there was nothing that I could do. . . I knew I needed to take care of myself and take a step back, but I didn't. I wasn't given the opportunity to do that. So, my calendar is just chock full of clients and so basically became a thing where I was going to go into work the day that I had signed up, do the work, do the best that I could, but if I had nothing left to give, ok, I'm a warm body now. Which is not the way myself, I would like to do therapy. I like to be engaged, I like to be present with the client. I like to know that I am actually caring about what they're dealing with and set aside whatever else is or isn't going on in my life enough to just be with them for an hour. Be a witness or a facilitator, you know, just somebody who cares and to not be in that place all of a sudden is really scary.

A.J., Jane, and Phil also experienced fear, as well as intrusive and hyper-vigilant reactions.

A.J. A few months later I noticed that I started having nightmares about [the client/patient] at night. To the point, I mean, really bad nightmares. Like I would wake up trembling and thinking about him and just really having a hard time. I started having intrusive thoughts during the day about it. Fourth of July fireworks would just be scary for me. So this, he died in March and I remember, it was around the July time period, 'cause I remember the 4th of July and going, "How many little kids are going to get burned with fireworks? Why do people do that? It's so insane. . .You know, kids are out playing with sparklers and I'm like, those terrible parents! Why are they letting their kids to that? Don't they know how dangerous that is?". . . [I became] hyper-vigilant.

Jane Well probably the first experience [with compassion fatigue] was as a new therapist and I did my practicum in an agency and that's when I really did the work with adults molested as children and probably as a new therapist or even getting my clinical hours and being supervised, I was real eager to know everything about what I was doing, did a lot of research. And as I read the book I started having nightmares and I started experiencing, almost like as if I had been a victim myself even though I knew that I hadn't and I knew it was a direct result of what was written in this book. It was really frightening.

Phil I've heard a lot of stories that are just really, really bad. And there were times when I would experience vicarious trauma. I remember one incident where I went home and I couldn't control my own shaking. My hands, my whole body was shaking and it scared me to death the story I heard. And I really respected my boss, so I called him up and said, "My hands my whole body was shaking and it scared me to death the story I heard." And I really respected my boss, so I called him up and said, "What do I do?" He said, "This is called vicarious trauma.". . . I couldn't get the images out of my head either . . .it was the images.

Phil also describes becoming cynical and paranoid as a result of encountering compassion fatigue:

Phil Burnout, cynicism. I began to resent my decision to be a therapist. I began to resent going to work. I began to resent people in the

> field. And it not only affected work, I finally became aware of it after a while how miserable I was. I felt dirty when I was cynical. I even started looking for other jobs, but in the falling economy, there was nothing.

> Phil I began to trust people less. I began to be suspicious of everybody; that people were going to hurt me. I mean almost to the point, that I would question myself, how can I even be thinking this about these people. These people, even family members, how can I even question their loyalty to me, because I felt that the loyalties I had at work were gone. My efficacy and confidence as a therapist was gone so I started to doubt my efficacy and confidence as a husband, as a father. I doubted my spirituality. I mean I doubted everything.

Similarly, John experienced emotional responses as secondary trauma stress:

> John It's kind of this really disheartening disillusioning. It just made me want to . . really impacted me . . the sense of hope or the sense of optimism. You know everything you see in PTSD. This person's sense of hope that the world is a safe place. . . I don't walk around feeling like I'm going to be a victim of assault, but I just feel like the world's a more random place than I would like it to be. . . I don't know, it's just really rocks me to the core that if this is life, do I really, how . . . it zapped my sense of engagement and optimism and my sense of playfulness. . . What I tend to do is stew about it. Ruminate and maybe it's that vulnerability to obsessing, I don't know if that's helpful, I don't think it is, just things tend to churn.

Corporeal responses. Participants' narratives, as described in the data, suggest that in addition to feeling emotional responses, they also experienced corporeal responses of mind and body. In this context, corporeal refers to the physical body, its characteristics and its functioning and to cognitive processes associated with cognitive and mental functioning. For example, participants described feeling bodily pain, loss of body control, muscle tension, physical exhaustion, nausea (including throwing up), sensitivity to noise

and other sensory stimuli. Moreover, some participants experienced a lack of focus, lack of concentration, memory problems, distractibility, and confusion. These participants experienced a range of physical responses. Mary underscored her propensity to feel sensations physically in a symbiotic way with her clients. She also implied that subsequent physical challenges may have been related to this symbiosis and her encounter with, and attempts to navigate through, compassion fatigue:

> Mary Because I felt it like in my gut, in my heart, and I started becoming really good at the guessing with the energies because I believe I was connecting to their energies. So when I would tell them to hold that thought and do the EMDR, I sometimes think that the central nervous system actually activated my central nervous system. I believe that. I believe that's very interesting. I've been diagnosed since with ___which is a neurological disorder of the CNS. That's hard. . . The other interesting thing is the same clinician, my supervisor in the same practice, she developed a brain tumor. And another clinician in the practice had seizures. All three of us experienced something neurological.

Roxy, who was going through a separation and divorce during her struggle with navigating through compassion fatigue experienced physical symptoms as well:

> Roxy I almost came from the other end where there was so much going on, either personally or professionally, that was hard to contain, and so the time when I needed to be present with the clients, all that stuff made it difficult to kind of set aside,… Just tons of fatigue…Having to, it felt like at least twice as hard every session to make sure that stuff was set aside and I was staying engaged. Because normally talking to a client, I feel like I can be pretty present with their stuff and focused on them. So to have to fight that off and work twice as hard every session to stay engaged and stay present with what they're doing was exhausting.

Andrew experienced physical and mental exhaustion, describing feeling "wiped out." He also felt other physical symptoms.

> Andrew For me, definitely a lot, from a physical standpoint, tension and I didn't sleep well in general. A lot of tension. I tend to feel a lot of that in my stomach. I would go to the doctors every once in a while, but I tend to avoid that. I go in and they say there's nothing wrong, so I just don't go. Tension, stomach, pressure, which is self-imposed pressure, pressure to keep going because there's that financial reality.

Roxy, developed other physical symptoms—exhaustion, headaches and muscle tensions. Elizabeth felt that physical pain was both a precursor and result of compassion fatigue. Andrew's exhaustion was amplified by the stress of personal responsibilities:

> Andrew Here we're helping people out all day and we go home and we have a spouse or family member and they have their stuff going on and . . . . what? . . I've been helping people all day. It's hard to kind of be ON at home too. That's an aspect of compassion fatigue for me. . .I have little kids and they say, "Dad can you help with this Algebra?" I'm like, "AARRG, Algebra. My brain is exhausted." I don't say this to him of course. I sit down and help him, but in my head I'm thinking, "Oh man, I would love to just kind of sit down for a minute."

> Roxy I noticed myself getting headaches; not feeling rested and always feeling tired. . . Tension like in my neck and shoulders and things like that.

Jane and John underscored the corporeal responses associated with both secondary stress and compassion fatigue following working in crisis and trauma situations:

> Jane And I got violently ill the next day. And I was throwing up and it was this thing. I don't get sick like that and physically that was how I dealt with that. I got really physically ill. But I remember that night, the energy that was coming from that whole thing was

so. . . it was incredibly strong. It's almost like my body had to get rid of all that. I had absorbed something in that whole experience.

John We go in and talk to people who have these horrific things happen to them and traumas and empathize, that's like the instrument we use as our own empathy to try to be helpful. It just exhausts you, you get burnt out from it and experience compassion fatigue.

Participants physically felt the weight of clients' problems and emotions:

Jane So if somebody comes in the room and they're really angry, it affects me at a very, even my clients, if they came, I could feel that energy coming off of them and sitting through a session and dealing with that energy as well as helping them or whatever I was doing, it can be exhausting . . . And that's where the fatigue comes in.

Jennifer That's when I start noticing the compassion fatigue is I'll physically feel the weight of the other people's stuff on me.

Elizabeth Physical pain, I know all about it. Too many times to count. . . And we were really being tested on our actual skills at this point so it was very hard to concentrate because of the pain.

In addition to these physical reactions, some participants noticed mental or cognitive responses to the distress associated with compassion fatigue. Early in her career Jennifer describes being "thrown into the deep end" as she worked with difficult cases. At times she felt distracted and confused. Learning from her experience, she views these as signs of compassion fatigue then and now.

Jennifer 'Cause I'm more distracted, I'm not as invested in what's going on. I'm just kind of thinking my time's almost done. I'm just getting through the day rather than let me hear exactly what is going on and here's some ideas and how can we process through this? So I'm just not as engaged.

Similarly, Phil, who experienced compassion fatigue while doing a clinical practice and going to school stated.

> Phil I couldn't focus anymore. My acuity changed.

Mary experienced memory and acuity problems as well:

> Mary I started, some of my modality started slipping a bit in my mind. I couldn't recall some of my education at the time and it was worrying me and when I went to the neurologist I spoke to him about it I didn't know if something was happening neurologically, I was a 3.9 student in____ program and that something was definitely wrong. . . [and it's] very bewildering because ultimately I have backed completely off of counseling and have had to grieve that.

All of the participants were concerned and distressed by the emotional and physical responses which they experienced as they encountered compassion fatigue. These participants, either as a result of experiencing compassion fatigue, or concomitant to it, also professed dichotomous beliefs and feelings about themselves.

Dichotomous beliefs about the self. The majority of the participants described themselves in terms of having innate and empathic qualities—greater sensitivity and compassion, perhaps than the general population. This sensitivity was viewed as a "double edged sword" with its own dichotomy of both negative and positive effects. This giftedness took the form of being able to attach with clients, or to feel and connect to the energy of clients, including absorbing either clients' or family members' pain. Additionally, the participants described themselves as having gifted qualities associated with compassion and idealism, including neophyte idealism.

Yet, some participants also expressed feeling inadequate, weak, and different, experiencing a change in identity as a result of their discomfort with the dichotomous

feelings associated with compassion fatigue. For the majority of participants, this inadequacy was manifest in disappointment and apprehension over client outcomes and client suffering. For others, the dichotomy existed in an internal conflict of feeling good about their abilities, but inadequate about the temporal aspects of their lives. In all cases, the dichotomy existed as a dialectic which further added dissonance and interference to the framework of the self of the therapist.

In the context of the data collected, compassion is not just an awareness of another's suffering, but also a deep wish to relieve or alleviate that suffering. Phil called it "joy in compassion" and "lov[ing] to love." Like others, Mary described herself as "having extreme amounts of compassion," more than some others with whom she worked:

> Mary I remember in particular there was a lady with three children, four children total, three of them got killed in three separate traumatic incidents. When my supervision delegated her to me, they said "you can have her …she's crazier than hell." And I remember thinking, "I can't conceive of that. That's mean that's not me. I can help."

A.J. described herself as being "a bridge" as she dealt directly with families of burn victims. She had the ability and the task to connect with staff, victims' families, and victims.

> A.J. . . . and so there was one baby in there, and I'm good with babies I have to say, I'm really am, I'm good with kids. So docs and nurses grew to rely on me quite quickly to calm and soothe the babies that were pretty fussy. . . 'Cause in that environment, they are tough people who work there. They are typical of emergency rooms or ICU's. They are kind of a little more crusty and kind of insulate themselves from having those attachments and feelings. And they tend to stay a little more focused on the technical aspects of their jobs so that they can do it. And that's what helps them get through,

> but my role there was actually to be a little more comforting and calming and involved with the patients and also with their families. I kind of was probably in a little more vulnerable position to actually get a little more attached.

John designates this ability for compassion and empathy as an integral, but painful instrument of clinical work:

> John So I feel like one of the things that helps in this profession is to be thin skinned or sensitive, but as a result, it's like the safe cracker who sands his fingers in order to really feel all those ball bearings fall or whatever they're feeling for. It's like, you're a little more tender to those things in the first place, seeing a sad movie and feeling it. Or hearing a story and being horrified on the news. And so now what do we do as a profession? We go in and talk to people who have these horrific things happen to them and traumas and empathize, that's like the instrument we use—our own empathy to try to be helpful.

Germaine to John's response, Jane recognized that her reactivity was partly due to her innate sensitivity:

> Jane I know that I'm really sensitive anyway, I can't watch horror movies, I can't talk about things that are evil, because if I see a show on TV I will dream about it. I know my sensitivity level. . . I think for me I've always been a sensitive and introspective person even as a little child.

Moreover, she recognized that this sensitivity created an ability to sense others' (including clients') energy:

> Jane I can feel their energy. I could feel if I was in danger, if I was safe, if there was something not quite right here. I've always had that, almost intuitive ability to discern and so, the problem with that level of sensitivity is that even though it can be a real blessing, I've always said it's a two edged sword.

Other participants professed similar feelings and experiences:

Mary — I made note and charted it. I would say "where do you hold that pain and where do you feel it". I would guess it before they would say it. Because I felt it like in my gut, in my heart, and I started becoming really good at the guessing with the energies because I believe I was connecting to their energies.

Elizabeth — I was very empathic towards . . . I could take on, I started to take on his pain. My husband was beginning to check out, so I was beginning to take on his pain.

Jennifer — I believe that I pick up a lot of people's negative energy and [cranial sacral therapy] kind of take[s] that negative energy off me and I remember . . . A cranial, just clears that negative energy. And I feel lighter.

Wishing to access and utilize what she views as her innate gifts, Jennifer experienced neophyte idealism in the beginning of her career. An excerpt of her narrative as well as John's exemplifies this initial idealism which permeates the majority of the other participants' narratives:

Jennifer — I was so excited graduating from school to like, I want to help, I think my personal nature and I think for a lot of therapists, we are just natural fixers. We want to help people and kind of just dive in and do this, so I think that was a big part of it. . . I'm rubbing my hands together. It's like walking into a room that's all messy and you have the organizational skills to straighten it up and put things in order. So you go on with someone whose life is in chaos and pain and think I have the tools to help them heal and I love seeing people get better. When what I do makes a difference and I see people's pain reduced, their ability to engage and accept love and give love increased, that, you know, is a real high for me. I love that, to see that happen. So I think my expectation was, and kind of a personal goal was I wanted to be a very effective therapist and I wanted that to always be. To know that everyone I worked with would be better for the experience.

John — So part of it is probably a simplistic view that I held long ago that if you do this work, then people get better. It's kind of like a problem solving approach.

This idealism created an ecology in which participants had two responses, either distress over an inability to consistently and ideally relieve the suffering of their clients or family members, or distress over a crisis of professional and personal identity. Participant interviews highlight this distress.

Roxy	Well, not necessarily if it was worth it, but if I was any good at it. If I had the capacity to do the work anymore. I wondered if I was had been just too burnt out and compassion fatigued and couldn't do good work until I had taken a long break. If I liked therapy anymore, because I found myself when I was doing therapy, longing to be just doing anything else almost. And so you start to question like " Do I even really like this? Is this where my passion is; is it my purpose in life? The work is draining. I don't feel like I'm doing the work that I would like to do."
Jane	Sometimes as a therapist or as a social worker, you have to do these difficult things and you say to yourself "Who am I to do this? It's not, "Why do I have to do this? It's "How can I do this?" you know. . . I think for me personally I know that it has to happen. I knew she had to hold her baby that night. And there's those critical moments when the faint hearted might say, "Just give her a sedative and talk to her about it in the morning."
Phil	'Cause as I look back, all the clients I saw, there was a lot of change that went on with them and so I think they did, but then again I'm struggling with the whole "Am I a failure as a therapist?" So it's hard to be objective about it.
John	Oh yeah, no I've always done that. . .felt inadequate. Oh yeah, the efficacy, my ability to do therapy, yeah, that is something that might be more . . . I dealt with anxiety my whole life . . . I thought, "That's it." You know, everything, no matter what you do, there's this doubt that's underlying it. . . But there's always . . . when I was serving as ___, it was always Sunday night was hell, Monday morning like, "Oh, I probably did that wrong or I did that wrong."
	Yeah, my, it's never really been a real comfort zone. And every time walking in with clients, it's even on a day to day basis, I'm

> not really confident at, my wife, overheard me talking with a client, and this was just last week. And she goes, "Why do you, you know, view yourself as not doing very good work?" So I told her about the interview I had with you and I said "It will be good for me to talk, therapeutic maybe," I really, I don't know it it's just doubts, you know, having doubts but part of it's the failure as a clinician. You're going to fail with a certain number of clients. And part of it is just seeing people whose suffering doesn't improve with the work you do with them. And what I was telling my wife is that you know, "The worst thing is not that you fail, 'cause it would be one thing to fail and have people tell you, you fail and then they move on and go about their merry way, but what's worse is when you feel like you're failing and they keep coming back and so you just work in an ongoing way with people whose suffering doesn't end and they like working with you and they get a lot out of working, or something, out of working with you, but they never quite get better."

The internal dichotomy which participants experienced was also experienced in relation to their feelings about the profession or within the professional context. *Professional Context* is one of the properties of the subcategory of *External Context*, the next category under the main category of *EXPERIENCING DISSONANCE AND INTERFERENCE IN THE EXISTING FRAMEWORK.*

External Context

External Context and *Internal Context* are closely linked in that the interaction of the two contexts may create an environment in which compassion fatigue emerges within individuals and as well as systems and organizations. As participants described their experience of encountering and navigating through compassion fatigue, their narratives continually weaved within and between these two contexts in relation to their overall experience. Indeed, *External Context* is described as the external environment which interfaces with the internal context or self. This interface, particularly the individuals'

response and interpretation of the interface, makes up the self of the therapist/licensed professional. The emergent properties of this subcategory include the following: *professional context, client/therapist relationship context,* and *quality of social relationships (outside of the profession.)*

Professional context. The property of *Professional context* refers to licensed mental health professionals' professional setting. *Professional setting,* one of the dimensions of the property, *professional context,* does not refer to client population or clinical context, but rather to temporal, administrative, and monetary issues related to the participants' professional practice. These temporal issues include caseload, systemic expectancies, monetary compensation, degree of professional preparedness, administrative issues such as paperwork and charting, and work stressors and pressure. The other dimension of this property, *relationship with the profession,* refers to the participants' feelings about the profession and their professional identity. Each of these dimensions affected participants' sense of well-being on a continuum. Andrew, Roxy, Jennifer, Phil, and John all experienced a lack of well-being and a feeling of pressure because of work stressors, and caseload as described in excerpts from some of their narratives:

Roxy

> So I was [working farther away] for like four days straight. And basically I came home long enough to sleep and eat something. So I was living at work for like 12 or 13 hours or something like that four days of the week. Then I had three days back here in my community which I felt so disconnected from for the bigger bulk of the week. It was just weird. Like it really felt like I was living split lives.
>
> There was just a lot of pressure to perform at work as well. They had a pretty high rate of seeing clients. Like we were just expected to see a lot of client hours per week and that was stressful in and of

> itself. It was hard to be seeing as many clients as we were expected to see . . . I've gotten to a place where I am just praying I make it through the next 45 minutes instead of being present and caring for the client.

Andrew

> My schedule and my life, my lifestyle, was pretty hectic and the last couple years before I moved up to a full-time faculty member which, even though the schedule doesn't sound bad, and for full time faculty teaching a few classes, but there's all sorts of other stuff. It's a full time job, but it's more of a full time job and sometimes it's less problematic. So it's a full time job two different practices and I'd squeeze in, probably a day and a half at each one, at each practice. So full time job, day and a half times two that's three plus a full time job, plus the consulting stuff.
>
> I know there were times when I was half falling asleep sitting with a patient and of course that's bad. At the same time, shoot, I can't sleep much 'cause here's my schedule, so my sleep is here. I'm waking up early to take patients and blah, blah, blah. That sort of stuff catches up. It's really easy to get into that cycle of just going and going and going.

In addition to feeling workload pressures, Andrew felt psychologically unprepared for the struggle of having to meet his temporal and monetary obligations to himself, his clients, and to his family. Roxy and Phil expressed similar sentiments.

Andrew

> I don't think we talk about this enough in graduate school, in prepping student, or even not even graduate school, but continuing ed., anything or licensed professionals. I think it's really easy to get locked into making money to live, not just to play around or something, but just making money to live. As full time faculty I wasn't making much money. It didn't pay much. I can tell you how much it was, it's not a lot. . . not making much money at a full time job, you have to do something so I'm seeing all these patients. And even that a lot of them were manage care insurance patients. So that doesn't pay that much and of course I'm getting a percentage the practice is making something and I'm getting a percentage of that. So you're just working and working and working to barely make it.

Roxy Yeah, so I felt like I knew what I needed to do for myself, or to recognize when I needed to do that. But I didn't have a clue as to what is normal or ok or expected with the industry standards. "Like were employers taking advantage of me or is that just normal?" And when you're an associate and provisionally licensed, you know, you have to pay your dues because that's people's attitudes in this industry. So you're definitely not going to get the same kinds of benefits or treatment as people who have been practicing for years and years.

Phil . . . but if they didn't show up, I didn't get paid and so I had to start, there was a time there, probably about a year and a half or 2 years where I was scheduling 40-42 clients a week, just so I could make ends meet financially.

Because, I remember one year, I don't remember the exact year, but I remember the time of the year. I'm reminded every year almost like an anniversary trauma, where my paycheck dropped ___ within two weeks and that's how it happened very often there where I would get a really great paycheck and then people wouldn't show up and then my paycheck would be terrible. I couldn't make . . . it was very hard to maintain the cost of living. . . I mean, that's how I tried to maintain, this very fast paced position there and I was always looking for a new job.

John Yeah, and there can be, "Oh boy, the day is stretching on. I've got this many more today. Oh boy, it's Tuesday and I've got this much left in the week." And again, that comes and goes, fortunately. I think I would quit today if that's what my day was all about. But then, "Oh boy, how many more years do I have to do this?" That's when you know, I saw a noticeable increase in kind of that burden that it felt like it was, like your plow guy, just pulling the plow.

The disquieting pressure which the participants discuss is punctuated by Andrew, who professed the conflict that he liked being a psychologist, he liked the profession, but he believed it was hurting him.

> Andrew — So just pressure to keep going and at the same time realizing "That when's this going to stop or is this going to stop. 'Cause I know I can't keep going like this. Not in any healthy way." So that kind of conflicted thing, I have to keep going and it's killing me.

This inner conflict highlights the other dimension of the property of *professional context—relationship with the profession.* This relationship includes the dichotomous feelings that some participants developed towards the profession itself and to their professional identity. This dichotomy is illustrated in some of the participants' descriptions:

> Phil — I didn't care. And that was hard because I love the field. I loved the field and hated it at the same time. I've found it to be useless and extremely beneficial at the same time. I doubted it had any actual use in the world. I really, really, I struggled, bad. That's the best way to describe it.

> Andrew — I love it and it's a weird job.

> Elizabeth — So the spiritual purpose [of being a therapist] was sort of a visual that I had out in front that was a love/hate relationship. I didn't really want it. I wanted it to leave me the heck alone, sick of it. Sorry if that sounds terrible. Again it's a love/hate thing. One day I can talk all great about it, the next minute it's exhausting.

Workload, caseload, administrative work, financial, and temporal concerns were all contributory factors, according to participants, for feeling compassion fatigued.

Client relationship context. Professional burnout and the relationship with the profession, including dissonance in that relationship, affected the homeostasis or the dissonance in the relationship and interaction participants had with clients. Thus *client/therapist relationship* is a property of the subcategory of *External Context.* The feelings of compassion fatigue which John symbolically describes, connects that sense of workload pressure with the dissonance he felt, at times, within the client/therapist

relationship context. John's statement connects workload, burnout, and the internal responses which all participants experienced in varying degrees prior to navigating through compassion fatigue.

> John I know that people get raped. I know that people are addicts, 'cause they can't handle life, but to have to be side by side with them and go through that? "When have I done it enough? It's kind of like, can I just be done now? Have I had my fill?" I think that's where, when you say compassion fatigue, it's like, isn't there a point at which it's just like, "Ok, you've done your share? . . . not just be done with this session, 'cause there can be that too, oh boy, another ½ hour of this session . ."

John's quote highlights the reality that compassion fatigue may flourish in more than one clinical setting. *Clinical setting* is one of the dimensions of the *client/therapist relationship.* The other is *therapeutic interaction.* Clinical setting is defined as the clinical clientele with whom the individual participants work. For example, some participants have worked with a broad spectrum of clinical issues such as addictions, mood disorders, and partner relational problems. Other participants have worked with death and dying, hospice, and crisis. Still others have worked exclusively with trauma and abuse. Two of the participants have worked almost exclusively with children. One participant has worked with mental issues associated with physical illness. Despite clinical context and clientele, many participants detailed the extremity of their clinical environment during the time in which they encountered compassion fatigue.

> Elizabeth Then after that I think I was the first student to get into a hospital working in the ER. They usually didn't want interns there, but I begged them. I really did. I was very fearful of a client dying on me and I wanted to face my fears of suicide and even though I grew up seeing that several times, I needed to be in a setting where, I guess it sort of came in consistently, plus they had a psych unit there that I knew they were going to let me go to see to. I

guess I just needed, I've always been a person if you're going to face your fear, you've got to run through it and so I said "Where's the scariest place, by far the emergency room, and the psych unit."

For me this was the scariest place. And I worked in the middle of the night, so it was very difficult, I was pregnant through a lot of that and had a three year old at home at the time. Yeah, definitely saw it. You know, they came in, attempted suicide numerous times with gunshots to slicing their arms, you name it and I was a crisis worker, so I had to do the interviews.

A.J. Any non-burned skin you're just really grateful for, you know, and so I could touch him just on the top of his head, and with sterile gloves, but you have to be really, really careful, you know, as far as infection because it's just, their immune systems are so compromised, just anything, you know, can give them a bug and they're gone.

. . . and I mentioned, sometimes family members coming in and masking and gowning, coming into that environment, and just seeing their, even if they don't see their own family members, seeing other people and hearing the wailing, in a burn unit that can't give many pain meds, because it lowers the respiratory system's capacity and people can die.

Jennifer The majority of my clinical work has been working with children. I work with children who have been in foster care and adopted through foster care and are currently in foster care. I work for a small private agency that contracts with the local division of child and family services. I work primarily with children. I do have some private clients, but I see them through our agency. All of the children have been abused and neglected.

You're just finishing school and BAM you go, "You know, a child so severely disordered that I really didn't know what I was doing. I felt like I was treading water trying to figure out what was driving her behavior". And I worked with her in her home. We do a lot of in home services. And we had to work in the living room because we could not get into her bedroom you could not see the floor in her bedroom. You couldn't open the door . . . was like, she could

> slide through. None of her clothes were in the closet because the closet door was broken and there was too much stuff in front of it. It was all over the floor and she had a guinea pig that didn't help the smell of the room, the general ambiance.

> Jane — They don't really understand what that raw emotion is like and I just remember one mother in particular. . . So they brought the baby in and they were working on him and of course they couldn't revive him and the mother was, I was in the room with the mother and I think her parents were there and she was just sobbing, she goes "That's not my baby; that's not my baby; somebody needs to go and find the mother of that child." And we couldn't get her to go look or anything and it was the hardest thing and finally I said you've got to take this baby and she's got to hold this baby in her arms because she has to know.

> John — You're like a cage fighter. You go and they lock the gate on that cage and for that 45 minutes you're just alone with that person's depression or their addiction or their marital distress or whatever. You're in the cage. And every day you get locked in the cage. You may get beat up, you may win that one, but one way or another you're in the cage and there is no . . . till the session is up, that's when the door opens, but you're in for the fight during that time.

> Mary — I've been through it with many, many people from suicides and families to the extreme details of things and I believe some of it has caused PTSD with me and I do believe in vicarious trauma, I believe in compassion fatigue. I also believe that vicarious trauma is something you can bring on PTSD on yourself.

The clinical setting or context of many of the participants also affected their therapeutic interaction with clients, including attachment to clients and experiences of countertransference. Following the death of one of her client/patients, with whom she had formed an attachment, A.J. noticed she became less attached to other infants. Other participants also had changes in their client/therapist relationships associated with countertransference occur as noted in the following excerpts:

Mary — Probably just because of the heaviness of having heard other peoples' stuff. That it can bring up your own stuff. And as much as I thought I had taken care of my own stuff, over and over again, there was some vicarious trauma that occurred . . . some countertransference. The counter transference going on. I tried not to allow that. I found it easier to do marriage counseling, because I was trained very well by a marriage counselor. And by keeping the relationship, so it's not triangulated . . . keeping it at a dyad rather than the triad, I found that doing that helped my energies not connect with theirs.

Jane — So when you have this guilt, you feel like you almost have to overdo with them like you kind of have to make it up to them somehow. She helped me understand, this was a personal thing that happened to me, it was with something in my own family, my extended family, and I went through some depression because of this particular circumstance. And I told her, that was exactly how I explained it to her.

Jennifer — Oh, I would get too whipped up internally and so angry. . . And I would get so angry and frustrated and I call it she pushed my mommy buttons. That's my own relationship with my mother had a lot of frustrating things.

"I'm getting too invested in this. This is pushing my own personal issues and I need to take a step back from that, but I used to just dread that appointment."

Roxy — Well, I guess there was just, with the divorce, there was a lot of preoccupation about where is this going, before the divorce, trying to figure out where the marriage was going if it was possible to resolve the issues, what decision I should make So that was, I think constantly weighing on the mind and then when I had clients coming in that were dealing with similar problems or things that triggered those kinds of oh yeah, " I'm dealing with this too what am I going to do with that. This is what the client is doing with that, why isn't my husband doing the same thing? . . . or you know, that is how she's dealing with it, how's that different than me or should I be doing it more this way?" So, like, clients coming in

might trigger me kind of going down this thought process of my own problems and it was hard. . .

Roxy So I would say my compassion fatigue did come from counter transference. . .

Elizabeth It didn't matter which age they were, again, we all endure pain, so it made me not feel alone. Sometimes I would feel selfish in doing that, then I didn't 'cause I thought this is what it's all about. It's about the human connection. Of course my focus is the child though, but that's what I would get out of it without saying. Just being there and hearing their stories, and helping them made me in turn gain a strength every time, to just keep going, keep doing 'cause it's worth it. But there's no question though, I have to be honest, that if they would say something that I could directly relate to, or if I went into the home environment and saw things, that maybe in my younger years could relate to, or even at that time period, I definitely got triggered.

Elizabeth Yes, I had moments of that for sure. Moments of countertransference. People would come in and they would complain about stuff and I was like, "Please, you don't know what pain is." I had moments to myself where I'd be like, "You're going to divorce your husband over that?" That made me angry that they would want to give up on their husband who they were committed to spiritually, you know, and at the level of what I was trying to commit to and put into my own marriage. I know there's a time and place possibly to let go, but when they can't put that kind of effort, I definitely would find myself gritting my teeth and saying "hold back _____ 'cause you're about to blow on this person". I would instead make myself ask them more questions so they could hear themselves. Boy was I flooded.

A.J. So, you know, I developed quite a little attachment with him. The other thing about a burn unit is the patients are there for a very long time, sometime years while they are recovering. So we had [the patient] for at least 6 months, you know, so this is my daily ritual. As soon as I would get there, I would go over to his crib and say hi to him and see how he's doing. Um, there was just some kind of little attachment there and I was looking, it was exciting to

> see him getting stronger and better. I was looking forward to the day where maybe we could pick him up and hold him. And it probably it was several months later, I did ok, you know I just did my job, I was careful to not attach to other patients as much.

A.J. also implies that her previous miscarriage had been a contributory setting from which compassion fatigue developed.

> A.J. But my husband and I just really – we were at that time where we really, really thought it was time to have another child and it was really disappointing to have the miscarriage. And it was a little bit later. It wasn't an early miscarriage. I was about five months along, so it was a really hard one for us. Right during the same time, I'm working in the burn unit, and the thing, I think psychologically preparation is a big part of preventing trauma and compassion fatigue and whatever. I was not very psychologically prepared when I went to the burn unit, I guess I thought of – I don't know – people who work in the oil field would be there or, you know, but I didn't know a third to half of our patients were pediatric patients and were actually babies.

Countertransference reactions and attachment centered interactions, such as those explained, were often directly connected to participants' *quality of relationships outside the profession.* This concept, the final property of *External Context,* highlights past and current causal factors associated with participants' encounter with and responses resulting from compassion fatigue.

Quality of social relationships outside of professional context. Individual participants, as they encountered and navigated through compassion fatigue, were impacted by their past and present perceptions of external experiences and relationships. These relationships include family of origin relationships, past social relationships, and current and past family and social dynamic.

Jennifer, a single woman who experiences positive social support, but a lack of partner support, intimated that she had family of origin issues which contributed to her countertransference—what she called her "mommy buttons." Phil and Elizabeth look back on their past family dynamic, suggesting that compassion fatigue started in their family of origin, prior to become a licensed mental health professional.

> Phil It was very personal. It affected everything. Compassion fatigue probably started long before even the professional stuff kicked in. It was family related stuff, not with my wife or kids, but my family of origin and other things like that which have all been pretty much almost resolved at this point.
>
> Elizabeth Now I haven't had every form of anxiety, not myself, mainly generalized anxiety but again it can sent you into a depression in which I definitely had at one time in my life and then almost again, well definitely again another time just not as severe. But through the traumas through my life, I did have one moment when I was ready to be done. . .but again, several events have occurred on top of that one; that was kind of the finishing one. I was alone a lot as a kid. Literally by myself, my mother wasn't there, so I spent a lot of time alone and those were ways I had to learn how to cope and that.

Wishing for and needing support, during the time in which she experienced compassion fatigue and burnout, Roxy was impacted by the separation and divorce from her husband. Elizabeth was also affected by partner relational struggles.

> Roxy It was probably hardest during the time leading up to the decision to divorce because there was all that ambiguity. Oh not just a lack of support, but the biggest problem I had to deal with . . . separation through divorce process. It was probably hardest during the time leading up to the decision to divorce because there was all that ambiguity and one of the biggest, you know, areas where I should have had support in my life, was the biggest problem.
>
> Elizabeth But then I noticed my husband started checking out. As we had our second child, and he had some struggles with the first one, but this

> one, I don't know if it's because I gained so much weight, plus I had injuries, plus it was traumatic again, those kinds of things, I don't know. But I saw him checking out again. Because our first pregnancy was very traumatic. So I think maybe he was going through flashbacks, things like that. So I was worried about him. I was very concerned about him.

Participants have emphasized the influence of friends and family, relative to compassion fatigue. Roxy expressed not having time to discover new social relationships and potential convivial means of support because of her workload.

> Roxy . . . that's the thing with my schedule as crammed as it was of client hours, I couldn't keep up with case notes. So that's part . . if there was one thing that would say that I had to take home from work that wasn't necessarily worrying about clients, but it was the stress of, like, this cloud of case notes always looming. Like I am never catching up, I'm getting more and more behind, and so even on the weekends it was "when am I going to get this work done?" . . . Or not doing paperwork sometimes because I was too burnt out and then stressing about it which made me fatigued. So both of them. Yeah. Paperwork, working on the weekends, but then sometimes, like even when I wasn't doing it, I'm stressing about it's not getting done.

Similarly, Andrew felt pressure and conflict over wanting to spend more time with his family, but didn't feel like he could do so because of the workload and pressure related to providing for his family.

> Andrew Yeah, I mean, I'm married, family, my wife since we had kids, has mostly been at home with the kids. We made that decision and which is another kind of good and bad thing. 'Cause she's been able to be with the kids and help out at schools and everything and it's been great. They're a little older now so she's thinking about looking for a job even to kind of get back at the school, which is great 'cause . . . That's good and we both like that and the kids are doing well, but I'm sure there's also that pressure that I'm the sole bread winner.

> I wasn't able to change a whole lot in my schedule because I felt locked in like that. "What can I change." I guess of course as I mentioned earlier, I could have talked to my wife and say "I'm dying here, can you get a job." But I didn't and I guess that's certainly something on my side . . .

Mary experienced secondary stress related to a traumatic experience with a friend. She attributes some of her compassion fatigue symptoms to this experience, particularly because she felt abandoned by her friend afterwards as the cognitive changes Mary was noticing became worse following the experience.

> Mary One of my friends came in through the doorway of my home rushing and screaming, screaming and looking for me and it heightened all my senses. She was screaming that her husband had just killed himself. And all I could do was get her and sit her down and she's small and I got her on my lap and held her and rocked her and rocked her and rocked her and cried with her and she was wailing, wailing and crying and screaming.

Other participants attribute their ability to acquire resilience in the face of compassion fatigue to a positive dynamic between themselves and their partners.

> Jane It was really frightening. I can remember coming to the realization that I needed to take a step back. If it was going to disrupt my own life, my relationship with my husband, that I couldn't allow me helping someone else, destroy what I had.

> Phil I went home frequently and to my wife, who is my best, best friend and I would say, "This was the stupidest thing I've ever done. What a waste." She knows me very well. I have a tendency to be a little dramatic. I'm very lucky. I married the best person in the world.
>
> During the time my wife also got a part time job which was really hard for me. I like to be the bread winner. I'm a little prideful of that and, but it was actually a huge blessing in disguise because it helped us get through.

John	Yeah, enough that it bugs my wife. "Why do you apologize for whatever, you know, you're doing your best? Why are you thinking . . ." part of it is that I have empathy for people and I wish . . . really part of it is a wish that therapy could do more to help them and seeing my own inability to help is uncomfortable. [My wife] is definitely who I talk with and unload with, like when she brings it up, like I'll be feeling something and thinking something, and then she'll ask me about it and I'll just start crying. This happened about a week or two ago. I didn't even realize myself that it was that raw, but she's so tender with me that just her asking me about it is enough to bring that to the surface and make me feel like it's safe. I can be vulnerable with her. I'm so grateful. For someone like me, if you had a spouse who was like, pull yourself up by your bootstraps, it would just not work.

The influence of partner, familial, and social contexts as reported by the participants corresponds with a need for developing support on many fronts as participants encountered and navigated through compassion fatigue. *Developing support*, a subcategory of the next thematic category, was one of the ways that participants were able to process the disturbance they had experienced.

Processing the Disturbance

As previously illustrated, the way in which the internal and external contexts of the individual participants intersected—the way their existing framework coalesced—accounted for the dissonance and interference they experienced. At some point, each participant came to a juncture where they processed through the dissonance and interference as part of their ability to navigate through the experience. This juncture was often a tipping point which occurred after participants came to a realization of what was transpiring both inter-psychically and intra-psychically. They became aware of the effects of the disturbance and they recognized a need to change their internal and external

circumstances. *PROCESSING THE DISTURBANCE*, the second category, is operationalized by suggesting a series of actions and steps which resulted in a change in participant functioning and an ability to navigate through compassion fatigue. This change often occurred gradually over a process of time as participants tried different coping strategies.

The subcategories of *Becoming Aware of the Effects, Recognizing A Need To Change,* and *Developing Support* are the subcategories which represent this process. Of note, the process occurred within and between these subcategories and was neither linear nor circular. As representations of the participants' narratives, each of these subcategories affects the others in a conjoint relationship. Some properties of these subcategories were more salient than others depending on the unique nature of each participant's narrative. While punctuating that uniqueness, it is also important to note the overall recurrence of these subcategories and their properties relative to each participant's navigation through compassion fatigue.

Becoming Aware of the Effects

Two properties, *personal factors* and *professional factors,* exist within the subcategory of *Becoming Aware Of The effects* of the disturbance caused by compassion fatigue. *Personal factors* may also be viewed as inter-psychic or intra-psychic processes. Many of the participants were able to notice changes within themselves and their view of the external world which created greater awareness of their ongoing navigation through compassion fatigue. It is noteworthy that much of that awareness came in degrees and through looking back at the experience, though some of the awareness occurred simultaneous with their experience. This phenomenon of looking back is particularly true

with those participants who experienced compassion fatigue early in their career and have since continued to work in the field for many years.

Personal factors. Mary compared her personal effects to the properties of a sponge—absorbing too much and not being able to 'wring out' what she had absorbed. She first began to notice the heaviness as not being as carefree as she had been previously. Roxy became aware that she was simply trying to "survive." John developed an increased sensitivity to conflict, while A.J. developed a sensitivity to her extreme work environment.

Mary	I would say, um, a sponge. A sponge can sometimes gather up a lot of water. And hold a lot and get very heavy, have a heavy heart, heavy to the core, even too heavy for it to do any more good for anyone else, to sop up any more. And getting a sponge and wringing it, in whatever way there is to release it, is so important, so that sponge can be light again and it can function and do the purpose it was meant to do.
John	I've become more introverted for sure since dealing with compassion fatigue. Just don't want to be . . . I'm even more thin skinned than before. Like, if I see people being rude to other people or, it's like, it makes me almost nauseous, it's almost like I've become, what's the word, almost vicarious, thin skinned. I don't even want people to be rude to each other. If my kids are teasing, it's like my tolerance for it, which there is teasing, there's going to be, it's like I go from here to here. . . I just won't tolerate as much teasing. Then I have had it up to the top of my head. But even if I see another adult being inconsiderate with each other, it's just like, I don't call them on it usually because it's in settings. But it's like, why do that and why even be inconsiderate? The world has enough harshness.
A.J.	. . . seeing other people and hearing the waling, in a burn unit that can't give many pain meds, because it lowers the respiratory system's capacity and people can die.

In addition to emotional effects, Mary and Roxy noticed cognitive functioning changes within themselves—memory problems and a loss of ability to acutely focus.

Mary Everything was sort of a negative influence and finally it came to the point I started to have the realization that I started having a little bit of memory problems. And the memory started slipping a bit and I thought maybe something is wrong and this is getting to me a bit maybe it's, maybe I need to back away.

Roxy I would go in, put in my hours, see the clients, do the best that I could muster at that point in time, but I couldn't invest enough of me or develop my skills or talents in that point in time 'cause there was just no room for that it was just survival. So, I really noticed that it was a problem when I noticed myself watching the clock. And really kind of having the attitude going into a session that I cannot wait till this is over.

Jane found herself also feeling the repercussions of the extremity associated with compassion fatigue.

Jane It's almost like having an out-of-body experience when you are the person having to do that . . . I was having that experience because you have to almost reach somewhere deep inside to have the courage.

So I think, you know, that one just stuck in my mind, because I never had that experience ever again, but there was something that was really, and that's why I'm saying my sensitivity level is a double edge sword for me because of, I think at many levels, physically, spiritually, emotionally, you do get rid or unload or it goes away. I don't know, I just recognized it quickly and what I did was step away.

Roxy also tried to take a step back, but was not provided with that opportunity by her employer, experiencing a lack of professional support. A.J. noticed that those around her did not understand what she was feeling, nor did they initially acknowledge it.

Roxy — But I recognized pretty early on that I was getting pretty burnt out and went to my employer to say I need to take some time off.

A.J. — I just felt like this was huge; "He's gone, I have no way to process it, no one to talk to about it because everybody has already moved on. They're fine with it."

Some participants became aware of, and began to process many of the personal factors of compassion fatigue in hindsight.

Jane — But I think it was because in some ways the same agency that I was working for, and that was kind of, I was put in that situation to have to deal with these victims. And there was this certain group that they were giving me. So [compassion fatigue] happened simultaneously. So I think I just realized that. It wasn't like I was a 20 year-old, I was in my late 30's and had some life experience.

Jennifer — I guess to be aware that when I do find it, what I find, one of the other signs that I know I'm there, is my ability to empathize and be emotionally available with a client when I'm with the, is shut down or is not as clear.

I'm just getting through the day rather than let me hear exactly what is going on and here's some ideas and how can we process through this. So I'm just not as engaged. That's probably the best word. I tend to disengage a little bit because I'm overloaded. There's just like nothing left, so until I replenish myself, I lost that ability to be as engaged with clients as I want to be.

Andrew — I think the experience is broad and not I woke up this one day and felt this. When I think about it, it's probably it's some extended period of time really, not a really discreet, this month or this year I felt this kind of up and down maybe probably longer than I want actually.

That hindsight, which led to awareness development, assisted participants to see the connection between the personal and professional effects of compassion fatigue. A.J. noticed her lack of desire, Phil noticed his resilience in the face of the effects.

A.J. I kind of was probably in a little more vulnerable position to actually get a little more attached. I just was going through the motions, but I was not as excited to go to work.

Phil [Compassion fatigue] definitely started to kick in during the last job. I worked there for 6 years. I guess an indication of the environment should have been apparent to me when 13 other therapists came and went during the 6 years that I worked there. I was the only one who ever stayed.

Participants' awareness of personal factors created a mental milieu where they were able to begin to notice the ramifications of compassion fatigue on their professional lives. Their micro/internal context was affected by, and affected, their macro/professional context.

Professional factors. *Professional factors,* the second property of becoming aware are related to participants' becoming aware of changes within their professional lives as a result of compassion fatigue. The participants noticed these changes as they interfaced with their client, supervisors, and other mental health professionals. They noticed they became either more reactive or more avoidant with their clients. Some noticed becoming too invested in client narratives or client outcomes—as Jennifer put it, being "sucked into the client's vortex." Moreover, as they compared themselves with what they observed in other professionals, several participants felt that they were deficient or that something must be wrong with them because other professionals seemed to be tolerating their situations with greater facility.

Some of the participants determined that they needed to simply work harder in order to compensate for what they felt was a deficiency. Unfortunately, this extra emphasis on pushing themselves only exacerbated the fatigue and the bewilderment. Such fatigue led some participants to struggle staying focused with their clients, while

others dreaded seeing some clients. Many lost a sense of professional identity as a result. With their professional identity compromised, participants looped back into a loss of personal identity in a recurrent reciprocation of distress. For example, Phil, who experienced a change in his relationship with his supervisor, also experienced a change in his relationship with his clients and with himself.

Phil

The [supervisor] even verbally attacked me on more than one occasion. He was very passive/aggressive with me at times. And I could tell he had been burned out for years . . . it went downhill.

And I didn't realize it because it was so gradual and so subtle. I still looked up to him as a mentor because he's brilliant. He's very brilliant as a psychotherapist. He's a psychologist by trade and he is an expert in trauma. And so . . . so yeah. It was hard to see, but now that I've been out of that job for several months now, I can look back and see how his own cynicism was being put on to me.

I mean that particular colleague he lost his license and everything . . . which affected all of us. And so my boss started getting really grouchy and really cynical and saying he needed me to work more hours, which I didn't have that to give. And so I did the best I could. It progressed from that point on up until the day I quit. He became even more cynical with me.

I became resentful to those people who expected something be given to them because I found people actually do not expect life to give them something and work through their difficulties and try to strive, they're much more content, but these folks just turned over and died. And so even my effectiveness as a therapist changed, just as a result of my own resentment. At least I think it did.

'Cause as I look back, all the clients I saw, there was a lot of change that went on with them and so I think they did, but then again I'm struggling with the whole "am I a failure as a therapist?" So it's hard to be objective about it . . . "I'm not good enough."

Like Phil's narrative, the following examples from the others' narratives underscore ways in which participants became aware of how their relationship with clients was either affected by compassion fatigue or, conversely, contributed to compassion fatigue:

John	It's surprising how drained it made me. How much I dreaded . . . 'cause again, having done it for years and years, you just get to the point where you show up for work and do your job and do a good job or not you go home at the end of the day and you kind of put it aside, but it surprised me after all these years to find that you know, really squirming to have to go to work and then having a full schedule with back to back clients just . . . it always is hard, but it seems like it got to a new level of difficulty and wanting a break, just wanting out. Like seeing other people in more straightforward professions and just thinking what a great thing that would be.
Jane	So [I] had training in that. I had gone to a big seminar. I knew really well what affects that and had studied that, so I realize that that was happening to me because of the work I was doing and when you identify too closely with the people that you're working with or you're really sensitive and you've feeling a lot of empathy, you have to be really careful that that's where the victimization comes in.
Jennifer	[Clients] want you to believe where they're coming from and buy into their perception of the way they view the world, so when they're ill, that version is very twisted, but I've found that the more you work with some of the really sick people, and they'll throw things out at you and you'll start, at least I will start saying, "Wait? What? No that doesn't seem right to me, but I'm not sure anymore." It's, you know, you get kind of caught up in their distortions and that's where it's like, this case is really confusing me and I will bring it to my team and staff it.
Jennifer	The fact that she worked so hard to gain my trust and was so proud of the fact that she was being more honest, that pushes my buttons. Most of my kids lie. They're all liars. Some of them are really good at it.

Yeah, I think I'm experiencing countertransference.

Mary The counter transference going on. I tried not to allow that. So I found it; I found it easier to do marriage counseling, because I was trained very well by a marriage counselor. And by keeping the relationship, so it's not triangulated . . . keeping it at a triad rather than the dyad, I found that doing that helped my energies not connect with theirs.

Roxy I would go in, put in my hours, see the clients, do the best that I could muster at that point in time, but I couldn't invest enough of me or develop my skills or talents in that point in time 'cause there was just no room for that it was just survival.

Roxy Because work was very strenuous and just hard . . . but I recognized pretty early on that I was getting pretty burnt out and went to my employer to say I need to take some time off. This isn't I'm getting sleepy or something and such, I'm getting burnt out and I've gotten to a place where I am just praying I make it through the next 45 minutes instead of being present and caring for the client. Which is so NOT me. So not who I normally am.

Roxy Because normally talking to a client, I feel like I can be pretty present with their stuff and focused on them. So to have to fight that off and work twice as hard every session to stay engaged and stay present with what they're doing was exhausting.

A.J. It was in hindsight that I noticed that. I just was going through the motions, but I was not as excited to go to work.

Becoming aware that work was difficult was also a factor for Jane and A.J.

Jane I think one of the things that I've found in my work, and I don't know that this happens so much with clinical counselors and therapists, if that's all you're doing all the time, in my field as a _____, there's a lot of demands and there's a lot of, we don't just work with, we do a lot of other things besides trauma work and all of that. There's a lot of tasks that are associated with

our job. There's too much work and you have all different levels working.

A.J. And it was the culture that had a very large bearing on that because there is definitely, in these work areas, there is a strong culture of sucking it up basically. Now I did attempt to talk to my husband, as many people do that work, you know, with HIPAA guidelines, we didn't have HIPAA back then, but still using confidentiality, you don't have to use any identifying information, you can say we have this really bad case at work. But when you haven't worked in that crazy of an environment, there's really not a lot of that that an outsider can understand.

Jane It's one of those things that nobody else wants to do and so they always look to the _____ to be the person that goes and does that and I've had some really wonderful spiritual experiences through that, but it's really difficult when you have to do that over and over and over again.

When Roxy became aware of the dissonance and interference of burnout and compassion fatigue, she recognized she needed to change her clinical hours, but she was not supported in that premise. Her narrative emphasizes the way in which many of the participants began to view the profession and the professional context as a whole.

Roxy I felt invalidated, I felt [my director] wasn't getting it and I felt "totally trapped……like, I've got to keep working because I'm about to be the sole provider for myself. This is the only job that I have."

Roxy When I say it just became a job, I basically, I had to treat it like I was just going and doing my hours. They are the ones sending clients my way, I sit in the chair and honestly, the way that they treat the system that they have set up sometimes, it really is just like sometimes they want one of their intensive clients to be sitting in front of a warm body.

Jane We didn't do a very good job at the hospital of doing that for the [profession] (allowing for stepping away) and I found that much of

	the time it was very isolating and so what you start to do is pull away.
Andrew	We don't talk about it though (compassion fatigue). Or we do in an ethics class and say, "How dare anyone do this," and "Boy you people better never do this."

Andrew's reference to systemic silence regarding compassion fatigue is indicative of why some participants felt an inability to attenuate their circumstances. For a time, the majority of the participants appeared to have been caught in a situation in which they had no choice—that external events and internal changes they experienced were beyond their control. However, all the participants came to a point in which they began to recognize that without changing their internal and external circumstances, their dissonance and distress might become deleterious. Indeed, participants reached a tipping point as they came to *recognize a need to change.*

This recognition is represented by the second subcategory under the category of *PROCESSING THE DISTURBANCE.* This process of becoming aware of the personal and professional effects of compassion fatigue included making initial connections between their distress and its contributory factors. This process continued as participants engaged in *internal examination* while continuing to make connections between what they were experiencing and the contributory factors which needed to be changed in order to navigate through the distress of the compassion fatigue they were experiencing.

Recognizing a Need to Change

Each of the participants came to an internal state in which they determined that something must change in order not to hurt themselves personally and professionally. One participant described this as getting to a point where she could not stay in pain any

longer. Remarkably, the change process which the participants experienced was similar to the progressional model of change which often takes place with their clients. The participants came to a place where they moved from being acted upon, to taking action. They did this, initially, by practicing *internal examination, making internal adjustments, and making professional adjustments.* These actions are conceptualized as properties of the subcategory of *Recognizing a Need to Change.*

Internal examination. *Internal examination* refers to introspection regarding personal and professional identity. As participants examined their personal and professional identity, including conflicting and dialectic beliefs about that identity, participants began to change their perspective about compassion fatigue. Some of this change took place inter-psychically, as participants analyzed the extremity of their work environment, recognizing the need to separate from that environment. Participants also began to examine their personal and professional sense of self. This examination provided both time and space for trying out ways to change their circumstances.

Jennifer	The process is… it's got to be ongoing. I work a lot of hours every day and even in the cases that are being successful, it's emotional and draining and I just need to refill myself.
Phil	And I could walk away. And so by _____, the old director decided he was done and it was transferred over to me. I was the full director. And I was done with the _____. And at that point, just getting out of that job, the cynicism, the lack of trust with people, that started to go away. It started to go away.
Roxy	I wondered if I liked therapy anymore, because I found myself when I was doing therapy longing to be just doing anything else almost.
Mary	It makes me wonder what type of a person I am or what type of own hurts that I had that I would absorb someone else's hurts .

Jennifer So I think my expectation was, and kind of a personal goal was I wanted to be a very effective therapist and I wanted that to always be. To know that everyone I worked with would be better for the experience. And I think most of the time I think they're at least better. It might not be where I would like to see them be.

John Yeah, my, it has never really been a real comfort zone. And every time walking in with clients, it's even on a day to day basis, I'm not really confident at . . , my wife, overheard me talking with a client, and this was just last week. And she goes, "why do you, you know, view yourself as not doing very good work?" I really, I don't know it it's just doubts, you know, having doubts but part of it's the failure as a clinician. You're going to fail with a certain number of clients. And part of it is just seeing people whose suffering doesn't improve with the work you do with them. And what I was telling my wife is that, "you know, the worst thing is not that you fail, 'cause it would be one thing to fail and have people tell you, you fail and then they move on and go about their merry way, but what's worse is when you feel like you're failing and they keep coming back and so you just work in an ongoing way with people whose suffering doesn't end and they like working with you and they get a lot out of working, or something, out of working with you, but they never quite get better."
What I've found is that you don't really know, that's the dread of walking into the schedule for the day, you don't really know whether someone's issues are going to be . . . if you'll feel in the end like you contributed or someone's just going to have this trauma that they're dealing with right now or a couple where someone's been hurt so badly the pain is right there and you're going to be with them in the pain. And that's our job. That's what we do, but there's a part of me that just goes, it's my job, it's what I do, you can be there with them, but you've got to just suck it up and go to work. It might happen today, so there's a little bit of bracing yourself. There is a little bit of a feeling . . . "I've had my fill and I'm compassion fatigued and I can keep doing it, but where's it going to come from?"

Phil I hated it, the profession . . . And I loved it simultaneously.

> It was really hard. And so what happened was after that, after I changed my curriculum a bit, backed off, I went on vacation last year and this is when things really started to change. My wife and kids and I planned a vacation, 10 days, and we went to _____. It was last year and that is our family place. That's where we go. And it was wonderful. It was the first vacation I had ever gone on as a husband and a father where I truly left everything at home. And the reason I did is because I had to. The moment I left the state line I no longer was _____ the therapist. That guy was dead. I was _____ the father and the husband again and I had so much fun.

Phil came to tipping point about the need to change. He determined that he would have to make adjustments internally and professionally, similar to circumstances employed and experienced by other participants:

Phil	I didn't feel stressed during that vacation. I completely let my hair down. I was me again. And even my wife and my kids pointed out that "Dad, you're back, you're here again." As soon as the vacation was over, and we started driving home, I sobbed because I knew I was coming home to this. I cried.
A.J.	So all of these things started coming out and I certainly recognized that this wasn't normal for me. What is going on, this is really weird.
Roxy	I need to take care of myself, I need to take some time away so that I can come back and do a good job with my clients. That's exactly right. And at that point in time I was not allowed to do that.
Jane	I can remember coming to the realization that I needed to take a step back. If it was going to disrupt my own life, my relationship with my husband, that I couldn't allow me helping someone else, destroy what I had.
Jennifer	So I found what I almost use diagnostically now to figure out if somebody has a personality disorder is what is my internal state when I'm around them. And if I find that I'm very confused by a client, that they seem very incongruent, and their behavior doesn't

> match what they're saying, and then I start to question there's more going on her, but then I was, just like, confused. So I would take a step back and kind of go, "This is her issue."

The participants' internal examination led them to make connections between the disturbance they were experiencing and the potential internal and external causes of that dissonance and interference. *Making internal* and *professional adjustments,* the other two properties of *Recognizing the Need for Change,* were important steps in assisting participants in processing and negotiating compassion fatigue. By noticing, analyzing, and examining their individual and professional circumstances, they were able to connect their distress as a departure from their normal personal and professional condition. They began to make adjustments.

