Helping Till It Hurts? A Multimethod Study of Compassion Fatigue, Burnout, and Self-Care in Clinicians Working With Trauma Survivors

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Helping Till It Hurts? A Multimethod Study of Compassion Fatigue, Burnout, and Self-Care in Clinicians Working With Trauma Survivors

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There is burgeoning interest in secondary traumatic stress, compassion fatigue, and self-care in the helping professions. This multimethod study focused on therapists' stress and coping in their work with trauma survivors, identifying factors related to resilience and burnout. Semistructured interviews were conducted with 20 clinicians subscribing to a systems perspective, and 104 clinicians were administered a questionnaire inquiring about their caseloads, trauma history, coping styles, emotional self-awareness, work stress, compassion satisfaction, compassion fatigue, and burnout. Interview data demonstrated that therapists detect job stress through bodily symptoms, mood changes, sleep disturbances, becoming easily distracted, and increased difficulty concentrating. Self-care strategies included processing with peers/supervisor, spirituality, exercise, and spending time with family. In the quantitative study, social support, work hours, and internal locus of control accounted for 41% of the variance in compassion satisfaction. Multiple regression procedures accounted for 54% of the variance in compassion fatigue and 74% of the variance in burnout. Implications for clinical training and organizational policy are discussed.

Keywords: compassion fatigue; secondary traumatization; professional self-care; organizational policy

Local and global events have raised our collective consciousness about how traumatic events like the September 11 attacks and Hurricane Katrina affect specific communities ("Ground Zero" in Manhattan, New Orleans) and specific populations (e.g., fire fighters, police, service workers, military personnel, and their families). For example, a few studies have examined the efficacy of service delivery to those hardest hit by the 9/11 attacks (Figley, 2002). A less studied phenomenon is the impact of extended exposure to traumatized populations on helping professionals providing such services (Adams, Boscarino, & Figley, 2006). It has become increasingly evident that the psychological effects of traumatic events, such as childhood sexual abuse, domestic violence, catastrophes, war, and terrorism, reach beyond those directly affected (Bride, 2007). This is an important area of investigation because healthy, psychologically present, and committed professionals are in a better position to offer assistance to trauma survivors than those providers who suffer from symptoms of compassion fatigue and burnout. Drawing from descriptive and numerical data, this study first explores the experiences and perceptions of clinicians working with trauma survivors—their recognition of symptoms of job stress, their identification of resources that enhance their resilience, and their discussion of specific strategies for professional self-care. Second, using cross-sectional data, the study examines the significant roles played by social support, work environment, emotional self-awareness, and trauma history in therapists' reported levels of compassion satisfaction, fatigue, and burnout. Implications of this study for organizational policy, and the way we think about coping strategies, are also presented.

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Review of the Literature

Charles Figley (1995) declared stress to be "normal and natural byproduct of working with traumatized people" (p. 573). In a study (Davidson & Smith, 1990) of outpatient mental health clients, 84% to 94% reported a history of traumatic events such as child sexual abuse, domestic violence, exposure to combat zones, and displacement. This suggests that helping professionals are regularly in contact with trauma survivors, and it makes sense that listening to traumatic case material or "tough stuff" (e.g., that especially severe child sexual abuse case file making the rounds at an agency, a returning veteran who lost a leg and several of his or her friends, a survivor's detailed account of a sexual assault) for 30 to 40 hours a week or longer could lead to acute distress. Repeated and frequent exposure to persons suffering from posttraumatic stress symptoms can result in *secondary or vicarious traumatization*, leading to symptoms of posttraumatic stress disorder (PTSD). PTSD is "an adjustment disorder that may develop as a result of exposure to an extraordinary stressful event or series of events" (Figley, 1995, p. 571). Common symptoms of PTSD include anxiety, startle responses, fatigue, sleep disturbance, intrusive thoughts, difficulty concentrating, and problems controlling anger (American Psychiatric Association, 2000; Keane, Wolfe, & Taylor, 1987).

Vicarious or secondary traumatization is a process by which a professional's inner experience is negatively transformed through empathic engagement with clients' trauma material (Cunningham, 1999; McCann & Pearlman, 1990; Pearlman & MacIan, 1995). In this process, trauma discussed in therapy sessions is transferred from clients to the therapist, who then becomes susceptible to psychological distress and PTSD symptomatology (Figley, 2002; Nelson-Gardell & Harris, 2003; Sabin-Farrell & Turpin, 2003). The stress generated from conducting trauma therapy can accumulate over time, penetrating every aspect of the therapist's life (Carbonell & Figley, 1996; Coppenhall, 1995; Pearlman and MacIan, 1995; Valent, 1998). For example, vicarious traumatization can disrupt a helping professional's beliefs of their "world and interpersonal relationships" such as their perception of safety and the ability to trust others (Pearlman & Saakvitne, 1995; Robinson, Clements, & Land, 2003; Schauben & Frazier, 1995). In sum, there can be a cost to caring (Figley, 1995).

