

University of Nevada, Reno

**Compassion Fatigue Curriculum Infusion:  
A Three-Part Workshop for Social Work Students**

A thesis submitted in partial fulfillment of the  
requirements for the degree of Master of Social Work

by

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THE GRADUATE SCHOOL

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prepared under our supervision by

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requirements for the degree of

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## Abstract

This study looked at a developed and implemented compassion fatigue workshop for Bachelor's and Master's level social work students. Looking at an overall sample of 108 students, students reported higher than average levels of compassion satisfaction, comparable levels of burnout and higher than average levels of secondary traumatic stress compared to a national sample of human service professionals on the Professional Quality of Life Scale 5 (ProQOL 5). Results indicated that self-compassion, mindfulness and over-identification were significantly associated with scores on the ProQOL 5, suggesting that self-compassion and mindfulness may help students prevent and cope with compassion fatigue while over-identification may be a risk factor. The number of years a student had been working in the field was significantly negatively associated with scores on the ProQOL 5, signifying that the more experience a student had in the field, the lower their reported levels of secondary traumatic stress. Students reported that they used information from the workshops, implementing it in a variety of ways in their internships such as utilizing the learned coping strategies themselves, sharing them with clients and recognizing signs of compassion fatigue in field placement supervisors and colleagues. These results demonstrate the importance of continuing to educate students about compassion satisfaction, burnout and secondary traumatic stress.

**Key Words:** compassion fatigue, burnout, secondary traumatic stress, compassion satisfaction, professional quality of life, mindfulness, self-compassion

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I suggest that burnout is not the result of hard work but of a sense of futility. People can work hard for long hours if they feel that they are making a difference. But if they feel their efforts are being wasted, then no matter how hard they work, it won't make any difference, then any task becomes too hard.

- Harold Kushner, Who Needs God?

### **Introduction**

Social workers are employed in a number of settings and work with an assortment of populations. As a result they can come in contact with many stressors on the job. Encounters with clients and organizational conditions can take a toll on social workers' mental and emotional health which can negatively impact the clients they serve, the organizations they work for and their decisions about whether or not to remain in the social work profession. The seriousness of this impact has led to topics such as burnout and compassion fatigue. Burnout is defined as a long-term stress reaction of helping professionals who work with people that is usually attributed to work-related factors (Noushadd, 2008; Stamm, 2010). Compassion fatigue is defined as the natural emotional and physical response to discussing someone else's trauma and the corresponding stress of wanting to do something about it (Figley, 1995).

In this paper "compassion fatigue" will encompass all terms related to compassion fatigue including burnout, vicarious trauma and secondary traumatic stress. Compassion fatigue is becoming increasingly studied in the field of social work and as a part of social work education. If social workers become more aware of this issue as students, they will be better able to prevent, identify and cope with it in their field placements and later in the workplace, which will be better for them, the populations they serve and the organizations they work for. The prevalence and impact of compassion fatigue make this topic essential for further study and intervention.

## **Reasons for Studying Burnout and Compassion Fatigue**

**Prevalence.** One issue associated with studying compassion fatigue is that it is becoming increasingly prevalent. It is not only an issue for social workers but for people in other professions as well including fireman and paramedics (Beaton, Murphy, Johnson, Pike & Corneill, 1999), doctors (El-bar, Levy, Wald & Biderman, 2013), nurses (Dominguez-Gomez & Ruteledge, 2009; Gates & Gillespie, 2008), dieticians (Gingras, Jonge & Purdy, 2010), masseuses (Blau et al., 2012) and clergy (Roberts, Flannelly, Weaver & Figley, 2003), to provide a few examples. Many studies have been done looking at this issue with specific groups of social workers, including hospital social workers (Dane & Chachkes, 2003; Badger, Royse & Craig, 2008) and Child Protective Service (CPS) workers (Bride, Jones & Macmaster, 2007) as well as therapists including clinical social workers, psychologists and psychiatrists (Adams & Riggs, 2008; Bober & Regehr, 2006).

In one study looking at secondary traumatic stress, a normal response to hearing about another's trauma with indicators that may be somewhat similar to Post-Traumatic Stress Disorder (Figley, 1995), Bride (2007) found that 70.2% of responding social workers admitted that they experienced one symptom of secondary traumatic stress in the previous week, 55% met the criteria for one of the core symptom clusters of Post-Traumatic Stress Disorder (PTSD), and 15.2% met the core criteria for PTSD. In a study of 363 child protective service workers, approximately 50% reported "high" or "very high" levels of compassion fatigue and 7.7% noted "high" or "very high" risk for burnout (Conrad & Kellar-Guenther, 2006). In another study, 13% of 1,121 mental health providers were found to be at high risk of compassion fatigue or burnout (Sprang, Clark, & Whitt-Woosley, 2007).

**Turnover.** Another reason that compassion fatigue is becoming of increasing concern is because of turnover. In the field of social work, high rates of turnover (the total number of employees who have left an organization in the past year divided by the total number of staff for that same time period times 100 (Pollack, 2008)) have been recognized as a problem for several decades because of their impact on social service delivery (Powell & York, 1992). These high rates are not a localized problem but affect the field internationally. In England and Wales turnover rates as high as 81% have been reported, and staffing is considered more problematic in the field of social work than any other profession (Evans et al., 2006). In South Africa, organizations note that it is difficult to retain staff because the government pays employees more (Pollack, 2008). In the United States, approximately one-fifth of social workers leave the field in the first five years of work and 19% of social workers with licenses reported that they were not active in a social work job (Center for Health Workforce Studies, 2006). Trends of high turnover are only expected to continue in an upward trend (Harlow, 2004).

Turnover negatively affects organizations, social workers and clients. In organizations, both direct and indirect costs are accrued through turnover. Direct costs include separation costs such as exit interviews and separation pay; replacement costs such as communicating job vacancies and interviews; and training costs such as classroom training and on-the-job instruction (Harlow, 2004; Mor Barak, Nissly & Levin, 2001; Pollack, 2008). Indirect costs, while harder to measure, can consist of loss of efficiency of employees before they leave the organization, coworkers' productivity as they deal with fluctuations in caseloads and loss of efficiency while new staff members are trained (Mor Barak et al., 2001). Martin and Schinke (1998) note that burnout and limited social services tenure are major factors of staff turnover.

Mor Barak et al. (2001) also list burnout as one of the four best predictors of intention to quit and an important variable in predicting turnover.

**Ethics.** Another reason that burnout and compassion fatigue are of concern to the profession as a whole are the ethics involved. Social workers experiencing compassion fatigue are distressed, and that distress can affect a number of areas in their life, including personal and professional (Wharton, 2013). When their professional life is affected, it hinders social workers' ability to work with clients, and this is not ethical given the National Association of Social Workers (NASW) Code of Ethics. Sections 4.05a and 4.05b of the Code of Ethics address the impairment of social workers in the form of any personal problems they might have, stating that it is social workers' responsibility to seek help or take any other steps they need to in order to protect their clients (National Association of Social Workers, 2006). Wharton (2013) notes that while social workers are ethically responsible for monitoring themselves under this code, it is sometimes difficult for them to determine when their impairment is affecting them on the job. He states that it is important for friends, family and colleagues to note this impairment. The NASW Code of Ethics supports this in sections 2.09a and 2.09b, which talk about what social work professionals should do if they notice a colleague's impairment (National Association of Social Workers, 2006). Thus, those in the social work field are ethically bound to address these issues to protect the people they serve (Everall & Paulson, 2004).

### **Students as a Population**

Helping professionals are not the only ones affected. Studies have shown that social work students are also at risk (Cunningham, 2004; Harr & Moore, 2011; Harr, Brice, Riley & Moore, 2014). Using the Professional Quality of Life Scale IV, Banko (2013) reported that social work students scored slightly above average on the burnout scale. This is consistent with

Harr & Moore's (2011) findings that social work students are at equal risk for compassion fatigue and slightly higher risk for burnout than other helping professionals, although a more recent study with a larger sample size suggested that social work students experienced lower levels of compassion fatigue than the helping professionals in the sample (Harr et al., 2014).

In spite of this risk, students aren't being educated about these issues (Dziegielewski, Turnage & Roest-Marti, 2004). Professionals in the field have said they wished they had known more about compassion fatigue before entering the field, and that it is an important topic for students (Bride & Figley, 2007; Smullens, 2012; Wharton, 2013). As a result, studies and professionals have cited a need for there to be more work and research done with students, including incorporating information into the curriculum and addressing student's possible reactions and self-awareness (Bussey, 2008; Courtois & Gold, 2009; Dane & Chachkes, 2003; Didham, Dromgole, Csiernik, Karley & Hurley, 2011; Grant & Kinman, 2011; Han, Lee & Lee, 2012; McKenzie-Mohr, 2004; Miller, 2001; O'Halloran & O'Halloran, 2001). In one study, students themselves cited the importance of such information, stating that after taking a workshop on burnout they felt the knowledge they learned was imperative and that it should be delivered in the curriculum in some way, with more than half finding the information they received in the workshop to be very relevant and helpful (Roembke, 1995). Problems of compassion fatigue in social work students and this research leads to the purposes of this study.

### **Purposes of this Study**

It has been suggested that the best defense against compassion fatigue is education about it, including a strong understanding of it, possible risk factors and symptoms that might be present (Figley, 1995). As a result of this, there are two purposes of this study. The first is to develop and evaluate a workshop about compassion fatigue for the School of Social Work at the

University of Nevada, Reno based on literature and current studies about workshops or curriculum specifically designed for students. These workshops are designed to increase education about compassion fatigue and terms related to it and help students practice coping mechanisms surrounding these issues. There have been studies developing and implementing a trauma certificate recovery program, curriculum, and workshops to address compassion fatigue with social work students (Bussey, 2008; Dane & Chachkes, 2003; Grant & Kinman, 2011; McKenzie-Mohr, 2004) and one workshop specifically looked at whether or not students retained information from these workshops (Roembke, 1995), so this study will look at whether or not students learned any new information and whether or not they were able to apply the information they learned in their field placements. The other purpose of this study is to further test the Professional Quality of Life Scale 5 (ProQOL 5) and the Self-Compassion Scale (SCS) with social work students. The Professional Quality of Life Scale R-IV has been studied with social work students (Banko, 2013; Harr & Moore, 2011; Harr et al., 2014) but when this paper was written a study with students using the Professional Quality of Life Scale 5 was not located.

## **Background**

### **Compassion Fatigue and Other Terms**

It is necessary to define compassion fatigue as there are a variety of definitions and other terms that appear in related literature and defining these terms has been referred to as a “taxonomical conundrum” (Stamm, 2010). These terms have evolved over time and some have emerged at the forefront of others. Research studies cite the 1970s as the first time that one of these terms was used, and that was burnout (Noushad, 2008; Zellmer, 2005). According to Figley (1995), the term burnout was first coined by Freudenberger (1975) and later expanded on by Maslach (1976). In the 1980s and 1990s, however, other terms began to emerge to further

describe the effects on helping professionals of working with people who have experienced trauma. Figley (1995) states that there were various other terms in the 1980s that preceded compassion fatigue but were referring to it, such as compassion stress (Figley, 1995). Additional terms coined by other authors included secondary victimization, co-victimization secondary survivor, savior syndrome, emotional contagion, and countertransference to some extent, to provide a few examples (Figley, 1995). It has been suggested that countertransference is related to compassion fatigue (Figley, 1995; Gentry, 2002), but this idea has also been disputed in the literature (Berzoff & Kita, 2010).

The term compassion fatigue itself originated with Joinson in 1992 in the nursing literature (Figley, 1995; Stebnicki, 2000) and later was expanded to the psychology and trauma literature by Charles Figley, PhD in 1995 (Stebnicki, 2000). Currently, there are three researchers that have done significant amounts of research and who are associated with the three currently accepted terms: compassion fatigue (Figley), secondary traumatic stress (Stamm) and vicarious trauma (Pearlman) (Stamm, 2010). There is some disagreement in the literature surrounding secondary traumatic stress and vicarious trauma and whether or not the terms are distinct or the same (Adams, Boscarino & Figley, 2006; Stamm, 2010). Canfield (2005) argues that it is important to differentiate between the terms secondary traumatic stress, vicarious traumatization and worker burnout because they are markedly dissimilar processes. However, attempts to delineate real differences, especially between secondary traumatic stress and vicarious traumatization, have not generally been effective (Stamm, 2010). Similarly, while earlier literature uses the terms compassion fatigue and secondary traumatic stress synonymously (Figley, 1995; Figley, 2002) other literature including Figley and Roop (2006), Pearlman and Carnigi (2009) and Stamm (2006) suggests that compassion fatigue and vicarious trauma are not

synonymous with Post-Traumatic Stress Disorder (PTSD) or secondary traumatic stress (as cited in ProQOL.org, 2014b) as people can experience negative effects from secondary exposure to trauma like changes in worldview without meeting criteria for a diagnosable disorder such as PTSD (ProQOL.org, 2014b).

### **Definitions**

In this paper, the terms most currently in use that are associated with compassion fatigue will be defined as they have evolved over time to provide context for the studies in the literature review. These are not the only definitions of these terms in the literature or the only terms that are related to compassion fatigue.

**Trauma.** Before further exploring compassion fatigue such as secondary traumatic stress and vicarious trauma, it is first necessary to define trauma, a core piece of their definitions. Two similar definitions of trauma are “a serious physical or emotional injury or shock that can cause significant damage or distress or disruption” (Follette & Pistorello, 2007, p. 1), and “an extraordinary and potentially dangerous and life-changing event linked to human response (Figley, 2009, p. 2). Many events constitute trauma including physical violence, physical injury, psychological violence, terrorist attacks, natural disasters, and accidents, to provide a few examples (Bussey, 2008).

In the diagnosis of Post-Traumatic Stress Disorder (PTSD), the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) states that in order to meet the criteria for having experienced a traumatic event for a diagnosis of PTSD a person must have experienced “exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” (American Psychological Association (APA), 2013, 271). In addition to this, the DSM 5 further explicates that this exposure can be anything from a person having directly

experienced themselves, learning about the trauma indirectly from a close friend or relative (in this case, if the trauma was actual or threatened death that death had to be violent or accidental), or

“repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e. g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures (American Psychiatric Association” (APA), 2013, p. 271).

While there are diagnoses in the DSM 5 related to responses to trauma such as Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder and Adjustment Disorders, to provide a few examples, The U.S. Department of Veterans’ Affairs (2014) notes that “all kinds of trauma survivors frequently experience stress reactions” (para. 3).

**Burnout.** Burnout has been defined as “a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations” (Pines & Aaronson, 1988, p. 9). It is a long-term stress reaction of helping professionals who work with people that is usually attributed to work-related factors (Noushadd, 2008; Stamm, 2010). More specifically, burnout has been conceptualized by Maslach (1976) to include three facets: emotional exhaustion, depersonalization, and reduced personal accomplishment, each of which can be measured with the Maslach Burnout Inventory (Maslach & Jackson, 1981). Emotional exhaustion refers to helping professionals having depleted emotional resources at such a level that they do not psychologically feel like they can help others. This is linked with negative feelings towards clients to the extent that they start to feel that clients are deserving of their problems and might even feel callous towards or detached from their clients. Lastly, reduced

personal accomplishment happens when helping professionals feel less competent and evaluate their work negatively so that they feel they are not making a difference (Maslach & Jackson, 1981; Noushadd, 2008).

Unlike compassion fatigue, burnout is a process that occurs more gradually and is usually associated with helping professionals who have been in the field longer (Noushadd, 2008; Zellmer, 2005), though other research suggests that new professionals may be more susceptible to burnout (Maslach, Schaufeli & Leiter, 2001). Other instruments that can measure burnout besides the Maslach Burnout Inventory (Maslach and Jackson, 1981) include the Professional Quality of Life Scale 5 (Stamm, 2009)

**Compassion Fatigue and Secondary Traumatic Stress.** Figley (2002) uses the terms compassion fatigue and secondary traumatic stress synonymously, though as mentioned previously recent research mentions they may not be synonymous (Stamm, 2010). Compassion fatigue and secondary traumatic stress are the normal behaviors and emotions that happen as a result of hearing about another's trauma and the subsequent stress of wanting to help (Figley 1995). Figley (2002) notes that when people try to view the world through suffering they suffer as a result and are less able to bear others' suffering (Figley, 2002). Some signs of compassion fatigue can include a sense of isolation, a diminished sense of enjoyment, loss of hope/sense of dread working with certain clients, difficulty concentrating, increased anxiety, hypervigilance, depression, emotional/physical exhaustion, frustration, irritability and avoidance of hearing/witnessing a client's traumatic material (Figley, 1995; Gentry, 2002). Other signs include secretive self-medication, obsessive and compulsive desire to help certain clients, inability to let go of work, thoughts or feelings of inadequacy as a helping professional, somatic symptoms and insomnia (Figley 1995; Gentry, 2002). The signs of compassion fatigue and

secondary traumatic stress are often considered to be somewhat similar to Post-Traumatic Stress Disorder with avoidance, arousal and intrusion symptoms (Figley, 1995). These indicators can affect many domains of a professional's life including their physical/somatic state, personal relationships and work performance (Figley, 1995).

There are a variety of measures and instruments that measure compassion fatigue and secondary traumatic stress including the Compassion Fatigue Self-Test (Figley, 1995), Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004) and the Professional Quality of Life Scale 5 (Stamm, 2009) to provide a few examples. Bride, Radey and Figley (2007) offer a more complete list of scales and explanation of the focus as well as an evaluation of reliability and validity of each.

**Vicarious Trauma.** Vicarious trauma is defined as covert cognitive changes in the core aspects of the self that happen as a result of hearing about another's trauma (McCann & Pearlman, 1990; Dane & Chachkes, 2003). The term vicarious trauma was coined by McCann and Pearlman (1990) and is more fully explained through the Self-Constructivist Model. The model discusses how humans construct their own realities through schemas, and that this is how they make sense of the world in a meaningful and manageable way. Vicarious trauma disrupts the way they make sense of the world and changes the meaning in areas such as dependency/trust, safety, power, independence, esteem, intimacy and frame of reference in such a way that the experiences may no longer be manageable (McCann & Pearlman, 1990).

Vicarious trauma is more of a conceptualization of how helping professionals' identity, worldview and spirituality (McCann & Pearlman, 1990) are changed as a result of working with people who have experienced trauma similar to how a trauma survivor's own worldview might change as a result of trauma. There are a variety of theoretical approaches for looking at trauma

and how people respond to and process it that come from a variety of perspectives including Psychodynamic Theory, Cognitive theories and Stress and Coping theories, to provide a few examples. The Self-Constructivist Model is a Cognitive theory.

***Self Constructivist Model.*** The Self Constructivist Model (McCann & Pearlman, 1990) looks at how helping professionals' view of the world can be impacted by (in this case specifically vicarious trauma) hearing about others' trauma. It postulates that helping professionals are impacted by vicarious trauma across five main domains: frame of reference, self capacities, ego resources, psychological needs and the sensory system. Frame of reference refers to the lens of reference through which a person sees the world, and under this concept vicarious trauma disrupts identity, alters helping professionals' world view and disrupts their spirituality. Self capacities refer to helping professionals' ability to comfort or soothe him/herself, which is damaged by vicarious trauma, as well as not being able to enjoy activities previously enjoyed and having difficulty tolerating strong affect (McCann & Pearlman, 1990).

Ego resources are the ability to relate to the outside world in a constructive way. Due to vicarious trauma, helping professionals' ability to maintain appropriate boundaries, humor, and empathy are all negatively impacted by vicarious trauma. Psychological needs refer to basic needs that every human being has, including safety, trust, intimacy, esteem in self and others and control. Experiencing vicarious trauma helping professionals identify with the helplessness of the trauma victim and lose their faith in self and mankind, their ability to control situations and trust in themselves as well as feel unsafe in the world. Lastly, sensory system refers to somatic disturbances, numbing and intrusive images, all of which are caused by a social worker experiencing vicarious trauma (McCann & Pearlman, 1990).

**Professional Quality of Life.** The combined feelings of helping are known as professional quality of life, and are a balance of compassion fatigue, or the “bad stuff” (Stamm, 2010) and another term, compassion satisfaction, or the “good stuff” of helping (Stamm, 2010). Compassion satisfaction is enjoyment helping professionals derive from being able to help others well (Stamm, 2010). It can be related to “providing care, to the system, work with colleagues, beliefs about self and altruism” (Stamm, 2009, slide 6). In general, the more compassion satisfaction a person has, the less compassion fatigue they have, and vice versa (ProQOL.org, 2014a; Stamm, 2009; Stamm, 2010).