Making internal adjustments. Relational difficulties, experienced by Roxy and Elizabeth, caused them to make personal adjustments in order to attenuate the disturbance of compassion fatigue.

Roxy

> The divorce, marriage decision thing was a big problem in itself and so that finally, a decision finally got made with that and for me personally that took a lot of the mental and emotional strain away not having that unknown or that ambiguity anymore. But then came all the divorce process stuff which was taxing and difficult in a lot of way, but still not nearly as hard as the not knowing. So, just the fact that that decision got made, alleviated some of it.

Elizabeth

> But now my husband and I were ready to divorce. I already knew that I could only help him with so much. I knew at this point, I couldn't save him, couldn't be his therapist . . . So I knew at this point I had no choice for my children's sake, but to let him go. It was absolutely terrifying and then had to turn around. . . move to this new state and start my career on a whole new path and then find a place to live and plan a divorce.

Conversely, Phil, who experienced positive partner support, attributes his motivation for making internal adjustments to that support.

Phil My wife has been trying to convince me to go back to therapy for years. I wasn't ready, I wasn't willing, but finally when I was willing I made the . . . I decided I needed to work through this stuff myself. I was done, I was just done. I had done all I could myself and I was tired. I was tired of feeling divided and so I've been going back and trying to take care of that. But on top of that it's just, how do I describe this, there's still stuff I'm working on. Especially the whole "Am I good enough as a therapist?" Some days I feel like I do pretty good. Some days I feel I do ok and other days, I'm just not sure. I don't know how to . . . I found with myself I don't know how to measure if I'm a successful therapist or not. My old beliefs just don't work. Seeing people get better, I don't even know what that means anymore. Especially now working with addicts.

So, I'm not good enough and a sense of what more can I do without putting myself, again, in a position where I'm going to burn myself out. 'Cause that's not a place that I want to be again. I'm just now to the point to where I feel safe around other people, close people.

Similarly, John and Elizabeth were able to make internal adjustments in negotiating compassion fatigue, motivated by family relationships.

John Mainly though, at that point, I'm doing good and providing value can be at a higher level sort of motivator. But at some point, it's just, most of the way I talk myself through it is, I have [children]. . . I'm measuring how far they are to self-sufficiency (both laughing). I wasn't doing that when I started my career. "When will all my children be self-sufficient?" Just saying I love them and I'm going to keep showing up at work. If I show up at any other job it wouldn't . . . I kind of work myself into a corner here, where I need to show up at THIS job because it's what I've been trained to do.

Elizabeth My children are literally a visual in front of me. Their faces are planted in front of me all day every day. They are, I want to make

> sure for as long as I'm with them, that they have a mother that doesn't give up and doesn't leave them by her choice. I don't want them to ever experience what I did, so when I feel at my worst and want to check out, and those moments I've had . . . I promised them before I even created them, that I would never leave them. Not in that way. I would never let fear take me down. So that's how I push through.

Other participants 'pushed through' by making internal adjustments which included looking at their work as a 'job.'

> Roxy I sucked it up and kept going at, you know, and try to adapt to where I was with the burnout, like I knew I couldn't give my clients what I would like to give my clients, I just, at that point, I felt I needed to starting treating it just as a job. I would go in, put in my hours, see the clients, do the best that I could muster at that point in time, but I couldn't invest enough of me or develop my skills or talents in that point in time 'cause there was just no room for that it was just survival.
>
> Phil And so once I get up there (work), I feel pretty good, and when I come home, _____ the therapist is dead.
>
> That's the best way to describe it. I separate it the best I can. I never, I will never work and live in the same community, ever.
>
> John Really it's a blessing because I don't have to raise _ kids and be working more than full time now. I'm working about 45 hours a week and that's a great blessing . . . of something that will pay the bills. If I go home and am not working, I feel a great blessing I can be with the family and so on. And so I kind of put in, pay the dues, put in the hours as unpleasant as it is some days. And other days it's great. You have enough of those magic moments . . . ok this is something that I can deal with and help and any of those day provide a break.

Others participants made internal adjustments by trying to find ways to cope with the heaviness.

A.J. But there were other babies I invested as much energy of myself in as well up to that time and I think I just became a little bit, oh, detached.

And it probably it was several months later, I did ok, you know I just did my job, I was careful to not attach to other patients as much.

Jennifer Right, 'cause the process is… it's got to be ongoing. I work a lot of hours every day and even in the cases that are being successful, it's emotional and draining and I just need to refill myself.

Elizabeth So being able to find that balance of being engaged, feeling energized that I'm available to them, but not to the point where I become enmeshed.

Again, if I could relate, I would have those moments. I would constantly have to go " _____, _____ , separate, separate." I would just scream it in my head. When I was, especially in this moment of being flooded, from home, 'cause I went to work physically exhausted and mentally already, so I didn't have a whole lot to give.

Mary Yeah, it's a metal clipboard that I would put my client's chart on. It had a pen attached and I would just kind of lift it up if I felt like it was a little heavy what they were speaking of. I would lift it up a little bit and just talk to them and move forward….to protect [my heart.]

Jane So when you're called in the middle of the night and they tell you they've got a 17 year old just brought in with a gunshot, self-inflicted, you're trying to prepare yourself mentally as you're driving to the hospital for how you're going to deal with the family and sit with them and just help them to get through a horrible experience.

Like Jane, who made internal adjustments by preparing herself mentally, Elizabeth developed self-talk skills as a way to internally adjust.

> Elizabeth So I would have to go in there and this skill came from when I was a kid. I went through so much turmoil at home, so much turmoil, again, being mom, the domestic violence and abuse. Saw in my house. My mother was a severe alcoholic so I saw these things daily and I could go to school and it was my relief. Yes, instead of wallowing in my pit of despair, I had to learn to, which is how I teach my clients, what good things have occurred." What are the good things? Focus on those."

Internal adjustments included participants changing expectations of themselves personally and professionally, allowing for time and space to disengage and step back from clients and their problems. Additionally, participants took steps to create psychological preparedness and resilience in the face of external stressors and internal responses.

Making professional adjustments. As a result of becoming aware of the effects of compassion fatigue and trying internal adjustments as a way to cope, participants were able to see the ways in which their micro and macro contexts affected each other. For example, many participants felt that their macro context was beyond their control. However, when they began to make adjustments, they took risks to alter their macro context as well. As the participants made comparisons, internally examined themselves, and made internal adjustments, they began to likewise make professional adjustments. The concept of *Making Professional Adjustments* is a property of *Recognizing a Need to Change.* Making internal and professional adjustments moved participants to a place of intentionality. As participants became intentional, they created a different contextual ecology. Roxy's internal dialogue, reflected in her statement below, is an example of the process of internally examining and becoming more intentional professionally.

Roxy They don't seem to value the work that I have put in here and the dedication and commitment that I've had thus far, and so I need to find a place where it's possible for me to be human.

Andrew, who also internally dialogued, came to a place where he became more intentional, compared his situation metaphorically to being at a decision point—was he willing to move through the muck to a mountain or would he give up? He chose to risk professionally by finding a new job and moving to another state as a way to ameliorate the contextual contributors to his compassion fatigue.

Roxy Definitely was scary letting go of a salaried full time position and start going part time. There's been lots of ups and downs and from getting to that point to where I am now.

Andrew "It's messy and briars and rocks and it's just a mess and do I go across that to go to my mountain or do I go back in the house", kind of thing?

I started looking for different sort of jobs, 'cause, again, as much as I loved teaching and I loved where I was, the program and the department and everything, again, full time job, by the time I left it was _____

That's what they're paying and my raise, 'cause I was there for a few years, was 2% or woo hoo! So I'm thinking "Ok in 20 years, maybe I'll make _____ going at this rate." That's no good, so I started looking around which is partly how I found this position, my current position. I started looking around. I wasn't able to change a whole lot in my schedule because I felt locked in like that. " What can I change?"

Phil Coming back, it was like 1000 pounds was being put back on my shoulders. Of the financial responsibility, but mostly, not so much that, of being in a job that was so miserable with a boss that was so passive aggressive and even cynical with me. The very thought of it just destroyed me. So I sobbed, I said to my wife, I'm done. So I came home and I literally sent emails to every person I knew internationally. And I met some people through my academics

> nationally as well, created some relationships and started asking for any job. Anything, I was ready to walk away from my house. I didn't care what it was. And a few days back I got an email back from a colleague who said it's funny you're looking for a job, I'm looking for somebody to replace me in the next year or so. Would you be interested in coming up for an interview, it's a part time job and it's this type of place. It was a residential inpatient place. This is the type of work we do. He's also a trauma worker just like myself. And we both have very similar, like philosophical approaches and beliefs when it comes to trauma recovery and so that really attracted me. So I went up and was hired on the spot.

Other participants made professional adjustments by either taking a step back from counseling, separating emotionally from their clients, or changing their clinical context.

> Jane — I stopped doing my counseling. I said "I need a break. I'm going to focus over here instead. . ." So I think, after I got all my hours, that's when I stepped away from the counseling piece, face to face, and I just believe that's when I did that. My work was almost completely with that population then and I knew that until I was on better ground with that, that it wouldn't be healthy for me to do that.
>
> Everybody looked at me because I was the one who was supposed to be strong and they saw me just sobbing and they just looked at me like, they were very uncomfortable I could tell. I wasn't with the family I was with, I was with the staff. That was another time when I stepped back and said "I've got to have a break. This isn't working right now. This is hurting me."
>
> Mary — This went on for a few years and I actually did adoptions work and I thought that maybe this would give me a positive feeling because adoptions can be a positive.
>
> And I knew that for my best physical health and well-being that I needed to step away and then I had to deal with my own grief with that.

Jennifer When I disengage, that's a healthy thing where I've really been able to leave it there. And release it. When I have to step back, it means I'm doing work, I have to step back and figure out "where the heck I am with this. Am I overinvolved?" . . . and get clear and get my objectivity back.

Two participants tried more teaching as a way to make professional adjustments in an effort to negotiate their compassion fatigue.

Andrew I think of how things are different now and I happened upon this good job where I still teach for fun. 'Cause I like teaching. I've been teaching since graduate school. I enjoy teaching. I have a great rapport with the students and just processing stuff and learning. 'Cause really, I learn, just like with my clients, I learn from them. I'm not the only person here. I like that process. So I do that for fun.

Phil I loved teaching . . . I started teaching and going to school here at [university]. That was a big help. That was a jump start.

The teaching, because I really enjoy teaching. It's neat to be involved and watch people grow and I work with, whether it's bachelors, undergraduate folks, or graduate, it's neat to watch them learn and to be involved in the learning process. 'Cause I learn, I am a bit of . . . I'll probably be an eternal student. I love to learn.

Becoming intentional about professional changes did not just have a professional effect on participants. Just as making internal adjustments aided participants in creating the courage to make professional changes, reciprocally, making professional changes empowered participants to continue to mitigate the internal emotional and dialectic effects of encountering and navigating through compassion fatigue. Those effects were also allayed by participants being able to normalize their circumstances. In hindsight, A.J. realized that she was part of the vanguard of those who experienced compassion fatigue

and did not yet have a construct with which they could explain what they were experiencing.

> A.J. And the first thing, we didn't know what compassion fatigue was, and really not even a lot of information. This was in the early 80's. The DSM had just come out with PTSD in it, but people still back then tended to think of Vietnam vet or people who were veterans that have that.

Despite not having a name for what she was experiencing, A.J. was aided by her supervisor to understand that what she was experiencing was normal and explainable. In this way, her supervisor, as part of a support network, became a way in which A.J. could likewise become self-supportive in order to navigate through compassion fatigue.

Developing Support

Like A.J., all participants described the development of support as a primary factor in navigating through their experience of compassion fatigue. Certainly, as they became aware of the effects of experiencing compassion fatigue and recognizing a need for change, participants began to seek support and to develop support along a number of fronts.

In structuring the analysis of the data, *Developing Support* as the third subcategory of *PROCESSING THE DISTURBANCE,* emerged as four properties or types of support. These properties of *developing support* are *professional support, outside of profession support (social support), spiritual support,* and *self-support.*

Professional support. *Professional Support* may be defined as support within the professional milieu. The two dimensions of that support are supervisory and collegial support. All the participants experienced a dimension of support from both supervisors and colleagues. The two ends of that spectrum of support could be categorized as either a

lack of support or an abundance of support. When Roxy began to experience the effects of compassion fatigue, she approached one of her supervisors, hoping for validation of her need to step back. She did not receive that supervisory support.

> Roxy — Well, the way that the conversation went down, it was complete invalidation, complete disregard for this fatigue being anything. Like, he mentioned, "Try sitting forward in your chair, or take a walk between sessions. " And I thought, "Just like, wow, you're not getting this. "

On the other hand, several participants experienced positive supervisory support during the time in which they encountered, and were navigating through, compassion fatigue—particularly early in their careers. Jane, A.J., and Jennifer give credit to their supervisors for normalizing their experience and for validating their need to step back from clients and clinical work.. Additionally these three participants were able to process their feelings as a result of their interface with supervisors.

> Jane — I had two supervisors for my clinical hours . . . And there was this certain group that they were giving me. Those were the clients that were being handed to me, they [supervisors] actually protected me too by some of the training that I was given. So it happened simultaneously. So I think, after I got all my hours, that's when I stepped away from the counseling piece, face to face, and I just believe that's when I did that.

> A.J. — And after a particularly bad nightmare that I had, the next day I talked to my supervisor at the burn unit and she had been gone during this whole time, and I had covered for her so she had just gotten back and was back, so I was able to talk to her and I told her, I asked her if she remembered [pseudonym] and she did. And I kind of told her what happened and I was having nightmares. "What is going on?" I thought again that she might have some answers though I hadn't gotten any from any of the other staff. I said, "How do you deal with this?"

> She said, “First of all, what you’re going through is a normal reaction to this very bizarre environment we’re in.” She said, “There are people who are traumatized by just visiting their family members here on this unit. I mean we see people looking so deformed without skin, in so much pain.” She said, “There is a lot of trauma here and so you know, people who work here have a couple of different reactions.”

A.J. And she said, “That’s ok too because I’m planning on moving on to another job. I don’t think this is a place people should stay for too long unless they have, you know, the kind of, psychological make-up and lifestyle that would allow them to do it because it’s very intense. . .” And then she gave me some good advice, so I had the awareness. . .She gave me that support and connection of somebody to talk to normalize it and diffuse some of the feelings. It was the first time I was able to actually really process it. And she was a very good listener, and very, very helpful.

Jennifer I think one of the things that’s helped me with it is I had people to staff it with. I wasn’t sure what was going on and it was very reassuring that they agreed with me and could see the chaos and the lack of balance, so I found it much easier to be engaging with [the client].

Similarly, Phil, who as a beginning licensee, had felt support from his supervisor, experienced a change in that support later on. Phil attributes diminishment of support as the turning point which helped to catalyze his compassion fatigue.

Phil That is when things changed at the job, the actual work site. And that’s when it slowly started to get worse for me. One thing I know about myself, I like good professional support. I like to have that system in place so that I can continue working. And once that was gone and once my boss just kind of he was already somewhat cynical just by nature . . . But he became very cynical and more aggressive with me once that support and that mentorship was gone, I still way trying to get it. I didn’t realize I was trying to get it, but looking back I was. And I wouldn’t get it and he would push against me and stopped having supervision with me, stopped staff meetings, everything.

Furthermore, Phil attributes the diminishment in his supervisor's support to systemic toxicity within the agency for which he worked. Phil experienced that toxicity as a systemic response to a colleague losing his license. Phil had noticed changes in the colleague, and had tried to offer help to no avail.

Phil It was awful and that was when I really started to go downhill. He showed up one day and handed in his resignation and said I'm leaving. I've also left my wife and kids. I immediately knew something bad had happened and I had an inkling of an idea . . . and there were times when he would staff with myself and our supervisor what we was doing . . . and I would say, "Okay guys, when is enough, enough?"

Phil's concerns focus on the need for seeking and providing continual collegial support, a step which many participants felt was an important part of navigating through compassion fatigue.

Phil And I had other professionals I was working with who said. . . "What are you doing? You're going through this stuff." And I didn't see it.

Mary I wish that I would have had someone else, that some other self-care therapist, another therapist that may have experienced it.

Mary I think that all therapists need to have an outlet or another therapist or a very good friend that can listen to them without judgment and to get that understanding

Roxy And I really think now at this point, because I was talking to a colleague that's in the exact same place as I was, this was about a year ago, and she's questioning all those things too.

Roxy I think it needs a good kind of checks and balances for us as therapist. Like sometimes we don't see that as someone else sees it in us. If we see it, at least having an opportunity to kind of share

that and then have support and compassion and you know support to do what we need to take care of ourselves.

Jennifer And there's enough of us involved, that I can blow off steam with colleagues.

Jennifer It's, you know, you get kind of caught up in their distortions and that's where it's like, this case is really confusing me and I will bring it to my team and staff it. And they'll throw out suggestions and help me come up with ideas of ways I can do it and ground me, help me, like, "No this is not you, this is their issue, you know, I would have done exactly the same thing," or things like that, that kind of see it more clear.

Jennifer Very important. We only meet once a month, but we also call each other and they'll call me because I'm our clinical director which, I think is my title. I'm second in command. So if they can't reach my boss, they'll call me. "I've got this case, I don't know what to do, or this is . . ." and we'll staff it and come up with ideas. If nothing else, it's just reassurance that no, it's not you, it's your client's problem and you just have someone to talk with.

Elizabeth Otherwise I knew I needed to go to therapy, so luckily my colleagues were therapists and the ones I trusted were, so I felt great relief being able to share with those people I trusted so I didn't need to go to separate therapy that time.

A.J. The people who work in that environment usually understand it better and are better, that's why we have the peer support system, is they're much better able to support and normalize with somebody else an outsider doesn't get it. And even trying to explain it, it breaks down. The communication breaks down. So you really can't get that kind of support and those words of comfort and normalizing from somebody else because it all sounds weird to them. Then they do and it was the machine failure that caused that, there's just things, it's too hard to explain.

John Definitely, and then my partner here is great. He's just a great person to talk with about the ups and down and burnout. He works so hard, though even he's been in the profession just a handful of

> years, he works so hard, that he's worked himself into veteran status very quickly, so he knows everything.

In her narrative, Jane made a succinct statement about collegial support, declaring "therapists need therapists." However, she also gave a caveat that finding "safe" and trusted colleagues was an important part of navigating through compassion fatigue.

> Jane I had two supervisors for my clinical hours. One was for the agency and the other was at the hospital and I've always been able to speak to peers if I'm feeling anything at all I always bounce it off somebody else. If it's something in my gut if something emotionally if I'm feeling like I might be off a little bit or whatever, I go right to someone who can help me sort and make sure I'm good.
>
> I went through that experience of depression and then coming out of the depression and then again I reached out for help. That's a good tool.
>
> Jane Therapists need therapists. And so recognizing when you need help and that will save you. Believing people when they talk to you, that will save you, but you have to have people you trust. But I really think that for me, I had to go through those experiences, so I could truly help other people.

However, she also adds a caveat that it is important to find "safe" and "non-toxic" colleagues—an approach which was an important part of helping her navigate through compassion fatigue.

> Jane When you've got everybody just as wiped out as they can be, and you've come off of one of those experiences I shared with you. And there are many, many experiences. And you go to a colleague, one of your peers and say "I just had the worst night in the whole world and you just need to talk to somebody." And they go, "Like we don't all have those kinds of nights". And so there's no empathy whatsoever, and it's because they are tapped out.

Jane I learned you have to find safe people. You have to be wise enough to know who to go to and who not to go to. So you have to just, need to . . . You have to know people well enough that you don't really have to trial and error. You just need to go to somebody, but you have to go to somebody who's safe. And will help you to unload or to debrief or just emotionally do what you need to do and that's really, really important to navigate through.

In addition to collegial support, many participants developed a support network outside of the profession which was equally, if not more important, in aiding them to navigate through compassion fatigue. That support outside of the profession consisted of family and friends on the one hand, and support from health professionals, including psychotherapists which were not colleagues.

Outside of professional support. Individual participants' narratives suggest that they experienced a range of support outside of the profession. For example, Elizabeth and Roxy longed for greater support in this context.

Elizabeth "I'm just too tired. I've got to sleep. I wish I had support. I wish I had parents" was probably the main thing I would say. "If I just had a mom's shoulder to cry on or a sister or something. Somebody to just be real with." And that's where it became difficult for me. Because I couldn't let out any of my pain.

Roxy [The] areas where I should have had support in my life, was the biggest problem.

As other participants experienced compassion fatigue, they found beneficial support from family and friends.

Jane I can remember talking to my husband about it, saying " I'm really worried about something," and just sharing with him.

Jennifer I'm very active in my church and going there and being refreshed and replenished helps. I spend time with my family members and that helps and try to spend time around healthy kids that have

healthy parents. So I don't go around thinking everybody's like this.

John [My wife] is definitely who I talk with and unload with, like when she brings it up, like I'll be feeling something and thinking something, and then she'll ask me about it and I'll just start crying. This happened about a week or two ago. I didn't even realize myself that it was that raw, but she's so tender with me that just her asking me about it is enough to bring that to the surface and make me feel like it's safe. I can be vulnerable with her. I'm so grateful. For someone like me, if you had a spouse who was like, pull yourself up by your bootstraps, it would just not work.

John Yeah, like I think people might kind of bury it or dismiss it or just say "I gotta do the work, I gotta do and kind of suck it up and move on, but I think to be able to keep being empathetic with people you have to be real yourself." To feel home is a safe place too. There's still demands of family life, but it's a safe to say I don't even want to go on vacation this year. I just want to veg in the back yard or whatever and have that be ok. Or be gardening and not be interrupted with demands . . . just that she doesn't judge me by saying, "Why are you always out there and not spending time with me?" Just understanding that feels like it hard.

Phil and Elizabeth sought outside assistance from a mental health therapist, while Mary and Jennifer received assistance from a kinesiologist, and a massage therapist respectively.

Phil My wife has been trying to convince me to go back to therapy for years. I wasn't ready, I wasn't willing, but finally when I was willing I made the . . . I decided I needed to work through this stuff myself. I was done, I was just done. I had done all I could myself and I was tired. I was tired of feeling divided and so I've been going back and trying to take care of that. But on top of that it's just, how do I describe this, there's still stuff I'm working on. Especially the whole "Am I good enough as a therapist?" Some days I feel like I do pretty good. Some days I feel I do ok and other days, I'm just not sure.

Elizabeth Now I know I'm almost there, but now I'm in therapy because my fears flooded me and I said now it's time to go back to therapy to face this last thing that's keep you after your true dream. I'm in therapy now, I knew it was time and I'm at a point now where everything's stabilized, yet my fear is overwhelming.

Phil It started to go away. I still struggled with it, but at one point, and this was in December of last year, I knew there was no way I could do it by myself, so I finally went back and I found a new therapist for myself. And I've been going since, off and on; probably twice a month.

The narrative of Elizabeth, as she navigated through compassion fatigue, is an example of not finding outside of profession support. As a result, she processed through her disturbance by developing both professional and spiritual support as indicated below.

Spiritual Support.

Elizabeth Just like I teach anger management, you know, luckily I think about what I preach A LOT. Because I never want to look like a bad example, so I get up, walk away, take a breath and breathe and I would pray for someone in the hallway. "Please can I just grab someone." "I've got to tell them something quick before I blow." And luckily, a supervisor would be there or another colleague and they would immediately go, "Oh I know, I understand I feel that way too and then I'd go ok, this is normal, you're all right, you're all right. Now go back in there and do what you need and cry later."

Jennifer Yeah, and I'm a very religious person so I will pray and turn them over to a higher power. It's like, it's beyond my means to fix, I'll do what I can, but I'm turning them over.

(So, spirituality has been part of your ability to navigate through compassion fatigue.)

A very big part. I don't think I could do it without a level of spirituality. I'm sure for many people involved in therapy who don't necessarily believe in God in some way, but for me, I don't know that I could do this work without that because then it would feel, I would feel a lot more hopeless and helpless.

Jennifer Where this way, I feel like I have help. On this side and the other side. That I have spiritual help. And I believe I've seen miracles with the clients I've worked with and had some amazing spiritual experiences. Some of them sought for and some of them just BAM out of the blue.

Elizabeth I mainly had to accept the fact that "Once again, _____, you've got to figure this out on your own," and I basically become very dependent on [God] and very dependent on my own skills that I've learned throughout my life to get through it.

Elizabeth There are quite a few things that I pull from that actually that keep me grounded . . . I was constantly being challenged with trying to separate it so it didn't overdrain me to the point where I had to quit. You know, there were some days I definitely wanted to. I'm not going to lie. I really, really did, but yet once I got in the door a peace would always come over me; a relief oh, "I got here, I can't believe I made it." The drive alone, I would cry on the way, things like that and I was begging for strength. "I don't want to lead a group tonight, I don't want to hear other peoples' crap, I don't want to relate to another flipping person. Please don't let me hear that," but then I would get in there, get in the door and I don't know just, phewsh, gone, so very interesting how that happened.

Elizabeth I very quickly learned I physically fell on my knees and that's where I belong. I had to surrender completely 'cause I could not do this by myself. There was no physical way.

Likewise, Jennifer, John and Jane all highlighted their need for spiritual support in order to temper the interference of compassion fatigue.

John And sometimes miraculously, like I pray every day for help that the Lord will guide them, guide me, strengthen my ability to be

there for people and miracle happen most days. It's pretty cool, but WHEW, you know, the burn out is definitely there. It's kind of one of those things, I have strong positives towards my career and strong negatives. I can see a career that had much less negative, but probably wouldn't be nearly as positive feelings.

Jane So this time around I was not remembering. It was like it was being taken away

Self-support. Correspondent to spiritual support, participants developed self-support as they processed the disturbance of compassion fatigue. This self-support included trying self-care strategies, but mostly was accounted for by allowing themselves time and space to heal.

Mary Yes. I was not, yea, I didn't make it about me. It wasn't about me as a therapist, it was about them. And I would literally speak to myself, "It's not about me." If there was something, a thought I might want to share with them or something, I would say, "It's not about me" to myself.

Roxy So even after my life did come into more balance I would say it still took a while before I felt restored enough to start growing again.

Roxy And so, it was kind of a long process of deciding, eh, "nobody's saving me or helping me here,"

Roxy I think a lot of it was just time passing. Like once I found more balanced in my life, like for the last few months I've been kind of stressing out and wondering why I'm still not able to sit down and read through a book. Why do I not want to read books that I'm very interested in as far as, professional development and stuff like that? I just don't want to. Anytime I try to make myself, it just doesn't stick.

A.J. Well, it, um, it took me a few years, I'll be honest, to really figure out how to have a better balance in my life that really sustained me through the kind of work that I do.

Jane So I think that was my first experience with learning that it's ok to take care of yourself before you try to take care of somebody else. That's very appropriate and healthy.

Jennifer I think I learned how to take care of myself in the process.

The development of support was not a one-time process but, as is the case with the other categories and subcategories, a circular and ongoing process of navigating through compassion fatigue. As participants developed dimensions of support along a number of fronts, they were able to make and sustain internal and external changes more readily.

Making Changes to the Existing Framework

As participants processed through the disturbance of encountering and navigating through compassion fatigue, they made changes to their existing framework—namely, their *Internal Context, Professional Context,* and Their *Context Outside Of The Profession.* In other words, the participants' framework remained similar to the framework in which they had experienced the dissonance and interference of compassion fatigue. However, now they were experiencing and making changes within that framework which resulted in a different and more balanced response to navigating through compassion fatigue.

Internal Context

While participants had previously lost homeostasis as a result of compassion fatigue, by processing through the disturbance, the internal terrain of participants changed. These internal changes were manifest in their emotions, cognitions, and personal practices which created a protection of the core self. In this case, the core self

refers to a more balanced sense of self and a protection against dichotomous feelings or absorption of client suffering and pain.

Emotions. Participants were able to create internal balance as they found ways to process and offload their negative emotions. The dimensions of this processing ranged from verbal processing to a more physical or ritualized processing of emotions.

Roxy So I felt like I needed to find a job that was closer to home, so that when I was working, be in my community maybe open up more time for that. By being part time and not having, so if I'm not seeing a client . . . I had more room to just be myself when I'm not sitting in front of a client. I felt more like myself because I had a life again and was finding passion and joy instead of just being tired all the time. So when I am in front of a client now, I have more of myself to bring instead of being this automaton . . . instead of being this automaton. I've become more balanced.

Mary I actually would do a ritual that I didn't realize I began doing. I would come home and take a bath, a hot bath to relax and release what was going on and energetically it probably helped me.

Mary Yeah, it's a metal clipboard that I would put my client's chart on. It had a pen attached and I would just kind of lift it up if I felt like it was a little heavy what they were speaking of. I would lift it up a little bit and just talk to them and move forward . . . to protect . . . And I believe those skills are grossly under taught in graduate school, grossly, and actually should be on a bachelor's level because these people are going in because they are caring people, they care about the world, they care about what happens and helping others, they need to care about, there should be classes on self-care.

Mary I would get fatigued during the sessions from the heaviness of the things sometimes I would try to blow back the energy as well.

Roxy The place I was working at, I found another job doing therapy at a place that's much more supportive of you being an individual, a person who has needs and a life outside of the life and is much more flexible. So, my personal life was getting more balanced,

	work life getting more balanced and I had to fight pretty hard for that to be able to happen . . . life became more balanced
Jane	But this one day, this little boy had been run over by the school bus, and it was just a very sad experience and I was the one involved with that. After it was all over with, I was so tired I stood at the desk and I stopped and I knew I was crying for me.
Jane	You just can't believe the things that happen to people, the choices they make, you know, and I think by that time around, why not, you know, it was more, I was more, it was a better place. I was in a better place with all of that I think. I knew because of the way I was responding to it and that it wasn't, I was able to not internalize it and . . .
Jennifer	A cranial, just clears that negative energy. And I feel lighter. That's when I start noticing the compassion fatigue is I'll physically feel the weight of the other people's stuff on me.
Phil	I'm just now to the point to where I feel safe around other people, close people, but they still pop up occasionally and it's annoying, but it's more of an annoyance now . . . I just acknowledge it and am aware of it . . . accept that it's just a feeling and there's no basis or foundation for it and then I just being me.
Elizabeth	Yes, I had to let my emotions out because of my _____ disease. My body does not allow me to hold stuff in. I pay a big price for that. So I have to let them out physically or emotionally.
Jennifer	One of the things, an NLP technique. . . Neurolinguistic Programming technique is, imagine like a giant sifter. So sometimes in the car going home, I'll imaging a sifter coming up through me and it can be really just not going through. It will just keep going through my body sifting out the stuff that is not mine and leaving it and letting it flow away. I'll do that until mentally it flows free and it's not stuck. And it's interesting 'cause it definitely; I can feel the weight of it as I'm trying to move it through. Keep going and keep going until it moves free and another thing that I do is I'll say, " I'm _____. I'm only_____ and anything that's attached to the core of me that

> is not part of me in negative energy or a negative entity, needs to leave now." Just to separate that I am not them and as much as they would love for me to take their burdens, they're not mine. I don't have to take them. So I do little things like that to do maintenance.

Cognitions. Additionally participants experienced a change in cognitions as a result of navigating through compassion fatigue. Sometimes this change was deliberately practiced, while other participants noticed positive cognitive changes as an outgrowth of their process of negotiating compassion fatigue. The dimensions of these cognitions included taking a stance of personal non-judgment and becoming more attuned to the signs of compassion fatigue. By becoming more attuned, participants were able to avoid the injurious lows they had previously experienced at the beginning of their encounter with compassion fatigue. Some of that attunement included preparing and fortifying themselves mentally.

Roxy	I feel like I'm kind of just getting to a place where I'm ready to start growing and learning and expanding again.
John	I would say the main thing I've done is energy management. Just trying to recognize that I only have so much energy and it's really depleted on days. I'm not going to commit to a lot of things, so I can do bedtime with the kids, but I don't expect a lot out of me for bedtime or I may, you know, just try to not demand too much of myself. That's really wimpy, but it's really been necessary. If I'm going to keep working in this profession, you've got to just respect how much . . . and part of it again might be age. You only have so much energy the older you get . . . pacing is definitely the word for it.
Jane	Maybe be the one who calls on the phone to tell someone their loved one was killed in an accident or is dead. All different things. So when you're called in the middle of the night and they tell you they've got a 17 year old just brought in with a gunshot, self-

	inflicted, you're trying to prepare yourself mentally as you're driving to the hospital for how you're going to deal with the family and sit with them and just help them to get through a horrible experience.
John	What I've found is that you don't really know, that's the dread of walking into the schedule for the day, you don't really know whether someone's issues are going to be . . . if you'll feel in the end like you contributed or someone's just going to have this trauma that they're dealing with right now or a couple where someone's been hurt so badly the pain is right there and you're going to be with them in the pain. And that's our job. That's what we do, but there's a part of me that just goes, "It's my job, it's what I do, you can be there with them, but you've got to just suck it up and go to work." It might happen today, so there's a little bit of bracing yourself. There is a little bit of a feeling . . . "I've had my fill and I'm compassion fatigued and I can keep doing it, but where's it going to come from?"
Mary	Yes. I was not, yea, I didn't make it about me. It wasn't about me as a therapist, it was about them. And I would literally speak to myself, "It's not about me." If there was something, a thought I might want to share with them or something, I would say, "It's not about me," to myself. And I would just continue to go on with them and rejoice in what they did and their goals and what they could do. But I believe in my own self that I did not do that for myself.
Elizabeth	I have a mission, spiritually and I have a mission to my family. I finally took the risk to create a family which was always very careful for me also, but now that I've helped create these lives for these children, and for myself a new family, no one's going to take that from me. I'll go down fighting like a mad woman, so everything I had in me was for them.
Mary	I would build upon their (client) strengths, there was some joyous times and I would rejoice with them, wherever they were at and whatever they could do.

Jane So I think that was my first experience with learning that it's ok to take care of yourself before you try to take care of somebody else. That's very appropriate and healthy.

Jane And wouldn't you feel that deep compassion and love for another person, that's what you're feeling. That doesn't make you a bad person. Sometimes I think we get confused because we think that unless we went through what they went through, we can't understand.

Jane So when we start to feel that compassion for them and that deep sorrow, it can get confusing. Once she reframed that for me it helped me understand that that's how God feels when we have hard times. But he still can't take it away from us. So we can't do that for others. That took me a step back and I said, "I don't have to fix it. I don't have to make it better and I don't have to make it part of me."

Jane I'm saying that I feel like every experience I've ever had was helpful to me. It was an opportunity for growth. I think that's helped me a lot to recognize that instead of why me or poor me or feeling sorry for myself saying, "That was an interesting experience and what did I learn from that?" I think I've done that much of the time to always look for meaning. I always look for the teacher, and I always look for what do I do with this now.

Phil I feel [experiencing compassion fatigue] has also been a beneficial thing for me. It's made me question myself . . . It's required me to either grow or give up. And I've never quit anything. I've wanted to and so it's put me in a position, a very difficult and hard position to evaluate how I see myself. How I evaluate myself, how I, not only see myself as a professional, but as a husband, a father, a son, a brother. All the different roles in my life that have either molded me or affected me to be who I am today and some relationships that I thought were lost have been remade that were pivotal and important. I don't know they would have any other way. And so it's been a very good thing. It's not something I'd like to repeat again, you know, 'cause it's been very, very challenging. It's probably the hardest thing I've ever gone through. And I've gone through some tough stuff, but this is the worst.

Jennifer Yeah, a lot of times they come. If the family's prepared the client's prepared and open and I get a sense . . . and everything falls into place and I feel like I'm being helped and they're being helped, there's just lovely synergistic healing going on that's well beyond my ability. And it's pretty awesome. Those are the kind of things I hold on to, to ride out the times when you feel like you're trudging through the mud.

Jennifer [A sign is] I'm more distracted, I'm not as invested in what's going on. I'm just kind of thinking my time's almost done. I'm just getting through the day rather than let me hear exactly what is going on and here's some ideas and how can we process through this. So I'm just not as engaged. That's probably the best word. I tend to disengage a little bit because I'm overloaded. There's just like nothing left, so until I replenish myself, I lost that ability to be as engaged with clients as I want to be. And that's a fine balance I think or being engaged with them and let them know you care about them, without being so invested that you lose yourself in it. And your objectivity and your ability to disengage. That you can't go live with someone, which some of my families would love it, and I have been told this. "If you could just come and live here, this would help."

As participants made intentional changes to their cognitions, they were also able to notice changes within the way they viewed the profession. For example, Roxy noticed that as she made professional adjustments, as part of processing through the disturbance, she became less cynical. Other participants were able to make changes in their professional context as a result of negotiating the interference of compassion fatigue. Moreover, participants noticed that making changes within their professional context acted as a bulwark against compassion fatigue.

Professional Context

Participants, as they encountered compassion fatigue, spoke of experiencing dichotomous feelings about the profession. Those dichotomous feelings were somewhat

attenuated by making ongoing changes to the Professional Context. Those changes, the properties of the category of *Professional Context* are *making professional changes* and *creating a healthy client/therapist relationship.*

Making professional changes. Some participants have made professional changes, inoculating themselves against compassion fatigue, by practicing generativity and providing ongoing support to other professionals.

A.J. Well the metaphor that comes to mind for me as I kind of imagine myself drowning in a dirty stinky swamp. And then floating out and getting my head above water and kind of floating in some clean water for a while, but with my head barely held above then eventually getting out and being able to help other people out of that water. Being saved from drowning.

Jane Therapists need therapists. And so recognizing when you need help and that will save you. Believing people when they talk to you, that will save you, but you have to have people you trust. But I really think that for me, I had to go through those experiences so I could truly help other people.

A.J. The isolation and the loss of humor are what they were able to identify in hindsight. It is still to this day, that's it's really affected this group. Of course as professionals we go, "Holy Cow, why didn't we see this coming? Could we have done something, you know, to prevent this in our colleague?" I did support the folks though after he died. They called me in to help support them, but it just is like a reminder that wow, if we don't really proactively take care of ourselves, here is where we end up. This is the end of the line. Either that or people leaving the profession, which is sad in a different way.

A.J. OK. Well, coming up to the present moment, I help, I'm the director of the [Program] for [facility]. So anyone who has a situation that could potentially cause compassion fatigue, I actually reach out, I established this program, I reach out and respond to them. I will call them, I have trained a peer support system in all our facilities so there is somebody that they can talk to if they start

having any feelings about a situation and it is somebody that will recognize and reach out to them and assess what support is needed. We sometimes provide some group support, but we do a lot of individual support too. So it's really been a big part of my work since then, to help to others and help support others in dealing with compassion fatigue.

A.J. It's interesting because I get immediate credibility no matter how crusty an ER doctor is or an ICU nurse or whatever, when I say, "Yeah, I've worked in the burn unit." That's all I have to say and they say, "Whoa, ok, you do know what you're talking about."

A.J. And the fact that I can say, "Yeah, I've experienced this; I've been there and I know there is a way through this." Now I'll tell you sadly, there, before I established these support programs and whatever, there were at least three people I knew of who suicided here at this _____. . . Ultimately, that is the worst outcome that can happen, but their colleagues identified it and say that they had lost their sense of humor, that they started isolating themselves and they usually could point to usually a series of bad outcomes or sometimes one particular case. It doesn't seem to have a rhyme or reason what exactly it is. It's just situations. One nurse in particular who worked on the ___, young, darling, she had had three bad outcomes all child abuse cases, just terrible situations and they died, all of them died like in a one month period of time and while yes there were other things going on in her life, she had recently separated and was going through a divorce, she had some financial problems, other things, everybody who knew her said that was what put her over the edge.

A.J. I put a little PowerPoint together and somebody said, "Hey can we put this on the web?" I said, "Sure." And I get emails from all over the place saying is it all right to use your PowerPoint with this group or that group and what do you think about this. And I love that, you know I always say of course use it because I want the word out there I want people to be supportive. That's been very healing and gratifying for me.

Jane One of the neat things about doing counseling and, I was lucky because almost all of my work, I did do some EAP work too, but I

worked for an agency when I did my practicum and then when I actually just worked for them . . . Right, they use those resources for like … was one of our clients.

Jane Uh huh and internalize that. You feel like it's yours to carry out by yourself and that can be . . . that's not good. It's not healthy. Well that happened, it wasn't just me it happened to, it happened to my fellow workers. One thing that I try to always do when people had something really horrible they went through, I would always sit and talk to them and let them do that with me. I was very compassionate that way.

Jennifer With the help of, this has been a team effort. This is not a one-person family.

The other dimension of *making professional changes* which participants engendered was learning to become aware of, and avoid, systemic compassion fatigue. Systemic compassion fatigue refers to a systemic contagion which exists within some mental health organizations which creates an external context wherein compassion fatigue may flourish. This external context, delineated in the sections on developing support, includes lack of systemic support and a dearth of positive emotions within a particular system. Some participants, as part of navigating through compassion fatigue, took definitive steps to avoid systemic compassion fatigue.

Roxy I felt like I knew what I needed to do for myself, or to recognize when I needed to do that. But I didn't have a clue as to what is normal or ok or expected with the industry standards. Like were employers taking advantage of me or is that just normal. And when you're an associate and provisionally licensed, you know, you have to pay your dues because that's people's attitudes in this industry. So you're definitely not going to get the same kinds of benefits or treatment as people who have been practicing for years and years.

I think that I could have, left to my own devices, I could have done a pretty good job of taking care of myself well enough for this to

never have happened. So I think it's really important for employers to be respectful of employees needs and to be hands off enough to let them do what they've got to do.

Jane Or they don't have the skillset. Or there's just some toxic stuff there that won't allow them to have compassion for another person because they might be mad at you because you, whatever, you . . . those kinds of things can enter in. I think in that kind of setting you really have to have, and I think most work places try to do this now, but you need to be able to meet together as a group and talk things over and especially when there's been a traumatic event. And they do try to do that to kind of help everybody.

Roxy And while I do, like I think that this was addressed pretty well in my graduate program as far as, like, there's a self in the therapist that you've got to take care of yourself and watch for transference and countertransference and you know take time off. This happens to a lot of people; it was normalized, but my graduate program didn't have very good connections out in the community to know this is a good place to work, or let me introduce you to this person and maybe you can have them as a mentor or work with them, or this is what you can expect from employers about pay or benefits, you know, this is when they're working you too hard or not enough. Those kinds of things, like I didn't know the industry and I was left completely on my own to find a job or where to go from here after I graduated. I was just drifting and . . .

Phil And I had explained that over the next could be few weeks or 6 months I'm going to be decreasing till I'm gone for good. He became more cynical. He actually verbally attacked me again . . . I could walk away.

And so by [specific date], the old director decided he was done and it was transferred over to me then I was the full director. And I was done with the _____. And at that point, just getting out of that job, the cynicism, the lack of trust with people that started to go away. It started to go away.

Creating a healthy client/therapist relationship. The other property within the subcategory of *Professional Context* and the category of *MAKING CHANGES TO THE*

EXISTING FRAMEWORK is *Creating a Healthy Client/Therapist Relationship.* As participants processed the disturbance and interference of compassion fatigue, they made ongoing changes within the dimensions of the client/therapist relationship. These changes, the dimensions of creating a healthy client/therapist relationship are creating healthy boundaries and separating from client outcomes. As participants generated these practices, they gained a greater sense of healthy compassion for their clients.

Jennifer A lot of the population I work with does have neurological impairments from prenatal exposure to drugs and alcohol and early neglect. It changes brain function. We're learning so much about that and just to accept the fact that for some of these kids and their parents, there's only so much we can do . . . Yes, I do think I accept more that I'm not going to be able to fix everything and be ok with that and to just really be able to go home and say this is not my life. This is not my life; it's not personal.

A.J. Well I think when I went into that job and up until the point that [the patient] died, I would fully invest myself with the patients and families emotionally. Maybe to the point that I didn't always have the best boundaries because I think that's something that you kind of have to learn as a new therapist.

A.J. So I was the face of the burn unit at the funeral and with the families and that actually was pretty rewarding, so, I was fine with that. That really did change after [the patient.] I did not go to any funerals after that.

Jane I think I learned pretty good boundary work.

It helped me to finally straighten it out in my mind because, as a therapist, you know, you've had this experience, you sometimes feel like you're working 10 times harder than they (clients) are.

And it kind of makes you angry, so if you can, again, step back and recognize there is something wrong when you're working harder than they are, that it's their experience and if they don't want to move forward, it's not your fault . . . It's not your problem. You're

just there for them and you'll help them when they're ready, but it has to be them.

Yes. I see it much like our relationship spiritually with God. He doesn't ever force anything on us. So why do we get confused and try to do that to each other ?

Jennifer To just do what I could to be nurturing and supportive, point out the good things she was doing, point out the thinking errors, try to help guide her a little bit, but not invest myself in whether or not she graduated from high school, get a job, have a successful relationship. I had no control over that.

Jennifer I think I learned how to take care of myself in the process. Because I'm single and I don't have children, it's easy to kind of throw myself into the work. So I still struggle with that, of not working too much, but still paying bills and having enough to live, but I think the balance of I can't make my whole life about work and I can't make my work about other people's choices . . . be so upset in my personal life that I can't function in my personal life if you choose not to take advantage of it.

Jennifer Remembering the successes and remembering that you can be effective and that really I'm doing a lot of the same things with everybody. It's not like I do something special and different with those I'm very successful with, than the ones I feel like I'm not being successful. It's the degree of their ability to embrace it and accept it. That's helped to just go, you can choose to accept what I'm sharing with them or not. Most of what's coming from me is not just from me. It's clinical research and people who've found success with it and they want to not accept it, it's their choice.

Jennifer So being able to find that balance of being engaged, feeling energized that I'm available to them, but not to the point where I become enmeshed. Yeah, when it's really on track. At a really good level of engagement. Because if I get overly engaged with them, I lose my objectivity and I'm not helping them.

Jennifer So you do have a balancing act of being engaged and loving toward them, and I love a lot of my clients, I really do love them

and care about them, but I'm not good to them if I become a part of their family. I lose so much effectiveness. It's a fine balance between engaging too much and too little.

Jennifer One other thing that I've learned to recognize is that there's just going to be some clients that I don't really like. Our personalities don't connect. Our personal belief systems are very different and I recognize it does impact the therapy some, but the more I'm kind of aware of it, it doesn't have to impact it that much. You can still do good work with people you don't particularly care for as long as you're aware of that. It's when you're kind of blind and accept some people are just different. We don't always connect with everybody as well as other.

Phil I'm much further along than I was 3 or 4 months ago, but what helped was changing the job helped. I like the separation between my job and home. 100%. So this 50 minute commute is not a bad thing. Not terrible.

Phil Having a new place, having new people around to work with and new client population. These people who check into this place are there voluntarily. They also have a higher socio-economic group. They're usually about middle class. We get a lot of upper class as well which also is interesting. It's a completely different experience. The trauma stuff that I still do a lot of, as well as the addiction work, it looks the same, but . . .

Elizabeth Yes, instead of wallowing in my pit of despair, I had to learn to, which is how I teach my clients, what good things have occurred. "What are the good things? Focus on those. Are there any?" And yes I'd get mad having to think about them, because they weren't what I wanted. The way I wanted them, but when I did pull from my experiences with people, or the ones who reached out to me, it wasn't exactly what I hoped for, but they were very profound and the people meant it from their heart and those moments, again, I connected with people at work. Those were profound moments that I'm lucky to even have those. I'm lucky to connect with people like that. Even though they're paying me. How sad is that. I even feel guilty from that, you know. 'Cause I'm getting something out of it. The fact that I'm getting something out of it, makes me want

to give to them even more ‘cause they’re giving me a gift and so once I add them all up and allow them to penetrate me completely, let’s go, let’s just keep going, but it’s not always easy.

Elizabeth I would take my anger and make myself form questions toward the person I was angry with so they could hear themself. I wanted to make sure. Something kept saying make them hear themselves talk. So I would ask them, find new ways to ask questions and then I would allow the person that was in pain or felt shamed I’d educate on that subject and then give them a chance to emote and share their feelings and see if it would help create compassion. I focused on try to create compassion and getting them to be real.

John As far as other things though, what was it . . . it is helpful to see that the value of what we offer is not solutions ‘cause that’s something that’s been reiterated to me and if all we do is walk with them (clients). Did you hear about the woman who was hit by a bus? . . . And then the officer, who was one of the first on scene, they’re taking care of the emergency with the vehicle was going to roll, so he dived under there to take her pulse to see if she’s breathing. And he goes to leave and she said, “Don’t go.” I’ll tell this to couples, for men that problem solving orientation is so strong, but I tell them how in the hospital later, it wasn’t the crane operator who got the bus off of her that she’s calling to tell him thank you, it’s this guys who was just with her in her suffering and really both needed to happen, but the most important thing to her was that personal presence of someone while she was in the midst of suffering. As incomplete as that seems sometimes, it’s better to have that than to be alone in it.

Jennifer Yeah, and I’m a very religious person so I will pray and turn them over to a higher power. It’s like, it’s beyond my means to fix, I’ll do what I can, but I’m turning them over.

Contextual Changes Outside of Profession

In addition to professional changes, participants made contextual changes outside of the profession in order to negotiate the disturbance of compassion fatigue. These

changes, the dimensions of this subcategory are *pursuing creative outlets* and *practicing ongoing self-care.*

Pursuing creative outlets. Participants were able to affect the effects of compassion fatigue through practicing creativity. This creativity was specifically outside of, and completely different than, professional pursuits. Participants' self-care consisted of doing things outside of the profession with family or friends.

Andrew — I have time to do my music and do other things. I play basketball with my son a lot. We do physical things. We love to hike around here and we do a lot of outdoor stuff and a lot of fun stuff like that and so it's a different lifestyle now and because it's a good job, a good paying job, there's not that pressure that there was with my other combinations of work where I had to go and go and go and drive myself nuts like that. I'm really fortunate and thankful that this has happened. Because I think back, "What if this job didn't . . . if I didn't happen to see it?" I just happened to go through on the APA monitor has job listings in the back of it every month. Sometimes I look and sometimes I don't 'cause I know all the jobs out there and they don't pay well. Still in that rut. If I didn't happen up this, man what would I be . . . I'd be dead by now or something.

A.J. — And that has made a world of difference because when I dance the rest of everything goes away and I have pure joy and it's so fun, so . . . Completely engaging mentally, physically in every way, I'm in another world when I dance and so this world is completely shut out, it's gone, so it's that good of an escape. I connect with, oh there's another whole world out there. And I have people who aren't in healthcare and I think that's really, really important when all your friends are people that you work with or other therapist or whatever, is actually not real good because you don't get the same kind of balance as if you're talking just to people who are a little more diverse and so the world of dance has given me that. It's been a wonderful balance and wonderful friends and connection.

Practicing ongoing self-care. Participants' self-care consisted of doing things

outside of the profession with family or friends.

Jane I think for me, hard work is actually cathartic for me. So if I have to really work through something emotionally, if I can just do something really physically just wipes me out, it has a cleansing effect on me. So I'm just completely exhausted from physically just wearing myself out because when I'm don't I can see what I've accomplished and you have that sense of look at what I did.

Jennifer I'm very active in my church and going there and being refreshed and replenished helps. I spend time with my family members and that helps and try to spend time around healthy kids that have healthy parents. So I don't go around thinking everybody's like this.

Andrew I guess going back, part of my sanity, and this is why I mention it to students, is my extra stuff, my music stuff and my family do a lot together. That's a great source of support for me. But my music is an important thing in my life. I can call myself a musician first and everything else second. We would perform and rehearse and do show and all sorts of things. And that was one of the big things that kept me going. That kept me sane 'cause I knew that, ok good, I've got a rehearsal. Good 'cause it's fun and it's a good time. I happen to like the guys. We all liked each other so that was a good kind of social thing and you know playing and performing is always a good release for me. A creative . . . everything. So that was something that kind of helped me 'cause I knew I had that and I could do that and it's going to be fun. We have this coming up. I'll keep going 'cause I have this fun thing going on to.

Andrew Yeah, in a different way I think that my other jobs as a teacher, if you're any good at it, those are both creative pursuits. You need to be creative in those jobs to do any good. So, that's also something that I like about the work that I do 'cause it's exciting, it's a creative, it's a good process and so the music part is another type of creative thing for me.

Andrew And we like to do things. At the time we were in _____, we lived near the beach. My kids grew up at the beach, they love the beach. Just going down and walking around and that's always a

real energizing thing for me so I kind of regain my strength on the weekends and by spending that time with the family.

Phil — It was really hard. And so what happened was after that, after I changed my curriculum a bit, backed off, I went on vacation last year and this is when things really started to change. My wife and kids and I planned a vacation, 10 days, and we went to _____. It was last year and that is our family place. That's where we go. And it was wonderful. It was the first vacation I had ever gone on as a husband and a father where I truly left everything at home. And the reason I did is because I had to. The moment I left the state line, I no longer was _____ the therapist. That guy was dead. I was _____ the father and the husband again and I had so much fun.

John — When I'm alone and out in my yard or under a tree somewhere or on the trail. We have a trail that we ride our bikes on with our kids, I'm refilling my tank . . . Now I keep exercise going, maybe 45 minutes almost every day. And that I keep doing and it's helpful and my wife and I ran a half marathon the last couple of years. But I'm not like getting whole hearted into running or anything just because it's not my goal to become a runner. I really look at what can I do that sort of helps.

Elizabeth — At least exercise has been my out ever since I was a kid. Sports was my survival. Being able to hit a ball, kick a ball, something like that 'cause I played basketball, volleyball, things like that and at least going to the gym and really pushing hard in my classes or with weights or whatever. All of that was taken because of my physical ailments that I had from the C-section and the muscle tears and the weight gain. I atrophied greatly. My body atrophies very quickly. I don't have a gifted body at all when it comes to that, and if I'm bed ridden or anything for a time, "Phew . . . Oh my golly, it's like walking up the biggest hill you can imagine and holding a 90 pound backpack." So it was exhausting. I had no outlets on a physical level and that's what I desperately needed. So my anxiety would go up because I couldn't go scream it out, you know, get it out through physical activity. So I was left with doing small little exercises at home little things at a time which was a big test for me to get benefit out of that, so . .

Jennifer I believe that I pick up a lot of people's negative energy and they kind of take that negative energy off me and I remember . . .

(You mean going and getting a massage or a cranial massage . . .)

A cranial, just clears that negative energy. And I feel lighter.

A.J. To learn that skill. I thought I knew how to relax. You can always get better and I've always done yoga and that's helpful, but I added some additional tools in my toolbox that really helped and the meditation was extremely helpful and I dance.

A.J. . . . if we don't really proactively take care of ourselves, here is where we end up. This is the end of the line. Either that or people leaving the profession which is sad in a different way.

Discussion

The initial interview process with the participants afforded fertile ground for an exploratory data analysis of licensed mental health professionals' experiences with encountering and navigating through compassion fatigue. The participants' rich description of their narratives, including the process of experiencing compassion fatigue responses, processing through the responses, and making changes as a result, implied a process of moving from being acted upon to become more action based and intentional. Each of the participant's responses to the initial round of questions suggested that while each individual narrative was unique, recurrent themes existed within each of the narratives and responses. This uniqueness might be explicated by the following analogy: the participants have existing framework. An equalizer exists within each participant's framework. The framework is exposed to internal and external stimuli, thus manifesting a nexus of stressors which rise and fall depending on individual circumstances. A bar

exists, and if the stressors surpass the bar, a response occurs. The accumulation of the responses may reach a threshold that creates dissonance and interference in the existing framework. This interference and dissonance constitutes a disturbance of previous functioning. That disturbance, once processed and mitigated causes a lessening of the disturbance and a change within the framework.

In explicating the participants' experiences within the context of grounded theory, the participants' responses to first round questions suggest a process in which the experience contains a variability which exists between categories, subcategories and properties. Each property within a subcategory is interrelated, as is each subcategory. Depending on the individual narrative, some subcategories and properties appear to be more salient than others. Although, all of the subcategories and properties are universally recurrent in the participants' responses, some are more developed than others, suggesting, at this juncture, a preliminary theoretical structure. Based on this preliminary analysis, a second set of interview questions were devised in order to deepen an understanding of the participants' experiences with encountering and navigating through compassion fatigue. These questions are as follows:

1. Many participants have identified a personal dichotomy in terms of being very sensitive and empathic or talented as a clinician vs. feeling flawed or inadequate in the job. Have you experienced this and how did you navigate this dichotomy? If not, have you had a change in the way you think about yourself as part of this process? If so how did that change in how you see yourself occur?