Vicarious or secondary trauma is also referred to as *compassion fatigue*. The positive opposite of this phenomenon is compassion satisfaction, the sense of reward, efficacy, and competence one feels in one's role as a helping professional (Figley, 2002). Another construct found in the literature is burnout, which is a condition characterized by emotional exhaustion and depersonalization. Secondary trauma and burnout have been differentiated as constructs and are seen as having unique effects on professionals' well-being (Figley, 2002; Jenkins & Baird, 2002; Robinson et al., 2003; Sabin-Farrell & Turpin, 2003). If one were to attribute affective domains to the three constructs, one could say that compassion fatigue dwells in the neighborhood of fear and anxiety, compassion satisfaction in pleasure or happiness, and burnout in emotional exhaustion and lack of self-efficacy (Figley, 2002; Larsen, Stamm, & Davis, 2002).

Only a few studies have examined secondary traumatic stress and coping strategies used by therapists working primarily with trauma survivors (Bober & Regher, 2006; Figley, 1995; Street & Rivett, 1996). Although little is known about what factors predict resilience and health in helping professionals, researchers (e.g., Conrad & Kellar-Guenther, 2006) have pointed to the protective function of social support and having access to opportunities to process traumatic aspects of the work. One risk factor is that full-time therapists tend to socialize less, reducing their circle of friends (Evans & Villavisanis, 1997). Overall, the literature, and supervision and training talk, point us in the direction of further education and increased leisure time as ways of effectively dealing with the inevitable work stress associated with our roles as therapists. Many coping strategies come highly recommended by theorists, researchers, and trainers in the area of secondary or vicarious trauma, but there are few studies specifically evaluating the effectiveness of these approaches on reducing stress. Bober and Regehr (2006) found that social workers, psychologists, nurses, and physicians

> generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities, and supervision . . . However, there was no association between the belief that leisure and self-care were useful and time allotted to engage in these activities. (p. 7)

Bober and Regehr (2006) also found no association between use of specific self-care strategies and reduction in secondary traumatic stress. If individual

coping factors are not the key, then perhaps contextual factors can shed light on the phenomena of compassion satisfaction, compassion fatigue, and burnout. The occupational stress of helping professionals who work with trauma survivors, and the organizational and structural correlates of job-related stress of such professionals, have begun to receive attention (Bober & Regehr, 2006; Regehr & Cadell, 1999). Examples of organizational components include workload, social support, and work environment (Bell, Kulkarni & Dalton, 2003).

In this article, the purpose of the qualitative study was to explore emergent themes, including stress symptoms and coping strategies of helping professionals who specialize in the treatment of trauma survivors. The quantitative study then sought to determine the individual and contextual factors that predict compassion satisfaction, compassion fatigue, and burnout in a sample of systemically oriented therapists working with trauma survivors.

Qualitative Study

Method

Moving beyond observable, surface behavior, inductive researchers analyze both the inner and outer perspectives on human behavior. An in-depth, understanding of participants' "definition of the situation" is achieved by actively participating in the subjects' lives, thereby gaining insights about the empirical social world in question (Rist, 1977). Less concerned with the sheer numbers of subjects, inductive research seeks to access the richness and detail of subjects' narratives and ways of making meaning. Statistician and quantitative researcher Cronbach (1975) noted, "Descriptions encourage us to think constructively about results. . . . There are more things in heaven and earth than are dreamt of in our hypotheses, and our observations should be open to them" (cited in Rist, 1977, p. 45).

Participants. The interviews were conducted with 20 clinicians, 16 female and 4 male, working in agencies treating survivors of child sexual abuse in a large metropolitan area in Texas. The interviewees ranged from 28 to 57 years of age and had worked with child sexual abuse from 2 to 16 years with a mean of 8 years. Although all interviewees subscribed to a systemic therapeutic approach to treating sexual abuse cases, they held various professional licenses and certifications. Ten were Licensed Social Workers (master's level), two were Ph.D. Counseling Psychologists, 4 were Licensed Professional Counselors (master's level), and one held credentials as both a licensed professional counselor and licensed marriage and family therapist. Of the participants, 15 were White, 2 were African American, 2 were Latina, and 1 was Asian.

Procedure. The semistructured interviews were conducted individually and featured open-ended questions regarding how they recognize stress, how their personal and professional lives are affected by job-related stress, and the coping skills they use to relieve stress. The interviews were audio taped with the informed consent of the participants and were approximately 1 hr in duration. Following transcription of the interviews, the data were coded and analyzed using the grounded theory approach (Charmaz, 1983; Glaser & Strauss, 1967; Strauss & Corbin, 1998) aided by HyperRESEARCH 2.7, a software program (ResearchWare, 2004). The first stage of inductive analysis method involves the categorization and sorting of data into codes or labels that serve to separate, compile, and organize descriptive data (Charmaz, 1983). HyperRESEARCH permits the researcher to assign multiple codes to the same data, and then store and retrieve coded data. For example, as the user views a segment of an interview, HyperRESEARCH presents an index of code names or categories. Then one chooses an existing code or creates a new one as it emerges from the data and the program records the location of the text along with the code name. Coding categories can be retrieved and combined over a set of interviews through data reports, which are organized through the use of descriptors and/or the selection of multiple codes.

A method of constant comparison was used to capture commonalties (recurring themes, words, and phrases) in the experiences of the participants. This method is intended for studies with multiple sources of data and, thus, is appropriate for this study because each participant is considered a separate data source. The major coding categories and themes emerging from the descriptive data were used as a springboard for further quantitative investigation.

