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Social Work Master's Clinical Research Papers

School of Social Work

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2016

# Compassion Fatigue and Compassion Satisfaction among Professionals Working With Survivors of Sex Trafficking

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## Recommended Citation

Goettl, Nicole, "Compassion Fatigue and Compassion Satisfaction among Professionals Working With Survivors of Sex Trafficking" (2016). *Social Work Master's Clinical Research Papers*. 568.  
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Compassion Fatigue and Compassion Satisfaction among Professionals Working  
With Survivors of Sex Trafficking

by

Nicole Goettl, B.S.

MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work St. Catherine University and the  
University of St. Thomas St. Paul, Minnesota in Partial fulfillment of the Requirements for the  
Degree of Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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According to The Victims of Trafficking and Violence Protection Act of 2000 (PL 136-386), sex trafficking can be defined as “the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” (Section 103.8b). The act explains recruitment for trafficking often focuses on women or girls who are vulnerable due to poverty or lack of growth opportunity and often involves force or coercion, including false promises of economic opportunity (PL 136-386, Section 102.4, 2000).

Trafficking comes in multiple forms, in multiple locations. What the Polaris Project refers to as “street trafficking” is what was in the past referred to as prostitution in which women are expected to make a specific amount of money per shift to be given to the “pimp” (Polaris Project, n.d). Street prostitution is only one form of trafficking, other forms include escort services, night clubs, rent for hour hotel rooms, homes in hard to find locations, etc. (Raymond, & Hughes, 2001).

Women end up as victims of sex trafficking through a variety of ways including, but not limited to, kidnappings, being sold by family members, or by willingly entering trafficking due to false promises of a better future (Reiger, 2007). Traffickers often prey on people who are vulnerable. In fact internationally, recruiters often target people from impoverished nations who may be oppressed (Raymond, & Hughes 2001). Trafficking schemes are sometimes run by a single person, a family, or by elaborate groups of organized crime (Raymond, & Hughes 2001).

Globally there is an estimated 20 to 30 million people living in slavery today, with women and girls encompassing the largest proportion of victims (Dosomething.org, n.d). Many people do not recognize the impact of sex trafficking in their communities. This may be because

sex trafficking is often hidden in the United States tucked into typical neighborhoods or occurring in private locations such as strip clubs and spas (Soroptimist, n.d).

Women who are trafficked often face extensive physical and emotional abuse and are frequently forced to live in slave-like conditions. The website of a global women's organization, Soroptimist, explains "Victims often experience post-traumatic stress disorder, and with that, acute anxiety, depression and insomnia. Many victims turn to drugs and alcohol to numb the pain." (Soroptimist, n.d).

Recent research has continued to explore how professionals working with survivors of trauma are affected emotionally using a framework referred to as compassion fatigue. People who work in professions that are emotional in nature are at risk for high levels of compassion fatigue due to hearing the stories of clients as well as coming to the conclusion that changing society seems like an impossible task (Compassion Fatigue Awareness Project, 2013). For the purpose of this project compassion fatigue can be defined as

a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/ numbing of reminders, and persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (Figley, 2002, p. 1435)

Although working with populations who have experienced traumatic events can lead to compassion fatigue, it can also lead to what is known as compassion satisfaction. Compassion satisfaction will be operationalized as "the pleasure that a helper gets from doing their work well and the ability to contribute to the well-being of others" (Stamm, 2005; as cited by Harr, 2013, p.

74). According to Harr (2013), compassion satisfaction can be improved by agency practices and is what motivates professionals to continue work despite the presence of compassion fatigue.

Considering the amount of people involved in sex trafficking globally and locally, it is likely that social workers and other professionals will encounter survivors of sex trafficking at some point throughout their careers. Although research has focused on compassion fatigue in regards to natural disasters, terrorist attacks, and trauma survivors in general, minimal research has focused specifically on professionals experiences of compassion fatigue when working with survivors of sex trafficking, and the complexity of their experiences. The purpose of this study is to evaluate how local professionals working with the survivors of sex trafficking prevent and manage compassion fatigue while maintaining compassion satisfaction.

## **Literature Review**

Compassion fatigue and compassion satisfaction evolved over the last couple of decades and is often connected with concerns such as social worker burnout. This literature review considers multiple aspects of compassion fatigue, including conceptualization, consideration of its impact on professionals, prevention of development, and attention to working with survivors of sex trafficking.

### **Conceptualizing Compassion Fatigue**

Compassion fatigue initially had a narrow definition, but over the years researchers have made connections between compassion fatigue, secondary trauma, vicarious trauma, and job-burnout. This section will consider the interconnections between these concepts.

“Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others” (Figley, 2002, p. 1434). Throughout the literature, researchers identify some differences in the operationalization of compassion fatigue. For example, some authors align compassion fatigue directly with secondary traumatic stress (Figley, 1995, 2002). Secondary traumatic stress can be operationalized as “the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress from helping or wanting to help a traumatized or suffering person” (Figley, 1995, p.7; as cited by Bride, Radey, & Figley, 2007, p.155).

Although the use of the term compassion fatigue has varied throughout the literature, recently it has become a term that encompasses not only the concept of secondary traumatic stress but also elements of the concept of job-burnout (Figley 1995, 2002a, 2002b; as cited by

Adams, Boscarino, & Figley, 2006). Although Compassion Fatigue is sometimes thought to include elements of job-burnout, some authors consider compassion fatigue and job burnout as separate but similar concepts (Clark, Sprang, & Whitt-Woosley, 2007; Craig & Sprang, 2010; Killian, 2008; Thomas, 2013). One notable difference between the concepts of job-burnout and compassion fatigue are that job burnout occurs over time and less abruptly than compassion fatigue, which can result from one notable incident (Conrad & Kellar-Guenther, 2006). Figley (1995) notes that job-burnout happens over a longer period of time and develops due to feelings of emotional exhaustion.

Not only are compassion fatigue and secondary traumatic stress used interchangeably by some authors, at times secondary traumatic stress and vicarious trauma are used interchangeably as well. However, a study looking at the similarities and differences of the two concepts used the Compassion Fatigue Self-Test for Psychotherapists and the TSI-Belief Scale (Revision L) and discovered that although secondary traumatic stress and vicarious trauma are similar they effect professionals differently and should be viewed as separate constructs (Jenkins & Baird, 2002). Although the constructs have some differences they are similar in that “secondary traumatic stress, vicarious trauma, and compassion fatigue, all refer to the negative impact of clinical work with traumatized clients” (Bride et. al., 2007, p.156).

For the purpose of this research, compassion fatigue will include elements of secondary traumatic stress while being closely aligned with job-burnout. Maslach (2001) defines job burnout as the result of prolonged stress at work resulting in “overwhelming exhaustion, feelings of cynicism, and detachment from the job” (p. 399). According to Maslach, Job burnout results



from being over-worked, not receiving adequate support from supervisors or co-workers, and confusion about job demands.