In this paper compassion fatigue will be used as an encompassing term that loosely indicates all terms associated with it including burnout, secondary traumatic stress and vicarious trauma and more notably, distress that professionals may feel in their work helping others. This is consistent with Stamm’s (2009) Compassion Satisfaction – Compassion Fatigue Model that breaks the term compassion fatigue into burnout and secondary trauma. This model can be found on the Professional Quality of Life website at [http://www.proqol.org/Compassion\\_Satisfaction.html](http://www.proqol.org/Compassion_Satisfaction.html).

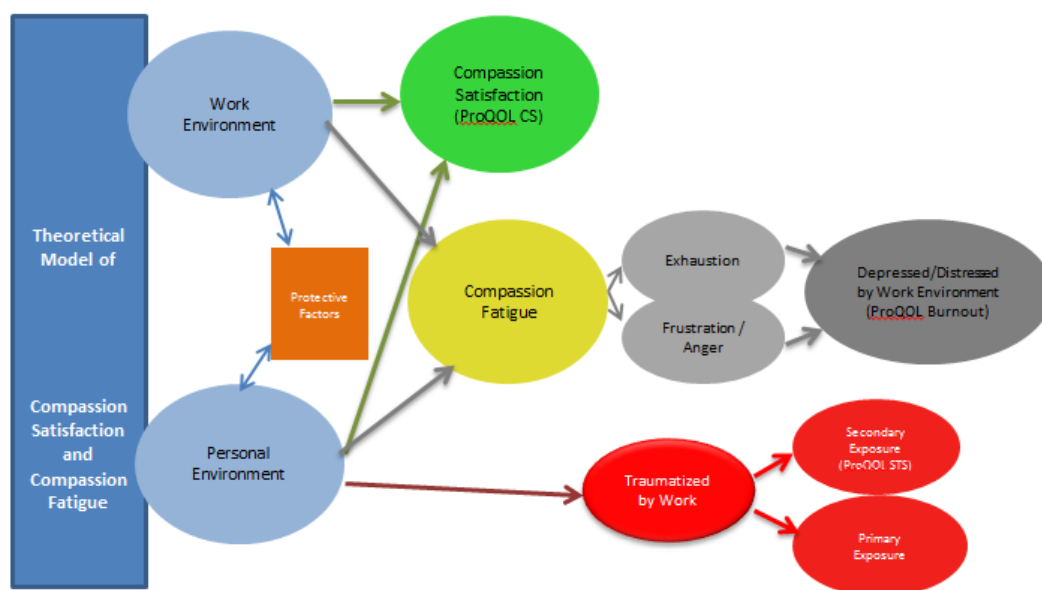
The development of the term compassion fatigue has allowed for a more solution-focused term than burnout, which seemed to suggest more of an ending point for helping professionals who seemed beyond help (Fahy, 2007). The addition of the term compassion fatigue has allowed for more discussion about prevention and treatment efforts as well as the possible dangers of helping professional work (Fahy, 2007), and has therefore led to more research being done on the subject. While many of the terms associated with compassion fatigue are presented with symptoms and signs, compassion fatigue should not be viewed as a pathological condition or shameful weakness (Gentry, 2002). Compassion fatigue is not a diagnosis but more of a

descriptive term (ProQOL.org, 2014b), thus the identification of compassion fatigue with measures and instruments is more to help professionals recognize what they are experiencing and seek help both for themselves and therefore those they are helping.

## **Literature Review**

### **Influencing Factors**

There are a variety of influencing factors that may play a role in the development of compassion fatigue. One model that shows the progression of these factors into compassion fatigue or compassion satisfaction is the Theoretical Model of Compassion Satisfaction and Compassion Fatigue created by Beth Hudnall Stamm in 2009. An adapted version of this model is presented in Figure 1 to conceptualize the relationship between contributing factors, the development of compassion fatigue and the different forms compassion fatigue can take as well as where these concepts fit on the Professional Quality of Life Scale 5 (ProQOL5), a measure used in this study which can be found in Appendix B. For the objectives of this examination, the influencing factor of Client/Person Helped Environment will not be focused on and was therefore removed from the model. Additionally, protective factors were added to the model to demonstrate the role they can play preventing and/or moderating the development of compassion fatigue. Sometimes protective factors can aid in preventing compassion fatigue and in other instances serve to ameliorate the effects of compassion fatigue and therefore seemed a necessary addition in the progression of the model. While work environment and personal environment factors can lead to both compassion fatigue and compassion satisfaction, in this section they will be discussed in terms of their contribution to compassion fatigue specifically.



**Figure 1: Adapted from the Theoretical Model of Compassion Satisfaction and Compassion Fatigue**

Original model ©Beth Hudnall Stamm 2009 retrieved from [http://www.proqol.org/Full\\_CS-CF\\_Model.html](http://www.proqol.org/Full_CS-CF_Model.html).

**Work Environment/Organizational Factors.** There are a variety of work factors that can play a role in the development of compassion fatigue that are out of an individual and their control. A few of these are perception of organizational support, lack of supervision, high case load and isolation at work (Allen, 2010; Bercier, 2013; Radey & Figley, 2007). In child protection workers perception of organizational support was found to be related to levels of compassion fatigue as well as compassion satisfaction (Allen, 2010). Similarly, Choi (2010) found that supportive networks within an organization are crucial to prevent or reduce compassion fatigue. Supervision has been found to be an important part of mediating such negative reactions, partly because it is good to process with someone who has more experience and partly because supervisors can help with diversifying a caseload or make it smaller if that might help ameliorate symptoms (Pearlman & Saakvitne, 1995; Radey & Figley, 2007). Isolation

at work also makes it hard to process distress and so symptoms like depression or anger might only worsen if not talked about (Bercier, 2013).

Other organizational factors that might influence the development of compassion fatigue are lack of control, interaction with clients, value conflict, role conflict and perceived unfairness in rewards (Bercier, 2013; Radey & Figley, 2007). Not having any control to change things that might need to be changed like caseload or interactions with clients (for example, social workers who work with people who have experienced trauma or lots of people who experienced trauma are more likely to have compassion fatigue than those who don't) so not being able to diversify a caseload in terms of client interactions could make the situation worse (Bride et al., 2007). Value conflicts with the workplace or practice and role conflict in terms of the work being doing can also contribute to compassion fatigue as this is a key factor in emotional exhaustion (Jayaratne & Chess, 1984). Lastly, perceiving that someone else is getting promoted or better hours when a person thinks they deserve them impacts burnout and compassion fatigue (Radey & Figely, 2007).

Having a combination of the risk factors mentioned previously only puts helping professionals at more risk. For example, according to Sprang et al. (2007) "limited resources, geographical isolation, few colleagues (limited peer support), and highly demanding caseloads create a 'perfect storm' of burnout risk among rural clinicians" (p. 273). Given this, the workplace environment can definitely put helping professionals at risk for compassion fatigue.

### **Personal Environment Factors.**

***Demographic Risk Variables.*** People bring their past and present to the work they do as a helping professionals, including the "schemas and beliefs (and stigma beliefs), their social support systems (both positive and negative), their history of trauma and illness, their families

and their economic situation” (Stamm, 2009, slide 17). As a result, there are personal environment characteristics and past history that could make individuals more vulnerable to compassion fatigue. Some personal characteristics that make helping professionals more susceptible to compassion fatigue are gender, history of trauma, age and living in a rural area. It is unclear whether or not there are gender differences in reported burnout. Some studies showed higher burnout-scores for men than women, others showed higher scores for women than men, and others found no differences in burnout based on gender in one review study (Maslach et al., 2001). History of trauma has been shown to be another risk factor, especially childhood trauma (Figley, 1995; Williams, Helm & Clemens, 2012), though one study found no association between personal histories of childhood or adult trauma with scores on their measures of compassion fatigue except in individuals who sought treatment (Bober & Regehr, 2006). Age is another factor. Burnout is reported to be higher among younger employees than people over 30 or 40 years old, but age is confounded by work experience so burnout might be more of a risk earlier in a person’s career (Maslach et al., 2001). Other studies note that burnout is usually associated with helping professionals who have been in the field longer (Noushadd, 2008; Zellmer, 2005). Lastly, living in a rural location also makes professional more susceptible to compassion fatigue, as professionals who live in rural areas generally have less access to social support (Sprang et al., 2007).

***Cognitive Risk Variables.*** The way individuals look at the world can also make them more or less susceptible to compassion fatigue. How individuals perceive stress can be greatly influenced by their personal history and how they assess the circumstances. Because of this, biological and psychological vulnerabilities an individual has can affect the degree to which individuals experience psychological distress following theoretically stressful situations

(Atkinson, Atkinson, Smith, Bem & Nolan-Hoeksema, 1996). Constructivist Self-Development Theory further supports this noting that people use their constructed cognitive schemas to make sense of the world around them, and they restructure these experiences when they interact with clients who have experienced trauma (Pearlman & Saakvitne, 1995). Given this, individuals who assign negative meanings to these experiences or have difficulty making sense of the trauma in areas such as trust, autonomy, initiative, competency, identity and intimacy, common psychological faculties that are damaged when exposed to trauma, (Erikson, 1963 as cited in Herman, 1992) would be more vulnerable to compassion fatigue.

Attributional styles that people have can also affect the way they interpret events. If people attribute negative and stressful events internally and blame themselves, they are less susceptible to compassion fatigue than if they attribute them externally and blame them on forces such as providence, destiny or omnipotent entities (Injeyan et al., 2011). Similarly, Han et al. (2012) suggest that emotional contagion (“one’s susceptibility to synchronize with others’ emotional states and expressions” (p. 441)), over-identification tendency (“a stream of negative thoughts” (p. 441) where a person over-identifies with these negative thoughts) and trait anxiety (“a general predisposition to fear and worry” (p. 442)) are cognitive personal attributes that can put students more at risk for compassion fatigue. Each of these traits involves judgment and negative self-evaluation that lead to higher stress and more predisposition.

***Intrapersonal Risk Variables.*** In one study looking at how intrapersonal skills/abilities affect the risk of compassion fatigue, lower mindfulness and emotional separation scores were associated with lower compassion satisfaction and higher burnout scores (Thomas, 2011), suggesting that people who had less mindfulness and less emotional separation were more at risk for burnout. Similarly, personal distress is one aspect of the empathy construct, and in multiple

studies higher personal distress is associated with higher compassion fatigue and burnout and lower compassion satisfaction (Thomas, 2011; Thomas, 2012; Thomas, 2013). Thomas (2011) questions whether different aspects of empathy might have differing effects on the therapeutic process, and in Thomas's 2013 research personal distress was found to be the only piece of the empathy construct to be associated with compassion fatigue, burnout and compassion satisfaction. Therefore, it is possible not all empathy or types of empathetic engagement would have a negative effect on empathetic quality of life specifically.

Similarly, one author, Radhule Weininger, describes how in his own personal experience he had been taught that getting too close to patients would only make him less professional, take more of a personal toll and leave him burned out and exhausted, therefore implying that emotional openness and empathic availability put a professional more at risk for compassion fatigue (Weininger & Kearney, 2011). Through Weininger's twenty years of practice, however, his opinion is that "rather than being protective, a standoffish and distant professional demeanour" (Weininger and Kearney, 2011, p. 50) is actually damaging to clients and puts clinicians at greater risk. Thomas (2011) acknowledges that while separating emotionally may help with quality of life, its effects on other clinical areas such as therapeutic alliance, professional motivation and collaborative work between therapist and client are unknown, and that it is important that if clinicians maintain emotion separation to avoid burnout that they are not causing other unforeseen negative consequences (Thomas, 2011).

**Protective Factors.** While there are factors that put helping professionals at more risk for compassion fatigue, there are also factors that can help protect them. There are both elements innate to individuals and concepts and skills that helping professionals can develop to produce resiliency. Having and using social support and active engagement in self-care strategies have

both been suggested as protective factors and interventions to ameliorate negative effects of people who work with those who have experienced trauma (Figley, 1995; Killian, 2008). In one study, clinicians believed that debriefing and supervision both supported their resilience in coping with and preventing compassion fatigue (Killian, 2008). Working in organizations that offer benefits and have staff development options (Hesse, 2002), a supportive team mentality and a supportive agency environment (Harr, 2013) are examples of working in an environment that has protective factors. Sprang et al. (2007) note that specialized training and caseload variety also help to protect helping professionals from compassion fatigue.

Spirituality has also been found to be a protective factor, as “reminding ourselves of the importance and value of the work we do is a powerful antidote to the spiritual damage created by vicarious traumatization” (Pearlman & Saakvitne, 1995, p. 391) and a reminder of the meaning and hope that can be lost when working with people who have experienced trauma. Another possible protective factor is hope. Schwartz, Tiamiyu and Dwyer (2008) found that social workers in private practice reported less burnout and had higher hope than social workers in public practice. In the nursing literature, hardiness is noted as a protective factor. Hardiness can be defined as “a pattern of attitudes and strategies that together facilitate turning stressful circumstances from potential disasters into growth opportunities” (Maddi, 2012, p. 8). It is composed of three Cs: challenge, commitment and control. Challenge means acknowledging that life is naturally stressful, commitment is continued participation in what is going on in the world and control is turning the situation to a person’s advantage. When a person has all three Cs they have existential courage and hardiness (Maddi, 2012).

Weininger and Kearney (2011) suggest that some protective factors to compassion fatigue include helping professionals countering isolation, embracing complexity and holistic

self-care. They also note that exquisite empathy, a form of empathetic engagement, can be a protective and revitalizing factor (Weininger & Kearney, 2011). The term exquisite empathy was coined by Harrison and Westwood (2009) and refers to empathetic engagement where clinicians give more of themselves in clinical encounters but do this in a way that is enriching for both clients and therapists, meaning they are very present, engaged and boundary-maintaining. Therapists do this by understanding a client's emotional state but not entering it. Exquisite empathy can be practiced and it can be sustained like many professional practices through mindful self-awareness (Harrison & Westwood, 2009). Thomas (2013) suggests that intentionally managing internal emotional states might be an intrapersonal protective factor.

Harr et al. (2014) suggest that compassion satisfaction may be the most effective approach to prevent or cope with compassion fatigue. They state that compassion satisfaction emphasizes a strengths perspective and can help students to sustain meaning and purpose even when confronting disheartening challenges (Harr et al., 2014). In their study they found that students with higher levels of compassion satisfaction described lower levels of compassion fatigue (Harr et al., 2014). In another study of students, Ying (2008) found that self-detachment and social support buffered against emotional exhaustion, suggesting self-detachment and social support could be preventative. Other protective factors can be found in the interventions that are currently suggested to prevent and cope with compassion fatigue. As Pearlman and Saakvitne (1995) note, “. . . therapies are often characterized by a unique depth of intimacy. The connection we have with our clients, through humor, love, and pain, can be profound. We feel nourished by such connections” (p. 403).

Gentry et al. (2004) suggest that there are five resiliency skills or antibodies that could also be protective/resiliency factors when it comes to compassion fatigue. These skills are self-

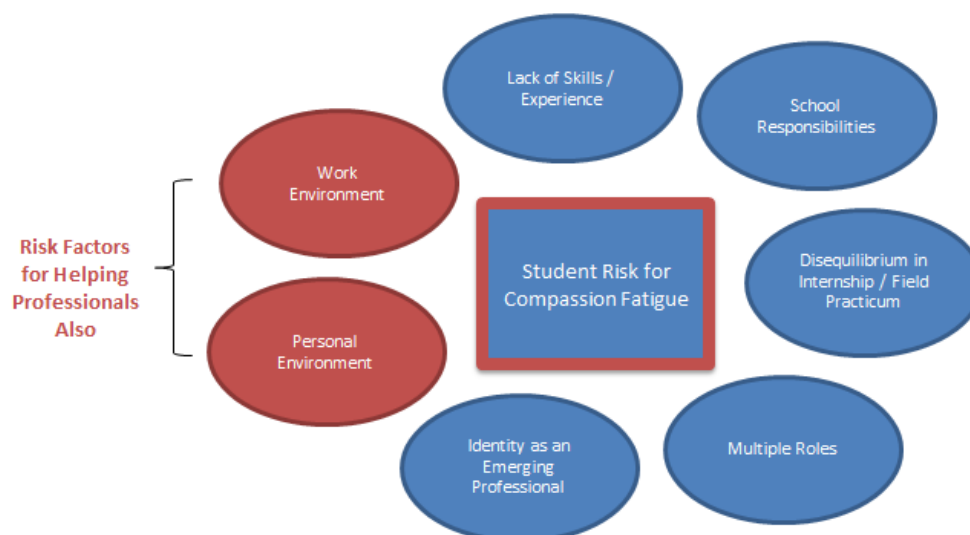
regulation; intentionality; perceptual maturation; connection and support; and self-care and revitalization. Self-regulation is the ability to control the Autonomic Nervous System by intentionally moving away from the overstimulation of the Sympathetic Nervous System (SNS) towards the relaxation of the Parasympathetic Nervous System (PNS), thus consciously relaxing one's muscles even when facing a perceived threat during the workday. Intentionality consists of two parts: deliberateness and integrity. Deliberateness refers to the ability to deliberately react to something instead of reacting compulsively or impulsively and integrity is awareness of intention. Self-regulation seems connected to the idea that mindfulness or meditation help with compassion fatigue (Ringebach, 2009; Thomas, 2012).

Perceptual maturation is a perceptual shift that can cognitively happen with awareness. For example, several perceptions to become aware of are noting there may be lots of perceived threat in a situation, but very little danger, and that the workplace always demands more than people can give so living up to the workplace expectations is not necessary. Intentionality and perceptual maturation are related to the idea that people construct their reality and have the power to perceive events differently (McCann & Pearlman 1990; Radey & Figley, 2002; Thomas, 2011). And social support and self-care are commonly cited strategies for ameliorating the effects of compassion fatigue (Birnbaum, 2008; Bober & Regehr, 2006; Radey & Figley, 2007).

The information presented above regarding the relationship between compassion fatigue as well as the risk factors and protective factors can best be explained by the adapted Theoretical Model of Compassion Satisfaction and Compassion Fatigue, shown in Figure 1. This figure demonstrates how work environment and personal environment can lead to compassion satisfaction or compassion fatigue, and then how compassion fatigue can lead to negative

feelings and/or burnout or secondary traumatization at work. The figure also demonstrates how work environment and personal environment don't always result in compassion fatigue or in symptoms of compassion fatigue that are more severe when they are prevented or mediated by protective factors.

**Student Risk.** Students also have additional risk factors that come into play because of their roles as students. This risk can best be explained by the Factors Involved in Student Risk for Compassion Fatigue Model presented in Figure 2. In this model, many stressors that students experience can contribute to their risk for compassion fatigue. Some of these risks, such as work environment and personal environment, are the same risks that professionals might have that were noted as possible contributing factors to the development of compassion fatigue and were presented above in Figure 1 in the Adapted Theoretical Model of Compassion Satisfaction and Compassion Fatigue. However, students also have additional stressors such as educational disequilibrium in field placements, the compounding of the multiple roles they endorse, a lack of skills/experience that professionals may already have and the uncertainty of their identity as an emerging professional as well.



**Figure 2: Factors Involved in Student Risk for Compassion Fatigue Model**

Students are susceptible to the same factors that professionals are such as personal environment factors and work environment factors. One example of a personal factor is a previous experience of trauma. As mentioned earlier, people who experienced trauma previously are more susceptible to compassion fatigue (Figley, 1995; Williams, Helm & Clemens, 2012). As a result of this, when teaching trauma material in the classroom it is important to be aware of how many students might be more vulnerable to having a reaction to trauma content. In one study, one half of the participants reported a trauma history before entering the program (Ringebach, 2009). In terms of work environment factors, like professionals if students do not have sufficient supervision they are also more susceptible to work-related emotional exhaustion (Kanno & Koeske, 2010). With more proficient supervision, students might feel more empowered, which could help them avoid emotional exhaustion (Kanno & Koeske, 2010).