Findings

Responses by the participants were coded under the following four major categories: recognizing symptoms of work stress, risk factors in developing

burnout, definitions of self-care, and specific self-care strategies.

Recognizing work stress: Therapists' symptoms. A major theme from the interviews was therapists' awareness of and sensitivity to the stress they acquired from working with trauma survivors. All the therapists reported that they were able to identify their stress via bodily symptoms such as muscle tension and headaches, and lack of energy. Here is a quotation from a female therapist that reflects salient symptoms of burnout:

> I think I get overwhelmed, and overwhelmed for me comes in two forms: I get physically, emotionally and mentally exhausted, and I also become emotionally shutdown and I am not as emotionally responsive to people. I feel like I don't have any more to give, it is all used up and gone.

Note the quality of enervation and the sense of being wrung out with nothing left to give that is prototypical of burnout syndrome. The next quotation from a female participant gives voice to symptoms of stress-induced fatigue as well:

> I think that sometimes for me forgetfulness is also a sign when I am trying to do too much and can't remember all the things I need to complete. And I think that one of the things that happens to me is that like, I lose track of time. I sometimes lose days. I don't even realize what day it is or what the weather is like outside.

This quotation reflects an experience of tunnel vision or "disconnection" from the environment in which therapists can lose touch with the hour, the day, or the weather due to a preoccupation with stressful situations at the job. Regarding additional symptoms of work stress, 6 therapists discussed experiences with sleep disturbance when work stress increases. Here is a representative quote from a male participant:

> When I wake up in the middle of the night and I can't go back to sleep because my head is going through everything that happened that day, that's a red flag for me. Trouble sleeping is a major sign that I am overstressed.

Another phenomenon associated with work stress reported by 4 female participants and 1 male participant was intrusive thoughts while not on the job, for instance, during intimate moments with one's partner or spouse. Here are three quotations on this subtopic, the first two from female participants and the third from a male:

> 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. We have had to learn how to do that and I think that having conversations with clients about negative sexual experiences can really skew your thoughts about sex unless you are able to be honest and talk about your feelings with your partner.

> There are still times when I see a videotape of a client talking about abuse that's just horrific that I can't get out of my head. Then I can't be intimate with my husband at all, I just can't, and I tell him, "You know, I saw something at work . . ."

> After an especially tough day at work, I just want to unwind, and sometimes, sexual situations can be a trigger for a specific abuse case I heard that day. When that happens, we both have to be patient and understanding, and usually, we are (laughs).

Two females, and one male, respectively, talked about their detection of symptoms of anxiety, panic, and agitation in themselves when they become stressed on the job:

> I notice I am more agitated, not as patient, and feel edgy like I want to scream.

> I just get more anxious and keyed up when I'm more stressed about work. I get very panicky. I get dizzy, lightheaded, the usual panic attack stuff.

> Okay, I'll confess! There have been times after a really challenging day on the job where I have blown the horn and vented out the window in traffic. No tailgating, no threatening language, but frustration can boil over on the toughest days!

Risk factors. All 20 therapists identified several key risk factors in developing work stress and compassion fatigue. They are listed in the order of frequency that they were mentioned in the interviews, with the most frequently occurring listed first:

- High caseload demands and/or workaholism
- Personal history of trauma
- Regular access to supervision
- Lack of a supportive work environment
- Lack of supportive social network, social isolation
- Worldview (overabundance of optimism, or cynicism, etc.)
- Ability to recognize and meet one's own needs (i.e., self-awareness)

Some participants articulated these factors as significant to the constitution of "self-care." Indeed, most of the interviewees pointed to these elements as crucial to their being able to sustain themselves as "healthy" enough to address their clients' problems in productive manners. These risk factors were of great interest to the author as they provided direction for what kinds of variables could be measured in the quantitative portion of the study.

Self-care: Definitions and strategies. Therapists were asked to talk about what self-care means to them. Most commented that it was an important area of professional development, but that it had rarely been addressed in their clinical training or in continuing education. Here are three quotations, the first two from female participants, and the third from a male:

> I think it [self-care] is important because we're modeling for our clients. And because of the nature of any kind of therapeutic work, you have to recognize that after a client leaves and if you don't get rid of the stress then it just kind of builds up pretty soon. Then you're getting all the stuff confused and mixed up—What's my stuff and what's your stuff.

> Self-care would be those items that I do for myself as proactive, to keep from experiencing burnout, or the physiological problems.

> I would define self-care as definitely taking time for yourself not only during the day, at work, but also at the end of the day when I go home and trying to deal with as much of the day during my day and leaving it here, and trying not to take it home.

Specific strategies of self-care utilized by therapists included process time and supervision, quality time with friends and family, exercise, and spirituality. For instance, many of the interviewees discussed processing time and how significant this activity was to their "healthy" engagements with their clients. Here is what two female interviewees had to say:

> One of the main things I do is talk to the people that I work with here that I trust and respect. I get a lot of support from either talking about the cases themselves and getting help with specific issues, or just talking about how it feels doing this kind of work.