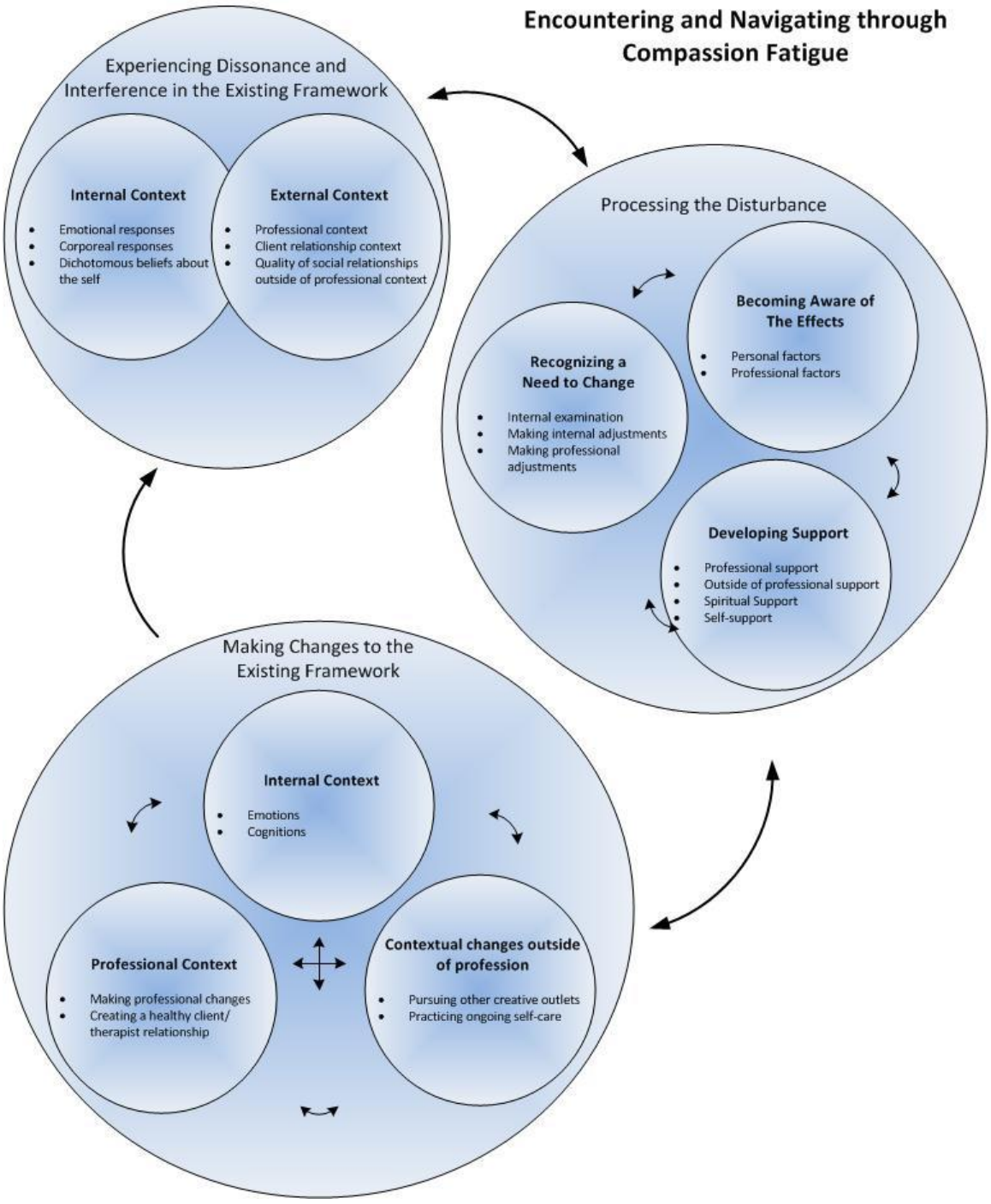
2. Some participants have also identified a dichotomy in terms of the way they feel about the profession in general. Have you experienced this? If so, how have you navigated through the dichotomy? If not, have you had a change in the way you think about your job or role as a therapist as part of this process? If so, how did this change occur?

3. Individual participants have identified that after experiencing CF, they felt that something needed to change both internally and professionally. How did you make the connection between becoming aware of what was happening and knowing you needed to change something?

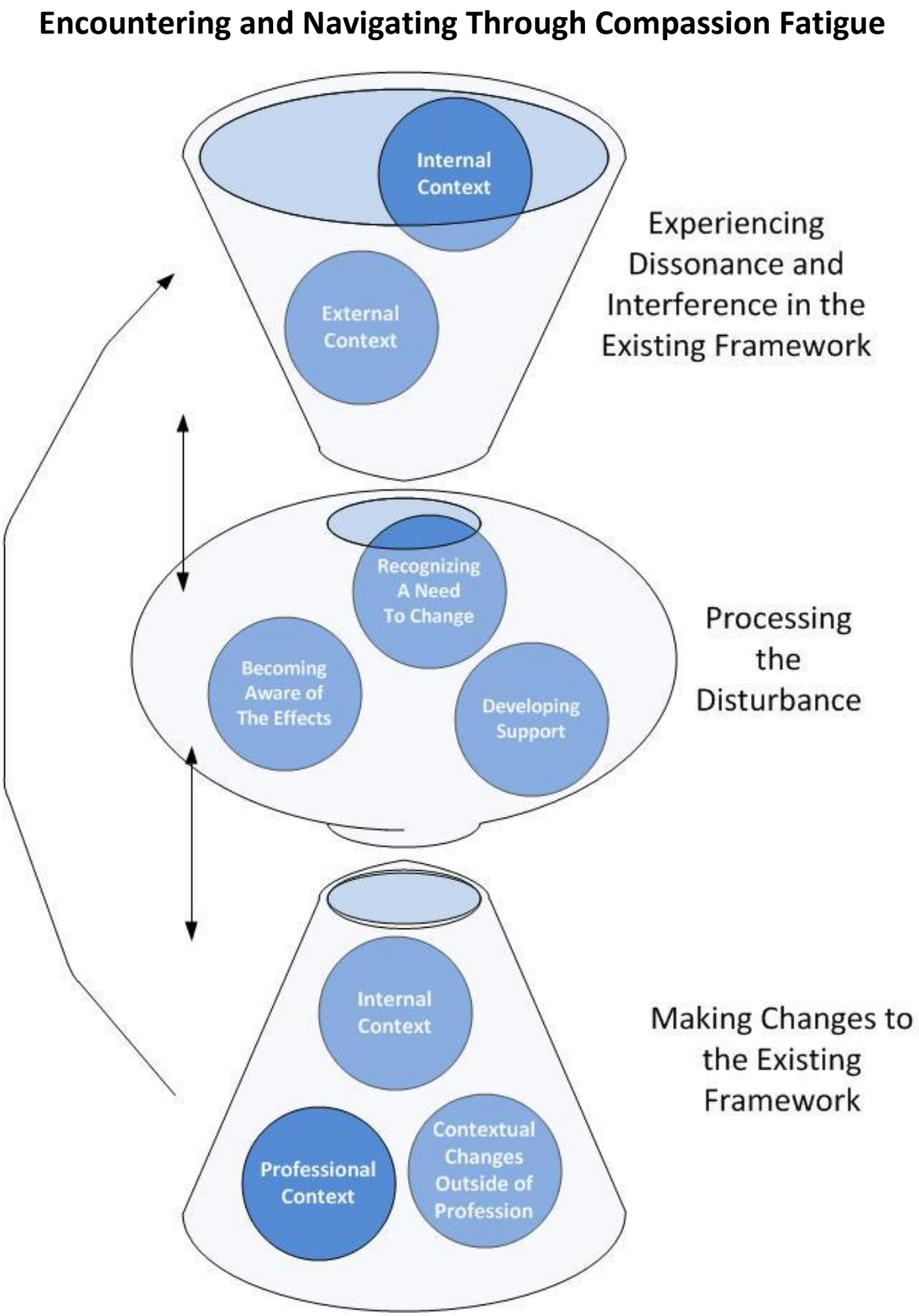
4. Some participants have given a sense that navigating through compassion fatigue is not a linear, one-time process. Have you dipped in and out of compassion fatigue or experienced a cycling of CF? If so, can you describe an overall picture of how this happened for you?

5. Most participants have identified that during the process of navigating through Compassion Fatigue they changed from feeling like they had no ability to control or change what was happening to them (being acted upon) to a place of intentionality (taking action). Was this your experience and if so, can you describe an overall picture of what that was like for you?

6. All of the participants have described the extreme or difficult context of their work environment. Could you briefly explain the process of how you transitioned from your work context, back into your life outside of work context?



Appendix E, Figure 1. Round One Analysis – Categories, Subcategories and Properties



Appendix E, Figure 2. Round 1 Analysis Funnel Diagram – Categories and Subcategories

Appendix F

Second Round Interviews

Introduction

An analysis of the round one interviews laid a foundation for an initial theoretical structure which provided a description of the experiences of mental health professionals encountering and navigating through compassion fatigue. This structure was derived from conceptualizing the data according to categories, subcategories, properties, and dimensions. The first round categories were EXPERIENCING INTERNAL DISSONANCE, with the subcategories of *Internal Context* and *External Context*; PROCESSING THE DISTURBANCE, with the subcategories *of Becoming Aware of the Effects, Recognizing a Need for Change,* and *Developing Support*; and MAKING CHANGES TO THE EXISTING FRAMEWORK, with the subcategories of *Internal Context, Professional Context, Client/Therapist Relationship Context,* and *Contextual Changes Outside Of The Profession.*

I formulated the second round questions based on a desire to increase the depth of understanding around specific categories and properties and to further define and refine specific ideas which emerged from the data. I conceptualized these ideas based partly on the symbolic interaction extant in the data following transcription. The metaphorical descriptions the participants provided of encountering and navigating through compassion fatigue connoted a symbolic internal struggle and a process of navigating through that struggle.

Some participants described part of their struggle as ‘being thrown into the deep end,’ ‘being a cage-fighter,’ ‘becoming a sponge that needed to be wrung out’ or ‘a fight

between light and dark. The following excerpts are all of the participants' descriptions of their struggle with compassion fatigue from a symbolic or metaphorical perspective.

Mary	I would say [it's been like] um, a sponge. A sponge can sometimes gather up a lot of water. And hold a lot and get very heavy, have a heavy heart, heavy to the core, even too heavy for it to do any more good for anyone else, to sop up any more. And getting a sponge and wringing it, in whatever way there is to release it, is so important, so that sponge can be light again and it can function and do the purpose it was meant to do.
Roxy	I think the whole human to robot to human again thing is a good metaphor. Like, this is so overused, but I felt like by the time I went to my employer, I felt like I was drowning and stuff and felt like I was being pulled under by some force and being pushed down by him when I was reaching out to like, a life preserver here. "I need some support to get me out of this place where I feel like I'm drowning," and nope. And so, it was kind of a long process of deciding, "eh, nobody's saving me or helping me here, so I'm going to start swimming sideways and swim to shore." And it took forever.
A. J.	Well the metaphor that comes to mind for me as I kind of imagine myself drowning in a dirty stinky swamp. And then floating out and getting my head above water and kind of floating in some clean water for a while, but with my head barely held above then eventually getting out and being able to help other people out of that water, being saved from drowning.
Jane	I think for me, hard work is actually cathartic for me. So if I have to really work through something emotionally, if I can just do something really physically just wipes me out, it has a cleansing effect on me. So I'm just completely exhausted from physically just wearing myself out because when I'm done I can see what I've accomplished and you have that sense of look at what I did. So for me I look at [compassion fatigue] like you're going to have those battles and you go into battle and you fight just as hard as you can and then you step back from the front line, you build up your reserves again and you go for the next battle.
Jennifer	And mine would be being in a flood . . . Just drowning in other people's stuff and having a hard time breathing . . . So that would be where I just get this feeling like I can't get my head above water kind of thing . . . And I feel like to get out, when I feel like I'm in

that flood, and I'm finding a way out, it almost feels like magic. It feels like I'm being lifted up that I just come out of it. I feel lighter that I can kind of just float out of it.

Andrew "I want to get to that mountain over there, that's a great mountain and I want to climb it and see what I can see. You walk out to start your journey and the whole land in front of you is just muck. It's messy and briars and rocks and it's just a mess and do I go across that to go to my mountain or do I go back in the house, kind of thing? I've been thinking about that for a while and try to think. I've got to figure out some how to get out of this muck so I can get there to the mountain." I think that I was in the muck for a while and now I'm a little closer to the mountain actually. The muck's important, it's part of life, I guess, but at the same time for therapists in our position, we really need to be careful because it's really easy to get stuck in the muck like that and to feel the pressure to take care of people and to do work and make money and all that kind of stuff.

Phil I've often described it, and it's not just with compassion fatigue, it's with a process that's always been underneath that has been part of it is it always feels like, using absolutes, when I'm in the thick of it I feels like, it feels like I'm fighting a faceless man. That I can actually see the person in my head, but there is no face to it, but yet they are the same height, stature and everything as me. And it doesn't matter how hard I swing, that other person never fights back, never falls down. They just keep coming at me, advancing and they won't die.

Elizabeth Yes, there is a metaphor that would be meaningful. And I just put, I literally have one leg to stand on and that leg was my children. They're my children so they keep me going. . . I've always known in my life that there's a constant battle between light and dark. Constant battle. But the light has to shine bright . . . it has to shine bright for the fight for life and um . . . and once again the darkness is trying to take me down, but I know now that I've had to experience this level of trauma in order to do this particular dream . . . What's probably about to happen will not be easy and I have to be able to endure that. Now I have the skillset to do that. I've always kept this a secret and finally voiced it which was freeing beyond belief, but it's one moment, every day is just one little tidbit at a time as I feel safe and letting it go, but yeah.

John Like a cage fighter. You go and they lock the gate on that cage and for that 45 minutes you're just alone with that person's depression or their addiction or their marital distress or whatever. You're in

> the cage. And every day you get locked in the cage. You may get beat up, you may win that one, but one way or another you're in the cage and there is no . . . till the session is up, that's when the door opens, but you're in for the fight during that time. Wow . . . that is really an apt metaphor . . . That really speaks to me. You feel like, I'm reluctant, I hate violence but here it goes 'cause I've got to do my best to pound the heck out of this person's depression and working against whatever is their trauma, their other symptoms, self-esteem has been low for years or whatever. And they are paying you to . . . if they could get what they need out of a self-help book they would 'cause it's a lot cheaper. They're paying you because you're going to enter in their heart and soul and try to be there and they're getting beat up without your help and they need you to at least to battle with them for a while. It's an honor to be invited into that with a person and it's also intimidating, but I think that's the metaphor that I'm . . . and when you've been beat up enough you just . . . that's compassion fatigue to me. You get beat up enough in the cage, you've got to keep going back in. I used to go in a lot more. A lot less reluctantly. There's always been the highs and lows.

These symbolic descriptions provide a backdrop for an analysis of the data which also suggested that a personal and professional dichotomy existed within the participants' beliefs about themselves and the profession. These dichotomies form part of the underpinnings of participants' experience of encountering and navigating through compassion fatigue.

Analyzing the data of the participants' narratives engendered a sense that a greater understanding was needed regarding these dichotomies. However, I was not sure if these dichotomies existed as a precursor to compassion fatigue or concomitant with compassion fatigue. In other words, did they exist prior to compassion fatigue, or were they initiated by participants' encounter with compassion fatigue? Additional analyses of the data indicated that a resolution and acceptance of the dichotomies may have been part of the experience of navigating through compassion fatigue. The need to deepen

understanding of these concepts resulted in the formulation of the following round two questions:

1. Many participants have identified a personal dichotomy in terms of being very sensitive and empathic or talented as a clinician vs. feeling flawed or inadequate in the job. Have you experienced this and how did you navigate this dichotomy? If not, have you had a change in the way you think about yourself as part of this process? If so how did that change in how you see yourself occur?

2. Some participants have also identified a dichotomy in terms of the way they feel about the profession in general. Have you experienced this? If so, how have you navigated through the dichotomy? If not, have you had a change in the way you think about your job or role as a therapist as part of this process? If so, how did this change occur?

In addition to understanding the internal dialectic of participants, a data analysis indicated a need to refine the category of *PROCESSING THE DISTURBANCE*. For example, further data was needed to gain understanding into the way in which participants recognized the need to change their individual circumstances both internally and externally (professionally). Their data suggests that they experienced the effects of compassion fatigue until those effects became palpable and untenable. Participants then took some kind of action.

Moreover, an analysis of the round one data pointed to the cyclical nature of compassion fatigue, as experienced by most participants. The data pointed to the potential for increased awareness and changes over time as participants cycled through compassion fatigue more than once. The need for greater depth and breadth of understanding regarding these concepts led to the formulation of two additional questions:

3. Individual participants have identified that after experiencing CF, they felt that something needed to change both internally and professionally. How did you make the connection between becoming aware of what was happening and knowing you needed to change something?

4. Some participants have given a sense that navigating through compassion fatigue is not a linear, one-time process. Have you dipped in and out of compassion fatigue or experienced a cycling of compassion fatigue? If so, can you describe an overall picture of how this happened for you?

Participants' narratives also indicated that a portion of navigating through compassion fatigue may have included moving from perceiving a lack of control over what they were experiencing to more intentionality. Finally, the third preliminary category of *MAKING CHANGES TO THE EXISTING FRAMEWORK* needed additional filling in of data to help conceptualize how participants were able to transition out of reactivity into attenuating their compassion fatigue. The data evinced a need to deepen these concepts and led to the formulation of the final questions associated with the round two interviews:

5. Most participants have identified that during the process of navigating through compassion fatigue they changed from feeling like they had no ability to control or change what was happening to them (being acted upon) to a place of intentionality (taking action). Was this your experience and if so, can you describe an overall picture of what that was like for you?

6. All of the participants have described the extreme or difficult context of their work environment. Could you briefly explain the process of how you transitioned from your work context, back into your life outside of work context?

These structured questions were used as the basis for the second round interview with each participant. The format of these round two interviews was very similar to that used in the round one interviews. The same nine participants were interviewed using a semi-structured interview format. Each interview was recorded. When possible, the interviews were transcribed within a few days of the interview itself. During the transcription, I reviewed each recording several times to ensure the accuracy of the data. I also reviewed the recordings for symbolic nuances, which I then memoed during the transcription process. This particular memoing was important in order to preserve the

flavor of the interviews and refresh the conceptualizations. Although the raw data itself is the pre-eminent source of the theoretical structure, a review of the raw data alone would not have reflected the multidimensionality and nuances of the symbolic interaction inherent in participants' stories.

A grounded theory methodology of both open and axial coding was employed for the second round of interviews. Each transcript was analyzed using these coding procedures. I then used index cards, labeling individual color-coded cards with a specific category, subcategory, and property according to a matching color. By generating this exercise and by using the data as the point of comparison, I was able to work through which categories needed to be collapsed, expanded, moved, and/or re-conceptualized. Following this potential reconceptualization, I returned to the data and generated both individual and integrated memos of each transcript as well as a sorted table of participants' interview responses under the headings of the re-conceptualized categories.

Reconceptualization of the Categories

This reconceptualization was generated as an analysis of the second round data elicited the conclusion that the first round analysis needed rounding out and reconfiguring. The analysis revealed the emergence of a central category related to encountering and navigating through compassion fatigue—that of *BECOMING INTENTIONAL*. Becoming intentional was deemed to be the central category because of its central and pivotal relationship to the whole process of navigating through compassion fatigue. As participants shifted from feeling a loss of control of their internal and external circumstances to a regaining of control or taking action—practicing intentionality—they were able to move through and negotiate compassion fatigue. This central category is not

the foundation of participants' experience, but rather, is the fulcrum of both encountering compassion fatigue and navigating through it. This fulcrum punctuates the participants' experiences leading up to becoming intentional, and those which come after becoming intentional in both a circular, linear, and concurrent process. Thus, *BECOMING INTENTIONAL* is not the foundational category, but truly the central category. The collected data reveals that this category is influenced and influences what occurs in the participants' experience before and after becoming intentional and is related to all the other categories and subcategories. Indeed, each participant moved through to a place of intentionality as they negotiated their experience with compassion fatigue.

As a result of the second round interviews, *BECOMING INTENTIONAL* was one of the four categories delineated in a reconceptualization of the structure which illustrates encountering and navigating through compassion fatigue. In this reconceptualization, four categories were indicated. Each of these categories was further operationalized by delineating subcategories as follows. The first category is *EXPERIENCING INTERNAL DISSONANCE*, with subcategories of *Internal Context* and *External Context*. The second category is *PROCESSING THE EFFECTS*, with subcategories of *internal* and *professiona*l. The third, and central category, is *BECOMING INTENTIONAL*, with subcategories of *Making Perceptual Changes, Developing Support,* and *Making Professional Changes.* The fourth and final category is *CREATING ONGOING CHANGES TO THE EXISTING FRAMEWORK*, with subcategories of *Internal* and *External Contexts.*

Experiencing Internal Dissonance

The first round interviews underscored participants' narratives of experiencing personal and professional dissonance as a result of encountering compassion fatigue. Initially that dissonance was conceptualized as being internal dissonance and external dissonance. A revisiting of the concept of dissonance suggested that the dissonance was not internal and external separately, but rather an internal response to a collision of the external environment with the internal sense of self of each participant.

Internal Context

Beliefs about the self. In general, individuals develop a set of perceptions based on experience and learning. Though not explored extensively due to the thrust of the study being about the process of navigating through compassion fatigue, the assumption is that these participants possessed a set of perceptions based on their experience prior to encountering compassion fatigue. Confirmed by the data extracted from the round one and two interviews, the nine participants manifested self-perceptions of both an idealized sense of self and an inadequate and/or vulnerable sense of self both personally and professionally on a dimensional continuum. Participants' beliefs about themselves and the profession are conceptualized as part of the dissonance associated with compassion fatigue properties of the internal context associated with that dissonance. For example, all participants described themselves as being either extra sensitive, empathic, gifted, or professionally idealistic, particularly at the beginning of their careers. Some described themselves as absorbers, a bridge, or idealistically invested in client outcomes. Almost all participants implied a sense of neophyte idealism at the beginning of their careers—a perception which matured over time as they navigated through compassion fatigue.

On the other hand, some or all participants also described themselves in terms of feeling vulnerable, inadequate, or weak while questioning their professional efficacy. Some participants felt both gifted and inadequate all their lives. Others felt situational inadequacy, questioning their efficacy, depending upon their ability to cope with their work environment or client outcomes. Still others experienced a loss of idealism. These perceptions and beliefs were altered, shaped, and broadened as a result of interfacing with the external context. Almost all participants professed experiencing an internal dichotomy, which in turn affected their sense of self and self-identity both personally and professionally.

Mary had a perception that her ability to absorb clients' pain was both a sign of strength and weakness—a strength because she could feel and experience others' pain, but a weakness because she was unable to separate from it.

> Mary . . . my inadequacy, I didn't feel like helpless as a person, I actually felt strengthened after I helped them. Sometimes, I believe I probably gave them some of my own strength and my own . . . my energy, my physical energy. It may have taken from me in a physical way, as you know, I've been chained down with a very systematic illness . . . What did that mean? That weakness meant as a therapist that maybe I felt inadequate because other therapists did not feel that and maybe something was wrong with me. Because when I would go to a particular therapists, that are smart supervisors, to tell them and maybe talk about things, they had either learned or have a sense mechanism to let it go real easily.

The sense of inadequacy experienced by Roxy was directly related to the way she felt as a result of being burned out. At the beginning of her career she was not expecting to experience what she experienced.

> Roxy I think I got to a place with burnout that I was just . . . in the office I don't think I felt particularly competent. I knew I was just burned out and really questioned if I could do the job or should be doing the job at all.

A.J. experienced a personal dichotomy early in her career, stating that as a result of being "real empathic" and "a sensitive person," she is at "greater risk for [compassion fatigue]." Although most participants reported feeling effective and adequate much of the time, some also reported experiencing a personal dichotomy during the course of their lives.

Jane	That dichotomy exists for me personally in everything. Not whether . . . it's not like I . . . it's who I am in every circumstance and so it's not like when I become a therapist, all of a sudden I become an expert or I become inadequate. I think I feel that way about being a mother and being a wife, being a friend . . . in any setting.
Jennifer	That's all been my experience. I've felt all of those [inner dichotomies].
Elizabeth	Of course I've felt that [inner dichotomy]. I think you kind of have to in order to grow. But I think I work really hard to check in with myself to see if that is what I'm feeling . . . those fears have been with me all my life.
Phil	Yes I did experience it as I stated before. How I experienced it was a lot of discomfort. It took a couple of years for me to kind of resolve it. I don't think I'll ever truly be completely resolved of it, but lately definitely I've resolved it much more than it was before.

Participant John described, in his first interview, that his dichotomous views of self were colored by the fact that he "questioned [his] ability to do therapy" and personally felt at times "oh, I probably did that wrong or I did that wrong." In his second interview however, he clarified that he "pushed [his] own inadequacy in different ways" in his life, but that compassion fatigue had not triggered it or made it worse. He distinguished between feeling flawed and feeling vulnerable—a dimension of the continuum of beliefs about the self.

> John I haven't had much of the flawed thing itself. But I have the strength and the sensitivity and the vulnerability, but the vulnerability doesn't seem like a flaw to me. It just seems like a price, it exacts a high price.

However, like Roxy, John felt burned out and affected by client outcomes.

> John It's not a matter of adequacy to be with someone and not be overwhelmed by that, the pain of what they're dealing with of getting me to burn out and I'm sure it was not just that. That was sort of a poignant time of that . . . I've certainly pushed my own inadequacy different ways in my life but [compassion fatigue] really hasn't triggered that.

Beliefs about the profession. While much regarding participants' professional idealism was elucidated and explored in the first round analysis, participants' second round responses deepened and clarified the nature of the professional dichotomy.

For example, Jane expressed feelings about client outcomes as an inner conflict which contributed to compassion fatigue susceptibility.

> Jane Yeah, I always know that when I'm doing [feeling dichotomous feelings about the profession] that because I stop feeling . . . for me it's fear. It's when I stop feeling faith, it's when I stop feeling authentic because I've let my over anxiety, in [clients'] behalf, rule what's going on, and so I think that's one of the hardest things in any role is removal of . . . being a therapist is not getting overanxious and trying to prove a point.

A. J. also experienced conflicting feelings about the profession early in her career stating "early in my career that was huge for me."

Like Roxy and John, Andrew and Phil experience or experienced professional burnout commensurate with a professional dichotomy. Andrew also faced dichotomous feelings associated with his professional identity. He identified his feelings professionally as "golden handcuffs."

> Andrew The 'golden handcuffs' thing . . . You're locked into something wonderful; but you're locked in.

Andrew I definitely feel that [professional dichotomy] and have probably for most of my career . . . I get resentful or angry, there are times when I think about the insurance industry and how they really don't pay us enough for doing private practice work. They really don't pay us enough. They don't pay us what we're worth. Personally there is research on this. We know that the work we do as therapist is helpful and effective for all sorts of things, and yet we're not really paid for that. I have struggled teaching grad students who of course are coming in with stars in their eyes and say we'll do some fun work and we'll have masters or doctorates and make a lot of money and everything.

Jennifer First of all, I mostly love [my profession]. I mostly enjoy it and feel like I am helping and I get enough positives back that give me that little boost to want to keep going. I think where compassion fatigue comes in for me in this, is if I work too much. So it becomes too much a part of my world and I do get to where I just don't want to do it anymore.

Similarly, Mary and Phil dealt with professional dichotomous feelings. Both believe that they have not, nor may ever, completely reconcile that sense of inner conflict regarding the profession. When Mary was asked in the second round interviews if she had experienced that professional dichotomy she responded thusly:

Mary Yeah, actually I have. I have empathy and love for being a therapist, I mean gratitude, but I question sometimes too. I question. I lost a little bit of faith in therapists for a bit and trust, to be quite honest with you . . . Yeah, I loved initially learning and feeling like I actually received something back from it, maybe secondary gain, I don't know in a good way. That I was doing something and helping and doing good. I took that in and I was being of service and I felt good about that. What I didn't like is how it affected me physically, personally and maybe even, I've been told, a change in personality.

Phil Yeah, I experience that [dichotomy]a lot. How have I navigated? I haven't navigated, I am navigating. I really haven't come to a full resolution and I don't know if I ever will, but if I were to describe it, I would say also that the system itself, the career field itself is inherently flawed. It tries too hard to be scientific and based on logic and putting everything on logic alone, makes it inherently flawed itself because human beings are not logical.

External Context

As participants manifested certain beliefs about the self or the profession, either intrinsically, or as a result of encountering compassion fatigue they experienced internal discomfort and dissonance. Individual and collective accounts from participants denote the foundational context of encountering the dissonance associated with compassion fatigue is the interplay of those above elucidated perceptions interfacing with the external context of the world around them. The internal self of the therapist is the central concept of this category, with the self of the therapist and self-perceptions being affected by the external context. Conceptualizing the dissonance in this way renders a distinction from the round one conceptualization, in that all of the dissonance experienced by participants is more accurately classified as internal. In other words, the external context is part of the larger category of experiencing dissonance because participants' exposure to the external context causes a dissonance in the internal context. The external context which acts upon the internal context consists of *professional environment, client suffering,* and *quality of social relationships* outside of the profession.

Professional environment. The property comprising participants' *professional environment* was formerly classified in the round one analysis as *professional context*. The dimensions of professional environment are workload and professional expectations. *Professional setting* does not refer to client population or clinical context, but rather to temporal, administrative, and monetary issues related to the participants' professional practice. These temporal issues include caseload, systemic expectancies, monetary compensation, degree of professional preparedness, administrative issues such as paperwork and charting, and work stressors and pressure. Additionally, in the case of

some participants, these expectations were self-imposed and driven specifically by financial pressure. Details and data regarding the property of professional environment were fully expounded in the round one appendix as workload expectations, such as the expectation of long hours, no breaks, no provision for fatigue or impairment, "thrown into the deep end," "no room for being human," and being given the systemic message to "suck it up."

Quality of social relationships. Another area of the external context which affected participants' internal sense of well-being was the quality of their social relationships. In round one, participants' data was operationalized to show a connection between dissonance associated with compassion fatigue and participants' relational functioning outside of the professional milieu. While this was a fully robust property operationalized in round one, in round two Mary also added additional thoughts which included the idea of friendship. She had friends who were not supportive of her when she became ill as a result of compassion fatigue. She believes this phenomenon circled back to exacerbate her already existing dissonance and distress. What she experienced highlights the dimensions of social relationships which range from distressed to functional—dimensions which directly connect with other categories and their dimensions (such as developing support).

Mary	Because I gave so much of myself to other people in counseling and as a friend and empathic everything, I guess deep down I had a hope or expectation, I'm not sure which is a better word, that others would reciprocate and maybe you're getting out of me what's really going on. And I found it's the opposite when I was diagnosed with __. That people almost ran like hell. And it hurt and I have hurt about it right now. It hurt. My very best friend, I know she was trying hard to comfort me and everything, but she was saying stupid things like, "My Gosh, I just feel like you wanted to stake out in the dumps."

Exposure to suffering and pain. The present or past perception that some participants experienced as a result of the relationship dynamic either with family, professional colleagues, supervisors, or friends, led some participants into believing that they had to suppress their emotional responses. Participants' attempts to suppress emotions were very difficult because of their exposure to client suffering and pain and/or exposure to their own personal suffering or pain—the two dimensions of this property.

The dimensions of this property could be further classified as direct or vicarious exposure to pain and suffering. Participants' witnessing of that suffering may be described as either visually witnessing the suffering, as in the case of participants A.J. and Jane, or hearing and being exposed to client stories. For example, Mary felt being exposed to client suffering catalyzed her absorption of client pain. Roxy and Elizabeth were affected by the painful experiences of the couples with whom they worked. A.J., Jennifer, Jane, and Elizabeth worked specifically with children and witnessed the suffering of those children. They also experienced working with crises or death and dying. Phil, Elizabeth, and John all worked with trauma survivors. This property, renamed from the former tentative property of *client relationship context* within the first category, is more acutely operationalized by illustrating that client pain affected participants' sense of self and their professional identity.

Moreover, participants' experience of dissonance was also tied to their own suffering and physical or emotional pain. For example, Mary experienced a stroke and was eventually diagnosed with multiple sclerosis. Similarly, Elizabeth experienced several bouts of illness and physical pain during the period when she encountered and negotiated compassion fatigue. In addition, Elizabeth along with Jane, Jennifer, and Phil

experienced the emotional pain associated with painful experiences with partners or family of origin members. John described being hospitalized for anxiety as a child. A.J. had recently had a painful miscarriage.

Although this category was fully described and operationalized in the round one analysis, Elizabeth added additional insight and depth to the category by discussing both dimensions of exposure to suffering—on a personal level and a more macro level context.

Elizabeth Unfortunately, I think compassion fatigue has been cyclical only because of the many different physical events that I have been through. Then helping my husband through some of his physical and emotional conditions and then having children with health conditions, just those alone in our immediate family have made it hard just because of all the healing that has to occur on a personal level or reaching out to your family. So definitely over the past . . . five, pretty much the whole time. I would say, even recovering from my pregnancies, which was right after I graduated, I think there have been many challenges. Some are harder than others though. Some weren't as intense. The work always provided more relief for me than anything, but the physical pain and going to work and trying to concentrate and things like that, I know affected me. I just couldn't be all there. So went in and out, I would say, for sure.

Elizabeth I feel like, I don't know if it's because of where I live, I think the field can affect you where you live, what area of town you live in, the economy, all of those kinds of things. I feel like in the past year or so, just because of the way the economy is right now, I feel like there is more out of our control than there used to be and I notice that I even have moments of hopelessness that I feel like, gosh I don't know how to help this person some times because there is so much out of their control. Trying to find a way to ground them. It almost feels like we're getting flooded with certain types of problems because of the way the economy is right now . . . So many people with no jobs and seeing the men come in who are suicidal because they can't provide and the women don't have the education or the background, they can't get jobs that are worth anything, so they can only turn to so many people for help and then the whole housing market . . . There is so much that is out of people's control, I have to admit I don't know what to say and I don't know what to do except help them get it out and do our best

> to brainstorm ideas, but I do feel like, "Wow, I have no idea what to do. I don't know what to say. I don't know."
>
> Elizabeth I do feel like the field itself is not able to provide in the ways that people are needing right now in our day and time. There is not enough out there to help people right now. I think we are hurting. The resources aren't there. We're even working with soldiers quite a bit and even the military is not providing . . . even they are more helpful with mental health, and they've got more of an open mind, they are running out of resources. We are flooded with soldiers, we are flooded with people who are losing their jobs and home and I had a hard time finding information to help these people and give them . . . except their church. The churches are starting to not give in the ways they normally give. I've already had many churches and their leaders say, "We're sorry, we can't do that. They're going to have to find their family." And that's where I'm left and I've got to help these people put down their pride and talk to their families and they don't necessarily want to do that. It's not a good relationship what have you and it just feels like, "What do I do now?" So I do sort of feel like we're running out of resources and not sure what to do. I don't know if that makes sense.

Elizabeth's quote underscores participants' need to process the effects of the dissonance they were experiencing as a result of the interface between the internal sense of self and the introjection of external contextual experiences both past and present. At some point, each individual participant came to a place where they began to process the effects of compassion fatigue. Processing the effects was a necessary component in the progressional cycle of moving towards resolution or management of their compassion fatigue. This processing moved participants closer to a sense of internal harmony.

Processing the Effects

Based on the round one data, the introjection of the external context into the self of the therapist (internal context) was conceptualized as the foundation for the dissonance and interference participants experienced. In short, this interface constituted the underpinning of participants' encounter with compassion fatigue. As a result of the

interconnection of the two contexts, participants experienced effects both internally and professionally. At some point, each participant came to a juncture where they began to notice and pay attention to the dissonance they were experiencing. Most participants had to come to a place where the effects could not be ignored. Round one data implied that a tipping point occurred where participants began to recognize a need to process and navigate through their dissonance and distress. This phenomenon seemed to occur after participants came to a realization of what was transpiring both inter-psychically and intra-psychically. The purpose of some of the round two questions was to better formulate what participants experienced and how the processing of their experience helped them to recognize a need to change. What were the effects of their disturbance? How did they know they were being affected by compassion fatigue? And specifically, when did they come to a point of being aware? Most participants came to that awareness in hindsight or when the effects of experiencing compassion fatigue began to hamper their ability to function optimally both personally and professionally.

PROCESSING THE EFFECTS, the second category, is conceptualized by suggesting a series of internal and professional effects which occurred within the milieu of each participant's experience. These effects affected participant functioning in both the inter-psychic and professional domains. While each participant's narrative is unique, certain similarities occurred with all the participants which may be divided into the two subcategories of *Internal* and *Professional Effects.*

Internal Effects

Participants noted two types of internal effects associated with compassion fatigue—*emotional responses* and *corporeal responses.* Both of these responses and

effects were fully explored in round one and explicated in the round one appendix. An analysis of the round two data deepened the two properties by showing the interconnectedness of mind/body/emotion responses associated with compassion fatigue. In addition to experiencing emotional effects, which Mary said were similar to PTSD, she also became aware of the seriousness of her compassion fatigue when she noticed corporeal effects associated with mental functioning. This awareness alarmed her. She did not fully process what was happening until she visited a physician who told her she had had a stroke.

> Mary I started having memory problems. And I started realizing that there was something going physically wrong. I don't know if it was, you know, what was happening, but I felt more depressed, I noticed I was actually jumpier. I startled easier. I noticed, yeah, the memory and I noticed a little bit of decline in the cognitive with . . . in memory . . . the association of all of my modalities that I learned. I could not recall the name of my modality, like CBT . . . I could not remember that. It was kind of like I didn't want to, and I don't know if subconsciously it was overload and so when I started realizing that, I started questioning and I even said it to a supervisor. "Do you think maybe I have ADD or something?" which was, you know, kind of a funny thing. She said, "I don't think you just develop it all of a sudden in life," and she said, "No, it would have been difficult to go through graduate school." So I was questioning it, my physical capabilities.

> Mary When I actually forgot some patients' appointments and when I felt like I couldn't remember certain things or concentrate on what they were saying. I felt that it was necessary for me to back away.

A.J. noticed that the mind/body/emotion effects were impairing her functioning and she recognized the potential that they could become worse and have a permanent effect. This recognition moved her to a place of becoming aware that she needed to change her circumstances.

> A. J. I think because the compassion fatigue was affecting my functioning to such a degree, that I recognized, I know, if I didn't

> do something kind of drastic, I certainly couldn't function at the level I was, and was concerned it might even get worse . . .Yeah, the tipping point really was lack of sleep and then going to my supervisor and saying, "There is a problem, what should I do here?

Jane, pointing to the pain she had experienced as a positive because it created awareness which she could not ignore, discussed many emotional and physical responses in her first interview. She summed up those effects.

> Jane It's a positive thing like pain. If we didn't have pain, we wouldn't know that something is wrong that we need to take care of.

Similarly, Jennifer experiences ongoing corporeal effects which are a signal of potential problems with compassion fatigue. Her data along with data from Elizabeth, spoken in the present tense, indicates the potential of the cycling or spiraling nature of compassion fatigue and the need which some participants expressed for remaining continually aware of the effects: in the present here-and-now, so as to pre-empt those effects.

> Elizabeth Um, I think some of your typical compassion fatigue symptoms will come on. My body will tingle . . . sometimes I even get like a slight pressure in my chest or in my head or my hands get sweaty. My heart will race and that's not always panic, it's more of, "Ew, I know what that is." Sometimes I had panic and it was probably the only time I can remember was when I worked with some abuse victims. Just because I grew up with that and I've worked with a lot of abuse victims, but sometimes it's more just my heart aches for them and more so that I can't handle this, but I definitely feel my clients, a lot of times, I do put myself in their shoes. I try not to let it flood me or anything, but I want to let them know I'm human and that I care, but the going back to what I was saying before, there is no doubt that I will get some of the anxiety symptoms.

> Jennifer I think one of the ways I started noticing is physically. It's like, I don't have as much energy. I want to isolate more, I don't feel like I want to talk to my family or friends that much 'cause it feels too draining.

Hearkening back to the round one interviews where they provided detailed descriptions of their emotional and corporeal responses, Phil and John summed up the tipping point of awareness for themselves in the following way:

> Phil — Let me reflect on the first interview. Making a connection with how much my professional life was interfering with my personal life. Having anxiety where it went through the roof that I never had had before and as much, and also with that I started focusing much more heavily, as odd as it sounds, on the career. Thinking "it's because I'm not good enough, I have to get better," which just made it worse. It took me deeper into it. And finally, it just got to the point that last year, I said, "Enough is enough." I really just couldn't do it anymore, and so I basically did everything I could to get out of full time practice.
>
> John — So, it was kind of coping while at the same time seeing that this is a bigger problem than just coping . . . where I was saying, "This is not just a matter of coping, it's not just using those little coping things that would address how big this is starting to feel. Taking a chocolate bar to work isn't going to be enough. It's even bigger than that."

Similarly, the magnitude of the effects of compassion fatigue were felt by Elizabeth, who reached and continues to reach points where she becomes aware that she needs to process the 'flooding' effects of her internal dissonance.

> Elizabeth — I know for me when I get that flooded feeling and sometimes I sit in it too long, and try to be too strong, you know, and think it's not going to affect me, but when you go through your own personal life events and they do add up on a physical or emotional or both, you know, you have to . . . when you can't apply your own basic tools that you would normally use in your life 'cause you couldn't apply the tools . . . so I know when I can't do my basic regimen of my daily things to keep myself balanced, when I lack that desire, I'll go ahead and give myself a break for a little while, maybe a week or two, and then when I can see I'm really struggling to get back up again, that's when I know I've got to reach out for help and I've got to talk to someone and get it out because it's to that point that it is overwhelming me. So I know that it's time that I have to apply new skills.

She also expressed that she is aware that she becomes drained of compassion because of extraneous role functions which create emotional and physical fatigue.

> Elizabeth Yeah, I think a lot of them are just basic fatigue of trying to be supermom and just trying to be a wife and a mother and a worker and that's not easy to do. Plus do things in your community. It's very hard for women to do those things and we know we are going to get tired. It's going to affect us. There are times when I can roll with it, and I accepted that as part of the deal, and, like I said, there are other times when I'm more physically in pain or somebody in my family or someone I know is in more heavy emotional pain. Those will wear me down a bit more just because they take more time. And so I'm just tired. That's really the main thing.

Professional Effects

While some participants noticed the effects of compassion fatigue on an internal level, some also became aware of the connection those effects were having on their professional lives. Indeed, participants saw a need to process the effects on a professional level as well. The universality of those effects may be divided into three properties as participants experienced *burnout, client/therapist relational issues,* and *countertransference.* Andrew came to the conclusion that in order to maintain his integrity he had to make a change in his circumstances because of the effect it was having on him in terms of internal pressure and professional exhaustion.

> Andrew And for several years before I moved, I started teaching a supervision consultation class and of course, supervision is one of the places you actually study and address the issues of burnout and probably what you call compassion fatigue and those sorts of thing. They come up in supervision and consultation. So here I am reading book and articles, doing continuing ed. classes on supervision and of course every time I hear stories where I connect with "Yeah, yeah, I'm doing that, yeah, I'm doing that too." I felt like they do as I say, not as I do sort of approach whether teaching or parenting or therapy even. So I had enough of those experiences where, "Yeah, I can't keep doing this while I'm teaching students about being healthy therapists." Teaching student about boundaries or about professional competence or about all these wonderful ideas that we have that we hold important as therapists. "I can't do

> that and keep my integrity and do the crazy stuff that I'm doing with my schedule and lifestyle and everything." I really started thinking, racking my brain again, "What work can I do, what can I do here? So I think I had enough of those experiences, especially that I knew something had to change.

Burnout. Part of the reason Andrew 'knew something had to change" was because he recognized that burnout was literally "killing" him. In the context of the data collected, burnout may be defined as emotional exhaustion—being drained of compassion (what Jane called being "tapped out)," depersonalization—(what Roxy noted as a loss of humanness), and a sense of reduced motivation to push forward. Burnout may also be characterized as a questioning of self and the success of the self (as was the case with almost all the participants as noted in the round one data.) Some participants bumped up against the perceived demands of the system in which they worked—demands which exceeded their natural ability to match with their personal and temporal resources. This scenario was the case for Roxy, A.J., Jane, Jennifer, Andrew, Phil, and John. Although burnout was extensively explored in round one, in round two several participants expounded more fully on noticing and experiencing burnout as part of the process of reaching a tipping point. This noticing created a thrust toward navigating through compassion fatigue.

Mary I noticed that the cycling of it of burnout and CF then I would change into some other category of counseling and it seems like I went all the way through it through a lot of different things that people went through until I thought, "I think I just have brain overload all together and disappointed in humanity and people." Then when it became trying, trying to evaluate myself here, came a time, like I told you, I needed it . . . and I had extreme disappointment in people.

Roxy Yeah, there was this day when I was working with clients and I noticed going into the sessions toward the end of the day I was sitting there not literally watching the clock, but in my mind I was

so involved in "I just have to make it through the next 45 minutes." That was very not me. When I have clients coming in to see me, I really want to be there with them. I want to help them, you know, as much as I can for the time that they are investing in me as far as just not the cost of the session, but are trusting me to help them with these issues that are just devastating to them. I like to just be present and work with them and so the fact that I was so wrapped up in "I've just got to make it through the next 45 minutes" was just a complete attitude shift that when I noticed that I was just like "WOW, we've got a problem. There is something wrong here. Something's got to give."

Roxy I guess I try to think of [burnout] as a step beyond CF. I had compassion fatigue, then it went one stage further to kind of crispy fried burnout or several stages.

Jennifer So it's not so much about loving the job, it's like ideally I would like to work just 3 days a week and I think I would look forward to those days instead of, "It's Monday. . .dread. I've got 60 hours to go until the weekend." 'Cause I don't usually do anything during the week. I work long hours and even if I'm done earlier. I don't want to go hang out with friends or go to the movie, I just want to go home and relax. So that what comes in for me, is recognizing when you work too much and then this balance because I need the money. When you're the sole support, so it takes . . . and it also gets where I don't want to talk to anybody because, "Ok, what do you want from me?" and "I've got nothing to give." So it can come in that way.

John Um, I think it went with how aversive my work started to become. And I say that, it's all relative. It's not like it was totally worse at once. It just gradually became more of a grind. I just had to try to show up and do it and I felt that inner resistance to it. And then, just the sense that it's too draining to work this way long term. That was when I knew something needed to happen.

Roxy I think I got to a place with burnout that I was just . . . in the office I don't think I felt particularly competent. I knew I was just burned out and really questioned if I could do the job or should be doing the job at all.

Client/therapist relationship. In addition to confronting burnout, participants had to process through their feelings about their relationships with their clients. Participants noticed and learned to negotiate over-investiture in their clients' clinical

outcomes. Some participants experienced this investment as both an emotional high when clients manifested success and an emotional low when they demonstrated chronicity. This property of feeling the effects of the client/therapist relationship was reconceptualized from the round one property of *professional factors* under the subcategory of *becoming aware of the effects.* In that data, Mary describes feeling that her identity was attached to helping in situations where other therapists called clients "crazy." In the round two interview, she discussed the gains she felt from working with clients. She also noted the internal struggle she felt regarding clients' willingness to change.

> Mary I would notice that when I was with clients, that if something was coming up or if we had spoken about something before and I saw a repetitive behavior and reminding them that it was a repetitive behavior, and if I would feel a sense of frustration or, you know, trying to get them to where they needed to see it themselves, I would have to do exactly that, checking in with myself and telling myself, "It's not about me, it's not about me, they need to see this or maybe there is something else going on, they're not getting this." Or getting them to the point of changing . . . I had to tell them, "I can't do the changing for you, you have to decide." But I had an internal struggle with it sometimes.

John called this a problem with chronicity, or an over saturation of clients with chronic problems which produced negative professional and internal effects for him.

> John Well, one thought that came to mind –I love the thought that "I spiritually commit to bear others' burdens, mourn with those who mourn, and comfort those who stand in need of comfort." To me, our profession sort of guarantees that we have lots of opportunities to do that. And so the chance to really be let into what other people are going through . . . I have been surprised over the years how little of the process of therapy is some skill set where I am able to have someone heal. It's more that they spill their guts and I sit there with them in the midst of the emotion and empathize and validate. Afterwards, they say—"Wow, I've never opened up that much before." So that's such a unique process to people. And so that process was a lot harder when I was in that state of compassion fatigue or in that mode, because it just felt like—"Really am I going to expose myself to that?" There was a part of

> me that would kick in and I just felt like a witness who just has to stand and witness these horrors that happen to people and feel their pain with them. But I was not happy about having to do that job again . . . I don't know of a point, but there was a realization that I had that this particular work with _____ um had disenchanted me with the profession.

Another dimension of investiture in client outcomes resulted in participants feeling a "high" when clients did well—what some participants called a "professional high" in the round one data. Jennifer expounded upon this phenomenon in her round two interview:

> Jennifer But often it is energizing, especially when sessions go well, I get all jazzed. So . . . It's definitely more energizing when you feel like you're making a difference and you see their growth. You see their healing, they're moving forward. They are getting more excited about their life. They are finding more joy and they're happiness and success, is my happiness and success.

Countertransference. The client/therapist relationship was also affected by participants' countertransference which several participants cited in round one as a contributory factor to experiencing compassion fatigue. Some participants, in the second interview as well, emphasized noticing and processing countertransference:

> Mary I had some countertransference going on and so I realized ok, "It's not about me, it's not about me."

> Jennifer Most of the time I feel effective. That I do have empathic gifts and talents for this and I feel like I have good skills, so when I do feel like I'm flawed and I can't really help this person, it's sometimes countertransference or feeling like they're wanting me to fix their stuff and not putting forth their own effort, so I'm feeling like helpless that I can't impact their situation.

> Elizabeth I definitely have had moments [of countertransference]. It's probably more with marital . . . marital can be really tough sometimes, but a lot of times I will get triggered, like during a session I'll catch myself, I feel it coming on and then, I don't know, I just do this . . . you know how you do the stop kind of thinking almost like the rubber band method. I kind of snap the

> wrist mentally in my head and really just try to put myself in their shoes. Not try to compare but then go, instead, put there where it needs to be. I start to compartmentalize I guess in a certain way. I get out of my emotional part and I have to do sort of a visualization to do that or there have been times when I think I've shared with a client, "Wow, I can sort of relate to you on this and I'm kind of feeling something from this, but I need to let you know that, but I'm going to let that go." Sometimes it feels appropriate to share that sometimes and they usually like that it depends on their personality type. But I can tell the people who like people who can relate and the ones that really don't care or don't want to know. So, I don't know, sometimes it grounds me and then I get back to being the clinician again.

The above thoughts from Elizabeth are reflective of the participants' movement from processing the disturbance to becoming more aware of their perceptions; making perceptual adjustments while practicing ongoing internal awareness. This internal awareness was a background to participants' adjusted perceptions surrounding their circumstances and effects associated with compassion fatigue. The participants' data from the first round of interviews implied that part of the experience included feeling a loss of control and then taking that control back—becoming intentional in some form. Jane stated that this practice of intentionality was often learned by degrees and because of benchmarks within her professional cycle and her multiple experiences with compassion fatigue. In hindsight, she has been able to see that the accumulative effect of her experience provided "wake-up calls" which created a setting for becoming aware of a need to change—including becoming intentional about that change.

Jane

> Well for me I've got significant points during my career and my life where . . . I'm a very loyal person, so I will sometimes stick with something a long time, a lot longer than I ought to and it's usually, you know, through spiritual . . . something happens that's pretty major that is a wake-up call for me saying, "Ok, you're done here. So you know, move on." That's a real general statement that there are definite points that I can go right down the list and tell you when that happened and that.

This portion of the data is reflective of the participants becoming aware, while taking intentional actions and steps which resulted in a change in functioning and an attenuation of the effects and the dissonance they were experiencing. This change often occurred gradually over the passage of time as participants tried different coping strategies which included changing their perceptions. *Making Perceptual Changes* is one of the subcategories of the thematic and central category of *BECOMING INTENTIONAL*.

Becoming Intentional

As participants processed the effects of encountering compassion fatigue, as previously noted, they reached a tipping point wherein they made a decision, took action, or changed to an internal locus of control in some way. Sometimes that action or intentionality was manifested by moving forward with intensity and purpose, sometimes by stepping back or giving themselves an easing of their circumstances. This tipping point served as a catalyst for navigating through compassion fatigue and becoming more intentional—moving from being acted upon to acting. The concept of being acted upon is what one participant, off of the recorded interview, referred to as 'the tail wagging the dog.' The data in general suggests that not all participants became intentional in the same ways or in equal degrees. However, a comparison of all the data indicates an emergence of three main themes or subcategories associated with intentionality: *Making Perceptual Changes, Developing Support* and *Making Professional Changes.* These three subcategories are interrelated and reflect an experience by participants which was both linear and concurrent. Indeed, all participants' universal experiences are associated in some way with one or more of these subcategories in varying degrees of frequency, intensity, and duration.

The concept of intentionality, in the context of the data, may be defined as behaving with a purpose in mind. That purpose includes a desire to change or shift a circumstance, both internal and external. Participants' narratives suggest that each, unique to their circumstances, were looking for a modicum of hope as a result of their struggle and experienced dissonance. For all of them that hope began to be restored by becoming aware of their perceptions and adjusting those perceptions. In some cases this adjustment included moving from feeling helpless or somewhat victimized to a renewal of the belief in their own capacity. For others the perceptual change was a purposeful acceptance or surrender.

Making Perceptual Changes

Practicing internal awareness. This perceptual change, in part, took the form of becoming internally aware and *practicing internal awareness.* In the data analysis associated with the round one interviews, this internal awareness was conceptualized as the properties of *internal examination* and *making connections.* Those properties were explored and operationalized. As I analyzed the round two data, it became evident that these two former properties could be collapsed into the one property of *practicing internal awareness.* The dimensions of this internal awareness ranged from becoming attuned to the signs of compassion fatigue in themselves or in others and becoming aware of the cyclical nature of compassion fatigue.

For some participants, this internal awareness took the form of monitoring their reactivity as noted in the following data.

> Elizabeth If I feel the emotions coming on or anxiety, I try to recognize it, again I can usually do it pretty quickly, but then I'll say, "You can't stay in that _____. You've got to put it over here. I can tell if it's going to be intense or not and I've got to . . ." I've

learned that skill from playing sports. You definitely learn you've got to put that over there or it's going to affect your play; your job. Whether it's sports or work, whatever, I have to move that over so I can stay focused.

A. J. Yes, because I changed jobs, I didn't stay helpless at that point, so after I had the awareness, after I discussed it with my supervisor and friends, I decided that, "Oh it is time for me to move on to a different job, it is time for me to do something different and I can, I'm not helpless and I don't have to continue to put myself at risk of this situation or suffer through it."

Jane I think when I feel where my strengths come out is that I can do well in those roles when I use the knowledge I have and the skill level I have . . . Yeah, and I think that time, when we really feel inadequate, that we really draw on knowledge instead of empathy.

Jane I guess I am very aware that if I'm starting to feel like the victim, that I'm the problem, so if I start feeling those things, that's when I usually get much better with my boundaries or put limits or step back and start asking appropriate questions as to "What's going on; why are you feeling this way; what is happening here; what steps do you need to take to pull this back into the right perspective and get back into balance?"

Jennifer So it's knowing, for me, I just feel it in my body. I do feel that kind of weight on me, but I also feel foggy that I can't really listen and be emotionally available to my clients when I feel like I'm just going through the motions and counting the hours. "Ok I've given this many hours today." Instead of really thinking about and pondering and working with the client. Even if they're stuck, let's see what we can do different and shift, in working with them as a team trying to figure out how to help and move forward.

Jennifer I think it has been a gradual education of just more awareness of myself and more awareness of the profession and the more I've learned, and it's very helpful to talk to other clinicians, "Oh ok, it's not just me," you know, it takes the "what's wrong with me?" and says, "This is kind of a normal part of our profession." It's important to keep yourself aware when that's starting to happen then do something about it. Yeah, I don't feel like I'm helpless to deal with it like I have no choice, I have to go further down, it's like, ok, and I start recognizing it and say, "What can I do?"

Jane And how you deal with that, what I said before, step back, ask questions of what's going on. You get stronger each time and you

> don't have to keep learning the same lesson over and over again. It's a different lesson. And you can't say that "I've got that figured out so I'm never going to let that happen to me again, no, you just have that situation figured out. You're going to get to learn that lesson over and over again because that's how you grow."

Jane suggested that part of the monitoring or attunement she practiced came from being spiritually attuned or honing her spiritual intuition as a way to stay aware.

> Jennifer And for me that's key to keeping balance and keeping clear and maintaining that compassion. And I continually get spiritual affirmations for me that I'm doing what I'm supposed to be doing . . . You could say spiritual practice, but also that faith in a higher power helps me manage the compassion fatigue because I feel compassion from Him, my savior, that feeds my compassion for others.

In the process of practicing internal awareness, some participants discovered that they needed to be aware of the way they viewed their clients as a potential sign of compassion fatigue.

> Jennifer Then I can come back and look at it better later and go "ok, what do I need to improve?" 'Cause none of us is perfect. What part of mine that I need to look at and gain more skills, do I need to do some work on myself so I'm not taking on their stuff, or putting any of my stuff on them? And recognizing that it's not my job to fix everybody. It's their issue and I'll do what I can, but if they're not going to do the work, I can't make them. It's their responsibility and I have what I have to bring to the table. If they choose not to use it, you know . . .
>
> Jane Yeah, I always know that when I'm doing that because I stop feeling . . . for me it's fear. It's when I stop feeling faith, it's when I stop feeling authentic because I've let my over anxiety, in their behalf, rule what's going on, and so I think that's one of the hardest things in any role is removal of . . . being a therapist is not getting overanxious and trying to prove a point, but just being kind of at peace with things and letting things happen naturally in the way that they need to that will help that person grow and experience what they need to. They're not going to GET IT until they are prepared to get it.