Tobin and Carson (1994) also note that social work students are under large amounts of stress during training even before assuming the dual role of practitioner and student. They suggest that students cannot obtain the full benefit from their training if they are exposed to persistent and prevalent stressors and that if they continue with those stressors then the only

thing they obtain from their preparation might be burnout (Tobin & Carson, 1994). This stress may be related to a variety of factors including diverse roles that they must play such as that of student, intern, and employee, for example, which can cause “role-strain, role-overload and role-ambiguity, which most often result in intense feelings of stress” (Dziegielewski et al., 2004, para 2). While disequilibrium or disillusionment (Sweitzer & King, 2009) is only a normal part of the process of learning in field placements, this disequilibrium can lead to feelings of a lower sense of accomplishment, lower self-esteem and higher depressive symptoms, with more advanced master’s level students reporting more of these feelings than entering master’s students in one study (Ying, 2011). In another study, however, undergraduate students were cited as being the most at risk, with a note that as a result of educational disequilibrium students “might show high levels of psychological distress and often experience low self-esteem, emotional exhaustion, anxiety, self-doubt and stress” (Harr et al., 2014, p. 237). These feelings may be related to the fact that students may also not have the experience or skills to work successfully with clients who have experienced trauma (Harr et al., 2014) and are also trying to negotiate their identity as an emerging professional as they work with clients (Ying, 2011), a process that can be both exciting and difficult to navigate in the context of their learning experiences.

Another explanation for this stress during training is that preparation in the classroom is different than what is necessary to prepare for the field. According to Experiential Learning Theory, learning is “the process whereby knowledge is created through the transformation of experience” (Kolb, 1984, p. 41). In this theory, there are four ways to grasp a learning experience: concrete experience, abstract conceptualization, reflective observation and active experimentation. When anyone learns something through experience, they can then reflect on this experience, formulate abstract conceptualizations and test them with active experimentation

(Kolb, Boyatzis & Mainemelis, 2001). In thinking about this theory, Campbell (1999), noted that classroom learning often focuses on the cognitive aspects of learning and is under no obligation to provide for the experience of affective learning, which is common in field placements. Thus, students aren't as prepared for affective learning (Campbell, 1999) and might therefore be at risk for complications during the learning process.

Field placements are situations where students may have difficult experiences. In one study students reported that they encountered at least one traumatic incident during field practicum that was emotionally or physically upsetting and a small number of these students described these traumatic experiences as noteworthy to them (Didham et al., 2011). Though the events with the most significant impacts on students were related to field supervisors and faculty consultants, exposure to these traumatic events without sufficient coping and processing could put students at risk for developing compassion fatigue (Didham et al., 2011). Students were impacted in a variety of ways by these experiences and reported that they had changes in sleeping, eating, concentration, psychoactive substance use, confidence, and academic performance because of field placements (Didham et al., 2011).

Besides experiencing educational disequilibrium and stress in field placements, students may not be receiving the support they need from field instructors or faculty liaisons. In one study where field instructors and students were interviewed about field event perceptions, field instructors reported that they might not ascertain situations that are difficult or upsetting for students (Barlow & Hall, 2007). Additionally, even though students are affected and distressed by their work with clients and the amount of stress from field placements, they don't always convey this to field instructors or faculty liaisons (Barlow & Hall, 2007). While students are privy to stressful situations during field placements, they also don't always have the space in

which to process them even in field seminar due to lack of space and time (Moore et al., 2009). This suggests that there is a discrepancy in what students need in terms of emotional processing and what they are getting. With students also being at risk for vicarious traumatization and secondary traumatic stress just from material they are exposed to in the classroom (Cunningham, 2004), it is clear that the conglomeration of stressors such as work environment factors, personal environment factors, educational disequilibrium in field placements, the confusion of multiple roles, a lack of skills/experience and the uncertainty professional identity can put students at risk for compassion fatigue.

## **Interventions**

### **Individual Interventions.**

*Self-Care.* Individual strategies, especially self-care, are one important way to prevent or cope with compassion fatigue. There are a variety of methods that can be used for self-care including exercising, taking time off, allowing for self-reflection, journaling, eating right, getting personal therapy, medication and visiting with friends and family (Birnbaum, 2008; Bober & Regeher, 2006; Figley, 2002; Neff, 2009; Radey & Figley, 2007). Journaling is one method that has recently been found to be helpful for students in regards to improving self-care practices and processing their experiences and feelings (Moore, Bledsoe, Perry & Robinson, 2011; Shannon, Simmelink-McCleary, Im, Becher & Crook-Lyon, 2014).

Another method that students found to be helpful is engaging in macro practice as self-care, with the idea that thinking about issues on policy or macro practice levels is helpful because it allows for seeing the bigger picture, which can be useful if someone is not feeling effective in their individual practice (Shannon et al., 2014). Humor can also be helpful in coping with compassion fatigue to let off some steam (Figley, 2002), and as one nurse put it, “You’ve

got to laugh, or you'll cry – or go crazy” (Schwarz, 2005). Discussing cases and having regular supervision and therefore processing can also help prevent or cope with compassion fatigue (Birbaum, 2008).

Radey & Figley (2002) also suggest that helping professionals have the power to influence their own thinking to help prevent or cope with compassion fatigue. They suggest that positive affect (feelings like those associated with being appreciative and liking, pleasant ones) can be increased by physical, intellectual and social resources. In particular, the inner “compassionate core” resources like prospering and resilience and accrued wisdom from life experiences can help professionals to interpret experiences in a way that allows them to better manage compassion fatigue (Radey & Figley, 2002). For example, the article notes a personal experience where the author was interviewing combat veterans. The author explained that in lacking sufficient internal resources and having an under-developed compassionate core meant an inability to put the heard stories in the context of the broader world. Once the author gained understanding of post-war combat stress reactions, the positivity-negativity ratio (the ratio of positive feelings to negative ones (Fredrickson & Losada, 2005) became positive (Radey & Figley, 2007). This is something that helping professionals can keep in mind when thinking about self-care.

The reason that something like this would be effective is because of Fredrickson's (1998) Broaden-and-Build model of positive emotions. In general, negative emotions like anger and sadness narrow an individual's thoughts and actions so they can only focus on specific actions like survival. In contrast, positive emotions like love, compassion and contentment can expand an individual's thoughts and actions so that their personal resources build. Positive emotions can undo negative emotions (Frederickson, 2000). Frederickson (2000) suggests there are a variety of

ways to cultivate positive emotions and combat negative ones such as relaxation therapies like imagery exercises, muscle exercises and meditation exercises (which can build contentment) and finding positive meaning (including explanatory style, or the way the individuals construct meaning in day-to-day experiences which can be done through cognitive therapies) (Frederickson, 2000).

Additionally, technology is providing further methods of self-care. Telehealth is the provision of services through the use of telecommunications (Larsen & Davis, n.d.). Telehealth can help professionals by providing a service that can help restrict isolation. Clinicians in rural areas who might be more isolated or clinicians experiencing social barriers or low access to supervision can use telehealth services to connect with other helping professionals and/or their own therapeutic work to help mediate compassion fatigue (Larsen & Davis, n.d.).

The psychologists at the National Center for Telehealth & Technology, the Defense Department's primary agency for applying innovative technology to issues of psychological health and traumatic brain injury, also found a way to use technology. They developed a phone app called the Provider Resilience Phone App for health care providers treating military personnel (National Center for Telehealth and Technology, 2014). The app allows users to see when their last vacation day was, provides stress-busting and compassion satisfaction tools, and shows users their more recent-scores on the Professional Quality of Life measure. The idea is that if professionals can maintain an awareness of their levels of burnout, compassion satisfaction and secondary traumatic stress, their last vacation day and strategies to help cope with compassion fatigue then they will stay healthier and be able to more effectively help their clients (National Center for Telehealth and Technology, 2014). Two other strategies that can be helpful for coping with compassion fatigue are self-compassion and mindfulness. Because these

two strategies were included in the workshops in this study, these strategies will be explored in more depth.

***Self-Compassion.*** Neff (2003; 2009) defines self-compassion as when a person has compassion for themselves when they are failing, going through a hard time or observing things they don't like about themselves in the same way they would have compassion for others. Self-compassion has three components: Self-kindness, humanity, and mindfulness. Self-kindness refers to people being accepting towards themselves when they are aware of their flaws and experiencing pain instead of censuring themselves or ignoring what they are feeling. It is an acknowledgment that all people fail and have troubles, so people should be warm towards themselves when they inevitably have these experiences (Neff, 2003; Neff, 2009).

Common humanity refers to the idea that people can feel alone when they are exasperated about not getting what they want. It is acknowledging that everyone feels pain and errs, and self-judgment and thinking that a person is the only one is inaccurate (Neff, 2003; 2009). In common humanity there is an understanding that there are "external" factors like culture and biology that play a role how people act. Acknowledging common humanity means accepting the interdependence of people and therefore understanding that shortcomings don't have to be taken so personally because they are a part of the greater human experience.

Lastly, Neff (2003; 2009) defines mindfulness as watching negative thoughts and feelings but not judging, subduing or rejecting them (Neff, 2003; Neff, 2009). Each of these components help define self-compassion, and are not to be confused with self-pity, self-indulgence, or self-esteem (Neff, 2003; Neff, 2003; Neff, 2009) which are not self-compassion. Awareness of these facets of self-compassion can be improved through exercises and meditations (Neff, 2009).

Another suggested way to increase self-compassion is to have compassion for others (Breines &

Chen, 2013). The amount of self-compassion a person has can also be discovered using the Self-Compassion Scale (Neff, 2003; Neff, 2009).

Self-compassion is important in promoting perceived competence and mental health for students (Ying, 2009) and has been found to be a predictor of students' well-being (Neely, Schallert, Mohammed, Roberts & Chen, 2009). In the case of two facets of self-compassion specifically, over-identification and common humanity, over-identification worsens the experience of stress and common humanity improves coping, suggesting that self-compassion could be an important self-care method (Ying & Han, 2009). In a study of students by Ringenbach (2009), measures of self-compassion were positively associated with measures of compassion satisfaction and negatively associated with measures of burnout and compassion fatigue, signifying that self-compassion may be another method of mediating compassion fatigue (Ringenbach, 2009). Similarly, research with caregivers has shown that caregivers who have been trained in self-compassion are less likely to experience compassion fatigue and have more compassion satisfaction (Neff, 2011). This may be because self-compassion helps to provide caregivers with the skills they need to avoid becoming stressed or burnout out with the people they work with.

***Mindfulness.*** Besides Neff's (2003) definition of mindfulness as part of self-compassion, there are many other definitions of mindfulness. Bishop (2004) proposes that mindfulness has two parts: 1) self-regulation of attention that stays focused on the present moment and 2) a view of the present moment and one's experiences that is "characterized by curiosity, openness, and acceptance" (Bishop, 2004, p. 232). The goal of mindfulness isn't to prevent thoughts, feelings or sensations but only to notice distractions as they arise and then turn attention back to the present moment (Schure, Christopher & Christopher, 2008). Mindfulness has been known to be

helpful for stress through programs such as mindfulness-based stress reduction (MSBR) which allows participants to be fully aware of their present moment (Schure et al., 2008). MBSR has been found to reduce stress, negative affect, rumination, state and trait anxiety in therapists in training (Shapiro, Brown & Biegel, 2007). It has also been found to increase positive affect, self-compassion and mindfulness (Shapiro et al., 2007), all self-care strategies that mediate the effects of compassion fatigue (Christopher & Maris, 2010; Radey & Figley, 2002; Ringenbach, 2009).

Thomas (2012) found that participants who reported being more mindful had less compassion fatigue and burnout and higher compassion satisfaction. It was also noted that mindfulness was inversely related to personal distress and the negative influence of personal distress on compassion fatigue, burnout, and compassion satisfaction was lower with the presence of mindfulness (Thomas, 2012). Similarly, Ringenbach (2009) reported that counselors who engaged in meditation practices stated that they had higher levels of self-compassion and lower levels of burnout than those who didn't. When integrating mindfulness as a self-care strategy into training, Christopher & Maris (2010) discovered that mindfulness is a way that training programs can teach strategies of self-care to students to help prevent compassion fatigue. Mindfulness aided students in tolerating difficult emotions and as a result students were more able to put clients' difficult emotions in "holding environments" (Christopher & Maris, 2010).

The effect of the coping methods and strategies described above on distress is not known (Bober & Regehr, 2006). In terms of specific types of self-care, Banko (2013) reported that students most often maintained their personal and professional lives while psychological self-care was the least maintained strategy on average. And while Bober & Regehr (2006) found that participants believe that leisure and self-care strategies are useful, there was no correlation

between these beliefs and time spent engaging in these activities, though participants who believed supervision was valuable were more likely to dedicate time to it. Similarly, no significant correlations between use of specific individual coping strategies and recounted professional quality of life were found (Bober & Regehr, 2006; Killian, 2008). In spite of studies noting the lack of self-care strategies in spite of beliefs (Bober & Regehr, 2006), studies agree that self-care strategies are important in mediating the effects of compassion fatigue (Figley, 1995; Moore et al., 2011; Shannon et al., 2014). Helping professionals and researchers can become more aware of their beliefs surrounding coping strategies and the amount of time they spend toward such activities using the Coping Strategies Inventory (Bober, Regehr & Zhou, 2005).

**Group Interventions.** There are a variety of interventions that can happen at a group level to help influence the effects of compassion fatigue. These include Critical Incident Stress Debriefing (CISD), Defusing, Interactive Psycho-Educational Group Therapy and General Self-Care Exploration Groups (Bourassa & Clements, 2010). CISD is a seven-phase debriefing model that usually happens after exposure to a traumatic event or crisis intervention (Bourassa & Clements, 2010). Defusing is only one session that takes place at the end of a work day to provide support and reduce stressful feelings (Bourassa & Clements, 2010). Another model that has been helpful is Interactive Psycho-Educational Group Therapy, which is a 16-week group intervention for PTSD but may also be helpful in professionals who are experiencing compassion fatigue symptoms similar to PTSD (Bourassa & Clements, 2010). General self-care exploration groups could be a helpful support group and organizational intervention that could take place in the work setting and aid helping professionals in preventing and coping with compassion fatigue (Bourassa & Clements, 2010).

**Training Interventions.** Besides group interventions, there have been a variety of trainings designed that professionals can attend. These include the Accelerated Recovery Program Model (ARP), Stress Inoculation Training (Bourassa & Clements, 2010) and the Compassion Fatigue Prevention and Resiliency Workshop (Gentry, 2000). The ARP model has a five-session treatment protocol that works toward the completion of major objectives and treats professionals that have compassion fatigue (Gentry, Baranowsky & Dunning, 2002). It has been found to be effective in decreasing participants' compassion fatigue and burnout and increasing compassion satisfaction when implemented as Certified Compassion Fatigue Specialist Training, which is a shorter, skilled implementation of the ARP (Gentry, Baggerly & Baranowsky, 2004). According to Meichenbaum (1996), Stress Inoculation Training is a three-phase intervention that aims to increase coping skills that would help to prevent compassion fatigue, though it is not known if it helps to prevent compassion fatigue (as cited in Bourassa & Clements, 2010). The Compassion Fatigue Prevention and Resiliency Workshop is a one day training that includes five professional resiliency skills (Gentry et al., 2004). While these groups and trainings vary in length and purpose, they all have similar goals of working to help professionals cope or prevent compassion fatigue.

**Organizational Interventions.** There are other techniques that can be helpful in terms of preventing and coping with compassion fatigue that do not fall onto the shoulders of an individual, and these things can happen in the workplace. Organizations and supervisors making sure that caseloads are limited or diversified can be important to prevent social workers from becoming overwhelmed or having too much of the same type of case (Hendrikson, 2013). Appropriate supervision to help recognize compassion fatigue early and provide a place for processing is important (Hesse, 2002). Team consultation is optimal to brainstorm interventions

and keep clinician risk in perspective (Azar, 2000). Organizations providing adequate benefits and advancement opportunities that make workers feel like they are valued and can improve in the agency. Sharing with employees the effects compassion fatigue can have, instilling humor into the daily atmosphere and encouraging individual actions are also important steps that agencies can take (Figley, 2002).

**Student Interventions.** As students are at risk for compassion fatigue and burnout in the classroom and in the field (Cunningham, 2004; Harr & Moore, 2011; O'Halloran & O'Halloran, 2001), besides interventions that have been employed in the workplace to educate professionals and help them cope, there have also been a variety of methods employed to help students. These methods fall into three categories: those suggesting how to limit secondary traumatic stress and vicarious trauma as a result of trauma coursework in the classroom, interventions to help educate students and interventions to help students cope with negative emotions that may lead to compassion fatigue.

**Classroom.** It has been shown that students can experience secondary traumatic stress and vicarious trauma just as a result of being exposed to trauma content in the classroom (Cunningham, 2004). In order to ameliorate this, Cunningham (2004) recommends a variety of strategies to reduce the risk of students having a more adverse reaction to traumatic content when they are in the field. The first suggestion is for instructors to use case vignettes, simulations, standardized cases or role plays in the classroom with traumatic material so students can first be exposed to this kind of material in the safe environment of a classroom. It is also suggested that when presenting graphic traumatic material it is presented with appropriate emotion instead of a detached manner because this allows students to be forewarned about the material. It is also recommended that instructors be aware that students who react strongly (and who may be

presenting with vicarious traumatization) could disrupt the process of the group, that students may inappropriately disclose information of previous trauma in the classroom setting, that some students will be resilient and not have negative reactions, and that their classroom needs to be a safe place where student distress is dealt with instead of ignored. Overall, Cunningham (2004) recommends that instructors think about how they are presenting traumatic material to students and introduce self-care as a strategy for dealing with traumatic material early in students' careers to help avoid reactions that might lead to vicarious traumatization.

In another study, O'Halloran and O'Halloran (2001) suggest that students who take courses on trauma and violence can experience secondary traumatic stress in the classroom. In order to address this, they suggest a format to ameliorate secondary traumatic stress among students in the classroom and present self-care strategies. They recommend designing content by using Herman's Trauma Theory stages of safety; remembrance and mourning; and reconnection to teach students about trauma while lessening the likelihood of secondary traumatic stress. They also recommend including self-care strategies (which they divide into four categories: biobehavioral, affective-cognitive, relational and spiritual) into the curriculum to further aid students in processing the content material.

Black (2006) suggests a different model for teaching trauma in the classroom. In his model, incorporated established principles of trauma treatment including a) resourced, b) titrated exposure to traumatic material and c) reciprocal inhibition is recommended as a way to deliver educational materials in an education setting. Here, resourced refers to incorporating serenity scenes into the class to allow students to focus on material not related to trauma during the class. Titrated exposure to traumatic material refers to titrating the material so that students receive "small manageable doses" (Black, 2006, p. 269) of traumatic material and then they are

grounded or resourced before being exposed to the next material so that their ability to cope with the material is not overwhelmed. Lastly, reciprocal inhibition is similar to titration of exposure in that relaxation responses are paired with the opposite trauma response to eliminate the control of the trauma response and replace it with the more adaptable relaxation response. Black (2006) notes that teaching trauma in this way will help students to not become overwhelmed by trauma material and possibly provide inoculation for students as they become professionals.

Miller (2001) also proposes a variety of methods in the classroom to make sure students are not negatively impacted by traumatic material. These include the professor being attuned to both their own reactions to the material and students' reactions to the material; the differentiation of the classroom and therapy; and journal writing as a tool for enhancing reflection. Students thoughtfully engaging with their traumatic childhood experiences and introducing students to the possible impact of the traumatic material are also encouraged. Miller (2001) proposes that instructors have many responsibilities in teaching students about trauma and keeping the above methods in mind will help them to teach their students about trauma in a way that can create a "safe frame for learning".

Additionally, Newell (2014) recommends that case studies and self-care strategies be included in both micro and macro practice curriculum. They note that knowledge of self-care and compassion fatigue is consistent with several of the standards established by the Council on Social Work Education's 2008 Educational Policy and Accreditation Standards including the core competencies 2.1.1 (identify as a professional social worker and conduct oneself accordingly), 2.1.3 (apply critical thinking to inform and communicate professional judgments), 2.1.6 (engage in research informed practice and practice informed research) and 2.1.7 (apply knowledge of human behavior and the social environment).

*Education.* As compassion fatigue can be influenced by work with people who have experienced trauma, teaching students about trauma and their possible reactions to it is an important part of education. One such program that was specifically created to address trauma included implementing a trauma response and recovery certificate program (TRRCP) to help expose students to trauma work and provide them with the tools they would need to address and cope with trauma in the field (Bussey, 2008). Bussey (2008) felt that “By presenting a framework of trauma as a normal response to often-horrific situations . . . students can better understand their traumatized clients and their own reactions” (p. 142). The purpose of educating students about compassion fatigue is to help them understand that they are normal reactions to hearing about trauma (Figley, 1995) and help give them the tools to understand the clients and their own reactions, such as compassion fatigue.