> Having a supervisor, having people to talk to on the team. I try to do that with the debriefing here because the only people who know what is going on with me are the people that work here with me.

Debriefing or *processing* sometimes came in many forms, sometimes "catch as catch can":

> If someone shoots past my door (peer/supervisor), I always try to get them to stop and talk. You have to have people to process with, and have people to process with that *get* it. That understand not only the dynamics of sexual abuse, but why it is stressful. I don't see any way to do this work without that.

> Talking to friends or coworkers about it, going out to dinner, socializing, playing with my daughter— those things relieve stress. There are times when I talk to my mom and mother-in-law about some of the heartaches you go through.

Exercise. Another common strategy was physical exercise. Twelve therapists stated that this was an essential ingredient for their sense of well-being. Here are two quotations from female participants:

> I go for walks. I have my sneakers in my desk and I try to take a walk in the neighborhood because it is really pretty. I try to do various things outdoors whether it's planting in my garden or going for a bike ride with my daughter. I plan to go to the gym at least two to three times a week or get some exercise. I exercise in front of the TV.

> Working out helps as long as I'm not facing the building when I am across the street at the gym. Planning to exercise can have the opposite effect, though. If I plan two nights a week and I don't have anything else going on, I go and I am okay. When I plan to go workout and then something keeps me at work, then it is even more frustrating.

Spirituality. All therapists in our study cited spirituality as playing a major role in their self-care. In the coding process, the larger category of "spirituality" was comprised of the subcategories of church, spirituality, and faith. One may wonder what this "spirituality" entails. Most of the interviewees gesture to specific definitions. For them 'spirituality' referred to

a worldview that positions them outside the "individual." It is a relationship with a larger force that guides them in their overall life and more specifically, their practices. Here are two quotations from female participants:

> Spirituality plays a very significant role. I am an instrument, you know doing this, the work that I do . . . there is something far greater than myself that will guide me. I do meditation and my morning ritual.

> Spirituality is critical to my self-care, in the sense that it is my belief system that there is a force and an energy and a mind beyond my own, with purpose and design. The ultimate responsibility for individualism and results rests in the hands of providence. I find that trust is extremely critical, therefore my level of trust gives me strength and support in unmanageable variables.

Discussion

Working with often severely traumatized clients, most of the respondents in this study identified symptoms of work stress in sleep disturbances, becoming easily distracted, having difficulty concentrating, and changes in mood. Therapists recognized mood changes in such behaviors as feeling edgy, becoming less patient with peers and family members, and feeling anxious or panicky. It is interesting to note that all of these bodily symptoms are diagnostic criteria for PTSD and are initial evidence that therapists who work with severely traumatized clients do run the risk of developing secondary traumatic stress. Somatic techniques, such as body awareness and dual awareness, can be invaluable resources in the therapy process, and perhaps therapists could make use of these techniques to ameliorate their own job-related secondary stress reactions (see Rothschild's *The Body Remembers, 2000).*

Along the lines of gender, a higher percentage of female participants expressed concerns about how traumatic case material might impinge on personal relationships with partners and children. This may be a function of women's socialization and cultural expectations that they be caregivers and emotionally attentive to their family members, and it may also be indicative of the role overload experienced by many women trying to meet lofty expectations of them in both the professional and private spheres of their lives. The same percentage of female and male participants *(4* out of *16* women, and 1 out of *4* men) reported that case material sometimes negatively affected their sexual relationship with their partners at home. Although this study was exploratory in nature, this finding suggests that this is an issue that affects both sexes, despite stereotypes about men's "capacity for compartmentalization" across life spaces. Further research could be conducted on how helping professionals' coping and self-care strategies run parallel and diverge across gender.

Primary and vicarious exposure to trauma can impinge on helping professionals' well-being and compassion, but specific identified practices/strategies may help ameliorate the effects of personal and professional traumatic events such that they do not impinge on the quality of therapy and do not precipitate burnout. Therapists' narratives about their work stress and coping suggest the importance of maintaining peer support, participating in continuing education, and accessing new information and techniques. Finally, debriefing with supervisors, consultants, and colleagues was reported as a basic, crucial strategy that may ward off secondary traumatization, but further research using advanced statistical procedures is needed to explore the complex relationships among these factors. The next section of the article tests three hypotheses derived from the findings of the qualitative study.

Quantitative Study

Method

Subjects. The sample comprised *104* therapists *(21* male, and *83* female) specializing in the treatment of trauma survivors, primarily children referred by Child Protective Services for their experiences of sexual abuse. Some therapists also carried in their caseloads persons who were adult survivors of domestic violence. The participants came from three agencies in a large metropolitan area in the southern United States. The sample was quite diverse: *48%* White, *21%* African American, *21%* Latina, and 10% Asian. Participants ranged in age from *25* to *64* years *(M = 38.65, SD = 11.17).* Regarding credentials and licensure, *36* participants were licensed professional counselors (LPCs), *25* were both LPCs and licensed marriage and family therapists (LMFTs), *17* were LMFTs only, *14* were licensed social workers, and *12* were counseling psychologists. The average time in the helping professions was *9.02* years, and the

average number of cases per week ranged widely from 5 to *40 (M = 18.6, SD = 11.2).*