Jane — I think with any new position that I took or clients and things like that, sometimes you can get in over your head rather quickly and I think we talked about this. Sometimes you don't recognize until you're in the middle of something what you really have in front of you. So it's one of those things where with the cycling for me it's been usually there with each new position or situation. And usually once you've got that kind of figured out and down and it's not a problem anymore, then it's time for a new position or a new degree . . . I think what you do is build strength. Each time you go through something really hard, it makes you stronger and it's time to take another step forward and unfortunately some people completely give up.

The thought which Jane postulated, points to other participants' experiences of becoming aware of the cyclical or spiraling nature of compassion fatigue. For some, as cited in both the first and second round of interviews, compassion fatigue was, and is, a recurrent phenomenon from which participants have gained greater resilience and strength over time. The following excerpts from participants' responses attest to the need for becoming aware of the potential for compassion fatigue as a spiral or cycle.

A. J. — I think I had a severe enough case that I would say it's more dipping a little bit into it. I realized that keeping that level of awareness is key. And so you have to kind of be aware when things are starting to go that direction and do something about it and probably the blessing for me is that I had such a severe case early on in my career and had to deal with things that many therapists don't have to deal with. You know it was kind of a glaring red light flashing red light going. "Stop, stop, this won't work." So luckily I've kept that level of awareness and when it's started to go that way I've been able to step back and say, wait a minute, I'm feeling like I need to get some balance in my life here.

Jennifer — I'll feel pretty good and work and work and work and it's like PHEW. And I need to do something to energize myself. I think I said I also started to get cranial-sacral massages every month to kind of . . . that is so energizing for me. For me it is cyclical and I've learned that I need to do a maintenance. And when I do that, I don't cycle as much. Or I don't get so much compassion fatigue when I take little breaks to take care of myself in between.

Andrew I think in the focusing on the past few years before I moved, I think, there was probably a lot of up and down as the regression line was going down, it was up and down and up and down on a downward slope. I don't know that I was ever walking around depressed or anything like that. Not that kind of place, but there were certainly times when I would wake up in the morning, "Aargh, heavy sigh, push through, let's go." Other times it was fine, I was content and get up and go.

Phil There would be times when I felt like I was doing a pretty good job and I was competent, then I would dip into it where I wasn't feeling competent and then I would dip back out. It definitely, not only was a cycle, but it was spiraling downward.

Elizabeth Unfortunately, I think it has been cyclical only because of the many different physical events that I have been through. Then helping my husband through some of his physical and emotional conditions and then having children with health conditions, just those alone in our immediate family have made it hard just because of all the healing that has to occur on a personal level or reaching out to your family. So definitely over the past . . . five, pretty much the whole time. I would say, even recovering from my pregnancies, which was right after I graduated, I think there have been many challenges. Some are harder than other though. Some weren't as intense. The work always provided more relief for me than anything, but the physical pain and going to work and trying to concentrate and things like that, I know affected me. I just couldn't be all there. So went in and out, I would say, for sure.

John I think it will still come and go and even there are times when I feel that lift of spirit and energy, but I will say like I had a couple—one of the things that I really hate is when I have a couple fight in my office. I had one do that yesterday and I really just didn't feel that deflated by it like I was when I was in the midst of that compassion fatigue. It's just like sometimes they do that and I honestly looked at how I can learn from it and try, but it wasn't questioning myself like, "Why do I keep getting back into these situations, or why do I even do this?" I definitely didn't feel the same sense of deflation that I had when I was experiencing the worst of the compassion fatigue. But yeah, I definitely feel like there will be and are days that I'll be exhausted and I'll crash and need a break. And again, that's the thing about the compassion fatigue, when you finally recognize it that it's a distinct situation and you're in a different place, it can really lull you into not recognizing it because our work is so emotionally engaging and potentially draining anyway that I might have said in the past,

> "Well, this is just life as usual," and then suddenly realizing, "Wait—this is not life as usual. I usually pop out of this better and I'm not." But, I do feel that the cycle of it rings very true to me.

The above excerpt from John's data suggests that acquiring healthy compassion is also a cycle which is preceded by an *Internal Context Adjustment,* the other property of *Making Perceptual Changes.*

Internal context adjustment. Participants' manifested a perceptual maturation as they made internal perceptual adjustments based on their increased attunement and awareness of reactions and feelings associated with encountering and navigating through compassion fatigue.

Roxy changed perception by allowing herself to become "human" again.

> Roxy So some of the changes that I made were short term survival, I have to get through this or I'm going to withdraw kind of a thing. Some of them were more long term in that I need to find a better job where I can be human again . . . I was in a place for a while where I felt victimized a little bit and stuck. But, you know, humans are survivors and there is only so long that you can take being in that place without, if you're not dead, you have to do something to get out of it. So apparently burnout doesn't kill you. So I had to keep kind of struggling to find some way to get through it and I think eventually I took ownership of it. If I don't like my circumstance, I can look around and find someplace else to work and be. It's a rough economy, but I can go and see what I can find.

Other participants made perceptual adjustments by coming to a place of peace and acceptance with the dichotomous feelings they had experienced and with the double edged nature of their own giftedness relative to empathy and compassion.

> A. J. I think a dear friend of mine who I saw just shortly after I went through compassion fatigue. Well shortly, it was about a year or so after I went through my experience, she got a really severe situation. And I have worked with her as a colleague and she became completely disabled from her career as a result. She and I discussed it and really it was around that time that I came to the

conclusion, this is a good thing. To her she was almost mad at herself that she was so empathic.

A. J. I became very resolved with it. That because I'm a real empathic, sensitive person, I'm going to be more high risk for it. I feel fine about that . . . I came to the conclusion that if I had a choice of how to be, I would want to be an empathic person. And if that comes with some risk for compassion fatigue, that's ok, because the alternative is much worse. Not being sensitive and not having any compassion or empathy for others.

Jennifer I don't feel like it stays in an inadequate place. I definitely get there if I've had a real frustrating day. It's temporary, but that's where I take some distance, do something different, really think about it, and usually I can just let that go. That I did the best I could.

Phil locates moving to acceptance as a "surrendering" to the dichotomous feelings he had experienced. His narrative suggests that accepting the dichotomy stops the internal struggle and releases the compassion fatigue.

Phil I can say that when it comes to resolution, it's much more of a, how can I describe it, basically just a surrendering, that's the way I can describe it. I've done my best just to surrender and to basically accept everything that I can do and that's the whole idea of the serenity prayer; I guess would be the best way to describe it. Just accept what I can do and do my best and do it well and with the inherent flaws which I'll always have, I just kind of bear it. Not forget about it because they're just there, but not let them consume me is the best way to describe it.

Phil also adjusted his internal contextual perceptions regarding his ability to help his clinical clients. Jane echoes his sentiments.

Phil Even if I didn't think about it or talk about it, the feelings and everything were still there. Now, I've gotten better at compartmentalizing and on top of that I've come to a more comfortable realization that the clients that I work with despite their misery and difficulties and even illnesses, even the possibility of them dying, because I work with folks in rehab, they were doing just fine before they met me.

Jane Yeah, I totally see . . . I think this is part of the humility part of it . . . I learned that I'm not the only one who can do what I do. And that no matter how much people tell you and they count on you and nobody else can make them feel that good, that that's not a true statement. That you were the right person for them at that time. There will be other people who will do the same thing for them. There is no reason to think that you are indispensable because you aren't. This is as honest as I can be. I have no doubt that there are other people who will fill in the gaps or take your place and do a beautiful and wonderful job.

While compassion fatigue was catalyzed in John through a combination of burnout and secondary traumatic stress, he believes that his experience helped him to gain resilience against potential compassion fatigue reactivity in the future—reflective of a perceptual adjustment for him.

John Yeah there's a sense that if there's something hard in the future, then again we'll see how it unfolds over time, but there's a sense that, I guess I have to say it's something challenging, it's their waiting and I don't need to be as nervous about what might challenge or overwhelm me . . . Anyway, given hard stuff I can have this to draw on.

He defined part of his experience of becoming intentional and making internal contextual adjustments as not taking action, but being still and acknowledging a "willingness " and an "allowing."

John So, maybe part of the shift for me was that I actually shifted to making a definite choice not to solve things when I couldn't solve things and that's what I view . . . not being able to solve problems or coming up short or the ability to really solve anything. And so the ability to just really be still is a different approach for me. I'm thinking of it as passive rather than intentional, but it's just intention on a different level. To transcend the pattern I have now and to try something different and what I'm trying differently is being still and not engaging in any more frantic attempts to try to make things better.

John Yes, that is definitely what has happened. It's easing or allowing rather than acting. It definitely took a willingness to make a shift.

The "willingness" he talks about signifies a different dimension of intentionality, much like Phil moving to a place of acceptance and surrender. In their two cases, as well as those of the other participants, their perceptual changes attest to the capacity of the mind to change and shift paradigms, thus changing the overall internal terrain and experience associated with compassion fatigue. That paradigm shift included learning and being intentional about seeking and developing support along a number of fronts.

Developing Support

Another category of *BECOMING INTENTIONAL, Developing Support* was explicated in the round one interviews based on the data from participants. This subcategory, which remained the same following the round two data analysis, was deepened as a result of that analysis. The properties of this category, namely *professional support, outside support, spiritual support, and self-support* remained the same, as did their dimensions.

Professional support. The dimensions of professional support are *supervisorial support* and *collegial support*. The description provided by Roxy, Jane, Phil, and Elizabeth in the round one data, point to the potential hazards which may exist when trying to receive support from toxic colleagues and supervisors. Most participants became very intentional about avoiding those hazardous relationships, and became intentional about seeking positive support instead. As participants received this positive support, through validation and the normalizing of their experience, this support assisted participants to become more intentional about developing and maintaining long-term support. For example Mary found that her reactivity was abated by talking to colleagues.

> Mary Yes, it was generally not in session that I would do that. I didn't act unconfident or that it was bothering me in session. It was

> afterwards, after they would leave and you know, our minds are very powerful and unintentionally it would be in my mind and I would be thinking, "What other modality can I do?" I noticed that I had to talk it out with other therapists that's what I would do, is try to debrief the session.

Similarly, Phil and John reported having a perceptual transformation and feeling supported as a result of talking to another professional through participating in the study. A.J., Jane, and Elizabeth found validation from both supervisors and other professional colleagues.

> Elizabeth Well, I guess there has been a change since doing this with you. It helped me to mainly talk about it with someone in my field. Because I don't feel like you can do that very often. It changed me and made me feel like yeah, it's possible to talk about it with a colleague and not be ashamed by it. I never was, but I never felt like I could share it. I feared of being judged and I never just didn't feel safe talking about it. It's just not something, I think I've tried with a few different people, but they definitely sent out signals that were "Oh that sounds weak or you shouldn't do that or I don't know." I definitely didn't feel safe. It was a change for me. The change was having that freedom to feel like it is possible to talk to a colleague about that.
>
> A. J. So I probably did that for a period of several months before I realized, "Oh I don't have to do that." It really was her insight. I don't know if I would have come on that idea as [my supervisor] said, "You know, you don't have to do this."
>
> A. J. I always sought for help and I think I said that in the first interview. I went to other professionals that were my peers. The one thing about being a _____ is you always have a supervisor or someone who is in your profession that you can go to and if I needed time off or be taken off the call schedule, I requested that.
>
> Jennifer I have to make the effort to connect . . . I promised that I'll go to breakfast with colleagues once a month. That we did our studying for our licensing exam together. We had so much fun doing that that we decided to keep meeting once a month. So the three of us do that and that's a release. All these other things that . . . I feel like because I don't have an immediate family, I have to work harder to not work so much.

Elizabeth I make sure to do some kind of education for myself, but if I need to get more, then I try to be honest with myself and say, "I may not be able to give this person quality care." So I refer out or I really make sure I'm up front with them as far as my experience goes, so they can choose if they want to stay with me or not. That way it's all on the table, but at the same time, I'll do continual learning or I'll check with my mentors that I feel safe with and chat with them about it or get some tools from them, or . . . whatever the case may be, I do whatever I can to navigate through that appropriately.

Elizabeth I think that, since I've been here, I've felt more freedom, because I'm working in more private practice now. There is a freedom that comes with that. So I can have conversations with colleagues that are definitely different than when I worked in an agency, so I like . . . I like that, and it's helped me a lot.

Elizabeth Again, once I weighed it all out and just said, "This is what you can handle, you're going to have to start there." Luckily I didn't have to be thrown into just whatever comes at me. I've put myself in an environment where I felt, in a sense, safer, but I also was around people who could mentor me. Because initially it was definitely terrifying I think. And I needed guidance all the time. I needed guidance and reassurance because I think there is no question, that during that transition, I needed all of that. Because I feared hurting someone and just as much as I feared someone dying on my watch. I thought, "Oh, I've got to get through these fears. This is going to eat me alive." But that's when I worked really hard during that transition was working through those fears. The only way I could do it, honestly, was again working with people who had been in the field and talking it through, giving me things to recognize, really learning how to ask the right questions and that kind of thing.

Elizabeth I openly said the things that I didn't do well at and feared and needed help with, but the things I enjoyed or wanted to challenge myself with, I asked for help constantly and guidance from people who I thought, you know, have been there and done that. They really helped me a lot and that helped me navigate, say you know, these are the things _____ you should start with and add on from there in little bits at a time.

Outside Support. The majority of participants cited outside support as

significant, and provided thick data to attest to that support in the round one interviews. Mary, Roxy, Jane, Andrew, Phil, Elizabeth and John all described the significance of support, or the ramifications of a lack of support, from partners. Jennifer attests to the benefit of seeking support from friends and intentionality of that commitment.

> Jennifer Because I'm single, I don't have children and don't have a husband, I think sometimes a transition back into my personal life is more of a challenge because I don't have a husband and kids pulling me. I don't have people who say, "You need to pay some attention to me." I have a little bit of that from friends and from family, but generally, it's like, I could work 24/7 and not that many people would notice, so it's more like I have to do it for me and I have to make the effort to connect with friends.

Conversely, Mary described the deleterious effect of a lack of friend support and poor therapeutic support.

> Mary Because I gave so much of myself to other people in counseling and as a friend and empathic everything, I guess deep down I had a hope or expectation, I'm not sure which is a better word, that others would reciprocate and maybe you're getting out of me what's really going on. And I found it's the opposite when I was diagnosed with __. That people almost ran like hell. And it hurt and I have hurt about it right now. It hurt. My very best friend, I know she was trying hard to comfort me and everything, but she was saying stupid things like, "My Gosh, I just feel like you wanted to stake out in the dumps."

> Mary I lost specifically trust with women therapists at that time. Because I had an incident with another women therapist . . . And so, going back to your question, I lost, I couldn't go to therapy.

Spiritual support. Like other participants as described in their first interviews, Mary described turning to developing spiritual support as a way to compensate for a lack of support in other areas. This support is defined as drawing on metaphysical help, a dimension of the property of developing *spiritual support.*

> Mary I have felt both of those and I believe I navigated it through by actually drawing upon my own belief on a higher power and own

belief system was I was an instrument in God's hands rather than what I knew, in order to help the client.

Jennifer I don't know if I could do that without that. For me, it's the spiritual component is such a big piece, that I don't know if I could do what I'm doing without that. And I know there are plenty of therapists out there who are agnostic or atheist and don't have a belief in a higher power, but for me I really don't know if I could do this profession and maintain any kind of balance without that.

John It was partly a spiritual process too, as you experience days like that, you know that's part of life and you plead to God for deliverance . . . and so you pray for help, and pray for God to bear the burdens and then it doesn't happen that day maybe, but a little relief that day and then you have to go back to work the next day. But it's this ongoing process of crying out for spiritual help.

Jane . . . and when it wasn't for me anymore to be in a certain position, I paid attention to the spiritual promptings and prayed and was very directed in what to do.

Phil I slowly, over about a three year period, started building up, getting some faith, getting some faith in myself and some faith in something higher than myself to guide me out of this crud. That's how I would describe it. And recently I would say it's getting better, and better, and better. I feel like I have a whole lot more control over my own direction, my own choices as well as my own outcome.

Self-support. While several participants' accounts represented in the round one interview data, explored the idea of self-support, Phil's account, part of round two, enhances the idea of self-support by not giving up on himself. That is, becoming one's own advocate.

Phil But I was still moving forward. I didn't quit school, I didn't quit my job or anything and just call it quits.

Phil I actually feel a lot more hopeful now. I'm not as scared. I've had a lot of cruddy things at work happen lately like bosses quitting on me and stuff and one boss trying to fire me. And I'm just like, I got scared, but at the time, I didn't care. Not enough to have nightmares over it or lose too much sleep. A little bit was lost, but when I found out there were problems at work, I came home and

> told my wife, "I'm going to go into private practice. I'm done relying on other people." I can take care of myself now. Having her full support as well.

Andrew and John also noted the changes which occurred when they became more self-supportive.

> Andrew: But I'll think back every once in a while. I was doing this the other day, I guess I was thinking about your study, I was just kind of driving around thinking, "Gosh, what would it be like if I were still back there and doing my thing back in _____." I just have this kind of feeling wash over me that it would just be the same, I would still be doing the crazy rat race that I was in. Not getting any further ahead because that's our business how can, what else could I do that would get me out of that rat race? I had a full time job and all these other private practice clinical things. It was a crazy rat race. Just to barely scrape by financially. I explained to you that I loved all the work. All fun, good, interesting work. It was a rat race that was exhausting and killing me.
>
> John: . . . and asking my wife for slack with the financial demand, arranging things at work so that I can still do my job, but not have it be, you know—having a little more wiggle room, being willing to be a little bit more of a junkie to get on line and look up interesting websites or if I have a break between sessions, I don't expect myself to do follow up calls, but instead just crash and take a nap or whatever.

As participants developed self-support, providing themselves with time and space to heal, they were also able to make professional changes. *Making Professional Changes*, the final subcategory of *BECOMING INTENTIONAL* was an important part of shifting participants' locus of control back to the participants themselves. In doing so, participants were able to more fully overcome and navigate through the effects of compassion fatigue.

Making Professional Changes

As a result of becoming aware and practicing intentionality through making internal adjustments and developing support, participants were able to change their macro context in many respects. For example, almost all the participants, at some point, felt that

their macro context was beyond their control. Yet, when they began to make micro adjustments, they were empowered to make professional adjustments which in turn created a different contextual ecology, internally and externally. Sometimes these adjustments constituted a risk either professionally or monetarily. In round one, the experience of making professional changes was conceptualized as a property of the subcategory of *Recognizing a Need to Change.* An analysis of the round two data indicated the necessity for expansion and reorganization of this property into a subcategory of its own—*Making Professional Changes.* This expansion was accomplished by adding the property of *seeking new learning* to the existing property of *making professional adjustments.*

Adjusting professionally. As the participants became more purposeful about navigating through their dissonance and distress, in addition to making perceptual adjustments and developing support, they also made professional adjustments. Indeed, every participant's data chronicles adjusting professionally. This adjusting included finding a new work environment, changing workload, or changing their clinical context. All of these actions may be represented by the dimensional concepts of stepping forward or stepping back along a continuum. Some of the participants purposefully tried both actions, as was the case with Jane as described in her round one interview. Mary also attempted to move towards different clinical contexts. Eventually she felt that in order to preserve her health she had to leave the profession—an action which she described with both grief and difficulty.

> Mary — Yes, I was basically very compassionate for my clients and it was interesting I would get a wave of different people like those who had been sexually molested, or things like that that went through and it seemed like it would be heart wrenching to hear that. It

> wasn't something I had experienced, I would feel like I would like to see more marriage counseling now to get away from that because it was a burnout with that. I would do marriage counseling. I actually enjoyed marriage counseling because I felt like I was a better therapist because of the triad and I would try to keep myself out of the dyad and I wouldn't own their feeling as much. So I was trying to lean more toward marriage counseling. Then I also cycled through and did adoptions. Now adoptions, I had, you know, I finally went through a period of burnout with that because there was a couple of failed adoptions. Well I'm an adoptive mother. I've adopted a child. Obviously, I have personal issues with it.

> Mary And how I made the change was I started backing away from it, limiting my appointments and phasing out even. And then that's when I actually was proactive or maybe reacted to what happened. I went to, I knew it had to be something physical. It wasn't just emotional . . . That's what I'm trying to deal with now with my health. And I've backed away from clients because I thought if I'm not, what I've always been told in counseling, if you're not emotionally healthy, it's not good to be counseling other people and I don't want to damage them in any way. And if I was getting any type of vicarious trauma from it, I didn't want to do anything in turn, I wanted to be healthy.

On the other hand, for Jennifer, stepping back didn't mean that she has changed her practice, but rather, that she separated herself mentally until she was able to determine what to do next. Her account illustrates the connection between being aware of effects and drawing on support. Moreover, she indicates that stepping back professionally is related to purposeful perceptual adjustments as well.

> Jennifer Most of the time I feel effective. That I do have empathic gifts and talents for this and I feel like I have good skills, so when I do feel like I'm flawed and I can't really help this person, it's sometimes countertransference or feeling like they're wanting me to fix their stuff and not putting forth their own effort, so I'm feeling like helpless that I can't impact their situation. Then I usually just have to step back. One of the things is to make sure that my own personal life is balanced. That I have supportive people around me and do things that are not therapy based, like go have some fun and separate myself from it. But try not to dwell on it.

A. J,. who affirmed that she had felt dichotomous feelings about the profession as well as a sense that she did not have control over her circumstances, acknowledges the value of her supervisor in imbuing her with a feeling that changes jobs was appropriate. This support empowered her to have the courage to move forward.

A. J. Early in my career, the professional dichotomy, that was huge for me. And then I found kind of a place of peace with it. It hasn't bothered me since.

I think I questioned it awhile, discussed it a lot with others. I, you know, from the job that I was working at the burn unit when I experienced compassion fatigue, I actually left my job and went into something different and it was less intense than the work I was doing there. Of course anything is less intense than that work. That was partly on the guidance of the supervisor that mentored me through it. "People can't work here forever unless they are kind of a crusty person and you don't have to work here forever. You can stay in the profession and yet not work here. There is plenty of variety out there." And so I did, I went into a more outpatient kind of setting and it was much less intense.

Other participants, similarly and purposefully changed their professional setting and employment engendered by either outside or self-support.

Roxy And when I was in the process of looking for other jobs, I didn't know if I was looking for a therapy job. I was just looking for any job that sounded appealing that might be enough and was open to whatever, but the options that were coming up for me at that point in time, were therapy jobs. And it wasn't until I had gotten another therapy job and been able to leave the other place full time, and just have some time and distance between me and that job and me and the divorce, that I started to feel like myself again. Have some experiences where, "Yeah, I do like my job and yeah, I am good at this."

Andrew Once I was able to make some changes as you recall some big changes, moving and changing jobs, changing schedules, those sorts of things, that helps a great deal to relieve some of the pressure, some of the insane scheduling and so it wasn't so much rethinking self, but what do I need to do differently in terms of how I'm doing this job, how I'm living this career. Because how I was doing it before was 5 jobs and 60 hours a week. It just wasn't

working. And so, making the big job change, move, etc., kind of shifting my life around a little bit or a-lot-a-bit actually, helped kind of calm a lot of the things that were really interrupting how I was doing my job.

Andrew I made that kind of no control to control action, transition and again, I think that it was a pretty major one. Unearthing my family from friends and school and unearthing myself from friends and jobs and family. My family is in ____. Unearthing them and going to a completely different place. Not too far away relatively speaking, but to where we knew absolutely nobody and we're starting completely over. A fairly big transition I believe. As scary as that transition is and could be, I think we've done well, so that's a good thing.

Both Andrew and Phil pursued teaching as a way to professionally adjust. When queried about the idea of moving from a feeling of no control to taking back control—becoming intentional, this was Phil's response:

Phil Well, what's changed is my job environment that helped and it felt good to . . . it felt good to get out of a job environment where most of this was happening and to see that my larger mission to provide for my family, still could happen. I felt much, much better, I was like, Wow I can do this. I don't have to just rely on this one place and one person forever." Like I was afraid I had to and from then on it's just gone up to the point where I'm opening my own practice now. Contacting old referral sources and they're excited that I'm going to be in practice again. They want to send me clients, and I have interns and other people want to come work for me. Now I just feel I'm going to do whatever the hell I want.

Phil Oh yes. That is so cool. Very much so. (moved from a feeling of loss of control to control.) For the longest time I felt completely trapped in the field and the job I had chosen and finally, again, around the intentionality that kicked in even before I hit that bottom it kicked in . . . and that's when I decided, "I've got to get out of this completely." I still love it. That's when I went back and did graduate school. I just didn't want to do that stuff full time any more. I wanted to teach.

Seeking new learning. In order to further his professional teaching career—a part of his professional adjustment—Phil returned to pursuing formal education. His action

was indicative of other participants who sought new learning on either a formal or informal basis. The property of *seeking new learning* is conceptualized by the dimensions of purposefully moving towards learning or purposefully moving away from learning. Roxy's narrative encompasses both sides of this dimensionality. She attributes procuring a new job as the reason she wanted to come back to a place of seeking learning. She also attributes these steps as a way in which she reconciled her professional dichotomy and changed her locus of control. Similarly, A. J., Elizabeth, and Jane also made that attribution. By taking the action of seeking new learning, they gained greater confidence in their skills. That confidence, in turn, assisted them in navigating through, and even inoculating themselves against future effects of compassion fatigue:

Roxy	I knew that I needed to do better self-care or needed to have more opportunity for self-care and I don't know. I think when the opportunity wasn't really there to engage in self-care in the way that I had anticipated would be best, I had to find other ways to try to do that and part of that meant withdrawing professionally and investing less in my job while still making a big change in looking for another job where that was going to be more possible. So some of the changes that I made were short term survival, I have to get through this or I'm going to withdraw kind of a thing. Some of them were more long term in that I need to find a better job where I can be human again and I think since being able to come back from being so compassion fatigued, I've gotten to a place where I can read books again, and continue to develop myself and work on the parts that maybe were a little bit haunting back in that point in time where I was really questioning if I could do this job. I can read and get more information and do the things that a clinician does to continue to learn and develop.
A. J.	I resolved the dichotomy by reading more, talking to more people, taking more classes. So I do have, you know, two masters and a doctorate and a post doctorate from ____, so that could have been part of it.
Jane	I think when I feel where my strengths come out is that I can do well in those roles when I use the knowledge I have and the skill level I have. I don't know if that makes sense, but . . .

> Yeah, and I think that time, when we really feel inadequate, that we really draw on knowledge instead of empathy.
>
> Elizabeth — But I definitely dove into it, but I felt, like this is part of it too because if you don't understand all of the different facets of mental health and what you're looking at, then when you do try to diagnose someone, you may not know what you're looking at. So you need to be able to feel out of the extremes so that you can maybe recognize certain things. I think we get stuck in a pattern we only see certain types of people, certain income levels, and we kind of comfortable and cozy. I think that's why I did that because I wanted to make sure that my brain was turned on to many facets of mental health and that kind of gave me, that one and a couple others, gave me chances to stay up with . . . more educated about all of it.

Creating Ongoing Changes to the Existing Framework

As participants processed through the disturbance of encountering and navigating through compassion fatigue, they made initial changes through purposeful action. In taking intentional action, they were able to change to their existing framework—namely, their *Internal Context, Professional Context,* and *Context Outside of the Profession.* In other words, the participants' framework remained similar to the framework in which they had experienced the dissonance and interference of compassion fatigue. However, now they were experiencing and making changes within that framework which resulted in a different and more balanced response to navigating through compassion fatigue. Moreover, participants moved to a more harmonious internal context and a reconciliation or acceptance of the personal and professional dichotomous feelings they had previously experienced.

Internal Context

While participants had previously experienced dissonance internally as a result of compassion fatigue, by processing through the disturbance, the internal terrain of

participants changed. These internal changes were manifest in their emotions, cognitions, and personal practices which imbued a protection of the core self. In this case, the core self refers to a more balanced sense of self of the therapist.

Emotions. Participants were able to create internal balance as they found ways to process and offload their negative emotions. The dimensions of this processing ranged from verbal processing to a more physical or ritualized processing of emotions. These dimensions of emotional processing connect back to the property of distressed *emotional responses,* responses which participants had experienced as they encountered compassion fatigue. Emotional processing also connects to the property of self-care in that the processing of emotions is a subtle and internal form of self-care. As previously noted, Mary, Elizabeth, and John categorized the ability to verbalize their 'story' as a way to modulate their compassion fatigue responses. This modulation took the form of reflexivity and emotional processing.

> John — Since talking with you I've felt less hate, I've felt some of my enthusiasm returning for being able to do psychotherapy and part of it, that comes and goes for me which if I'm trying out, if I'm in a process of discovering experimentation and I'm trying out some new stuff with couples now that's really fun and cool and so I have less of that hate for it. It's really a blast so that may come and go again in the future but part of was the, again the resolution that came as I talked to you and after and part of it is this that's enabled me to just kind of relax and feel like I can go to work and not have to. Before I talked with you I was really so protective about not working more than 40 hours a week and if I got 45 hours that I'm working and every extra takes that much out of me, I can do the 25 clinical hours without too much stretching but if I see more people, I just call and tell them I'm totally drained and where essentially it's felt like somebody needs to be seen, I can, or if we need more money for this or that, or we want more income I can schedule a few more people. It will be fine; in fact it's probably going to be interesting and sometimes even exciting.

Elizabeth And once I got past that, then it felt sort of freeing a little bit to just do that. Share with somebody who has a heart.

In her previous round one interview, Jane had discussed physically processing her emotions through crying or throwing up. She deepened her explication in round two by sharing her feelings regarding her professional role. This role constituted carrying a "sacred" trust to protect and be a receptacle for client stories. She has been able to "hold" those stories and "lock" them away, citing the singular experience of sharing with another professional.

Jane That's kind of an interesting question because it was one of those things that I thought about after you and I talked the last time. It's interesting to me that I have not shared these experiences with really anybody and so what you would think from that is, "Why am I keeping all this stuff inside of me and I'm not going to anybody and talking about it?" Especially after some real extreme things. I think for me, I protected my family. I didn't want . . . the horrific things that I saw. I knew it would hurt them to even hear about it. So I protected other people from having to go through the same thing that I went through by experiencing that. When I shared with you some of those things, it was as real as if it was happening all over again.

Jane I feel that, I knew that I couldn't ever really tell people without making it less than it really was. Even though I felt like I was protecting other people, in fact, I think I was protecting the actual event or what happened because I couldn't do justice , I couldn't . . . I don't know. There are a lot of feelings I have around that just talking about it right now with it, you know, maintaining people's privacy and I don't know, it is sacred ground that you're on when people are sharing with you things that are so personal or even tragedies that are just unbelievable, you just don't tell other people about that. And so for me I've put a lot of things inside of me and I'm sometimes not even aware that they're there until something triggers those memories. So I think, how I transitioned back . . . I'm really good at it. I'm not saying that in a proud way. I'm saying I've become so . . . it's a natural thing for me to have someone talk to me about something and just not repeat it until, it's almost like, it goes into the file cabinet that gets locked and those memories are whatever are there to only come out when they are absolutely needed for another purpose . . . Like a file cabinet that

> you lock, the cabinet that you always have to keep locked because you have a responsibility to protect people. Information and their lives, and so I just, for me, it's become second nature.

Sharing and having another person receive their story has been helpful in participants' modulating the emotional responses of compassion fatigue. This form of narrative sharing connects with the property of *Developing Support.*

> Mary — I would transition by debriefing and whether it had been with another therapist or if I had spoken to my husband and told him something on the cases, not giving descriptive things, in order to debrief. And talking about what I had done and everything else, actually I felt good and I would transition and without me knowing it, my husband would pat me on the back and "That's good, hun. Thank goodness they have someone like you," something that would help to put me in a better place.

> John — It has been thought provoking. I've talked to my wife about it quite a bit. The primary thing I've noticed is . . . the compassion fatigue is easing even a bit more. I feel a little different a sense of rather than wanting to or needing to avoid sessions that I feel a sense of inner strength which is a relief. I guess it comes in its own time and I can definitely feel that.

Much of this property was operationalized in round one. However, additional insights were added by participants regarding non-verbal processing or off-loading of emotions, including emotions which they perceived had been absorbed from their clients. A. J. has learned to practice off-loading her emotions by using the ongoing practice of non-verbal rituals.

> A.J. — That's a huge part of how I've managed. One particular nurse talked about having really clear boundaries around work and the home and some kind of ritual to let the stress of work stay there and not contaminate you when you leave work and the home environment. She told me about a little ritual that I just captured. We have a revolving door at _____ that you go out to the parking structure. She said every time she felt the air on her face as the revolving door goes around, she imagined it washing off all the stress and everything that happened that day and leaving it there at work 'cause she would walk unencumbered out to her car and then

by the time she got home, she would be fully ready to be present at home and not let what happened during the day affect her. So making it very conscious, because it doesn't happen otherwise. You can just still be pondering and worrying and thinking and if you make it a conscious effort to do that, it really helps.

A.J. There is one other thing along with the ritual, another gal taught me to do rituals when I'm having grief or loss and that was really helpful as well.

The message she would use is, she had a place in her house where she would go and reflect and meditate on a particular patient that had died or a situation that she had experienced some loss. Maybe it was even a long term patient that she cared for that got better and left, or moved away and she wasn't going to see them anymore. She would light a candle, she would meditate about them and then when she felt like she had processed her grief and had her tears, a good cry or whatever, she would blow the candle out and she would kind of let it go at that point. But she had a very conscious process of crossing the grief and loss as well. So I adopted that as well and that has been very helpful. Since we can't just ignore the grief and loss that is a part of the picture for compassion fatigue, unresolved grief and loss. And when you proactively and consciously deal with, validate, honor it, process it and then let it go, makes it a lot easier.

Mary And take a deep breath and realize I had to regain more energy for myself and I took action by trying to deep breathe. I noticed that I would be shallow breathing. I would to slow my breathing and also try to talk about the case. I also noticed that there was something very physical that I did, that if I got upset, I would take, like if it hyper-aroused me, I would take a hot bath. That sounds weird, but it's almost like a cleansing process to restart my thinking.

Cognitions. In addition to practicing ongoing emotional processing, participants practiced and maintained a more positive cognitive stance. The dimensions of those cognitions, positive self-talk and taking a personal stance of non-judgment, are connected with the property of emotional processing in that practicing ongoing positive cognitions assisted participants in self-regulating their emotional responses. This practice constituted a perceptual and cognitive maturation as the participants maintained

perceptual flexibility. This perceptual flexibility may be described as adjusting to ongoing circumstances through accommodation rather than assimilation. By becoming more attuned, participants were able to avoid the injurious lows they had previously experienced at the beginning of their encounter with compassion fatigue. Some of that attunement included preparing and fortifying themselves mentally.

Mary	I would try to tell myself in my mind; my mind-talk is "It's not about me. It's just not, this is not me. It's not mine."
A. J.	Well I think the contrast, and I certainly have known some people in contrast that shut off or withdraw or they just don't get compassion fatigue 'cause they are pretty insensitive or maybe they really lack empathy. I certainly don't want that. I don't know, I just kind of embrace it. It's a double edged sword for sure. I appreciate the fact that I have that capacity for empathy.
Jane	I saw much of my own belief system in things that I had gone through earlier in my career because I have the same belief system she has about work, and that you just keep going until you drop dead. That, you know, it doesn't matter if you're not getting enough sleep or not taking care of yourself; doesn't matter, 'cause your job is to take care of everybody else. So the biggest change that I've seen in my is I've given myself permission to not do that anymore . . . So, that is a huge change for me and I'm very confident that it's ok not to work yourself to death.
Jennifer	Just that I think it's part of our profession. I think if any therapist says they don't have compassion fatigue, they're not a good therapist . . . I think if you're really putting your heart into it and care about your clients, it's going to come. The sign of a good therapist is recognizing it and kind of self-caretaking in the process. It's just whatever our personal stuff is, none of us is perfect. If we're not aware of what we're bringing into a session, we're not a good therapist, but if we're not bringing anything in there that we're totally objective and separate and like, "Your stuff is never going to bother me." Then I don't think you're a good therapist either
Phil	Just the fact that, I don't say this to brag, that I am good at what I do, and because I strive to be good at everything I do, I don't like to be complacent, I don't like to do anything half way. But yet at the same time, I know that I'll never be perfect and it's just a

> matter of accepting that whatever that idea of perfection that I have, it's flawed in itself. I'm trying not to pay attention to it, so I guess I'm just, what I've been doing is trying to have a 'diet' basically of some perfection just to leave it alone and let it be and do my best and hope for better things instead of expecting the worst because of my inadequacies. The best way to describe it is to simply say a surrender of the inadequacies and accepting myself as who I am. Human, flawed and doing the best I can and not only doing the best I can.

Phil and Roxy both developed a stance of non-judgment which included building on the resilience they had acquired as a result of navigating through compassion fatigue. As they cycled through compassion fatigue they learned to accommodate their experiences by first noticing their responses, then becoming intentional, and finally building on their learned resilience. This accommodation has been made possible because of being empowered by new skills and new perceptions over time.

Phil	I actually feel a lot more hopeful now. I'm not as scared. I've had a lot of cruddy things at work happen lately like bosses quitting on me and stuff and one boss trying to fire me. And I'm just like, I got scared, but at the time, I didn't care. Not enough to have nightmares over it or lose too much sleep. A little bit was lost, but when I found out there were problems at work, I came home and told my wife, "I'm going to go into private practice. I'm done relying on other people." I can take care of myself now. Having her full support as well.
Roxy	I think I was, even though I have some sense that the expectations at the other job were a bit high, you know, I still kind of think I internalize some of that stuff and having a chance to be employed by somebody else and see their way of running a business. It shifted my, I felt like I developed more compassion for myself and for what I had been asked to do for so long and that was really helpful for me in being able to validate who I am. I do actually enjoy. I think I kind of had sort of a softening toward myself that helped me end up being able to be more present with my clients.
Jane	Ok. Um. I think it's ok and it's a good thing to feel inadequate. Because if you don't feel inadequate you don't have the humility to really hear what people are saying to you. You have all the answers. And it keeps you learning. Because I feel that every client

> and every person who has ever come into my life, has been a teacher to me as well.
>
> Jane It's a positive thing like pain. If we didn't have pain, we wouldn't know that something is wrong that we need to take care of.

The ability, manifested by participants, to accommodate new experiences was partly facilitated by acknowledging the potential cycling of compassion fatigue and viewing compassion fatigue as a difficult, but growth producing experience as encapsulated by the following excerpt from Jane's narrative. Her response also implies a stance of personal non-judgment.

> Jane I think, and I explained to you, that we talked about the cycling of compassion fatigue and I told you that's how we grow as we see it, but we're going to get it from a different perspective because I believe that when we look at things, when we don't have experience, we don't even understand all the different angles of what we're looking at. We can only look at it through the eyes and the experience that we've had up to that point and yes our values and all of that play into that which is internal things, but those things change, because as you gain experience, like little baby, you learn to crawl and then you learn to walk and then, you know, how to say more than two work sentences, you know, you grow and that's how it is in this profession, or in life. We continue to add to what we have internally to look at our world and as we do that, and we actually experience things, we can become better and better equipped at being able to see more angles and more things coming from different directions and how to maneuver into an internal world that keeps changing. Until we get to the point, and that's what I was saying, that's the reason why it will happen again. It will happen differently because it's going to be another opportunity for me to learn something from a different angle. But when I started out, I didn't see all the things that I see now. And it changed who I am.
>
> Compassion fatigue or experience, yeah. It changed who I am because if I hadn't navigated well through those things, I would be stuck and I would keep looking at stuff in the exact same way. So basically what you're saying, or what she's saying is, "If we can't do that as clinicians, how can we expect our clients to be able to change?"

Creating meaning. Jane's credo highlights the final property of creating and maintaining changes within the *Internal Context*, the category of *CREATING ONGOING CHANGES TO THE EXISTING FRAMEWORK.* Whereas, when participants initially experienced internal dissonance, their ability to discern meaning from the experience was obfuscated by the effect, all participants were able to come to a place where they attributed meaning to their experience. This meaning attribution created a sense of clarity about their experience. *Creating meaning*, a property of the *internal context*, includes the following dimensions: *positioning the self in a larger context* and *acknowledging the growth* achieved.

Positioning the self in a larger context refers to spiritually positioning oneself into the world of others or the universal experience. Jennifer did this by connecting her experience to a sense of mission. This sense of mission was operationalized in rounds one and two by citing the data from several participants.

> Jennifer Yes, I do feel like this is my professional mission. I don't think it's my whole life mission to be a counselor, but I think it is part of my personal and professional mission to be a healer and to be able to have the gift of seeing the need in others and help them feel better about themselves and lift them up. And help them move forward in their life. I do feel a sense that I have that ability and when I feel like I'm not tapped into that ability, then that's another warning sign that I need to take a break, go do something different, I need to step back, need to call a colleague.

> Jennifer Because I feel that I have a compassionate and loving heavenly father and savior, I feel like I have, when I feel the compassion by reading the scriptures and serving others and going to church and doing those things that are part of my religious practice, I feel an energizing and confirming feeling that this is what I'm supposed to do. That I'm in the profession where I can best use my talents and abilities. That even when it's hard and I feel frustrated and I do have compassion fatigue, I won't stay there, I can continue to move forward and be a healer and that gives me a great sense of

peace and comfort and just a reassurance that I'm ok and I'm doing what I can do.

Elizabeth Well, the main thing to me is not feeling alone in the journey. To me that's the true message that, not only do I want to send to myself as a clinician, but as a person and then mostly I hope my clients feel that same way because I think as we all process through all of our pain of all kinds, we have to have this connection that we're not alone in our journey and that will decrease our shame, our guilt of all kinds, and then hopefully if you are spiritual and you keep that and you can maintain that connection and take out that shame factor after whatever, you can continually ask for forgiveness. You can ask for cleansing of sorts, whatever way you do that. Staying connected spiritually and then with all the beautiful people around you is really the key to preventing yourself from getting out of control. Or even if you do, it happens to people too. Staying connected though is the key.

Other participants cited the transformation associated with acknowledging the growth associated with CF.

Phil When it comes to resolutions, I believe, and again this is just my belief and a lot of this I'm speaking through my own lens, my own context I guess you'll want to put it. There is no way things cannot be resolved. Now I believe there are some things in this life that are biological struggles that people have to cope with. But things like CF, these kinds of experiences they do mold us and change us. We can resolve them. I don't think resolution makes it feel like it didn't happen because that's not possible, but resolution is the whole idea. I don't remember which artist it was, which artist sculpted the statue of David.

I don't know if this is really true, but I heard somewhere that said he always saw it in there, he just had to chip a piece away until it showed itself and that's what I think resolution is. I think resolution is coming to self-actualization. It's coming into who we can become; our fullest potential. It's living an ethical life. Aristotle described it for living as shooting for the highest good and to me that's resolution. It doesn't mean just a paradigm change and you just go with it. It means you are being chipped away into something much more refined and that's resolution. I believe every human being has that capacity. It's individual and it cannot be compared from one person to another because everybody is so different.

	Yes, I really do not feel any resentment toward this stuff. Occasionally I do, let me take that back. I don't feel like I used to, I actually feel much more humility and gratitude toward it now than I did even 6 months ago. I would never want to go through it again, because I didn't necessarily choose it, but I am grateful for it and whatever the artist wants to chip away at me next, bring it on. I want to grow.
Jane	It has; it's helped me feel a lot of wisdom. As I've worked through compassion fatigue, I have grown from each one of those experiences and I have gained wisdom from those experiences, but it also has taught me that I will experience it again.
John	Even talking to you about it has been helpful, spilling my guts partly, having others try to understand. But how it shifted since then, sort of a sense of a foundation of believing there are going to be hard things like that and that I'll be able to deal with and hope that I'll be able to help some.
A. J.	I think it's changed me for the better as well. It added kind of like another rich layer. I don't know if I have the exact words . . . well it's like this other surround . . . that I otherwise would have been unaware of and there is no way I could have been empathic or compassionate to people to the level that I have been had I not gone through that myself. So I appreciate that fact and I appreciate that I went through it, like I said, in an intense enough way and early enough in my career, that I could then recognize getting close to that after that happened and I could also recognize that other people and kind of understand what to do 'cause we didn't even have the term compassion fatigue when I went through it. I didn't really have something to call it. We kind of called it burnout. It didn't feel exactly like they described burnout. So it was good at least, to have that awareness and yeah, I feel thankful that I had that. I don't regret it.

External Context

Accompanying their encounter with compassion fatigue, participants experienced dichotomous beliefs about the profession which contributed to their internal dissonance. Some participants resolved this dichotomy by seeking learning or developing support. Others continued to resolve and reconcile their compassion fatigue through creating ongoing changes in the *External Context. External context*, as a subcategory of

CREATING ONGOING CHANGES TO THE EXISTING FRAMEWORK, is further explicated by three properties—*professional context, client relationship context,* and *pursuing creative lifestyle outlets.* All of these properties were explored and elucidated in the round one data and further deepened during the round two interviews.

Professional context. Some participants have made professional changes, inoculating themselves against compassion fatigue, by practicing generativity and providing ongoing support to other professionals. Providing this support is one aspect of the dimensions of ongoing changes to the professional context. In addition to the data collected in round one, participants added the following ideas to practicing providing support to others.

Jane	And that's why I think even though we want clinicians not to get compassion fatigue, it's really how you learn. There are a lot of things to be taught in grad school and in our training to help us to know how to remove ourselves or fix the things that need to be fixed quickly and that's what the value is out of all of this is to help other people gain from what people have experienced so they don't have to go down the same road.
A. J.	Um, yes I am very much, well I may have talked to you about this, I actually looked for people who seemed resilient despite years of working in a real stressful context. Some of the nurses at ____and the emergency room personnel who are used to dealing, ICU nurses, people who are used to dealing with a lot of intensity, a lot of death and dying and child abuse and all kinds of, you know, intense things. I actually asked them, "Ok how do you do this, you've been here 25 years or 30 years, what do you do?" And they shared with me the rituals that they do on a daily basis to help them and so I created some rituals for myself and started using them.
Jennifer	I think it has been a gradual education of just more awareness of myself and more awareness of the profession and the more I've learned, and it's very helpful to talk to other clinicians, "Oh ok, it's not just me," you know, it takes the "what's wrong with me?" and says this is kind of a normal part of.

The other dimension of ongoing changes in the *professional context* is avoiding systemic compassion fatigue. Roxy and Phil add insights to those already provided in the round one interviews.

Roxy I think that I still have a feeling that there are a lot of people in this industry that say that they are client based but it's business based, you know. I was at a place where it was more business focused. For all I know, I think he is fairly good at running a business, but, well, from the perspective of it's still running and successful and it's running, but I think there are a lot of people out there who don't run businesses well or I think there are a lot of people in the mental health field who try to open up a clinic and it becomes, you know, a fairly good study in mental illness itself. I don't know . . . I think sometimes we aren't aware of clinicians of how our personal stuff is affecting business or getting in the way of good working relationships with colleagues or employers or employees. So I think that I'm still, like I feel that aspect of the field can be pretty messed up, but as far as the work that we do with clients, it's actually client centered. I think it's a great job.

Phil Yeah, I experience that a lot. How have I navigated? I haven't navigated, I am navigating. I really haven't come to a full resolution and I don't know if I ever will, but if I were to describe it, I would say also that the system itself, the career field itself is inherently flawed. It tries too hard to be scientific and based on logic and putting everything on logic alone, makes it inherently flawed itself because human beings are not logical. And I don't think that it should be a science, I think it should be a marriage between almost a three-way with philosophy and science and an art. Because those who do it well are very artistic with it. And I do my best as a practitioner to practice things that are research based, but I try to do my best as well to do it in a very individual and artistic fashion because I do not believe in doing something because a book tells me to do it.

Client relationship context. As participants created ongoing changes within their *External Context*, they practiced, and are continuing to practice, *creating boundaries* and *separating themselves* from client outcomes. These two actions represent the two dimensions of *client/therapist relationship* in this category. This separation may also be defined as moving to a state of healthier compassion rather than neophyte idealism and is

connected to the property of *making perceptual adjustments.* For example John, who had previously worked long hours to the point of being drained stated that if he becomes drained, he postpones his appointments. This change is a new course for him. The following excerpts from Jane, Jennifer, Elizabeth, and Phil deepens the data further regarding establishing boundaries with clients.

Jane	I think a lot of it depends on. One of the things we have to remember as clinicians, we have to have good boundaries. We have to remember there is agency involved, that our clients, or whoever sits in front of us, stands beside us and has the right to feel and think and choose as they desire. Sometimes in our attempt to really want them to understand not to make a mistake, we want to reach in and stop them from doing something that we see as a disaster, and that's when I think I stop being true to myself and true to them and start leaning heavily on skills and knowledge and trying to prove a point . . . try to stop them from doing something as I don't see as helpful or good for them to do. I think that's when I see my weakness because my weakness is do I not trust that they can be strong enough to make a mistake and be ok?
Jane	Yeah, I always know that when I'm doing that because I stop feeling . . . for me it's fear. It's when I stop feeling faith, it's when I stop feeling authentic because I've let my over anxiety, in their behalf, rule what's going on, and so I think that's one of the hardest things in any role is removal of . . . being a therapist is not getting overanxious and trying to prove a point, but just being kind of at peace with things and letting things happen naturally in the way that they need to that will help that person grow and experience what they need to. They're not going to get it until they are prepared to get it.
Jennifer	It really is a balance of taking care of yourself but also being emotionally available and attuned and connected to your client.
Elizabeth	Of course I've felt that. I think you kind of have to in order to grow. But I think I work really hard to check in with myself to see if that is what I'm feeling. And if I am, I take responsibility for breaking it down and seeing what's creating that dichotomy. "What happened? Do I just feel inadequate because I'm not trained properly or what have you?" Or sometimes if I encounter something new, sometimes I'll want to just, maybe just refer them out. Is that kind of what you're getting at? If it's something like I

> don't feel I can handle? . . . I think the times when I feel that way, our field for me, tends to, your different types of people in the field that are hard core getting training and certifications every day, it seems like, or you've got people who do their own self-education and the go off their life experience, maybe a combination, you know, and they feel confident enough with that and a lot of times I do feel confident enough that if I don't then that's when I make sure to do some kind of education for myself, but if I need to get more, then I try to be honest with myself and say, "I may not be able to give this person quality care." So I refer out or I really make sure I'm up front with them as far as my experience goes, so they can choose if they want to stay with me or not. That way it's all on the table, but at the same time, I'll do continual learning or I'll check with my mentors that I feel safe with and chat with them about it or get some tools from them, or . . . whatever the case may be, I do whatever I can to navigate through that appropriately.

> Phil — One positive thing is I've always worked quite a distance away from my home. So I've always had quite a distance in separation between the two things. And so the time when I go to work would kind of give me time to get into that. Basically to switch hats. Put in the therapist hat and on the way home, for the most part do my best to take it off. I would be the best I could, but after a while there was as if the hat was still hanging by my ear.

Moreover, in round two, participants expanded the idea of separating themselves from client outcomes.

> Jane — Yeah, I totally see . . . I think this is part of the humility part of it . . . I learned that I'm not the only one who can do what I do. And that no matter how much people tell you and they count on you and nobody else can make them feel that good, that that's not a true statement. That you were the right person for them at that time. There will be other people who will do the same thing for them. There is no reason to think that you are indispensable because you aren't. This is as honest as I can be. I have no doubt that there are other people who will fill in the gaps or take your place and do a beautiful and wonderful job.

> Phil — Even if I didn't think about it or talk about it, the feelings and everything were still there. Now, I've gotten better at compartmentalizing and on top of that I've come to a more comfortable realization that the clients that I work with despite their misery and difficulties and even illnesses, even the possibility

> of them dying, because I work with folks in rehab, they were doing just fine before they met me.
>
> Phil — And so if I can do my best, then I hope that they'll get it and figure something out. But if they don't, it's on them, and not me. So that's kind of how much more it is and now I pass that on to my interns. I remind them that "Yes, you guys have compassion; yes, you want to empathize and help people and this is your job."

Pursuing lifestyle outlets. Creating boundaries and separating the self from client outcomes might be viewed as an intrinsic form of self-care. Outward self-care is defined as, and is a dimension of, the property of *pursuing lifestyle outlets,* with the other dimension being *practicing creativity.* In round one this property was formulated under the concept of *External Context*, but has been reconceptualized as *pursuing lifestyle outlets.*

In the round one interviews, Mary talked about her practice of yoga, A. J. discussed participating in a dance group, Jennifer discussed going to lunch with friends or providing service to others outside of the profession. Roxy enjoys listening to music as a form of creativity and self-care.

> Roxy — I drive home and I listen to music. And for me the music is really an important part of the drive home. I guess I kind of listen to music that fits my mood if I want it to or maybe shifts it a little bit. I really kind of connect with it when I'm listening to it so it really is kind of a cathartic thing for me.

Andrew highlighted spending time with performing and enjoying music as well. He also considers spending time with his family as a form of self-care. He provided more details of both those pursuits in the following data:

> Andrew — I think overall I have a calmer sense of things a calmer base in life than I had before that's for sure. Which means I'm around my family more which is good for me and good for them. We do more things together which is good for me and them. Yeah, it really has been . . . again, I think a greater sense of calm and less stress and worry.

> Andrew Hopefully we'll keep the band. When I was in the middle of all that, it was pretty active with my group. We would get together either to rehearse or perform depending on the month or the time of the year, summer is actually pretty busy. We do some outdoor concerts in the park and things or shopping areas, whatever. At least every other week if not sometimes every week we would get together for rehearsal or performance and even my own practicing in my room. I usually have a music room in the house, in my room working on things. I still take lessons to work on things, so I'm sitting down practicing something, playing over something, trying something out. My own time like that or the band . . .
>
> Andrew I'll wake up extra early. I go to bed early. So I'll get up early and everyone's asleep so I'll go downstairs and practice. Summer's a little different, during the school year the kids have a lot of homework, so I'm helping them do homework. It's good for them and good for me. But just spending that kind of time because it's kind of freeing for me.

Andrew had previously used music as a way to decompress, even before and during the time he was experiencing compassion fatigue. The implication is that while creating self-care strategies was significant for him, it was, in and of itself, not enough to assist him in overcoming the effects of compassion fatigue. He also chose to become intentional about making professional changes. Regaining his life, in turn, diminished his sense of isolation, pressured emotions, and burnout. His story speaks to the similarity of process which exists with all the participants. Indeed, while each participant's chronicle of navigating through compassion fatigue is unique, each had to employ a process of steps and choices in order to retake control of their lives and facilitate their own healing.

Discussion

The second round of interviews deepened and augmented the round one data in several ways. Participants affirmed dichotomous beliefs about themselves and the

profession. For all of the participants, these dichotomous beliefs and feelings had been a seedbed for their distress—a seedbed which had been planted with external stressors including their *professional environment, the quality of social relationships,* and *exposure to suffering.* Participants also affirmed that becoming aware of, and processing their experience, had brought them to a place of reconciliation or partial reconciliation of their dichotomous beliefs. In addition to recognizing and processing the effects of compassion fatigue, some of that reconciliation occurred as a result of practicing intentionality and change. Intentionality, which manifested in developing support, transforming perceptions, and making professional changes, took the form of purposefully moving towards or purposefully moving away from specific perceptions or external circumstances. Becoming intentional is the central category of the theoretical structure which describes participants' experience, because becoming intentional was the pivot upon which most participants changed from feeling the effects of compassion fatigue to navigating through the effects. The act of, and result of becoming intentional, was a move towards reconciling feelings about client outcomes and the general demands of the profession. Moreover, overcoming burnout and finding ways to process emotions also assisted participants to move through their distress. It is noteworthy that many of the metaphorical descriptions of encountering compassion fatigue were water oriented. The water or environment in which participants found themselves metaphorically drowning or struggling was often fetid—certainly unpleasant and even life-threatening. Other metaphors, which connoted struggle, were also indicative of a fight, impairment, getting beat up, or a loss of control.

The implication of participants' data further suggests that taking back control of their internal and external context, either by taking action or purposefully surrendering or allowing, assisted them in negotiating the struggle. Some of the participants were assisted by telling much of their story in its entirety—a cathartic effect. Processing their emotions, either verbally or non-verbally was one of the ways in which participants created ongoing changes. In turn, creating ongoing changes was a way of maintaining the momentum they had achieved through changing perceptions and processing their emotions. Indeed, participants conveyed the importance of creating ongoing changes to their internal and external context. Those ongoing changes included providing support, education, and assistance to other professionals. Adopting such a stance, along with making professional changes either clinically or by setting, assisted participants to avoid systemic or counteract systemic compassion fatigue.

Some participants found self-care to be an important imperative in maintaining healthy compassion and resilience. Practicing creativity, spending time with family and friends, or spending time alone were all valuable forms of self-care described by participants.

