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A Phenomenological Study: Marriage and Family Therapists' and Clinician's Perceptions of How Secondary Traumatic Stress Affects Them and Their Families

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A phenomenological study: Marriage and family therapists' and clinician's perceptions of

how secondary traumatic stress affects them and their families

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Of the Requirements for the Degree

Doctor of Philosophy in Marriage and Family Therapy

By

Norja Cunningham

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WE HEREBY RECOMMEND THAT THE DISSERTATION BY

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Entitled

A PHENOMENOLOGICAL STUDY: MARRIAGE AND FAMILY THERAPISTS' AND

CLINICIAN'S PERCEPTIONS OF HOW SECONDARY TRAUMATIC STRESS

AFFECTED THEM AND THEIR FAMILIES BE ACCEPTED IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN MARRIAGE AND FAMILY THERAPY

APPROVED BY:

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Abstract

Multiple facets of clinicians' lives are influenced by compassion fatigue including physiological well-being, the perspective of clinicians in relation to the world, and psychological and emotional reactions to trauma triggers (Figley, 1998). Work stress research considers the systemic effects of stress on workers' relationships. Research also shows that romantic relationships are negatively influenced by work stress (Sanz-Vergel, Rodriguez, Bakker & Demerouti, 2012). This phenomenological study investigated the lived experience of three clinicians and how compassion fatigue was experienced in their relationships with their partners and children. Clinicians completed the Professional Quality of Life assessment and those with a score of 23 or higher on the secondary traumatic stress and burnout subscales participated in an interview. The major themes that emerged in this study were: (a) awareness of the effect of compassion fatigue on relationships; (b) awareness of clinician's psychosomatic symptoms related to compassion fatigue; (c) awareness of the effect of compassion fatigue symptoms on the clinician's social interactions; (d) awareness of the importance of clinician's boundaries and self-care after the onset of compassion fatigue symptoms; (e) heightened awareness of spirituality or religiosity after the onset of compassion fatigue; and (f) awareness of the children's presence mitigating compassion fatigue symptoms. This dissertation also addresses the implications of this study regarding self-care, the limitations of this study and future research.

Dedication

I would like to dedicate this dissertation to my late father, Norman Lewis Cunningham.

Since the age of five, I talked about being a doctor. My father didn't live beyond my 10th

birthday, but I know he's smiling from heaven knowing that I kept my word to myself, and

honoring the Cunningham name. I love you dad, and I trust this makes you proud.

Acknowledgements

There are so many who deserve acknowledgements, because of their moral, academic, spiritual and coaching support. Without these individuals my process through this research would not have been as an enriching experience, as it has become. My dissertation turned into a life experience that is now an opportunity for others' lives to benefit from it. I am so grateful that I could utilize my life and the lives of others to bring greater understanding about compassion fatigue, self-care and the power of relationship.

I am so thankful for God, His grace, endurance and strength, which He shared with me through this process. Without His presence in my life and within, I would not have completed this dissertation.

I would like to acknowledge and express gratitude for my Pastor, Apostle West, who prayed for me through this process. Her prayers and messages on Sundays kept me focused on finishing this process and gave me the spiritual strength to pass through that finish line. I appreciate her consistency and relationship with God, which gave her the strength to be victorious through tough times. She is an awesome example of what self-care through relationship and spirituality look like. I hope my commitment to God develops into a similar undying commitment she has to Jesus Christ's lived example.

I would also like to thank my mother, who was a great moral support and also a major portion of my bias statement. I am glad we were able to come through these past few years with persistence and support. A true mother's love never ceases and my love for my mother will not cease.

The support of my sisters is beyond description, and they were present just when I needed it. Our heart-to-heart discussions led to a stronger bond and support, when giving up appeared so

much easier. I am thankful to have sisters like you. You two are the best sisters in the world.

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I am thankful for my theory triangulator who assisted with the interviews and analyzing the data, which turned into confirmation of my themes. Her support was on time, and she was easy to work with. It was a great pleasure to have her join me in this process.

The support of my awesome dissertation chair and committee is incomparable. Because of their support, my end result is polished and ready to present to all. Their patience and firm hand were balanced well, and I appreciate their coaching through this process.

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Chapter One

Introduction

Providing therapy can be exhausting and clinicians may internalize a series of traumatic experiences transferred through their clients or while working in a distressing environment. This experience as a clinician can lead to *compassion fatigue* (Figley, 1995). Compassion fatigue is defined by two major symptoms, secondary traumatic stress (STS) and burnout (Figley, 1995; Figley, 2002; Jenkins & Baird, 2002; McCann & Pearlman, 1990; Stamm, 1999). STS's symptomatology is the same as posttraumatic stress disorder (PTSD), with symptoms including intrusive thoughts, hyper-vigilance, avoidance of thinking about trauma events, and nightmares (Figley, 1995 & 2002). Burnout is the onset of emotional exhaustion, depersonalization, disillusionment and feeling a lack of accomplishments influenced by working with distressed clients and job related crises (Figley, 1998; Maslach, 1982).

Compassion fatigue is a term that emerged from years of research, starting with research on burnout in the 1980s. The burnout research focused on clinicians who worked with highly distressed patients. Figley (1995, 1998, 2002), Maslach (1982) and others (Jenkins & Baird, 2002; McCann & Pearlman, 1990; Stamm, 1999, 2009, 2010) were the pioneers of this research. Figley noted that prolonged periods of caring for a family member with PTSD led to the caregiver experiencing physiological and emotional arousal; this suggested that PTSD symptoms are transferable within families (Figley, 1998). According to Figley (1998), burnout is a result of consistently helping traumatized clients who experienced a series of crises or are in constant distress. The more a caregiver aids a loved one with PTSD symptoms, the more likely caregivers

will experience burnout symptoms (Figley, 1998). Figley's (1995, 1998, 2002) research shows

that trauma symptoms can influence families relationships by creating more distress in

marriages, increasing anxiety, depression and stress levels in caretakers and influencing trauma

symptoms in children of parents with posttraumatic stress symptoms.

      Rationale. Secondary traumatic stress disorder is similar in symptomatology to

posttraumatic stress. This study focused on how trauma influenced clinicians and their families.

Considering that PTSD and secondary traumatic stress (STS) are similar, the effects described

previously may be similarly expressed in clinicians' families, leading to the research question:

what is it like for clinicians and their families to experience compassion fatigue?

      Why is the connection between compassion fatigue and family so important? The

marriage and family clinician's perspective is built upon systems theory. One main concept of

systems theory posits all elements in the system influence each other (Gagliardi, Guise, &

Vickers, 1997). Compassion fatigue is the burden carried by the clinician and the clinician is a

part of a family. Therefore, I propose that the clinician's family is influenced by the clinician who

suffers from compassion fatigue, which takes Figley's research a step further, as he focused on

how trauma work affects clinicians, not their families. Relational interactions can be influenced

by compassion fatigue, without the family members' knowledge that the clinician is suffering

from compassion fatigue. These thoughts are not currently reflected in the literature, which is a

compelling reason to conduct this research.

      As described earlier, secondary traumatic stress and posttraumatic stress disorder have

similar symptoms. STS is the transference of traumatic stress symptomatology through

witnessing another's experience via story-telling or perceiving the PTSD symptoms firsthand

(Nelson & Wright, 1996).

Figley (1998) highlighted the systemic effects of PTSD and how it influenced family members. As early as World War II, symptoms of trauma were transmitted among members of a family system. Nelson and Wright (1996) found that female partners of male veterans with PTSD experienced over-responsibility, role confusion in the home, unmet needs and an inability to consistently cope with stress. These findings suggest trauma symptoms negatively influence partners and home life, further suggesting that trauma symptoms are transferrable.

Chapter Two

Review of the Literature

Professional Quality of Life

Professional quality of life is a concept specific to compassion fatigue research. The idea that helpers' work lives can be influenced negatively or positively has been shared by Figley, Pearlman and Stamm for many years via studies, books and presentations (Stamm, 2010). Helpers include health care professionals, clinicians, social workers, firefighters, attorneys, police officers, clergy, airline and transportation staff, disaster site cleanup crews, and others who provide assistance during or after highly distressing events. Professional quality of life has two potential outcomes: compassion satisfaction and compassion fatigue. Compassion satisfaction is the positive response of helpers working in distressing work settings. Compassion fatigue is the negative response of helpers working in trauma-laden work environments.

Theoretical model of compassion satisfaction and compassion fatigue. Compassion satisfaction and compassion fatigue are two potential outcomes that may result when treating trauma clients or working in clinically distressing environments. There are three main environments that influence these outcomes: the work environment, the client environment, and the personal environment. The work environment includes how much clinicians enjoy working with their colleagues, their pay, support as a result of administrative structuring, and so forth. The client environment is related to the severity of the symptoms being treated, how much therapy is fostering change and the client-clinician relationships. The personal environment is based on clinicians' ability to manage stress, how competent clinicians are regarding treatment and clinicians' perception around support they have to fulfill their duties. Depending on the experience in these three areas, compassion satisfaction or compassion fatigue can be the result.

Positive regard toward the three areas leads to compassion satisfaction. In contrast, negative experiences in all three areas can yield compassion fatigue.

Compassion fatigue. Figley is the pioneer researcher of secondary traumatic stress and compassion fatigue. Since the mid-eighties, Dr. Figley examined this concept and Stamm followed. According to Stamm (1999), compassion fatigue is the long term influence of "helping or wanting to help a traumatized or suffering person" (p. 10) and perceiving little to no improvement. Sixty percent of clinicians exhibit signs of secondary traumatic stress during the first year of disaster relief work or while working with traumatized clients (Figley, 2002). STS symptoms have an onset in as little as 10 days after exposure to a client's trauma story (Figley, 2002).

Compassion fatigue is mitigated by compassion satisfaction. Compassion satisfaction is the clinicians' perceived satisfaction with their clinical treatment resulting from observing their work as beneficial to their clients and being satisfied with their work environment. If clinicians are satisfied with their work, client, and personal environments, the clinicians function normally and are in good psychological, emotional, and physical health. Once the clinicians view their work, client, and personal environments in a negative frame, their work or professional practices are negatively influenced. The clinicians' work can then influence their ability to cope with the trauma narratives of their clients (traumatized by work), leading to exhaustion, anger, frustration, and depression (Stamm, 2009).