Procedure. The author administered a questionnaire comprised of instruments measuring social support, personal trauma history, affective coping style, self-care strategies, burnout, emotional self-awareness, work environment stressors and resources, and work drain. Social support was measured using the *17*-item Likert-type scale, the Social Support Index (McCubbin, Patterson, & Glynn, *1982),* and a sample item was "Members of my community talk to each other and provide help or assistance when someone needs it." Personal trauma history was assessed by listing a variety of traumatic events and asking whether the event had happened to them, how many times, and how stressful it had been at the time of its occurrence. To tap experiences too difficult to name or disclose, the questionnaire also asked participants if an event had happened that they were not comfortable talking about and how stressful that event had been. Affective coping was measured by the *28*-item Brief COPE (Carver, *1997),* a reliable instrument tapping subjects' tendency to use coping strategies such as positive reframing, active coping, denial, self-distraction, denial, and venting. A brief instrument for measuring the frequency of use of self-care strategies was derived from participants' responses from the qualitative study (e.g., exercise, leisure time, supervision, prayer, and meditation). Symptoms of compassion satisfaction and compassion fatigue were measured by the Professional Quality of Life III: Compassion Fatigue and Satisfaction Subscales, R-III (Stamm, *2003;* e.g., "I avoid certain activities or situations because they remind me of frightening experiences of the people I help" and "I get satisfaction from being able to help people"). Symptoms of burnout were tapped by using five items from the emotional exhaustion subscale of The Maslach Burnnout Inventory (Maslach & Jackson, *1981;* e.g., "I feel emotionally drained from my work"). The ability to identify one's emotional states (e.g., "I have feelings that I cannot quite put into words") was tapped by a brief *14*-item version of the Emotional Self-Awareness Questionnaire (Killian, *2007).* Participants' perceptions of the work environment were tapped by questions designed by the author and focused on resources, sources of stress, and work morale (e.g., "My agency or organization shows that it values the work that I do"). Participants' sense of autonomy, or locus of control, at work was measured by five questions devised by Trudeau, Russell, de la Mora, and Schmitz *(2001;* e.g., "I take part in making decisions that affect me on the job"). Work drain, a condition where job-related stress spills over and affects one's ability to enjoy off-work hours at home (see Roehling, Moen, & Batt, *2003),* was measured by five questions adapted by the author (e.g., "I think about work when I am at home").

The questionnaires were completed during a regularly scheduled administrative meeting at the three agencies. Using the workplace as the data collection site ensured that completion of the instruments would not demand additional and/or personal time from the research participants. In addition, administering the instruments at work ensured that a 100% of all therapists who were present that day contributed to the data collection, effectively diminishing the threat to internal validity presented by selection via a potentially lower return rate from participants who were very low on compassion satisfaction and/or very high on compassion fatigue or burnout. Alpha reliabilities for the measures were good, ranging from *.80* to *.91.*

Informed consent was obtained and confidentiality was maintained. The numerical data were analyzed via correlation and multiple regression procedures. Three major hypotheses were to be tested: (1) social support and locus of control at work will have a positive relationship with compassion satisfaction and clinical contact hours will have a negative relationship with compassion satisfaction; *(2)* work drain, lack of morale at work, and neuroticism will have a positive relationship with burnout; and *(3)* work drain and history of traumas will have a positive relationship with compassion fatigue and emotional self-awareness will have a negative relationship with compassion fatigue. As some items measuring compassion satisfaction, compassion fatigue, and burnout tend to be highly intercorre-lated, these variables were not entered as predictors of one another in the regression analyses. Finally, in light of previous findings (Bober & Regehr, *2006),* individual coping strategies were not expected to correlate significantly with compassion satisfaction, compassion fatigue, or burnout.

Results

What factors are associated with compassion satisfaction in therapists working with clients who have

survived traumatic experiences (i.e., what factors buffer therapists from stress and predict their resilience)? Via a multiple regression procedure, three variables accounted for 41% (adjusted R^2) of the variance in the dependent variable of compassion satisfaction ($F = 14.32$, $p < .001$).

The three variables and their standardized Beta coefficients (Figure 1) were as follows: social support ($B = .46$), weekly hours of clinical contact ($B = -.37$), and therapist's locus of control at work ($B = .22$). Level of reported social support from friends, family and community was the most significant predictor of compassion satisfaction ($p < .001$); working a greater number of hours per week with traumatized clients reduced levels of reported compassion satisfaction ($p = .007$), and having a greater sense of control or efficacy at the workplace (being able to have a say about what happens at work, having one's own space to work, etc.) was associated with higher compassion satisfaction ($p = .047$).

A second multiple regression procedure found that three variables accounted for a quite substantial 74.1% (adjusted R^2) of the dependent variable burnout ($F = 45.92$, $p < .001$): Symptoms of work drain ($B = .49$), lack of work morale ($B = .30$), and neuroticism ($B = .20$; Figure 2). Feeling so stressed at work that you think about it at home and it impinges on your enjoyment of interacting with family members is the most significant predictor of burnout. Clearly, not really getting away from the workplace mentally or emotionally when one leaves it physically is a risk factor. One therapist commented that she mentally cuts or snips her anxious ties to the job as she exits the building to facilitate her transition to another space and to be more fully present at home. Next, low morale—being frustrated with agency policy, not feeling one's efforts and accomplishments are recognized or affirmed, and so on—is another significant factor, and one of which that administrators should take note. Finally, neu-roticism also contributed to compassion fatigue, with persons who experience stronger negative affect scoring higher on compassion fatigue.