In organizing and conceptualizing the participants' experiences within the context of grounded theory, an analysis of participants' second round data assisted in the emergence of a relatively sound theoretical structure. This structure included a consistent structure of categories, subcategories and properties. Yet, the structure that emerged is also variable because of the dimensionality of the properties and subcategories established. That variability connects the categories together in a linear, non-linear, sequential, or concurrent process depending on the individual narrative.

With a firm structure conceptualized, the purpose of the third round interviews was to validate the emergent structure and to ensure a salient connection between the categories. The following third round questions were formulated with that goal in mind:

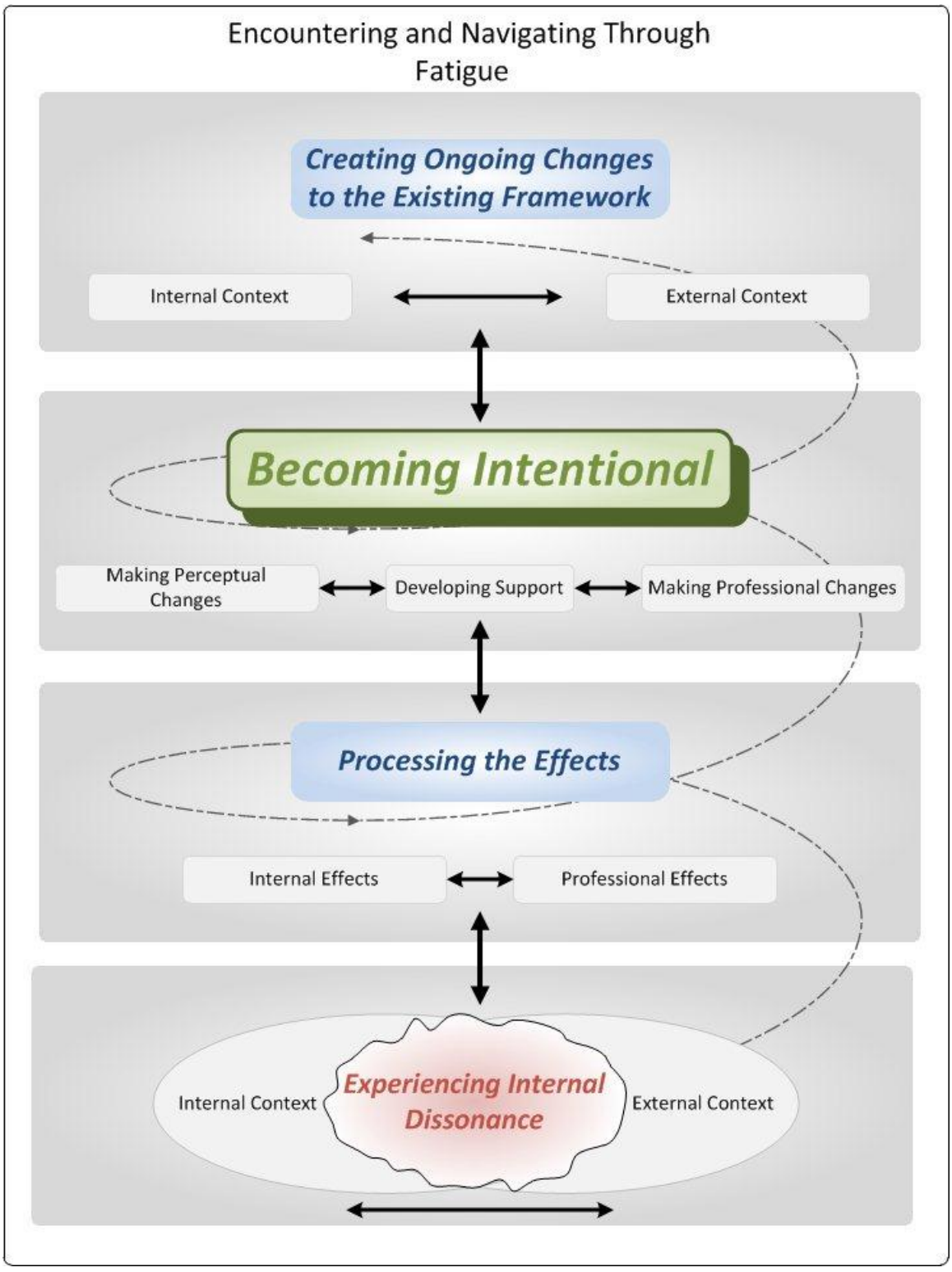
1. Participants have described that when they encountered compassion fatigue, they felt drained of compassion. What internal adjustments did you make which helped you to release the compassion fatigue and regain healthy compassion? (Did that healthy compassion change from the original?)

2. Participants have cited that the passage of time was an important part of navigating through compassion fatigue. How did developing support provide you with that time and space?

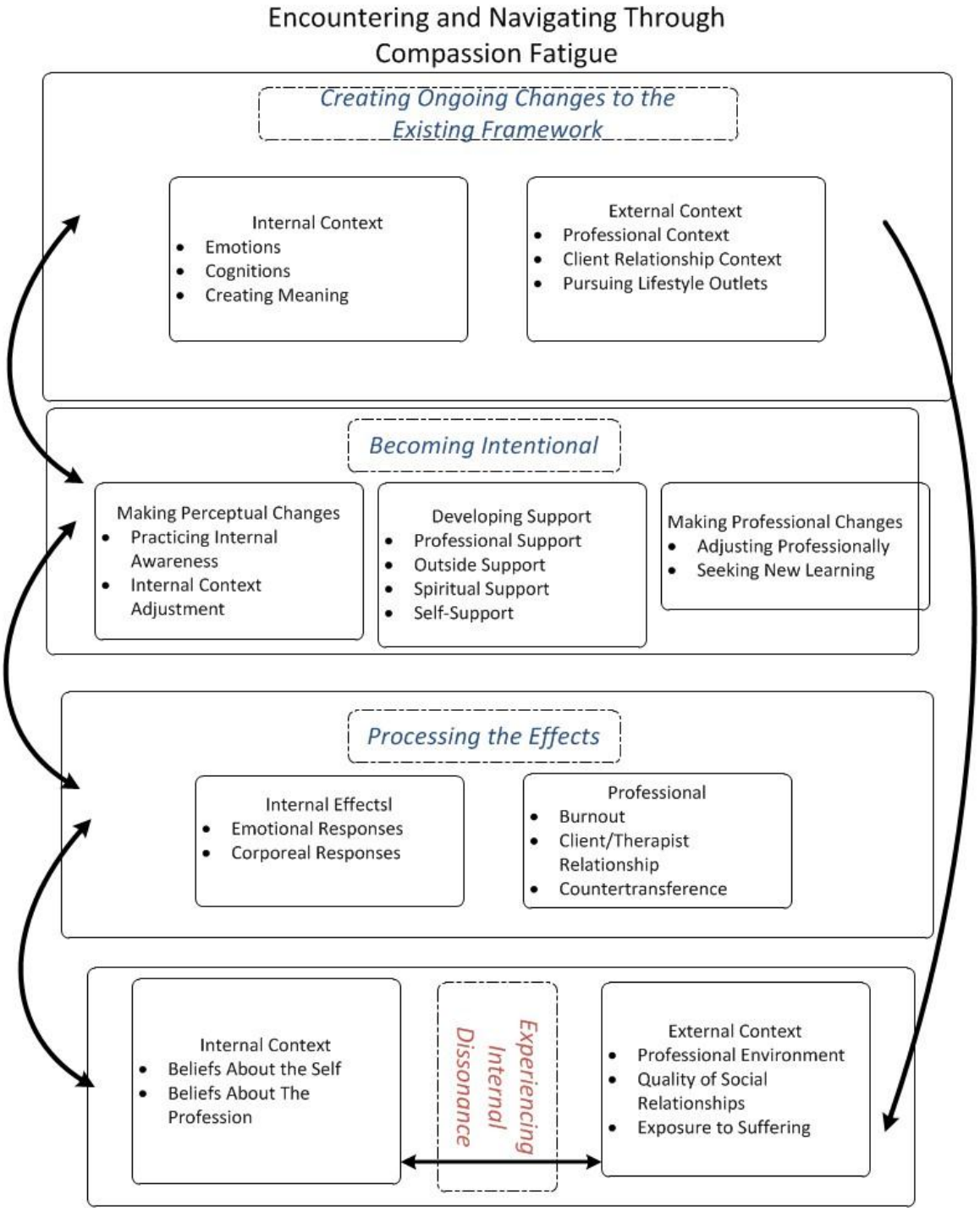
3. How has perceiving this as a growth experience helped you to move from experiencing the negative reactivity of compassion fatigue, to more positive emotions, feelings, and actions?

4. Most participants have identified that they sought new learning experiences as a way to navigate through CF. How has seeking new learning assisted you to make perceptual adjustments about your professional identity and your feelings about the profession? (the dichotomy)

5. Is there a metaphor which would be meaningful for you which describes the experience of *not* feeling compassion fatigue?



Appendix F, Figure 1. Round 2 Analysis – Categories and Subcategories – Encountering and Navigating Through Compassion Fatigue



Appendix F, Figure 2. Round 2 Analysis – Comprehensive Categories, Subcategories, and Properties – Encountering and Navigating Through Compassion Fatigue

Appendix G

Third Round Interviews

Introduction

The round one participant interviews provided rich data representative of the experiences of mental health professionals as they encounter and navigate through compassion fatigue. An analysis of that data led to the formulation of a preliminary theoretical structure. Participants provided additional depth and specificity to the data during the second round of interviews. An analysis of this data provided greater insight into the participants' experiences. By coalescing and analyzing the data from the first two rounds of interviews, a more solid theoretical configuration emerged. As a result, some categories, subcategories, and properties were re-conceptualized and re-ordered.

Because a relatively concrete structure emerged during the first two rounds of interviews, the purpose of the round three interview questions was to validate this developed structure. The goal of the third round was also to ensure that the properties and dimensions connected the entire formation together in a cogent flow of analysis proportionate with the participants' experiences and responses. As such, the round three questions were specifically designed to validate and confirm that the conceptualized connection between categories was accurate. Hence, the first four round-three questions were process, rather than content, oriented. The final, round-three question was designed with the idea of transposing the metaphorical descriptions of encountering and navigating through compassion fatigue which the participants had previously provided. The purpose of this transposition was to facilitate viewing the other dimensionality of the whole experience of encountering and navigating compassion fatigue, thus providing a greater

depth and understanding of the spectrum of participants' narratives. The round three questions were as follows:

1. Participants have described that when they encountered compassion fatigue, they felt drained of compassion. What internal adjustments did you make which helped you to release the compassion fatigue and regain healthy compassion? (Did that healthy compassion change from the original?)

2. Participants have cited that the passage of time was an important part of navigating through compassion fatigue. How did Developing Support provide you with that time and space?

3. How has perceiving this as a growth experience helped you to move from experiencing the negative reactivity of compassion fatigue, to more positive emotions, feelings, and actions?

4. Most participants have identified that they sought new learning experiences as a way to navigate through CF. How has seeking new learning assisted you to make perceptual adjustments about your professional identity and your feelings about the profession?

5. Is there a metaphor which would be meaningful for you which represents your conceptualization or experience of not feeling compassion fatigued?

The round three interviews were conducted in a similar manner to the first two rounds in that they were held with all nine participants, individually, using a semi-structured format. Each interview was audio-recorded. I transcribed each of the nine interviews within three days of each interview, reviewing the recordings several times for accuracy and nuance.

Data Analysis

Much of the specific sequence of analysis from the first two rounds of interviews is detailed in the corresponding round one and two appendices. In general, the round one analysis resulted in the development of a preliminary structure which was re-conceptualized following the round two interviews and round two analyses. Participants' data was generally consistent through all three rounds of interviews as the multiple

interviews served to enrich, deepen, and confirm the progression in the theoretical conceptualization.

Round Three Analysis

The round three data was analyzed in a similar manner to the analyses conducted following the first two rounds of interviews. This analysis included employing micro-coding, axial coding, and selective coding. I then created a sorted table which reflected a comparison of all the transcripts arranged according to categories, subcategories, properties, and dimensions. The purpose of this assemblage was to substantiate the developed conceptualization of participant's data from all three rounds of interviews, and served as a form of triangulation of the data. The analyses of all three rounds focused on parsing out micro and axial codes from individual participant responses and assembling the coded responses into thematic categories, subcategories, and properties. However, in order to ensure that the structure fit with each participant's unique process of encountering and navigating through compassion fatigue, and as part of the process of connecting categories through dimensions, I re-visited each participant's responses individually in order to evaluate if those responses followed the structure. I then created memos of each participant's narrative within the flow of the structure.

Memoing

The memoing process enabled the connection of categories together at this stage of the analysis. I generated many integrated memos associated with the data analysis. These memos were interfaced as part of the analysis simultaneous with axial and selective coding. Brief memos were included in the sorted table of data. A brief outlined

form of the categories, subcategories, properties, and dimensions served as an additional explicative memo.

Diagram Overview and Exposition

Finally, I formulated several figures as a way to crystallize the structure in brief form. These diagrams include detailed diagrams of each of the nine subcategories with their corresponding properties and dimensions (See Figures 1-9). In each of those nine figures, categories are designated by all capital letters, subcategories by bold font, properties by regular font, and dimensions by italicized font. Two larger diagrams of the entire theoretical structure were also produced—one condensed and one comprehensive (see Figures 10 and 11).

Inherent in the participants' stories is the idea that compassion fatigue exists as a process along a continuum of dimensions of experience. This dimensionality reflects both the unique experience of individual participants, and the universally similar process which occurred among all the participants. The dimensionality also reflects the 'humanness' of each participant's experience. The nine participants' data may thus be viewed as both specifically and individually dimensional and universally applicable as a whole. The majority of participants reported experiencing compassion fatigue as both a linear and circular process. An analysis of the data also reflects a concurrent process in that participants' responses imply some simultaneous experiences reflected within the subcategories, properties, and dimensions.

Some participants described the progression through compassion fatigue as an escalating or de-escalating cycle. Because of both the cyclical and linear nature of the process, two-directional vertical arrows were placed between categories on the large

diagrams. Moreover, two- directional horizontal arrows were placed between subcategories within each category to note that the movement through navigating compassion fatigue was both horizontal and vertical. A spiral was also superimposed on the structure to denote the cyclical nature of negotiating compassion fatigue reflected in the categories, subcategories, and properties as linear, circular, and/or concurrent experiences.

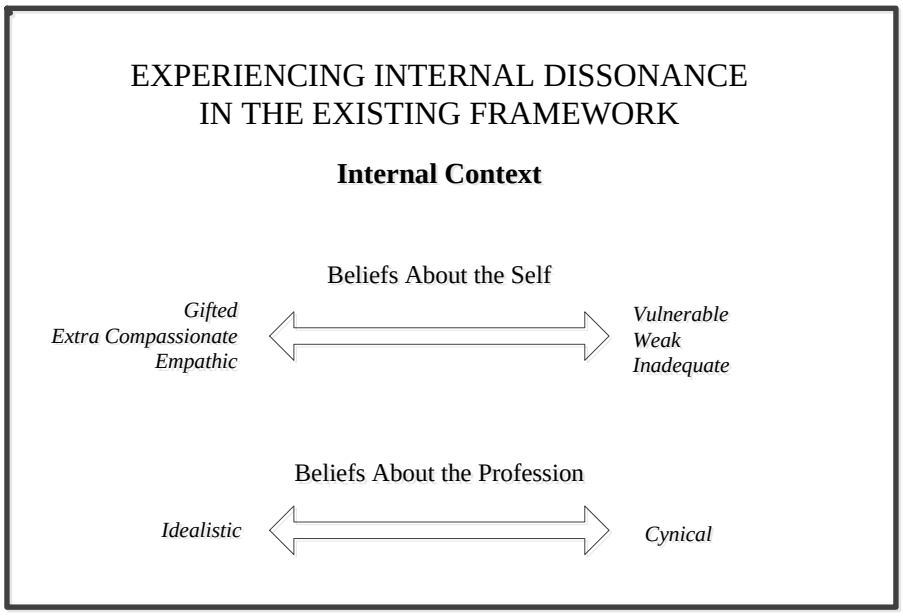
The two large diagrams were constructed to flow from bottom to top illustrating the foundational category of *EXPERIENCING INTERNAL DISSONANCE IN THE EXISTING FRAMEWORK* at the bottom of the structure—the disruption which provoked participants' encounter with compassion fatigue. The category of *BECOMING INTENTIONAL* is more pronounced in the two large diagrams as a way to illustrate its central status.

An Elucidation of the Structure

The round three interviews served to reinforce and confirm the data previously collected and to add further depth to the categories of *EXPERIENCING INTERNAL DISSONANCE IN THE EXISTING FRAMEWORK,* with the subcategories of *Internal Context* and *External Context; RECOGNIZING AND PROCESSING THE EFFECTS,* with the subcategories of *Internal Effects* And *Professional Effects; BECOMING INTENTIONAL,* the central category, with the subcategories of *Transforming Perceptions, Developing Support,* and *Making Professional Changes;* and, *CREATING ONGOING CHANGES TO THE EXISTING FRAMEWORK,* with the subcategories of *Internal Context* and *External Context.*

Experiencing Internal Dissonance in the Existing Framework

Concomitant with compassion fatigue, participants developed an internal dissonance. In the case of most participants, the dissonance escalated over a period of time. This dissonance was catalyzed by the interface of dichotomous personal and profession beliefs in the *Internal Context* (Figure 1) coupled with triggers from *External Context* (Figure 2).



Appendix G, Figure 1. Properties and Dimensions of the Subcategory of Internal Context (Category: Experiencing Internal Dissonance in the Existing Framework)

Connecting the Properties of Beliefs About the Self And Beliefs About the Profession Within the Subcategory of Internal Context

An analysis of the round one data revealed that participants had dichotomous beliefs or perceptions regarding the self. The dimensions of these beliefs ranged from feeling gifted, extra-compassionate, extra-sensitive, and empathic, to feeling weak, vulnerable, or inadequate—examples of the dialectic. Some of these feelings were inherent; others were engendered as a direct result of encountering the internal dissonance associated with compassion fatigue. In round two, every participant except

one expressed having experienced a range of dichotomous beliefs about themselves which were exacerbated as a result of the effects of the dissonance associated with compassion fatigue.

Correspondent to beliefs about the self, all the participants also experienced a dimensional range of beliefs about the profession. These dimensions were exemplified by Mary, who expressed giftedness related to extreme compassion and the ability to intuit her clients' feelings and emotions, yet she also felt weak personally and professionally that she was not able to separate herself from those feelings.

> Mary — Yeah, I loved initially learning and feeling like I actually received something back from [the profession], maybe secondary gain, I don't know in a good way. That I was doing something and helping and doing good. I took that in and I was being of service and I felt good about that. What I didn't like is how it affected me physically, personally and maybe even, I've been told, a change in personality.

Phil, who in previous rounds of interviews had related both his "love" and "hate" for the profession, experienced these conflicting personal and professional beliefs as both uncomfortable and disquieting. Having experienced contrasting dimensions in both the properties of *beliefs about the self* and *beliefs about the profession*, his narrative is an example of the link between the two properties. These two properties are additionally linked in that professional idealism or cynicism was influenced reciprocally by a gifted sense of self as opposed to an inadequate sense of self. Jane's data is an example of this phenomenon. In round two she revealed that she had felt dichotomous feelings about herself most of her life. In round three, Jane discussed *Making Professional Changes* as a way to move through neophyte idealism and unrealistic self-expectations to a greater perceptual maturity regarding how to self-protect against the cycle of compassion fatigue.

She reconciled her dichotomous beliefs by moving to a place of acceptance about the dichotomy itself and by developing a greater perceptual maturity about herself in relation to the profession as a whole. This perceptual change included changes in perceptions about client outcomes.

> Jane — Well, I think the difference is that I think when I was a new _____ I didn't. . . I was kind of naive about my own ability. I think I probably didn't do as good as job as, um stepping away from things or taking a break or asking for help or, you know all of those, all of the above because you kind of initially you think you can do it all or you get this feeling that you have to do it all, I mean you put a lot of your own, you know, ah, constraints on what you should be doing. There's a lot of idealistic beliefs going on initially, or you don't do this, you're really going to have to take care of yourself.
>
> Jane — That dichotomy exists for me personally in everything. Not whether. . it's not like I . . . it's who I am in every circumstance and so it's not like when I become a therapist, all of a sudden I become an expert or I become inadequate. I think I feel that way about being a mother and being a wife, being a friend . . . in any setting.
>
> Jane — We have to remember there is agency involved, that our clients, or whoever sits in front of us, stands beside us and has the right to feel and think and choose as they desire. Sometimes in our attempt to really want them to understand not to make a mistake, we want to reach in and stop them from doing something that we see as a disaster, and that's when I think I stop being true to myself and true to them and start leaning heavily on skills and knowledge and trying to prove a point . . . try to stop them from doing something as I don't see as helpful or good for them to do. I think that's when I see my weakness because my weakness is do I not trust that they can be strong enough to make a mistake and be ok?

In her second round interview, Jennifer also reflected on her dichotomous beliefs of the self. She revealed in her round three interview that these beliefs were somewhat catalyzed by professional inexperience. Her data is included as an example of the way

beliefs about the self and beliefs about the profession are interconnected and mutually modulating.

> Jennifer So I had that for many years before I finally became a therapist to where I could see that boy just even reading about this stuff impacts me and I'm not even personally involved and so professionally I think there's that feeling of, "Like okay I know all this theory, I know all these ideas but now I have to actually do something." And often times I feel graduate school, although I had a great graduate school experience, is more about theory and ideas of diagnosing and what kind of mental illness and things can come up for people and not as much, so what do you do about it? You know, how do you help it heal? There was some of that but I think not as much as, you know, so I went in kind of feeling inadequate that I didn't have enough intervention skill and as I got into it more I would feel that compassion fatigue but I think I knew what was happening.

An additional response from Jennifer illustrates the way in which perceptions regarding professional success affected beliefs about the self on the other dimensional side of each property within the *Internal Context*.

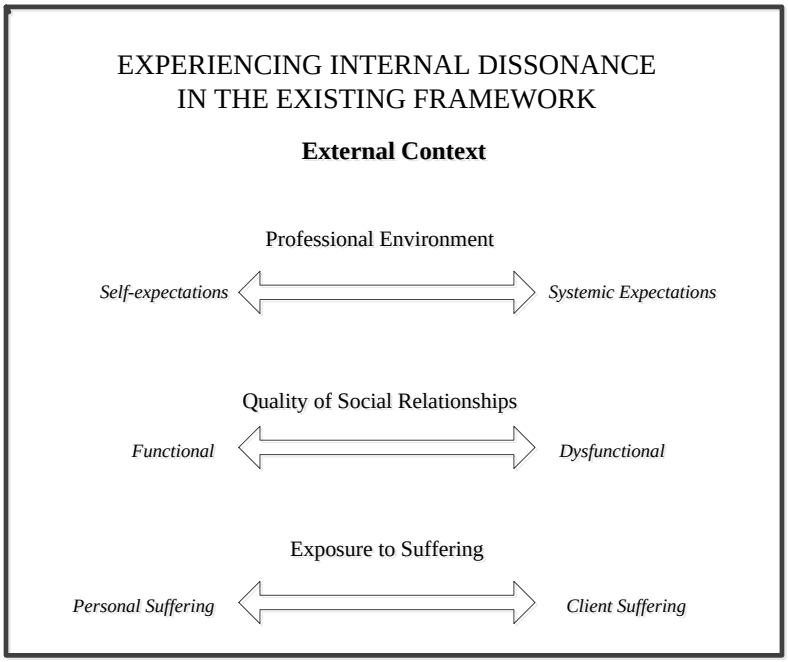
> Jennifer I'm rubbing my hands together. It's like walking into a room that's all messy and you have the organizational skills to straighten it up and put things in order. So you go on with someone whose life is in chaos and pain and think, "I have the tools to help them heal and I love seeing people get better." When what I do makes a difference and I see people's pain reduced, their ability to engage and accept love and give love increased, that, you know, is a real high for me. I love that, to see that happen.

As she encountered compassion fatigue, Roxy's beliefs were also modified both personally and professionally.

> Roxy I think something that's dangerous about compassion fatigue and situations where people aren't supporting that is that when I was in that place of being so burnt out—I thought it was me, I wasn't sure if I wanted to keep doing therapy anymore because I wasn't sure if I was good at it or if it was right for me, or if I even got myself into a place where I was kind of irrecoverable as a therapist.

The Influence of the Properties of the *External Context* on the Internal Context

The previous excerpts of data, not only demonstrate a connection between beliefs about the self and beliefs about the profession, but they also point to the interface between those belief/perceptions and *The External Context.* The *External Context* is classified as external triggers—circumstances which precipitate or catalyze a series of cascading responses and/or events. In this context, the triggers are *professional environment*, *quality of social relationships,* and *exposure to pain and suffering.* The response which occurred as a result of the external triggers, in the case of these participants, was escalating internal dissonance and distress. In all cases this distress up-surged until the effects of the dissonance and distress could not be ignored.



Appendix G, Figure 2. Properties and Dimensions of the Subcategory of External Context (Category: Experiencing Internal Dissonance in the Existing Framework)

Professional Environment. A Property of the External Context. The

aforementioned data from Roxy implies the connection between the internal and external contexts. She experienced the triggers associated with *systemic expectations,* a dimension of *professional environment* within the subcategory of *External Context*. These systemic expectations catalyzed a measure of her distress.

Similarly, in the round one and two interviews, Phil discussed the *systemic expectations* placed upon him by his agency. He felt an increase of distress as a result. This distress in turn created a greater dichotomy in his beliefs about himself and the profession. He experienced a *systemic expectation* to "suck it up," as did Roxy and A.J..

Phil also experienced the other dimension of the property of *professional expectations,* that of *self-expectations*. Roxy, Jennifer, Phil, John, and Andrew all reported self-expectations associated with the necessity of financially supporting themselves or their families. Their data also ties back to feelings about the profession, or what Andrew termed "golden handcuffs."

Andrew	The 'golden handcuffs' thing . . . Sure, 'golden handcuffs.' You're locked into something wonderful; that you're locked in.
Phil	I did, I have a stubborn streak to me. I like a good challenge. I enjoyed the challenge. I enjoyed learning and I saw it as almost a constant, day to day learning experience to work with individuals who had been through similar traumas but experienced it and demonstrated it and their symptomology and pathology was so different. And it was fun to even find patterns in it. The theories I learned in school started to come to life. I loved it, but what happened was the requirements of working there was to have 30 clients a week. Because, I remember one year, I don't remember the exact year, but I remember the time of the year. I'm reminded every year almost like an anniversary trauma, where my paycheck dropped ___ within two weeks and that's how it happened very often there where I would get a really great paycheck and then people wouldn't show up and then my paycheck would be terrible.
John	I just keep my own practice going, but now doing a little more administrative work, but it's what pays the bills, you know,

> teaching is, you have to do a lot in order to, of adjunct, if you have full time professorship, it would be different. So I've stayed out of necessity and get some good feedback from clients. I always wish I was better at what I do, but that's my experience in practice.

Almost all participants at some point manifested and experienced high or idealistic *self-expectations*. Mary, when faced with difficult clients who other therapists labeled as 'crazy,' believed she could help because she did not manifest that level of judgment on her clients.

> Mary When my supervision delegated her to me, they said, "You can have her . . . she's crazier than hell." And I remember thinking, "I can't conceive of that. That's mean that's not me. I can help."

Roxy experienced a loss of self-expectations in comparison with her initial idealism.

> Roxy It started to get scary and just distressing, like you don't feel good about yourself when you can't do the kind of work you take pride in, but there was nothing that I could do . . . I knew I needed to take care of myself and take a step back, but I didn't. I wasn't given the opportunity to do that. And I guess another description of how I felt after that meeting with my employer was incredibly angry.

A.J. didn't recognize the level of trauma associated with her work prior to experiencing compassion fatigue. For a time, she attempted to accommodate her *self-expectations* based on perceived *systemic expectations.*

> A.J. Right during the same time, I'm working in the burn unit, and the thing, I think psychologically preparation is a big part of preventing trauma and compassion fatigue and whatever. I was not very psychologically prepared when I went to the burn unit, I guess I thought of – I don't know – people who work in the oil field would be there or, you know, but I didn't know one-third to one-half of our patients were pediatric patients and were actually babies . . . One morning when I came in and went to his crib and he wasn't there and so I grabbed one of the nurses and I said, "Did they take [the patient] back to bathe him?" She said, "Oh no, he died last night. Hey, there is this patient over here we really need

> your help with will you come on over here?" A complete surprise. And he had been getting better and so I didn't think that was going to happen. And I had seen a few patients die already, but they had maybe been admitted for a day or two, and then they had passed away . . . I hadn't had this experience of getting attached to a patient. It really, getting some kind of relationship with him, and then to have him suddenly pass away . . . So, I sucked it up and that's what I did, 'cause I thought, "Ok, we don't acknowledge it, we don't talk about it. We just move on and take care of other folks." I just kind of swallowed it.

In their first round interviews, Jennifer and Elizabeth both spoke of expectancies associated with being thrown "into the fire" or being thrown "into the deep end." Elizabeth actually chose to push her expectations of herself by "facing her fear."

> Elizabeth Then after that I think I was the first student to get into a hospital working in the ER. They usually didn't want interns there, but I begged them. I really did. I was very fearful of a client dying on me and I wanted to face my fears of suicide and even though I grew up seeing that several times, I needed to be in a setting where, I guess it sort of came in consistently, plus they had a psych unit there that I knew they were going to let me go to see to. I guess I just needed, I've always been a person if you're going to face your fear, you've got to run through it and so I said, "Where's the scariest place, by far the emergency room, and the psych unit." Because they come in and they're at the worst of the worst and I'm sure a state hospital would be top of the line, but for me, I wasn't planning on going that route. For me this was the scariest place. And I worked in the middle of the night, so it was very difficult, I was pregnant through a lot of that and had a three year old at home at the time. Yeah, definitely saw it. You know, they came in, attempted suicide numerous times with gunshots to slicing their arms.

Jane also spoke of *self-expectations* associated with working in crisis or death and dying circumstances. Her narrative as well as others' speaks to how the property of *professional environment* intersects with the property of *exposure to pain and suffering.*

Exposure to suffering and pain— a property of the external context. As participants practiced within the mental health profession, they were exposed to their

clients' suffering, pain, and/or trauma. The dimensions of this property are *clients' suffering and/or trauma* and *personal suffering and/or trauma.* This exposure may be defined as traumatic stress. In the case of exposure to client suffering some participants experienced secondary traumatic stress. Other participants, exposed to their own trauma and suffering, experienced primary traumatic stress.

Exposure to the suffering, pain, or trauma of their clients was a trigger which, for several participants, increased their dissonance and distress. Secondary traumatic stress was engendered as some participants worked within differing clinical contexts. These clinical contexts included a variety of settings including working with mood disorders, addictions, abuse, medical issues, crisis, and trauma recovery. Many instances of exposure to client pain and suffering were described previously in the exposition of the round one and round two interviews. A recapitulation of some of those descriptions evinces a connection between this property and other properties and categories.

John's beliefs about himself and the profession as well as his *client/therapist relationship* were also affected by exposure to client suffering.

> John Yeah, my, it's never really been a real comfort zone. And every time walking in with clients, it's even on a day to day basis, I'm not really confident at, my wife, overheard me talking with a client, and this was just last week. And she goes, "Why do you, you know, view yourself as not doing very good work?" So I told her about the interview I had with you and I said, "It will be good for me to talk, therapeutic maybe." I really, I don't know it it's just doubts, you know, having doubts but part of it's the failure as a clinician. You're going to fail with a certain number of clients. And part of it is just seeing people whose suffering doesn't improve with the work you do with them. And what I was telling my wife is that you know, the worst thing is not that you fail, 'cause it would be one thing to fail and have people tell you, you fail and then they move on and go about their merry way, but what's worse is when you feel like you're failing and they keep coming back and so you just work in an ongoing way with people

> whose suffering doesn't end and they like working with you and they get a lot out of working, or something, out of working with you, but they never quite get better.

His distress escalated as a he worked, over a protracted period of time, with a client who had experienced trauma.

> John I don't know of a point, but there was a realization that I had that this particular work with _____ had disenchanted me with the profession.

John's narrative is an example of the connection between all the properties within the *External Context,* namely, *professional environment, exposure to suffering and pain,* and *quality of social relationships*. Further, John believed himself to be highly sensitive, connecting back to his *Internal Context* as a precursor to experiencing compassion fatigue.

> John So I feel like one of the things that helps in this profession is to be thin skinned or sensitive, but as a result, it's like the safe cracker who sands his fingers in order to really feel all those ball bearings fall or whatever they're feeling for. It's like, you're a little more tender to those things in the first place, seeing a sad movie and feeling it. Or hearing a story and being horrified on the news. And so now what do we do as a profession? We go in and talk to people who have these horrific things happen to them and traumas and empathize, that's like the instrument we use as our own empathy to try to be helpful. It just exhausts you, you get burnt out from it and experience compassion fatigue.

John reported working in a pressured professional environment. When coupled with exposure to suffering and pain—secondary traumatic stress—his beliefs about the profession were altered. In time, the amalgamation of these phenomena, his sensitivity, his beliefs about the profession, his high self-expectations, and his exposure to suffering and pain all increased his dissonance and distress. Fortunately, John, by self-report, experienced high functioning within the *quality of [his] social relationships.*

Likewise, Jane explained that her personal sensitivity rendered her more susceptible to the trigger of exposure to suffering or trauma.

> Jane I'm really sensitive anyway, I can't watch horror movies, I can't talk about things that are evil, because if I see a show on TV I will dream about it. I know my sensitivity level.

She, like A.J. and Phil began to have nightmares as a result of working with clients. All three of these participants moved to a place of *RECOGNIZING AND PROCESSING THE EFFECTS* of the secondary traumatic stress they were experiencing.

> A.J. OK. A few months later I noticed that I started having nightmares about [the patient] at night. To the point, I mean, really bad nightmares.
>
> Phil I've heard a lot of stories that are just really, really bad. And there were times when I would experience vicarious trauma. I remember one incident where I went home and I couldn't control my own shaking. My hands my whole body was shaking and it scared me to death the story I heard. And I really respected my boss, so I called him up and said "What do I do?" He said, "This is called vicarious trauma. Go home and do this, this, and this. It will calm it down."
>
> Jane So I realize that that was happening to me because of the work I was doing and when you identify too closely with the people that you're working with or you're really sensitive and you've feeling a lot of empathy, you have to be really careful that that's where the victimization comes in.
>
> Jane I can feel [clients'] energy. I could feel if I was in danger, if I was safe, if there was something not quite right here. I've always had that, almost intuitive ability to discern and so, the problem with that level of sensitivity is that even though it can be a real blessing, I've always said it's a two edged sword.

The above two excerpts of data illustrate the connection between the dissonance associated with secondary traumatic stress and the property of *client/therapist relationship* within the category of *RECOGNIZING AND PROCESSING THE EFFECTS.*

The effects experienced by Jane are similar to those of Mary and A.J.. A.J., who was exposed to suffering and pain working in a hospital burn unit, presents data which also connects secondary traumatic stress to *emotional responses* and *corporeal responses.* She began to experience hyper-vigilance and fatigue. Additionally, her experience affected her work within the area of *client/therapist relationship* contexts associated with becoming attached or disengaged from clients.

> A.J. But my role there was actually to be a little more comforting and calming and involved with the patients and also with their families. I kind of was probably in a little more vulnerable position to actually get a little more attached. . . I was a bridge.

Similarly Mary, who worked within a variety of clinical contexts, began to feel the physical responses of her clients even before they did

> Mary I made note and charted it. I would say, "Where do you hold that pain and where do you feel it?" I would guess it before they would say it. Because I felt it like in my gut, in my heart, and I started becoming really good at the guessing with the energies because I believe I was connecting to their energies. So when I would tell them to hold that thought and do the EMDR, I sometimes think that that central nervous system actually activated my central nervous system.

Data from Mary also connects the property of *exposure to suffering and pain* to the property of *beliefs about the self* (she perceived herself as empathic and extra sensitive). Additionally, Mary's chronicle connects *exposure to suffering and pain* to the properties of *emotional responses, corporeal responses,* and *client/therapist relationship* within the category of *RECOGNIZING AND PROCESSING THE EFFECTS.*

Jennifer began to see the need to process the effects of her dissonance associated with exposure to extreme clinical environments. Her narrative also connects *exposure to suffering and pain* with the category of *RECOGNIZING AND PROCESSING THE*

EFFECTS. She described feeling a "weight" and "heaviness" around clients. She also began to question herself. This phenomenon connects her exposure to suffering and pain back to her beliefs about herself.

> Jennifer So it's like, "Am I crazy?" Or, you're starting to question whether or not you're the one who has problems.

Roxy also questioned herself as a result of exposure to her own suffering. During the time in which she experienced compassion fatigue and what she terms "crispy, fried burnout," she was struggling with the internal pain associated with a severing of her partner relationship. Mary was exposed to her own suffering as she began to experience the deleterious effects of a stroke and [a debilitating disease.] A.J. had had a recent miscarriage which caused her distress. Elizabeth had been exposed to physical challenges and to the pain associated with past abuse. She had also experienced the personal pain and loss associated with a family member's violent death. Her narrative presents some of the data which connects the two dimensions of *exposure to suffering and pain* to the property of *quality of social relationships*.

Quality of social relationships—a property of the external context. The quality of social relationships as a property has two dimensions, functional and dysfunctional. This property also refers to the quality of social relationships both past and present. A.J., Jane, and Jennifer reported functional partner relationships. Roxy attributed some of her ability to cope to functional friend relationships. Conversely, Mary reported a dysfunctional friend relationship, Roxy and Elizabeth had partner relational problems. Additionally Phil and Elizabeth had been exposed to difficult and/or abusive familial relationships in the past:

Phil	It was very personal. It affected everything. Compassion fatigue probably started long before even the professional stuff kicked in. It was family related stuff.
Elizabeth	I grew up in domestic violence almost on a weekly basis, so I saw tons of violence, lots of, saw suicides. . . And a lot of sexual abuse, those kinds of things. So there was a lot of trauma. I was alone a lot as a kid.

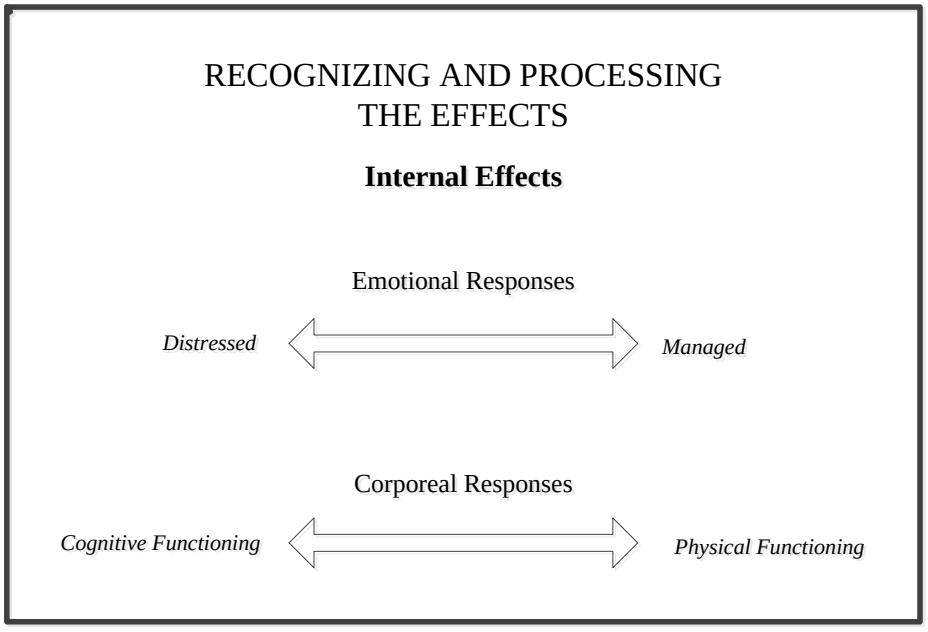
Certainly, for some participants, particularly for those who experienced dysfunction in their past and present relationships, the quality of those relationships acted as an external trigger. This trigger further exacerbated the dissonance and distress they felt internally as they experienced compassion fatigue. This dissonance influenced participants' experiences with *countertransference*. This influence signals another aspect of the connection between *EXPERIENCING INTERNAL DISSONANCE* and *RECOGNIZING AND PROCESSING THE EFFECTS* associated with that escalated dissonance.

Recognizing and Processing the Effects

The data from all three rounds of interviews regarding exposure to client suffering, not only connects the properties within the category of *EXPERIENCING INTERNAL DISSONANCE,* but it also demonstrates the way that this foundational category is connected to the next category in the structure. This category *RECOGNIZING AND PROCESSING THE EFFECTS* includes both *Internal* and *Professional Effects* as subcategories. As participants' dissonance escalated, they came to recognize *emotional* and *corporeal responses* as *Internal Effects*. Participants also began to recognize and process the *Professional Effects* of their dissonance—*burnout, client/therapist relationship* contextual problems, and *countertransference.*

Connecting the properties in the subcategory of Internal Effects

The data regarding the *emotional* and *corporeal responses* experienced by participants demonstrates a connection between these two properties within the subcategory of *Internal Effects.* The property of *emotional responses* was fully described in the appendices associated with the round one and two interviews of participants. In that previously delineated data, participants described a plethora of emotions which were the affective outgrowth of their dissonance and distress. Those emotional responses may be viewed on a dimensional continuum of experience between *extreme distress* and more *managed emotional responses*. Similarly, *corporeal responses* were clarified in former appendices as the dimensions of *cognitive functioning* and *physical responses.*



Appendix G, Figure 3. Properties and Dimensions of the Subcategory of Internal Effects (Category: Recognizing and Processing the Effects)

However, the connective link, which some participants experienced, between *emotional responses* and *corporeal responses* was only implied. The following excerpts of data, more concretely, illustrate that link:

Phil, who experienced secondary traumatic stress because of exposure to client suffering, became frightened and paranoid. He also experienced the physical response of "shaking."

> Phil I remember one incident where I went home and I couldn't control my own shaking. My hands my whole body was shaking and it scared me to death, the story I heard.

Similarly, Elizabeth described being "flooded" with "numerous feelings", which she noted exacerbated the physical pain she was also experiencing.

> Elizabeth Grief, trauma, doesn't matter, it's pain. Pain is pain. Physical pain, I know all about it. Too many times to count.

Mary and Jennifer both described their emotional effects as a physical heaviness as well. Mary, likewise, experienced a stroke. She attributes some of the cause of her stroke and the development of [a debilitating disease] to experiencing the emotions associated with secondary trauma.

> Mary In fact, I believe, it did a little bit of damage [physically] to me in some way. In that I wondered, as I got sick with [auto-immune disorder] which involves your central nervous system, EMDR involves your central nervous system completely and I felt I wonder if this is EMDR that has done this or if the counseling is what has made me sick.

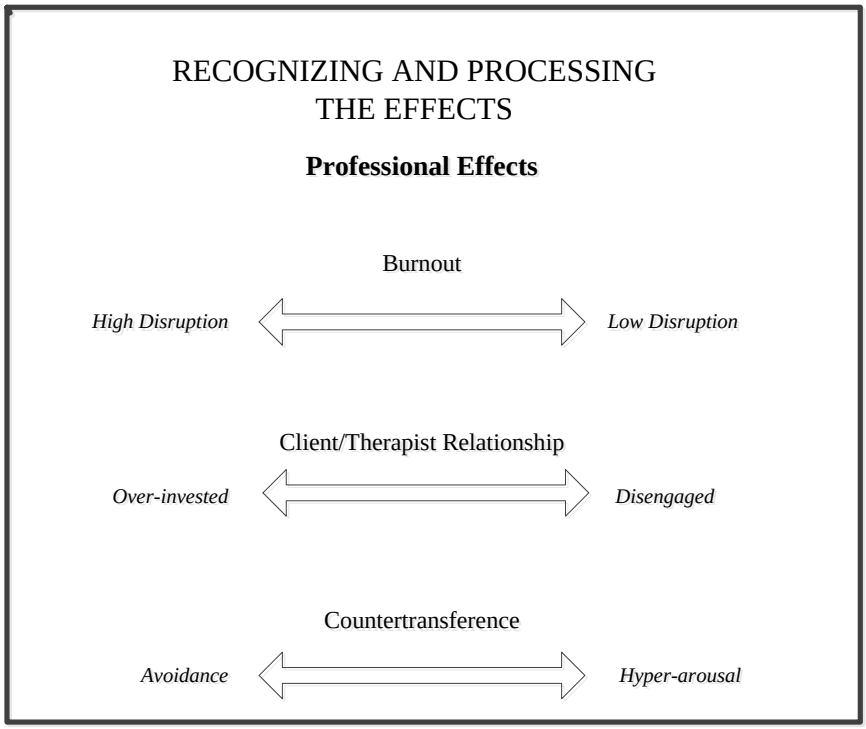
Andrew and Roxy also experienced physical responses associated with emotional responses. Andrew, who felt isolation also felt physically drained and exhausted.

> Andrew It's easy for us to you know isolate out there and so I certainly felt isolated in my you know my struggles.

Roxy felt emotionally "scared" and physically "exhausted" at the same time. Her emotional tension transitioned to physical tension as part of the effects of compassion fatigue. This portion of the data from Roxy and Andrew as well as data from Phil and John, exemplifies the connection between recognizing and processing *Internal Effects* and *Professional Effects.* All these participants reported intense effects associated with *burnout*, one of the properties of *Professional Effects.*

Connecting the properties within the subcategory of Professional Effects

As previously noted in the explication of the first category, the contributory element of the External Context in evoking dissonance and distress was connected to participants' experiencing the Professional Effects of that dissonance. The categories of Professional Effects—burnout, client/therapist relationship, and countertransference are qualitatively correlated with the properties of professional environment, exposure to suffering and pain, and quality of social relationships. As a result of this correlation, the properties of Professional Effects are also indirectly influenced by beliefs about the profession and beliefs about the self.



Appendix G, Figure 4. Properties and Dimensions of the Subcategory of Professional Effects
(Category: Recognizing and Processing the Effects)

Burnout—A property of professional effects. Burnout, as a concept was operationalized in the former appendices describing the analysis of the first two rounds of interviews. However, conceptualizing the property of burnout as it connects with, or is influenced by other properties, was an important part of the third round analysis. In the context of the conceptualized structure, the dimensions of burnout are *high disruption* and *low disruption.* In other words, some participants experienced higher levels of burnout than others. Certainly, as they attenuated their distress, participants' burnout diminished.

Burnout, in light of the data analyses of all three rounds, is closely associated with professional *environment* as well as clinical context, including participants' *exposure to suffering and pain*. All participants, at some point in their career, worked in an extreme

environment. Whether that environment was characterized by clinical context or extreme amounts of time spent doing therapy, for the participants, burnout was a phenomenon associated with professional demands outweighing personal resources to meet those demands. This circumstance applied to the Andrew's experience of burnout who felt like he had no choice but to "go, go, go…"

> Andrew If I didn't see the clients then I wouldn't make money which means I couldn't pay my bills. As full time faculty, you can't really work more and make more. I guess they would let you teach an extra class here and there, but there was a certain way you had to do it so you can't really say I'm going to make more money this month. So just pressure to keep going and at the same time realizing that, "When's this going to stop or is this going to stop? 'Cause I know I can't keep going like this. Not in any healthy way." So that kind of conflicted thing, "I have to keep going and it's killing me."

Burnout, when combined with secondary traumatic distress, seemed to increase the likelihood of the effects of compassion fatigue being amplified. This aspect of burnout was experienced by John. The following excerpts of data illustrate that carrying a large caseload, a contributory component in John's burnout, was aggravated by his concern over clients in general and his exposure to client suffering.

> John Yeah and then you know, it's sort of like death by 1000 blows 'cause you have that case, but I have the other things, there's kind of this unrelenting, into the office comes a guy who couldn't feel like he could handle life eight years ago, so he started doing something to cope. For him it was [cough medicine], but it's like, if I can't handle life and I back away and use some addiction or some other coping thing, well not 8 years later when I see him he's even in worse shape and in withdrawal from the addiction. It's just these case after case of vulnerable people in situations that overwhelms their abilities and now after the fact we're trying to put the pieces back together. Feel like therapy is a real weak tool sometimes when you've dealing with those kinds of really difficult situations. Again, I've had this discussion with my wife a lot. It's better that they come see you than nothing, yeah that's true. I would hate that they have nothing, but . . .

Like John, the participants who worked long hours or were involved in intensive multi-sensory clinical environments reported experiencing burnout. This was the case for Roxy A.J., Jennifer, and Elizabeth.

Roxy	I sucked it up and kept going at, you know, and try to adapt to where I was with the burnout and compassion fatigue, like I knew I couldn't give my clients what I would like to give my clients . . . that's the thing with my schedule as crammed as it was of client hours, I couldn't keep up with case notes. So that's part . . . if there was one thing that would say that I had to take home from work that wasn't necessarily worrying about clients, but it was the stress of, like, this cloud of case notes always looming. Like I am never catching up, I'm getting more and more behind, and so even on the weekends it was, "When am I going to get this work done?"
A.J.	So I went over there and it's, even for people who are really seasoned ER doctors or people who have worked in ICUs, the burn unit is a whole level above in terms of difficulty and intensity. It's a very unusual environment.
Jennifer	So it's not so much about loving the job, it's like ideally I would like to work just 3 days a week and I think I would look forward to those days instead of, "It's Monday (dread), I've got 60 hours to go until the weekend." 'Cause I don't usually do anything during the week. I work long hours and even if I'm done earlier. I don't want to go hang out with friends or go to the movie, I just want to go home and relax. So that what comes in for me, is recognizing when you work too much and then this balance because I need the money. When you're the sole support, so it takes . . . and it also gets where I don't want to talk to anybody because, ok, "What do you want from me?" And, "I've got nothing to give." So it can come in that way.
Elizabeth	No… this time I was exhausted I really didn't want to; I didn't really want to do therapy. I really just wanted to get out of here. I still do, I'm still really whooped.

Phil, who also worked both long clinical hours and in an extreme clinical environment, found that his burnout began to affect his relationships outside of the

profession. His data serves as an example of the connection between the first two categories.

> Phil Slightly. And she just said, "_____ you know this was the right decision. We've been through this before. You're tired, you're burned out. You know this. Let's find a new place for you to go." But we looked for years. And it continued, but it didn't just affect work, it affected home.

The above data also demonstrates the connection between the properties of *Professional Effects,* in that if those participants who experienced burnout also experienced either client/relationship problems or countertransference, the burnout was aggravated.

Burnout was also connected with the property of *emotional responses.* Those who reported burnout also reported concurrently becoming cynical, feeling avoidant, feeling robotic, or feeling dread over having to see all clients or certain clients as exemplified by the following excerpts from participant narratives.

> Phil Burnout, cynicism. I began to resent my decision to be a therapist. I began to resent going to work. I began to resent people in the field. And it not only affected work, I finally became aware of it after a while how miserable I was. I felt dirty when I was cynical. I even started looking for other jobs, but in the falling economy, there was nothing. I was ready to become a mailman.

> Roxy And it's not even really client oriented to me all the time or cost effective or anything like that. So if they need to fill a slot with a client to have a session even if you aren't the best person to see them or even if the client shouldn't be in therapy for another hour or whatever, they're going to schedule you for that. So, my calendar is just chock full of clients and so basically became a thing where I was going to go into work the day that I had signed up, do the work, do the best that I could, but if I had nothing left to give, "Ok, I'm a warm body now."

Other participants experienced feelings of isolation associated with burnout.

> Elizabeth [Isolation] is all I've ever known.

Roxy Those kinds of things, like I didn't know the industry and I was left completely on my own to find a job or where to go from here after I graduated. I was just drifting and . . .

Andrew It's easy for us to you know isolate out there and so I certainly felt isolated in my you know my struggles . . .

In addition to being associated with *emotional responses,* burnout was connected or concurrent with *corporeal responses* such as participants' descriptions of being "wiped out," "tapped out," or "drained."

Andrew Yeah I was kind of wiped out. I felt, you mentioned several things physical and emotional whatever. Probably a good handful of those and it's embarrassing to say and of course I had, this probably gets into some of the other question as far as what to do and all because it brings up in terms of ethical issues

(You mean like impairment)

Yeah and impairment's a strong term, but

(it is)

I know there were times when I was half falling asleep sitting with a patient and of course that's bad. At the same time, shoot, I can't sleep much 'cause here's my schedule, so my sleep is here. I'm waking up early to take patients and blah, blah, blah. That sort of stuff catches up. It's really easy to get into that cycle of just going and going and going.

Jane I think at different levels. I remember there was another time when I had a baby that was a severely handicapped baby and it was being tube fed and the baby was Hispanic and the mother couldn't deal with the death. We were in the ER for hours. We couldn't get her to give the baby up so the . . . I remember emotionally just doing that for, I mean, you can do a lot in short periods of time, but when it goes on for hours, you are just . . . your own ability to have that kind of compassion is tapped out.

John explained a feeling of being physically and emotionally drained associated with both burnout and the quality of his clinical *client/therapist relationships.*

> John — What I've found is that you don't really know, that's the dread of walking into the schedule for the day, you don't really know whether someone's issues are going to be . . . if you'll feel in the end like you contributed or someone's just going to have this trauma that they're dealing with right now or a couple where someone's been hurt so badly the pain is right there and you're going to be with them in the pain. And that's our job. That's what we do, but there's a part of me that just goes, "It's my job. It's what I do." You can be there with them, but you've got to just suck it up and go to work. It might happen today, so there's a little bit of bracing yourself. There is a little bit of a feeling . . . "I've had my fill, and I'm compassion fatigued and I can keep doing it, but where's it going to come from?"

Client/Therapist relationship—a property of professional effects. In the context of the data, the effects of encountering the dissonance and distress of compassion fatigue were experienced within the *client/therapist relationship,* a property closely related to the property of *burnout* and the property of *beliefs about the profession.* Participants had varying beliefs about their abilities or about the mental health profession. In the case of their client/therapist relationships, the dimensions of participants' experience included being either *over-invested* or *under-engaged* with clients or with client outcomes. These dimensions were modulated, in part, by the dimensions of participants' *beliefs about the profession. Beliefs about the profession* were influential depending upon the dimensional range of those beliefs ranging from *idealistic* to *cynical.* Furthermore, the effects within the *client/therapist relationship* were also affected by the dimensions of *burnout* which participants experienced.

John, whose data described a high disruption of burnout, experienced both dimensions of *the client/therapist relationship*. On the one hand, because of *prolonged exposure to client suffering and pain,* John ruminated about his clients. On the other hand, he reported becoming disengaged:

John What I tend to do is stew about it. "Ruminate" and maybe it's that vulnerability to obsessing, I know if that's helpful, I don't think it is, just things tend to churn.

John Well, one thought that came to mind –I love the thought that I spiritually commit to bear others' burdens, mourn with those who mourn, and comfort those who stand in need of comfort. To me, our profession sort of guarantees that we have lots of opportunities to do that. And so the chance to really be let into what other people are going through. . .I have been surprised over the years how little of the process of therapy is some skill set where I am able to have someone heal. It's more that they spill their guts and I sit there with them in the midst of the emotion and empathize and validate. Afterwards, they say—"Wow, I've never opened up that much before." So that's such a unique process to people. And so that process was a lot harder when I was in that state of compassion fatigue or in that mode, because it just felt like—"Really am I going to expose myself to that?" There was a part of me that would kick in, and I just felt like a witness who just has to stand and witness these horrors that happen to people and feel their pain with them. But I was not happy about having to do that job again.

Mary also reported ruminating over her clients' problems

Mary When I also noticed it, as well was that is those issues would, even though I tried hard not to think about them, and compartmentalize them as their problem and would still find myself sometimes reflecting to it.

Attaching to the client and to client outcomes was an effect which A.J. had to process following an escalation in her distress which led to a turning point. She moved from being "quite" attached to becoming much attached to other clients subsequent to this turning point.

A.J. Um, so whenever he would fuss, I would go over and just pat him on top of the head and start singing little goofy songs, I'm not a good singer, but he liked my voice, which I appreciated. Few people do . . . so. So, you know, I developed quite a little attachment with him. The other thing about a burn unit is the patients are there for a very long time, sometime years while they are recovering. So we had little ____ for at least 6 months, you know, so this is my daily ritual . . . As soon as I would get there, I would go over to his crib and say hi to him and see how he's

> doing. Um, there was just some kind of little attachment there and I was looking, it was exciting to see him getting stronger and better. I was looking forward to the day where maybe we could pick him up and hold him . . . I hadn't had this experience of getting attached to a patient. It really, getting some kind of relationship with him, and then to have him suddenly pass away.

Jennifer experienced an over-engagement within the client/therapist relationship in the following way:

> Jennifer Almost like I'm getting sucked into their vortex of their confusion in their own life.

Her data coincides with a round one response in which she discussed her feelings about herself in relationship to client outcomes:

> Jennifer So I think my expectation was, and kind of a personal goal was I wanted to be a very effective therapist and I wanted that to always be. To know that everyone I worked with would be better for the experience. And I think most of the time I think they're at least better. It might not be where I would like to see them be.