Because of the lack of a clear definition for the term compassion fatigue, the literature uses different ways to measure compassion fatigue. Due to the complexity of defining compassion fatigue, Bride et al. (2007), suggests using multiple scales when assessing for symptoms of compassion fatigue as no one measure has been shown to adequately assess for every aspect of the concept.

Recently Research has begun to focus on compassion satisfaction as well as compassion fatigue. Radey and Figley (2007) suggest clinical social workers should focus more on promoting compassion satisfaction and focus less on compassion fatigue. According to the authors the three key factors of compassion satisfaction include positive affect, self-care, and resources, which all influence one another and play a key role in developing either compassion fatigue or compassion satisfaction. The authors suggest focusing on an increase in these three areas as a way to increase compassion satisfaction.

### **Compassion Fatigue in Multiple Professions**

Compassion fatigue effects people of many different professions. For example, when studying compassion fatigue in nurses, Yoder (2010) found that about 16% of nurses experienced compassion fatigue. Through interviewing nurses, the author found that nurses attributed compassion fatigue to work with patients, caseload size, and self-doubts regarding competency. The nurses in the study used a variety of coping strategies when faced with

symptoms of compassion fatigue ranging from overly engaging with patients to trading work assignments or even finding a new career (Yoder, 2010).

Compassion fatigue and compassion satisfaction have also been studied amongst child protection workers. For example, Conrad and Kellar-Guenther (2006) found child protection workers to be at high risk for developing compassion fatigue, but that under ten percent of workers surveyed actually qualified as experiencing compassion fatigue. This may be because the majority of workers were experiencing high levels of compassion satisfaction, which the study showed minimized the experience of compassion fatigue.

### **Predicting and Managing Compassion Fatigue**

Many researchers have focused not only on the causes of compassion fatigue, but ways to fight compassion fatigue and encourage compassion satisfaction. Figley (2002) discusses important aspects in preventing and managing compassion fatigue for therapists. Figley suggests providing professionals with education on compassion fatigue, desensitizing the professional to the trauma through exposure mixed with relaxation, and encouraging professionals to enhance support networks in order to prevent and manage compassion fatigue.

Although compassion fatigue has been shown to affect people in nursing and child protection, much of the research has focused on the experiences of mental health professionals and volunteers working with clients who experienced different types of trauma. Some research focused on compassion fatigue specifically following work with disaster.

For example, in a study looking at compassion fatigue, Boscarino, Figley, and Adams (2004) studied compassion fatigue with social work counselors in New York City who worked

with individuals who experienced trauma from the World Trade Center terrorist attacks. These researchers found that the more social workers were involved in recovery efforts the more they experienced secondary trauma. The study also found that having social support at work functioned to protect social workers from experiencing secondary trauma and burnout. A later study by the same authors using the same sample found that people who were experiencing high levels of secondary trauma were also experiencing higher levels of job-burnout (Adams et al., 2008).

Other studies focused on work with nonspecific sources of trauma. Craig and Sprang (2010) completed a survey of 532 trauma specialists and found having more exposure to clients with PTSD as well as working in an inpatient unit lead to greater experiences of compassion fatigue. Alternatively Craig and Sprang found several protective factors. These include: (a) working in a community mental health center, (b) years of experience, and (c) the use of evidenced base practices increased compassion satisfaction in trauma specialists. Although the authors predicted female gender would predict compassion fatigue and burnout, this hypothesis was not supported.

Consistent with those findings, Craig and Sprang's (2010) study, Wagaman et al. (2015), found the amount of time spent as a social worker can have an effect on compassion satisfaction, for example, more years of experience equated to higher levels of compassion satisfaction. Wagaman et al., also found that having more empathy can positively influence levels of compassion satisfaction among social workers. In particular the research cites emotional regulation, affective response, and self-other awareness as playing an important role in empathy and suggests training practitioners in these areas to increase compassion satisfaction for

practitioners. Harr stresses the importance of supervisors and agencies to assure compassion satisfaction by creating a positive, value-oriented environment while monitoring trauma exposure and caseload size as way to prevent staff turnover. Harr (2013) also found that the feeling of being part of a team can have a positive impact on compassion satisfaction amongst workers.

Recently, it has been shown that the use of mindfulness by professionals can play a role in compassion satisfaction. For example, in a study with Decker et al. (2014), it was discovered that social workers who used elements of mindfulness more often experienced more compassion satisfaction. It was also noted that less use of mindfulness among social workers lead to higher levels of compassion fatigue. Consistent with those findings Thielman and Cacciatore (2014) studied 41 volunteers working with bereaved clients who experienced a traumatic death and found mindfulness worked as a form of compassion satisfaction. Furthermore, the researchers found the volunteers own experiences with experiencing their own losses did not lead to elevated levels of compassion fatigue. This is contrary to other research that has shown personal history of trauma leads to higher levels of compassion fatigue.

In a qualitative study of 20 mental health practitioners, Killian (2008) assessed how practitioners describe their experiences with and how they manage work stress. As well as feelings of general anxiety, participants described feeling the consequences of stress in their bodies through headaches, memory loss, and insomnia. About one fourth of participants even eluded to work stress affecting relationships at home. The participants revealed a list of seven risk factors throughout their interviews that contribute to work stress and compassion fatigue including “high caseload demands, personal history of trauma, supervision access, lack of support, worldview, and ability to recognize and meet one’s owns needs” (Killian, 2008, p. 36).

Interestingly every practitioner interviewed spoke to the importance of spirituality in regimens of self-care, although interpretations of the word appeared to vary. Another notable self-care piece uncovered through the interviewing process was the ability to engage in conversation with co-workers or supervisors regarding client situations as well as time spent outside of work engaging in social activity.

Consistent with Killians findings regarding the role of spirituality in self-care, Brady, Guy, Poelstra and Brokaw (1999) found that as more people were exposed to clients who had been sexually abused, the more participants closely identified with spirituality. The authors caution that it may be that people working with difficult trauma populations may have identified as more spiritual in the first place.

### **Sex Trafficking**

According to the Victims of Trafficking and Violence Prevention Act, An estimated 700,000 humans are trafficked annually around the world, with an estimated 50,000 being trafficked directly into the United States (PL 136-386). Recently in the United States laws have been enacted that take aim eradicating sex trafficking. For example, in 2000 the Victims of Trafficking and Violence Prevention Act was enacted with the intention “to combat trafficking in persons, a contemporary manifestation of slavery whose victims are often women and children, to ensure just and effective punishment of traffickers, and to protect women and children” (Sec. 102). Despite new laws, the sex trafficking industry continues to flourish. This may be due to the continued marginalization of women around the world. According to Rieger (2007) an underlying ideology behind the sex trafficking of women and girls is the oppression of women and viewing women as sexual objects.