Compassion fatigue also influences clinicians' world-views. Specifically, it can influence the perception of safety, trust, self-esteem or confidence, intimacy with self and others, and control of self and others (Figley, 2002). Another important symptom associated with compassion fatigue is the *silencing response*. This symptom is a reaction to the clinician's world-

view being negatively influenced. It is a coping mechanism where clinicians refuse to speak

about a traumatic event, directly or indirectly tell their clients to "just get over it", minimize

clients' traumatic experiences, fake interest or fake listening, have a fear of what their clients will

say, blame the clients for their experiences, and/or feel numb or avoidant before sessions. The

silencing response is positively correlated with compassion fatigue (Figley, 2002; Stamm, 1999).

The silencing response can also lead to clinicians making unethical decisions (Negash & Sahin,

2011). These decisions can influence clinicians' professional efficacy.

Figley (2002) and Stamm's (1999) research suggests professional and personal factors can

influence the likelihood of clinicians expressing compassion fatigue symptoms. Clinicians'

susceptibility to compassion fatigue increases if their job roles are undefined, if they have a high

caseload, have low pay and low work status, high conflict between work and home demands, are

provided little individual supervision and have little time to discuss cases with colleagues

(Figley, 2002). Personal factors that lead to compassion fatigue are inadequate coping skills, little

time with family and friends, and little time for self-care (Figley, 2002). Spiritually, clinicians are

vulnerable when suffering from compassion fatigue, if they do not have a belief system or

connection to a higher power (Figley, 2002).

Trauma transmission conundrum. According to Figley (1998), compassion fatigue is

explained by the *trauma transmission conundrum*--one family member feeling the pain of

another or a clinician feeling the pain of a client. Exposure to PTSD-diagnosed individuals leads

to experiences of physiological and emotional distress. Further illustrating this, Killian (2008)

conducted a mixed-method study which focused on work stress and coping while working with

trauma survivors. There were 20 participants who were interviewed and 104 participants who

completed a questionnaire inquiring about their caseload, coping styles, self-awareness, work

stress levels, trauma history, compassion satisfaction, secondary traumatic stress and burnout.

The four themes that emerged from the interviews were, "recognizing symptoms of work stress,

risk factors in developing burnout, definitions of self-care, and specific self-care strategies"

(Killian, 2008, pp. 34-35). In total, 20 participants were interviewed to discuss their symptoms of

work stress. One of the participants reported "mental, physical and emotional exhaustion…,

emotionally shutdown…, forgetfulness when…trying to do too much…, and having trouble with

sleeping" (Killian, 2008, p. 35). Another participant expressed the following:

> I definitely carry feelings home from work and then have to figure out a way to deal with
>
> those interpersonally without it having a negative effect on our relationship. Work stress
>
> affects the sexual relationship in that you can have intrusive thoughts of a story that you
>
> may have heard from a client at the most inopportune moments and then you have to be
>
> able to talk openly with your partner. (Killian, 2008, p. 35)

This participant explained how clinical work affected her home life and the intimate relationship

she had with her partner. Astin (1997) also conducted a qualitative study on how work with rape

victims influenced her as a clinician. This narrative of her experience comes from the perspective

of vicarious traumatization and information processing theory. She explained how she was

affected by her work and how her worldview was changed by her work. Astin described a change

in her safety needs following secondary exposure to sexual trauma as follows:

> I suddenly find myself more critical of the quality of locks in my home and
>
> replace them with better ones. The car door is always locked when I am driving.
>
> I am more careful with whom I speak in public. I find myself wondering why
>
> that guy is walking toward me and clutch my keys ready to strike out if I have to.
>
> I question the motives of others much more readily and never assume they mean

no harm to me (p. 106).

The research by Killian (2008) and Astin (1997) show that trauma is transferrable from clients to clinicians, and clinicians can experience negative symptoms associated with treating highly distressed clients.

The *model of compassion stress* (Figley, 1998), and the work of Killian (2008) and Astin (1997) clarify how PTSD symptoms can be transferred from person to person. *Empathic ability* (Figley, 1998) allows caretakers to notice another's pain that can lead to *emotional contagion*--experiencing the pain another feels. This can motivate caretakers to provide help--*empathic concern*, which leads to right responses, in tone, timing, and temperament that can help the suffering family members or clients--*empathic response* (Figley, 1998). After exhausting all support for the suffering family members or clients, disassociation may occur. Sometimes those helping the sufferers feel a sense of achievement for successfully facilitating the relief of the PTSD symptoms. If the helpers unsuccessfully alleviate trauma symptoms, then this can influence *compassion stress*--physiological and emotional stress experienced vicariously. Compassion stress and prolonged periods of caring for PTSD-diagnosed individuals can lead to *compassion fatigue* (Figley, 1998).

How Trauma and Stress Affect Relationships

Traumatic stress and relationships. Relationships can be influenced by traumatic stress. More specifically, marriages and parent-child relationships can be influenced negatively by trauma. For example, couple relationships can be influenced by traumatic stress (Lev-Wiesel & Amir, 2001). If one partner suffers from PTSD, the other partner can reflect secondary trauma stress symptoms. The couple relationships may suffer as a result from anger-hostility and anxiety creating a perceived decrease in the quality of the marital relationship. Thus, marriages can be

influenced by PTSD symptoms being transferred from one partner to another (Lev-Wiesel &

Amir, 2001). Couples' adaptation to trauma can be negatively influenced by a lack of resources

and a history of unresolved trauma (Nelson & Smith, 2005). Couples with trauma histories report

lower marital adjustment and higher individual stress symptoms (Nelson & Wampler, 2000).

Couples also experience difficulty due to triggers that resurface memories of past trauma,

boundary and intimacy issues (Henry et al., 2011).

    Partners of PTSD sufferers also experience secondary traumatic stress. Partners may

become over-responsible or over-function for the partners with PTSD (Figley, 1998). Secondary

traumatic stress may be connected to the divorce rate among veterans with PTSD symptoms--

38% of veterans' marriages ended in divorce 6 months after the Vietnam War (Figley, 1998).

White women married to PTSD sufferers reported anxiety, insomnia, and feeling distracted

(Figley, 1998). Conversely, minority wives reported feeling anxious but focused their concerns

toward the welfare of their children (Figley, 1998). Other symptoms expressed by wives of

PTSD sufferers included startle response, helplessness, hypervigilance, and protecting children

from the potentially violent suffering husbands (Figley, 1998). Relational assumptions are

influenced by the trauma event (Figley, 1983; 1985).

    Children also can experience symptoms of secondary traumatic stress. Figley (1983)

posits all family members should be considered victims of a traumatic event, whether they were

initially victimized or not. Children can be influenced by hearing trauma stories from their

parents and witnessing trauma first-hand. Figley (1998) found that children expressed symptoms

similar to their war veteran parents, including rage, depression, guilt, loss of impulse control,

nightmares, and flashbacks.

    Parents may also experience secondary traumatic stress when caring for their children

who experienced a traumatic event (Figley, 1998). Parents may experience intrusive thoughts, nightmares, flashbacks, feelings of detachment or estrangement from others, restricted influence, emotional and physiological distress and avoidance of activities (Figley, 1998). Trauma laden parent-child relationships can lead to two major reactions: parents absorb their children's symptoms leading to not noticing the child's PTSD, or children attempt to shelter their parents from feeling more pain (Figley, 1998).

Traumatic injuries and relationships. Traumatic brain injuries (TBIs) are as a result of harm to the head, which causes brain damage. TBIs are diagnosed in 1.7 million injury cases annually, and 80% of the cases live and are released from the hospital (CDC, 2012). TBI symptoms include, "disinhibition, inattentiveness, behavioral immaturity, depression, anxiety, apathy, increased anger and aggression, hyperactivity, impulsivity, social awkwardness, and social withdrawal" (Trenchard, Rust, & Bunton, 2013, p. 1218). Symptoms of posttraumatic stress can also manifest up to three months post-head injury (Trenchard et al.). The intensity of the symptoms determines if a patient has mild, moderate or severe TBI. Because TBI patients' cognitive functioning is impaired, a caretaker assists the patient to maintain a decent quality of life. Caring for this population can be distressing (Sander et al., 2013). In most cases, relatives or partners are the caretakers of TBI patients. The emotional well-being of the caretakers can be negatively influenced by supporting the TBI patient.

Family or partners see consistent exposure to TBI symptoms as burdensome**.** More specifically, research shows that caretakers experience caregiver burden, anxiety, depression and stress while aiding a loved one with TBI (Jordan & Linden, 2013; Nonterah et al., 2013; Sander et al., 2013). Research results also revealed dysfunctional relational dynamics between the TBI patient and caretaker, including enmeshment (Suppes & Fins, 2013). These results suggest that

caretakers of TBI patients are expressing similar symptoms as the patient due to unclear or diffused boundaries. These findings further support that trauma symptoms can be transferrable, even if the trauma began as physical harm. Furthermore, this suggests the possibility that clinicians who treat TBI patients may experience secondary traumatic stress.

Work stress and relationships. Meadors and Lamson's (2008) research participants stated they carry traumatic stress from work to home. Similarly, studies were conducted regarding stress at work and how it influences home life. Conservation of resources theory suggests the more resources (things, characteristic, energy or conditions) one has the more resources the individual can obtain and maintain; this is called the *gain spiral* (Meadors & Lamson, 2008)*.* Demands placed on the people deplete their resources and lead to a *loss spiral*, which increases stress in them and negatively influences their work-home life (ten Brummelhuis & Bakker, 2012). This idea is important because it suggests that access to more resources decreases the likelihood of stress crossing over into the home life. Therefore, spillover and crossover are a concern when the demands at home or work outweigh the resources an individual or a system can access. Based on this theory, spillover and crossover of stress are a direct result of a lack of personal and contextual resources (ten Brummelhuis & Bakker, 2012).