Investiture in client outcomes caused an *emotional response* in Jane. Her data implies the connection between the *client/therapist relationship* and the category of *BECOMING INTENTIONAL* through stepping back

> Jane It helped me to finally straighten it out in my mind because, as a therapist, you know, you've had this experience, you sometimes feel like you're working 10 times harder than they are . . . And it kind of makes you angry, so if you can, again, step back and recognize there is something wrong when you're working harder than they are, that it's their experience and if they don't want to move forward, it's not your fault . . . It's not your problem. You're just there for them and you'll help them when they're ready, but it has to be them.

Similarly, Jennifer's data points to a connection between feelings about the *client/therapist relationship* and attenuating those effects through *BECOMING INTENTIONAL.*

A.J. cited the potential risks of being over-invested in client outcomes. Her data, as she speaks of a colleague, points to the dissonance which can occur which escalates to a crisis. Additionally, her description chronicles the connection between *emotional responses, client/therapist relationship* outcomes, and *quality of social relationships*—clarifying another example in which the first two categories of the structure are connected.

> A.J. Ultimately, that is the worst outcome that can happen, but their colleagues identified it and say that they had lost their sense of humor, that they started isolating themselves and they usually could point to usually a series of bad outcomes or sometimes one particular case. It doesn't seem to have a rhyme or reason what exactly it is. It's just situations. One ____ in particular who worked on ____, young, darling, she had had three bad outcomes all child abuse cases, just terrible situations and they died, all of them died like in a one month period of time and while yes there were other things going on in her life, she had recently separated and was going through a divorce, she had some financial problems, other things, everybody who knew her said that was what put her over the edge.

Countertransference—A property of professional effects. While some participants experienced issues related to the *client/therapist relationship,* other participants cited experiencing *countertransference* as part of their distress. *Countertransference* was operationalized in former appendices. The third round analysis indicates that, particularly *countertransference* associated with trauma or extremity of personal suffering is an effects of the dissonance associated with compassion fatigue. Connecting the dimensions of *countertransference* to other properties and categories was also a part of the round three analyses.

In this context, the dimensions of *countertransference* are *high disruption* and *low disruption.* As clarified in the explication of the first category of *EXPERIENCING*

INTERNAL DISSONANCE, the property of *countertransference* is influenced by and connected to the properties of *exposure to suffering and pain* and *the quality of social relationships,* both past and present. Indeed, Roxy, who was triggered as she worked with couples, even as she was facing a separation and divorce, believes that her compassion fatigue came from experiencing countertransference.

> Roxy So that was, I think constantly weighing on the mind and then when I had clients coming in that were dealing with similar problems or things that triggered those kinds of, "Oh yeah, I'm dealing with this too what am I going to do with that? This is what the client is doing with that, why isn't my husband doing the same thing?" Or you know, "That is how she's dealing with it, how's that different than me?" Or, "Should I be doing it more this way?" Or things like that . . . So, like, clients coming in might trigger me kind of going down this thought process of my own problems and it was hard, and I mean I feel like I did a pretty good job, but it was hard to set that aside and stay focused.

> Roxy So I would say my compassion fatigue did come from counter transference.

Roxy's data also demonstrates the connection between the property of *countertransference* and the properties of *emotional responses* and *corporeal responses.* Additionally, her data manifests the connection between experiencing *countertransference* and experiencing a lack of *professional support,* a dimension of one of the properties of the next category, *BECOMING INTENTIONAL.*

> Roxy Another component of fatigue that I mentioned a minute ago is being in session and noticing lots of client things triggering my stuff. Having to, it felt like at least twice as hard every session to make sure that stuff was set aside and I was staying engaged. Because normally talking to a client, I feel like I can be pretty present with their stuff and focused on them. So to have to fight that off and work twice as hard every session to stay engaged and stay present with what they're doing was exhausting. Not having support outside of work really contributed to the fatigue. I noticed myself getting headaches; not feeling rested and always feeling tired.

In their first and second round interviews Jennifer and Elizabeth likewise discussed the connection between the *quality of [their] social relationships* and their experience with *countertransference*:

> Jennifer — Oh, I would get too whipped up internally and so angry . . . Yes, whipped up! And I would get so angry and frustrated and I call it, she pushed my mommy buttons . . . That's my own relationship with my mother had a lot of frustrating things. So, when, I use that when it gets too turned up.
>
> Jennifer — Most of the time I feel effective. That I do have empathic gifts and talents for this and I feel like I have good skills, so when I do feel like I'm flawed and I can't really help this person, it's sometimes countertransference or feeling like they're wanting me to fix their stuff and not putting forth their own effort, so I'm feeling like helpless that I can't impact their situation.
>
> Elizabeth — Yeah, 'cause when I was here being completely alone, my abandonment started to flood me more than anything. Fear of being alone and then I did more marital therapy here than I've done anywhere which was awful . . . Yes, I had moments of that for sure; moments of countertransference. People would come in and they would complain about stuff and I was like, please. You don't know what pain is. I had moments to myself where I'd be "Like you're going to divorce your husband over that?" . . . That made me angry that they would want to give up on their husband who they were committed to spiritually, you know, and at the level of what I was trying to commit to and put into my own marriage. I know there's a time and place possibly to let go, but when they can't put that kind of effort, I definitely would find myself gritting my teeth and saying, "Hold back _____, 'cause you're about to blow on this person." I would instead make myself ask them more questions, so they could hear themselves. Boy was I flooded.

Approximately half of the participants reported moderate to *high disruption* over experiencing *countertransference.* The other half implied *low disruption* by implication or because of not mentioning it as part of their encounter with compassion fatigue. Those participants who experienced a dimension of *countertransference* as well as *burnout*, or issues within the *client/therapist relationship* all reportedly recognized the need to

BECOME INTENTIONAL about attenuating their disturbance, dissonance, and distress associated with *RECOGNIZING AND EXPERIENCING THE EFFECTS* of compassion fatigue.

Becoming Intentional

The data from participant interviews ubiquitously validated *BECOMING INTENTIONAL* as the central category of the theoretical structure relative to participants' experience. This central category, including its subcategories of *Transforming Perceptions, Developing Support,* and *Making Professional Changes,* is the pivotal category on which the process of encountering and navigating through compassion fatigue hinges. Indeed, *BECOMING INTENTIONAL* is the thematic fulcrum which transformed participants from *EXPERIENCING INTERNAL DISSONANCE* and *RECOGNIZING AND PROCESSING THE EFFECTS* of that dissonance to taking a course of action. That purposefulness, the source of participants' intentionality, constituted a seedbed for developing resilience and healthy compassion as participants practiced *CREATING ONGOING CHANGES TO THE EXISTING FRAMEWORK*. All categories, with their attendant subcategories, properties, and dimensions may be connected, in some manner, to this central category.

Connecting the properties in the subcategory of transforming perceptions

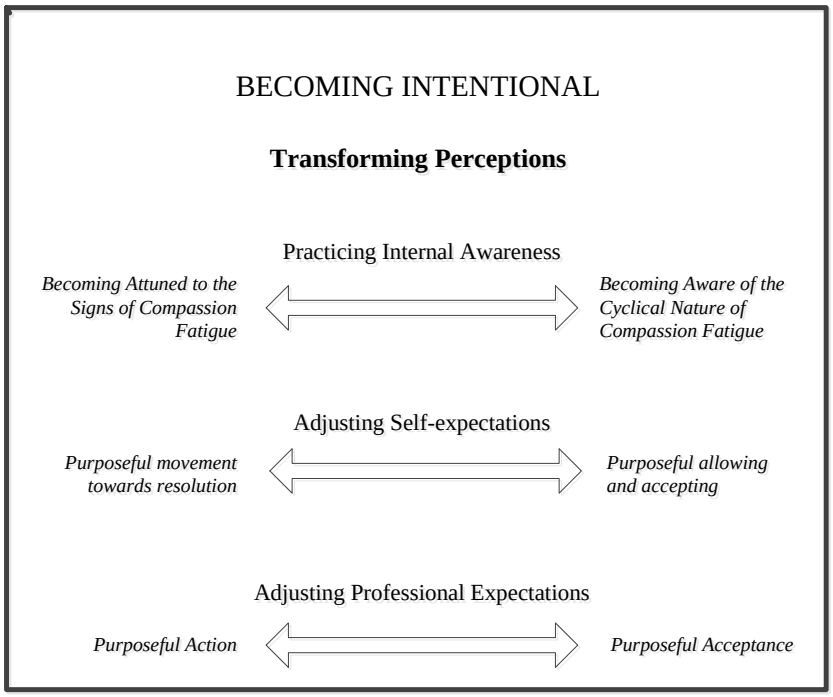
As participants' dissonance escalated to a point where they recognized and processed the effects of that dissonance, they also came to a turning point in which they began to examine their responses to the effects. Each participant, in both similar and unique ways, became more perceptually attuned, over time, to the signs and nature of compassion fatigue. Furthermore, they began to make perceptual adjustments, both

personally and professionally, as a result of that increased attunement. Making those perceptual changes was part of the process of *BECOMING INTENTIONAL*.

The most significant and overarching perceptual change which participants made, occurred in the process itself of *BECOMING INTENTIONAL.* For many participants, they had experienced the perception of a lack of control over what they were experiencing. All participants, once they gained an inner attunement regarding compassion fatigue, changed their perceptions. In this regard, becoming attuned connects directly back to the category of *RECOGNIZING AND PROCESSING THE EFFECTS.* Participants grew in awareness of those effects over time. This awareness may be viewed from the perspective of inoculation against compassion fatigue. The more participants became aware of and processed the effects, the greater was their potential to develop resilience. A parallel example would be the introduction of pathogens into the body. The first time this occurs, the individual may become very ill. Then the body builds up antibodies so that the next time the pathogen is introduced, the body senses it and becomes resilient against it.

Attendant to becoming attuned to the nature and signs of compassion fatigue, participants were able to transform their perceptions as they specifically adjusted perceptions about the self and the profession. During the round one and two data analyses, these perceptual changes were reflected in one category. An analysis of the round three data clarified the need to separate perceptual adjustments into the two categories of *self* and *professio*n. In addition to crystallizing the conceptualization regarding participants' perceptual adjustments, separating these two properties more fully connected them back to the modulation of *beliefs about the self and beliefs about the*

profession, properties within the first category in the structure. Hence, these perceptual adjustments connect directly back to the initial category of *EXPERIENCING INTERNAL DISSONANCE IN THE EXISTING FRAMEWORK* and the subcategory of *Internal Context*. This dissonance, experienced in the *Internal Context*, resonated within the dichotomous beliefs participants held about themselves or the profession. These beliefs or perceptions had been the seedbed of the original distress. Adjusting perceptions about those beliefs was a large part of the perceptual transformation which aided participants in navigating through compassion fatigue.



Appendix G, Figure 5, Properties and Dimensions of the Subcategory of Transforming Perceptions
(Category: Becoming Intentional)

Practicing internal awareness—A property of the subcategory of transforming perceptions. As participants increased in their practice of internal awareness, they became more intentional about maintaining an internal locus of control.

The dimensions of *practicing internal awareness* are *becoming attuned to the signs of compassion fatigue* and *becoming attuned to the cyclical nature of compassion fatigue.* Internal awareness, for participants, constituted a self-monitoring which not only connects with processing the *internal* and *Professional Effects,* but also with *CREATING ONGOING CHANGES IN THE EXISTING FRAMEWORK.*

In the round two interviews, all participants discussed the cyclical nature of compassion fatigue. One participant, A.J. reported that her compassion fatigue, at the beginning of her career, had been so severe that she had only slightly dipped into it subsequently.

> A.J. I think I had a severe enough case that I would say it's more dipping a little bit into it. I realized that keeping that level of awareness is key. And so you have to kind of be aware when things are starting to go that direction and do something about it and probably the blessing for me is that I had such a severe case early on in my career and had to deal with things that many therapists don't have to deal with. You know it was kind of a glaring red light flashing red light going, "Stop, stop, this won't work. So luckily I've kept that level of awareness and when it's started to go that way I've been able to step back and say, "Wait a minute, I'm feeling like I need to get some balance in my life here."

In addition to becoming attuned, her data speaks to maintaining attunement—part of the process of becoming resilient within the category of *CREATING ONGOING CHANGES.*

Similarly, Roxy, who has been in the mental health field the shortest amount of time of all participants, feels that as a result of her experience, she will be more attuned to the signs and potential cycling of compassion fatigue.

> Roxy I don't think that I've gone back to a place where I'm feeling that again yet. Part of that might be that I haven't been in practice for forever. So, I wouldn't say that I've had a recurrence of it, but I

> wouldn't rule that out. I can see that being something that would come up again.

The other participants were much more specific and definitive about the cyclical nature of their experience. Elizabeth and Jane attributed the cyclical nature of experiencing compassion fatigue as concurrent with the cyclical nature of their life experiences.

> Elizabeth I think it has been cyclical only because of the many different physical events that I have been through. Then helping my husband through some of his physical and emotional conditions and then having children with health conditions, just those alone in our immediate family have made it hard just because of all the healing that has to occur on a personal level or reaching out to your family. So definitely over the past . . . pretty much the whole time. I would say, even recovering from my pregnancies, which was right after I graduated, I think there have been many challenges. Some are harder than other though. Some weren't as intense. The work always provided more relief for me than anything, but the physical pain and going to work and trying to concentrate and things like that, I know affected me. I just couldn't be all there. So went in and out, I would say, for sure.

Elizabeth's narrative implies a connection between the cyclical nature of the experience and exposure to suffering and pain.

> Jane I think with any new position that I took or clients and things like that, sometimes you can get in over your head rather quickly and I think we talked about this. Sometimes you don't recognize until you're in the middle of something what you really have in front of you. So it's one of those things where with the cycling for me it's been usually there with each new position or situation. And usually once you've got that kind of figured out and down and it's not a problem anymore, then it's time for a new position or a new degree.
>
> Yeah, I think what you do is build strength. Each time you go through something really hard, it makes you stronger and it's time to take another step forward and unfortunately some people completely give up.

The above data from Jane highlights the connection between *practicing internal examination* and developing *resilience,* a dimension within one of the properties of the subcategory of *Internal Context* within the category of *CREATING ONGOING CHANGES TO THE EXISTING.*

Andrew and Mary also affirmed the cyclical nature of their particular experience with the effects of compassion fatigue.

> Andrew Yeah, I certainly agree that it's not just a straight thing, kind of up and down . . . I think in the focusing on the past few years before I moved, I think, there was probably a lot of up and down as the regression line was going down, it was up and down and up and down on a downward slope. I don't know that I was ever walking around depressed or anything like that. Not that kind of place, but there were certainly times when I would wake up in the morning, argh, heavy sigh, push through, let's go. Other times it was fine, I was content and get up and go.

His comments also imply his greater attunement to his internal terrain and ecology.

Mary, who affirmed "absolutely" that she had cycled in and out of, attributes that cycling to her innate sensitivity and extra compassion.

> Mary I was basically very compassionate for my clients and it was interesting I would get a wave of different people like those who had been sexually molested, or things like that that went through and it seemed like it would be heart wrenching to hear that. It wasn't something I had experienced, I would feel like I would like to see more marriage counseling now to get away from that because it was a burnout with that. I would do marriage counseling. I actually enjoyed marriage counseling because I felt like I was a better therapist because of the triad and I would try to keep myself out of the dyad and I wouldn't own their feeling as much. So I was trying to lean more toward marriage counseling. Then I also cycled through and did adoptions. Now adoptions, I had, you know, I finally went through a period of burnout with that because there was a couple of failed adoptions. Well I'm an adoptive mother. I've adopted a child. Obviously, I have personal issues with it.

Mary's data connects *practicing internal awareness* with the properties of *beliefs about the self, countertransference,* and *burnout,* three concepts within the first two categories of the theoretical structure.

Phil has experienced the cycling of compassion fatigue. His narrative connects this concept back to *beliefs about the self* and correspondingly to the perceptual adjustments he made in order to reconcile those beliefs. In other words, for Phil one of the signs of compassion fatigue, to which he became more attuned, was when he felt the pull and distress of the dichotomous *beliefs about the self.*

> Phil There would be times when I felt like I was doing a pretty good job and I was competent, then I would dip into it where I wasn't feeling competent and then I would dip back out. It definitely, not only was a cycle, but it was spiraling downward.

An analysis of the data from both John and Jennifer shows a direct link between *becoming attuned to the signs of compassion fatigue* and *become attuned to the cyclical nature of compassion fatigue.*

> John Yes. And I think it will still come and go and even there are times when I feel that lift of spirit and energy, but I will say like I had a couple—one of the things that I really hate is when I have a couple fight in my office. I had one do that yesterday and I really just didn't feel that deflated by it like I was when I was in the midst of that compassion fatigue. It's just like sometimes they do that and I honestly looked at how I can learn from it and try, but it wasn't questioning myself, like, "Why do I keep getting back into these situations, or why do even do this?" I definitely didn't feel the same sense of deflation that I had when I was experiencing the worst of the compassion fatigue. But yeah, I definitely feel like there will be and are days that I'll be exhausted and I'll crash and need a break. And again, that's the thing about the compassion fatigue, when you finally recognize it that it's a distinct situation and you're in a different place, it can really lull you into not recognizing it because our work is so emotionally engaging and potentially draining anyway that I might have said in the past, "Well, this is just life as usual." And then suddenly realizing,

> "Wait—this is not life as usual. I usually pop out of this better and I'm not." But, I do feel that the cycle of it rings very true to me.

> Jennifer I'll feel pretty good and work and work and work and it's like PHEW. And I need to do something to energize myself. I think I said I also started to get cranial-sacral massages every month to kind of . . . that is so energizing for me. For me it is cyclical and I've learned that I need to do a maintenance. And when I do that, I don't cycle as much. Or I don't get so much compassion fatigue when I take little breaks to take care of myself in between.

The above data from Jennifer and John point the relationship between attunement and a processing of the effects themselves—the second category in the structure. The following data from Jennifer, taken from both the round one and round three interviews emphasizes the connection between *becoming attuned to the signs of compassion fatigue* and *become attuned to the cyclical nature of compassion fatigue.*

> Jennifer 'Cause I'm more distracted, I'm not as invested in what's going on. I'm just kind of thinking, "My time's almost done." I'm just getting through the day rather than "Let me hear exactly what is going on?" And "Here's some ideas." And, "How can we process through this?" So I'm just not as engaged.

> Jennifer You know, how do you help it heal, there was some of that but I think not as much as, you know, so I went in kind of feeling inadequate that I didn't have enough intervention skill and as I got into it more I would feel that compassion fatigue but I think I knew what was happening.

Adjusting perceptions about the self—a property of transforming perceptions. For the participants, the foundation of encountering compassion fatigue began with an internal dissonance partly attributable to a dialectic within participants' *beliefs about the self.* These beliefs were modulated and affected by external triggers which produced an escalation of the dissonance and distress. The resulting escalation led participants to a turning point where they began to recognize and process the effects. As participants adjusted their perceptions of the self, some reconciled, or were

in the ongoing process of resolving, the former dichotomous beliefs about the self. This reconciliation or resolution was achieved through perceptual adjustments reflected in the two dimensions of this property, *purposeful movement towards resolution* and *reconciliation through purposeful allowing and accepting.* These two dimensions were not clearly defined until the third round interviews. The difference between the two dimensions is a more subtle and complex dialectic than is the case with the dimensions of other properties. The first dimension is more active and ongoing, while the other reflects a finality of acceptance and allowing. Both dimensions reveal the unique internal processes of the individual participants.

In many cases, participants' experiences reflect both sides of the dimensionality of this property. A.J.'s data reflects that multi-dimensionality of perceptual changes. Her data also indicates a connection between perceptual adjustments and *practicing internal awareness.* Moreover, citing the passage of time is an indication of her movement towards becoming *self-supportive,* a concept categorized in the subcategory of *Developing Support*.

A.J. Because it wasn't, it wasn't just, I think there were situations where I felt, "Oh wait a minute I'm not tuning in to where they are at and what they're going through." In a way there's kind of a selfishness that you get into when you're thinking of, ah, "Poor me, ah, in a way when you're overwhelmed with compassion fatigue." And so I would say, you know, it's a just having kind of an awareness of that, is part of it but then I think it's part of the healing process to that you don't really fully get over that until things overall start getting better with your compassion fatigue.

A.J. Yeah, because I had some like, let me give you an example because it's a little bit clearer. Um, one of my son' teachers. . . I was, you know, getting kind of frustrated with her that she wasn't putting a little more into her job, even though she was nine months pregnant and I thought, "Why doesn't she just go off and let the substitute come in if she's having troubles staying awake during

> class or whatever," you know. I was just really kind of harsh and critical and my family looks at me like, "That isn't you, you're empathic and you're sounding kind of mean." And even my son said, "Mom, that's mean. She is doing the best she can." So I, I remembered just kind of backing up and going, "Oh, okay that is, you know, it's kind of like I'm in a bad mood, I need to, a, you know, rethink my position on that." But then with some distance when I looked back at overall at how I was doing, I saw numerous examples of where I was a short in my patience, um, not as empathic of others, feeling so overwhelmed with my own grief and pain, you know, fatigue that I was going through the symptoms, I was going through that it made it hard for me to see what other people were going through. And so it, it was kind of a both I made some internal adjustments as I would get feedback from others going, "What, what is wrong with you?" But then over time as I became more aware I made that adjustment as well.

The following description from A.J. also illustrates the connection between *transforming perceptions* and *CREATING ONGOING CHANGES* through *changing cognitions.*

> A.J. Um, you know, it's a bit like having PMS. Um, or PMDD as they call it now. Um, you know, when you're in a terrible place and you know that it's a limited to time and that perhaps your perceptions are more pessimistic then they'll be in a day or two. I kind of learned I had, I suffered from pretty severe, um, a, you know dysphoria, all right and just for a day or two, but man it would hit me pretty hard and I had to learn that this, don't take this too seriously. It might feel different tomorrow. So in a way it's like that but if I got kind of a feeling of overwhelming at work I would take a step back and go, you know, I just need some balance, I need, it's not , this is not how life really is. I'm seeing one angle and one aspect of it and I need to get a more balanced perspective.

Similarly, Jane adjusted her perceptions through allowing herself to move to a place of *personal non-judgment* and by *positioning herself in a larger context,* both dimensions within properties of *CREATING ONGOING CHANGES.*

> Jane Um, well I think for me I've learned that I think in some ways in life we think we have to fight battles, we think we have to always struggle and as I'm getting older I'm realizing that much of the struggle is internal for me and that anything external is what I

> allow it to be and so allowing myself to just feel joy and not judge and just stay completely, I think I'm learning that what I said here just a few minutes ago that can regard another person's ability to figure things out for themselves and that it's going to be okay. That to me is the opposite of compassion fatigue because what you're doing is being positive and allowing yourself to have faith that they will grow and that I will grow just as we're supposed to be.

Jane's data, as well as the data below from Andrew, points to *BECOMING INTENTIONAL* or taking action through acceptance. This movement allowed Andrew to continue to create changes associated with *self-support* and *practicing positive cognitions.*

> Andrew I think I mentioned in one of our talks that, the past few years that I've, I'm kind of learning, focusing, trying to practice acceptance and commitment therapy a type of cognitive behavioral therapy. That has a lot to do with that kind of, you know letting go, accepting, you know kind of stuff from an active not passive sort of letting go. And I think I, you know I've tried to use, you know those sort of ideas and techniques myself as far as just kind of being present with the client, really trying to focus on, you know whatever is going on with that and with myself and just being aware of those things. Kind of that to greet the clients in that way and then again to decrease internal pressure to you know go, go, go, go, go a just kind of allowed me a to feel a little more refreshed.

When queried about whether he thought purposeful acceptance was intentional, Andrew responded in the affirmative.

> Andrew Definitely. That take on it certainly is an eastern, it is specifically eastern in those ways. The whole mindfulness part of it and everything,

Additionally, when asked to specify how letting go and accepting had been intentional, he followed with a thoughtful response.

> Andrew The answer is in the question. It's letting go, it's saying hey you know I need to kind of stop and you know sit with this because it's the struggle that makes it bad and the struggle in the internal sense I guess and the pressure and struggling with the pressure, I have to

> do it but now, then just all that angst that I've been experiencing before, you know when we wrestle with that stuff that's, that's what leads to whatever stress or suffering or whatever you want to call it . . . And so the letting go part does that. You're accepting okay this is, this is how it is. Some of this of course I can control some of it I can't but kind of letting go of the struggle itself is very much an intentional thing. It's not a passive "I'm getting beaten up and there's nothing I can do about it" but more of an act of you know I am going to you know let go and see what happens and accept where I am and see what we can do.

On the other side of the dimension, Phil took purposeful perceptual action to reconcile his sense of feeling dissonant and "divided," feelings reflected in the first category of the structure.

> Phil The best way I can describe that is I realize that I had a choice. I had a choice to continue being unhappy and living in that fashion and doing everything to support that way of living or I can do the opposite. That's basically what it came down to is choices and I know that sounds like one choice but it was many, many small choices and still continues to be many small choices. And so was that the change in reality for me, looking at things from a different perspective, that I had a choice and I could choose differently.

John and A.J. changed their perceptions by accepting their own extra-sensitive natures.

> John So, if I could have found a way to before not to empathize I would have gladly done that. I couldn't quite find a way to just go through the motions with this type of work. Yeah, and I would say that, and part of that is from a practical stand point, I don't have any of those very mechanical concrete skills that, the kinds of things that might be easier for me. I mean all I've got is that, that sellable commodity of empathy and, so I better stick with it. But, it seems like quality of life wise it seems like the other options aren't that attractive really when it comes right down to it.

> A.J. I became very resolved with it. That's because I'm a real empathic, sensitive person, I'm going to be more high risk for it. I feel fine about that.

Jane similarly accepted that her extra-sensitivity was "a double-edged sword" that she was willing to deal with in order to have the use the gifts she felt she had to assist her clients

Adjusting perceptions about the profession—a property of transforming perceptions. *Adjusting perceptions about the profession* was an integral part of participants' experience of *transforming perceptions.* The dimensions of this adjustment are *purposeful action* and *purposeful acceptance.* The data from Elizabeth is an example of the connection between adjusting perceptions regarding the personal self, the professional self, and the profession in general. By adjusting her perceptions regarding her professional self, she also had a perceptual adjustment regarding her overall perception of self. These perceptual adjustments were related to her practice of *ongoing processing of emotions, Developing Support,* and *creating positive cognitions.*

Elizabeth	Oh yeah I was just a, but I kept saying you know, "You don't have it near as bad as what she does." And then I kind of slapped myself and was like, "You know better than that. Separate yourself, you know you can't compare in order for you to get well you have to push through it and don't deny it, don't put it back in the corner somewhere because it's going to come back out and bite you in the butt. Just admit where it's hurting you and do what you're supposed to do and quit acting all cocky or whatever and confident."
Elizabeth	You know you got to, because that's how I teach my clients, I was like you have to, "Don't lie because you will pay." And I still feel my body pays in certain ways because my body handles anxiety in its own fun little way like everybody else, but I can definitely tell as I've talked about it and got it out and I've felt a lot better.
Elizabeth	Let's see… well I think, definitely, getting my perception corrected and being able to be honest about it. As we can, I think we can all develop our own perception of what compassion fatigue is and it can almost sound shameful and I don't, I know that it's normal but I like that I've had a chance to talk to a professional that this is normal, it's okay. It's a part of life and we shouldn't

> feel any shame from it and it's helped me to move more. I definitely think I was more private about it. I still reached out to a few people but not as many, only because of the reactions that I've gotten from other professionals throughout the years. I don't always feel safe, but it's helped me now to say, "You know what I don't care what you think, you can act that way all you want but this is how I feel and there's nothing wrong with me admitting to these things and taking the steps necessary to keep myself strong or take a break when I need to take a break."

While Elizabeth's narrative demonstrates a connection between adjusting perceptions and reaching out to *develop support,* her perceptual adjustment also included moving from feeling a sense of shame about what she was experiencing to normalizing the need for support.

> Elizabeth I think that I overthink everything. I've definitely reached out to other people because I always feel in that connectedness is what keeps us together even if we don't say anything and that's pretty much what I did that whole day was just didn't say much of anything, just hold their hand and stay by their side, got them food, things like that and then other therapists and I, we prayed together. We just got by each other, checked in with each other and then I did the same thing at work and then when I came home I definitely download to my husband because I feel safe and then I do some guided imagery.

> Elizabeth And I already knew the lady, the gal that I worked with was going to have a reaction to that. Usually she does but this time she didn't and I'm glad that I didn't let my fear get in the way, worried about what she would say or saying, or putting someone else out if I needed a break. I'm grateful that I've gotten the confidence to just admit there is nothing shameful about this—compassion fatigue.

Elizabeth's narrative also connects *transforming perceptions* with the property of *ongoing processing of emotions*—a property in the category of *CREATING ONGOING CHANGES.*

> Elizabeth I think being able to talk about it as openly with this particular research study or whatever it is you're doing here, I've never been able to really be as open about it. I mean it wasn't discussed at school very often, if it was it was more like just go get help and but

> again it wasn't even talked about like it was a normal thing. And that's again once again just sort of made me feel like ooh that's pretty shameful, just like with any job, any job I mean I worked in the corporate world for years around New Yorkers and stuff and then through that you don't show weakness, you know being an athlete all those years, you don't show weakness. In this field you definitely have to balance out or you're in trouble or you're going to hurt somebody.

Phil also had to learn to trust other professionals again. After he had experienced the toxicity of a cynical supervisor, he had to adjust his professional perceptions by taking action towards the re-development of trust.

> Phil Let me think. What I had to do was start exercising trust again in other people, because that's what had been ultimately kind of shot. And I had to start exercising again almost like a weak muscle. And so I had to start practicing it again, I couldn't just think about it, I had to do it. . . It's the whole idea of learning the opposites of things. I learned what it felt like to be, you know to not have any compassion towards individuals, to become cynical and what that did has actually taught me exactly how I did not want to be. And so I had to begin practicing how I wanted to be even though everything in me said, "No, I can't trust people." And then, but I fought through it definitely it took some restructuring when it comes to my belief systems and my perceptions of reality.

Andrew described his perceptual adjustment regarding the profession in the following excerpt of data:

> Andrew I have to say I keep hitting a word I used earlier, it's kind of lighter. Floating down the stream sort of a thing, instead of fighting upstream . . . And just a, whatever stick or leaf something. You know floating down the stream and it's okay. It's an enjoyable ride and sometimes there are bumps and rapids you get stuck along the edge and you keep kind of going. It's not tiring because you're floating not fighting or paddling or something, just going with it a little bit.

Responses from Roxy and Jane connect perceptual adjustments regarding the profession with the subcategory of *Making Professional Changes*, also an essential component of the category of *BECOMING INTENTIONAL.* Their data also connotes the *purposeful action* dimension of this property.

Roxy Um, I think that description of it being drained is a good one. I just had to get into place where I could follow my instincts, which was, I need to take care of myself, I need to have, you know, the opportunities to have something more to give somebody. So, I had to do what I did as far as finding other jobs and working less apart and just having more of a self, more of a life again and that there was more in that reservoir I guess.

Jane You become . . . the thing you have to realize is there's physically things that are happening as well when this happens, so you consider yourself shutting down. . . I get tired, I get irritable, um, I find that my normal reaction to the situation changes and you know that it's not normal, that I'm not responding. The way I'm responding is not a normal response to what's going on. So that's when I know I need to step back and, and ah remove myself from the situation.

Alternatively, John's data, while connected to the properties of *spiritual support* and *creating meaning,* reflects the *purposeful acceptance* dimensionality of *adjusting perceptions about the profession.*

John God's timing was a big part that enabled me to be at peace with the sense that there hadn't been a second of pain that you've gone through wasted. That it's all sort of built the foundation that I'll have and it will be valuable in a way that we don't usually put a high priority on these kinds of things, were able to do this, you know like I said the sense of being able to hear people what they're going through and empathize in ways that I haven't been able to before. No doubt, there's a silent strength there that will just be there. If I had been able to resolve things on my own then I wouldn't have been able to be stretched in that way and that has really enabled me to accept the painful part of the timing and what it's been like to go through compassion fatigue.

John You couldn't have summarized better what happened to me. Once I perceived it as a growth experience it's like, you know, I would have never put it this way before but it's sort of implicit belief that was going on for me in the midst of it was that, that woman shouldn't have to go through what she's gone through. If it were going right there's something wrong that this isn't working. If it were going right and the way it should be I wouldn't be going through this either. If I had been able to help her more or something's all wrong here, what in the heck is going on? And just saying, "Wow, this really is a stretching and growth experience." It

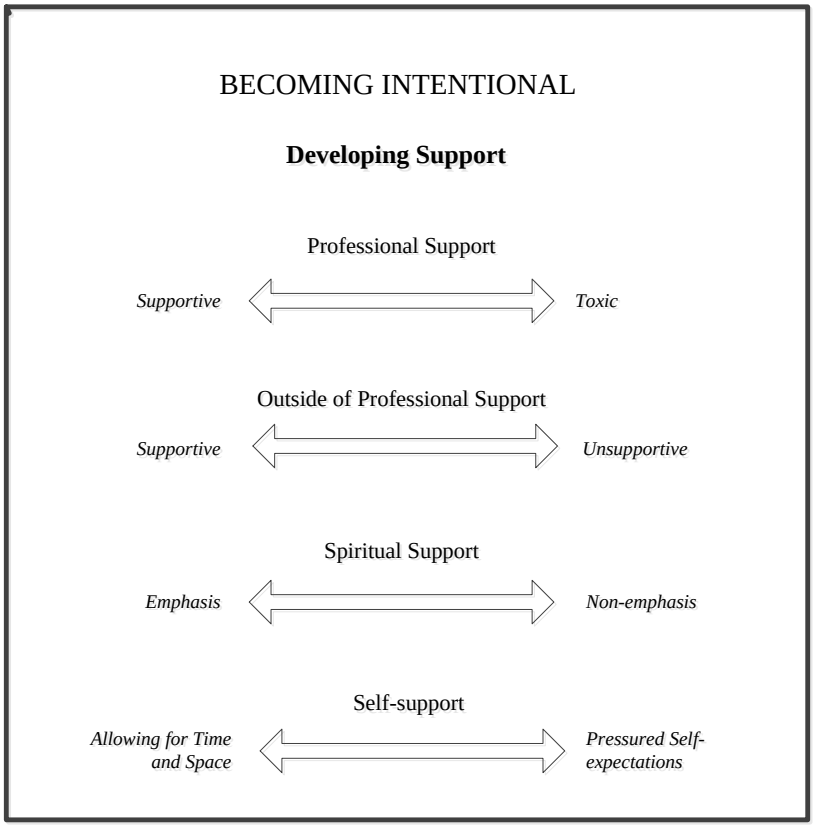
> has this huge value to it and boom it's like it just transformed it. It's in that very way of perceiving it and not that I landed

As participants adjusted their perceptions regarding both the self and the profession, they were able to move to a place of action or acceptance regarding their *beliefs about the self* and *beliefs about the profession*. Moreover, participants were able to facilitate support, eschew toxic support, and seek out positive support. *Developing Support* was an important factor in participants' *BECOMING INTENTIONAL*.

Connecting the Category of Becoming Intentional to the Other Categories Through the Subcategory of Developing Support

The development of support along a number of fronts was a significant part of the process of participants making a turning point in their navigation through compassion fatigue. In general, the dimensions of *Developing Support* illustrate either experiencing supportive networks or a dearth of support. When participants experienced a paucity of support, they had a more difficult time modulating the effects of compassion fatigue. However, all participants found ways to engender support from other areas of their relationships. Additionally, all participants developed greater self-support in the process of navigating through compassion fatigue. As participants developed and received support, those providing support assisted participants in a number of ways. First, they helped normalized the experience of compassion fatigue. Second, they validated the individual participants as participants made a decision to alter their professional context and milieu. Third, they provided a way for participants to process through their emotions and feelings. Fourth, they bolstered participants' morale. And, fifth, they set an example of healthy compassion and resilience. Likewise, as participants became self-supportive.

They gave themselves time and space to heal from compassion fatigue, suspending or lessening their expectations of themselves.



Appendix G, Figure 6. Properties and Dimensions of the Subcategory of Developing Support
(Category: Becoming Intentional)

Professional support—A property of developing support. Following the analysis of the round two interviews, the dimensions of professional support were defined as professional and collegial. During the round three analyses, I re-conceptualized those dimensions to reflect the lack of support as the other dimensionality of this property. This reconceptualization of the property confirms general professional support whether clinical or collegial, with the dimensions of the property being *supportive* and *toxic.* Several of the participants used that word to describe an aspect of professional support.

As an *in vivo* coded word during the analyses, the use of the word denotes even more than a lack of support, but rather support or supervision which was harmful and deleterious in nature within the context of professional relationships and professional support. This important distinction speaks to the necessity of developing adequate and supportive supervisory relationships either as a supervisor or a supervisee.

During the round three interviews, participants provided data which connects this property with other categories and subcategories in the structure. For example, Roxy had experienced toxic support from an supervisor who was neither validating nor understanding of her compassion fatigue symptoms. As previously discussed in the appendices explicating rounds one and two analyses, Mary, Roxy, A.J., Jane, and Phil all experienced a lack of collegial support or toxic support. This lack of support was linked with experiencing greater distress and effects associated with compassion fatigue. In her round three narrative, Roxy discusses this relationship between professional support and an escalation or attenuation of effects.

> Roxy I think that's why, I mean I had my supervisor but there is only so much that he could do. But I think that's why I got to that place of burnout and compassion fatigue in the first place, because I knew what I needed to do, um, because of my personal issues to kind of take a break and come back and take care of myself, but the reason why it got to the point that it got too was because I didn't have that opportunity. I wasn't supported in my needs to take care of myself.

Jane's data excerpt shows a relationship between perceptual adjustments, developing professional support and modulating her neophyte idealism to achieve a greater perceptual maturity regarding her professional roles.

> Jane Well I think I kind of answered that in the last question is that I learned to give up the idealism, I learned to ask for help when I needed it. I learned that it's actually better to admit when I can't do it and it's you know. So I think I've, I've kind of grown up or you

> kind of start to let go of, um, you just, you just let go of the need to see everything for everybody. You know, and I think that's the best way you can describe it is that over time I have learned that, that's not my challenge I don't have to do that and it's okay and really it's actually is a transition to learning about yourself and recognizing it and realizing that honestly what probably drew you to the profession in the first place was the need to be needed and as you go through it and you learn that, you get your needs met [through support] you realize that, that initially that need was for yourself and as you help other people and they help you to learn more about yourself, then you realize that you don't have to be needed in that way, to be whole or to be overworked, that you know, its, you kind of take yourself out of the equation.

Jennifer draws on professional support as a way to create greater *self-support* and *self-care* during her discretionary time. Professional support also assists her in *processing her emotions*. Both *processing emotions* and *creating self-ca*re are properties within the category of *CREATING ONGOING CHANGES*

> Jennifer Well first of all clinical support has been really helpful. I can call colleagues. I have lunch with colleagues once a month where we can kind of discuss the therapeutic issues and the strains on us and some of our most difficult situations. I feel understood, I feel like we can kind of vent it and release it a little bit, some of the stresses of compassion fatigue and also get ideas about ways to help and I find that very healing.

Andrew, whose main support came from his partner and from himself, has over time, developed a relationship of professional support with his colleagues. Prior to that support, he had experienced systemic and self-expectations as part of his *professional environment*. Those expectations had contributed to his original distress. His current supervisors and colleagues had given him the latitude to explore and be creative in his job. This creativity has helped him to maintain an internal locus of control, which shift has in turn has assisted him in continuing to modulate his effects.

> Andrew Yeah, I think so and, and from a lot of what we've talked about I think you, you can see that. You know the time and the

> environment change, job change and all that. You know that's certainly played a role on that. Support, I guess, and its indirect support and I think this is an unfortunate thing that I did and that probably other independent contractor male therapists and private practice you know whatever, it's easy for us to you know isolate out there and so I certainly felt isolated in my you know my struggles and even though I've probably talked to a colleague here and there that was never unfortunately a real strong having to get support from you know the practice owner or another friend of mine who's a therapist or anything like that. I mean my wife's always been supportive of whatever we kind of figure out together. She was definitely supportive of this move and fortunately, phew, I'm relieved that she's really loved it here and my kids are doing great so you know that's been a nice, a good thing for all of us. So there's never really been any real kind of formal support. I say kind of indirect or informal and my current boss right now, I work with _____ so part of it is they don't know what I'm supposed to be doing and it's a new position and so no one really knows what I'm supposed to be doing and so they've you know he's a good boss and that he said, "Hey you know what, go for it. You know figure out whatever you're doing and whatever you want to do and here's things that you know I want you to be doing but you know otherwise you know figure it out." And so I've had that kind of fun, or I consider it fun freedom to you know kind of go and work things out and I'm also involved in a lot of different things and that also keeps it interesting. So even though he doesn't know it of course he's certainly contributed to my doing better in the field.

Elizabeth also discusses the difference between avoiding toxic professional support and drawing on positive professional support.

> Elizabeth Yeah, I definitely stay away from those who, when I ask them how they're doing they just don't even flinch,… "I'm fine, nothing's fazing me at all . . ." These are other therapists and they just don't seem to have a whole lot of feeling about it. What I did as a crisis worker that day and then seeing a couple of clients so he and I had a chance to sort of download and then [another therapist and I] both shared a little bit about our histories and how that is affecting us as therapists and how we have to keep that in check.

> Elizabeth Yeah. I've learned the hard way to put those in place ahead, you know when I need it right away, I have to be very aware with my career, I don't always do it as well on my personal life, but in my career, I'm pretty darn good about making sure that I get the support that I need because I've met lots of wonderful people. I

> don't have a ton that I feel safe with but I have a few and that's enough for me.

Outside support—A Property of the Subcategory of Developing Support. In prior rounds of interviews, the majority of participants cited outside support as significant, and provided thick data to attest to that support in the round one interviews. Mary, Roxy, Jane, Andrew, Phil, Elizabeth and John all described the significance of support, or the ramifications of a lack of support, from partners. Jennifer and Roxy cited the significance from friends. Phil and Mary discussed the role of seeking outside mental health and physical health support.

The dimensions of *outside support* are *supportive* and *unsupportive.* All participants experienced a dimension of *outside support along a continuum.* These dimensions connect this property with the properties of *quality of social relationships* in the category of *EXPERIENCING INTERNAL DISSONANCE* and *creating self-care*, a property of *CREATING ONGOING CHANGES.* All participants cite spending time with individuals outside of the profession who are supportive as one of the ways they have maintained changes and continued to navigate through compassion fatigue. In round three, Mary, Roxy, and A.J. all highlighted connections between *outside support* and other categories in the theoretical structure.

> Mary It was not and I had to see a male therapist here in ____ and he has absolutely helped me to heal through some of that and a, yeah. And so I actually lost trust in some of the counseling arena and I don't know if it was, I really don't know completely what it was, well I do know what it was. My friend sought counseling and her and I kind of backed away from each other like, "Sweetheart let's split our friendship up a bit," And so, but in the end maybe that was healthy. We are still friends, it was maybe we needed that split, you know what I mean, it got, it got to be too enmeshed.

The above data demonstrates the connection between *outside support* and *processing emotions.* Roxy's data is indicative of the connection between *Making Professional Changes* and receiving support.

> Roxy — Okay so, for me I have a very good support system outside of work, and a support system that helps validate that like what was going on there was not okay, and I'd say that the main problem that I had was that, um, I didn't have professional support . . . And so because I had the support outside of work, um, and I had, you know, this knowledge that I just had to do something, I couldn't keep going as I was going, I was able to feel like I could find another job and that I should look and that it was okay for me to continue to pursue, um, you know, a state where I could do self-care and that I found a job where I could do that. So having that professional support at that point in time was huge, and it made all the difference.

Receiving feedback from her husband, whom she identifies as a large part of her outside support network, has assisted A.J. to maintain attunement to the signs of compassion fatigue.

> A.J. — Hum. . .I think I recognized right away, um, that I wasn't being as patient with other people and I, you know, my husband actually kind of has always let me know. The answer is that. He's, my husband and my children are very empathic people and so if I get a little off or a little less than patient, um, yeah they check me, they give me a little reality check.

Spiritual Support—A property of developing support. Some participants drew on spiritual support. The dimensions of spiritual support are *emphasis* and *non-emphasis.* Although spiritual support did not constitute a large part of the data, it seemed significant to separate from other aspects of *Developing Support* because of its connection with the property of *creating meaning,* one dimension of which is *positioning the self in a larger context.* As discussed in the two previous rounds of analysis, as some participants drew on spiritual support, they developed perceptions around a sense of mission or a sense of

their professional work with in a larger more universal context. This positioning was one way in which participants have been *CREATING ONGOING CHANGES* as a means of maintaining their intentionality. In addition to previous data which has been elucidated in other rounds, Phil and John added the following data to the analysis:

> Jennifer I don't know, I would think it's just really feeling encircled about with the arms of God's love. Feeling God's love around me and feeling his angels and his support that I'm not doing it alone.
>
> John Yes, there's something about the strength that kind of wells up again like that well spring spiritual coming from God or whatever that enables you to feel engaged more because there was that protect in there somewhere, almost like I don't want to be exposed to people in trauma because I know it will engage empathy and I just can't bear it anymore.

Self-support—A property of the subcategory of developing support. Distinct from other approaches to *Developing Support*, participants' development of self-support was internally generated, but often tied to developing and receiving the other aspects of support previously discussed. The dimensions of the property of *self-support* are *allowing for time and space* and *pressured self-expectations*. As discussed in the exposition of the first category of the structure, some participants, as part of their professional setting, had specific self-expectations. These self-expectations were often temporally driven—dealing either with time or monetary compensation. For other participants, these self-expectations revolved around their sense of giftedness (beliefs about the self) or their idealistic beliefs about the profession.

A restatement of some of the data from the first two rounds, illustrates these connections. For example, A.J. had just seen a colleague navigate through some of the issues associated with compassion fatigue, that she, herself, had grappled with early in

her career. Her response demonstrates movement through the dimensions of this category and connects back to the category of *EXPERIENCING INTERNAL DISSONANCE.*

A.J. I saw much of my own belief system in things that I had gone through earlier in my career because I have the same belief system she has about work, and that you just keep going until you drop dead. That, you know, it doesn't matter if you're not getting enough sleep or not taking care of yourself; doesn't matter, 'cause your job is to take care of everybody else. So the biggest change that I've seen in me is I've given myself permission to not do that anymore.

So, that is a huge change for me and I'm very confident that it's ok not to work yourself to death.

John's excerpt from round two demonstrates the connection between *self-support* and taking a stance of *personal non-judgment,* a dimension of the subcategory of *creating positive cognitions,* within another category of the structure, namely *CREATING ONGOING CHANGES.* His narrative also connects back to developing spiritual support.

John To just spend days feeling that way, and again it was partly a spiritual process too, as you experience days like that, you know that's part of life and you plead to God for deliverance. . . It's just . . . and so you pray for help, and pray for God to bear the burdens and then it doesn't happen that day maybe, but a little relief that day and then you have to go back to work the next day. But it's this ongoing process of crying out for spiritual help and knowing and asking my wife for slack with the financial demand, arranging things at work so that I can still do my job, but not have it be, you know—having a little more wiggle room, being willing to be a little bit more of a junkie to get on line and look up interesting websites or if I have a break between sessions, I don't expect myself to do follow up calls, but instead just crash and take a nap or whatever. So, it was kind of coping while at the same time seeing that this is a bigger problem than just—do those little coping things every day, but then when I needed more and more, it came to the point where I was saying, "This is not just a matter of coping, it's not just using those little coping things that would address how big this is starting to feel. Taking a chocolate bar to work isn't going to be enough. It's even bigger than that."

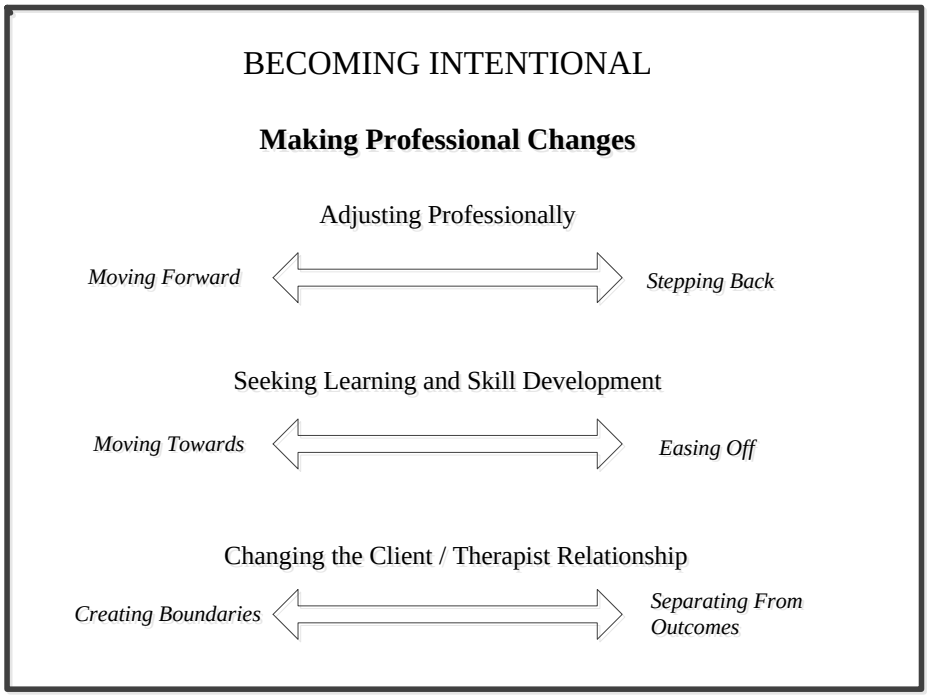
Additional responses from the round three analysis serve to highlight the dimensionality of the self-support and strengthen the connection of this property to other categories.

Mary	Oh well, I absolutely found it to be true. Time and space was definitely an element that I had to separate myself from others and I found it, I found it to be a, to be much more helpful in order for me to regain my own health.
Roxy	Well, I think that's just more of a natural state that we have and it was more just needing to . . . it's so internally to create that space, I just needed time and space to shield myself . . .
Jennifer	Yes, and again partly because I'm single and have had no children. I think everybody needs to be self-supportive, but I particularly, I think people in my circumstance you have to find ways to nurture yourself.
Elizabeth	Yeah I think it's because we have support at work, in the community, and a lot of times where I work at this place, people don't talk to each other as much. Support staff and us do but the therapists don't. Everyone keeps to themselves more. It's not like where I used to work. So a lot more is on your plate, you know you just have to go reach out for yourself, find what you need.

The above excerpt from Elizabeth demonstrates a need for continued reflexivity in the process of navigating through compassion fatigue. In her case, becoming self-supportive may have been the foundation for her ability to develop other support. At one point, she had eschewed reaching out. After reaching out she was able to attenuate her emotions. This analysis implies a relationship between pressured self-expectations (a lack of self-support) and emotional effects. As participants fostered reflexivity, developed support, and transformed their perceptions they also took measures, as they deemed necessary or desirable, to make professional changes. *Making Professional Changes* was part of the process of participants practicing intentionality or *BECOMING INTENTIONAL*.

Connecting the Category of Becoming Intentional to the Other Categories Through The Subcategory of Making Professional Changes

The subcategory attendant to the participant responses regarding professional changes has been re-conceptualized or adjusted with each subsequent round of interviews. Following the third round of interviews, the property of *client/relationship context* within the subcategory of *External Context* under the main category of *CREATING ONGOING CHANGES* was moved to the subcategory of *Making Professional Changes.* The justification for this move was that further analysis indicated that as participants *separated from client outcomes* or *created boundaries* it was part of the process of *BECOMING INTENTIONAL*. Furthermore, this property was renamed *client/therapist relationship context* to more closely link it to the similarly named property associated with *EXPERIENCING INTERNAL DISSONANCE.* The two properties and their dimensions serve as a further connection between the foundational and the central categories of the structure.



Appendix G, Figure 7. Properties and Dimensions of the Subcategory of Making Professional Changes.
(Category: Becoming Intentional)

Adjusting Professionally—A property of making professional changes.

Each participant's account of encountering and navigating through compassion fatigue includes adjusting professionally. This adjusting comprises finding a new work environment, changing workload, or changing their clinical context. All of these actions may be represented by the dimensional concepts of *moving forward* or *stepping back* along a continuum. For example, Mary changed clinical contexts several times as a way to attempt to process through her effects. Roxy and Andrew reported moving forward by becoming self-supportive and finding a place of work where, in the case of Roxy, she could become "human" again, and in the case of Andrew, he could avert a deterioration of his physical and mental well-being. Phil also changed his clinical setting, partly attributable to support from his wife. Similarly, with her professional supervisor's encouragement, A.J. moved to a different clinical setting. All of these examples point to

the dimension of *moving forward.* On the other side of the dimensionality, Jane, Jennifer, and John discussed adjusting professionally by *stepping back.* Some participants' responses allude to experiencing both dimensions of this property depending on the situational context. All of the participants' narrative point to the link between *RECOGNIZING AND PROCESSING THE EFFECTS* and *BECOMING INTENTIONAL* through *Developing Support* and *adjusting professionally.* Roxy encapsulated this adjustment when she said the following:

> Roxy — So, I would say that I did kind of, I was in a place for a while where I felt victimized a little bit and stuck. But, you know, humans are survivors and there is only so long that you can take being in that place without, if you're not dead, you have to do something to get out of it. So apparently burnout doesn't kill you. So I had to keep kind of struggling to find some way to get through it and I think eventually I took ownership of if I don't like my circumstance, I can look around and find someplace else to work and be. It's a rough economy, but I can go and see what I can find. If where I am working is really that great, then it will help me get a perspective on ok, it really isn't such a bad place to work and now I choose to stay here. Or I can find another job that is better and go there. So, I can do this for an amount of time and I keep trying to survive and make it through on this end then I'll find a job.

This piece of data captures the essence of the way that *BECOMING INTENTIONAL* allowed her to move to a place where she was self-supportive. Becoming self-supportive allowed her time and space to adjust professionally and to ameliorate the effects of compassion fatigue.

Other links indicated by the data collected from the round three interviews are highlighted below.

> Jane — Um. . . I think probably what I've done is that I've recognized when I'm just completely done or, you know, I just don't have anymore, um, to give and that's what I do, it's just a like I think I've said it before, kind of take a step backwards and I, I removed myself from the situation so that I can be in a better place.

Jane demonstrates that she steps back as a way to avoid losing compassion while *creating healthy compassion* as part of *CREATING ONGOING CHANGES.* She is attuned to the potential effects, and she purposefully steps back as a way to maintain resilience.

> Jane — Well I think I've, actually I just went through a situation where I was with a really, really tough situation for the last two and a half weeks, um, with a patient. I went on vacation for four days and when I came back everybody else was just completely tapped out and stressed out when I got there and I felt I had enough energy, I had enough. Being away from it for four days I was in pick up a phone and have a conversation when nobody else could, and I felt energized because I felt like, it is okay now. That's the best I can explain is that just taking a break sometimes is the most important thing you can do.

Andrew, whose data exemplifies both dimensions of this property related the following about stepping back. When queried about how he tolerated the discomfort of taking a professional risk, this was his response.

> Andrew — That sounds like the answer, I, you know, kind of I did that I guess and part of, you know, kind of made some of the internal shifts and external shifts that we talked about. It just kind of happened. It probably, and I know I keep tying things back to this big move and everything, but it kind of was a major planned happenstance in our lives where you know I came across the job posting for this position and sent an application and my resume, whatever, just sent it in, got a call back, got an interview, and the job offer, and that I flew out and looked around and made sure things were okay, then told my full time employer that, because I was full time at ____, which didn't go over well but, oh well. Right at the end of the fall semester when this all had happened and then I had to break it to my private practices and then all my clients and everything like that so there was a lot of pressure, a lot of tension because it was a big move with my family and all these work situations and it, you know it was unpleasant and not at all fun and I just kind of had to, you know, suck it up so to speak, say, "Hey, this is going to be the best thing for us."

Being able to tolerate the discomfort of becoming vulnerable and risking professionally was also an element cited by Phil in his third round interview, but his adjusting reflects a more active dimensionality in this particular case. His response also links to renewing his commitment to developing healthy *professional support*.

> Phil — It goes right along with my prior statement. It was practicing and actually intentionally engaging in activities that required me to trust and then I was able to actually begin to start to trust people and then develop support systems again. At that point I didn't feel like I had that much support, if anything I was, I was, I questioned everybody and their motives. And so I had to actually practice in, in that everything was okay and actually engage in relationships, like everything was okay and then add time to it, it just, it's taken, it took months. I couldn't give you an exact amount but several months.

John's quote also reflects the strong link between receiving support and having the courage to adjust professionally.