People who escape sex trafficking are found to have complex physical and mental health needs. This may be due to the complexity of the abuse and living in a form of slavery for extended periods of time. According to Reiger (2007), “Many forms of subordination, including gender, class, race, and immigration status, dangerously intersect to create the experiences of trafficking victims” (p. 234). Furthermore, victims of sex trafficking are often stripped of their rights and encounter physical and emotional abuse daily. According to Shauer (2006), “Trafficking is slavery because it includes fraud or extortion in recruitment and coercion, restraint, gang rape, threat of physical harm, loss of liberty, and loss of self-determination on arrival in the destination industry” (p.146). Not only are trafficked women deprived of human rights, often times women in sex trafficking are raped by multiple people daily with no opportunity to seek medical attention to for injuries (Rieger, 2007).

A recent study of women seeking post-trafficking services in Europe found that the vast majority of the 192 women surveyed reported experiencing physical and sexual abuse while being trafficked (Zimmerman et al., 2009). Zimmerman and colleagues (2009) found the women suffered from complex physical symptoms including memory loss, weight loss, headaches, gastrointestinal issues, vaginal pain and infection, broken bones, and much more. Furthermore, women who are trafficked are at significant risk of contracting a sexually transmitted infection or unwanted pregnancy (Hudra, 2006). Many trafficked women are not allowed access to adequate health care (Gajic-Veljanoski & Stewart, 2007; Reiger, 2007).

Not only do women who have been trafficked experience significant physical health concerns, they also experience psychological distress. For example, Tsutsumi and colleagues researched women in Nepal, post trafficking, and found every one of the 44 women to be

experiencing depression and nearly all of the women to be experiencing symptoms of PTSD (Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008). Zimmerman and colleagues found that when comparing the mean scores of the 192 post trafficked women relating to anxiety, depression, and hostility to that of the general population, participants' symptoms were in the 95<sup>th</sup> percentile (Zimmerman et al., 2008).

### **Compassion Fatigue and Sex Trafficking**

Because supportive services for survivors of sex trafficking is a relatively new area of practice, little is known about the experiences of compassion fatigue among social service providers working directly with survivors of sex trafficking. Some research indicates the experience of compassion fatigue when working with clients who have experienced sexual violence is unique from the experience of compassion fatigue when working with clients who have other trauma experiences. For example, it has been shown that when sexual violence is involved, professionals working with victims often experience more significant psychological distress when a higher amount of their clients are victims of sexual abuse (Schauben & Frazier, 1995). Similarly, in a study including 1,000 women therapists Poelstra and Brokaw (1999) found that the more experience therapists had with patients who experienced trauma involving sexual abuse, the more they suffered from symptoms of post-traumatic stress disorder. Consistent with those findings, Kliner and Stroud (2012) also discovered working with survivors of sex trafficking to be especially difficult compared to other populations, which could be explained by the extent of the abuse and the long period of time the abuse occurs for the population.

In their study, which consisted of 12 women in a variety of helping professions, Kliner and Stroud (2012) found working with survivors of sexual violence can have a negative impact

on staff emotionally, physically, and professionally. The interviewees received a questionnaire followed by an interview with a researcher. The researchers found working with survivors of sex trafficking to lead to experiencing symptoms of secondary trauma, such as flashbacks, as well as symptoms of job burnout. The professionals felt that the work followed them home and sometimes resulted in negative ways of coping, such as drinking. The research also showed professionals felt they were under supported by co-workers and lacked adequate training on working with survivors of this type of trauma (Kliner & Stroud, 2012). Contrary to some research, caseload size had no effect on symptoms of secondary traumatic stress and job burnout among participants.

To date, there is minimal literature focusing on the unique trauma experiences of survivors of sex trafficking and the extent compassion fatigue and compassion satisfaction exist among people working closely with survivors of sex trafficking. This study will add to the literature specific to professionals working with survivors of sex trafficking and explore how local professionals working with this population prevent and manage compassion fatigue and maintain or enhance compassion satisfaction.



### Conceptual Framework

This research utilized the theory of self-efficacy as a way to conceptually guide the research. According to Bandura, what he refers to as *efficacy expectations*, or whether or not a person believes they will be successful, can influence the amount of time and energy put forth by a person as well as influence whether or not a person will shut down when faced with obstacles or utilize coping strategies (Bandura, 1977). Bandura states “Efficacy beliefs influence how people feel, think, motivate themselves, and behave” (Bandura, 1993, p. 118). One purpose of this study is to understand how people experience, prevent, and manage compassion fatigue as well as what motivates them to continue their work.

Bandura cites four contributors to efficacy expectations. The first of these is termed *performance accomplishments* and says the more a person can successfully complete a task, the more confident the person feels about completing that task, and other tasks again (Bandura, 1977). In the literature review, personal feelings of inadequacy or feeling underqualified was a common predictor of compassion fatigue. *Vicarious Experience* is the act of person modeling and successfully completing a dreaded task for another person. (Bandura, 1977). An example could be a way a supervisor shows staff members how to complete a dreaded task. Another contributor to self-efficacy, *verbal persuasion*, is the idea that a person is more likely to be successful in a task if they are told they will succeed (Bandura, 1977). An example of this could be a supervisor informing a staff member they are likely to succeed at a new task. The fourth contributor, *emotional arousal*, suggests that if a task creates arousal or anxiety, a person is less likely to believe they will succeed and may even avoid the situation all together. Bandura suggests exposure to the anxiety provoking situation as a way to mitigate the anxiety.

This study will focus on two research questions. The first question will focus on compassion fatigue and is as follows: How do professionals working with survivors of sex trafficking prevent and manage compassion fatigue? The second research question will focus on compassion satisfaction and is as follows: How do professionals working with survivors of sex trafficking maintain compassion satisfaction?

## **Methods**

### **Research Design**

The research study is a qualitative research study. The data was used to assess how participants experience compassion fatigue and compassion satisfaction when working primarily with survivors of sex trafficking. The study consisted of semi-structured interviews with three professionals, consisting of survivor advocates as well as licensed therapists, who work primarily with survivors of sex trafficking. The questions revolved around the unique experiences working with survivors of sex trafficking, experiences with compassion fatigue/compassion satisfaction, how professionals prevent and manage compassion fatigue, and what agencies have in place to promote compassion satisfaction and prevent compassion fatigue.

### **Protection of Human Participants**

The research study was assessed through the University of St. Thomas IRB application process. Participants were emailed a consent form seven days before the interview date. An additional informed consent form was brought on the day of the interview for the participant to sign and was reviewed with the researcher. The informed consent form assured participants of anonymity and that they could stop the interview at any time. The informed consent form will be kept in a locked safe in the home of the researcher for three years following the interview. Participants were informed the interview would be recorded and the recordings will be deleted following completion of the project. The typed transcriptions of the interview will be kept for three years following the interview and will be stored on a password protected laptop. The transcribed interviews do not contain any identifying information. Any printed copies of the transcribed interviews were shredded upon completion of the project. Participants were given the

opportunity to ask questions and received the information of the researcher and research chair for future questions regarding the study. The interview recordings were stored on a password protected phone and were deleted following completion of the typed transcription.