Another method to help educate students is to incorporate the material directly into classes. Dane (2002) addressed vicarious trauma in required social work classes. She felt that content has to be included in practice method courses and field practicum. Through four content themes including personal, organization, societal and spiritual, she defines four concepts from literature: burnout, countertransference, empathy and vicarious traumatization; allows students to examine their own personal attitudes; helps them identify organizational support; and provides information about spiritual renewal and self-care.

Another study administered Maslach’s Burnout Inventory to students in the classroom as well as provided a seminar about burnout (Roemke, 1995). In terms of Maslach’s Burnout Inventory, the study found that on two dimensions of the inventory, emotional exhaustion and depersonalization, the 21 students scored higher than Maslach’s sample of helping professionals, suggesting higher burnout. Students also scored higher on the personal accomplishment subscale,

suggesting less burnout, as Maslach says that higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale suggests burnout (Roembke, 1995). From these results Roembke (1995) postulated that graduate student burnout might look different than that for mental health professionals as mental health professions have vague, uncertain and subjective tests on the job while graduate students have a highly structured environment with rewards for achievements like grades, scholarships and acknowledgments (Roembke, 1995). These results are consistent with those of Tobin and Carson (1994) who also administered the Maslach Burnout Inventory to social work students and noted that stress might manifest itself differently in social work students than qualified social workers, possibly as a result of short term contracts or unpaid voluntary work that social work students do.

Through surveys, Roembke (1995) objectively measured that students learned information about burnout and felt it was applicable by virtue of attending the seminars. Besides scoring higher on a post-test quiz than on the pretest about this information, 67% of students also felt the information provided was very relevant or most relevant and 77% found it to be very helpful or most helpful. Overall, the students who participated felt that learning about burnout was professionally valuable and that the knowledge provided was imperative and should be delivered in the curriculum in some way (Roembke, 1995). While these results were positive, Roembke (1995) that it is unclear from the study whether or not providing information about burnout to students will be useful in helping them to prevent burnout in the future (Roembke, 1995).

***Coping Interventions.*** Besides educating students about trauma and compassion fatigue, there are also studies looking at incorporating material and workshops to help students cope with

them. These studies centered on the use of mindfulness techniques and self-care journaling assignments.

*Mindfulness.* One mindfulness study was a four year study with 33 participants looking at the influence of teaching mindfulness to counseling graduate students through hatha yoga, meditation and qigong. The material was a 15-week, 3-credit mindfulness-based stress reduction course that looked at how students' positive physical, emotional, mental, spiritual and interpersonal health were affected by the course as well as effects on counseling skills and therapeutic relationships. The rationale for the study was that there are some research studies that show promising results for helping to reduce burnout in helping professionals through mindfulness-based stress reduction (MSBR). Of note, this study found that students experienced emotional changes as a result of the content including "increased ability and capacity to deal with so-called negative emotions" (Schure et al., 2008, p. 53). Students were able to have a place to process negative emotions that arose for them and contributed to stress they were experiencing and changed across five different themes: a) physical changes, b) emotional changes, c) attitudinal or mental changes, d) spiritual awareness and e) interpersonal changes. This study suggests that courses including content about how to cope more effectively with negative emotions may help students to incorporate those skills into practice and lower their risk for compassion fatigue as they may become less reactive to events in the field that are related to stress or anxiety (Schure et al., 2008).

Another study looking at teaching mindfulness to 12 students was an eight-week group. The purpose of this group was to provide an "accompanying place" where students could look at thoughts, feelings and conflicts in a non-judgmental way (Birnbaum, 2008). The goals of the group were to help students become more self-aware and increase their emotional support in

handling field and academic stressors. The study found that students were able to use learned techniques to help regulate and cope with intense emotional states (Birnbaum, 2008). Given that experiences in field placements and later in the workplace can produce intense emotional states that contribute to compassion fatigue, it is possible that mindfulness groups such as this would be helpful in preventing or helping to cope with compassion fatigue.

Gockel, Burton, James & Bryer (2013) note that while mindfulness training is becoming suggested as a way to reduce stress among trainees in the helping professions and nurture clinical skill progress, many mindfulness-based interventions are long and therefore difficult to integrate into standard curricula. To overcome this, they looked at integrating small 10 minutes per session doses of mindfulness training into a clinical interviewing class with 132 students. They found that students who received the mindfulness training conveyed significant changes in counseling self-efficacy but not well-being. Though their well-being did not improve, it was demonstrated that even a small 10-minute dose of this type of training can help develop students' clinical skills, particularly helping students to be more present with clients during sessions. Students also reported that they found the training to be valuable, pertinent to being a clinical practitioner and useful once they entered field (Gockel et al., 2013).

*Self-care assignments.* Besides mindfulness, incorporating self-care was another method for helping students. A study looking to help students cope with high levels of stress that could become a risk factor for compassion fatigue discusses incorporating a self-care assignment into a class of 22 students to not only teach students about the importance of self-care but to help them learn to employ it (Moore et al., 2011). The self-care assignment was a biweekly self-care journal where students talked about their self-care, especially any self-care activities they did, issues that were being addressed with their actions, and how those activities helped their

spiritual, mental, emotional, social and physical well-being (Moore et al., 2011). The study found that stress reduction resulted from these journaling exercises and some students continued to journal, showing that they felt this self-care exercise was helpful (Moore et al., 2011). Incorporating self-care assignments like help students learn to cope with emotions they might encounter in the field and later help with compassion fatigue.

An additional study examining self-care also incorporated journaling assignments with 17 students as part of self-care (Shannon et al., 2014). The study found that students employed a variety of self-care strategies including physical strategies of self-care such as playing hockey, running, dancing, etc.; relational strategies such as sharing their feelings with friends, supervisors, therapists, etc; and cognitive strategies of self-care including deliberate distractions and mindfulness and meditation practices during the semester. Students noted that practicing self-care was difficult because of the stresses of graduate school and a lack of time. Many students expressed that they intended to do more self-care, but it was noted that this was especially harder during busy times during the semester when there were many deadlines (Shannon et al., 2014). Shannon et al. (2014) concluded that content like this is important for social work students as their growth and awareness over the 15-week course increased surrounding these terms. They also concluded that giving students choices influences their likelihood of their practicing these techniques.

Although the amount of time invested differs as does the format, whether through a certificate program, a class, a workshop or a group, each of these studies has the same main objective: to help students learn about compassion fatigue, cope with negative emotions and learn more about how self-care will aid them in coping. While their methods were different, each study found that the technique they employed was useful to students in some way in helping

them become more educated about compassion fatigue and effective in helping them cope with negative emotions. The idea that these types of interventions are effective lead to research questions of this study and the development of the workshops.

### **Research Questions**

The four research questions of this study are as follows:

1. Were students' ProQOL 5 scores significantly different in the fall/spring?
2. Were students' pre ProQOL 5 scores correlated with self-compassion scores, especially mindfulness and over-identified subscores, from the SCS?
3. Is there a relationship between demographic variables, specifically level of field experience and age, and scores on the ProQOL 5 scale?
4. Did students find the workshops to be useful?

These research questions will fulfill the two purposes of this study: To develop and evaluate a workshop educating students about compassion fatigue for the School of Social Work at the University of Nevada, Reno. In this evaluation it will be determined whether or not students were able to use or apply the material they had learned in these workshops in their field placement and this will be discovered through the fourth research question. The other purpose of this study is to further test the Professional Quality of Life Scale 5 (ProQOL 5) and the Self-Compassion Scale (SCS) with social work students, which will be addressed with the first three research questions. This study was approved by the Institutional Review Board (IRB) at the University of Nevada, Reno prior to its implementation. The study used a mixed-methods, quasi-experimental design to answer these questions.

## Methods

### Measures

**Demographic Questionnaire.** The Demographic Questionnaire was created specifically for this study. It collects basic demographic information such as age, race / ethnicity, gender, and year in the program to provide a few examples. It was used in this study to help answer the third research question about the relationship between demographic variables and level of field experience. See Appendix A for a copy of this measure.

**Professional Quality of Life Scale 5.** The Professional Quality of Life Scale 5 (ProQOL 5) is copyrighted by Stamm (2009) and is the fifth version of the Professional Quality of Life Scale. It is a 30-question measure that asks questions that can be broken down into three scores: compassion satisfaction, burnout and secondary traumatic stress. The scale asks respondents to identify how often they have had the following experiences in the last thirty days. Some question examples include: “I feel overwhelmed because my case [work] load seems endless”, “I believe I can make a difference through my work” and “I avoid certain activities or situations because they remind me of frightening experiences of the people I [help]”. Scores are computed by adding item scores and the total score is calculated by adding responses for each question and reversing the negative score items (only reverse scored for certain questions in the burnout scale). The numbers recorded for each question are then added to determine the score and the sum of the questions is converted to a score after being converted to a t-score and finally a z-score ( $zscore * 10 + 50$ ). For the compassion satisfaction scale the average score is 50 (sum of questions is between 23 and 41; SD 10; alpha scale reliability .88), for the burnout scale the average score is 50 (sum of questions is between 23 and 41; SD 10; alpha scale reliability .75) and for the secondary traumatic stress scale the average score is 50 (sum of questions is between

23 and 41; SD 10; alpha scale reliability .81) (Stamm, 2010). For each of the scales about 25% of people score below 43 (sum 22 or less) and about 25% of people score above 57 (sum of 42 or more), so scores of 43 or less indicate a low risk, scores between 23 and 41 indicate average risk and scores of 57 or more indicate high risk (Stamm, 2010). In this study, the sum scores before converting to scores are reported.

According to Stamm (2010), versions of the Professional Quality of Life Scale has good construct validity in over 200 published research studies. The three scales of the ProQOL 5 have separate constructs. The compassion fatigue scale has inter-scale correlations of 2% shared variance ( $r = -.23$ ;  $\text{co-}\sigma = 5\%$ ;  $n = 1187$ ) with secondary traumatic stress and 5% shared variance ( $r = -.14$ ;  $\text{co-}\sigma = 2\%$ ;  $n = 1187$ ) with burnout. The burnout and secondary traumatic stress scales measure separate constructs in terms of how the secondary traumatic stress scale measures fear while the burnout scale doesn't. The shared variance between these two scales is 34% ( $r = .58$ ;  $\text{co-}\sigma = 34\%$ ;  $n = 1187$ ). It is used in this study to answer the first, second and third research questions and to provide awareness to students about their professional quality of life scores. A copyrighted version of this measure is available in Appendix B.

**Self-Compassion Scale.** The Self-Compassion Scale (SCS) was developed by Neff (2003). It is a 26-item measure designed to measure self-compassion across six subscales: self-kindness (“When I’m going through a very hard time, I give myself the caring and tenderness I need”), self-judgment (“When times are really difficult, I tend to be tough on myself”) common humanity (“When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am”) isolation (“When I fail at something that’s important to me, I tend to feel alone in my failure”), mindfulness (e.g. “When something upsets me I try to keep my emotions in balance”) and over-identification (“When I fail at something important to me I

become consumed by feelings of inadequacy”). Subscale scores are computed by adding item scores and the total self-compassion score is calculated by reversing the negative subscale items and then adding all subscale scores together. Neff (2003) reports that this measure is a “psychometrically sound and theoretically valid measure of self-compassion” (p. 244) in areas including cross-validation, test-retest reliability, discriminant validity, factor structure and construct validity. It is used in this study both to answer the second research question and as a tool for students to become aware of their own self-compassion. A copyrighted version of this measure can be found in Appendix C.

**Usefulness Questionnaire.** The Usefulness Questionnaire was created specifically for this study. There are three parts to this questionnaire. The first part ascertains how useful students found the material (including questions such as “Did you use any of the information you learned in the workshop in your field placement? If so, how or under what circumstances?”), the second looks how new the material was for students (including questions such as “If there was new information, what information was new?”) and the third part addresses what feedback students had about the workshops (including questions such as “Do you have suggestions on how to improve the workshop?”). This questionnaire was used to answer the fourth research question. See Appendix D for a copy of this measure.

## **Theory**

There are many processes and emotions that take place during the learning process. Understanding theories behind these is helpful in explaining both periods where students might be more susceptible to compassion fatigue and the three-part workshop structure in this thesis.

**Five-Stage Model of the Internship Process.** Sweitzer and King (2009) identify five developmental stages that students go through in a field placement or an internship: Anticipation,

Disillusionment, Confrontation, Competence and Culmination. The first stage, Anticipation, involves excitement about starting the internship, a sense of eagerness and hope, as well as nervousness and anxiety. This stage can also be termed the “What if . . .?” stage.

Disillusionment, the second stage, involves the time period when interns feel that this internship is not what they expected as they discover what they thought their internship was going to be like is different than what it actually is. This is referred to as the “What’s wrong with my internship?” stage. The third stage is the stage where the second is resolved, and it is known as Confrontation. In this stage interns face and study what they are going through and figure out how deal with issues that may have arisen in the Disillusionment stage such as role understanding, interpersonal and intrapersonal issues (Sweitzer & King, 2009).

Having come through the third stage, interns then find themselves in stage 4: Competence. This is the stage where students’ morale is high as they gain confidence with the skills they have gained and their learning. Lastly, in stage 5 comes Culmination. This is a period of reflecting back on the internship and getting ready to leave. As such, there is a mixture of feelings including feelings of pride over accomplishments but also sadness about leaving. Based on the many feelings of highs and lows of an internship as outlined by this model, it makes sense that students might be more at risk of developing compassion fatigue in different stages in the process. For example, when a student is dealing with Disillusionment they may be feeling more negative emotions and may be more likely to experience compassion fatigue than when they are in the Culmination stage and feeling confident in their abilities and the anticipation of moving forward (Sweitzer & King, 2009).

The Field Coordinator in the Social Work department at the University of Nevada, Reno felt that in her experience, students seem to enter the Disillusionment stage at around eight weeks

into their internship, so that is when the workshop on individual coping strategies was given to help students through that part of the process. The third workshop was given early in the second semester, at a time when students had been in their field placements for about six months and seemed like an appropriate time for students to apply the information they had learned in all three workshops to cases and reflect on their experiences with the workshop material so far.

**Thorndike's Laws of Learning.** Thorndike (1913) discussed how someone learns information best in Thorndike's Laws of Learning. He postulated that there are three laws of learning (which have since been expanded on by other theorists): the Law of Readiness, the Law of Exercise, and the Law of Effect. Overall, these laws explain how people are able to produce behavior that is appropriate to the situation in which they live (Thorndike, 1913). The Law of Readiness is the idea that when someone is ready to do something, then when they do it, it is satisfying. If they are not ready to do it, then doing it is annoying. If they are ready to do something but not able to do so, then that is also annoying. This is especially true for learning. According to this law, since a person must be ready to learn such information, the workshops in this thesis were only given to students in a field placement as being in a field placement would include the myriad of feelings and stages described in the Five-Stage Model of the Internship Process (Sweitzer & King, 2009).

The Law of Exercise comprises two other laws: the Law of Use and the Law of Disuse. The Law of Use suggests that when a connection is made between a situation and a response, the connections strength is increased. This is true for memory and application of material. The Law of Disuse states that when a connection is not made during a situation and a response during some length of time, then the connection's strength is decreased, and the person might not be able to use the information because no connections were made. Thus, practice and repetition will

strengthen connections but not using the information will weaken them (Thorndike, 1913). Given these laws, students have to practice and use the information they are learning in their field placements, or even in classes and work experiences, for them to continue to retain that information.

Lastly, the Law of Effect states that when a connection between a situation and response is made and it is followed by a positive state of affairs, then the connection's strength is increased, or therefore positively reinforced. To incorporate the Law of Effect, people must not only make these connections but have them reinforced (Thorndike, 1913). Assuming this, students would not only need repeated lecture content but they also would need periods of connection. Having three workshops allowed for these periods of connection especially in the second and third workshops with the discussion of students' scores on the Self-Compassion Scale measure and their discussion in small groups applying lecture information they had learned about compassion fatigue to case material. These connections could also take place in their field placements or work environments.

## **Procedures**

**Workshops.** The two purposes of these workshops were to increase education and help students practice coping mechanisms surrounding compassion fatigue. All Bachelors of Social Work (BSW) and Masters of Social Work (MSW) students currently in a field placement and therefore a field seminar class at the University of Nevada, Reno participated in a three-part workshop about compassion fatigue. The workshops were mandatory for these students but participation in the survey portions of the workshops and inclusion of data in the study was not mandatory. The workshops were delivered by the Master's student writing this thesis. Each workshop was 50 minutes in length and this time period included surveys when indicated below.

**Workshop 1.** The first workshop took place at a mandatory social work orientation in August before school started. Two separate workshops were delivered on August 19th: 1) MSW Concentration students (MSW students graduating and doing their second field placement) and 2) BSW and MSW Foundation students (MSW students who were not graduating and who were in their first field placement like the BSW students). The first part of the workshop was administering a survey which included the Demographic Questionnaire (Appendix A), the ProQOL 5 (Appendix B), and the Self-Compassion Scale (Appendix C). The content for this workshop was then delivered in a lecture-style and included definitions of compassion fatigue and its related terms, why compassion fatigue would be talked about at orientation, who has compassion fatigue (including students), and some of the causes of compassion fatigue. The slides for this workshop and the accompanying notes are presented in Appendix E.

**Workshop 2.** The second workshops took place the week of October 5th. Content was delivered to students in four separate workshops: 1) Sunday, October 5<sup>th</sup> to a distance learning class; 2) Monday, October 6<sup>th</sup> to a combined seminar of BSW students; 3) Wednesday, October 8<sup>th</sup> to a combined seminar of MSW Concentration students and 4) Friday, October 10<sup>th</sup> to MSW Foundation students. This workshop was delivered lecture-style and included a review of the terms introduced in the last workshop, an overview of coping strategies (with a specific focus on self-compassion and mindfulness as coping strategies) and a discussion of Long SCS scores that were returned to students. The workshop also included a handout which comprised definitions of terms and resources for coping. The slides for this workshop, the accompanying notes and the handout (the handout is on p. 152) can be seen in Appendix F.

**Workshop 3.** The third workshops took place at the end of February and the beginning of March. Content was delivered to students in four separate workshops: 1) Wednesday, February

25<sup>th</sup> to a combined seminar of MSW Concentration students; 2) Friday, February 27<sup>th</sup> to MSW Foundation students; 3) Saturday, March 7<sup>th</sup> to a distance learning class comprised of BSW students; and 4) Monday, March 9<sup>th</sup> to a combined seminar of BSW students. The first part of this workshop was delivered lecture-style and content included a review of the terms discussed so far and group / organizational coping strategies. The next part of the workshop included three cases that were distributed to students. Students broke up into small groups, discussed the cases and some groups reported highlights from their discussion. The last part of the workshop contained a survey that included the Demographic Questionnaire (Appendix A), ProQOL 5 (Appendix B) and the Usefulness Questionnaire (Appendix D). The slides for this workshop, the accompanying notes and the cases used (the cases start on p. 168) can be seen in Appendix G.

**Confidentiality.** As these workshops were administered by a Master's level student who knew other students, student confidentiality was important. The confidentiality of the data was maintained using the Context-Determined, Rule-Generated Pseudonym (CDRGP) coding strategy (Carifio & Biron, 1980). Social work students' names were not collected, only their unique CDRGP code which they created using the first letter of their middle name, the first letter of the month they were born in, the first letter of their gender, the first letter of the name of their street and the first letter of their mother's first name. These codes were only used to connect the pre/post Professional Quality of Life Scale 5 (ProQOL 5) to each other, the ProQOL 5 scores to the Self-Compassion Scale (SCS) and to return scores on the SCS to students. Students were given a sheet that explained how to create their code and reminded of their code when the SCS was returned to them at the second workshop and when they filled out the ProQOL 5 again in the third workshop. A copy of what the CDRGP coding sheets looked like in the survey are included in Appendix H.

**Consent.** Though the workshops were mandatory, students were given the option of having their results included in the study or not. In order to help students more clearly understand this option, an information sheet was included for both the first and third workshops because those are the two workshops where surveys were included. Students were also given a sheet where they could check whether or not they wanted their survey to be included in the research study. A copy of the Information Sheet and Consent to Participate sheet are included in Appendix I.

## **Results**

### **Overall Sample**

There were 108 participants in the overall sample who ranged in age from 20-58 years old with a mean age of 29.26 (ages are from the pre ProQOL 5 given in August and do not reflect changes in age that may have occurred by the post ProQOL 5 at the end of February or early March). The majority of participants were female (86.1%), Caucasian (63.0%), and were full-time students (82.4%). As there was missing data, the sample of participants for each research question is different than the overall sample to accommodate missing data in terms of that sample. A complete description of the samples by each research question is presented below in Table 1. The sample for Research Question 3 is the same as the overall sample.