Crossover and spillover are two distinct processes of work stress being transmitted into family life. Distress absorbed from the work environment is the initiator of this process. This *emotional contagion* has a powerful effect on the lives of those connected to clinicians in distress. Crossover and spillover are potentially harmful to partners, children, friends and associates. Transferred distress is the result; the stressed worker is the carrier (Bakker, Demerouti, & Schaufeli, 2005).

Spillover expresses the transfer of stress from one person to another. This means the

accumulation of stress in one person at work can influence the increase of stress levels in another person. Crossover works differently. It is the transfer of stress from one system to another--more specifically from work to home. Crossover and spillover highlight the power stress can have on working environments, individuals and their relationships (Bakker et al., 2005).

Research highlights that spillover occurs between working couples. More specifically, husbands and wives can transfer positive and negative feelings about their jobs, including burnout symptoms, exhaustion, and cynicism (Bakker et al., 2005). Couples in early marriage who experience a stressful day report negative appraisals of their relationships (Buck & Neff, 2012). Crossover of negative and positive feelings at home can be transferred to work life as well (Bakker et al., 2005). The more demands placed on couples and fewer resources obtained by couples, the more spillover and crossover have negative effects on home life and work life.

If (both) home and work are not perceived as a resource, then it is perceived as a demand, which places greater stress on individuals and can negatively influence work performance and close (home) relationships. More specifically, research shows that an increase in emotional labor at work leads to a decrease in personal well-being. The decrease in well-being can negatively influence marital relationships (Sanz-Vergel, Rodriguez, Bakker, & Demerouti, 2012).

Research reveals that excess stress negatively influences relationships. Individuals may expose their partners or children to spillover stress, which leads to negative relationship dynamics. Spillover, crossover and conservation of resources theory are all theories that support the idea of traumatic stress having a systemic influence. Work on compassion fatigue has not included this perspective of how stress influences family and spousal relationships. In addition, compassion fatigue connects traumatic events (proximal or distal) to traumatic responses in clinicians.

As a review, compassion fatigue (burnout and secondary traumatic stress) and PTSD have been studied extensively for at least 20 years. STS, PTSD and TBI share a similar process with regards to transference of symptoms. Research shows that PTSD can be transferred between people and stress can be carried from work to home. STS is the result of transmission of trauma-like symptoms from a PTSD client to a clinician. This process is similar to someone with PTSD or TBI vicariously traumatizing a family member. This process is also supported in the work stress research with regards to spillover. Therefore, this process of transferring trauma and stress symptoms from one person to another is very clear. By the same token, research has not investigated if compassion fatigue influences clinicians' families. This study will investigate the lived experience of clinicians and the clinician's perception of their families experience with compassion fatigue. Drawing on this literature, and based on this gap, my research question for this study is as follows: how do clinicians experience compassion fatigue or secondary traumatic stress for themselves and in their families?

Chapter Three

Methods

The overarching question for this research project was: how do clinicians experience compassion fatigue or secondary traumatic stress for themselves and in their families? This question was investigated using heuristic phenomenological methodology (Creswell, 2007). Heuristic phenomenology begins with the researcher having a personal question that is universally relevant (Creswell, 2007). As described by Moustakas (1994), data were gathered and a reduction process utilizing Colaizzi's method of analysis was employed. Heuristic phenomenological methodology and procedures were the best approach to answering the research question because it allowed for my story to be honored and for me to engage in self-reflection on the research process. I also bracketed my perspective, so the results were based on the intended meaning of the participants and also allowed for more than one individual's lived experience of compassion fatigue to be honored (Creswell, 2007). Most importantly, it allowed for the participants' responses to reflect their own meaning of their experiences with compassion fatigue. Thus, the participants' themes showed how compassion fatigue influenced their own lives, as well as those of their live-in partners and children.

Procedures

This study had two phases. The 1st phase was to administer the Professional Quality of Life assessment (ProQOL; Stamm, 2009, 2012) to assess for the presence of compassion fatigue--an inclusion criterion--and the 2nd phase was to complete face-to-face interviews, based on the inclusion criteria (described further below). Therefore, during the first phase, an email or face-to-face solicitation included an information sheet with the screening assessment attached. The information sheet is located in Appendix D. Participants were also solicited via social media

(Facebook) by liking "Norja's Research" page and sharing this study with fellow clinicians who were eligible to participate in the study. The potential participants solicited by social media were requested to contact me via email; then I would submit the ProQOL and demographics page. All participants (included and excluded) were from the New England region of the United States of America working at mental health agencies, schools and private practices. Each participant in the 1st phase received a scripted message including the results from the ProQOL via email (Appendix E). The clinicians who chose to participate in the initial phase of this study provided consent for that component of the research by completing the ProQOL assessment.

       Screening with the ProQOL. A paper and pencil assessment (Professional Quality of Life, Version 5; Stamm, 2009, 2012; sample items can be found in Appendix B) was administered to establish who would participate in the study. The inclusion criteria were as follows: the clinicians were actively providing treatment to distressed clients; the clinicians lived with a partner and had at least one child; lastly, the participants had at least a score of 23 for each subscale, burnout and STS. The Professional Quality of Life assessment (ProQOL; Stamm, 2009, 2012; Appendix B) measures two constructs, compassion satisfaction and compassion fatigue, which has two subcategories: burnout and secondary traumatic stress (STS). Compassion satisfaction is one's level of pleasure received from conducting his/her work. Burnout is one's level of symptoms expressed like fatigue, being easily frustrated, aggression and depression. STS is one's level of emotional and psychological reaction to working with trauma cases. The ProQOL has 30 items using 5-point Likert-type response scales (ranging from 1-Never to 5-Very Often). The ProQOL has three subscales--compassion satisfaction, secondary traumatic stress and burnout—each made up of ten items. The score for each scale was derived by adding the numbers, as instructed in the ProQOL self-scoring version (Stamm, 2012). The burnout scale

includes five responses that are reverse scored before summing the scale. Each scale can also be divided into three levels--low (22 or less), average (between 23 and 41) or high (42 or more). The author reported good construct validity, meaning this tool is measuring the construct (compassion fatigue) accurately (Stamm, 2010). There were no reported results for test-retest reliability. I received written permission to administer the ProQOL for the purposes of this study (Stamm, 2010; Appendix A).

The ProQOL (Stamm, 2009) assessment was administered to determine if the participants were suffering from compassion fatigue. Participants received confidential emails or a face-to-face report including results from the ProQOL (Appendix E). Twenty-three clinicians responded to the ProQOL assessment. All of the clinicians who completed the ProQOL assessment were from New England and worked as clinicians. Nineteen of the 23 clinicians did not meet the criteria to participate in the interview process. One met the criteria but declined to participate in the interview. Of the 19 excluded, 10 were married and/or had children, 8 were single with no children and 1 did not complete the demographics form. Each interviewee was required to have an assessment score of this combination--total score of at least 23 in STS and a total score of at least 23 for burnout. Every participant who scored 23 or above for secondary traumatic stress and burnout, and lived with a partner and had child(ren) was invited to participate in an interview. Seven of the 19 excluded met the partner and child requirements; however, either their STS or burnout scores (or both) were 22 or below (i.e., below the cut-off for inclusion). The average burnout score for the excluded participants was 21.3. The average STS score for the participants who did not meet the inclusion criteria was 19.7. The average scores for burnout and compassion fatigue for the participants who met the inclusion criteria were 26 and 24, respectively.

Recruitment. Once screening was completed, phase two of the study began. Heuristic

phenomenology is a methodology that calls for the researcher and participants to share their experiences through a self-reflection and interview process (Creswell, 2007). While I had hoped to interview at least five clinicians, with great effort, I was able to conduct three interviews. My data collection process began May 31, 2013 and continued with IRB approval until May 31, 2014. Within that one-year time span, I solicited via email to mental health agencies in the New England region, workshops, on a Facebook page and via phone calls to New England mental health agencies. At the same time, I was able to get three participants who had clearly experienced the phenomenon I was interested in and who gave me a clear picture of their experiences with compassion fatigue and how they think it affected their families.

The clinicians who met the criteria to participate in the interview received an email or face-to-face solicitation during a workshop at Antioch University New England. The email message is included in Appendix E. I reserved the right to call the participant if he or she did not respond within 48 hours of receiving the email. The phone call script is also in Appendix F. I intended to interview the clinician, partner, and children at the same time; however, clinicians showed no interest in their partners participating in the interviews with them--as expressed via email in response to an invitation to participate in the interview--and including children was a potential risk, based on the IRB requirements. So, I conducted the interviews with the clinicians and they provided their perspectives regarding how compassion fatigue affected their partner and children.

Interviews. I scheduled interviews with three female clinicians who responded and met criteria to participate in the second phase of this study. Each clinician participated in one scheduled interview. The interview participants communicated in English and resided in New England. The intent of the interview was to gather enough verbal data to have a clear

understanding of the participants' experiences and perception regarding their family relationships

while having compassion fatigue symptoms. Before the interview, each clinician signed a

consent form including their ethical rights as research participants (Appendix G). The

participants were advised to contact 211 if they needed a clinician, just in case psychological

distress occurred during or after the interview. Children and partners were not included in the

interview but were discussed during the interview.

The interview data were recorded by a video camera (which was the only recording

device available at the library) with the assistance of a theory triangulator (Guion, Diehl, &

McDonald, 2002, 2011). The consent included the participants providing verbal authorization for

the camera operator to witness the interview (Appendix G). In this phenomenological research

study, I asked preset open-ended questions (Creswell, 2007). The interviews lasted from 7.5

(Participant 2) to 25 (Participant 3) minutes. Every participant in the interview was asked the

first question as the overarching question and then the probing questions as shown in Appendix J.

The questions were chosen because of the literature expressing that compassion fatigue

affects clinicians physically, psychologically, relationally, professionally and spiritually (Figley,

1998). These questions also resonated with my personal experience. These questions allowed the

participants to share their experiences and perspectives of their partners and children's

experiences with compassion fatigue.