### **Sample**

Participants were recruited in the form of a purposive sample from local agencies working with survivors of sex trafficking. 11 people were sent emails or received phone calls asking about their interest in participating in the study. Of the 11 participants recruited only 4 responded. One person did not meet the requirements of the study and was not able to participate. Three of the 11 people agreed to participate in the study. Snowball sampling was also used and participants were asked if they knew of any other professionals willing to participate in the research following the interview.

Participants consisted of two survivor advocates as well as a licensed practitioner providing mental health counseling. The participants received an email describing the research process and the requirements of the participating in the study. The requirement was having at least one year of experience working with the population. Participants were asked to respond to the email regardless of their interest in participating. Participants were emailed a list of the interview questions and a list of definitions relating to the study prior to the scheduled interview date. Participants were given the choice of where the interviews would take place. The interviews took place in the agencies of employment of the participants.

### **Data Collection**

The research tool for the study consisted of a semi-structured interview, which included 12 interview questions (See Appendix A). There was no compensation for participating in the

study. The interview focused on what the participants know to be the unique difficulties and challenges of survivors of sex trafficking, how the participants understand compassion fatigue/compassion satisfaction, how participants recognize signs of compassion fatigue, how participants work to prevent compassion fatigue, as well as what agency practices are in place to address compassion fatigue and compassion satisfaction. The questions emerged as a result of what was discovered during the literature review. The list of interview questions were sent out seven days in advance along with a consent form explaining the research study and assuring anonymity of the participant. The interviews took place in the area of choice for participants and were between 35 minutes and 90 minutes in length. A Samsung galaxy S6 was used as a recording device which sat in between the participant and the researcher during the interview.

### **Data Analysis**

After the interview, the researcher transcribed the interviews word for word using a Microsoft Word on an HP computer. The researcher listened to the recording two times through to transcribe each section word for word. After the interviews had been transcribed the researcher analyzed the data for codes and themes. Open coding was used to find and underline code words throughout the interview. After the first level coding process was completed the researcher used the list of codes to find themes that exist throughout the interview.

## **Findings**

This research study assessed the impact and risks of compassion fatigue among professionals who work closely with survivors of sex trafficking, while also assessing compassion satisfaction among the group of professionals. The research revealed four primary themes and eleven sub-themes relating to the experiences of survivors of sex trafficking, experience of compassion fatigue, prevention and management of compassion fatigue, and compassion satisfaction.

### **The Illusion of choice**

Two out of three of the respondents spoke about the complications of working with clients who do not believe to be victims or consider themselves in need of services. Many of the clients with whom they work, believe that they entered into the sex trade of their own volition. The first respondent discusses how the myth of trafficking being a choice presents difficulty for workers as well as a sense of shame for the trafficked person. When discussing this concept, one respondent describes,

... well the initial thing is, is I think there is kind of this illusion of choice when it comes to trafficking and that really plays into shame. So “if this is something I chose, I don’t feel like a victim. I feel empowered”. So there might not be a recognition for needs for services.

She also indicated,

I mean with sexual assault survivors anyway, which trafficking is sexual violence, there’s always that level of shame and guilt about what happened. So it really is multiplied when people are trafficked because of the myth of “well it was my choice”.

Furthermore a second respondent discussed how some of the women served by the agency don't view themselves as being trafficked, much less identifying themselves as a victim.

... a lot of our younger girls will talk about hooking up with someone for a couple of hundred dollars and they won't ever say 'have sexual intercourse', but they say 'hook up' and they will say 'well that's not prostitution' and I say 'well baby it is, when you're trading anything for sex, and are you getting that money?'. Well that's another, ya know, "someone is selling you"

Another participant also speaks of a way of helping survivors acknowledge they are victims of trafficking. The respondent states,

I wouldn't say, like, 'you're a victim', but I might say 'well you told me that you checked out every time you had sex when you were selling or whatever. You numbed out, and what that tells me is you didn't enjoy it. Usually when you are having sex, you are present and you are enjoying it'.

### **Trauma Continuum**

Another theme that emerged through the interview process is a trauma continuum. This continuum included three parts: vulnerability to being trafficked, trauma while being trafficked, and therapist reactions to client experiences. Participants described the vulnerabilities of survivors into entering the life starting in childhood. The trauma continues due to all of the abuse experienced by survivors while they are "in the life". One respondent indicates, "The trauma runs deep from childhood trauma, to ACES trauma stuff, to being in life trauma. Ya know, beat by johns, beat by pimps, abandoned by families, um neglected by systems, revictimized by systems."

Participants also describe survivors experiencing mental health concerns, but it is not clear if this was a vulnerability of entering trafficking or if it is a result of being trafficked. Finally, the professionals hearing the stories of the survivors experience overwhelming emotions upon hearing the stories of the survivors, sometimes leading to symptoms of PTSD.

**Vulnerabilities.** Each of the respondents mentioned that people who are trafficked often experience trauma or instability in their home life prior to being trafficked. This theme indicates that survivors of trafficking often experience personal trauma that leads them to becoming a target for traffickers. When speaking to the history of trauma among survivors, one respondent explains,

A lot of the folks come from an environment that wasn't normal. Where their parents did it (referring to prostitution), where their neighbors do it, where there's a lot of violence in the neighborhood and not as much education. Where there is high poverty, and again, where violence and victimization is the norm.

Similar to this, another respondent describes,

People are picked up who are vulnerable anyway. They might lack supervision, or um, I don't know. Just ya know, their lives aren't very stable already. But we know that a huge indicator that someone might end up in trafficking is that they are already in the child protection system, which is a huge indicator that there is already something going on.

The respondent also speaks directly to the trauma history of the survivors. She states,

You are dealing with folks who probably have their own set of trauma, their own history of trauma, and they are adolescents so their brains are, I mean when you're talking about



brain development your brain development is skewed when you experience early childhood trauma.

**In the Life Trauma.** Not only do survivors experience trauma and instability in childhood, they continue to experience trauma while being trafficked. One respondent describes, “It’s just going from one trauma to another. Ya know, one group of guys. This man, this man, this man, do what you gotta do, ‘give me the money’... because you don’t get to keep the money”. Furthermore, the interviewees discussed physical and sexual abuse experienced by the pimp as well as the buyers. For example, when asked about the difficulties clients present with one respondent indicates “Short term-memory loss from a lot of head injuries, being beaten a lot. Stuff like that”. Later she also adds, “Um mental health, behavioral health, chemical dependency, um disconnected from their sexuality.

When discussing the extent of the trauma and things to consider when providing services to this population, one respondent states:

So a therapy a lot of people recommend for childhood trauma is narrative therapy... and if you think about trafficking and youth who have been trafficked can you think about how many narratives they would have to write? Even if it is only one or two experiences every couple of days and it has been going on for six months, ya know, how many stories you would have to tell would be, it’s ridiculous. It would be ridiculous to make somebody go through that. So the complexity of the trauma.