**Table 1: Sample Demographics by Research Question**

<b>Demographics</b>	<b>Research Question 1</b>	<b>Research Question 2</b>	<b>Research Question 3*</b>	<b>Research Question 4</b>
<b>Gender</b>				
Male	13 (18%)	13 (18%)	15 (14%)	14 (16%)
Female	61 (82%)	58 (82%)	93 (86%)	76 (84%)
<b>Age (In Years)</b>				
18-25	34 (46%)	33 (47%)	45 (42%)	37 (41%)
26-35	28 (38%)	26 (37%)	44 (41%)	36 (40%)
36-45	8 (11%)	8 (11%)	11 (10%)	10 (11%)
46-55	3 (4%)	3 (4%)	6 (5%)	5 (6%)
>55	1 (1%)	1 (1%)	2 (2%)	2 (2%)
<b>Race/Ethnicity</b>				
White/Caucasian	51 (69%)	48 (68%)	68 (63%)	59 (66%)
Black/African American	1 (1%)	1 (1%)	1 (1%)	1 (1%)
American Indian/Alaskan Native	0 (0%)	0 (0%)	1 (1%)	1 (1%)
Asian	1 (1%)	1 (1%)	3 (3%)	2 (2%)
Native Hawaiian/Other Pacific Islander	3 (4%)	3 (4%)	3 (3%)	3 (3%)
Hispanic/Latino	9 (12%)	9 (13%)	22 (20%)	15 (17%)
Two or More Races/Ethnicities	9 (12%)	9 (13%)	10 (9%)	9 (10%)
<b>Student Status</b>				
Full-Time	64 (87%)	61 (86%)	89 (82%)	75 (83%)
Part-Time	10 (13%)	10 (14%)	19 (18%)	15 (17%)
<b>Year in the Program</b>				
BSW (Bachelor's) Students	43 (68%)	40 (56%)	73 (68%)	57 (63%)
MSW F (Master's Foundation) Students	8 (8%)	8 (11%)	9 (8%)	9 (10%)
MSW C (Master's Concentration) Students	23 (24%)	23 (32%)	26 (24%)	24 (27%)
<b>Field Placement Year</b>				
1 <sup>st</sup> Field Placement	52 (70%)	49 (69%)	75 (70%)	61 (68%)
2 <sup>nd</sup> Field Placement	22 (30%)	22 (31%)	33 (30%)	29 (32%)
<b>Worked in Social Work (SW) in the Past</b>				
Yes	31 (42%)	31 (44%)	43 (40%)	37 (42%)
No	43 (58%)	40 (56%)	65 (60%)	53 (58%)
<b>Current Work in the SW Field</b>				
Yes	18 (24%)	17 (24%)	25 (23%)	22 (25%)
No	56 (76%)	54 (76%)	82 (77%)	67 (75%)
<b>Number of Years Working in the SW Field</b>				
<1	6 (19%)	6 (19%)	10 (23%)	6 (16%)
1-2 years	12 (39%)	12 (39%)	13 (29%)	12 (32%)
3-5 years	8 (26%)	8 (26%)	11 (25%)	10 (27%)
5-10 years	4 (13%)	4 (13%)	9 (21%)	8 (22%)
>10 years	1 (3%)	1 (3%)	1 (2%)	1 (3%)
<b>N =</b>	<b>74</b>	<b>71</b>	<b>108*</b>	<b>90</b>

\*The Research Question 3 Sample is the same as the overall sample.

## Research Question 1

*Were students' ProQOL 5 scores significantly different in the fall/spring?*

**Sample.** The participants for Research Question 1 only included surveys with complete and matched pre/post ProQOL 5 scores. There were 74 participants in the Research Question 1 sample who ranged in age from 20-58 years old with a mean age of 28.51. The majority of participants were female (82.4%), Caucasian (68.9%), and were full-time students (86.5%). A complete description of the overall sample is shown in Table 1.

**Findings.** A paired samples t-test was run to compare pre/post ProQOL 5 sums for compassion satisfaction, burnout and secondary traumatic stress. There were no significant differences between pre/post compassion satisfaction ( $t(73) = 0.67, p < .05$ ) and burnout ( $t(73) = 1.08, p < .05$ ) raw scores from the pre ProQOL 5 given in August and the post ProQOL 5 given in February or March. There was a significant difference in secondary traumatic stress scores with  $t(73) = 5.28, p < .05$ . and a p value of .000. All mean scores went down from the pre to post surveys. Analyses were run on the raw scores. Correlations for the pre/post survey by scores are shown in Table 2.

**Table 2: Paired Samples Correlations for Research Question 1**

Variables	Mean	Standard Deviation	t	P
Pre/Post ProQOL 5 Compassion Satisfaction Score	0.297	3.860	0.663	0.510
Pre/Post ProQOL 5 Burnout-score	0.622	4.948	1.081	0.283
Pre/Post ProQOL 5 Secondary Traumatic Stress Score	2.851	4.648	5.277	.000*
<b>N = 74</b>		<b>Degrees of Freedom</b>	<b>=</b>	<b>73</b>

\*Paired; statistically significant  $p < .05$

**Discussion of Findings.** All scores (compassion satisfaction, burnout and secondary traumatic stress) went down over time. It would be expected that compassion satisfaction scores would go down over time as students would be experiencing the different stages of internship, including the disillusionment stage and therefore might not have as much compassion satisfaction as at the start of their internship. There was a significant difference in secondary traumatic stress scores with a p value of .000 but no significant differences in compassion satisfaction or burnout scores. In terms of burnout and secondary traumatic stress, including secondary traumatic stress scores being significantly different, because this was not an experimental design, it is not possible to say whether or not the workshops had an impact on students' levels of burnout or secondary traumatic stress. Many factors may have influenced the drop in scores including coping strategies, the workshops, periods of time during the internship or sources of support, to provide a few examples.

### **Research Question 2**

*Were students' pre ProQOL 5 scores correlated with self-compassion scores, especially mindfulness and over-identified subscales, from the SCS?*

**Sample.** The participants for Research Question 2 only included surveys with complete pre ProQOL 5 and SCS scores. Only pre ProQOL5 scores were compared to SCS scores and not both pre ProQOL 5 and post ProQOL 5 because the SCS was only given at the same time as the pre ProQOL 5. There were 71 participants in the Research Question 2 sample who ranged in age from 20-58 years old with a mean age of 28.58. The majority of participants were female (81.7%), Caucasian (67.6%), and were full-time students (85.9%). A complete description of the overall sample is shown in Table 1.

**Findings.** A bivariate correlational analysis was run to look at correlations between compassion satisfaction, burnout and secondary traumatic stress scores from the pre ProQOL 5 and mindfulness and over-identified subscales on the Self-Compassion Scale (SCS). Significant positive correlations were found between the compassion satisfaction score and self-compassion ( $r(69) = 0.44, p < .01$ ), compassion satisfaction and mindfulness ( $r(69) = 0.52, p < .01$ ) and the secondary traumatic stress score and over-identified items ( $r(69) = 0.39, p < .01$ ). Significant negative correlations were found for the compassion satisfaction score and over-identified items ( $r(69) = -0.27, p < .05$ ), burnout and mindfulness ( $r(69) = -0.30, p < .05$ ), and mindfulness and over-identified items ( $r(69) = -0.49, p < .01$ ). All Pearson correlations and 2-tailed significance can be found in Table 2.

Table 3: Correlational Analyses for Research Question 2

N = 71		Pre ProQOL 5 Compassion Satisfaction Score	Pre ProQOL 5 Burnout- score	Pre ProQOL 5 Secondary Traumatic Stress Score	SCS- Total Score	5th Subscale SCS - Mindfulness	6th Subscale SCS - Over- Identified Items
<b>Pre ProQOL 5 Compassion Satisfaction Score</b>	Pearson Correlation	1	-.456**	-.022	.439**	.522**	-.274*
	Sig (2-tailed)		.000	.853	.000	.000	.021
<b>Pre ProQOL 5 Burnout- score</b>	Pearson Correlation			.479**	-.403	-.295*	.323
	Sig (2-tailed)			.000	.000	.012	.006
<b>Pre ProQOL 5 Secondary Traumatic Stress Score</b>	Pearson Correlation				-.254*	-.115	.392**
	Sig (2-tailed)				.032	.340	.001
<b>SCS- Total Score</b>	Pearson Correlation					.746*	-.781**
	Sig (2-tailed)					.000	.000
<b>5th Subscale SCS - Mindfulness</b>	Pearson Correlation						-.488**
	Sig (2-tailed)						.000
<b>6th Subscale SCS - Over- Identified Items</b>	Pearson Correlation						1
	Sig (2-tailed)						

\*Bivariate; statistically significant  $p < .05$

\*\*Bivariate; statistically significant  $p < .01$

**Discussion of Findings.** Significant positive correlations were found between the compassion satisfaction score and self-compassion, the compassion satisfaction score and mindfulness, and the secondary traumatic stress score and over-identified items. Significant negative correlations were found for the compassion satisfaction score and over-identified items,

burnout and mindfulness, and mindfulness and over-identified items. These results are consistent with findings from previous studies where over-identification was noted to worsen the experience of stress (Ying & Han, 2009). Similarly, overall scores on the Self-Compassion Scale were significantly positively correlated with compassion satisfaction and significantly negatively correlated with secondary traumatic stress, similar to findings in a study by Ringenbach (2009) where measures of self-compassion were positively associated with measures of compassion satisfaction and negatively associated with measures of burnout and compassion fatigue. This is also consistent with findings in another study where lower mindfulness and emotional separation scores were associated with lower compassion satisfaction and higher burnout scores (Thomas, 2011). Overall, these findings suggest that self-compassion, and especially mindfulness, can help mediate compassion fatigue, and lowering over-identification could also help prevent and cope with compassion fatigue.

### **Research Question 3**

*Is there a relationship between demographic variables, specifically level of field experience and age, and the sum scores on the ProQOL 5 scale?*

**Sample.** The participants for Research Question 3 included all students with any complete data (whether that complete data was from the pre ProQOL 5, the post ProQOL 5, or the SCS). There were 108 participants in the sample for Research Question 3 who ranged in age from 20-58 years old with a mean age of 29.26. The majority of participants were female (86.1%), Caucasian (63%), and were full-time students (82.4%). A complete description of the overall sample is shown below in Table 4.

**Findings.** A bivariate correlational analysis was run to look at correlations between compassion satisfaction, burnout and secondary traumatic stress scores from the pre/post ProQOL 5 and age and number of years working the social work field. There were no significant correlations between age and pre/post ProQOL 5 scores but number of years working in the social work field was significantly negatively correlated with the post secondary traumatic stress scores ( $r(106) = -0.23, p < .05$ ). All Pearson correlations and 2-tailed significance can be found in Table 4.

Table 4: Correlational Analyses for Research Question 3

N = 108		Age	Years Working in the Field	Pre ProQOL 5 Compassion Satisfaction Score	Pre ProQOL 5 Burnout-score	Pre ProQOL 5 Secondary Traumatic Stress Score	Post ProQOL 5 Compassion Satisfaction	Post ProQOL 5 Burnout-score	Post ProQOL 5 Secondary Traumatic Stress Score
Age	Pearson Correlation	1	-.079	.031	.046	.104	.201	-.092	.122
	Sig (2-tailed)		.417	.764	.658	.321	.072	.415	.280
Years Working in the Field	Pearson Correlation		1	-.039	-.163	-.140	-.056	-.195	-.231*
	Sig (2-tailed)			.707	.114	.181	.623	.083	.040
Pre ProQOL 5 Compassion Satisfaction Score	Pearson Correlation			1	-.534**	-.214*	.696**	-.471**	-.063
	Sig (2-tailed)				.000	.041	.000	.000	.593
Pre ProQOL 5 Burnout-score	Pearson Correlation				1	.547**	-.278*	.418**	.158
	Sig (2-tailed)					.000	.000	.000	.175
Pre ProQOL 5 Secondary Traumatic Stress Score	Pearson Correlation					1	.084	.107	.440**
	Sig (2-tailed)						.471	.361	.000
Pre ProQOL 5 Compassion Satisfaction Score	Pearson Correlation						1	-.643**	-.209
	Sig (2-tailed)							.000	.063
Pre ProQOL 5 Burnout-score	Pearson Correlation							1	-.420**
	Sig (2-tailed)								.000
Pre ProQOL 5 Secondary Traumatic Stress Score	Pearson Correlation								1
	Sig (2-tailed)								

\*Bivariate; statistically significant  $p < .05$ \*\*Bivariate; statistically significant  $p < .0$

**Discussion of Findings.** There were no significant correlations between age and pre/post ProQOL 5 scores but number of years working in the social work field was significantly negatively correlated with the post secondary traumatic stress scores, suggesting that the more experience professionals have, the lower their risk for secondary traumatic stress. This is consistent with one review article that noted burnout is reported to be higher among younger employees than people over 30 or 40 years old, but as age is confounded by work experience they note burnout might be more of a risk earlier in a person's career (Maslach et al., 2001). More research is needed to fully determine the impact of age and field experience and the effect it has on compassion satisfaction, burnout and secondary traumatic stress.

#### **Research Question 4**

*Did students find the workshops to be useful?*

**Sample.** The participants for Research Question 4 only included surveys where students had filled out a post survey and had answered any questions on the Usefulness Questionnaire. There were 90 participants in the sample for Research Question 4. Participants ranged in age from 20-58 years old with a mean age of 29.50. The majority of participants were female (84.4%), Caucasian (65.6%), and were full-time students (83.3%). A complete description of the overall sample is shown in Table 1.

**Findings.** The 11-question Usefulness Questionnaire included both scaled and open-ended questions. There were three main foci of the questionnaire: 1) how useful students found the material 2) how much of the information was new for students; and 3) feedback students had about the workshops. For each of these main concepts there was one scaled question and open-ended questions. The mean results of the three scaled questions are show below in Table 5.

**Table 5: Quantitative Results from the Usefulness Questionnaire**

<b>Questions</b>	<b>Mean</b>
On a scale of 1-10, how useful did you find this workshop?	7.8
On a scale of 1-10, how new was the information presented in the workshop?	5.8
How likely would you be to recommend this workshop?	8.2

For the open-ended questions, there were some categories for each question that students endorsed at higher frequencies than others and a variety of other responses. In terms of using information from the workshops in field placements, 76 of the 90 students (84%) who participated reported that they used the information in field placement while five (5%) reported that they did not. 18 students reported that they used the information by practicing self-care. 17 students noted that they used mindfulness practices and being present and calm in their field placements after taking the workshops and seven said that they were more self-aware and used more self-reflection. Other common responses to how students used information from the workshops in their field placements included sharing or using coping strategies with clients, being able to recognize compassion fatigue and burnout in others, being aware of how necessary self-care is and using more supervision. In terms of changing coping strategies as a result of the workshops, 63 (66%) students reported that they changed coping strategies they used when dealing with internship stress or compassion fatigue and 22 (23%) students reported that they did not. For those that did, 14 students stated that they did more self-care but did not specify the specific strategies they used. Commonly identified strategies of self-care included more time off (10 students), more exercising (nine students), more self-awareness (eight students) and more mindfulness (seven students). Other common ways that coping strategies changed included more stress reduction, more self-compassion and more sleep.

Students identified that there was some new information presented in the workshops. 30 students reported that at least one of the term definitions was new for them (whether compassion fatigue, burnout, secondary traumatic stress or vicarious trauma). 11 students noted that the role organizations can play as well as training and group strategies was new information and seven reported that they did not know about some of the coping strategies that were discussed. Five students said that the case study information was new as well. In terms of information that wasn't new, 41 students said that they learned the information in class, 11 students reported that they learned the information from these workshops, 10 said that they knew information from personal research such as articles and reading and nine students were familiar with information having learned it in supervision in their field placements. Other common responses included learning information from presentations or internships.

Students had a variety of feedback to give about the workshops. In terms of information that they felt was most valuable, 20 students reported that learning about the importance of self-care was valuable and 15 students noted that self-care tips and coping strategies was also important. Seven students said that the definitions of terms (including compassion fatigue, secondary traumatic stress, vicarious trauma and burnout) was valuable and seven found the signs of compassion fatigue to be as well.

Another question that can be valuable in feedback for future workshops to inform content that can be covered asked students to identify events or experiences outside their field placement that they felt impacted their ability to handle stress, burnout or trauma. For this question, students identified both negative impacts and positive impacts. 17 students identified that some form of social support impacted their ability to handle stress and these included classmates, family, friends, colleagues, faculty, religion and pets. Eight students noted that supervision positively

impacted their coping ability and other common responses included knowing how to read themselves and slowing down to take care of themselves. Regarding having a negative impact, six students reported that juggling life and having a lot going on affected their ability to handle stress. Five students reported that school negatively impacted them and three students reported that life stress and internship also had a negative impact.

Students had a variety of suggestions for how to improve the workshops. Six students recommended more hands-on activities and four said that more handouts, especially one on self-care strategies, would be useful. Other common recommendations included having more detailed information on organizational strategies and support and including more time for participants and their experiences. Recommendations surrounding the formatting of the workshops included doing a longer workshop, putting the workshops closer together to prevent forgetting information and presenting information earlier in the program. Suggestions on improving content covered areas such as including more information on burnout and disabilities, how to celebrate successes, creating a workplace culture and coping strategies, having clearer case studies, the presenter using more energy and bringing someone in from the field to speak.

**Discussion of Findings.** Based on the quantitative and qualitative data, students found the workshops to be useful and were able to incorporate the skills they learned in their field placements. Quantitatively, students reported an average of 7.8 for usefulness on a scale where a 10 is extremely useful, and 84% of students stated that they used information from the workshops in their field placements. Students used this information in a variety of ways, including coping strategies for themselves, sharing coping strategies with clients, and an increased awareness of their own responses as well as the responses of those around them. 66% of students reported changing the coping strategies they used based on the workshops,

incorporating more self-care strategies or doing more of the coping strategies they already used because of an increased awareness of the importance of self-care. These findings show that workshops like these are important in increasing awareness of compassion fatigue because that awareness can turn into the ability to apply that new knowledge in other settings, giving students skills that they can then use and apply later in the workforce as well.

Students were also shown to use the information they learned in the workshops in the third workshop on organizational strategies. In that workshop, students were given real-world cases and questions and asked to apply the information they learned to make recommendations to the professionals in the case examples (these case examples can be seen in Appendix G on page 165). While this application was not demonstrated in the survey as the survey was given at the end of Workshop 3 before students would know if they would apply that information in their field placement, discussion of the cases revealed that students were able to apply the information learned in the workshops to the real-world case examples. Students debated the necessity of intervening given the NASW Code of Ethics when they see a supervisor or colleague with compassion fatigue and the impact on clients. They recommended addressing several on the cases not just at an individual level with coping strategies but also brainstormed how compassion fatigue could be addressed in a given situation using a training or an organizational intervention. Students also differentiated between the terms, correctly identifying when a person in the case example had burnout as opposed to secondary traumatic stress, for example. Outside of the workshops, some students verbally reported that the information, especially on coping strategies, came at the “perfect” time for them, and said that they felt having these workshops increased the discourse surrounding self-care among students both inside and outside of their classes. With these results, incorporating workshops like these into curriculum is important because it allows

students learn information they can then apply and the ability to practice implementing that knowledge.

## **Discussion**

### **Note about Professional Quality of Life Scale 5 Findings**

In order to put the quantitative data in context, it is important to include a note on the results of the number of participants for the Professional Quality of Life Scale 5 (ProQOL 5) who scored in specific ranges for compassion satisfaction, burnout, and secondary traumatic stress. Participants scoring on any of the three scales receiving a raw score of 22 or less (score of 43 or less) were in the low range, a raw score of around of 23-41 (score of around 50) were in the average range and a raw score of 42 and above (score of 57 or more) were in the high range. In this sample of 108 students, there were no students that scored in the low range for pre/post compassion satisfaction and no students that scored in the high range for pre/post burnout or secondary traumatic stress. For the pre ProQOL 5 compassion satisfaction scale 30% of students scored in the average range and 47% scored in the high range, for the pre ProQOL 5 burnout scale 60% of students scored in the low range and 28% scored in the average range and for the pre ProQOL 5 secondary traumatic stress scale 49% of students scored in the low range and 37% scored in the average range. For the post-scores, the ProQOL 5 compassion satisfaction scale and the burnout scale were not significantly different and on the post ProQOL 5 secondary traumatic stress scale 63% of students were in the low range and 11% of students were in the average range. The score frequencies (given in raw scores) and percent of students in the pre and post tests for each of the three scales are shown in Table 6.