Due to a few clinicians' hesitation about participating in the interviews, I also posted the

exact questions posed in the face-to-face interviews via SurveyMonkey to every clinician who

participated in the ProQOL phase of the study, except the clinicians who were interviewed. All of

this was completed during the 2nd phase of this study, with IRB approval. This survey included

the same interview questions (listed in Table 1), allowing clinicians who met the criteria to

participate in the interview (but declined participating), and provided another avenue to participants to share their experiences. This was an attempt to include more participants who could be honored for their experience and add to the richness of the themes and exhaustive description in this report. Unfortunately, no one responded.

Data transcription and analysis. The theory triangulator (Guion et al, 2011) was responsible for listening to the camera recording and typing the interview verbatim. The transcription (Appendix H) included all of the verbal information shared by the participants. I reviewed the transcription to confirm it was the exact written account of the participants' words. Next, I refrained from reading the transcript for a minimum of seven days after the review (Moustakas, 1994).

The transcripts were reviewed again in order to select significant phrases, sentences and paragraphs. To determine significant sections, I underlined the phrases, sentences, and paragraphs that captured the thoughts of the clinicians and then wrote statements that summarized those selections. This is the process of reduction, where the thoughts of the participants were condensed from full explanations to clear themes and descriptions, conveying the experiences of the participant. Every paragraph or phrase deemed significant (or meaningful based on the research question) was underlined or highlighted. The phrases were then reworded as meaning statements. These meaning statements were significant expressions from the perspective of the participants reduced to fewer words. These meaning statements were written on index cards and placed in piles based on similar meanings. After this, themes were derived from the index card piles and an exhaustive description was written.

Themes are concepts established from the perspective of the participants' lived experiences shared in the interviews. The descriptive statements were written based on the

themes and specific quotes from the participants. These statements provided details about the

meaning of the themes and described the perspective of all the participants in one concise

paragraph. I compared my themes with the themes derived by the theory triangulator and there

was great similarity between the significant statements that made up each of our themes and the

themes themselves were the same. The accuracy of the themes and exhaustive description were

read, discussed and verified with one participant, as a member check.

Ethics and Risks Considered

This study entailed minimal risks, and ethical guidelines were considered, based on the

AAMFT code of ethics; confidentiality and responsibility to the research participants were the

two most important considerations (AAMFT, 2012). This study required the participation of

clinicians. For this reason, the consent form included a clause requesting that the clinicians

maintain confidentiality, refrain from sharing any information regarding their clients (AAMFT

Code of Ethics Principle 2.2) or take appropriate steps to mask the identification of their clients

(AAMFT Code of Ethics Principle 2.4). Client information could only be shared if the clinicians

received written permission from their clients prior to the interview (AAMFT Code of Ethics

Principle 2).

This study also required that I follow ethical guidelines. Confidentiality was maintained

on behalf of the research participants, and was noted in the consent form along with exceptions

(AAMFT Code of Ethics Principle 2.1). Research participants knew their information and

involvement in this study would not be disclosed to any sources, other than the theory

triangulator, and participants gave permission to record (AAMFT Code of Ethics Principle 1.12).

The data gathered was also stored appropriately, on a username and password protected web

drive only accessible via a username and password protected computer, for the purposes of

maintaining confidentiality (AAMFT Code of Ethics Principle 2.5 & 5.5).

AAMFT Code of Ethics Principle 5 (AAMFT, 2012), responsibility to the research participants, was also important in the implementation of this study. I had observers not directly involved in the research, three dissertation committee members and the Institutional Review Board (IRB), confirming that this study was following appropriate ethical guidelines (AAMFT Code of Ethics Principle 5.1). The steps that I took to maintain the confidentiality of participants were written in the consent form (Appendix G; AAMFT Code of Ethics Principle 5.3). I informed the participants they could withdraw at any time (AAMFT Code of Ethics Principle 5.4). As a precaution, the research participants were provided 211--a phone number that provides information to people for mental health support--as an option to locate a clinician if psychological distress ensued during the interview process (AAMFT Code of Ethics Principle 5.2).

Lastly, I was mindful of multiple (colleague/research participant) relationships while conducting this study (AAMFT Code of Ethics Principle 1.3). I utilized a decision making model entitled *Avoiding Exploitative Multiple Relationships* (Gottlieb, 1993) to determine if one of the clinicians could participate in the study. This decision making model included three dimensions: power--the power differential between the participant and researcher; duration--the length of the relationship; and termination--the definitive end to the relationship. I utilized this decision-making model with one of the participants whom I knew prior to this study. Because this participant and I had a minimal power differential, knew each other for less than a year and did not have a long-term close relationship, she was able to participate in this study.

Trustworthiness

Trustworthiness is a gatekeeping process in qualitative research for the confirmability

(the ability for the results to be supported by the confirmation of the participants and not from the motivation or bias of the researcher), credibility (the ability to establish the results are credible from the perspective of the participants) and dependability (the ability to replicate the study and have similar themes) of the results (Moustakas, 1994). In qualitative research, techniques including the practice called *epoché*--suspending all of my own judgment to read with little interpretation to maintain the purity of the meaning of the interviews--journaling and writing a statement of bias assist with increasing the trustworthiness of the results. Reducing personal bias through the use of journaling overtly expressing any potential biases and 'pocketing' the biases will allow the meaning of the words expressed by the interviewees to be as authentic as possible. My bias statement is a strategy to increase trustworthiness (see Appendix H).

Theory triangulator. I included a theory triangulator (Guion et al, 2011) in my research, who also assisted with videotaping the interview, transcribing the interviews and utilizing Colaizzi's data analysis method to derive themes from the transcript. A theory triangulator is a secondary researcher who is responsible for reviewing the same data I reviewed to confirm or refute the themes that emerged from the initial analysis by the primary researcher (Guion et al, 2011). By including a theory triangulator, the trustworthiness of the results is strengthened—the role of the theory triangulator improved the confirmability and dependability of the results (Moustakas, 1994) by reviewing the research data with a "new" and "different" perspective, because she was not emotionally invested in the research topic. More specifically, by working with a theory triangulator, the research has greater potential to be replicated by another researcher with ease. Another strength of working with a theory triangulator is that there are two converging descriptions of the data. This process further assisted with the trustworthiness of the

themes derived from the data.

Other techniques to increase trustworthiness. All of the documents regarding the participants in the ProQOL, interview participants, and a description of the research process were kept as an audit trail (Moustakas, 1994) in order to increase the likelihood of another researcher being able to replicate this study (dependability). Notes were taken as the research was being conducted to assist with recalling the steps I took to implement this study. I also engaged in personal introspection while conducting the research to remain aware of how this process made me think and feel about secondary traumatic stress. This audit trail was implemented to increase the trustworthiness of this study.

While conducting this research project, specific steps were followed to maintain fidelity to the methodology and to obtain results that were trustworthy. The initial email or face-to-face inquiry assisted with soliciting the participation of clinicians from agencies and other larger systems. Each participant understood his or her rights as a participant of this research project. A demographics form was also embedded in the email sent to each clinician (see Appendix C). These steps in this study provide support for the credibility of the results. This supports the confirmability of the study, as another researcher could follow these procedures with a similar population to test if the results are similar. Credibility is displayed here because I followed all of the appropriate steps ethically and based on the IRB for every participant to be aware of their rights and for me to maintain their identity without directly connecting it to their ProQOL results--to increase confidentiality. I also engaged in *epoché* (Moustakas, 1994), which means to suspend my own judgment regarding the interviews I facilitated and reviewed before deriving meaning from the participants' interviews. As noted earlier, this was partially accomplished by my writing of a statement of bias (Appendix H) and having the theory triangulator write a

statement of bias as well (Appendix I). In addition, I conducted a member check (Moustakas, 1994), by requesting all participants in the interviews to review the themes to confirm their perspectives were represented. As previously mentioned, only one participant responded to this request.

Participants

The participants in this study met the inclusion criteria noted above. The participants interviewed were three female clinicians who were actively working with at least one case where trauma was the focus of treatment, or where the environment was distressing. Participant one was a 35-year-old Caucasian female clinician who worked in private practice, full-time as a clinician. She had a partner and two children. Her STS score was 25 and her burnout score was 26. Participant two was a 27-year-old Caucasian female who was a doctoral clinical intern at a New Hampshire agency and academic training clinic. She had a partner and two children. Her STS score was 24 and her burnout score was 24. Participant three was a 56 year-old Caucasian and Jewish female school counselor who worked at a New Hampshire high school. She had a partner and three adult children. Her STS score was 23 and her burnout score was 28.

Chapter Four

Results

Themes

From the interviews emerged six major themes and three sub-themes, present in all three participants' transcripts. The major themes are: (a) awareness of the effect of compassion fatigue on relationships, which included three subthemes: (i) impatience with partner and children, (ii) family and friend relationships influenced negatively, and (iii) clinicians' responses to family and family's responses to clinician; (b) awareness of clinician's psychosomatic symptoms related to compassion fatigue; (c) awareness of the effect of compassion fatigue symptoms on the clinician's social interactions; (d) awareness of the importance of clinician's boundaries and self-care after the onset of compassion fatigue symptoms; (e) heightened awareness of spirituality or religiosity after the onset of compassion fatigue; and (f) awareness of the children's presence mitigating compassion fatigue symptoms. Each of these themes is explored in depth below, as is a summary exhaustive description.

Awareness of the effect of compassion fatigue on relationships. The participants reported an awareness of how compassion fatigue influenced their relationships. More specifically, the participants reported feeling very impatient with their partner or clients. They also reported feeling like they did not wish to hear any bad news from their children. The participants also spent less time with their families as a result of compassion fatigue, per their report. Family members also started to distance themselves emotionally and socially from their compassion-fatigued family member. The most salient effect of compassion fatigue on the participants' relationships was the negative effect on connection and communication between partners. There was a presence of discord or lack of communication reported by the participants.

Impatience with partner and children. The clinicians reported their awareness of being very impatient with their partners during the interview. This influenced their family relationships because the clinician expressed being less empathic when interacting with their children and partner. Here are some of the statements the participants shared that illustrate this theme.

I probably had a little less patience at home with her (partner), a little snappier.

On worse days… I don't have the level of empathy or sympathy that I need towards them (the children) at all times.