**Mental health concerns.** A third sub-theme that emerged relates to the significant mental health of survivors, and interviewees noted an association between mental health concerns and the trauma the survivors experienced. It is not clear if the mental health concerns

are present prior to entering the life, or as a result of the trauma experiences of the survivors. A significant portion of people trafficked are experiencing a negative impact on mental health. Given the extent of the trauma experiences of the person's trafficked it is not surprising that mental health concerns was a sub-theme that emerged as something experienced by survivors of trafficking. As one respondent indicates, "I think maybe at my best guess, something like 90 percent of our women are diagnosed PTSD".

Another respondent speaks to the hopelessness felt by the women along with the extensive list of mental health diagnoses. When discussing some of the mental health concerns that are common among the clients served, the respondent points out, "Helplessness, anxiety, anger, PTSD", and later states "Most of the time our girls are very depressed, very anxious, and they don't have a lot of hope, and that's what we see over and over again."

Furthermore, some women are experiencing addiction. One respondent indicates, "um a lot of our women are still foggy because they just got out of treatment". Later she indicates, "And um, 90 percent of our women are chemically dependent... we don't want to be sober when we are sleeping with all of these men".

**Overwhelming emotional experience of hearing client stories.** Each of the respondents spoke directly to the impact of hearing about trauma daily on the development of compassion fatigue. One respondent explains how she thinks of compassion fatigue stating, "how I imagine it is that when you work with people who have a lot of trauma and hurt and care and give a crap and you hear these stories it takes a toll." Each participant eluded to being effected themselves due to hearing what the clients served have been through. When asked about experiences of compassion fatigue one respondent explains when speaking of a specific client,

“So the compassion fatigue was when she first came here, knowing all of the abuse she went through and just being angry at those people that abused her.”

A second respondent describes a situation in which intrusive symptoms of secondary trauma emerged as a result of hearing about the trauma experiences of client’s day in and day out and how that impacted intimate moments of her life outside of work. The respondent describes:

Some of it would look like having flashes of people’s stories while I was being sexual. Because it was like something would trigger something I heard from somebody else and then I would have to stop. Like I would get freaked out.

Another respondent spoke to the possibility of developing secondary trauma as well as the possibility of their own trauma experiences resurfacing as a result of hearing about the complex trauma situations of survivor’s day in and day out.

The women that we serve and the youth that we serve, they come with high levels of trauma and if a person doesn’t have any traumatic experience to memory that they can relate with, this can be traumatizing. And if a person has his or her own traumatic experiences that he or she can relate with, this then becomes a trigger or a re-trigger, or re-victimization of sort. When speaking of a compassion fatigue experience one respondent indicates, “You feel like you’re going through a mental breakdown”.

Later the participant elaborates,

I just one day wanted to just walk away from my desk. I just remembered looking up at my office at everything on the floor and people were knocking on the door, ‘Are you okay?’... it was very intense moment.

Another respondent speaks to feeling helpless to assist a family and therefore wanting to avoid seeing the client as result.

If you are getting to the point where you start to see, um, get hyper-arousal, have intrusive thoughts, trying to avoid people, and that's gonna happen to the best of us, because sometimes it's so frustrating. You know you're gonna see this woman with 8 kids come and you're gonna wanna run because you know there's gonna be no such place with an apartment that's gonna be able to take care of them.

### **Self-Care**

The theme of self-care emerged through the interview process with each respondent. Through self-care, the sub-theme of spirituality emerged through the research as well as having adequate support systems, setting appropriate boundaries, and anticipatory awareness.

When discussing self-care, one client states, "I'll tell you this, that self-care is very important in our field". Later she elaborates

I might need to go see a movie or something. But I've gotta do something, um, to get out of that place. Otherwise, it's going to manifest itself into something really ugly... so that's what I do to manage mine. I just implement self-care. Self-care to the max.

Another respondent tells a similar story. She indicates, "Um so when I think of compassion fatigue I think about how well one is taking care of his or her self. Um, what are you doing when you leave work to rejuvenate for the next day?"

Clients indicate a number of different things they do for self-care. One client indicates, "So it's okay to cry. We don't cry in front of clients but when they leave, we'll go in to each

other's offices and then um a lot of tears". Another client mentions using enjoying time with her family. She explains, "um I spend time with my kid who is super cute, and helps me forget all of the stuff." Two of the participants also indicate that they themselves receive their own therapy. One respondent states, "I like therapy. I also hate therapy." Another respondent mentions "We are encouraged to have our own therapists.

Throughout the interviews, when asked about what agencies have or should provide for staff to prevent or manage compassion fatigue, the idea of having self-care included in the workdays came up within each interview. When asked what advice this respondent has for other agencies, the participant responded, "make sure the other organizations of self-care policies built in as well". Another respondent draws a connection between built-in self-care and effectiveness, the respondent explains, "If we can have on the clock self-care than we can have more effective advocates"

Some spoke of specific ways the agencies they are employed provide built-in self-care. One participant spoke of the encouragement to take a lunch break mid-day. The respondent explained, "Here we close the office an hour for lunch and you are really encouraged to take your lunch break. You can do whatever you want with it." Another respondent spoke of having a room focused on relaxation and meditation for staff members to use when feeling overwhelmed. The respondent explains, "So, um, in the meditation room you are free to be yourself." Later in the interview, the respondent states, "You know, where we need to allow a woman some calm down time or some recovery time from being re-triggered or that, we use the meditation space."

Each person interviewed spoke about benefit programs provided by their agency that help them to support and manage compassion fatigue. One participant describes “If you want to take off, just plan ahead and let’s do it, because those are the kind of things that prevent compassion fatigue”. Another respondent indicates, “We donate PTO, we’ve got employee assistance program. These are different things that um, are available to us for our self-care, which I’ve used once or twice.”

**Spirituality.** The sub-theme of spirituality emerged through the research. Two out of three of the respondents spoke of religion and spirituality significantly throughout the interview. When asked about what is done for self-care one respondent indicates she attends a church. She also states, “um I pray, I do the serenity prayer. God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.” A second respondent also spoke of religion often throughout the interview. At one point she indicates “There have been times when I had to go down to the meditation room myself and, um, pray and pray” later on in the interview she speaks of how entrenched this work is with her spirituality. Specifically, she states “Um this is so closely tied to my spiritual faith, it’s almost like a cloud ride.”

**Setting appropriate boundaries.** Another sub-theme that emerged is around setting appropriate boundaries with clients as a way to prevent experiencing compassion fatigue. It came up that it is often that people take home with them something from their day. One respondent indicates, “I’ve gotta say that 50 to 75 percent of our staff take home with them every client they see all day”. The same respondent states later in the interview about establishing boundaries, “... so you have to learn what they are and what healthy one’s are and you’ve gotta put them in place”.