A third multiple regression procedure found that four variables accounted for 54% (adjusted R^2) of the variance in the dependent variable of compassion fatigue ($F = 15.24$, $p < .001$): work drain ($B = 32$), therapists' sense of powerlessness regarding other social welfare or judicial systems that are failing their clients ($B = .32$), emotional self-awareness ($B = -.24$), and therapists' history of traumas ($B = .23$; Figure 3).

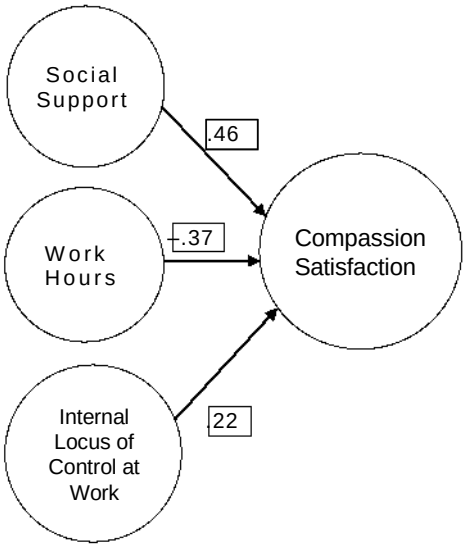

Figure 1. Standardized Beta coefficients of independent variables on the dependent variable of compassion satisfaction.

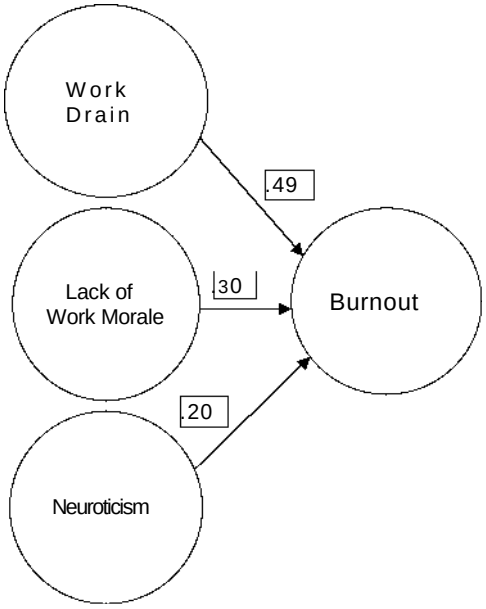

Figure 2. Standardized Beta coefficients of independent variables on the dependent variable of burnout.

First, feeling stressed from work to the point that it is distracting to the therapist after hours at home certainly could lead to compassion fatigue as well as burnout. It also makes sense that therapist's distress over larger system failures to help or serve their clients is associated with compassion fatigue, feelings of helplessness and powerlessness are

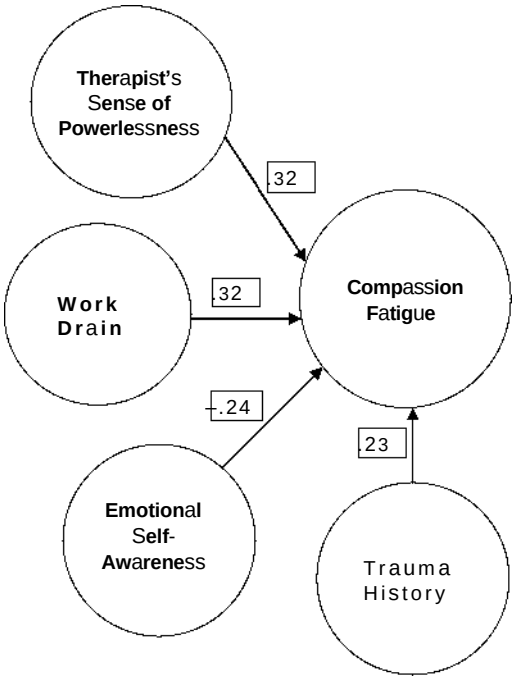

Figure 3. Standardized Beta coefficients of independent variables on the dependent variable of compassion fatigue.

frequent symptoms of persons with posttraumatic stress. If a therapist sees their clients not being advocated for or assisted by other social systems, this can lead to frustration and a sense of hopelessness in their efforts to make a difference. A lack of emotional self-awareness may be a risk factor for therapists because helping professionals can benefit from being emotionally in tune with themselves and being able to detect early a sense of being affectively worn down or exhausted so that they can alter their course and not develop more severe symptoms of compassion fatigue. Finally, a history of traumatic events can lead to posttraumatic stress symptoms that manifest themselves in the work context, especially if therapists' traumatic experiences are yet to be fully resolved and are negatively influencing their worldview, outlook, or perspectives on human beings or human nature.