Family and friend relationships influenced negatively. The clinicians expressed the act of letting go of their relationships because of the physical and psychological exhaustion they were experiencing. They also explained feeling so overwhelmed with the trauma stories from clients they were unable to be present for their home relationships. Here are some of the statements the participants shared that illustrate this theme.

We take one of my sons to a clinician, and the clinician has this great image that I love. When you're in a family, you're holding on to the string and so it's the circle of people… the three kids all holding onto this string. And when you (her son) have… attachment and abuse history… when things get rough he lets go of the string. I think that's true of me as well… And I think when things are bad, I was stressed out and I was so traumatized by what I was doing (clinical work) that there was no string… I was so overwhelmed that I wasn't even able to interact with my family, much less my friends.

…a feeling of, I didn't do a good enough job. I think that influenced my relationship (partner relationship) more because I would come home and be going over sessions in my mind and thinking, 'I didn't do that right. I wish I could have that one back'… and I didn't bring my best Self home 'cause I was elsewhere.

Clinicians' responses to family and family's responses to clinicians. The participants

shared feeling less connected to their partner while experiencing compassion fatigue. This led to

less communication with their partner. The clinicians also described their partners as having less

empathy about how work as a clinician influenced the clinician. This led to less communication

or more dysfunction within the partnership, per the participants' reports. Here are some of the

statements the participants shared that illustrate this theme.

> I had to… learn to renew myself from that experience (compassion fatigue) rather than
>
> getting stuck in the, what ifs and the burnout and considering it (the children) the same
>
> way that I consider my clients. What's going to happen next? What are they doing?
>
> What's that twitch mean? What's going on? Over analyzing.
>
> I can be a little, no excuses, with my kids… (with children)... You can talk to me about
>
> what's going on with you, but the excuses aren't going to work.
>
> I'm… less talkative with my husband. He doesn't like to talk about problems at work. (He
>
> says)… 'You're always talking about the bad things at work. My work is terrible.
>
> Only one (adult child of three children) who really ever wants to hear or has patience to
>
> hear how I feel about… the things that upset me at work…

Awareness of psychosomatic symptoms related to compassion fatigue. Participants

reported their experience with physiological reactions to clinical work. The reports included

feeling tension in their shoulders, headaches, feeling extremely tired or fatigued and overall

feeling flu-like symptoms. Participants shared experiencing the very same physical symptoms

that their clients reported. The clinicians reported being aware of their psychosomatic symptoms

during sessions, following sessions, or after arriving home from a full day of providing therapy.

Here are some of the statements the participants shared that illustrate this theme.

I have a lot of tension headaches; a lot of tension… in my shoulders… there are times

when… I feel like I have the flu. I feel like I get everything that my clients talk about,

like I have a lot of clients who have a lot of somatic concerns and I always get part of it.

I have certainly experienced trouble sleeping after working with really troubling stories

from people I am working with.

Awareness of compassion fatigue's connection to social interaction. Social interaction

was another concern for participants after the onset of compassion fatigue. Participants reported

feeling very isolated or wanting to isolate when tired and impatient. Participants also reported

being introverted. I am unsure if it was prior to or after the onset of compassion fatigue that the

participants perceived themselves as introverts. Participants also tended to experience more

individualized activities compared to more group related activities. Participants reported it was

difficult to consider participating in social situations. Here are some of the statements the

participants shared that illustrate this theme.

And this is going to be a terrible thing to say but I have…as a generality we have four

guidance counselors in our school district and I have not really found them to be that

supportive with each other so… Actually we have five guidance counselors in our school

district and the one whose partially in our district, I mean our school, the middle school

and also in the high school, he's probably the easiest but he works in the high school. His

boss is in the high school so he gets pulled more to the high school than in the middle

school. So I find being a guidance counselor very isolative, that's not a word but isolating

and in fact when I have an intern it's always really nice for me because then I actually do

have someone that they can talk about their stuff with me and then I can bounce stuff off

of them. So I really… it's a big plus for me when I have an intern, they help me with the

work plus it's another, it's a colleague for me.

I'm very introverted and so for me being in a crowd of people… and talking to clients - 5

or 6 clients a day--I'm done at the end… I don't want to talk to friends. I don't… like

sometimes I do emails, a little bit but I don't like… like I'm not out there talking to

people. And most of friends um we're really… So we have this the sort of community

acquaintance stuff but I don't have a lot of like deep, relationship friends things and I

don't seek them out really at this point. I wish I did sometimes but I don't have the energy

for it.

Awareness of the importance of boundaries and self-care after onset of compassion

fatigue. Boundaries are an important topic for participants in this study. The participants shared

their experiences regarding the symptoms of compassion fatigue and maintaining some distance

from their work. They also expressed the importance of monitoring the acuity level of clients

they treat to reduce the likelihood of experiencing compassion fatigue. All participants addressed

their rules around providing clinical treatment based on their experience with compassion fatigue

symptoms. The participants also shared being more aware of activities that helped them to

decompress and mitigated compassion fatigue symptoms. Self-care was addressed by every

clinician and included many activities and hobbies that allowed for time to enjoy life and spend

little time thinking about stressful topics (i.e., mental health concerns and larger system issues).

I just have to go to sleep. I just got to take a nap… zone out… watching silly movies or…

reading fluffy books.

I went into practice knowing I was burned out and knowing that I needed to keep

working so I have been able to over the past couple of years, sort of, hone my caseload a

little bit and learn some more boundaries and learn how to sort of do this (clinical work)

without burning myself out…

I really have to learn how to say no. I just can't… I work in town where there are very

few clinicians and so I get a lot of calls…

Heightened awareness of spirituality/religiosity after onset of compassion fatigue.

Participants expressed an increased awareness of spirituality and religiosity in their lives after

experiencing compassion fatigue. Participants began to consider the need for more of a spiritual

life, connection with God or recognized the lack thereof. The clinicians in this study expressed

relying more on a higher power or spiritual life after the onset of compassion fatigue.

Participants expressed the desire to attend their place of worship more often or find a way to

express and increase their spiritual beliefs. Every participant expressed a need to be connected to

God (or a High Power) in order to mitigate compassion fatigue. Here are some of the statements

the participants shared that illustrate this theme.

I think in some ways, it (compassion fatigue) helped me get one (a spiritual life)… I have

some spiritual beliefs; I would like to find something…

I think it (compassion fatigue) made me rely on my spiritual life more than I typically did

before I came into the profession… I had this idea of the kind of person I wanted to be;

the kind of clinician I wanted to be and then when you're sitting there with somebody

who has this heartbreaking story… that feels bad… so it made me do some looking

around in my spiritual beliefs…

My synagogue is like forty-five minutes from where I live. If I'm feeling fatigue then like

on a Friday night which is Shabbat, I'll want to go home and go to sleep or if we're

having Shabbat Saturday morning I'll be… I don't want to get up at 7:30 to get there on

time, you know I want to sleep in. And then I feel like I'm missing out because I really do

when I go, I always feel good. And I always feel like that was good use of my time so if

I'm feeling too fatigued, it's that sometimes the sleeping wins even though I probably, I

know it's not the best choice for me.

Awareness of children mitigating compassion fatigue symptoms. Children played a

major role in the lives of participants in this study. Clinicians reported children helped them to

redirect their thoughts from catastrophic to maintaining a positive outlook on life. Children also

assisted with increasing their physical performance and socializing; otherwise isolating and

sitting or sleeping at home. Children also provided the participants a reason to communicate with

their families. Children received most of the attention, even when suffering from compassion

fatigue symptoms, compared to partners who received little to no attention. Participants also

experienced fewer cognitive distortions about society because they wanted their children to feel

safe about their world through the lessons they shared. More specifically, one of the participants

did not feel as though the world was an unsafe place for all children, because she knew her

children had not experienced anything traumatic, compared to the child clients she was treating.

Overall, children were beneficial for mitigating the symptoms of compassion fatigue, based on

the perception of the clinicians, because the presence of the children provided some normalcy.

Here are some of the statements the participants shared that illustrate this theme.

I get tired and I get tired of talking and I don't want to sit down with them (children) and

ask how their day was… I really have to say, okay I'm going to spend time with you

(children) now… let's play a game and I'm going to take off the therapy hat and we're just

going to play this game and have fun. And um I had to sort of learn to renew myself from

that experience rather than getting stuck in the what ifs and the burnout and considering it

the same way that I consider my clients.

I think working with traumatized kids at my internship made me so grateful that (my) kids haven't gone through anything like that… That work made me more present to… really enjoy them. You know they have their parents and they have a house and all that stuff. So I think it actually made… that work made me more present to just you know just really enjoying them (as) little toddlers.

I sort of have friends in social life in clumps and so um it's more centered around my boys and their ages. Like I had a bunch of clumps when my youngest son was or my oldest son was youngest um and then now sort of around adoption and families and people that you know like… went to the same daycare with one of my sons and I like I hang out with the soccer moms when we're, we get there playing soccer.

Exhaustive Description of the Experience of Compassion Fatigue

Overall, the clinicians experienced an influence on their relationships, energy level and thinking patterns while living with compassion fatigue. These women were too exhausted to emotionally and physically engage in their relationships with their partners and children. This led to an emotional distance between the clinicians and their partners. The partners would distance emotionally from the clinicians when they anticipated hearing trauma stories. The clinicians also distanced from their partners because of the desire to rest and be alone to recuperate. The clinicians also reported not wanting to speak with their partners at times, especially when having to resolve a conflict because it required emotional energy and they were exhausted. They also felt their partners did not understand, so they felt it was best to pull away physically, mentally and emotionally at times.

Participants one and two had younger children and did not report disengaging from their

children. However, they spent time teaching their children to be grateful for their lives, considering the children did not experience trauma events like the ones heard by the clinician at work. Participants one and two also enjoyed social events only if the events included the children. Otherwise, the partners' social events were minimal to nonexistent. In these cases, these clinicians would rather rest or engage in solitary activities at home. Participant three, who had adult children, experienced some similar interactions with her husband (nonexistent social events). The adult children did not want to engage in discussions with participant three because they also did not listen to the trauma stories--this participant reported not providing any identifying information about her clients. One adult child provided emotional support until she became emotionally fatigued and disengaged from her mother.