Another respondent explains, “When you feel like you are the only one that can help somebody, that’s a problem. I mean, the biggest thing that I say is it is not on my shoulders to fix anyone.” The participant was indicating that feeling as though you are the only one that can help someone could lead to boundary crossing. “You want to do more than you can do, and you just have to be accountable for what you can do and within that, make it happen and be okay with that, you know.”

Similar to the prior statement, another respondent speaks to being aware of when you may not be the best person to help a specific client get their needs met and knowing when to refer out. The respondent describes this process below.

“Recognize when someone is too much for me, so making referrals out. Like, I can’t handle this person, or this person is too triggering for me , or the trauma is too complex for me. Basically say ‘I’m not the right person’.”

**Adequate support systems.** All of the respondents interviewed also spoke of the different ways in which their agency works to provide or encourage social supports among staff members. This theme speaks to developing a sense of togetherness. Participants spoke of having an openness around the subject of compassion fatigue. For example, the client states “We talk about it often. And I think it’s because our executive director cares so much about that and cares so much about us, it’s on her radar”.

Other respondents spoke of the necessity of supervision and consultation. One participant says, “Um, check in with your staff. Do supervision with your staff. Um, regardless of where they stand with education and experience, because that support will help navigate the skills that they do have and organize their skill tool box.”

Another subject that came up often was being encouraged to work with one another in the form of consultation. One respondent states “We do a lot of staff retreats where we talk about what we are doing and how we are doing.” Furthermore, one participant describes. “We do a lot of staff retreats where we talk about what we are doing and how we are doing”. Similar to this, another participant indicates “Well what we did last year was every other month, so six times, at our staff meetings we had um a faith based community would come into our staff meetings and provide massages, hand therapies, they would make a little luncheon for us and some crafts.”

**Anticipatory Awareness.** Another sub-theme that appeared when discussing how agencies can best support their staff in working to prevent and manage compassion fatigue is the theme of being educated about what compassion fatigue is and about the risks associated with developing compassion fatigue in terms of the population served. To illustrate this, one researcher said, “If you’re gonna hire people fresh out of school, um compassion fatigue should be an item on the on-boarding. There should not ever be an expectation that school teaches everything.” Another respondent also brings up the importance of understanding compassion fatigue. The respondent indicates, “One of the things is not being aware of what it is. I think that’s a big part of it. We’ve gotta be aware of what compassion fatigue is. That it is going to happen.”. Later in the interview, the respondent elaborates by saying

“So just to know that it’s a perpetual thing, and it’s hard, and it’s gonna be hard. And knowing what you’re getting yourself in to and knowing your population. Knowing what the risk factors are and what the barriers are, and just knowing that. Once you know that and you’ve got that in your crew and you understand that, then I think, um, it’s gonna reduce your compassion fatigue. “



## **Passion**

The theme of passion emerged through the research. The participants describe a drive to continue doing what they are doing. One respondent says, “We are making changes in hundreds and hundreds of people’s lives, and that’s what makes me continue doing what I’m doing”. Another respondent indicates, “Safe Harbor passed and I found a new found passion, because that don’t have to be the story of the young women today”. Three sub-themes were identified for this theme. The sub-theme of feeling as though this type of work is “a calling”. Another sub-theme that emerged relates to changing how success is viewed as a result of doing this work in order to recognize the small successes as significant. The final sub-theme has to do with a feeling that not enough has been done to combat sex trafficking and serve survivors.

**Being called to the work.** Another primary theme that emerged through the interviews relating to compassion satisfaction is the theme of self-efficacy. Each respondent spoke to feeling as though they are good at what they do. Some also spoke to a sense of feeling as though they were being called to the field or they belong in this field. For example, one interviewee states, “I just think, that I believe that I am called here, and I just pray ‘if you think that I’m not effective, if you want me somewhere else, just open a door and close this one.’”.

Similarly, another respondent also speaks feeling a sense of belonging in the field of trafficking.

The respondent states, “What became really clear was that this is where I belonged, um in kind of doing this thing... every time I was in a specific field of work there was a young woman there, with a pimp, who couldn’t make a decision because she had to answer to this pimp.”.

Furthermore when referring to work with clients as well as talking to people about sexual exploitation, the interviewee says, “People feel comfortable talking to me about it I guess, because they keep doing it so it must be working somehow. So to me that’s really important. I have the ability to do that so I need to do that.” This respondent feels as though because she is able to do this work and people are responsive, she must continue doing the work.

Another respondent speaks of being effective as well as having passion about the work she does. The respondent states, “Until someone somebody says ‘you know what, you are not effective’, I’ve still got fire and I’ve still got passion, so I’m gonna stay where I’m at”.

**Recognizing Small Successes** this sub-theme emerged in each interview. Participants described having to change the way they view success in their work with this population. One respondent discusses how she views the successes of clients: “So what we do look at is the mini successes. Like somebody I didn’t think would come back for their second appointment or third appointment... You know, you look at success differently for sure.”

Another respondent discusses their view of successes of the clients as well as of the systems serve client. The respondent states

You get that phone call that says, um, “we didn’t have room last night, but that woman that you were trying to get in, we have room for her now”. You know, because you don’t know where she slept last night, you’re calling immediately and she picks up on the first ring. That’s compassion satisfaction.

Following this statement of success of systems coming through for clients, the respondent also discusses viewing client successes differently. The respondent states: “Yeah, those little

moments, they matter. They matter. When you see that one woman whose been struggling with the GED and finally she's like 'booyah, we got it'. And you're like 'Hallelujah'."

The third respondent discusses a particularly relevant case for her in which she was able to appreciate the small successes. This respondent states; "She's been off the streets for three years...and that, that alone, that little piece, seeing her happy and knowing that (name of the agency) is helping her and that she feels safer, that is the satisfaction".

**More to be done.** Another sub-theme that emerged from the research is participants believe there is a lot more to be done in the area of sex-trafficking.

I am encouraged by all of the little girls that are yet to be born. All of the little boys that are yet to be born. So that they can enter a world that has minimized the exploitation that takes place of children commercially, or is free from.

Two participants spoke to the progress made for youth, but that there is still more work to do with legislation. For example, one participant describes

So when Safe Harbor passed, a few of our national partners called and was like 'congratulations'. And I was like 'I know it's gonna be sweet'. We're at 5 million now of the 13.5 million requested, so we have a ways to go.

She also notes "Imma be here for a while because too many women were missed, and I personally lost to many women to that lifestyle" Similar to this, another respondent speaks about more needing to be done for adults as well as youth. Specifically she says,

We need to take care of our babies and make sure the youth are getting the care they need, that's first and foremost, and that's a beautiful thing. But don't ignore our 30 and

40 and 50 and 60 year old women, cause they're the same as a 15 year old. They have just not had the opportunity to get out of the life up until now. But they're the same, they were abused as a young child, they were turned out, they have been under the control of a pimp or abuser.