As expected, affective coping style and specific self-care strategies were not significant factors in the multiple regression models on the dependent variables of compassion satisfaction, compassion fatigue, and burnout. However, affective coping style did play a role in overall work stress reported by the clinicians. Specifically, the use of emotionally negative or avoidant coping strategies, such as denial, acting like a problem does not exist, and venting, were significantly and positively associated with reported work stress ($r = .49$, $p < .001$), indicating some strategies are healthier than others in dealing with stressful work situations and conditions. In addition, use of proactive and *emotionally positive* self-care strategies, such as reducing workload, receiving supervision and socializing with colleagues were associated with lower reported work stress. In sum, the results of the three multiple regression procedures supported the three major hypotheses of this study, and therapists' sense of powerlessness and helplessness to affect processes in larger systems proved to be an additional factor predicting compassion fatigue.

Discussion and Implications

The helping professions can be quite stressful, even when workers are not first-responders in acute disaster situations. Although many studies on compassion fatigue and burnout have focused on professionals' reactions when delivering services in catastrophic circumstances, there are also high rates of burnout and turnover by therapists working in more typical scenarios—outpatient and inpatient environments and community health agencies (Kottler, *1993).* What are some of the factors that seem to protect helping professionals from the deleterious effects of secondary traumatization? It has been reported that individuals in the helping professions who worked in clearly defined teams were found to suffer less psychological strain, had great job satisfaction, and reported greater organizational commitment. The present study confirmed that social support was the most significant factor associated with higher scores on compassion satisfaction. Thus, therapists may wish to reflect on how much time for socializing, leisure, and/or hobbies they are allowing themselves to recharge after working with traumatized clientele. Being proactive in taking care of one's own mental health seems to be key, reaching out to other professionals, sharing concerns, and providing one another encouragement, possibly in a regular, structured group format (Evans & Villavisanis, *1998).* Maintaining peer contact and consultation provides an opportunity to share how one's work and personal life interact and affect each other, to examine what areas of one's life have been disrupted by this work, and to reality test by stepping back and assessing how much the work has increased one's cynicism or alienation.

Another finding was that higher hours of clinical contact were associated with lower compassion satisfaction. It behooves therapists (and administrators) to ask themselves how many cases are *too* many, and reduce workload when stress begins to interfere with their ability to concentrate, remember things, or when they become easily frustrated or irritable. Setting limits to avoid overwork or role strain is more than appropriate. In addition, therapists' sense of having a say or input at work, having their own work space, and being able to anticipate and control how many hours they must work each day are critical in being satisfied with their role as helpers. This is an important work environment variable that deserves the attention of agency administrators. Another significant factor is a history of personal traumas, which contributes to compassion fatigue, possibly via workaholism and a lack of acceptance of supervision. Accordingly, organizations should make employee assistance programs available (and affordable) to provide helping professionals opportunities to process personal traumas.

This study's findings have direct, practical implications for training, supervising, and continuing education of helping professionals. For instance, most of the therapists interviewed observed that they had not had any courses or specific training on professional self-care, and this was an important but neglected area in training. Also, as low emotional self-awareness and a history of trauma were associated with higher compassion fatigue, programs would want to facilitate therapist self-awareness and/or the self of therapist as important components of their curricula. The therapeutic processing of personal traumas and training in identifying and handling one's own emotional states and reactions might help reduce the risk of developing compassion fatigue. Programs in the helping professions could also consider adding a self-care component to their curricula and discuss techniques for maintaining health. These curricular considerations may serve to promote the long-term health of trainees and can help them maintain the quality of the care they provide their clientele long after they graduate.

Perhaps one should not be too surprised by Bober and Regehr's *(2006)* finding that there is no association between helping professionals' belief that leisure time and self-care are useful and the time they allot to these activities. There is a gap between what people profess they believe and what they actually do. Human beings are complex creatures, and carry innumerable contradictions, often thinking and believing one way, and behaving in another. A fundamental focus of both researchers and practitioners in the human sciences, such contradictions are common phenomena in our daily existences. Second, it is probably safe to say that all of us have experienced how time flies in modern times, and how our schedules just could not get any more busy and hectic, and then, somehow, become even more so (see Daly, *2001;* Fraenkel, *2001;* Fraenkel & Wilson, *2000).* Therefore, it is not a shock to discover that the gap between beliefs and behaviors extends into the domain of professional self-care practices.

However, before one concludes that all that is needed to ensure resilience is the adoption of individual coping strategies (e.g., leisure time, continuing education, etc.), there was no evidence in this study that using such coping strategies protects professionals from symptoms of traumatic stress. Corroborating the findings of Bober and Regehr *(2006),* the quantitative study found no significant correlations between the use of various coping strategies and reported levels of compassion satisfaction, compassion fatigue, and burnout in clinicians working with trauma survivors. Helping professionals' coping styles, although related to overall work stress, did not directly influence their resilience (i.e., compassion satisfaction) or symptoms of compassion fatigue and burnout in the high stress job of working with trauma survivors.