> John — Support, yeah that, I think it's very important, it's like you get worked and worked and worked. It's a process that requires time and I think it's nothing else like the answer that comes to mind is the support that I got, especially from my wife, was just it enabled me to stand back up and walk back into the flames again and try one more day, you know, like it enabled me to continue. Where without that support, who knows what it would have been, but it feels like when it's just been too overwhelming to face life alone. I like Sue Johnsons quote: 'To suffer is inevitable but to suffer it alone is unbearable.' And it felt like things were unbearable had I not had someone who was willing to empathize and be there with me and nurture me emotionally through that. I felt in a very regressed state, very in need.

Seeking learning and skill development—A property of the subcategory of making professional changes. During the interviews and consequent analysis of the third round, the property of *seeking learning and skill development* emerged as an important component of *BECOMING INTENTIONAL*, as a modulator of the dissonance, distress, and effects of compassion fatigue.

As such, *seeking learning and skill development* is directly related to the first two categories in the structure. Participants sought learning and skill development through both formal and informal educational experiences. Some participants moved towards learning and others eased off of learning as they navigated through compassion fatigue. *Moving towards* and *easing off* are the dimensions of this property. In round three almost all the participants expounded on the reasons why *seeking new learning and skill development* or easing off of new learning and skill development had been a significant part of navigating through compassion fatigue.

> John Again, I'd say it might be the reverse for me that there's sort of an easing off from doing as much reading and trying to, you know it's kind of more trying to back away from that if anything.
>
> Mary Okay, yes mine has been more informal learning and doing a little bit of discovering with reading about things, about post-traumatic stress, about compassion fatigue, about and doing my own self-discovery. And I think laying off actually some of the psychological learning arena. As I backed away from that I did other things that were, a little more light.

Like Mary and John, Roxy had, for a time, backed off of seeking new learning and skill development. However, over time, she became re-energized and developed a desire to increase her learning, as she had been doing prior to encountering and navigating through compassion fatigue.

> Roxy Okay, yeah so just kind of professionally I was thinking, you know, I don't know if I'm any good or if I should invest in these things and this but, um, my boss at the new place where I work at was encouraging me to, um, I guess submit a proposal for a presentation and try to do a little bit of research for that. But it was more just kind of, um, synthesizing what I tend to do in therapy and to make a presentation form, and doing that and studying for my licensing exam, it surprised me with both of them because it helped me reengage with the profession and care about it and realize, "I do like this and I am pretty good at some of these things." And my proposal um got accepted and so like that was

> kind of a little bit of a boost like I guess some kind of a validation that, "Oh, I'm not just, you know, just some lame, mediocre therapist who is just kind of dragging through this." Like I've got some things to offer and um it's exciting to be involved in a professional community and, um, and this is a good feel and I do like it and I think it's a good idea to continue to work and that so, that, you know, wasn't really related to, um, I guess the thing that got me into the place of compassion fatigue but it certainly gave it certainly gave a little bit of a boost.

Likewise, Jennifer values new learning as a way to reconcile dichotomous beliefs about herself and to continue to move forward professionally.

> Jennifer Well its certainly, I think new professional learning is very helpful to deal with my compassion fatigue because I think, at least for me part of compassion fatigue is feeling like I don't know what to do.
>
> You know, and if I try to be really careful and selective in the trainings because they are so expensive. But the trainings I go to are very invigorating and vitalizing and give me new ideas and refresh my memory about things I already knew and going to a conference or something with other therapists, it's like you get a chance to know that you're not the only one that struggles with some of these things and I can't think of a training where I didn't come out feeling vitalized and like ready, "Oh right, I want to try this, you know use this to help people."
>
> Jennifer And finally learning to trust, you know, continuing to gain intervention skills and, you know, ideas things like that but also just trusting the intuitive skills that you just kind of go with it as it comes and that you can do that.
>
> (You had already experienced it and cycled through it but also really increasing your skills, not just quick learning but increasing your intuitive skills.)
>
> Yeah and learning to trust them.

Phil, who entered a doctoral program as a way to attenuate his sense of dissonance and feeling "divided," also cited learning and skill development as a motivator for change.

Phil — The new learning gave me different, just different a, how can I describe it? Different examples of how to live, different ways to perceive things because all I knew is what I had known before. It was very difficult to change that, those, that way of living but seeking, you know, I would read things you know, I would study things, I would, and heck, I even went to therapy myself and all kinds of things and then met some good people. And I began to try to model myself after a different, different way until it started to feel correct. I guess that's the best way I can describe of how seeking further knowledge helped change my perception of myself and my professional identity.

Andrew also cites professional curiosity as a way to navigate through compassion fatigue.

Andrew — I started digging more and so, you know, I like books, you know books and articles and everything, so I kind of had jumped into that. And again it's a different take on some of what I was already doing. So I, you know, but I still got to learn some new stuff and new ideas and new names and everything and so I kind of did that on my own and also some continuing ed. sort of stuff, and so that kind of helped me again clarify what I was to do, and the scope of what I was to do and to look at, oh wait this ah, it re-energized me to, you know keep digging into the work and to try to affect the people and help out in different ways.

Seeking new learning and skill development, according to A.J. is one of the most significant means to both *BECOMING INTENTIONAL* and *CREATING ONGOING CHANGES.*

A.J. — I think new learning is one of the most powerful interventions to prevent compassion fatigue and to help people with it, um, it helps you become passionate about the positive aspects of your work and what you're doing and it gives you some exciting new ways of working. . . You know while I did all kinds of learning that, um, really helped me through that time period and it was in the process of learning that I actually first found out about compassion fatigue and went, "Oh, you know I had that." Because it wasn't until 1995 that Charles Figley came out with his book and his stuff on that and yeah . . .

Her opining also reveals a partial means to maintaining the positive benefits of *BECOMING INTENTIONAL* through providing support and education to other professionals in the field regarding compassion fatigue.

Changing the client/therapist relationship —A property of making professional changes. As noted in the exposition of the category of *RECOGNIZING AND PROCESSING THE EFFECTS*, participants were affected by their encounter with compassion fatigue as they either disengaged or became overinvested in client outcomes or in the client/therapist relationship. *Changing the client/therapist relationship context* was a noteworthy piece of participants' development of intentionality and *BECOMING INTENTIONAL*.

During the third round of interviews the intentionality of this change became more apparent. As a result, this property was moved to reflect the nature of the property as a component of the central category of *BECOMING INTENTIONAL.* This property had been elucidated in prior rounds of analysis. The round three analysis served to strengthen the relationship of this property to other categories in the structure. Almost all participants engaged in *changing the client/therapist relationship context.* In doing so, their actions reflected the dimensionality of this property as they *separated from client outcomes* and *created boundaries* between themselves and their clients. These dimensions illustrate the way in which *changing the client/therapist relationship context* directly modulated prior effects within the client/therapist relationship associated with experiencing the effects of encountering compassion fatigue. This property connects to other categories as well, as illustrated in the following excerpts of data. For example, almost all participants in the course of the three rounds of interviews, had discussed the

need for setting better boundaries with clients. Mary and Jennifer discussed the concept further in round three.

> Mary — Well, I actually had to a, I don't know if it, it was completely healthy but I had to back away from other people's problems. I had to, in fact I had to just completely back away from people that were kind of acting codependent with me or dependent upon me and were draining me a bit and that was not clients that was just other people, in my friends or just something like that . . . But I, yeah, and a, and recently I have been able to tell people, "Oh I'm sorry and that there is" . . . I don't let it drain me like I did before and get completely involved and inundated with it, thinking I let them own it and say, "Gee, I guess we all have, we all have problems and too bad they're going through this. I'm not taking it on like I did before."
>
> Jennifer — I think one is learning how to say no when I feel like my client load is full and saying no I can't take anybody else right now. So, that's not easy for me to do, especially if it's a personal referral and somebody I already know. Like a client, someone will call me and say they were referred by a client and I really like that client and you hear a little bit of their story they leave on you message and it's like, "Can I work that in?" Sometimes I can, but I've learned that sometimes I just have to say, you know maybe later or I refer them to somebody else.

Jennifer's data speaks to the development of healthy compassion and the avoidance of extreme 'highs' and 'lows' associated with over-investiture in client outcomes. Elizabeth's response mirrors that sentiment.

> Elizabeth — And I haven't always been perfect. I definitely have made mistakes early on but again that was the roller-coaster I was referring to. I just had to learn from my mentors and you know like, "Oh crap, I'm really messed up with this person now; what do I do? How do I keep myself from doing that?" And as long as I was being honest with it and open about it then I kept myself from having those over high, you know overly lows and big time highs.

The following data from Andrew highlights the connection between the dimensions of this property and the connectedness of the properties within the entire subcategory of *Making Professional Changes.* Whereas, Andrew had experienced the

former effects of feeling "dread" over his clients, he moved to feeling "lighter" as a result of the changes he made.

> Andrew — I have to say I keep hitting a word I used earlier, it's kind of lighter. Floating down the stream sort of a thing, instead of fighting upstream . . . And just a, whatever stick or leaf something. You know floating down the stream and it's okay. It's an enjoyable ride and sometimes there are bumps and rapids you get stuck along the edge and you keep kind of going. It's not tiring because you're floating not fighting or paddling or something, just going with it a little bit.

His ideas speak to similarities in the narratives of John, Elizabeth, Jennifer, Jane, and Mary who all concluded that client outcomes were not "personal." This fact does not mean that participants depersonalized their clients, but rather that by separating themselves from outcomes they could practice a healthier empathy and compassion.

> Jennifer — I think just a continual adjustment that I need to do is recognizing that I'm not responsible for someone else's mental health . . .That I can provide support and services and work with them but they're the ones that have to do it.

> Phil — I let them live the way they're going to live and I let myself live the way I need to live and if they want to walk and let me walk with them, I will do it.

> Elizabeth — . . . and I'm learning you know that's just the way it's going to be and I'll do the best that I can and give them options but I have very quickly put options on the table so I don't overload myself with this burden of you know I should be able to heal this person. Or, why are they so resistant? Because you could easily take that personal and I make sure to open the gate and give them options, give myself options and when it's not going the way it should then you know refer them out—do the things that I need to do. Keep them moving but not weigh me down or weigh them down.

> Jane — I don't know if that makes sense but you kind of take yourself out of the equation and you realize that you're not here to have your needs met, you're there to help facilitate somebody else and what they're going through and recognizing that you're going to learn in the process. Its, it's kind of complicated it's not an easy thing to explain that overtime I've become better at recognizing that its,

you know, you can still be a big part of helping people get through hard things and working through tough situations, that you need the honor and respect that it's their, their things and it's not yours.

Jane So it's really, really important that you don't try to do it for them or fix it for them or be everything for them. Because it's just you know, it's kind of a metaphor in life, we have to, when we have a baby we take care of them when they're a baby but as they, as they advance each month of their life, you stop and you take a little bit away, a little bit away, a little bit away until they can totally function on their own and, a I think that's what I've learned more than anything is that you have to have so much respect and regards for your clients' ability to find their own way and make their own mistakes and it's going to be okay.

An analysis of Jane's excerpt indicates the ways in which this property is connected to being self-supportive by allowing time and space. Furthermore, this property connects to the idea of acknowledging the experience of encountering and navigating through compassion fatigue as an upward spiral of growth and development. These ideas are connected to the final category of *CREATING ONGOING CHANGES.*

Creating Ongoing Changes

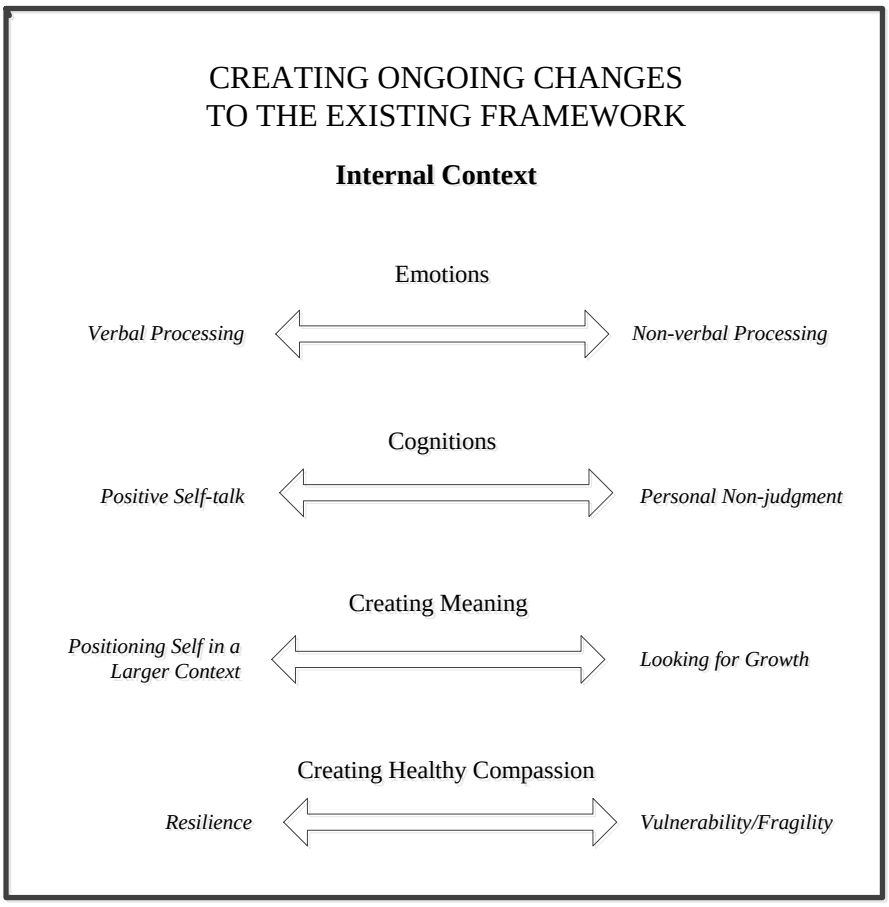
An analysis of the data of all three rounds of interviews with the nine participants involved in this study indicates a structure with an inherent linear process. However, because of the unique nature of each participant's narrative, this linear process also had, for some participants, a circular quality. For the most part, participants spiraled up and down during the process of navigating through compassion fatigue. However, this spiraling process may be largely characterized as an upward expansion of growth and movement towards becoming more resilient. This resilience includes the development of healthy compassion as opposed to experiencing compassion fatigue.

Once participants became more intentional about navigating through compassion, they mitigated many of their effects. As the final category in the structure, *CREATING*

ONGOING CHANGES is not a definitive end. In the round three interviews participants discussed ways in which they have cycled back through the structure. The word 'ongoing' implies that participants, in the present moment, are still impacted by their experience, largely, in positive ways. The subcategories of this category, *Internal Context* and *External Context* parallel the subcategories of *EXPERIENCING INTERNAL DISSONANCE.* The correspondence between these two sets of subcategories is indicated because the basic context has remained the same. However, the properties within the subcategories have changed proportionate with the ways in which participants have changed. Participants have internal processes which continue to be influenced by external factors. The difference exists in the way participants perceive and act. Although participants have changed their external and professional circumstances, an analysis of the data demonstrates that most of the navigation through compassion fatigue has been an internal metamorphosis.

Connecting the Properties in the Subcategory of Internal Context

Based on the conceptualized structure, the ongoing changes within the *Internal Context* created by participants are summed up in four properties: *processing emotions, creating positive cognitions, creating meaning*, and *creating healthy compassion.* These properties are interrelated in that they are descriptors of the internal processes which have assisted participants to continue to navigate through compassion fatigue.



Appendix G, Figure 8. Properties and Dimensions of the Subcategory of Internal Context (Category: Creating Ongoing Changes to the Existing Framework)

Processing emotions—A property of the subcategory of internal context. In the expositions of previous rounds of analysis, participants' ongoing practice of processing emotions was an important part of navigating through compassion fatigue, and developing *self-support*.

Participants were able to create internal balance as they found ways to process and offload their negative emotions. They processed their emotions first by recognizing they were in distress and were experiencing a plethora of negative and disquieting emotions. Those distressing emotions are characterized by the dimensions of the property

of *emotions* within the category of *RECOGNIZING AND PROCESSING THE EFFECTS.* The two properties of *emotions* and *processing emotions* are directly linked to each other in that as participants practiced *processing emotions* they modulated the distressing emotions originally felt as effects of compassion fatigue. The dimensions of participants' processing of emotions are *verbal processing* and *non-verbal processing. Verbal processing* is connected with receiving support from others or being self-supportive in that participants experienced positive support as a milieu in which they could safely process their emotions. *Non-verbal processing* refers to mental or physical actions which helped to offload emotions. These actions were intentional and sometimes ritualized as a subtle form of *self-care.*

This property was fully operationalized and described, particularly in the second round interview analysis. A recapitulation of the summary of participants processing of emotions strengthens the connection between this property and the properties of *emotions, creating self-care* and developing *self-support*.

As previously noted, Mary, Elizabeth, and John categorized the ability to verbalize their 'story' as a way to modulate their compassion fatigue responses. This modulation took the form of reflexivity and emotional processing.

> John Since talking with you I've felt less hate, I've felt some of my enthusiasm returning for being able to do psychotherapy and part of it, that comes and goes for me which if I'm trying out, if I'm in a process of discovering experimentation and I'm trying out some new stuff with couples now that's really fun and cool and so I have less of that hate for it. It's really a blast so that may come and go again in the future but part of was the, again the resolution that came as I talked to you and after and part of it is this that's enabled me to just kind of relax and feel like I can go to work and not have to, before I talked with you I was really so protective about not working more than 40 hours a week and if I got 45 hours that I'm working and every extra takes that much out of me, I can do the 25

clinical hours without too much stretching but if I see more people, I just call and tell them I'm totally drained and where essentially it's felt like somebody needs to be seen, I can, or if we need more money for this or that, or we want more income I can schedule a few more people. It will be fine; in fact it's probably going to be interesting and sometimes even exciting.

Elizabeth And once I got past that, then it felt sort of freeing a little bit to just do that. Share with somebody who has a heart.

In her previous round one interview, Jane had discussed physically processing her emotions through crying or throwing up. She deepened her explication in round two by sharing her feelings regarding her professional role. This role constituted carrying a "sacred" trust to protect and be a receptacle for client stories. She has been able to 'hold' those stories and "lock" them away, citing the singular experience of sharing with another professional.

Jane That's kind of an interesting question because it was one of those things that I thought about after you and I talked the last time. It's interesting to me that I have not shared these experiences with really anybody and so what you would think from that is, "Why am I keeping all this stuff inside of me and I'm not going to anybody and talking about it?" Especially after some real extreme things. I think for me, I protected my family, I didn't want . . . the horrific things that I saw. I knew it would hurt them to even hear about it. So I protected other people from having to go through the same thing that I went through by experiencing that. When I shared with you some of those things, it was as real as if it was happening all over again.

Jane I feel that, I knew that I couldn't ever really tell people without making it less than it really was. Even though I felt like I was protecting other people, in fact, I think I was protecting the actual event or what happened because I couldn't do justice , I couldn't . . . I don't know. There are a lot of feelings I have around that just talking about it right now with it, you know, maintaining people's privacy and I don't know, it is sacred ground that you're on when people are sharing with you things that are so personal or even tragedies that are just unbelievable, you just don't tell other people about that. And so for me I've put a lot of things inside of me and I'm sometimes not even aware that they're there until something

> triggers those memories. So I think, how I transitioned back . . . I'm really good at it. I'm not saying that in a proud way. I'm saying I've become so . . . it's a natural thing for me to have someone talk to me about something and just not repeat it until, it's almost like, it goes into the file cabinet that gets locked and those memories are whatever are there to only come out when they are absolutely needed for another purpose . . . Like a file cabinet that you lock, the cabinet that you always have to keep locked because you have a responsibility to protect people. Information and their lives and so I just, for me, it's become second nature.

Sharing and having another person 'receive' their story has been helpful to participants' modulating the emotional responses of compassion fatigue. This form of narrative sharing connects with the property of *Developing Support.*

> Mary I would transition by debriefing and whether it had been with another therapist or if I had spoken to my husband and told him something on the cases, not giving descriptive things, in order to debrief. And talking about what I had done and everything else, actually I felt good and I would transition and without me knowing it, my husband would pat me on the back and "That's good, hun. Thank goodness they have someone like you," something that would help to put me in a better place.

> John It has been thought provoking. I've talked to my wife about it quite a bit. The primary thing I've noticed is . . . the compassion fatigue is easing even a bit more. I feel a little different a sense of rather than wanting to or needing to avoid sessions that I feel a sense of inner strength which is a relief. I guess it comes in its own time and I can definitely feel that.

Some participants used *non-verbal processing* rituals as a way to off-load the emotions absorbed from their clients or their extreme clinical environment. A.J. has learned to practice off-loading her emotions by using the ongoing practice of non-verbal rituals. In a similar vein, Mary and Jennifer have also learned to process their emotions *non-verbally.*

> A.J. That's a huge part of how I've managed. One particular nurse talked about having really clear boundaries around work and the home and some kind of ritual to let the stress of work stay there

and not contaminate you when you leave work and the home environment. She told me about a little ritual that I just captured. We have a revolving door at _____ on the north end that you go out to the parking structure. She said every time she felt the air on her face as the revolving door goes around, she imagined it washing off all the stress and everything that happened that day and leaving it there at work ‘cause she would walk unencumbered out to her car and then by the time she got home, she would be fully ready to be present at home and not let what happened during the day affect her. So making it very conscious, because it doesn’t happen otherwise. You can just still be pondering and worrying and thinking and if you make it a conscious effort to do that, it really helps.

A.J. There is one other thing along with the ritual, another gal taught me to do rituals when I’m having grief or loss and that was really helpful as well. The message she would use is, she had a place in her house where she would go and reflect and meditate on a particular patient that had died or a situation that she had experienced some loss. Maybe it was even a long term patient that she cared for that got better and left, or moved away and she wasn’t going to see them anymore. She would light a candle, she would meditate about them and then when she felt like she had processed her grief and had her tears, a good cry or whatever, she would blow the candle out and she would kind of let it go at that point. But she had a very conscious process of crossing the grief and loss as well. So I adopted that as well and that has been very helpful. Since we can’t just ignore the grief and loss. That is a part of the picture for compassion fatigue, unresolved grief and loss. And when you proactively and consciously deal with, validate, honor it, process it and then let it go, makes it a lot easier.

Mary And take a deep breath and realize I had to regain more energy for myself and I took action by trying to deep breathe. I noticed that I would be shallow breathing. I would try to slow my breathing and also try to talk about the case. I also noticed that there was something very physical that I did, that if I got upset, I would take, like if it hyper-aroused me, I would take a hot bath. That sounds weird, but it’s almost like a cleansing process to restart my thinking.

Jennifer A cranial just clears that negative energy and I feel lighter.

Jennifer One of the things, an NLP technique is imagining like a giant sifter. So sometimes in the car going home, I’ll imagine a sifter coming up through me and it can be really just not going through.

> It will just keep going through my body sifting out the stuff that is not mine and leaving it and letting it flow away. I'll do that until mentally it flows free and it's not stuck.

The data from A.J., Mary, and Jennifer, connects to the next property of *creating positive cognitions* in that creating those cognitions intersects with mitigating the effects of negative *emotions.*

Creating positive cognitions—A property of the subcategory of internal context. In addition to *processing emotions*, participants practiced *creating positive cognitions*. Sometimes the development of positive cognitions was intentional, other times participants were able to see that their cognitions improved over time as a natural outgrowth of navigating through compassion fatigue. This property could be characterized as the development of self-compassion with the dimensions of *positive internal dialogue* and *taking a stance of personal non-judgment.* The dimensions of *creating positive cognitions,* self-talk, and taking a personal stance of non-judgment, are connected with the property of emotional processing in that practicing ongoing positive cognitions assisted participants in self-regulating their emotional responses. Most of the effects of compassion fatigue were experienced in the silent chambers of the internal terrain of participants. *Creating positive cognitions* existed within that same terrain as participants noted a need to be actively engaged in working towards creating positive cognitions. This practice constituted a perceptual maturation associated with the subcategory of *transforming perceptions* as participants made ongoing adjustments depending upon their circumstances. This process was defined, in the second round analysis as the difference between assimilation, which occurred when participants first encountered the effects of compassion fatigue, and accommodation, which occurred as

growth and resilience ensued over time. Their growing resilience assisted participants in fortifying themselves mentally, what Roxy termed "shielding myself" against compassion fatigue. By becoming thus fortified, participants were able to avoid the deleterious lows they had previously experienced at the beginning of their encounter with compassion fatigue. In other words, the experience, over time, had inoculated them.

Each participant's story reflects the ways in which they created positive cognitions as they continued to navigate through compassion fatigue. Mary talks about *creating positive cognitions* in terms of gaining momentum.

> Mary I'm trying to go back to that and a, to truly back to "Okay where was I before all of this?" I was a very positive, very positive, I can do this, I can do anything. What my mind can see and believe, I can achieve. And I've noticed the momentum, even with this, me running, trying to do it. You know what I mean, to be more positive about what I can do.

Developing self-support and allowing for time and space to heal were means by which A.J., over time, changed her cognitive stance. Her comments also connect this property with the subcategory of *Transforming Perception.* Elizabeth's data points to *taking a stance of non-judgment* as the basis for developing healthy compassion.

> A.J. Yeah, well I think what it is you can get in a place, at least I got in a place where all that was happening was death around me. And with time, I would say the time factor works to remind you, um, that life goes on and the birds are still singing and the sun comes up and it gives you that different kind of rhythm to remind you, oh, you know, it isn't all about that. There are some positive things happening; there is some good things; it gives you enough time to maybe have some breaks.

> A.J. Yes. I think it does take some distance and perspective in order to make that internal adjustment complete. You need that time, you need that space and then you can look back and go, "Wow I was in a really bad place, I need to make sure that I don't get there again, and what caused me to be there and what can I take away from this to have a better awareness to not get there again?"

A.J. Yes. Yeah and recognizing that you don't have to do it all, that if you get tired it's okay to say you're tired. Um, if you need help it's okay to ask for help it doesn't show, it doesn't make you any less able or compassionate or, you know, you know any of those things. It just makes you, um, healthier and it keeps you safer and its actually better for the people that you serve because then they, they get somebody that can, you know really one of the biggest jobs we have is there, as therapists and working as skilled as to model healthy behavior.

Elizabeth But I knew I had to tell myself that "I'm going to have my good days and not so good days." And you know let my client know that I might not be completely up to par, I might be a little tired for everything. But usually when I tell clients those things they understand and they know I'm human too.

Elizabeth also points to *creating positive cognitions* as a way to mitigate her negative emotions, including the fear she has experienced most of her life.

Elizabeth I don't want to ever do that and so I always want to get the grade in college and stood up for things that I believed in and took even for my religion and other things and they you know, came at me with knives and definitely stabbed me a lot but I definitely stayed well I feel like, but I'm definitely glad that I allowed myself to push through even harder. My perception, I feel is more healthy now of what this really is and that it's okay, like I said to talk about it and I just don't feel nearly as frightened of it.

Andrew's quote implies that *creating positive cognitions* is a way to maintain professional passion.

Andrew Well, I think that keeps it in some perspective or certainly a healthy perspective. That compassion fatigue is something that happened that it leads to something else and again it's not fun right now but we're heading somewhere with this and you know there's another side to you know the struggle right now. There's something beyond maybe I can't see it or I don't understand it but there's something out there and you know I'll learn from it and we're going to be doing new things. It's going to be a new adventure; I'm always into kind of figuring out new stuff or learning new things. Not in a flakey way like you know every month I'm trying a new something or whatever, it's a lot slower

> process for me. But just I like to kind of expand what I'm doing or how I'm doing something.

Phil, in his response, refers back to the metaphor he provided in the first round of interviews. He attests that his transformation is a rapprochement of his former sense of being "divided." He has transformed his perceptions about himself and his beliefs about himself.

> Phil — It took just sitting through the emotions because situations would become uncomfortable and then just realizing that, you know, "This is not a bad thing, this is just a thing and it's going to pass. I don't have to let it run me I can actually come much better on the end, other end."
>
> Phil — Going back to that whole faceless man there, there is no conflict. The faceless man is me and actually it's not a negative side of me. It's as if it has changed and transformed into some, not something that I faced but just something that just walks with me rather than me fighting it. It's just a part of me I no longer have to fight.

Phil's narrative attests to the growth experience associated with navigating through compassion fatigue. Growth attribution is one of the ways participants practiced *creating meaning* as a means of *CREATING ONGOING CHANGES* within the *Internal Context*.

Creating meaning—A property of the subcategory of internal context. The dimensions of the property of *creating meaning* are *positioning the self in a larger context* and *looking for growth within the experience.* These dimensions were operationalized in the round two analysis particularly. The round three analysis served to further crystallize the concepts surrounding *creating meaning* and to connect this property with other categories. Initially, participants experienced an escalation of internal distress which obscured their ability to perceive the experience from a growth perspective. In the midst of an upsurge of effects, participants describe going through a

linear and circular process over time before they could attribute growth or position themselves or their experience within a larger context. *Growth attribution,* in the case of these participants, has been applied in hindsight and is an ongoing pursuit. *Positioning the self in a larger context* has further strengthened participants' ability to navigate through compassion fatigue. They hope, in some way, that their experience will create a climate of systemic intentionality in order to aid others. This hope is indicative of a connection between this property and the sub-category of *Developing Support* and the property of *providing support.* Moreover, *positioning the self in a larger context* has a universal or spiritual quality which has aided participants in mitigating the effects of isolation and shame associated with encountering compassion fatigue.

The property of *creating meaning* was emphasized in the round two interviews and associated analysis, however, four passages from the round three data further deepen the conceptualization of the property.

> Mary It's taken me a lot time to look at it as a positive because, because I felt in some way it was damaging to me and where I had some grown momentum going through graduate school and those types of things I, I believe, I wondered and contributed some of my health problems to, to what happened, to the compassion fatigue or PTSD or whatever it was. I, I really thought my goodness could it have gone up every, you know any, everything in my soul and so it's just been recently and honestly I have to tell you, it's going through, going through this with you and talking about it and you helping putting some spin on it and how I have helped people and can look at it as how that has helped many people you know throughout the eternal perspective of it all, that it has, that it has recently helped change my, my perspective on it.

Like Elizabeth, and John, Mary has been able to position herself in a larger context, as well as look for growth in the experience as a result of extensive dialogue

regarding her compassion fatigue. Her data implies the connection between support, processing emotions, and the ability to create meaning out of the experience.

In retrospect, Jane looks at growth as a means towards n resilience, and to overall professional skill development. In other words, she views navigating through compassion fatigue as contributory to her becoming a better clinician professionally and a better person generally.

Jane Okay. I think part of, I think I've said this before but I'm always learning and I'm always growing and it's the profession changes for me as I'm learning grows and, um, I think even my perception about my role and I already answered that earlier that over time I have come to the realization about what my role really is and I think I kind of have to grow into that, and I have to make mistakes and I have to get wiped out and I have to go through some of those experiences in order to understand what I'm not and I think it's just like anything. I've had to fall down a few times to really learn how to walk right. Learn how you keep your balance. You have to get burned a few times to learn why you need good boundaries. You have to, you know, and I think overtime I've just gained a great deal of wisdom if I learn each time you fall. If you keep falling in the same place or in the same way you're not learning and so I think ideally that all these experiences help you to grow into an individual that, um, not only learns to get the right way or to at least figure out how to do it the right way if you start going down the wrong path and how to correct your course but you also recognizing how very important it is that your clients and people that you work with have the same opportunities.

Likewise, the effects experienced by Jennifer and Phil have improved as a result of seeing growth in their experience.

Jennifer Well I think I've surprised myself. I think I had an idea—"Okay I can give this much, I have this much." And it's almost like the more that's been asked, it's not been easy but I've stretched and have been able to give more than I thought I could and it's like, "Wow I didn't know I could do that."

Phil Well and the first thing that comes to mind if there was a metaphor, I can't think of a metaphor, it's been a part of me so without it I wouldn't have had a chance to grow.

Creating healthy compassion—A property of the internal context. In addition to creating meaning, participants have also learned, over time, to *create healthy compassion.* The dimensions of *creating healthy compassion* are *resilience* and *vulnerability/fragility. Creating healthy compassion* refers to becoming resilient and developing healthy empathy that is not draining, but engenders growth and development. Though a lofty goal, *creating healthy compassion* was viewed possible by participants based on the symbolic language they used to express their feelings about the concept during the round three interview process. While some participants still consider themselves to be more vulnerable and fragile, they were also able to provide data regarding the times when they have experienced resilience.

This property was fully expanded during the round three interviews. The following data from some participants connects the property of *creating healthy compassion* with other categories in the structure.

Mary had experienced tremendous challenges, physically and emotionally. She believes that many of these challenges were sequelae associated with encountering compassion fatigue. Though she still feels emotionally fragile, just prior to her round three interview, she was determined to run a half-marathon. She felt that experience was symbolic of her quest to regain a healthier compassion.

Mary	No, I guess that is a very good question because I'm not so sure I have gained, or regained all the healthy compassion yet.
Mary	I think it's interesting because I just recently been noticing that, that I'm able to, because I went through a period of time where I was, I was blatantly kind of mad about it at the same time, I don't care about other people, I don't care about, you know and I did but I just couldn't allow myself to go there.

When queried, Mary specifically chose to talk symbolically about finding "flow" again as a result of her efforts.

> Mary The metaphor that popped into my mind while you were reading that was a waterfall, a beautiful waterfall flowing to mist of capacities over these big rocks, you know falling freely and freely into a, you know a big pool area. I envision a place that I've, I actually went after I graduated from graduate school in _____ and a freely flowing with you know, the energies of it all and everything and afterwards through experiencing and navigating through everything that I did of it drying up and having kind of just a trickle and a not enough of a pool to even, even feed down below, you know to give anyone else substance.

Roxy also attests to her ongoing recovery from compassion fatigue and the experience of being blocked from feeling the "flow" she desired.

> Roxy I don't yet; I feel like, um, I feel like culturally it's still recovering. I wouldn't say that it's quite where it was before.

> Roxy I would say that I often have that perspective about things and maybe I just haven't worked through this one enough, because I think I'm still more in an angry and I guess maybe blinding state with it.

> Roxy Generally it just feels like living, I mean you do your work and it is rewarding, it's hard and challenging sometimes during, still, but it's okay that it's a little bit draining because there's plenty there and you feel like you're helping people most of the time and, um, your job is your job and your life outside of work is life and it's all okay and there is much more balance and just resilience and flow—like it, it's a doable experience, and it's even much more than that –it's enjoyable and I think its life giving for you or for your clients. So it's, you know, when you're in that place of compassion fatigue it's the opposite of that, I mean it feels like no flow—like things are getting drained from you and there's no life giving anything back and you feel more trapped and things get darker and it's a scary place.

A.J.'s passage of data connects the properties of *creating meaning* and *creating healthy compassion.*

> A.J. (Do you look at it as a growth experience?)

> Yes, very definitely . . . I wouldn't ah, wish to have not had it either because I think it's, I'm thankful that I actually learned rather early in my career and that I had the kind of support I needed to move through that. Um, I think it could be more devastating to someone later in their career. Um, so it, it helped me from the get go to kind of establish some things that I knew were going to help me be resilient and get through and otherwise I don't know, I just think it could have been much more serious consequences so I'm glad it happened the way it did.

Like A.J., almost all the participants expressed a measure of gratitude for the experience of encountering and navigating through compassion fatigue. This posture is the case with Jennifer, Phil, Elizabeth, and John.

Data from Jennifer and Phil attest to the connection between *creating healthy compassion* and *changing the client/therapist relationship*

Jennifer	I think if anything it's deepened as my understanding of the human condition has deepened, but I think I actually have more compassion for the difficulties and the roadblocks that can get in peoples way of change. And it's not so much that they don't have a desire they're just not sure how to do it and kind of figuring all that out and compassion for that process. So I think my ability to love and be compassionate, compassionate has increased.
Phil	I'd describe it as much more of a mature approach on compassion and on what it's, what it is for, what it's purpose is. I think all things have a purpose. Before there is almost a naiveté to it and I think that needs to, that's part of it and that's just part of the process and it's not a bad thing. No, I'm not saying I am completely 100% mature, I doubt I ever will be. But it's just, it's much more of a yes I have compassion, yes I can have empathy for others and yes that can be a very strong tool in a therapeutic process and you know not just in the job, but also just in life in general with other people. But ultimately the change is not going to happen unless the other person that wants it, it doesn't matter how compassionate or empathetic I am, I mean it really doesn't matter, they have to want it to. You almost have to go through the similar process that I have had to do in going through compassion fatigue. I'm happy to guide them through it and help them through it the best way I can. But in the end if they don't want to then, well they can suck it. Healthy compassion is making a balance between

> being too engaged and using that tool of compassion appropriately versus being too engaged in the outcome. I no longer feel as responsible for the outcome.

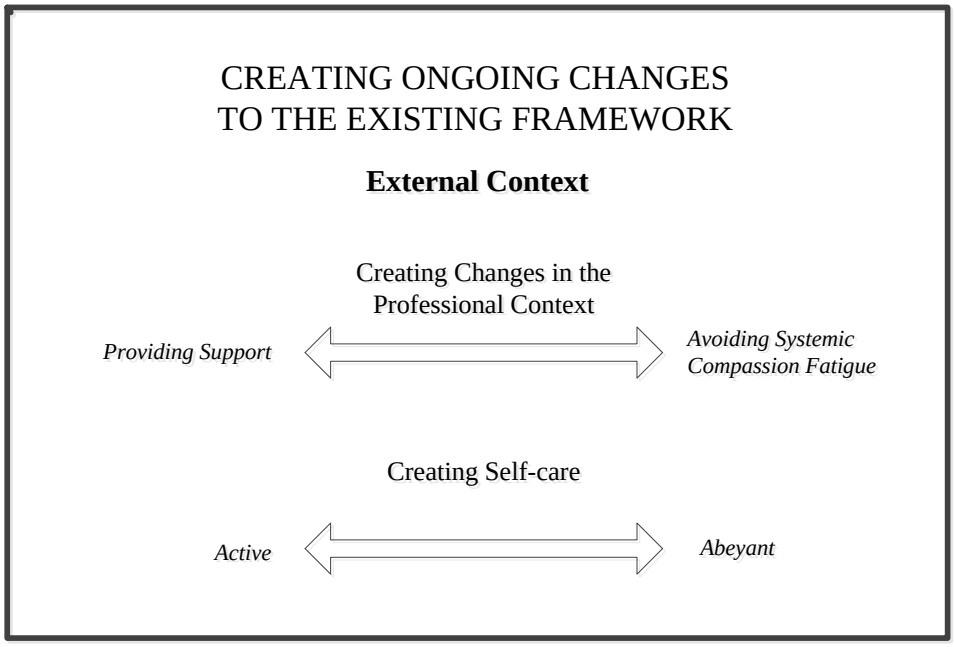
Elizabeth, who contended "I'm definitely stronger," also discussed the "ripple" effect of developing strength and resilience. Her passage attests to the connection between *Developing Support, providing support* and *creating positive cognitions.*

> Elizabeth The first thing that comes to mind is like the pebble in the pond with the ripple . . . I just visualize that okay things are flowing right now because I just felt like the world helped, you know this connected to that. I may have led him to this path but then that person helped lead into that and then that lead into that, I just felt a ripple effect. Things just flowing and that's when a person can be aware and also accept and forgive themselves and others and then actually take action and, and go and do and there's that moment where it just flows. You know, it may not last forever but in that moment it makes total sense. That will carry them throughout their next big learning experience I guess.

John's also discusses the long term benefits for him personally and professionally as he increases his resilience.

> John I don't remember exactly when that was but it was shortly after or maybe even somewhat kept the ball rolling during the talk you and I had and then shortly thereafter. I think it was, I don't remember or not if the conversation with you led me back during a meeting or something but I think it was on a Sunday where there was just this sense of vision that opened up to me. Through this whole thing its felt very different and has a bigger meaning that's part of the essence of my experience in life and what I'm capable of and ways that I can be there for other people, and how much things, how vulnerable I am to being wiped out by hard things, sort of like this breathtaking moment of, "Oh wow, So, that's what this is, that's how, I'm glad that, this is for extreme value. This is pure gold that's being refined here."

Connecting the Properties in the Subcategory of External Context.



Appendix G, Figure 9. Properties and Dimensions of the Subcategory of External Context (Category: Creating Ongoing Changes to the Existing Framework)

Creating changes in the professional context—A property of external context. The spirit of growth and development associated with the mental health profession in general, some participants have worked to create changes within their larger professional context. They have created these ongoing changes through adopting two characteristic professional stances, *providing support* and *avoiding systemic compassion fatigue.* As some participants have navigated through compassion fatigue, they have wished to provide support to others. This concept behind this support connects with the property of *internal examination*. As participants have become a*ttuned to the signs of compassion fatigue,* they are more likely to see those potential signs in others. This attunement enables to the potential for knowing how to provide support.

Other participants, who consider that they are still navigating through compassion fatigue, are working to avoid systemic compassion fatigue through avoiding ‘toxic’

professional colleagues and supervisors or through educating others. Almost all participants expressed the desire that their participation in the study would have the effect of fostering greater understanding of compassion fatigue's effects and amelioration. This desire is reflected in the following data from Roxy:

> Roxy I think also one more thing about the passage of time, I think something that's dangerous about compassion fatigue and situations where people aren't supporting that is that when I was in that place of being so burnt out—I thought it was me, I wasn't sure if I wanted to keep doing therapy anymore because I wasn't sure if I was good at it or if it was right for me, or if I even got myself into a place where I was kind of irrecoverable as a therapist and so, you know, we can really be losing people who are trained and who could do therapy and do it fairly well, because people aren't recognizing this is a real issue, and letting people do what they need to do.

A.J. experienced the extremity of compassion fatigue more than thirty years ago. Hoping not to lose any more "good people" in the profession, she has been able to provide support and education to others as a result of her experience.

> A.J. I think because, um, I feel like perhaps maybe I'm helping somebody else by talking about it . . . I think that there is a lot of people that haven't heard of that, or had any training of it in school

Jane, similarly utilizes the growth and resilience she has experienced as a result of navigating through compassion fatigue as a way to provide support and non-judgment to others. She, like A.J., is viewed by her colleagues, as having 'been there.'

Creating self-care—A property of the subcategory of external context. The data from A.J. and Jane suggests that providing support is also a restorative form of self-care. An analysis of their data implies that receiving and providing support enables and fosters balance, meaning, and growth. A.J. described this process symbolically.

A.J. Yeah, I think I would kind of see myself in, um, it's a goofy one. But a picture just kind of flashed in my mind. I've got my elbows locked with, um, a line of my positive support group so I'm like locked right up in a line of positive support and I'm standing on, oh what do you call those things, there's these funny little boards that we do in a palates class that they make you're, you're off balance and you have to constantly stay on balance and they do an exercise class with those. Their purpose is to help you be balanced and to strengthen your core . . . So I see myself on one of those and it's like okay I'm going to stay in balance, I'm going to keep my arms locked with this whole line of, you know, connections with others and then I have like I'm in a medieval costume with this shield in front of me and I'm going to be prepared and aware that this could happen.

Attention to self-care was not a universal phenomenon among participants. Although, most spoke of spending discretionary time with family and friends, for some participants, their self-care is *abeyant* and for others, self-care is more *active.* These two descriptors represent the dimensions of the property. For example, Phil discussed his experiences in navigating through compassion fatigue relative to his abeyant self-care.

Phil My self-care has really not changed as I have gone through this, but my anxiety has decreased as all the internal stuff has changed. And, I want it to keep changing.

Some link between self-care and navigating through compassion fatigue has been described throughout the conceptualization and analysis of all three rounds of interviews. In brief, self-care is related to *self-support*, *processing emotions,* and *the quality of social relationships.* The following data attests to the efficacy, for some participants, of self-care in *CREATING ONGOING CHANGES.*

Mary Oh it's a, it's great and it really it is, it is really great believe me to know that I did it again and a, because I used to be a runner and a just haven't done it in a while and stuff but you know there's, I paid a price for the pain but you know what, it made me think of a lot of things that I've done, you know if there's no pain there's no gain and a you know I had a psychological gain through it all.

Mary And keeping present in the here and now. . . Well, like I have done some deliberate deep breathing and yoga things and trying to keep my mind centered on the here and now rather than allowing, you know me to, I've never been one to have anxiety but this, whether this experience or whatever I've gone through has picked up some anxiety that I never ever had. I was always very positive and hopeful of everything and a, and I've realized that some of that positivity has waned. And I, I'm trying to get back to that and keeping in the present helps me do that, like through yoga or, you know what I mean, mind over matter, reading the books *The Secret*, thinking of the law of attraction, the things that before I ever entered into, you know, being a therapist actually got me through graduate school, got me through all this accomplishment that I had and I, and I'm trying to go back to that and a, to truly back to, "Okay where was I before all of this?" I was a very positive, very positive, "I can do this, I can do anything. What my mind can see and believe, I can achieve." And I've noticed the momentum, even with this, me running, trying to do it. You know what I mean?—to be more positive about what I can do.

The previous data from Mary, along with the following data from A.J. attests to the connection between *creating self-care* and *creating positive cognitions.*

A.J. I just remember how influential just even little positive experiences became during that healing time period. Um, just, you know, overnight camping trip and being back in nature or, um, going a to some kind of birthday party a for a family member, you know, just things like that, that kind of ties you back into the world of living and normalcy and gave you that kind of rhythm again so that it wasn't all bleak and overwhelming.

In addition to practicing positive cognitions, A.J., in previous rounds of interviews had discussed outside creative outlets as a form of self-care. This phenomenon was also the case for Andrew and Roxy, who both used music as a way to decompress and maintain balance. Jennifer has also found creative ways to use her discretionary time.

Jennifer Yeah, I think that's true, but for me you can take a break but it's also what do you do with that time? For me, I need to do other things, so it's not just about the passage of time. I need to be actively engaged in things that nourish me as well.

> Jennifer Doing things that don't have anything to do with therapy, going to plays, going to family events . . . You know things like that are really helpful to me. So time helps but I think also just really doing something entirely different, also.

Finally, Elizabeth combined *creating self-care* with developing *spiritual support* and *processing emotions non-verbally.* It has been a necessity for her to create ongoing changes in her negotiation of compassion fatigue. She attributes self-care as one of the ways she has been able to manage the cycle of compassion fatigue very recently.

An Example of One Participant's Experience Applied to the Theoretical Structure

During the period between the second and third round interviews, the city in which Elizabeth resides was severely affected by a crisis where many people were killed or injured. This crisis received widespread attention. As a licensed mental health professional, Elizabeth experienced the crisis first hand as she assisted others through the trauma they were experiencing. Some of these individuals she assisted had been directly involved with the crisis, or had known individuals who were directly involved.

Applying such an emotional and human experience to a theoretical structure is daunting. My concern about describing Elizabeth's experience was not to marginalize or trivialize the trauma of what had occurred. However, Elizabeth has kindly given me permission to share parts of her story as an example of the way her process matches the outlined structure of participants' encounter and navigation through compassion fatigue; she hopes that her story will imbue others with knowledge regarding compassion fatigue.

Experiencing Internal Dissonance

In prior interviews, Elizabeth had affirmed that she had conflicting beliefs about herself and the profession. She further affirmed that she had previously experienced triggers associated with an escalation of *EXPERIENCING INTERNAL DISSONANCE,* triggers which included all three properties within the *External Context* of this category.

Professional environment

During the aftermath of the crisis, the professional environment was extreme. She worked long hours and pushed herself physically, even beyond expectations.

Quality of Social Relationships

Elizabeth reported that during the crisis, she had been bolstered by the support and bracing of her family. However, because of past difficulties, she was also triggered by those relationships, feeling the dissonant effects of that triggering.

> Elizabeth And then you come home and it's at home too, I think that's where it got me because, you know it was at work and home. So I was trying so hard to separate myself and I think I did okay until I got home and that's where my weak spot is, when I come home.

Exposure to suffering and pain

While working long hours with victims of the crisis, Elizabeth was exposed to suffering, pain, and trauma. She describes her experience in this way.

> Elizabeth And hearing a lot of their reactions, even though I've done groups with people who have people who were murdered, I was right there in the meat of it and I hadn't done that, even though as a crises worker, I didn't quite recall it being quite this vivid.

> Elizabeth So, you know we were just in the muck of waiting to find out if, you know, if their family was still alive or not. So we were in that transition period.

Elizabeth's exposure to suffering and pain as well as experiencing the extremity of the environment, produced CF effects.

Recognizing and Processing the Effects

Because Elizabeth was attuned to the potential effects, she recognized them fairly quickly.

> Elizabeth It's so fresh in everyone's mind and I, you know, I went to a couple of the viewings and a funeral. So it goes a little bit deeper just because you get to know these families and it's all over the news. I think that when it's all over the news it heightens it to a whole other level. Everyone was just kind of on edge so just a, I think it heightened me, it heightened everybody just me or by being on alert. . . it just wasn't a comfortable feeling.

As part of her support network, her husband also recognized the effects. She describes both the emotional and corporeal effects of the experience.

> Elizabeth It's the first thing my husband brought up; he goes "Well I wonder what we're feeling today?" And ah I was crying pretty bad just because of the news and you know seeing it and then seeing my _____ and then going to the viewing that day. It just drained me; it really drained me.
>
> Elizabeth And it was extremely exhausting.
>
> Elizabeth And so it was hard for me to concentrate on my other clients.
>
> Elizabeth Work, it did get me at work this time. . . I found myself not being able to concentrate very well.

Her exhaustion and potential burnout, due to the emotional and physical exhaustion inherent in working with the crisis, catalyzed additional effects.

> Elizabeth This time I was exhausted I really didn't want to; I didn't really want to do therapy. I really just wanted to get out of here. I still do, I'm still really whooped.

Attempting to maintain attentiveness with all of her clients became more difficult in the immediate aftermath of the crisis

> Elizabeth And so it was hard for me to concentrate on my other clients, and then I had to check on them to see how they were doing, a lot of them weren't doing well. So it was a lot of crisis work with a lot of people.

Adding to her effects, she experienced some traumatic countertransference and flooding of past memories and experiences.

> Elizabeth Yes. So I always felt like if something ever did happen how would we get [away]? You know after you've been attacked before in your life, you can't help but when you go somewhere where you feel like you know, "Oh boy this is kind of a place where you could be trapped."

Becoming Intentional

Already knowing the signs of compassion fatigue, Elizabeth maintained internal awareness through most of the crisis.

> Elizabeth I definitely was experiencing a form of compassion fatigue.

This internal examination also fostered a perceptual change which helped her to become more self-supportive and supportive of her clients.

> Elizabeth Because I found myself, I didn't even realize I was doing it but I was trying to play tough girl again. I thought "Oh I'll reach out in a couple of weeks," but I needed to reach out right away. After doing the CD I realized that I needed to do it right away. Or I wouldn't be able to take on a client.

Elizabeth reached out for support during the crisis and in the aftermath of the crisis. In general she described seeking out other individuals who were not trying to 'tough it out.'

> Elizabeth I just have a moment of I think which I, to me is probably natural, you know, as long as I'm checking in with people, which I have been, not as many as I probably should be but, but again the

community kind of is doing that. So I think we are sort of checking in on each other and so I find myself calming down way more quickly than what I would have in the past for sure.

Elizabeth Yeah, I definitely stay away from those who, when I ask them how they're doing they just don't even flinch,… "I'm fine, nothing's fazing me at all,". . . These are other therapists and they just don't seem to have a whole lot of feeling about it. What I did as a crisis worker that day and then seeing a couple of clients so [another therapist] and I had a chance to sort of download and then [another therapist and I] both shared a little bit about our histories and how that is affecting us as therapists and how we have to keep that in check.

Elizabeth Yeah. I've learned the hard way to put those in place ahead, you know when I need it right away, I have to be very aware with my career, I don't always do it as well on my personal life, but in my career I'm pretty darn good about making sure that I get the support that I need because I've met lots of wonderful people. I don't have a ton that I feel safe with but I have a few and that's enough for me.

She reported being very intentional about seeking and finding healthy support. In a self-supportive move she went to her administrative supervisor to ask for time off.

Elizabeth I'm grateful that I've gotten the confidence to just admit there is nothing shameful about this—compassion fatigue.

Moving from a stance of shame to courage, self-compassion, and self-support was empowering for Elizabeth.

Not only did Elizabeth receive support from her husband, but she determined to take a break in order to visit and reconnect with her family. This determination was its own form of self-support.

In addition, she found other ways to be vigilant about self-support.

Elizabeth Yeah I think it's because we have support at work, in the community, and a lot of times where I work at this place, people don't talk to each other as much. Support staff and us do but the therapists don't. Everyone keeps to themselves more. It's not like

> where I used to work. So a lot more is on your plate, you know you just have to go reach out for yourself, find what you need.

Recognizing she needed to take a step back, she scheduled a vacation. She divulged that this was something she would have not typically done in the past.

> Elizabeth Well I scheduled a vacation for myself . . . and I'm going to be gone the last two weeks of this month and it's my first vacation in a year and a half . . . yeah, it's really good. It's motivated my husband and I both to move forward so I, I'm definitely taking a two week break.

Creating Ongoing Changes

Elizabeth, who had used guided imagery in the past, determined that she needed to use it again in this instance to assist her in processing her emotions.

> Elizabeth But in this instance it helped me release a lot that I was holding in and that's what helped me push through, I think, to ask for help.

The thought from Elizabeth speaks to processing emotions as a way to facilitate reaching out to others and to avoid isolation. Elizabeth also processed her emotions by talking through her experience internally or through non-verbal processing. Her self-talk was a subtle form of self-care by creating an internal environment of self-soothing.

> Elizabeth I slept a lot and then I had to again work on my self-talk, my thought process and really tell myself what I was feeling. I had to do some writing because I had a lot of anger, just overwhelming feeling of emotions. So I just had to write them out and look at them and I had just cried a lot and prayed for strength and then just kind of got out my anger through exercise and through writing.

> Elizabeth I think about it for a few minutes, but then my anxiety goes down and I'm fine but, but then it's always been in the back of my head, I thought "What if that happened? What if it did?" And then you know I move on.

She also took a stance of personal non-judgment about what she could and couldn't do. Her narrative implies setting appropriate boundaries for herself and clients.

Elizabeth When we're in that crisis mode to that level, I mean to be in an E.R as a crisis worker—that was nothing compared to what I felt this time. This was just a flood of people, very different. So I knew I had to give myself time and I think that's when I did the guided imagery that helped me realize you know it's a process you know that and they don't want to hear that, the clients don't right now because that just makes them angry. But I knew I had to tell myself that I'm going to have my good days and not so good days and you know let my client know that "I might not be completely up to par, I might be a little tired for everything." But usually when I tell clients those things they understand and they know I'm human too.

Elizabeth We tend to balance each other out as long as I allow myself to be vulnerable in a good way, not too far but you know at least so that they know why I look so tired. But then I just tell myself the truth, "Yeah it takes time. You know this already so be kind to yourself and let it, let the days just keep going." And as each day goes you know everyone's going to heal a little bit more, a little bit more.

During and following the crisis, Elizabeth has reached out to others to provide support. Hers is a beautiful example of first receiving support and then, in turn, being able to provide support.

Elizabeth But she felt a relief having a place to go where she wasn't going to be judged and she's getting and seeking out quite a bit more help. And for me it felt good just to check in with even just one professional. It felt nice to be able to do that. And then one other coworker, he was kind enough to check in with me to because he ended up getting a couple of clients and he was a little nervous about it. So we both just talked about you know, basically the main things that were bugging us when we were in the room just again being very tired, not being able to concentrate very well.

As Elizabeth implemented the ongoing changes she has already created, including providing support to others, she was able to keep herself protected from the severe effects of compassion fatigue.