**Table 6: Ranges by Score on the Professional Quality of Life Scale 5 (ProQOL 5)**

<b>Scales</b>	<b>Score Range</b>	<b>Frequency</b>	<b>Percent</b>
Pre ProQOL 5 Compassion Satisfaction Score	Low	0	0
	Average	43	30
	High	51	47
	Missing	14	13
Pre ProQOL 5 Burnout-score	Low	65	60
	Average	30	28
	High	0	0
	Missing	13	12
Pre ProQOL 5 Secondary Traumatic Stress Score	Low	53	49
	Average	40	37
	High	0	0
	Missing	15	14
Post ProQOL 5 Compassion Satisfaction Score	Low	0	0
	Average	40	37
	High	41	38
	Missing	27	25
Post ProQOL 5 Burnout-score	Low	61	57
	Average	20	18
	High	0	0
	Missing	27	25
Post ProQOL 5 Secondary Traumatic Stress Score	Low	68	63
	Average	12	11
	High	0	0
	Missing	28	26

N = 108 Students

In terms of overall means pre/post compassion satisfaction means ( $M = 41.53$ ,  $SD = 4.69$  and  $M=41.00$ ,  $SD = 5.19$  respectively) fell in the average range, pre/post burnout means ( $M = 20.39$ ,  $SD = 4.67$  and  $M = 20.04$ ,  $SD = 4.21$  respectively) fell in the low range and pre/post secondary traumatic stress means ( $M = 21.43$ ,  $SD = 5.01$  and  $M = 18.67$ ,  $SD = 3.92$ , respectively) fell in the low range. The mean scores for the pre/post for all three score samples are shown in Table 7.

**Table 7: Mean Scores on Professional Quality of Life Scale 5 (ProQOL 5)**

Scales	Number of Students	Mean (raw score)	Mean (t-score based on raw score mean)	Standard Deviation
Pre ProQOL 5 Compassion Satisfaction Score	94	41.53	56	4.69
Pre ProQOL 5 Burnout-score	95	20.39	49-50	4.67
Pre ProQOL 5 Secondary Traumatic Stress Score	93	21.43	62	5.01
Post ProQOL 5 Compassion Satisfaction Score	81	41.00	56	5.19
Post ProQOL 5 Burnout-score	81	20.04	49-50	4.21
Post ProQOL 5 Secondary Traumatic Stress Score	80	18.67	60	3.92

Scores range from 10-50.

### **Discussion of Findings.**

When looking at Professional Quality of Life Scale 5 (ProQOL 5) participants, the Professional Quality of Life Scale Manual (Stamm, 2010) notes that the average score on the compassion satisfaction scale for national employed human service professionals is 50 (raw score 23-41;  $SD$  10; alpha scale reliability .88), the average score on the burnout scale is 50 (raw

score 23-41; SD 10; alpha scale reliability .75), and the average score on secondary traumatic stress scale is 50 (raw score 23-41; SD 10; alpha scale reliability .81). For a normal sample, they report that about 25% of people score higher than 57 (42 raw score) and about 25% of people score below 43 (raw score 22), with 50% scoring in the average range. In order to determine this sample's mean scores in relation to the national sample of employed human service professionals, according to the Professional Quality of Life Manual raw scores had to be converted to t-scores. As a note from Stamm (2010), "conversion from raw scores to standardized t-scores is not strictly numeric as there are more scores available on a standardized t-score than on the raw score" (p. 31), thus there are two t-scores for the burnout-scores. In this study raw scores were converted to t-scores using the Table for Determining ProQOL T-Score from Raw Scores in the Professional Quality of Life Manual. The t-scores for each mean raw score are shown in Table 7.

The sample in this study is different from the national sample of employed human service professionals as the t-score mean for compassion satisfaction for students is 56 for both the pre/post ProQOL 5, which is higher than the average mean of 50, suggesting students had more compassion satisfaction than the nationally sampled employed human service professionals. In terms of burnout, the students had a mean of 49-50, which is comparable to human service professionals. On the secondary traumatic stress scale, students had averages of 62 and 60 for the pre/post ProQOL 5 scores respectively, both of which are higher than those for human service professionals.

There are three other studies that look at social work student samples, though they use the Professional Quality of Life Scale IV-R. The questions from the Professional Quality of Life Scale IV only have slight wording changes from the Professional Quality of Life Scale 5 and the

raw scores are the same, and the Professional Quality of Life Scale 5 provides conversions from raw scores to t-scores to compare findings across versions. In terms of compassion satisfaction, Banko (2013), Harr and Moore (2011), Harr et al. (2014) and this study found higher than average rates of compassion satisfaction for social work students, and in this study those rates were much higher than the mean of 50 with t-score averages of 56 for both the pre/post ProQOL 5. On the burnout scale, both Banko (2013) and Harr (2011) reported slightly higher levels of burnout than the national average, while Harr (2014) reported slightly lower levels of burnout and this study found comparable averages of burnout. For the secondary traumatic stress scale, Banko (2013) and Harr (2011) reported comparable mean scores for students while Harr et al. (2014) found a slightly higher average and in this study means of 62 and 60 for the pre/post ProQOL 5 scores were reported, well over the average of 50.

Based on these results, it seems that students have higher compassion satisfaction than helping professionals. It is less clear where students are located in terms of burnout and secondary traumatic stress, at least from these studies, suggesting further research is needed. The sample sizes for these three studies (40 students in Banko, 2013; 258 students in Harr & Moore, 2011; and 480 students in Harr et al., 2014) and this study (108 total students) are very different and the studies took place in different geographic areas including San Diego, CA (Banko, 2013), the Southwestern United States (Harr & Moore, 2011; Harr et al., 2014) and Reno, NV (this study) which may account for differences in results. Further research may help to determine levels of compassion satisfaction, burnout and secondary traumatic stress among social work students, especially with larger sample sizes and in different geographic areas.

## Theory and Results

There are many theories that could explain compassion fatigue and why it varies. As Azar (2000) notes, there are many ways to look how the subjective experience of the practitioner contributes to burnout. These include psychodynamic theories which believe burnout is a result of the therapist under-processing their history, stress-coping theories which highlight how practitioners engage in an effective way or not with work-related stressors, and systems-based views which look at how interventions help employees to normalize their reactions through supervisory structure and organizations. Other theories include cognitive-behavioral approaches which examine the discrepancy between expectations and reality can lead to negative attributions and negative affect (Azar, 2000) as well as Constructivist Self-Development Theory (Pearlman & Saakvitne, 1995) which focuses on individual meaning-making.

In the case of students, one theory that might best explain students' reported risk of burnout and secondary traumatic stress is Lazarus and Folkman's (1984) Stress and Coping Theory. According to this theory, a person's experience of stress, defined as a circumstance which occurs when individuals feel they can't sufficiently manage dangers to their safety and/or happiness or external pressures of what they are expected to do (Lazarus, 1966) is mediated by two processes: cognitive appraisal and coping. Cognitive appraisal first involves a person assessing their environment for whether or not there is anything happening in the environment that will affect them negatively or positively and whether or not that outcome is important to them (which is primary appraisal). While they are engaged in this they are also determining what they need to do (if anything) in order to achieve the best possible outcome for themselves (secondary appraisal) (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986). This then leads to a person's coping with those aspects of the environment, or their ever-changing way of

cognitively and behaviorally dealing with demands that are surpassing their resources (Lazarus & Folkman, 1984).

It is possible that though students do have a variety of stressors (such as was explained in the Involved in Student Risk for Compassion Fatigue Model presented in Figure 2 above) which do put them at increased risk for compassion fatigue including work environment, personal environment, educational disequilibrium in field placements, the compounding of the multiple roles they endorse, a lack of skills/experience that professionals may already have and the uncertainty of their identity as an emerging professional, they also have found ways to manage these stressors even when they exceed their resources by changing their coping strategies and/or finding additional resources. 66% of students adapted their coping strategies as a result of the workshops in this study, and students reported a variety of resources and support that helped them to manage stress including social support such as classmates, colleagues, family, friends, faculty, religion and pets as well as supervision and counseling, to provide a few examples. Students also reported that reading themselves and taking care of themselves helped them to effectively manage stressors. Given this wide array of support and techniques and students' willingness to adapt coping based on knowledge, it is possible that students are able to mediate stress and that it does not therefore play a role in their experiencing compassion fatigue.

Similarly, stress may be fundamentally different than compassion fatigue and therefore does not play a role in compassion fatigue itself. Roembke (1995) noted that graduate student burnout might look different than that for mental health professionals and Tobin and Carson (1994) stated stress might manifest itself differently in social work students than qualified social workers, so it is possible these explanations better clarify students' reported levels of burnout and compassion fatigue. In addition, students are only at field placements for a limited amount of

time (for the students in this study fifteen hours per week) versus professionals who deal with trauma-related material and work stressors forty hours a week, and that could also help explain the reported levels of compassion satisfaction, burnout and secondary traumatic stress in students versus helping professionals.

### **Study Limitations and Future Research**

All students in this study were given the workshops, and samples were based on complete data and the ability to match pre/post test surveys. While it did not seem that the samples were significantly different, there may have been differences in participants who chose to participate versus those who did not and those whose results were not included because they were not complete, so having the same sample sizes for each research question would yield more valid and reliable results. As the method used on the surveys was self-report, there may also be self-report bias that affected results. Given that this study was done in the Reno, NV area, these results might not be generalizable to other areas. Further research in geographic areas other than California, the Southwestern United States and Nevada and with a larger sample size looking at students' levels of compassion satisfaction, burnout and secondary traumatic stress could also yield interesting information about what compassion satisfaction, burnout and secondary traumatic stress looks like for students and improve the generalizability of results.

As this study was a quasi-experimental design and not an experimental design, it is not possible to determine if students' significantly lower scores on the secondary traumatic stress scale on the ProQOL 5 from the pre to the post test are a result of attending the workshops and learning skills to cope with compassion fatigue or some other factor. Future research studies randomly assigning students to a workshop condition and no workshop and not using a convenience sample like this study could yield interesting information regarding the impact of

the workshops, if any, on students' compassion satisfaction, burnout and secondary traumatic stress. Experimental studies following students over time could also examine the impact (or lack thereof) the workshops have on students' compassion fatigue, burnout and secondary traumatic stress when they are professionals in the field.

Further studies could also look at how students' levels of compassion satisfaction, burnout and secondary traumatic stress vary over time and how Sweitzer and King's (2009) Five Stage Model of the Internship Process play a role in whether or not students are experiencing burnout or secondary traumatic stress. For those types of studies further research about when students are typically experiencing the different stages, especially Disillusionment in Sweitzer and King's (2009) Model, would be important. If students' levels do vary in terms of where they are in the educational processes it would be interesting to study whether or not scores vary for helping professionals over time as well and what factors might play a role in that variation.

### **Recommendations**

Given that students learned some new information and were able to apply the information they learned or reviewed to their field placements, workshops like these about compassion fatigue and related concepts should be used in the future. Even if the information is not completely new to students, students benefit from learning some new information and having the opportunity to practice using the information within the workshop setting and then in their field placements. Students are an excellent group to introduce compassion fatigue to as they are already taking in information, adapting their strategies and coping with stress as part of their learning experience. Giving students this information before they enter the workplace allows them to be more prepared for when they encounter compassion fatigue in their colleagues and perhaps later in themselves.

Based on the feedback students provided about how to improve the workshops, there are a variety of factors to consider in terms of implementing the workshops again. Some student recommendations emphasized the content included in the workshops, asking for more in-depth information on some material. Feedback in this area also included having more hands-on activities, opportunities to share personal experiences and handouts to take home and use. Other suggestions included the timing of the workshops, such as having longer workshops or workshops closer together than the two months between the first and second workshops and the four months between the second and third workshops. Another suggestion was to include this information earlier in the program. These workshops were given only to students in field, and for the majority of students (92%) this was their last year in the program. Lastly, if the workshops are to be offered every year then students in the two, three and four year Master's program would be presented the material twice. In order to avoid this, workshops should be offered to Bachelor's level students and Master's level foundation students. These considerations should be taken into account if the material for these workshops continues to be used in the future.

### **Conclusion**

Given the results of this study, risk and levels of compassion satisfaction, burnout and secondary traumatic stress may change over time, thus it is important to consider factors that are at play in these and how they can best be addressed. In this study students reported higher than average compassion satisfaction and secondary traumatic stress, thus it is important that students continue to be educated about compassion fatigue. As the results in this study are consistent with previous findings, it is also important to keep in mind that self-compassion and mindfulness may play an important role in preventing and coping with compassion fatigue and over-

identification will put someone at greater risk. Having more work-related experience may also help in coping and preventing with compassion fatigue.

Without awareness and identification of compassion fatigue, it cannot be addressed, so incorporating material for students into already existing curriculum on professional quality of life and compassion fatigue is important. Social work students are not only able to learn new information, but they also have the abilities to adapt and use that information in their field placement settings. They also report noticing compassion fatigue in supervisors and colleagues in their field placements indicating the importance of students having the skills to address those situations. Having those skills, hopefully they will also then be able to use them long after they graduate. The results from this study suggest that it is important to continue to educate students so that they can have the knowledge and skills to prevent and cope with compassion fatigue both now and later in their careers.

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## APPENDIX A

### Demographic Questionnaire

## Demographic Questionnaire

**Please fill in or circle your response.**

- 1) What is your age?  
  
\_\_\_\_\_
- 2) What is your race / ethnicity?
  - a. White / Caucasian
  - b. Black / African American
  - c. American Indian / Alaskan Native
  - d. Asian
  - e. Native Hawaiian / Other Pacific Islander
  - f. Hispanic / Latino
  - g. Two or More Races / Ethnicities
- 3) What is your gender?
  - a. Male
  - b. Female
  - c. Transgender
- 4) What year in the program are you in?
  - a. BSW
  - b. MSW Foundation
  - c. MSW Concentration
- 5) Are you a full-time or part-time student?
  - a. Full-time
  - b. Part-time
- 6) Is this your first or second social work field placement?
  - a. 1<sup>st</sup>
  - b. 2<sup>nd</sup>
- 7) Have you worked in the social work field / social service agency in the past?
  - a. Yes
  - b. No

- 8) If yes, how long have you worked or been working in the social work field / at a social service agency?
- a. Less than 1 year
  - b. 1-2 years
  - c. 3-5 years
  - d. 5- 10 years
  - e. More than 10 years
- 9) Are you currently working in the social work field / at a social service agency outside of field placement?
- a. Yes
  - b. No

## APPENDIX B

### Professional Quality of Life Scale 5

### Professional Quality of Life Scale (ProQOL 5)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

- \_\_\_ 1. I am happy.
- \_\_\_ 2. I am preoccupied with more than one person I *[help]*.
- \_\_\_ 3. I get satisfaction from being able to *[help]* people.
- \_\_\_ 4. I feel connected to others.
- \_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_ 6. I feel invigorated after working with those I *[help]*.
- \_\_\_ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- \_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
- \_\_\_ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
- \_\_\_ 10. I feel trapped by my job as a *[helper]*.
- \_\_\_ 11. Because of my *[helping]*, I have felt "on edge" about various things.
- \_\_\_ 12. I like my work as a *[helper]*.
- \_\_\_ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
- \_\_\_ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- \_\_\_ 15. I have beliefs that sustain me.
- \_\_\_ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
- \_\_\_ 17. I am the person I always wanted to be.
- \_\_\_ 18. My work makes me feel satisfied.
- \_\_\_ 19. I feel worn out because of my work as a *[helper]*.
- \_\_\_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- \_\_\_ 21. I feel overwhelmed because my case [work] load seems endless.
- \_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
- \_\_\_ 24. I am proud of what I can do to *[help]*.
- \_\_\_ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
- \_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_ 27. I have thoughts that I am a "success" as a *[helper]*.
- \_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_ 29. I am a very caring person.
- \_\_\_ 30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.  
*Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)*

APPENDIX C

Self-Compassion Scale



## APPENDIX D

### Usefulness Questionnaire

### Usefulness Questionnaire

- 1) On a scale of 1-10, with 1 being not useful and 10 being extremely useful, how useful did you find the workshops?

1      2      3      4      5      6      7      8      9      10

- 2) Did you use any of the information you learned in the workshops in your field placement? If so, how or under what circumstances?

- 3) On a scale from 1-10, with 1 being nothing was new and 10 being everything was new, how new was the information presented in the workshops?

1      2      3      4      5      6      7      8      9      10

- 4) If there was new information, what information was new?

- 5) If any of the information in the workshops about compassion fatigue was not new, where did you learn that information from? (i.e. presentation, article, supervisor, class, etc.)

- 6) What do you think was the most valuable information you learned in the workshops?



1 2 3 4 5 6 7 8 9 10

## APPENDIX E

### Workshop 1

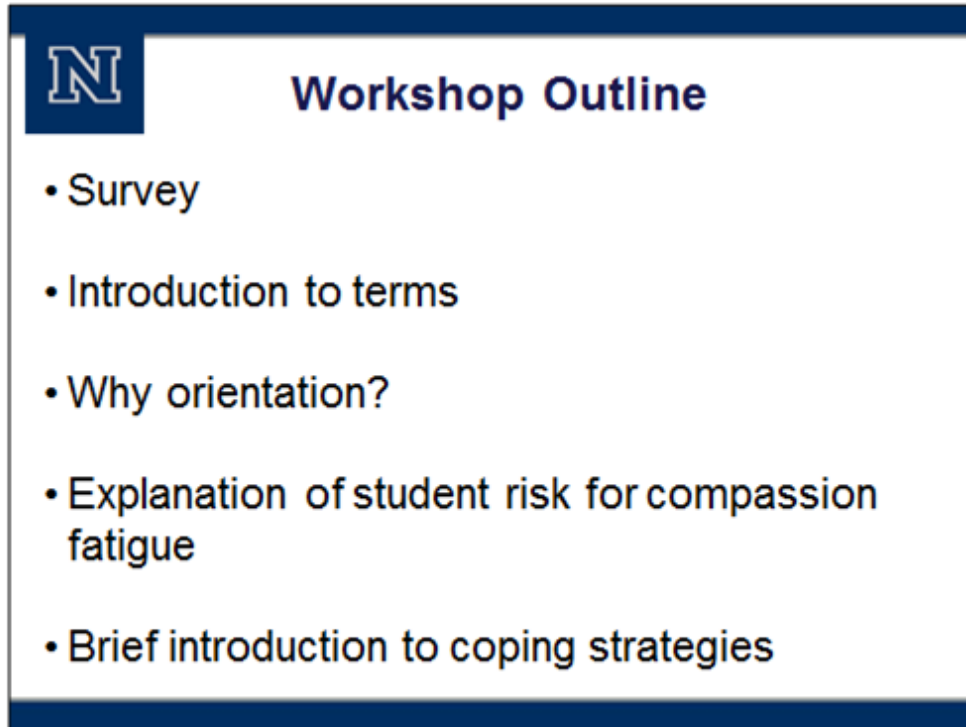


University of Nevada, Reno

# Compassion Fatigue

## Workshop 1





## Workshop Outline

- Survey
- Introduction to terms
- Why orientation?
- Explanation of student risk for compassion fatigue
- Brief introduction to coping strategies

You already took the survey, so we already have one thing out of the way. The next thing we will do is talk about compassion fatigue and terms that are related to it. We will then discuss why we would talk about compassion fatigue at orientation, how students are at risk and briefly introduce some coping strategies.

Figley (1995) defines compassion fatigue as the natural emotional and physical response to discussing someone else's trauma. Thus, compassion fatigue can come from daily work, especially if it relates to trauma. It can be related to the systems and frustrations that might come out of working in a system. It also can be a result of working with colleagues or even a person's beliefs about themselves, especially as they relate to how they view themselves as a professional and how they view their workplace, especially if they are negative, and how these beliefs might change as a result of working with clients, especially those who have experienced trauma.

Note: Some slides are not included, only the text that accompanied them. These slides include the CS-CF model, Compassion Satisfaction, Compassion Fatigue and People Bring Themselves slides from the Customizable Slide Set on the Professional Quality of Life website which can be found at [http://proqol.org/Customize\\_a\\_Presentation.html](http://proqol.org/Customize_a_Presentation.html).

**N** **Examples of Compassion Fatigue Signs**

hypervigilance      depression

emotional/physical exhaustion      irritability

insomnia      frustration

diminished sense of enjoyment      avoidance

Figley, 1995


But how does someone know if they are experiencing compassion fatigue? These are just some signs of compassion fatigue. As you can see, they cross all dimensions of a person's life including cognitive, behavioral, emotional and spiritual domains.