While conclusions are tentative due to the cross-sectional nature of the data, a number of contextual variables did seem to make a difference. A primary factor predicting lower scores on compassion satisfaction is *higher number of hours per week* spent working with traumatized people. Two other factors are associated with higher compassion satisfaction: higher reported social support, and higher internal locus of control at the workplace. Lower scores on work morale were a significant predictor of symptoms of burnout in the current study. This finding resonates with research highlighting the protective function of morale, cohesion, and adequate supplies for persons in stressful circumstances, such as army units that saw combat in World War II (e.g., Manning, 1991; Manning & Fullerton, 1988). Collectively, these findings suggest that working with trauma survivors all day and all week is hard work, and doing less of it per week may help us do more of it in the long term. The findings also suggest

that other working conditions play a role in our health as helping professionals. The results also indicate that we probably should stop expecting helping professionals to "pull themselves up by their bootstraps" by reducing their stress with standard individual coping strategies of leisure and continuing education, which are clearly not all that effective. This may require a change in our ways of thinking about self-care, a recalibration of our theoretical lenses, if you will.

Family therapists are known to be big fans of the systemic paradigm, seeing the value in looking at, understanding, and treating individuals and their presenting problems within a larger couple and family context. The move away from the atomistic, reductionist, anticontextual framework, frequently a feature of Western dominant discourses, was certainly a watershed event within the helping professions, but in the past decade, some therapists have called for another paradigmatic shift, one that asks us to look at couple and family systems in a larger *sociopolitical* structures and contexts (e.g., Killian, 2001), using a framework that includes clients' social locations on axes of power and privilege (race, gender, class, culture, etc.) relative to one another, relative to their therapist, and so on.

I propose a parallel paradigmatic shift in our understanding of therapists and professional self-care, where we look at professionals' stress and coping in structural, political, and organizational contexts. Agencies and organizations could begin to move from focusing on individual workers and their coping strategies, because this focus implies that helping professionals who are hurting are somehow at fault—they are not balancing work and life (i.e., "just take some leisure time"), or, they are failing to make use of their opportunities for supervision, or educational seminars that focus on individual coping responses. Instead, organizations could proactively take on the task of figuring out ways of distributing workload so that traumatic exposure of any one worker can be limited. For example, organizations could institute policy changes to help make the workplace a space where therapists feel a sense of collegiality and support, and where they feel they have a sense of control (e.g., having some say about administrative policies, experiencing a degree of predictability in their workload, etc.). Borrill et al. (2000) reported that individuals in the helping professions who worked in clearly defined teams were found to suffer less psychological strain, had great job satisfaction, and reported greater organizational commitment. Because social support is an important ingredient in our fight against compassion fatigue, then forging connections to broader community movements (e.g., participating in political advocacy for trauma survivors) might help us to resist the debilitating effects of alienation, isolation, helplessness, and cynicism. To combat compassion fatigue and burnout, agency administrators and therapists may also wish to ask themselves "How many cases are too many?" Answering that question, and then establishing an upward limit on case workload, could nip stress in the bud before helping professionals become overwhelmed or exhausted, and before compassion fatigue begins to interfere with their abilities to concentrate, to remember relevant information about their cases, and to "hold the hope" for their clients until such time that they can do so for themselves.

Conclusion

Primary and vicarious exposure to trauma can impinge on helping professionals' well-being and compassion, and although organizational factors seem to play a role, we have yet to identify specific practices/strategies that may ameliorate the effects of personal and professional traumatic events such that they do not diminish the quality of therapy and do not precipitate burnout. This study found that helping professionals should maintain social support, and this might take the form of sustaining an active social network and perhaps processing or debriefing with especially tough cases. The qualitative study pointed to several strategies of self-care that clinicians believed protect and enhance their resilience, including debriefing and supervision, and regular supervision was both required and used at the agencies at which the participants worked. Talking with supervisors, consultants, and colleagues may represent a basic, effective practice that can ward off secondary traumatization, but this must be investigated further. Consistent with Bober and Regher (2006), the present quantitative study found no significant correlations between use of specific individual coping strategies and reported levels of compassion satisfaction, compassion fatigue, and burnout. Perhaps there are measurement issues in how the coping strategies have been operational-ized in quantitative studies. Future studies employing alternative instrumentation for collecting data

on the strategies of debriefing and supervision may discover that these factors are significant predictors of clinician resilience. In addition, a larger sample size would allow more advanced statistical procedures to be used, such as structural equation modeling. Nevertheless, this study's results indicate that clinicians' individual coping styles, while related to overall work stress, do not directly influence their resilience or symptoms of secondary traumatization in a high stress job of working with trauma survivors.

As trainers, educators, and supervisors, we want to protect therapists from compassion fatigue, enhance their resilience, and help professionals deliver quality mental health interventions, but to achieve these goals, we may need to shift paradigms, moving our focus away from individualistic efforts at education and training and toward a more systemic approach of advocacy for healthier working conditions. Such a paradigmatic shift begs the question of whether organizations and agencies are willing to invest in mental health benefits for their employees and to alter workloads in order to avoid the costs of staff turnover, low morale, and concomitant reductions in the quality of the services provided. Put in narrative therapy terms, bureaucracy, paperwork, workaholism, low internal locus of control at work, and social alienation are allies to the *externalized problem* of compassion fatigue. By continuing to study this important topic, and through an alliance of organizations and their employees working together to implement policies that combat compassion fatigue's influence, it is hoped that the helping professions can develop best practices to sustain ourselves so that we can continue to do the work that we love.

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