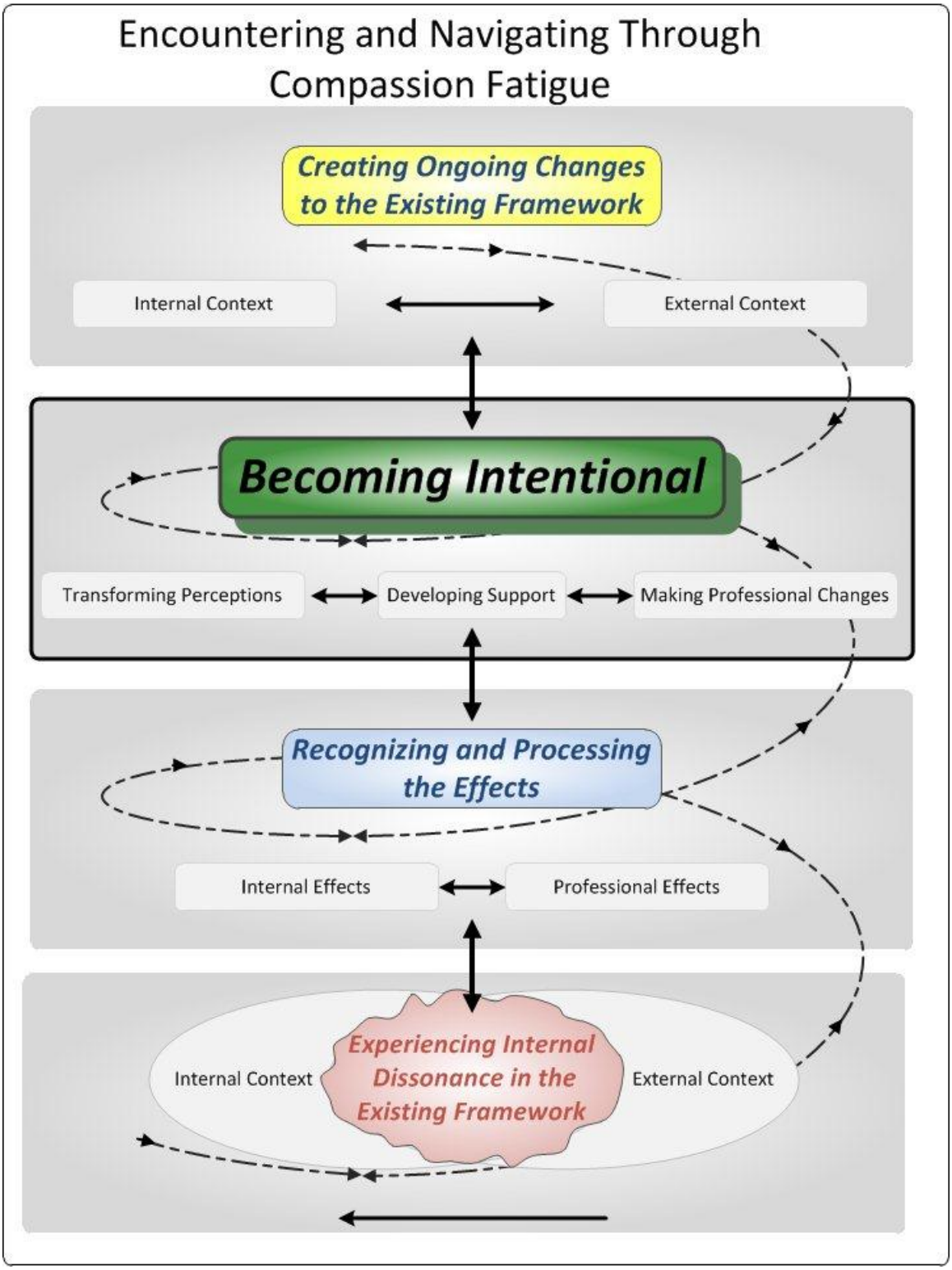
Conclusion

Her story and the stories of the other participants attest to the strength of the human spirit and to the courage of many individuals who work in the mental health

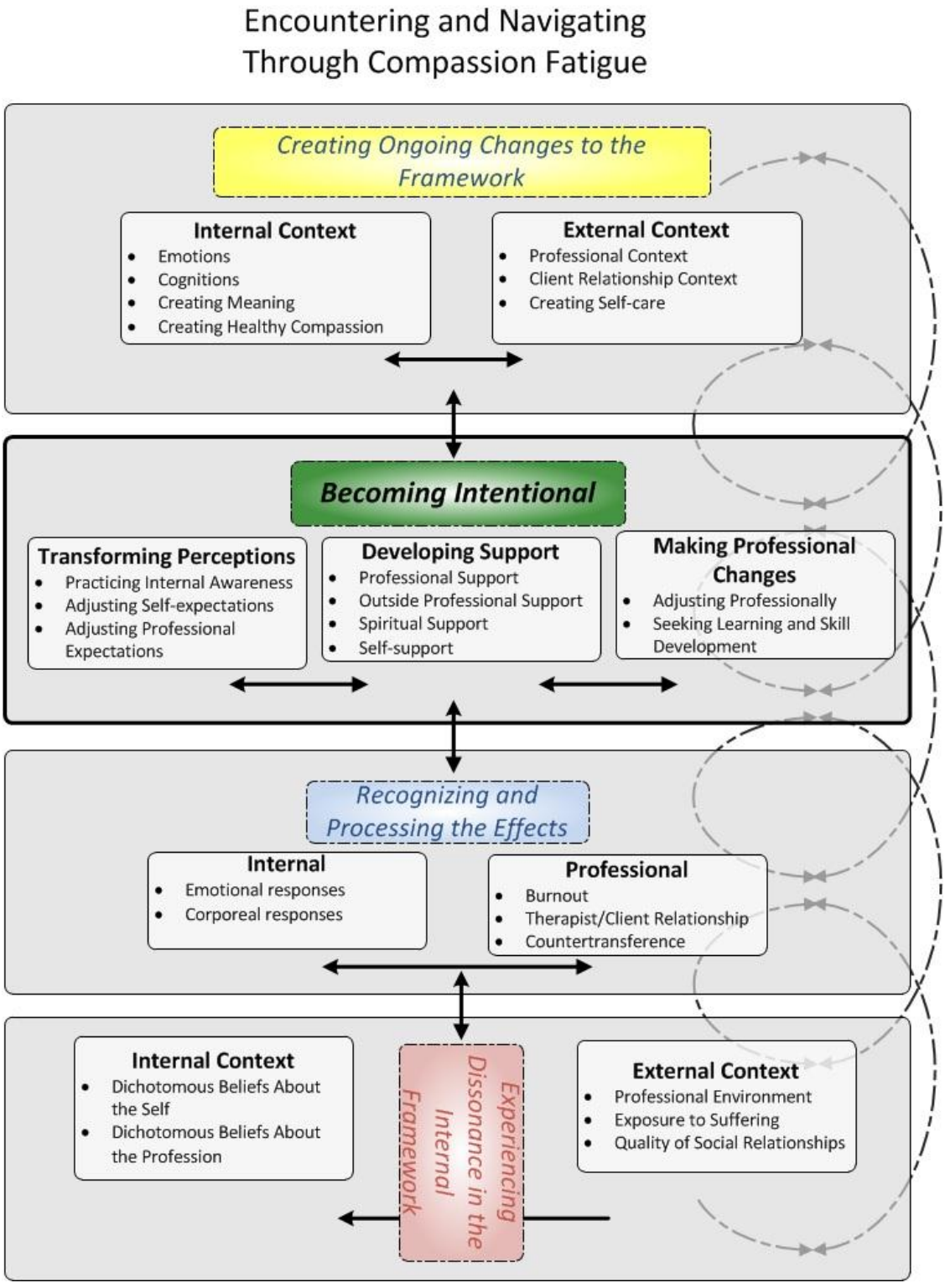
professions. Knowing the humanness of participants' experiences has enlivened the two-dimensionality of an otherwise technical theoretical structure. Attempting to place the experiences of encountering and navigating through compassion fatigue into that structure, while still honoring their experience has been daunting and challenging. Nevertheless, an analysis of their data has rendered the structure in such a way as to, hopefully, give profundity to their experiences.

In that light, the process of each participant's encounter with, and navigation through, compassion fatigue was both unique and similar to other participants' experiences. Those similarities are profound and may provide application to a larger and more universal context. As a result of this distinct, yet universal process, a solid and dimensional theoretical structure has emerged. This structure may be categorized as flexible and individualized because of the dimensionality which exists within the properties of each category and subcategory. The dimensions of those properties, give life to the distinct and unique experiences of each participant.

The participants themselves are the best authority regarding the validity of the structure. This concept emphasizes the role and necessity of member-checking as a form of strengthening reliability and validity to the emerging theory. As such, member checking is the final step in the data analysis.



Appendix G, Figure 10. Round 3 Analysis - Categories and Subcategories – Encountering and Navigating Through Compassion Fatigue



Appendix G, Figure 11. Round 3 Analysis - Comprehensive Categories, Subcategories and Properties – Encountering and Navigating Through Compassion Fatigue

Appendix H

The Experiences of Mental Health Professionals as they Have Encountered and Navigated through Compassion Fatigue

Brief Research Study Summary

This dissertation research has focused on the experiences of licensed mental health professionals as they have encountered and navigated through compassion fatigue. In order to gain greater insight into this phenomenon, I collected data from nine licensed mental health professionals who participated in three rounds of qualitative interviews. These interviews had a semi-structured format using open-ended questions, formulated with the intention of engendering detailed, thick, and rich responses. Each interview was audio-recorded. I transcribed these recordings, reviewing each recording multiple times in order to ensure accuracy of the data. The transcriptions of the interviews were analyzed using grounded theory methodology including open, axial, and selective coding. Additionally, I utilized integrated memoing in order to incorporate both process, symbolic interaction, and nuance into the data analysis. During the progression of the three rounds of interviews, participants were encouraged to deepen and clarify the descriptions of their previous responses in order to reach a point of data saturation regarding their experience.

As a result of the analysis of the first round of interviews, salient themes began to emerge from the data. The themes were chunked and sorted according to categories, subcategories, and properties which were diagrammed into a tentative theoretical structure. The round one interviews served as a basis for the preliminary structure which represented the experiences of the nine participants as they encountered and navigated through compassion fatigue.

The second and third round interview questions were designed to more fully understand both the participants' experiences as well as the internal and external processes which ensued as a result of that experience. Moreover, the questions were aimed at validating and confirming the emerging structure. An analysis of the second round of interviews revealed additional insights which led to a reconceptualization of some categories, subcategories, and properties. Dimensionality of the properties also began to crystallize. Following the second round interview analysis, a solid theoretical structured emerged that revealed the phenomenon in question. The purpose of the third round of interviews was to connect the categories of the theoretical structure together and to both confirm and validate the structure which had developed as a result of the data analysis of the round one and two interviews.

As a result of the analyses of all three rounds of interviews, and through a process of induction, I conceptualized a structure which describes the overall and general experience of the nine participants. Although every participant interview was unique, consistent themes and a ubiquitous process emerged which was reflective of the phenomenon in question. This structure is outlined according to categories, subcategories, and properties (See Figure 1, Diagram: Encountering and Navigating through Compassion Fatigue- specified categories, subcategories, and properties.) The diagrams of the structure are constructed to flow from bottom to top in that the first category of *Experiencing Internal Dissonance* conceptualizes the foundational experience of encountering compassion fatigue. The central category, *Becoming Intentional,* is more pronounced in the diagram and is conceptualized as the fulcrum on which the participants moved from encountering to navigating through compassion fatigue.

Experiencing Internal Dissonance

The first category, *Experiencing Internal Dissonance* refers to participants experiencing an internal disharmony which occurred as a result of the interference/distress associated with encountering compassion fatigue. Interference is classified, in this situation, as a disturbance in the homeostasis of the participant and his or her environment, the existing framework of which would be the self of the therapist. Contributory to that dissonance, all participants affirmed having dichotomous perceptions regarding themselves and/or the mental health profession. These dichotomous beliefs affected participants' sense of self or what may be termed as the self of the therapist. With the self of the therapist in mind, the two subcategories of this category emerged as *internal context* and *external context. Internal context* represents the perceptions of the individual participants. *External context* refers to outside and influential factors which, when interfaced with perceptions, catalyzed the dissonance experienced by participants. This dissonance led to participants experiencing certain effects—the effects associated with encountering compassion fatigue.

Recognizing and Processing the Effects

Based on an analysis of the participants' data, a coalescence of the external context with the internal context or self of the therapist was conceptualized as the foundation for the dissonance and interference participants experienced. In short, this interplay between the internal and external contexts constitutes the underpinning of participants' encounter with compassion fatigue. As a result of the interconnection of the two contexts, participants experienced both internal and professional effects. Moreover, the effects themselves augmented the internal dissonance participants experienced in a linear, concurrent, or circular process of increased distress.

Relative to suffering these effects, at some point, each participant came to a juncture where they began to notice and pay attention to the dissonance they were experiencing. Most participants had to come to a place, internally, where the effects became untenable and could not be ignored. A tipping point occurred where participants began to recognize a need to process and navigate through their dissonance and distress. This phenomenon seemed to occur after participants came to a realization of what was transpiring both inter-psychically and intra-psychically. Describing their experience of encountering compassion fatigue, all the participants recalled feeling internal effects as multiple dimensions of emotional responses and corporeal responses. Additionally, all participants experienced some form of professional effects associated with the dimensions of burnout, issues within the client/therapist relationship, and/or countertransference.

Becoming Intentional

In determining the process of participants' movement from recognizing the effects of encountering compassion fatigue to navigating through and processing the effects, a significant concept emerged during the first two rounds of data analysis. Many participants spoke of their initial experience as feeling acted upon or having less control of their circumstances versus taking action or regaining control of their circumstances. All participants affirmed that along a dimension or continuum of experience, they became intentional. In general, this intentionality took the form of purposeful action, or purposefully allowing or accepting. Indeed some participants moved forward and others stepped back. Whether through taking action or purposefully accepting and allowing, as participants became intentional through transforming perceptions, developing support,

and/or making professional changes, they began to take back control of their circumstances. Thus, participants were able to modulate the effects of the dissonance they had previously experienced. This attenuation was an ongoing process which some participants described as linear, concurrent, or spiraling back and forth or up and down. Over time, participants gained both resilience and a more balanced sense of healthy compassion.

Creating Ongoing Changes to the Framework

As participants processed through the disturbance of encountering and navigating through compassion fatigue, they made initial changes through purposeful action or purposefully surrendering to the process. This occurred as they intentionally made changes internally and professionally. In becoming intentional, participants were able to change their existing framework—namely, their *internal context* and *external context.* In other words, the participants' framework remained similar to the framework in which they had experienced the dissonance and interference of compassion fatigue. However, now they were experiencing and making changes within that framework which resulted in a different outcome—a more balanced response to navigating through compassion fatigue. Moreover, participants moved to a more harmonious internal context and an amelioration, reconciliation, or acceptance of the personal and professional dichotomous feelings they had previously experienced.

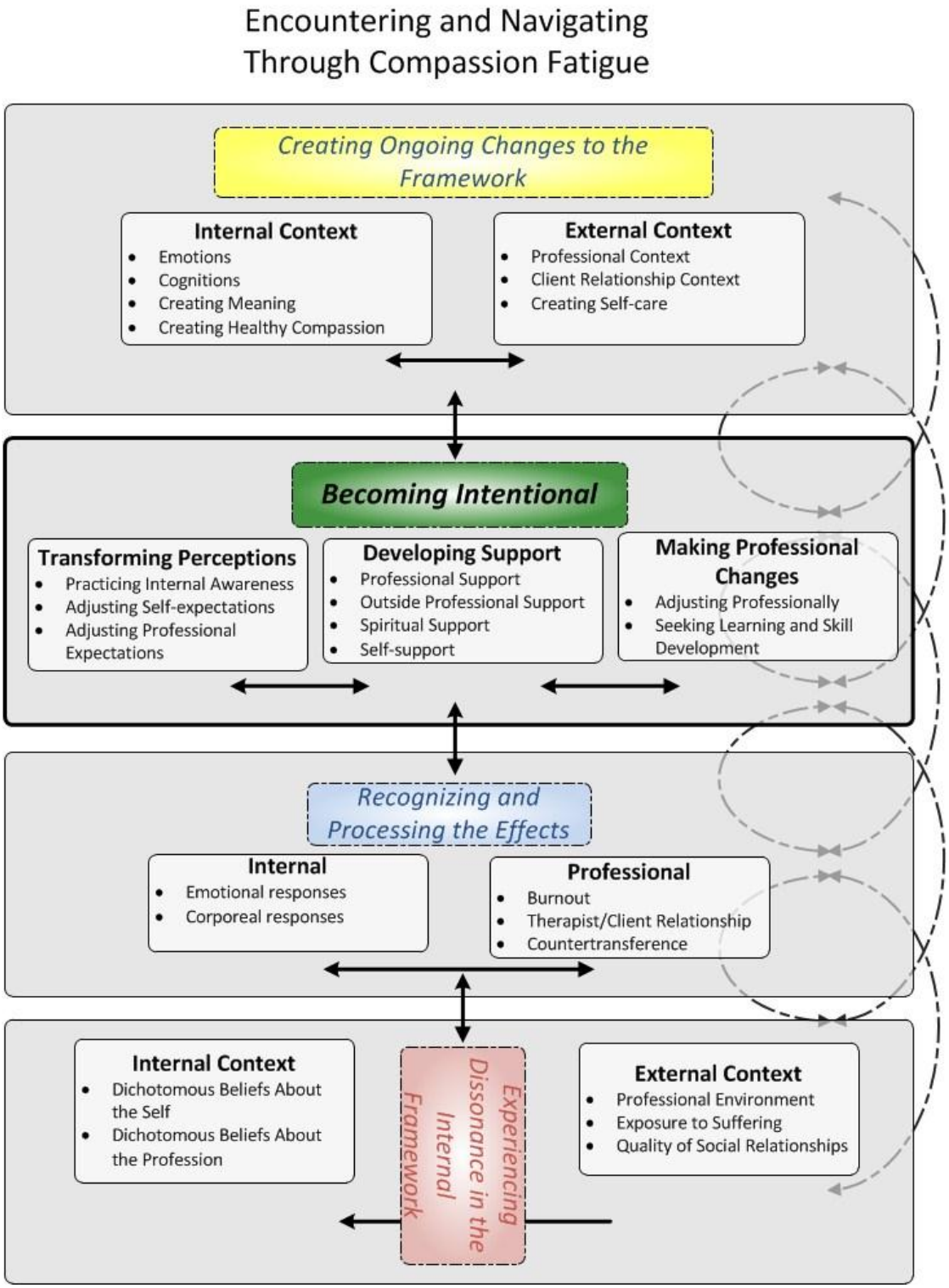
Participants were able to maintain these changes by processing their emotions and improving their self-cognitions. Participants noticed that they were able to work towards resilience, over time, as a process of building upon past experiences and continual skill

building. Viewing the dissonance they had previously experienced as a growth experience also rendered a long-term tempering of effects.

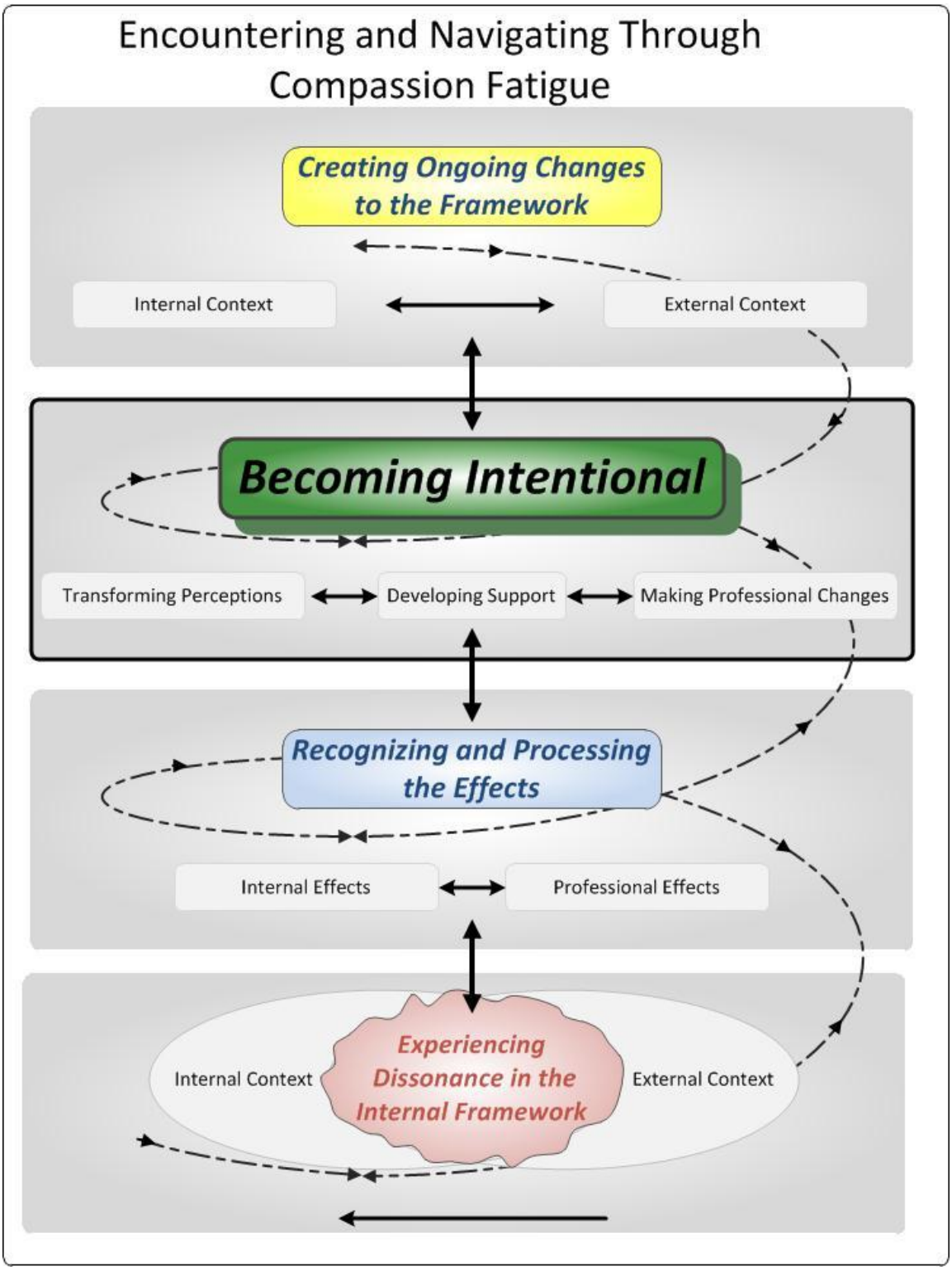
Some participants have been able to maintain changes in their external context through becoming supportive of other professionals and creating healthier boundaries with clients while separating themselves from clinical outcomes. In addition, participants have also developed self-care strategies which include practicing creative activities outside of the profession. Others have found value in inoculating themselves against compassion fatigue by spending time with family and friends.

Conclusion

The process of each participant's encounter with, and navigation through, compassion fatigue was both unique and similar to other participants' experiences. As a result of this distinct, yet universal process, a solid and dimensional theoretical structure has emerged. This structure may be categorized as flexible and individualized because of the dimensionality which exists within the properties of each category and subcategory. Also, the structure may be categorized as solid because of the similarities of participants' narratives in the context of the overall theoretical structure. Finally, in explicating the participants' experiences within the context of grounded theory, the data collected in all three rounds of interviews suggests a process of encountering and navigating through compassion fatigue in which the experience, as explicated by the structure, may be elucidated as linear, concurrent, or circular depending upon the individual participants' account. (See Figure 2, Diagram: Encountering and Navigating through Compassion Fatigue).



Appendix H, Figure 1. Diagram: Encountering and Navigating through Compassion Fatigue- Categories: color; Subcategories: bold; Properties: regular font



Appendix H, Figure 2. Diagram: Encountering and Navigating through Compassion Fatigue. Two-directional spiral and arrows represent linear, concurrent, and circular nature of the theoretical structure.

Appendix I

Member Checking

Member checking is one of the sequential steps used in grounded theory methodology. In order to increase and enhance both credibility and validity, I utilized member checking as part of the final stage of my analyses. The member checking interview was the fourth and final interview following the third round analysis. In generating member checking, my objective was to validate the theoretical structure which had developed as a result of the first three rounds of interviews and analyses.

My desire was to first, establish the accuracy of the data which I had collected from the participants, and second, to confirm the accuracy of the emergent theory relative to the participants' individual experiences. The theoretical structure, including a description of categories, subcategories, properties, and dimensions was briefly summarized with attached diagrams of the structure. The summary and diagrams were emailed to each participant along with a request for each participant to consider the following questions:

1. Does the summary, in general, accurately capture your experience of encountering and navigating through compassion fatigue?
2. How do your experiences correspond to the categories, subcategories, and properties? (Where do you see yourself and your experience in the structure?)
3. Do you feel that the diagrams capture your experience of encountering and navigating through compassion fatigue?
4. In the summary or the diagrams, was there any part of your experience that you considered significant that was not mentioned?

All of the participants had been informed regarding the member checking interview during the entire process of study recruitment and the three rounds of

participant interviews. In my communication with them, I encouraged them to review the summary and diagrams prior to the member checking interview. All nine participants were individually part of the member checking process and provided feedback based on the emailed questions as well as other questions which arose during each of the interviews. I also provided them an opportunity to ask any questions they might have regarding the study. The following participant responses to each question are listed below:

Question #1: Does the summary, in general, accurately capture your experience of encountering and navigating through compassion fatigue?

Mary	Yes definitely. There were a lot of places where I thought that. I thought the whole study was pretty much applicable to me . . . that's great you did a good job with that.
Roxy	Yes, you've done a good job. I feel it's pretty broad, but I think with all the different experiences you've had to incorporate into one kind of framework, it would have to be broad, but going through it I see my process in there. I don't know if I would have thought of it this way, but it definitely works, so yeah. I think you did a good job.
Jane	Yeah. I could tell, definitely could tell the parts that you and I had talked about from your summary . . . Specifically when you talked about how you defined the internal and the external and all of that. It made a lot of sense . . . You made your claim that the external and internal caused dissonance and that it was important to process and become intentional. Sort of ongoing. I thought that the summary really captured it well. I could understand it for how it applied to me.
Jennifer	Yes. I'm really impressed. Talking about it with you, it's sort of all these different elements all over, but looking it over it's really consolidated and kind of pinpointed them really well . . .

Absolutely, I just want to say, yes, yes, yes as I look at all the different elements.

Andrew — I read it and said "yeah, yeah" that makes sense to me . . . the actual narrative summary and my responses are consistent. I felt that sounds really good, I like that.

Phil — Yes . . . I like how you said and talked about how the process was very similar with everybody that you interviewed, but it was still very individual. Some of it was linear and some of it was spiral type thing, if I'm using your wording correctly.

Elizabeth — Yea. You did an amazing job of being able to transfer our emotional conversation in words that we exchanged, into such a theoretical summary and it still captures the moment.

I had to read it two times because I struggle with the theoretical stuff and at first I thought, phew this is heavy, but then as I read it through a second time, I could remember the emotions and I connected with all that theory emotionally. I could feel it.

John — It was really good. I thought it did.

A.J. — It comes close.

Prior to responding to the first question, A.J. discussed the categories at length. Her protracted response to the first question is coalesced into her response to the second question. All participants' responses to the second question are listed below.

Question #2: How do your experiences correspond to the categories, subcategories, and properties? (Where do you see yourself and your experience in the structure?)

Jane — Yeah, when we talked when you interviewed me before and you were in and out of these things, I think I expressed that my energy gets tapped out and that I have to learn from experience. I felt like you continue to grow and become more aware of when you're getting into burnout a lot quicker. You get further down the road of

your career. You adjust a lot quicker, so I just kind of see myself, I mean, this week when you go into overload, it can have a lot of external things that create more dissonance in your work from personal life and all those kinds of things that play a role in burnout. So you can't just completely separate everything out.

(Researcher: So, actually, the interface of those two [internal and external contexts] spoke to you?)

Yes.

Jennifer I think they correlate really well with my own experience. I've been really impressed. I've had several incidents that have really been difficult lately and these are exactly the things I'm doing to help manage them. I like it because we even talked about in our last staff meeting about all of us feeling the need for more support from each other and how we can do that and with your permission, I would love to share this with them.

Jennifer For me, a lot of times when I think about stuff and talk about it, it's sort of like all these little pieces out there and you pulled them together in a really nice structure that makes it nice to come back and refer to and go, ok if I'm . . . I can kind of go through it, whereas the quality of my relationships, kind of go, "How am I feeling? Am I feeling burned out, or feel supported and then what do I need to do, how can I become intentional? Oh yeah, I need to go back look at my spiritual support, professional support. Do I need to staff it with colleagues, do I need to get more balance in my life and not work as much?" And really become more aware of the things I need to change. "Have I crossed lines?" Things like that. Really being more mindful and just need to recapture that process of really trying to regain balance. It's all there.

Andrew Of course not all the bullets relate to my experience, but most of them do. I like the flow of the intentionality part and doing something about it. I mean compassion fatigue. I think it's pretty well, just my overall reaction response looking through it was consistent. Nothing obvious, especially if it's something that I went through . . . But nothing kind of stuck out in that way like that wasn't me at all the other people must be whatever. So it actually felt pretty good.

Andrew I'm following you on the diagram here and it's nice to kind of see how all that fits, yeah I think those are a lot of highlights.

Phil It does fit what I experienced.

That's the main thing that hit and seemed to make sense for me . . . Recognizing and becoming intentional especially as well as how you describe how recognition came, the different types of thinking or behaviors that came from it and recognizing and becoming intentional and then moving on through the dissonance, experiencing dissonance.

Roxy Most of the stuff on here, yes, I've experienced . . . Yes . . . Reading the bullet points underneath, I think that all of them fit my experience.

John I like the way, the idea of the dichotomy, even though it's not something that you're usually aware of, sort of dichotomy going on about confidence in the profession. What you should be able to accomplish or shouldn't. There is sort of a breakdown in that or some kind of, discord or dissonance, but it gives you something to work through. Sort of an empathic resonance that all of a sudden there's dissonance, so just a sense where there used to be connection and flow, all of a sudden it's jarring. I don't think even calling it a crisis is too strong of a word because even though you're not running around calling 911, you're definitely sort of at the end of a path that you don't really see how its' going to go forward, but you know it's untenable to continue as is. It's dissonance and it's a crisis . . . it was kind of academic portrayal. At the same time, it seemed like a bird's eye view of the process when you're looking at it from the overall pattern and trying to encapsulate it. That process, it was helpful to be able to stand back and look at the way the process went and see it was something that happened for other people too and that there's a common path which leads to some kind of resolution and peace. I thought it very well captured it. While I was probably still in the process of working through the compassion fatigue when we were talking, talking with you helped me get through that process.

John I think I probably tried to outrun compassion fatigue early in my career by learning more and always having a new passion. If a client's issue is discouraging, you have to accept that because I have this new thing to learn that is helping other clients today that's exciting and keep that interest level up. I sort of reached a level where that didn't work anymore; it came to a point of crisis.

Yeah, and the category that talked about easing off, I did think that one was definitely characteristic of what I experienced. I saw myself in those other categories too.

Elizabeth It all flows. From what I've looked at two times now and after you broke it down, it sure makes sense to me. It sure seems like the direction that I would go and have gone. I feel like you covered that well.

I can balance myself out in those three categories and there could be another one in there. But that's what's coming to me at the moment.

(Researcher: Do you mean the first three overall categories in the structure?)

Yes. Again, for me, I feel the triggers. I feel them going on. When I feel something coming on, I seek out help and become intentional. My own type of 9-1-1 without being that dangerous. It's just more of I get that universal distress signal myself, but for me, usually I can find a way to get help whether it's through support or through learning or whether . . . I have to fill one of those categories, and if I can't, that's when I'm sure I go bad.

Elizabeth *(Researcher: You've talked about how your experiences correspond to the categories, subcategories, and properties in the first three categories, how about the category of creating ongoing changes?)*

Yes, I see myself in all of that. Definitely.

Mary I think I became intentional and recognized the problem . . . and processing the effects. And I had to deal with experiencing the

> dissonance and the internal framework and on dissonance you mean actually . . . explain what you mean by dissonance.
>
> *(Researcher: That would be a lack of homeostasis. Feeling like something's not quite right. Like there is a conflict or lack of harmony internally that causes a disturbance or distress)*
>
> Ok, I have already been through all of that. I would say that I felt, I felt that the dissonance reached a point where I was very distressed and that I reached the point where I had a crisis.

Mary asked me then to re-summarize the structure. Following that verbal summary, she asked me to clarify the subcategory of *developing support*, and the properties *of providing support* and *processing emotions.* Following that clarification and explanation, I asked her if the specific components of the structure fit for her and her experience. She offered the following response:

> Mary Yes it does. Well, you've done a great job. You certainly have. I know I am very grateful to you because you helped me have some awareness through all of this.

A.J.'s response to the first and second questions developed into a lengthy discussion of how she saw herself within the subcategories and properties of the structure, particularly in the first two categories. Her response to both questions ended with the following exchange.

> A.J. *(Researcher: So if we go back to the original question, does the summary accurately captures your experience if you take into consideration the wide dialectic that exists in the emotional effects from numbness clear to hyper-arousal.)*
>
> That's right. Yes, yes . . . I think you've got it.

Question #3: Do you feel that the diagrams capture your experience of encountering and navigating through compassion fatigue?

Mary Yes, I do.

Roxy Uh, huh. I do think the general fit works. It helps to have your explanation because some of your terms are pretty generic like internal context or external context, but looking at it more closely and going over it, it does fit.

A.J. Yes. I actually thought your diagrams were really helpful and good.

Jane If I'm just looking at the diagram alone, I wouldn't be able to necessarily understand the process but after I read the summary first, it then made total sense to me. I think anybody that reads this paper or looks at it for its value will be able to do that.

Jennifer Yes, yes they do. I think the spiral one that's simpler, the less detailed one, I think is more eye-catching because of the colors and the visuals that you put in there, but I actually prefer the specific one because it breaks it down into smaller pieces.

Andrew I think you're right on track.

Phil Yes they do.

Elizabeth Yeah, definitely. . . . Obviously, it is circular and you do go in and out, so to me it flows.

John I thought the diagrams were cool. I thought they were a very good visual representation of the process.

Question #4: In the summary or the diagrams, was there any part of your experience that you considered significant that was not mentioned?

Mary No, I think you covered them by explaining the emotions and letting me talk about balance and crisis and things like that. I think you covered them.

Roxy I don't think so. It was all in there . . . You've done a good job.

A.J.	I really loved your work and I thought, gosh, I can really see this diagram being very useful in explaining it. What I would put, there's like a little vertical arrow in between the experiencing dissonance in the internal framework and the next box, recognizing and processing the effects. And that little arrow is right where I would put crisis. It kind of, that's the transitional point that fuels people, gives them momentum into that next box where they go when they say what's going on here. Otherwise, they just kind of stay in this other place. But there really is this feeling of crisis.
Jane	I don't think so. I was really paying attention. It really does capture my experience. I just like the way that you did it, very much.
Jennifer	This really rings true . . . I cannot see anything that I would add or feel that was left out. I think it covered and is really comprehensive.
Andrew	I like it. I'm impressed by the whole thing. . .you had a lot of stuff to go through. Even just for one person you had a ton of stuff and all together for several people, that's quite an accomplishment.
Phil	There is nothing left out.
Elizabeth	Nothing has popped out to me like oh, that doesn't flow or oh that doesn't make sense to me. It applies to me. I'm just making sure. The tipping point was the only thing I wanted to make sure that I was understanding it. *(Researcher: The tipping point is where you come to a point where you say, I have to take action.)* Right. What we just talked about. It flows to me. Yes. I think it's great. I think it's excellent.
John	No, I don't think so. You did a great job with it.

Deepening Understanding of the First Two Categories

The member checking interview served as a valuable tool in the analysis process, deepening and crystallizing an understanding of the specifics and the connections of the first two categories in the structure, relative to participants' experiences. Several participants commented on the classification of the first category as *EXPERIENCING INTERNAL DISSONANCE.* While some participants described that they felt a subtle and nuanced dissonance, others emphasized that this dissonance escalated into a much greater feeling of distress or crisis. A.J. described this escalation in an exchange characterized in the following excerpt of data:

> A.J. Really what it is, is a kind of existential despair people feel. It's a loss, it's a vacuum, it's a terrible abyss that they go into. So I don't think dissonance quite sums it up. It starts there, but it goes into such an overwhelming place that it really is an existential crisis or despair that leaves people feeling completely overwhelmed and lost. And disconnected from anything. So it isn't like, hey the world's not matching up with this, like cognitive dissonance usually suggests. It really is like a black hole . . . As a mental health professional, we have a hard time fessing up to that and describing that. In my existential despair I didn't happen to feel suicidal, but I think many people could . . . Because I think it's kind of starts out with the dissonance, but then it gets more serious. You have this sensing of alone and isolated and having an experience that no one else can understand or no one else has ever experienced. Partly because if you're a helping professional, unless you've got supportive colleagues around, your family isn't going to understand. We're taught because of confidentialities to not share details with others. So the isolation is really a big part of that. I think it does make people feel very empty. I guess that emptiness is the thing I didn't know where in your model it was captured, but it felt like you have the dissonance, then you have a terrible void of being alone and feeling that anything you dedicated your life to is gone. There is personal purpose and then there is this terrible abyss.

(Researcher: . . . The triggers of your own suffering and clients' suffering or your professional environment or problems with outside relationships. So all of that hits the beliefs about yourself and beliefs about the profession and this feeling of I'm gifted, I know I can help, but then those triggers come in. The tough part is not just the dissonance, the tough part is also the effects.)

Yes, that makes sense.

(Researcher: Why does it make sense in light of your experience?)

It makes sense that's where you kind of go in and feel the abyss. It's really that feeling like you have a unique experience you cannot share with anyone and you're completely isolated. And it's so overwhelming that it is really a place of severe distress . . . Well, it's a dialectic really. It's a high, high severe emotional distress, yet no specific emotion that can be expressed.

(Researcher: Perfect. So what you've just said, the dimensionality of all the properties, including the property of emotions, is the dialectic . . . Emotions is such an innocuous word, but when you think of it in terms of the dialectic or the range from one end of the spectrum to the other, that is encompassed in the dialectic (dimension).

Yes, exactly. . .it is really those extremes of emptiness, numbness, inability to find any connections with others. Feeling nothing and at the same time then on the other hand being in great distress.

Similar to A.J., Mary, Phil and John expressed that their dissonance upsurged to a point of crisis.

Mary I would say that I felt, I felt that the dissonance reached a point where I was very distressed and that I reached the point where I had a crisis.

(*Researcher: Where do you feel like that sense of crisis fits for you?)*

Well, when I started losing my modalities and couldn't remember.

(Researcher: So, if you look at the structure, where do you see the point where you reached a crisis?)

Somewhere around processing the effects.

Phil It does fit what I experienced. The word dissonance is maybe a little too clinical.

(Researcher: What word would you use?)

I mean, I know if I were just to get away from the clinical side, I would say, like I felt completely divided. . .just division. . . .I can explain what I felt. . .it felt like a downright crisis. That sense of crisis and loss of identity and lack of capacity that I believed I had to continue doing this kind of stuff.

(Researcher: Yeah. Mmm. So crisis . . . so, if dissonance was defined as like a tension which came from a combination or maybe even a conflict between two disharmonious or unsuitable aspects or dimensions of your experience, would that fit?)

Yes. I can see that.

(Researcher: So, if somehow I was able to also reflect that your dissonance escalated to crisis in the structure, would the structure feel more definitively close to your experience?)

Yes it would. Crisis is representative of what I went through.

(Researcher: So as you take a look, based on what we've just said, does that speak to your experience in relation to the structure.)

Yes, definitely.

John There is sort of a breakdown in that or some kind of, discord or dissonance, but it gives you something to work through. Sort of an empathic resonance that all of a sudden there's dissonance, so just a sense where there used to be connection and flow, all of a sudden it's jarring. I don't think even calling it a crisis is too strong of a

word because even though you're not running around calling 911, you're definitely sort of at the end of a path that you don't really see how its' going to go forward, but you know it's untenable to continue as is. It's dissonance and it's a crisis.

Elizabeth and Roxy also spoke of the dimension of *EXPERIENCING INTERNAL DISSONANCE* escalating to an internal crisis:

Elizabeth Any time you're a crisis worker or helping someone in crisis, you definitely know that you have to, like an airplane, you've got to usually you give the oxygen to the other person and then you give it to yourself, but in that case, I have to give it to myself or I can't help the other person.

(Researcher: Do you have to give it to yourself because you recognize you're in crisis in some respects too?)

Exactly, and I have to snap myself back to where I need to be. If I feel like I'm choking, I have to do something to keep myself from choking. If it gets too far, I have to ask for help. I try not to have a reaction in front of a client.

(Researcher: Right.)

Not that I'm not compassionate, I mean an overreaction.

(Researcher: Right. Can you see based on what you experienced after the [crisis incident in your hometown], can you see yourself in this whole structure?)

From what I've looked at two times now and after you broke it down, it sure makes sense to me. It sure seems like the direction that I would go and have gone.

(Researcher: Ok. Great.)

I feel like you covered that well. We talked about the trauma exposure to the client or the self. To me, you can be in a crisis when you least expect it, not because you've going into the fire, but because someone says something.

(Researcher: So true. In terms of the research maybe the spiral helps to speak to that?)

In that case, I think you've shown that crisis of CF precedes the recognition and processing the effects of CF.

Roxy *(Researcher: So, in light of what we've talked about, does experiencing internal dissonance fit for you?)*

Yeah, for sure. But I also felt distress. My crisis was when I went to talk to my boss about needing to take some time off for some self-care, and having him tell me that that wasn't an option for me and feeling like, I was in the process basically, of recognizing and processing and trying to become intentional and when it felt like that avenue was cut off for me to do that, it was a huge crisis. Even before that, sitting in a session and realizing that I was just watching the clock and dying for 45 minutes. That for me was like the internal crises, like 'I'm not ok here anymore. Something needs to be done and I need to act right away," and it was just really, really hard when I went to my boss and got that response from him. I remember I felt like I wanted to quit that very night and just crying on the way home and thinking, 'I can't do this anymore.'

Roxy's response speaks to the conceptualization of the structure, mirrored in the responses from participants indicating that the phenomena related to subcategories, properties and dimensions may also be experienced, re-experienced, and even concurrently experienced. Phil summed up this idea in suggesting that the category of *CREATING ONGOING CHANGES* is indicative of the spiral nature of navigating through compassion fatigue.

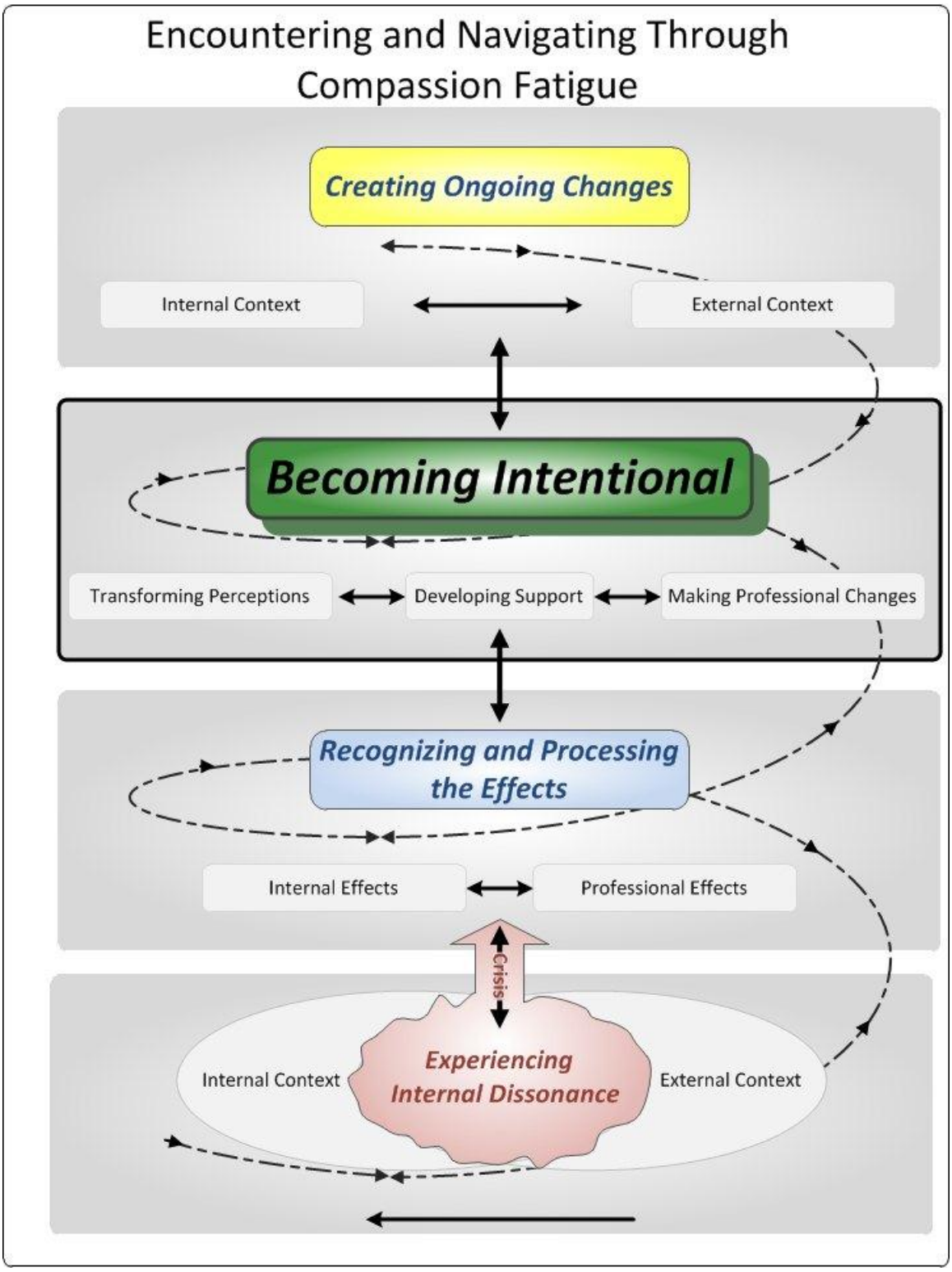
Phil The one thing I would add is the process is still ongoing. Even there is more external changes that I'm going to be doing in the near future as well. More stuff I'm learning about myself and more limits as well as more things I need to do to maintain myself emotionally and mentally and everything. It's still going to be ongoing for some time.

> *(Researcher: I think that's good. That's why I have made the category at the top of the diagram, ongoing changes. So you're pleased with the structure, you feel that it fits for you and your experience?)*
>
> Yes. And definitely I appreciated how you put for some it was linear and for some it was spiral. In my case it was very spiral sometimes. Very spiral. I would even get stuck in some spots for some time. Especially when I got stuck in that burnout where I was just like well I'm being, you wrote down in the summary and I liked it, the term acted upon. That's something that's still kind of a dissonance. I still experience that to some extent, but probably not to the extent I did before. Where before I would just go, "I'm just stuck." Now I say, "Well bag this, I'm done with this. I'm going to do something else and see." Behaviorally it's there, but internally the struggle is still there. Maybe not to the same extent, but definitely identifiable.

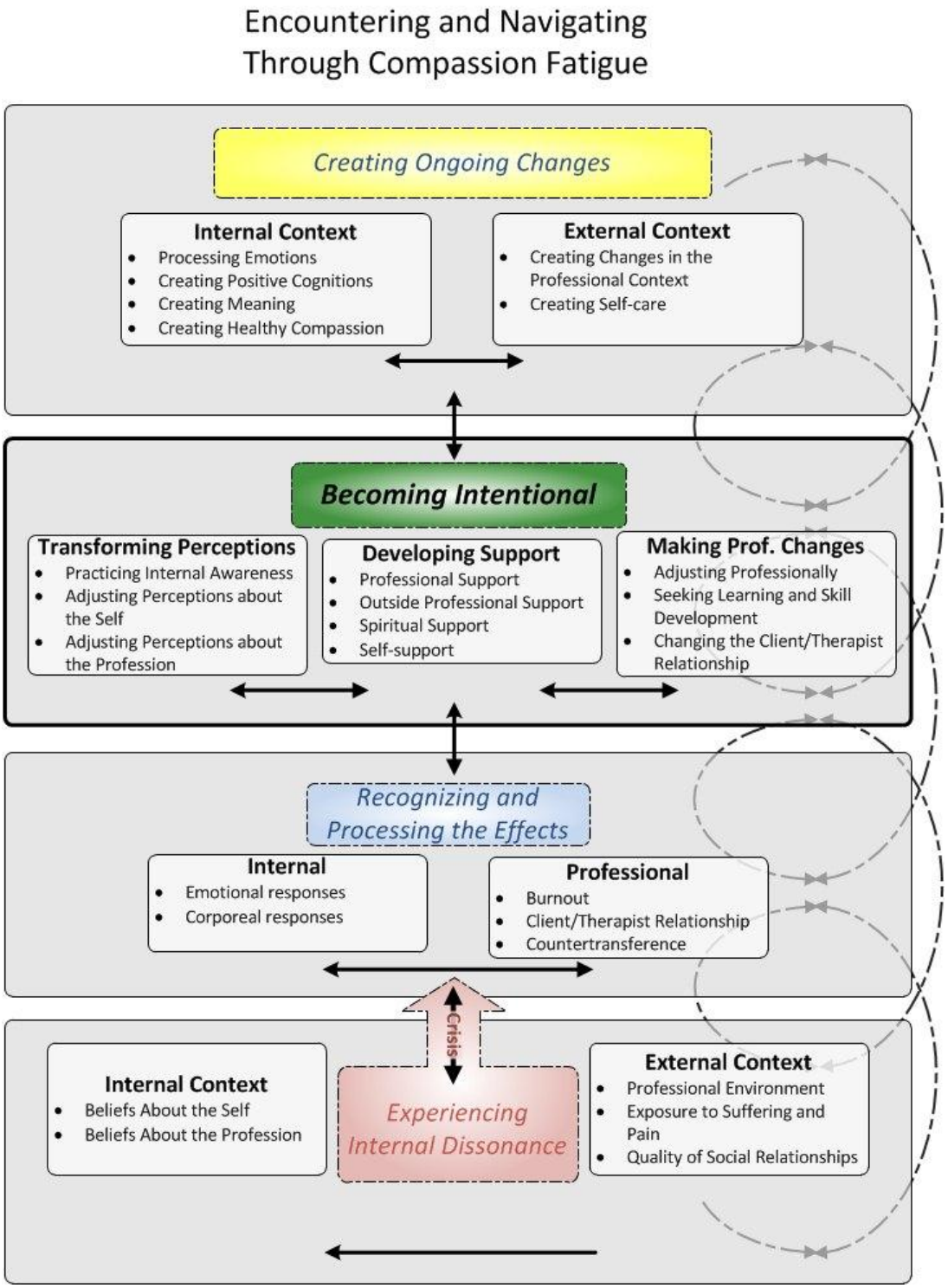
Conclusion

In light of the data provided by the participants during the member checking process, the dimensions of the category *EXPERIENCING INTERNAL DISSONANCE* may be conceptualized as participants' experiencing dissonance which may have remained both subtle and nuanced or may have escalated to a dissonant state of either distress, crisis, or both. Moreover, that dissonance/distress/crisis/ led participants to a point where they began to recognize and process the effects. Thus, the escalation of the dissonance rose to a point of awareness and recognition. Understanding this escalation deepens an understanding of the connection between the first two categories of *EXPERIENCING INTERNAL DISSONANCE* AND *RECOGNIZING AND PROCESSING THE EFFECTS* more explicitly. The attached diagrams reflect the dimensionality and the connection discussed (Figures 1 and 2). Moreover, understanding the escalated nature of

participants' dissonance points to participants' *BECOMING INTENTIONAL* as a means to mitigate the dissonance, distress, or crisis.



Appendix I, Figure 1. Final Categories and Subcategories – Encountering and Navigating through Compassion Fatigue



Appendix I, Figure 2. Comprehensive Categories, Subcategories and Properties Final – Encountering and Navigating Through Compassion Fatigue

Appendix J

Final Data Analysis Outline

Outline of categories – Subcategories – Properties – and Dimensions

Categories are in CAPITALS

Subcategories are in **bold**

Properties are in normal font

Dimensions are *italicized*

I. EXPERIENCING INTERNAL DISSONANCE (escalating to crisis)

A. Internal context

1. Beliefs about the self (*gifted/ extra compassionate/ empathic; vulnerable/weak/inadequate*
2. Beliefs about the profession (*idealistic; cynical)*

B. External context

1. Professional environment *(self-expectations; systemic expectations)*
2. Exposure to suffering and pain*(personal suffering; client suffering)*
3. Quality of social relationships (*functional; dysfunctional)*

II. RECOGNIZING AND PROCESSING THE EFFECTS

A. Internal Effects

1. Emotional Responses (*extreme isolation/avoidance; extreme hyper-arousal/hyper-vigilance)*
2. Corporeal Responses *(cognitive functioning; physical functioning)*

B. Professional Effects

1. Burnout (*high disruption; low disruption)*
2. Client/Therapist Relationship (*over-invested; dis-engaged)*
3. Countertransference *(affected; unaffected)*

III. BECOMING INTENTIONAL (Central/Fulcrum Category)

A. Transforming Perceptions

1. Practicing Internal Awareness (*becoming attuned to the signs of compassion fatigue; becoming aware of the cyclical nature of compassion fatigue)*
2. Adjusting Perceptions about the Self (*purposeful movement towards resolution; purposeful allowing and acceptance)*
3. Adjusting Perceptions about the Profession (*purposeful action; purposeful acceptance)*

B. Developing Support

1. Professional Support *(supportive; toxic)*
2. Outside Support *(supportive; unsupportive)*
3. Spiritual Support *(emphasis; non-emphasis)*
4. Self-Support *(allowing for time and space; pressured self-expectations)*

C. Making Professional Changes

1. Adjusting Professionally (*moving forward; stepping back)*
2. Seeking Learning and Skill Development (*moving towards; easing off)*
3. Changing the Client/Therapist Relationship *(creating boundaries; separating from outcomes)*

IV. CREATING ONGOING CHANGES

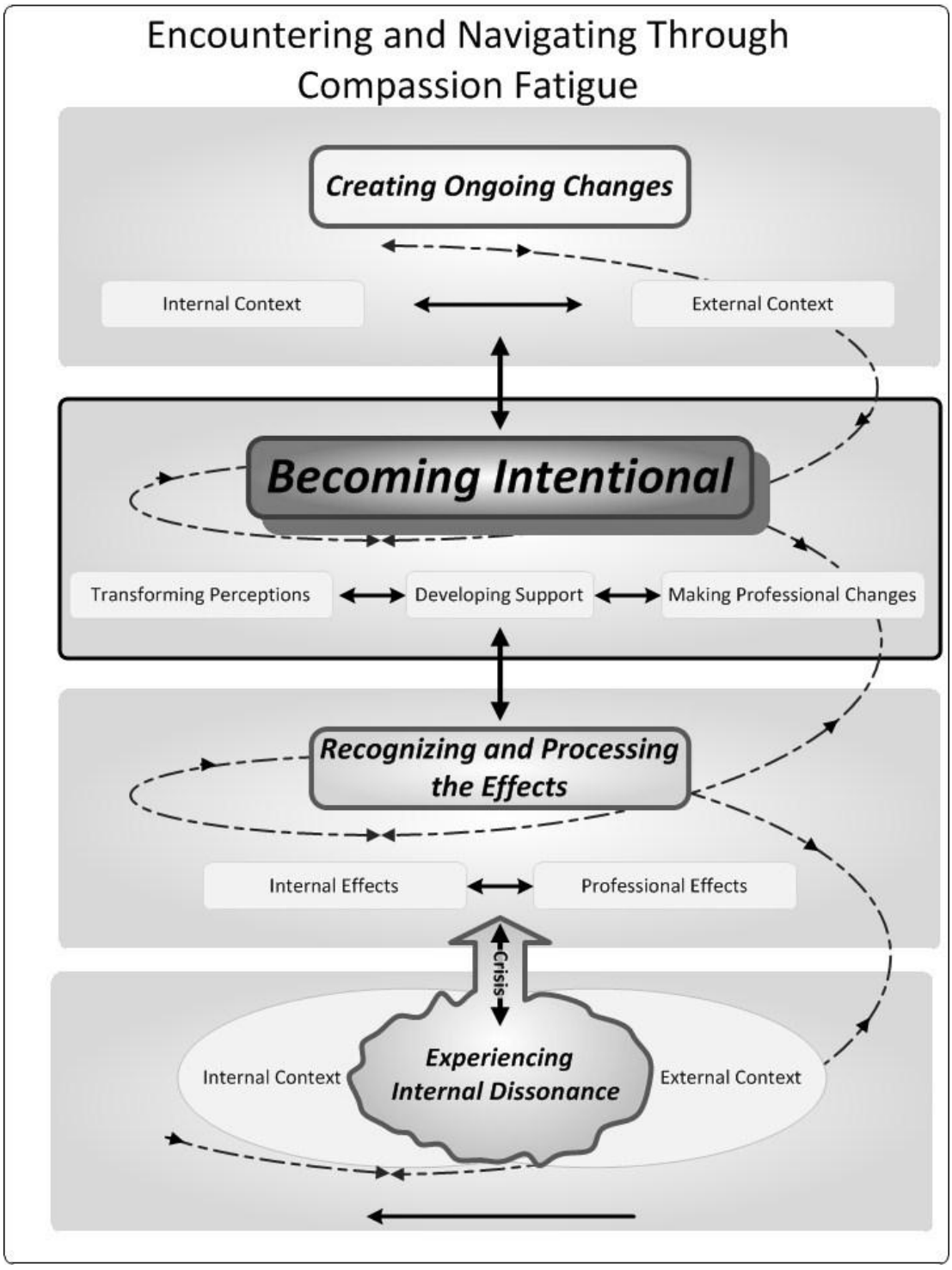
A. Internal Context

1. Processing Emotions *(verbal processing; non-verbal processing)*

2. Creating Positive Cognitions *(positive self-talk; a stance of personal non-judgment)*
3. Creating Meaning (*positioning self in a larger context; looking for growth)*
4. Creating Healthy Compassion *(resilience; vulnerability/fragility)*

B. External Context

1. Creating Changes in the Professional Context *(providing support; avoiding systemic compassion fatigue*)
2. Creating Self-care (*active; abeyant)*



Appendix J, Figure 1. Final Diagram in Greyscale