The relationship between work and all three of the clinicians changed as well. The clinicians chose to incorporate clearer boundaries. For example, participant one understood the importance of balancing less distressing and more distressing cases; this was a protective factor for this clinician to reduce her stress level at work. Therefore, the clinician was bringing less traumatic stress home. Participant three also experienced feelings of isolation while at work because feeling she wasn't supported by the few colleagues she had. Supervision was also minimal to nonexistent. This also exacerbated participant three's desire to maintain some healthy boundaries, in order to avoid compassion fatigue symptoms. This clinician was fully aware that she could over extend herself due to being one of a few clinicians in her school district.

Traumatic stress from work and the decline in positive relationship interactions led all three clinicians to think more about self-care. The areas of self-care included individual activities including television, creative activities and spiritual practices. The clinicians started thinking more about engaging in activities that freed their minds from focusing on the horrible stories

encountered at work. The clinicians also thought a lot about practices that assisted them with

relieving the physical effects of stress and increased their inner peace and balance. Every

clinician expressed the need for on-going self-care and a constant search for what works best for

their lives.

Chapter Five

Discussion

The results of this study show that compassion fatigue did influence the three participants' family and social relationships, the bodies of the participants, the clinicians' perceptions regarding work boundaries, how their children influenced their compassion fatigue symptoms and their awareness of spirituality after the onset of compassion fatigue. All of this is discussed in this section as is previous research that supports the themes found in this study. The implications and limitations associated with this study are addressed, and future research is suggested.

Awareness of the Effect of Compassion Fatigue on Relationships

The results honor that the three clinicians who experienced compassion fatigue also experienced exhaustion and a preoccupation with clients at times, which led to concerns about their partner relationships. The clinicians became more distant within their adult relationships and also participated in fewer social activities. Figley (1998) posits that couples must create a new *healing theory*, together, in order to reestablish stability in the relationship. This theory facilitates positive interactions between partners, allowing adaptability to a new reality after traumatic events. It is couple members' sense of working together as a team to resolve their stress that assists with the healing process (Figley, 1983; 1985). When members of couples support each other, this helps to maintain healthy relationships. Partners can trigger each other's traumatic stress responses, so individual and couple therapy is suggested to treat this dynamic and the associated trauma symptoms (Figley, 1998).

In this study, the clinicians were more conscious of what they shared with their children and did not want their children to fear the world. On the contrary, the clinicians were more likely

to teach their children why they should be grateful for their lives. The parent-child relationship was reported as the most positive relationship compared to the experiences reported by the clinician regarding their partner relationship. The children provided the clinicians an opportunity to participate in social activities. Lastly, the clinicians shared a desire and search for spiritual practices that assist with providing self-care and way to maintain a positive view regarding life.

The results show that compassion fatigue did influence these clinicians' relationships with loved ones. These findings strengthen the argument that trauma influences everyone, even those who provide treatment to trauma victims, and that trauma can spill over into family relationships. Trauma does influence clinicians, as evidenced by literature and workshops on vicarious trauma (Jenkins & Baird, 2002; McCann & Pearlman, 1990) and compassion fatigue (Figley, 1983, 1985, 1995, 1998 & 2002). Self-care is a well-studied topic, which emphasizes the importance of individuals, more specifically clinicians, to care for themselves. At the same time, little emphasis is placed on the clinician's family and how vicarious trauma or compassion fatigue can influence them. The results from this study show that clinicians' relationships can be negatively influenced by compassion fatigue symptoms.

It is important to recognize and discuss this topic because, I believe, many clinicians are not vocalizing how their work influences their family life. Family life is an integral part of life. Clinicians provide a lot of mental and emotional support to distressed clients, and these same qualities are required to maintain a partnership and parent-child relationship (Bowlby, 1982). How could clinical work not influence life at home? Studies show that crossover of stress from work to home life does occur. Crossover and spillover research supports the findings in this study. More specifically, the clinicians in this study shared that their compassion fatigue symptoms influenced their relationships (at home) with their partners--they were less patient

with their partners, argued more, talked less and the partners distanced themselves from the clinicians. Research on spillover and crossover supports these findings that couples are more likely to experience distress in their relationship when experiencing high levels of stress at work (Bakker et al., 2005; Buck & Neff, 2012). The Conservation of Resources (COR) theory is also supported by the findings in this study. Because the COR theory suggests that stress increases as resources are depleted, as clinicians utilize their emotional resources at work, this decreases the reserve of emotional resources for personal relationships. The clinicians in this study suggested wanting to be more withdrawn at home as work became more demanding emotionally. So, the COR theory coincides with the themes expressed by the clinicians in this study.

Awareness of Clinician's Psychosomatic Symptoms Related to Compassion Fatigue

The psychosomatic symptoms associated with these systemic effects of trauma are very salient and important to keep in mind while providing treatment to clients. Showalter (2010) discussed the physical symptoms associated with compassion fatigue, including "headaches, gastrointestinal disorders and sleep disturbance" (p. 240). The participants in this study expressed similar physical symptoms including headaches, exhaustion and muscle tightness.

Awareness of the Effect Of Compassion Fatigue Symptoms on the Clinician's Social Interactions

The clinicians' social relationships were also influenced negatively. Each clinician expressed little desire to socialize with peers. All three of the participants were too tired and were not interested in relational activities. Many of them expressed a desire to engage in solitary exercises. The clinicians could have introverted personalities, but personality was not assessed. At the same time, this could explain that compassion fatigue affects clinicians' desire to be emotionally available in relationships with other peers. It can be argued that relationships require

emotional energy (Lapides, 2011). When suffering from compassion fatigue, this ability to empathize and connect emotionally is impaired, therefore leading to little or no desire to connect with people outside of the professional domain of life.

Notably, the participants expressed a keen awareness of feeling isolated. This finding highlights that compassion fatigue exacerbates feelings of loneliness and isolation. Stein and Tuval-Mashiach (2014) interviewed soldiers who experienced war. All of these soldiers expressed trauma symptoms and a strong sense of loneliness due to perceiving no one would understand and others who have not experienced war will not be able to comprehend the feeling of war. The results from this study support that this same perception of loneliness is present when clinicians suffer from compassion fatigue. Although the clinicians do not experience PTSD, they did experience STS and explained they had a desire to spend time alone. One of the participants felt they were left alone at her job and two of them wanted to be alone at home. One participant suggested isolation was the result of a programmatic concern with her job. Two participants suggested this idea of being alone was perpetuated by their level of exhaustion, and the only way to replenish was to purposely isolate themselves. Therefore, this thought pattern can lead to lack of social life with peers or the disinterest in socializing, which leads to a feeling of isolation and loneliness.

Awareness of the Importance of Clinician's Boundaries and Self-Care After the Onset of Compassion Fatigue Symptoms

Clinicians in this study realized the importance of boundary setting once experiencing compassion fatigue. The clinicians were more aware of their time spent working and the level of severity of clients they were treating. This supports research by Bourassa (2012) showing that maintaining professional boundaries mitigated compassion fatigue symptoms. Distress, a

symptom associated with compassion fatigue, can be mediated by risk and resiliency factors such as clinicians' personal characteristics, character of clients, trauma clinicians' attempt to cope, and the therapy environment (Figley, 1995). This study supports these findings in that how clinicians manage their environment, their clients, and cope with distress can affect compassion fatigue symptoms.

Heightened Awareness of Spirituality or Religiosity After the Onset of Compassion Fatigue

The participants expressed a greater awareness of the need for a connection with God or higher power. Every clinician expressed needing to attend more spiritual practices or finding a spiritual practice that was "true" for them. This finding shows that spirituality or religiosity can play a role in mitigating compassion fatigue symptoms. Findings in previous research support that clinicians engage in spiritual practices for self-care, which mitigates compassion fatigue (Figley, 1995, 2002; Killian, 2008; Simpson & Starkey, 2006). This study highlighted the clinicians' increased thoughts about spirituality. It also highlighted clinicians' guilt for not being loyal to spiritual practices because of feeling physically exhausted. This shows that the contemplation or connection with God or a higher power was present for these clinicians.

Awareness of the Children's Presence Mitigating Compassion Fatigue Symptoms

Lastly, this study honors that secondary traumatic stress influences the perception of the clinicians (Figley, 2002). This study however, takes these findings a step further because the participants focused on their children, which helped decrease negative thoughts regarding the world's safety. The presence of children may have also provided a reason for the clinicians to maintain a social circle. Rearing children helped the clinicians to cope with compassion fatigue symptoms. This finding is potentially important because the children may have brought them out of the negative thought process associated with compassion fatigue. Research supports that

children are influenced by traumatic stress symptoms present in their parents (Herzog, Everson, & Whitworth, 2011). However, there is no research to support how children influence their parents with trauma symptoms. In this study, the clinicians' children provided an opportunity to relay the positive aspects of life, including socializing with others, playing, being loved by others and loving others. The partners heard most of the "horrible stories" from the clinicians, which may mean that their partners carried the stress associated with the "horror stories" with the clinicians, while the clinicians chose not to tell their children the stories about work because they did not want to burden their children with stressful stories. This led to the clinicians sharing their work experiences (in an age appropriate manner) to strengthen their children's gratitude for a safe and better life than some of the populations the clinician served.

Implications

Self-care was an important theme for the clinicians in this study with their children. Multiple dimensions of a clinician's well-being can be addressed from the results, including relational, psychological and spiritual improvement. The clinicians can engage in solitary activities that require little thought. This allowed the clinicians time to decompress from work and the stress of the clinical work. Clinicians can also set boundaries regarding time spent with clients and severity of psychiatric diagnosis on current caseload. By doing so, the clinicians will be able to regulate their stress levels at work, rather than being bombarded with distressing clients one after the other, in the course of one day or week. Clinicians could be mindful of how much they discuss work with their partner and older children. Based on this study, sharing "horror stories" from work led to family distancing themselves from the participants. So marriages and parent-child relationships could maintain connection by limiting how much work is discussed at home.