## Discussion

Much like the lack of a clear definition of compassion fatigue that exists within the research, it seems each participant had their own ways of interpreting and understanding compassion fatigue. However, they all had common ways in which they experienced, prevented and managed compassion fatigue. Many of the experiences of compassion fatigue align with the definition of compassion fatigue being the result of hearing the traumatic stories and wanting to. This ends up creating a sort of overwhelming emotion response with symptoms of secondary traumatic stress as well as burnout response and wanting to be able to help, sometimes more than what is possible. This is consistent with how the definition in the research that believes compassion fatigue consists of symptoms of secondary traumatic stress as well as burnout (Figley 1995, 2002a, 2002b; as cited by Adams, Boscarino, & Figley, 2006).

One theme that developed out of the research is the theme of an illusion of trafficking being a choice to the person who is trafficked, which makes working with this population difficult to provide services to at times. When looking at the definition of trafficking, it is in fact trafficking when recruitment or coercion are involved in recruitment (PL 136-386, Section. 102.4, 2000). This theme has not been explicit in prior research as a barrier to providing services to this population.

Furthermore it was shown that people who are trafficked experience significant trauma experiences. This is consistent with past research indicating that women who are trafficked often experience physical and sexual abuse (Zimmerman et. al., 2009). Moreover, Harr (2013) advised agencies monitor their exposure to clients who had experienced trauma as well as caseload size as a way to combat compassion fatigue. Although one respondent did point to trying to have

people with less complex trauma mixed into their caseloads to create a balance, all of the people who are trafficked have some trauma experience and therefore it cannot be avoided in the settings of the participants in the study in which all clients have trauma experiences.

Moreover, Kline and Stroud (2012) explained that working with survivors of sex trafficking may be more difficult than working with other populations, which could be explained by the extent of the abuse over a long period of time. The findings of this study support that the extent of abuse experienced by survivors of trafficking is a factor for professionals when working with this population.

Self-care emerged as a major theme in this research indicating the relevance of this for professionals working with survivors of trafficking. Not only did the participants indicate relevance of self-care outside of work, participants in this research also indicated they valued the way their agencies were able to promote self-care within the work day as well as by granting adequate time off and providing an open environment to learn about and discuss compassion fatigue. Another important sub-theme that emerged out of this theme is the importance of setting appropriate boundaries with clients. The research shows that it is important to establish personal boundaries while doing this work.

Furthermore, past research has also shown that spirituality can be an important aspect of self-care (Killian et. al., 2008). Participants in this research also indicated the value of spirituality in their lives in terms of the work do. Spirituality in this research relates directly to religion.

Much like the suggestion of Figley (2002) this study identified providing staff with education about compassion fatigue could be an effective way to prevent or manage compassion fatigue. Furthermore past research has pointed to expanding social networks as a way to prevent

and manage compassion fatigue (Adams, et. al., 2004; Boscarino et. al, 2004; Figley, 2002). This study also found that social supports are an important aspect when it comes to preventing or managing compassion fatigue.

This research is relevant for professionals and agencies who provide services to survivors of sex trafficking but also social workers in general. Given the amount of people trafficked each year, it is fair to assume that social work professionals will come across a person who has been trafficked at some point in their career. Professionals can use this research to understand compassion fatigue when working in this field as well as understanding the importance of implementing self-care and setting proper boundaries. Agencies can use this information to build self-care into jobs as well as provide adequate supports and education when working with this population.

One strength of this study is that the research focused on people who work closely with this population specifically. Prior research has focused on the impacts and experiences of compassion fatigue amongst professionals who work with people who have experienced other forms of trauma not specific to trafficked persons. Future research should include quantitative assessments of compassion fatigue as well as qualitative data regarding specific experiences with compassion fatigue and compassion satisfaction.

One unique aspect of the study is that two out of three of the participants interviewed for this project spoke of being a survivor of trafficking themselves or working side by side with other people who are themselves survivors of trafficking. Being a survivor may impact the experience of compassion fatigue and compassion satisfaction among professionals in the field

due to the possibility that hearing stories of clients who are trafficked could re-trigger traumas related to trafficking for the professional.

Future research should explore whether survivors experience compassion fatigue and compassion satisfaction differently than non-survivors of sex trafficking who work with other survivors of sex trafficking. Furthermore, the sample size of this study was small, a larger sample could enhance the findings of the research.



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## Appendix A

1. Tell me about what your professional role is and the work you do.
  
2. Thinking about clients who have been trafficked, without giving away specific client experiences or identifying information, what kinds of struggles and difficulties do these clients tend to present with?
  
3. Are you familiar with the terms "compassion fatigue"? If so, how would you define it, or how do you think about it?
  
4. Without disclosing identifying information or specific experiences of clients, tell me about a time you experienced compassion fatigue. What did that look like?
  
5. What do you see as compassion fatigue risks for clinicians doing this kind of work?
  
6. When compassion fatigue is present what actions do you take to manage compassion fatigue?
  
7. What actions do you take to prevent compassion fatigue?
  
8. Are there specific resources your agency offers to help clinicians to prevent and cope with this material?
  
9. In what ways is compassion fatigue like/not like working with other forms of difficult experiences such as burnout or general work stress?
  
10. Is there advice you'd offer to clinicians or to other agencies who might serve these clients in terms of ways to care for the staff/to prevent compassion fatigue?

11. Are you familiar with the term “compassion satisfaction”? If so, how do you define it, or how would you think of it?

12. What sort of experiences encourage you to keep working with this particular population?



## Appendix B



UNIVERSITY of ST. THOMAS  
MINNESOTA

### Consent Form

#### *Compassion Fatigue and Compassion Satisfaction among Professionals Working With Survivors of Sex Trafficking*

IRB Tracking Number: 840643-1

You are invited to participate in a research study about the experience of compassion fatigue and compassion satisfaction among professionals working with survivors of sex trafficking. You were selected as a possible participant because of your experience working closely with survivors of sex trafficking for at least one year. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Nicole Goettl, a Masters of Social Work graduate student. The researcher will be advised by Renee Hepperlen, a faculty with the Social Work Department of University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

#### **Background Information**

The purpose of this study is to gain an understanding of how professionals working with survivors of sex trafficking experience, manage, and prevent compassion fatigue, while maintaining compassion satisfaction. The study will consist of a 45-60 minute semi structured interview including 12 questions relating to the unique experiences of working

with survivors of sex trafficking and experiences regarding compassion fatigue and compassion satisfaction.

## **Procedures**

If you agree to participate in this study, I will ask you to do the following things: You will be asked to participate in a 45 to 60 minute semi-structured interview in a quiet location of your choice. There will be 8-10 participants in the study. The procedure will be audiotaped using a password protected phone.

## **Risks and Benefits of Being in the Study**

The potential risks of participating in the study include potential emotional distress as a result of being asked about experiencing relating to compassion fatigue.