**N** **Impact of Compassion Fatigue**

Personal Relationships

Physical / Somatic

Work Performance



[http://www.clipartclipart.com/free\\_clipart\\_images/frowning\\_stick\\_figure\\_man\\_holding\\_his\\_belly\\_0515-1103-2100-5834.html](http://www.clipartclipart.com/free_clipart_images/frowning_stick_figure_man_holding_his_belly_0515-1103-2100-5834.html)

Figley, 1995

Unfortunately, some of the signs noted on the last slide don't just affect professionals at work. As noted here, struggles in physical, emotional, cognitive and spiritual domains can lead to problems in personal relationships, physical and somatic problems, and obviously problems at work where the feelings started.

**N****Other Related Terms**

- Burnout
- Vicarious Trauma
- Secondary Traumatic Stress
- Compassion Satisfaction
- Professional Quality of Life

There are a variety of terms related to compassion fatigue, and this list isn't all-inclusive, but here are some other terms we will be looking at and talking about in these workshops. How many people have heard of burnout? Can any tell me their definition of burnout? Burnout is a long-term stress reaction of helping professionals who work with people that is usually attributed to work-related factors (Noushadd, 2008; Stamm, 2010). Burnout is often more associated with professionals who have been working in the field longer, though this isn't always the case. So when you think about burnout, think about work-related factors. When we talked about compassion fatigue we said it was a natural response to knowing about someone else's trauma, and while that happens at work, we are thinking about things more related to organizational structure like caseload and supervision. Vicarious trauma and secondary traumatic stress are related, with vicarious trauma being covert cognitive changes as a result of hearing about another's trauma (Dane & Chachkes, 2003) and secondary traumatic stress being the physical and emotional stress of knowing about another's trauma (Figley, 1999). The signs of secondary traumatic stress are often considered to be somewhat similar to Post-Traumatic Stress Disorder with avoidance, arousal and intrusion symptoms (Figley, 1999). Vicarious trauma involves more of a change in the way a person views something as a result of hearing someone else's story; for example, suddenly feeling unsafe in their apartment because they had heard someone else was attacked in their apartment. We will be talking more about compassion satisfaction and professional quality of life later.

But as we know, not every reaction we have on the job is going to compassion fatigue. There is also the enjoyment that comes from being a helping professional and helping people, and this is known as compassion satisfaction. It is often defined as a positive aspect of helping, and like compassion fatigue, can be related to helping people in the system, positive relationships and work with colleagues and positive beliefs about self including being a good social worker. It can also be related to altruism, which produces positive feelings in general.

The combined feelings of helping are known as professional quality of life, and are a balance of compassion fatigue and compassion satisfaction. In general, the more compassion satisfaction a person has, the less compassion fatigue they have, and vice versa (ProQOL.org, Stamm, 2010).

As we will talk about more later, the terms that we are discussing in this workshop are all related, and come together to create a person's professional quality of life.

**N**

## Why Orientation?

**Hello**  
new student

*orientation*

<http://oprs.usc.edu/2013/10/29/resources-from-orientation-to-clinical-research-at-uscl/>

- It's normal
- It's an ethical issue
- It's important to be aware
- It's good to be prepared

Right now, you may be thinking that this is more of a heavy topic to be looking at during orientation. After all, everyone is really excited about their internships right now and thinking about how they are going to help people soon, right? And it is good to be excited. Getting a placement was uncertain and stressful but now everyone is in the mode of preparing for field. But there are a lot of feelings associated with internships, which, for those of you who haven't read the book *The Successful Internship* yet, you will soon find out. It is important to be aware of possible reactions to better prepare for and cope with them. As we talked about earlier, compassion fatigue is a normal reaction and doesn't mean that a person is weak or a bad social worker; it just means that social workers deal with a lot on the job and need to make sure they are aware of how they are feeling so that their feelings don't affect their clients (Everall & Paulson, 2004). Not only is there a risk for compassion fatigue, but you might be working with other helping professionals who have compassion fatigue, and if you don't know what it is or what to do about it will make your internship that much harder. Another reason that burnout and compassion fatigue are of concern to the profession as a whole are the ethics involved. Social workers experiencing burnout and compassion fatigue are distressed, and that distress can affect a number of areas of their life, including personal and professional (Wharton, 2003).

When their professional life is affected, it hinders their ability to work with clients, and this is not ethical given the National Association of Social Workers (NASW) Code of Ethics. Sections 4.05a and 4.05b of the Code of Ethics address the impairment of social workers in the form of any personal problems they might have, stating that it is social workers' responsibility to seek help or take any other steps they need to in order to protect their clients (NASW, 2006). Wharton (2003) notes that while social workers are ethically responsible for monitoring themselves under this code, it is sometimes difficult for them to determine when their impairment is affecting them on the job. He states that it is important for friends, family and colleagues to note this impairment. The NASW Code of Ethics backs up this idea with 2.09a and 2.09b, which talk about what social work professionals should do if they notice a colleague's impairment (NASW, 2006). Thus, those in the social work field are ethically bound to start addressing the issues of burnout and compassion fatigue to protect the people they serve. It is also important for you to be aware of compassion fatigue because many social workers have expressed that they wished that they had known about compassion fatigue before entering the field so that they could have been prepared both for their own reactions and the reactions of others (Smullens, 2008). The purpose of this workshop is to start preparing you.

N

## Who Has Compassion Fatigue

- Social Workers
- Fireman
- Paramedics
- Doctors
- Nurses

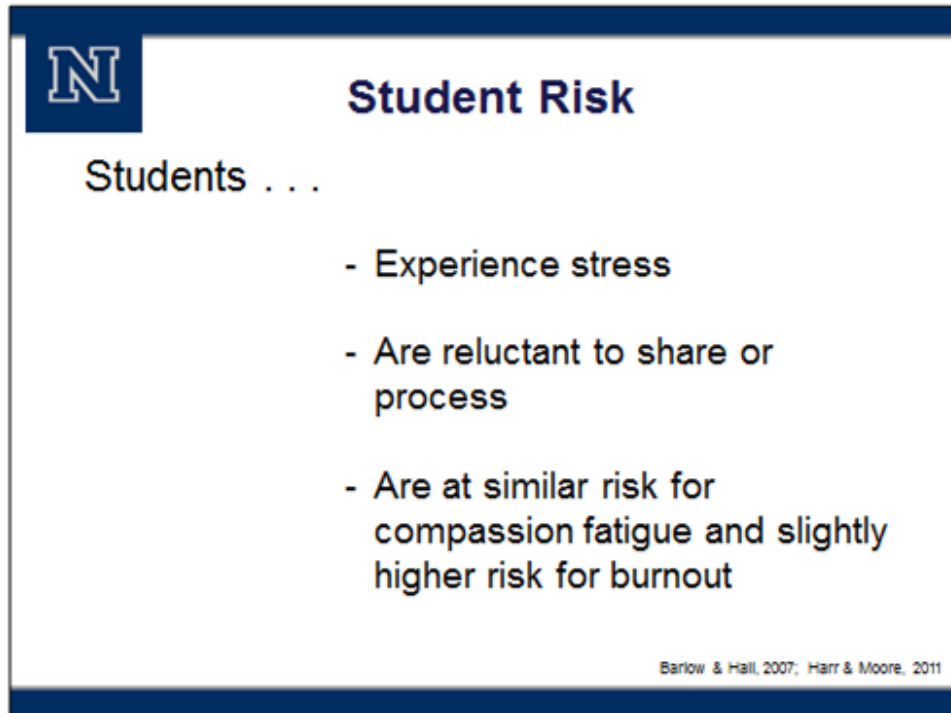


<http://www.guidestar.org/organizations/31-1713631/boca-helping-hands.aspx>

**... anyone in the helping professions!**

Adams & Riggs, 2008; Badger et al., 2008; Barlow & Hall, 2007; Beaton, Murphy, Johnson, Pike & Cornell, 1999; Bride, Jones & Macmaster, 2007; Dane, & Chachkes, 2003; Dominguez-Gomez & Ruteledge.; Harr & Moore, 2011

Another reason to talk about compassion fatigue at orientation is that pretty much anyone in the helping professions is at risk, not just social workers. These are a few other professions where people are at risk for compassion fatigue. Some others include massage therapists and clergy.



**N**

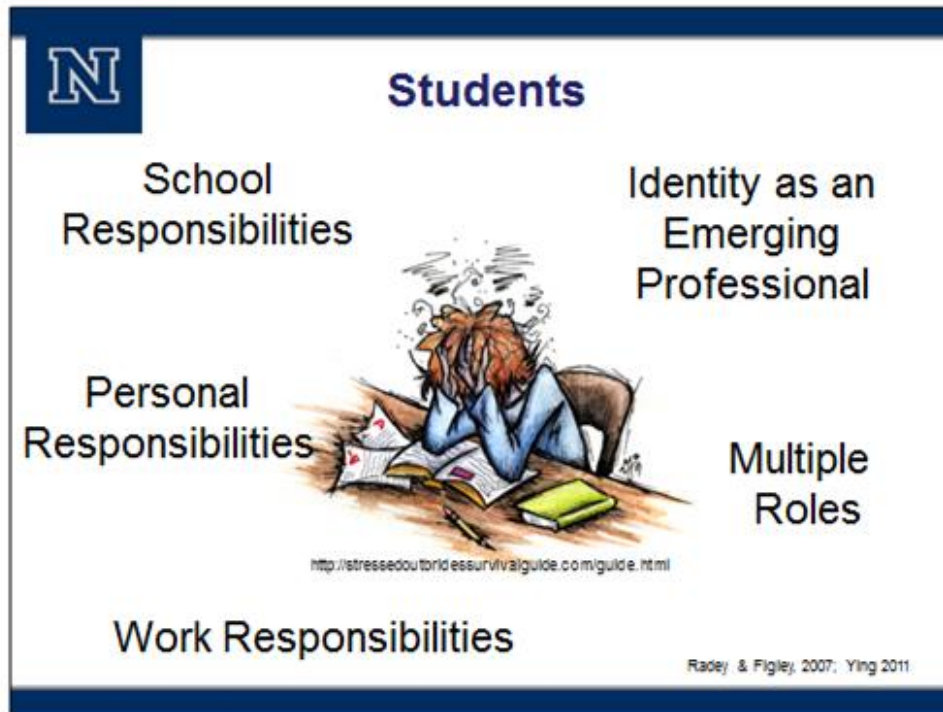
## Student Risk

Students . . .

- Experience stress
- Are reluctant to share or process
- Are at similar risk for compassion fatigue and slightly higher risk for burnout

Barlow & Hall, 2007; Harr & Moore, 2011

And while helping professionals are at risk for compassion fatigue, did you know that you are too? Students experience stress in field placements because there is a lot going on in field placements. Students sometimes aren't willing to share their experiences with faculty or field instructors though (Barlow & Hall, 2007), which can make it harder for them to cope with it. But they are at similar risk for compassion fatigue and slightly higher risk for burnout than helping professionals (Harr & Moore, 2011).



Students have a lot of stressors, and this added stress can make them more vulnerable to compassion fatigue. Students tend to have many roles such as being a member of a family, working, being at school, being an intern, etc. and this adds to their stress. They also have to balance school, personal and work responsibilities as well as start to understand their identity as an emerging professional. Having these additional stressors in addition to stressors in the internship put students at more risk.



But what causes some people to experience compassion fatigue?

That is a complicated answer, but there are a variety of factors that can play a role in whether or not a person gets compassion fatigue. The first factors have to do with personal attributes; people bring themselves to the job, and that includes their entire history, including everything listed on this slide.

N

## External Source: Organizational Factors

- Lack of supervision
- Interaction with clients
- High case load
- Value conflict
- Isolation at work
- Role conflict
- Lack of control
- Perceived unfairness  
in rewards

Bercier, 2013; Bride, Radey & Figely, 2007; Radey & Figley, 2007

Besides what people bring, factors at work can also contribute to compassion fatigue. Supervision has been found to be an important part of mediating compassion fatigue, partly because it is good to process with someone who has more experience and partly because supervisors can help with diversifying a caseload or make it smaller if that is something that would help (Radey & Figley, 2007). Similarly, isolation at work makes it hard to process compassion fatigue and so symptoms like depression or anger might only worsen if not talked about (Bercier, 2013). Not having any control to change things that might need to be changed like caseload or interactions with clients (for example, social workers who work with people who have experienced trauma or lots of people who experienced trauma are more likely to have compassion fatigue than those who don't) so not being able to diversity a caseload in terms of client interactions could make the situation worse (Bride, Radey & Figely, 2007). Value conflicts with the workplace or practice and role conflict in terms of the work being doing can also contribute to compassion fatigue signs such as anger, depression, frustration, exhaustion or a diminished sense of enjoyment. Last, perceiving that someone else is getting promoted or better hours when a person thinks they deserve them can also contribute to burnout and compassion fatigue (Radey & Figely, 2007).



## Coping Strategies

- Individual
- Professional
- Group
- Organizational

There are many ways to cope with compassion fatigue, but we are going to get into more specific strategies at the next couple of workshops. For now, it is important to know that there are different types of strategies. There are things individuals can do, including self-care like taking care of themselves; more formal and professional strategies, like forming groups at work or meeting regularly with colleagues; in groups, such as trainings, debriefings or group therapy; and things organizations can do, such as making sure employees have appropriate supervision and diverse caseloads, for example. We are going to talk about all of these more in-depth later.

## N

## For Next Time

- More on coping strategies
- More on self-compassion as a coping strategy
- Information on mindfulness-based coping strategies

I'm so excited.



<http://findyourjoyspot.com/how-to-have-an-exciting-day-today/>

## N

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**APPENDIX F**

**Workshop 2**

## Please Pick Up Your Survey

### Remember Your CDRGP Code:

First letter of your middle name (if no middle name, write "z")

First letter of the month you were born in

First letter of your sex: Male or Female

First letter of the name of your street

First letter of your mother's first name (if unknown, write "x")



University of Nevada, Reno

## Compassion Fatigue

### Workshop 2



University of Nevada, Reno

## Workshop Outline

- Review
- Recognizing signs
- Individual coping strategies
- Self-Compassion as a coping strategy
- Return Self-Compassion Scale and discussion
- Mindfulness as a strategy




University of Nevada, Reno

First we are going to review compassion fatigue and its related terms, and then do an activity related to distinguishing among those terms. As promised last time, we are going to go over individual coping strategies in more detail. We are then going to talk about self-compassion as a coping strategy, return the Self-Compassion Scale that you completed in the last workshop and talk about it, and then discuss mindfulness as a strategy.

## Review

- Compassion Fatigue
- Burnout
- Vicarious Trauma
- Secondary Traumatic Stress

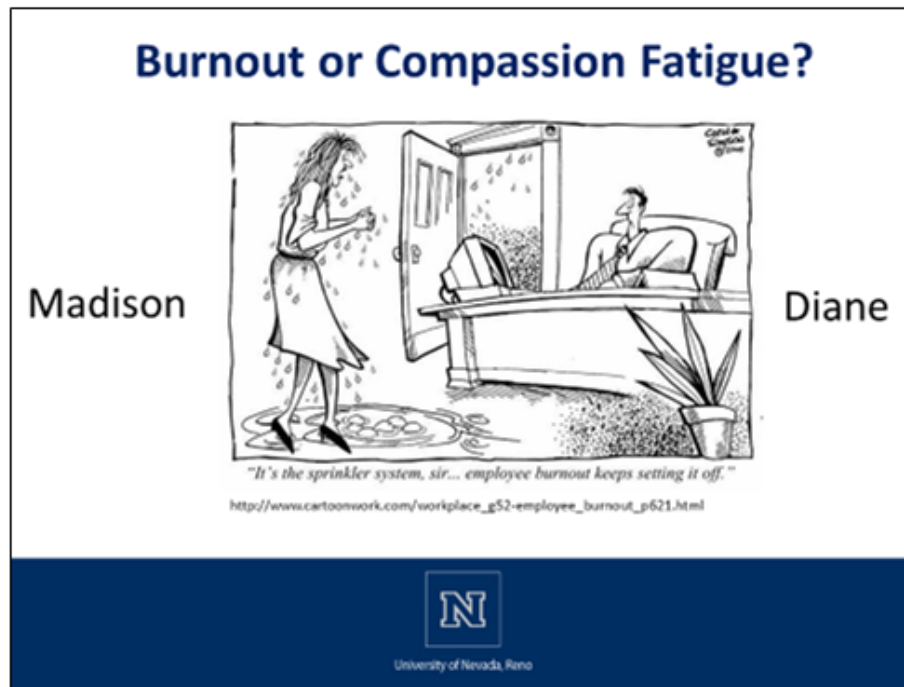


<http://www.clipartbest.com/clipart-nT08pp8Xc>



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Compassion fatigue is the normal physical and emotional reaction to hearing about another person's trauma (Figley, 1995). It is broken down further into burnout and secondary traumatic stress/vicarious trauma. Burnout is a long-term stress reaction of helping professionals who work with people that is usually attributed to work-related factors (Noushadd, 2008; Stamm, 2010). Burnout is often more associated with professionals who have been working in the field longer. Secondary traumatic stress and vicarious trauma are related, with vicarious trauma being covert cognitive changes as a result of hearing about another's trauma (Dane & Chachkes, 2003) and secondary traumatic stress being the physical and emotional stress of knowing about another's trauma (Figley, 1999). The signs of secondary traumatic stress are often considered to be somewhat similar to Post-Traumatic Stress Disorder with avoidance, arousal and intrusion symptoms (Figley, 1999).



Madison is feeling frustrated with her colleagues and her clients. Today she saw five clients, and four of them had experienced significant trauma. She is feeling exhausted, and she doesn't know if wants to hear about any more trauma and wishes she could avoid her last session of the day. Burnout or compassion fatigue? Compassion fatigue

Diane feels like her caseload is maxed out. She has paperwork on her desk from the last two weeks that she still hasn't gotten to and doesn't feel like she will get to this week. She is also feeling frustrated because she recently noticed that her coworker got promoted even though they only do half of what she does and hasn't been on the job as long as her. Is she experiencing burnout or compassion fatigue? Burnout

Remember that feelings that are more related to the work environment usually indicate burnout while feelings that are more related to client work and/or trauma are more signs of compassion fatigue.

## Vicarious Trauma or Secondary Traumatic Stress?

- Isabella

- Jack



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Isabella is a clinical social worker. She works mostly with clients who have been sexually assaulted. Lately as she walks to her car from work or the grocery store she can't help but think about being attacked in the parking lot like one of her clients was. She feels that parking lots are not a safe place and that she is small and vulnerable when she walks to her car alone, a feeling she had not had until recently. Is she experiencing Vicarious Trauma (VT) or Secondary Traumatic Stress (STS)? Vicarious trauma

Jack is clinical social worker at the VA. Recently, he has found himself avoiding asking clients questions that might encourage them to talk about their experiences overseas. He has had many clients describe in graphic detail their experiences at war and he has been having nightmares about being in war himself. He has also been having difficulty remembering parts of his sessions. Based on this limited case illustration, is he experiencing VT or STS? Secondary traumatic stress

One limitation of these perspectives to keep in mind is that they only encompasses the dimension of compassion fatigue in working with clients who have experienced (and are discussing) trauma.

## Compassion Satisfaction and Professional Quality of Life?



<http://edgewaterchurch.com/thanks-for-raising-hands/>



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Can anyone tell me what they remember about either compassion satisfaction or professional quality of life? Compassion satisfaction is the enjoyment that comes from being a helping professional and helping people. It is often defined as a positive aspect of helping, and like compassion fatigue, can be related to helping people in the system, positive relationships and work with colleagues and positive beliefs about self including being a good social worker (ProQoL.org). Professional quality of life is the combined feelings of helping, both compassion fatigue and compassion satisfaction. In general, the more compassion satisfaction a person has, the less compassion fatigue they have, and vice versa (ProQoL.org, Stamm, 2010).

## Compassion Fatigue in Your Placement?



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How many people have heard of self-care? Self-care is one important way to prevent or cope with compassion fatigue, and so all of these strategies are extremely important. Journaling is one method that has recently been found to be helpful for students in regards to improving self-care practices and processing their experiences and feelings (Shannon, Simmelink-McCleary, Im, Becher & Crook-Lyon, 2014).