Clinicians could also benefit from spending more time with family, especially their children. Playing with their children and engaging in their children's social activities helped to reduce their compassion fatigue symptoms in this study. Clinicians also talked more about how the world is a safe place for their children and discussed how they wished to instill gratitude in their children because of their privilege in comparison to clients' lives. This assisted the clinicians with viewing the world as a safer place and their lives in a more positive light. The clinicians also engaged in more social activities with their children, which may have led to more social interactions with other parents. This means, the clinicians may have been forced to be more sociable and engage with others beyond the usual discussions about "horror stories" at work. Clinicians could also start implementing spiritual practices in their everyday life. Based on the themes from this study, these clinicians were interested in finding a belief system to follow or felt guilty if they did not participate in the ceremonies associated with their belief system.

Limitations

This study has a few limitations that influenced the trustworthiness of the results derived from the data: the study would have been stronger with more participants; the inclusion criteria could have been based on the compassion fatigue scores in the ProQOL; I could have encouraged more time to answer all of the interview questions; the themes were very closely related to the interview questions; and I only interviewed Caucasian women.

This study provided results based on three participants in the interview process. A small number of participants, in comparison to quantitative research, is the norm in qualitative research; however, I was unable to reach the desired number of participants mentioned in my dissertation proposal. For this reason, my results would likely have been more comprehensive

and exhaustive had there been more participants in this study.

This study also required a score of at least 23 points in the burnout and secondary traumatic stress category of the ProQOL. This study focused on STS or compassion fatigue, which means at least a 23 in the STS category, would have sufficed to establish inclusion. So, there could have been an additional participant, based on this less-strict criterion.

The interviews were also very short, ranging in time from 7.5 to 25 minutes. The results could have been more descriptive had there been more data available. Therefore, if participants were encouraged to elaborate more and share more of their experience, this study could have provided more of an exhaustive description of the participants' experiences. The participants could also have been interviewed a second time.

Unfortunately, it was difficult to contact all three participants and receive a response for member-checking. Two of the three clinicians responded to my emails. When I emailed the results to the clinicians for member checking, one of the three participants responded with a confirmation that the results were "true" to her experience. One other participant agreed to review the transcript; however, she did not respond to the email with the transcript attached. Therefore, the member checking did not yield helpful responses and clinicians more readily participated when engaged face-to-face.

It appears the questions may have influenced the themes expressed in the results section. This phenomenon may be the result of my bias and the bias of the clinicians. The questions were answered based on their interpretation of the questions posed. I also perceived many of the themes within the context of the interview questions. Therefore, my perception influenced my choice of creating themes within the context of the interview questions.

Lastly, Caucasian women were the only clinicians who participated in this study. As a

Black American, providing more opportunities for people of other ethnic backgrounds to share

their experiences is very important to research. In qualitative research, providing a voice for

people of all different ethnicities adds to the richness of the diverse perspectives regarding life

and how ethnicity plays a potential role in life experiences. Of the 23 potential participants, two

were males. Neither male participant met the inclusion criteria, leading to no male interviewees.

Having males involved in qualitative research would provide the same diversity as I expressed

earlier for different ethnicities participating in qualitative research.

Future Research

While the clinicians answered the questions posed in the interview, many more questions

came up from the answers provided. The first question I would pose is: What is the experience of

clinicians with compassion fatigue while parenting children vs. adolescents vs. adult children?

All of the participants in this study were parents of children and adult children, and their

responses to how their children interacted with them was different, which can lead to inquiring

about the differences in developmental stages of the children.

Another question suggested by this study is, what are the best self-care practices for

female and male clinicians and their families? All of the participants in this study were females,

which lead to wanting to know more about how compassion fatigue influences male clinicians

and also can lead to the inquiry of how families can implement self-care practices together.

To add to the diversity of the research, how do minority clinicians'oexperience

compassion fatigue with their partners and children? This question will allow for voices of

different ethnic backgrounds to express their experiences and will bring honor to different

cultural backgrounds in a way that could enrich the compassion fatigue literature and the

perspective of helpers on a larger systemic level.

Next, what are the best ways for families to cope relationally with compassion fatigue? This inquiry takes the research a step further to discover ways that families are using their relationships to combat compassion fatigue. Fourthly, is the attachment bond between clinician and partner negatively correlated with compassion fatigue symptoms? I am wondering if the better the relationship is between the partner and clinician may reduce the likelihood of experiencing compassion fatigue symptoms.

This research also leads me to consider, does the contemplation of the need for spirituality/religiosity lead to implementation of spiritual practices? This inquiry was derived from the awareness of spirituality theme, leading to wondering if the thoughts and discussion about spiritual practices, leads to adopting a belief system and practicing it faithfully.

I am also wondering, does length of marriage effect lack of communication in the couple relationship due to compassion fatigue symptoms? The participants in this study were married for different amounts of time. The participant with the longest marriage alluded to talking less to her husband and possibly having more unhealthy communication with him. So, it made me wonder if the length of the marriage may affect communication around compassion fatigue.

Another question is: do years of clinical experience influence the effects of compassion fatigue on the clinician's relationships? The participants were at different stages of their career when discussing how compassion fatigue influences them and their family life. I wondered if years of experience would change how compassion fatigue affects family life. Do the families adjust to how trauma work affects their clinician, are they more aware of it as years pass, etc.

The clinicians in this study also scored in the "average" range in the STS and burnout category of the ProQOL assessment. All of the themes were derived from an "average" experience with regarded to STS and burnout. Would the results be the same or different if the

participants in the interview had "high" scores in STS and burnout? Also, would the clinicians' relationships be affected in the same way or differently, if they had "high" scores in STS and burnout?

Lastly, do different family constellations experience compassion fatigue differently, for example, two parents and children versus single parents with children versus single clinicians? All of the participants in this study were part of a two-parent household. Would the experience of compassion fatigue within their families be different if they were single parents or did not have children?

Conclusion

This study provided a platform for clinicians to share how compassion fatigue influences them and their family. My hope is to address this topic with a larger sample, in order to bring an appreciation to the voice of the clinicians experiencing the systemic effects of compassion fatigue. This research may lead to providing the best exercises and coping strategies for clinicians and their families. Society benefits from mental health providers and my desire is to assist clinicians in maintaining a balanced and healthy life. Once clinicians are at home, they are no longer mental health professionals, they are husbands, wives, moms, dads, sisters, brothers, friends, and so on. Their personal relationships are very important for their own quality of life and should be honored as such.

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Appendix A: IRB Approval

from:	**kclarke@antioch.edu**
to:	ncunningham@antioch.edu
date:	Sat, May 25, 2013 at 10:02 AM
subject:	Online IRB Application Approved:The lived experience of clinicians and families with compassion fatigue May 25, 2013, 10:02 am

Dear Norja Cunningham ,

 As Chair of the Institutional Review Board (IRB) for 'Antioch University New England, I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved.
 Your data collection is approved from 05/31/2013 to 07/31/13. If your data collection should extend beyond this time period, you are required to submit a Request for Extension Application to the IRB. Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,
 Katherine Clarke

Appendix B: Permission for Use of the ProQOL (Professional Quality of Life Scale:

Compassion Satisfaction and Compassion fatigue) www.proqol.org

Accompanied by the email to you, this document grants you permission to use for your study or Project.

The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion fatigue) www.ProQOL.org

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.

Stamm, B. H. (2010). The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion fatigue). Pocatello, ID: ProQOL.org. retrieved [date] www.proqol.org

Permission granted by
Beth Hudnall Stamm, PhD
Author, ProQOL
ProQOL.org
info@proqol.org

Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at www.proqol.org and www.proqol.org/Donate_Data.html. Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.

Appendix C: Demographic Information (1st phase)

Name _____

Age _____

Race _____

Spouse Y ___ N ___   Children Y ___ N ____ No. of Children? ____

Town _____ State _____

Phone # ____ - ____ - _____

Email _____@_____

Appendix D: Initial email or face-to-face or survey monkey solicitation (1ˢᵗ Phase)

Hello! My name is Norja Cunningham and I am a doctoral candidate at Antioch University New England. I am conducting a research study about the influences of trauma work on clinicians and their spouses and children. This study has two phases. This email is requesting your participation in completing a questionnaire called the Professional Quality of Life (ProQOL) assessment. This questionnaire will take about 10-20 minutes to complete. After completing the survey, please send it back to me via email. Your assessment will be scored and the scores will be submitted to you via email. Depending on your scores, you will also receive your eligibility to participate in the second phase of this study. The second portion of this study is an interview, requesting you share your story about how working with trauma clients influenced you, your spouse and your children. The risks associated with this study are the potential for extreme emotions to arise and the surfacing of relational concerns in the home. You may find a list of clinicians in your area to speak with (if you choose) or call 211 for a list of clinicians in your area. Thank you for your participation!

Sincerely,

Norja Cunningham, MS, LMFT

PhD Candidate

Antioch University New England

Appendix E: Email with ProQOL results (1ˢᵗ Phase)

Thank you for completing the ProQOL. Your score is (insert subscale scores). You are eligible to participate in a face to face 2 hour interview. You will be asked one main question and 6 follow up questions. Please answer them as you would like. The purpose of this interview is for you to share your story about how working with trauma clients influenced you, your spouse and your children. Would you like to participate in this interview? Please respond within the next 48 hours to schedule an appointment. If we do not receive a response within 48 hours, we will contact you by phone. Before the interview, we will provide a consent form explaining the purpose of the interview, your rights as a participant, possible risks and confidentiality precautions. The risks associated with this study are the potential for extreme emotions to arise and the surfacing of relational concerns in the home. You may find a list of clinicians in your area to speak with (if you choose) by calling 211 for a list of therapists in your area. Thank you for your participation!

Sincerely,

Norja Cunningham, MS, LMFT

PhD Candidate

Antioch University New England

Appendix F: Phone Script (1st Phase)

Hello (insert name). This is Norja Cunningham, the primary researcher who requested your participation in completing the ProQOL assessment. Thank you for completing the ProQOL. Your score from this assessment is (insert score for each subscale). These scores make you eligible to participate in a face to face interview. Would you like to schedule an interview slot with me? (Action: Schedule the interview.) Before the interview, we will provide another consent form explaining the purpose of the interview, your rights as a participant, possible risks and confidentiality precautions. The risks associated with this study are the potential for extreme emotions to arise and the surfacing of relational concerns in the home. You may find a list of clinicians in your area to speak with (if you choose) by calling 211 for a list of therapists in your area. Any questions? Thank you for your time. Have a great day.