A second risk of participating in the study includes a potential breach in confidentiality due to using technology to store information. To prevent this, audio-recordings will be deleted within 72 hours of data collection and transcripts will not contain identifying information. Transcriptions will be stored on a password protected lap top for three years following completion of the study.

There are not direct benefits to participating in this study.

## **Compensation**

No compensation will be offered to participants.

## **Privacy**

Your privacy will be protected while you participate in this study. To assure anonymity the recording and transcription of the interview will not include any identifying information.

The recording will be deleted within 72 hours of the interview and upon completion of the transcription. Any transcription will not contain identifiable information and will be kept in a password protected laptop for three years following the study. The consent form will be kept in a locked location in the home of the researcher for three years following completion of the study.

### **Confidentiality**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include an audio recording, a typed transcription of the interview, and a printed transcription of the interview. This researcher will be the only person to listen to the audio recording of the interviews. This researcher and research advisor will be the only people that will have access to the transcriptions during the process of completing the research study. Following completion of the study, the printed copy of the transcription will be shredded. Throughout the process of the study the transcriptions will be stored in a safe in the home of the researcher. The typed version will be kept for three years on a password protected laptop with no identifying information. Following the three year period the transcriptions will be permanently erased. All signed consent forms will be kept for a minimum of three years upon completion of the study. The consent form will be kept in a safe in the home of the researcher. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

### **Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the researcher or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. You can withdraw by informing the researcher you no longer wish to continue the interview, or by cancelling the interview in advance. You are also free to skip any questions I may ask.

## Contacts and Questions

My name is Nicole Goettl. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me by phone at (507) 380-2503 or email at [goet0053@stthomas.edu](mailto:goet0053@stthomas.edu). You may also contact my instructor at [hepp1989@stthomas.edu](mailto:hepp1989@stthomas.edu) or (651) 962- 5802. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or [muen0526@stthomas.edu](mailto:muen0526@stthomas.edu) with any questions or concerns.

## Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give my permission to be audio recorded during the interview.

**You will be given a copy of this consent form to keep for your records.**

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**Signature of Study Participant**

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**Date**

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**Print Name of Study Participant**

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**Signature of Researcher**

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**Date**

Appendix C

Good example to share.

# by a child welfare supervisor

describing the impact of her secondary traumatic experience

I thought I was doing well as a child welfare supervisor of one of the highest-risk areas in Ottawa, Canada. But that changed when I began having dreams—nightmares, really. As a manager for a unit of 10 child and family workers, I was struggling with cases that I could not assign. The workers had at least 30 cases already, many of which were extremely challenging.

As I began having the repeating nightmare, I took it as a warning sign to get the cases assigned and badgered my director to get other units to take the cases. But every night for two weeks, I had the same nightmare. I would see a young child around age 2 being sexually abused. It made me feel incompetent, because I could not stop it from happening. I would wake myself up, and then sit for hours with the images repeating in my mind. I did not share them with anyone, as I felt they were a reflection of weakness and inability to cope. Shaken by the nightmares and the intense situation at work, I found it difficult to stay focused. When I finally transferred the last case, I thought the nightmare would end, but it happened again that night.

When I went to work the next morning, I found out that a toddler had been brutally abused and murdered, then placed in a trash bin. The victim was part of an open case in another unit, but was the biological child of a mother in an open case in our unit—one that we had been intensely monitoring. What followed was an extremely difficult period of time for the already overwhelmed staff.

As I have become familiar with literature on the effects of exposure to traumatic stress, I wish I would have known about it at that time. This situation had a significant impact on me, particularly because it touched my own early traumatic experiences. Many years later, I still cannot speak about the circumstances of the death of this child without my eyes welling up.

**But I am not alone!**

Excerpted from "Addressing Secondary Traumatic Stress: Emerging approaches in child welfare" by Julie Collins, from Children's VOICE, March/April 2009, <https://www.cwia.org/voice/0903stress.htm>

A NARRATIVE

HANDOUT



## Overview

“Care providers are unique people. We have the gift of being able to connect with others in ways that are difficult to explain and even more difficult for others to understand. Our unique ability to emotionally join with our clients that allows us a near first-hand experience of their inner world is perhaps our greatest gift; it is also our greatest challenge.” --Karl La Rowe

**Burnout:** A state of physical, mental and emotional exhaustion caused by long term involvement in demanding circumstances. It is a prolonged response to chronic emotional and interpersonal stressors on the job which consists of exhaustion, disengagement or detachment, diminished feelings of self-efficacy and depletion. It is stress that is cumulative, relatively predictable, and can often be helped through a respite or habit/life change.

1. Burnout is a process, not a condition
2. Origins are usually organizational
3. Symptoms are directly related to the cause

### Symptoms could include:

- Depression
- Cynicism
- Boredom
- Loss of Compassion and Discouragement
- Decreased Work Productivity

## Trauma

Any event outside the usual realm of human experience that is markedly distressing (e.g., evokes reactions of intense fear, helplessness, horror, etc.) Such traumatic stressors usually involve the perceived threat to one's physical integrity or to the physical integrity of someone in close proximity.

**Secondary Trauma (Compassion Fatigue):** The experience of people who are exposed to the trauma of others through helping, or wanting to help a person experiencing trauma, and who as a result develop their own traumatic symptoms and reactions. A state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways as Post Traumatic Stress Disorder (PTSD). Similar to Critical Incident Stress (CIS), except that you are absorbing the trauma through the eyes and ears of your clients.

Symptoms typically mirror those of the clients and may include:

- Hyper-arousal
- Anxiety
- Intrusive thoughts
- Avoidance or emotional numbing
- Depression

**Costs of Compassion Fatigue**

- Job Performance goes down
- Mistakes go up
- Morale drops
- Personal relationships deteriorate
- Personality deteriorates
- Overall decline in health

**Vicarious Traumatization:** Vicarious Trauma is permanent cognitive and emotional changes that occur over time as a result of working with survivors of trauma. Its hallmark is disrupted spirituality, or a disruption in the trauma workers' perceived meaning and hope. It refers to the transmission of traumatic stress through observation and/or hearing others' stories of traumatic events and the resultant shift/distortions that occur in the caregiver's perceptual and meaning systems. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and becomes overwhelmed by this secondary exposure to trauma. (Figley & Kleber, 1995).

Outcomes of vicarious trauma are described as behavioral changes rather than symptoms.

**Vicarious Trauma Symptoms**

- Becoming increasingly judgmental of others
- Experiencing a disjointed sense of connection, including family and colleagues
- Becoming angry and cynical
- Losing hope and sense of meaning in one's work and relationships
- Becoming over involved
- Developing rigid boundaries
- Becoming isolated socially, emotionally and at work

\*Source: Adapted from

[http://www.valueoptions.com/providers/Education\\_Center/Training\\_Workshops/03\\_06\\_06\\_Compassion\\_Fatigue\\_Training.pdf](http://www.valueoptions.com/providers/Education_Center/Training_Workshops/03_06_06_Compassion_Fatigue_Training.pdf))