Appendix G: Interview Consent Form (2ⁿᵈ phase)

Dear Participant,

Thank you for participating in this research study. The purpose of this study is to understand the effects of clinical work on clinicians and their familial relationships. The purpose of the interview is to allow you to express the influences of compassion fatigue on your health, emotional well-being, social life, family relationships, work life and spiritual life. Some of your direct quotes may be included in the write up but your name will not be connected to your quotes. During the interview, you may wish to share some specific information regarding your job. If your job mandates you maintain confidentiality regarding your clients/patients, please be mindful of this. Do not share information if it easily identifies a client or if you have not received written consent to share their information.

The interview will be videotaped. The videotape will be kept in a secure place double locked, before and after the data is transcribed. The tape will be kept and unlabeled until the results are written into a report. The report will be reviewed by a committee overseeing my research. After the research is approved and I pass an oral defense of this study, I plan to submit the information to a peer-reviewed journal. After the paper is submitted to a journal, the paperwork, including the transcripts, videotapes and consent forms will be shredded.

You have a right to withdraw from the interview at any time. During or after this interview process you may experience some psychological distress, due to expressing some sensitive information. This interview asks you to express some experiences that may have been painful or psychologically burdensome to you. Again, this research is looking at how trauma work has influenced you, your spouse and your children. It may bring up some tough feelings for you, relational concerns and it may be difficult to share your story during the interview. Because of the potential for psychological risk, a list of three (3) mental health providers, in your area are provided to you for your use. You may also look for additional therapists in your area call 211. After the data is transcribed and written in report form, I will send a copy of that section to you via email. Please review it and provide feedback regarding its consistency with your experiences shared in this interview.

I, _____ understand and consent to all of the stipulations outlined above.

_____   _____
Signature (Clinician)   Date
Thank you for your participation!
Sincerely,
Norja Cunningham, MS, LMFT
PhD Candidate
Antioch University New England

Appendix H: Statement of Bias

As a Christian Black American female therapist and doctoral candidate, I worked with clients with trauma concerns. I spent more time assisting my clients and not as much on myself. I did not pay much attention to how the work influenced me. Like many therapists, we think about the clients and go into the field with the massive dreams of how we plan to save the world. I also went directly to my doctoral studies following undergraduate and graduate studies. During my clinical internships I also worked other jobs. During this period of time, lasting about four years (2006-2010), I spent my time going to school, working more than full time hours and providing clinical treatment. This took a toll on my body and mind. Around 2010, I started to notice a difference in my mood and how easily I became upset. I also started to withdraw and did not express myself as well as I usually did. I noticed there was a difference but I did little about the difference I noticed. I did not say, "Maybe I should stop or slow down." I almost felt guilty for being tired. I did not realize how much I needed to take care of myself until I realized how much my condition was affecting my work relationships and my ability to go to work (e.g., calling out sick more often than usual).

Then, I started looking at other therapists and saw how many years of clinical work influenced them personally. Some of the older clinicians looked really old and worn and the younger clinicians looked older than they should because of their frequent visits to the bar after work. I knew then, I did not want my life to look like theirs. This led to investigating how I could maintain my personal well-being while working with highly distressed and traumatized clients. These experiences also led to understanding the importance of my mental, emotional and spiritual health and taking advantage of appropriate supervision in order to maintain a professional standard as an MFT.

In my personal life, I continued to spend time with family and recognized how draining family experiences were for me. They were no longer fun, but cumbersome. What I once appreciated about family members became very frustrating and annoying for me. I found myself being snappier and less fun to be around. This led to family members viewing me as weird and eventually pulling away because they did not know how to help me or connect with me any longer. Now, I see it was not their fault. They did not change. I did. However, at the time, I felt as though they were to blame. And I did absolutely nothing (for a short period of time) to change anything about my family relationships. I did not care at the time because I was emotionally exhausted, which was dangerous. It was not until I began to see my mother and her condition (in 2011), did I snap out of my own world of fatigue and stress.

My mother had a very bad accident at work one day, leading a long leave of absence due to medical concerns. This accident led to doctors' visits with neurologists, speech therapists and physical therapists. My mother looked like herself but became frustrated because of her inability to think as quickly and remember as easily as she used to. There were not any conclusive diagnoses beyond a chronic concussion, which obviously was not enough for me. I was there taking care of her when she allowed me to support her. I was there when she became frustrated with her condition and when she could not sleep at night or became easily startled by a noise that sounded like her accident. She knew something was wrong, and as I was studying traumatic stress, traumatic brain injury crossed my mind, and this was an answer that made sense to me. It hurt me to see my mother burn toast because she forgot to retrieve it from the oven or stutter over her words. It bothered me to watch her in pain. I watched her hold her head in agony, as the pain spread from the crown of her head to her back.

One salient event; I was woken up by my mother early one morning as she was rocking

back and forth uncontrollably. This event led to emergency personnel being contacted. After the

ER visit my mother felt as though she was getting some answers, but it was still frustrating. Her

motor skills, memory and speech were affected for a short period of time. My support increased

after that. I started driving my mother to speech therapy and telling them a lot of her symptoms--

the symptoms she might have forgotten or was unaware of. I was almost afraid to let her go

anywhere without me, unless I knew she was in good hands.

All of this added to my stress level and led to some habits of withdrawing or shutting

down unless I had to deal with emergency situations. I did not want to have fun for the sake of

having fun all of the time. I did engage with people more, but they had to seek me out. Thank

God for my family, especially my sisters. They were inviting me to dinners and parties.

Otherwise, I would not have gone anywhere. I almost stopped living because of being exhausted

and tired of facing stressful situations. The one thing that always lifted my spirits and reduced

my stress was attending church services and meditating.

So, I know because of my connection with God, I am better today. As I consistently

participated in church services--the music, the reading of scripture, and listening to the

messages--I noticed differences in my mood and attitude about life. As I reflected during prayer

and joined in, I noticed symptoms of fatigue and disillusionment subsided. Then I started to

meditate and use breathing techniques when I noticed my heightened stress levels and

frustration. I also went through a substantial period of time where I prayed for health every

morning using Bible scriptures and also made up my own affirmation regarding health to state

every morning--"I thank God for my mental, physical, spiritual, financial and relational health."

All of these spiritual practices helped bring me out of my psychological and emotional low point

and kept me grounded mentally, emotionally and spiritually. In turn, I connected more with my

family and I feel like things are back to normal with regards to my close relationships. I am also experiencing an ease with connecting to new people and starting new relationships, which was a struggle in the past.

As a result, professional quality of life and burnout became an interest, leading to the study of compassion fatigue and what clinicians' lived experience with compassion fatigue looked like for them and their families (based on the clinicians' perspectives). And the most important point is, I believe compassion fatigue symptoms can be overcome through physical, mental, emotional, relational and spiritual means.

Throughout the process of completing this research, I maintained a personal journal to inform the process of my study. My story supported why I chose to utilize the heuristic phenomenology methodology for this study. It was important for me to gain insight regarding my own experience with compassion fatigue and to provide a platform for other clinicians to share their stories regarding compassion fatigue.

Appendix I: Theory Triangulator's Statement of Bias

[This is a statement from the perspective of the theory triangulator.] I think that compassion fatigue is a prominent issue in the work of helping professionals such as psychologists, therapists, social workers and counselors. The very reasons why workers are drawn to these professions, their desire to help people navigate the difficulties of their lives and their ability to empathize with the trials and tribulations that people face are the same things that have the potential to cause them distress in their own life. I majored in psychology in my undergraduate studies and I started my graduate studies in a clinical social work program with a similar desire. In my first year internship working in the Reunification and Permanency Department (Foster Care) of Social Services with a caseload of neglected and abused children from ages two to nineteen, I learned quickly that it was something I really couldn't do long-term. While I didn't experience the extreme of compassion fatigue in that one year, I did feel stressed and emotionally worn-out, one from tragedies the children faced but more so, from interacting and observing the mental and emotional states of the workers in the field. As part of the research requirement with the internship, I did a survey of forty-five workers (which was almost half of the workers in the family stabilization, child protective services (CPS), foster care, and adoption units and more than 90% had experienced burn-out during their career and more than 60% would have chosen a different career had they known what they know now.

In addition, throughout the year in midst of having conversations people expressed feeling symptoms of compassion fatigue. People took their work home with them literally, one worker after a client had aged out of foster care allowed the client to move into their house because she identified and empathized with her plight. I have listened to the stories of others having difficulties with sleeping and being overprotective of their own children for fear of

missing the signs of things such as rape or incest. I have seen people cry when parents were giving back custody of their children for fear that they would receive a call that the child had been killed and I noted that many people who worked in units such as adoption had once been CPS workers which essentially are like first responders and had moved to another unit due to case overload and emotional exhaustion.

By the same token, I later switched my concentration to administrative social work and in my 2nd year internship I had very little direct contact with the exclusion of focus groups and facilitator training and development, which suited me perfectly. While I don't believe compassion fatigue affected me personally, witnessing what my life could be like, how drained and unhappy I could be in the future doing direct practice steered me in a different direction. Maybe the fear of compassion fatigue affected me. I do not know, I simply believe that not everyone, even those with unlimited compassion for others and an innate desire to help, build and uplift, such myself are built to be direct contact helping professionals. Furthermore, I believe that even those who have the guts and ability, face a high risk of experiencing compassion fatigue.

Appendix J: Interview Questions

What is your family's experience of compassion fatigue (secondary traumatic stress)?

The other probing questions in this interview were;

How did compassion fatigue influence your physical health?

How did compassion fatigue influence your mental health?

How did compassion fatigue influence your social life?

How did compassion fatigue influence your spousal relationship?

How did compassion fatigue influence your relationship with your children?

How did compassion fatigue influence your work life?

How did compassion fatigue influence your spiritual life?