## More on Individual Coping Strategies

- humor
- having support and meeting with friends or colleagues in the field
- self-care plans
- stress management training
- case discussion and regular supervision



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Birbaum, 2008; Figley, 2002;

These are some other strategies that you might have heard less about. Humor can definitely be an aid in coping with compassion fatigue (Figley, 2002), and also using other students as a support system is helpful too. You could also meet with students outside of class to help process. Similarly, having a self-care plan is important. Not just having a plan but having a buddy system where someone else holds you accountable for sticking to that self-care plan can also be helpful. This doesn't mean that you have to take a trip in the middle of the semester, for example, but it does mean that you take time for yourself. It also means acknowledging that school is stressful, and there are always going to be times of the semester where your stress level is high, and that is completely normal. Becoming trained or utilizing stress management techniques can also be helpful, especially as we remember from the last workshop all of the stressors that students have to deal with. As we discussed in the last workshop, discussing cases and getting regular supervision and therefore processing can also help prevent or cope with compassion fatigue (Birbaum, 2008). Essentially, individual coping strategies are anything that falls under "self-care".

Coping with compassion fatigue does not just fall completely on the individual, however. So while today we are talking about individual strategies, at the next workshop we will also talk about some strategies that can happen in groups or organizations.

## Self-Compassion and Mindfulness



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There are a couple of individual strategies that we are going to talk about more today that you may not be as familiar with, and these are self-compassion and mindfulness. Has anyone heard of self-compassion or mindfulness before? How do you think they might help with compassion fatigue?

## Self-Compassion as a Coping Strategy

Having compassion for yourself when you are having a difficult time, fail, or notice something you don't like about yourself in the same way you would have compassion for others.



<http://www.mothers.com/help/topics/narcissism/thecasefornarcissism>



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Neff, 2009

We are social work students, which means that in general, we have a lot of compassion for other people. But do we have the same amount of compassion for ourselves? This is where self-compassion comes in. It is important to talk about self-compassion in relation to compassion fatigue because if a person is mean to themselves, it takes a lot of energy, which is energy they may need to cope with stressors on the job and maybe with compassion fatigue. Most times, however, we are not even aware of not having compassion towards ourselves and/ or the negative things we say to ourselves and the way that it affects how we work with clients or get through a day. Maybe we think, "I can't help that client. I have never been able to help clients like that before" and then we feel down and don't help the client when maybe we could have thought "I have never helped a client like them before" and then start thinking about strategies to help them.



## What Self-Compassion Isn't

- Self-pity
- Self-indulgence
- Self-esteem



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Neff, 2009

Self-pity isn't the same as self-compassion. When people feel self-pity, they become immersed in their problems and forget that others have problems too, feeling like they are the only ones who are suffering. In essence, they forget their humanity, that they are interconnected and having a similar experience with others (Neff, 2009).

Self-compassion also isn't self-indulgence. Sometimes people say that they don't want to be self-compassionate because they are afraid they will let themselves get away with anything, like saying "I'm stressed out today so to be kind to myself I'll just watch TV all day and eat a quart of ice cream" (Neff, 2009). This is self-indulgence, not self-compassion. Self-compassion is wanting to be happy and healthy, not just giving oneself pleasure. People are often hard on themselves when they notice something they want to change because they think they can shame themselves into action, but then sometimes people can face truths about themselves. The care in self-compassion provides a powerful force for growth and change without fearing self-condemnation (Neff, 2009).

Lastly, self-compassion is not self-esteem. Self-esteem is a person's sense of self-worth, perceived value or how much they like themselves. Sometimes in the United States trying to increase self-esteem can lead to narcissistic behavior and feeling like you have to be better than someone (and more of an individual) to feel good about yourself. Self-compassion is not based on a self-evaluation and means that you don't have to feel better than others to feel good about yourself, and it isn't dependent on external circumstances; it is always there. Research has shown that in comparison to self-esteem, self-compassion is associated with more accurate self-concepts, greater emotional resilience, more caring relationships behavior and less narcissism and reactive anger (Neff, 2009).

**SELF-COMPASSION DISCUSSION**

As a rough guide:

a score of 1-2.5 for your overall self-compassion score indicates you are low in self-compassion

2.5-3.5 indicates you are moderate in self-compassion

3.5-5.0 means you are high in self-compassion

Higher scores for the Self-Judgment, Isolation, and Over-Identification subscales indicate less self-compassion

Higher scores on Mindfulness, Common Humanity and Self-Kindness are indicative of more self-compassion

At the orientation workshop everyone took a survey, and one of the parts of the survey was Kristin Neff's Self-Compassion Scale. What we are going to do right now is return that scale with your scores of how much self-compassion you reported having at orientation.

Note: If time, here is a discussion about students' scores and what they mean. There will be 7 scores, one for overall self-compassion and then one for self-kindness items, self-judgment items, common humanity items, isolation items, mindfulness items, and over-identified items.

Average overall self-compassion scores tend to be around 3.0 on the 1-5 scale, so you can interpret your overall score accordingly. As a rough guide, a score of 1-2.5 for your overall self-compassion score indicates you are low in self-compassion, 2.5-3.5 indicates you are moderate, and 3.5-5.0 means you are high. Remember that higher scores for the Self-Judgment, Isolation, and Over-Identification subscales indicate less self-compassion, while lower scores on these and are indicative of more self-compassion (these subscales are automatically reverse-coded when your overall self-compassion score is calculated.) Over-identification refers to taking on client's stories and carrying them when you go home; really thinking about them and feeling like they are your own.

Professional Quality of Life 5— not a diagnosis, but gives a general idea of how you score. Don't want to score in the low range on compassion satisfaction or the high range for burnout and secondary traumatic stress. If you do may be time to think about these coping strategies we have been talking about. This tool is used for general awareness and as an aid in determining what things look like for you.

## If You Didn't Get a Self-Compassion Score

<http://www.self-compassion.org/test-your-self-compassion-level.html>



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## Self-Compassion Exercises

<http://www.self-compassion.org/self-compassion-exercises.html>



http://licamendedesign.blogspot.com/2013/01/sunday-life-practicing-self-compassion.html



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Neff, 2009

Note: Can do if time or just show on website if not. Dr. Kristin Neff has many exercises on her website that you can go to and do to practice increasing your self-compassion. All the links in this powerpoint will be included in a handout posted on the website. Can show handout here.

We are going to do a self-compassion exercise. I would like everyone to take out a piece of paper. Then read through this exercise.

|

### **Exercise 1**

#### **How would you treat a friend?**

#### **Please take out a sheet of paper and answer the following questions:**

1. First, think about times when a close friend feels really bad about him or herself or is really struggling in some way. How would you respond to your friend in this situation (especially when you're at your best)? Please write down what you typically do, what you say, and note the tone in which you typically talk to your friends.
2. Now think about times when you feel bad about yourself or are struggling. How do you typically respond to *yourself* in these situations? Please write down what you typically do, what you say, and note the tone in which you talk to yourself.
3. Did you notice a difference? If so, ask yourself why. What factors or fears come into play that lead you to treat yourself and others so differently?
4. Please write down how you think things might change if you responded to yourself in the same way you typically respond to a close friend when you're suffering.

#### **Why not try treating yourself like a good friend and see what happens?**

## Self-Compassion Meditation

<http://www.self-compassion.org/guided-self-compassion-meditations-mp3.html>



<http://freebigpictures.com/road-pictures/autumn-path/>

  
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Neff, 2009

Note: Can show the link to students. Can note that most of the meditations take about 15-20 minutes and that we don't have time for them but they can always go on to the website and use them.

## Self-Compassion Resources

<http://www.self-compassion.org/links-to-other-websites.html>



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Neff, 2009

This link will take you to a website that has many links and resources for further information and exercises on self-compassion. It is included your handout.

## Mindfulness as a Coping Strategy

“Concentrated awareness of one's thoughts, actions or motivations”(Think Mindfully, 2012).

To Practice:

- Use an anchor, such as breathing
- Notice thoughts and feelings
- Avoid judgment




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Think Mindfully, 2012

Mindfulness is about bringing thoughts back to the present moment. Thoughts are not to be judged but just noticed, with the realization that “thoughts are just thoughts”, not reality or truth. While being mindful, you don’t want to prevent yourself from having thoughts, feelings or sensations, only notice the distractions as they arise and then turn attention back to the present moment. A lot of people will use an anchor, such as breathing, for example. Remember, the goal is to notice thoughts and feelings, draw attention back to the present and avoid judgment (Think Mindfully, 2012).

## Mindfulness Exercise



<http://thinkmindfully.com/turning-towards-that-which-is-already-there>

  
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Think Mindfully, 2012


Note: Can do if time or not. Have students sit with their eyes closed quietly. Have them focus in on their breathing and then notice their muscles, how they feel, the sounds in the room, etc. Encourage them to notice thoughts but then to gently redirect to focusing on their breath. Will only take about 3 minutes or so.

## Mindfulness Resources

<http://www.unr.edu/counseling/virtual-relaxation-room>

<http://www.thinkmindfully.com/>

<http://thinkmindfully.com/try-it>



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These are some links that can help you become more mindful. They are included in your handout.

Note: If there is time, go to the third link and show how students can type information into the leaves and then watch them float away in the stream.



Directly from website: “The fast pace of military operations and frequent deployments affect the entire military community. For health care providers treating military personnel, the intense demands on their time and personal resources can lead to burnout, compassion fatigue, and secondary traumatic stress. Through psychoeducation and self-assessments, Provider Resilience gives frontline providers tools to keep themselves productive and emotionally healthy as they help our nation's service members, veterans, and their families.

The Provider Resilience home screen gives a quick snapshot of the user's overall resilience rating – generated through user self-assessments – and a reminder clock showing how long since the user last took a day off. Compassion fatigue, burnout, and secondary traumatic stress ratings can also be viewed in automatically generated graphs, allowing users to monitor their professional quality of life over time.

Provider Resilience also features stress-busting and compassion satisfaction-building tools. Videos by service members describing the positive impact health care providers had in their battles with stigma, depression and other issues help users remember why they do what they do. Stretches, daily reflection cards, and Dilbert comics give users a break from daily stress.

Provider Resilience was developed by psychologists at the National Center for Telehealth & Technology, the Defense Department's primary agency for applying innovative technology to issues of psychological health and traumatic brain injury.”(National Center for Telehealth & Technology, 2014).

## For Next Time

- Review
- Organization / Group Coping Strategies
- Case Scenarios
- Exit Survey



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## Compassion Fatigue Handout

### Definitions

**Compassion fatigue** - compassion fatigue is the natural emotional and physical response to discussing someone else's trauma. Thus, compassion fatigue can come from daily work, especially if it relates to trauma (Figley, 1995).

**Burnout**- a long-term stress reaction of helping professionals who work with people that is usually attributed to organizational work-related factors (Noushadd, 2008; Stamm, 2010).

**Secondary traumatic stress** - the physical and emotional stress of knowing about another's trauma (Figley, 1999). The signs of secondary traumatic stress are often considered to be somewhat similar to Post-Traumatic Stress Disorder with avoidance, arousal and intrusion symptoms (Figley, 1999).

**Vicarious trauma** - covert cognitive changes as a result of hearing about another's trauma (Dane & Chachkes, 2003).

**Compassion satisfaction** - the enjoyment that comes from being a helping professional and helping people. It is often defined as a positive aspect of helping, and like compassion fatigue, can be related to helping people in the system, positive relationships, work with colleagues and positive beliefs about the self.

**Professional Quality of Life** - the combined feelings of helping are known as professional quality of life, and are a balance of compassion fatigue and compassion satisfaction (ProQOL.org; Stamm, 2010). In general, the more compassion satisfaction a person has, the less compassion fatigue they have, and vice versa.

**Self-Compassion** - having compassion for yourself when you are having a difficult time, fail, or notice something you don't like about yourself in the same way you would have compassion for others (Neff, 2009).

**Mindfulness** - concentrated awareness of one's thoughts, actions or motivations (Think Mindfully, 2012).

### Website Resources

Self-Compassion exercises on Dr. Kristin Neff's website  
<http://www.self-compassion.org/self-compassion-exercises.html>

Self-Compassion meditation on Dr. Kristin Neff's website  
<http://www.self-compassion.org/guided-self-compassion-meditations-mp3.html>

List of other self-compassion website resources  
<http://www.self-compassion.org/links-to-other-websites.html>

UNR Counseling Center Virtual Relaxation room  
<http://www.unr.edu/counseling/virtual-relaxation-room>

Mindfulness Website  
<http://www.thinkmindfully.com>

Mindfulness Website - leaf on the stream exercise  
<http://thinkmindfully.com/try-it>

Provider Resilience Phone App  
<http://itunes.apple.com/ca/app/provider-resilience/id5599806962?mt=8>

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## APPENDIX G

### Workshop 3



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**Compassion Fatigue**


**Workshop 3**

Miranda Smith

The image is a presentation slide for a workshop. It features a dark blue header with the University of Nevada, Reno logo (a white 'N' in a blue square) and the text 'University of Nevada, Reno'. Below the header is an aerial photograph of the university campus, showing various buildings and green spaces. The title 'Compassion Fatigue' and subtitle 'Workshop 3' are centered in a large, bold, black font. The presenter's name, 'Miranda Smith', is centered below the subtitle in a smaller, black font. The background of the slide is a semi-transparent grey overlay on the aerial photo.

## Workshop Outline

- Review
- Group / Organizational Coping Strategies
- Cases
- Questions
- Survey



<http://hermanmiller.homestead.com/Workshop.html>

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Discussion Starter: What coping strategies have you been using that you learned in the last workshop? What have been the most effective and why?

## Review : First Workshop – Terms

**Burnout**

**Vicarious Trauma**

**Secondary Traumatic Stress**

**Compassion Satisfaction**

**Professional Quality of Life**

**Self-Compassion**


**Mindfulness**

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In the first workshop we talked about the terms related to compassion fatigue. Does anyone remember any definitions, or can anyone provide any examples of what these terms like at their internship or even where they work?

Burnout is a long-term stress reaction of helping professionals who work with people that is usually attributed to work-related factors (Noushadd, 2008; Stamm, 2010). Burnout is often more associated with professionals who have been working in the field longer. Secondary traumatic stress and vicarious trauma are related, with vicarious trauma being covert cognitive changes as a result of hearing about another's trauma (Dane & Chachkes, 2003) and secondary traumatic stress is the physical and emotional stress of knowing about another's trauma (Figley, 1999). The signs of secondary traumatic stress are often considered to be somewhat similar to Post-Traumatic Stress Disorder with avoidance, arousal and intrusion symptoms (Figley, 1999). Compassion satisfaction is the enjoyment that comes from being a helping profession and helping people. It is often defined as a positive aspect of helping, and like compassion fatigue, can be related to helping people in the system, positive relationships and work with colleagues and positive beliefs about self including being a good social worker. It can also be related to altruism, which produces positive feelings in general. The combined feelings of helping are known as professional quality of life, and are a balance of compassion fatigue and compassion satisfaction (ProQOL.org; Stamm, 2010). Having compassion for yourself when you are having a difficult time, fail, or notice something you don't like about yourself in the same way you would have compassion for others (Neff, 2009). Mindfulness is concentrated awareness of one's thoughts, actions or motivations (What is mindfulness, 2012).

- **Individual Coping Strategies**
- **Self-Compassion**
- **Mindfulness**



<http://thinkmindfully.com/turning-towards-that-which-is-already-there>

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We have already talked about what coping strategies you have been using. Two specific strategies we talked about in the last workshop were self-compassion and mindfulness.

Remember that self-compassion is having compassion for yourself when you are having a difficult time, fail, or notice something you don't like about yourself in the same way you would have compassion for others (Neff, 2009). This had to do with the scale I returned last time.

Mindfulness is concentrated awareness of one's thoughts, actions or motivations (Think Mindfully, 2012).

## Review: Types of Interventions

- **Individual Interventions**
- **Group and Training Interventions**
- **Organizational Interventions**



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At the first workshop I mentioned that there are three different levels of interventions. At the second workshop we talked about individual interventions, so today we are going to talk more about group, training and organizational interventions.

## Group and Training Interventions

- Interactive Psycho-educational Group Therapy
- General Self-Care Exploration Groups
- The Accelerated Recovery Program (ARP) Model
- Critical Incident Stress Debriefing
- Stress Inoculation Training

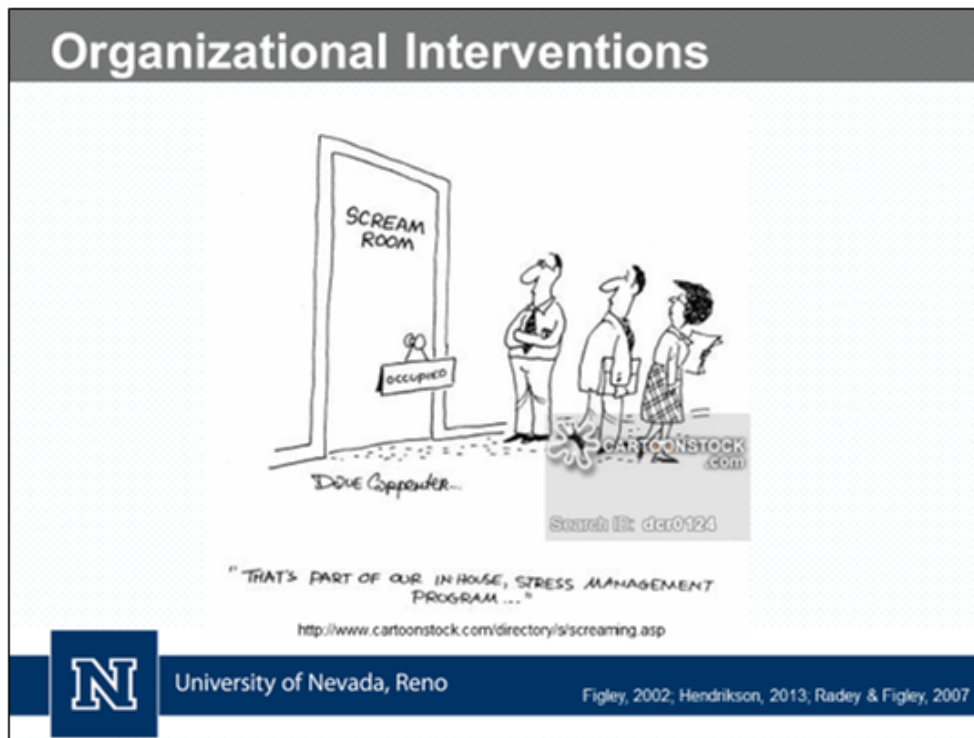


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Bourassa & Clements, 2010

These are some group interventions that have been found to help people cope with compassion fatigue. Each of these methods involves professionals and guided therapy or specific training according to their individual designs. For example, the Accelerated Recovery Program (ARP) has a five-session treatment protocol that works toward the completion of major objectives (Gentry, Baronowsky & Dunning, 2002). These include the Interactive Psycho-Educational Group Therapy, General Self-Care Exploration Groups, the Accelerated Recovery Program Model (ARP), Critical Incident Stress Debriefing (CISD), and Stress Inoculation Training (Bourassa & Clements, 2010). These interventions vary in length and purpose. Interactive Psycho-Educational Group Therapy is a 16-week group intervention for PTSD but may also be helpful in helping professionals who are experiencing compassion fatigue symptoms similar to PTSD (Bourassa & Clements, 2010). General self-care exploration groups could be a helpful support group and organizational intervention that could take place in the work setting and aid helping professionals in preventing and coping with compassion fatigue and related terms (Bourassa & Clements, 2010).


The ARP model has a five-session treatment protocol that works toward the completion of major objectives and treat helping professionals that have compassion fatigue and related terms (Gentry, Baronowsky & Dunning, 2002) while CISD is a seven-phase debriefing model that usually happens after exposure to a traumatic event or crisis intervention (Bourassa & Clements, 2010). Defusing is only one session that takes place at the end of a work day to provide support and reduce stressful feelings (Bourassa & Clements, 2010). Stress Inoculation Training is a three-phase intervention that aims to increase coping skills that would help to prevent compassion fatigue and related terms, though it is not known if helps to prevent compassion fatigue (Meichenbaum, 1996).



As we talked about in the last workshop, individuals aren't the only ones responsible for preventing or coping with compassion fatigue. There are a variety of things that can also happen in the workplace that can make an impact. Limiting or diversifying caseloads can be important to prevent social workers from becoming overwhelmed or having too much of the same type of case (Hendrikson, 2013). Appropriate supervision to help recognize compassion fatigue early and provide a place for processing is also important (Radey & Figley, 2002) as is organizations providing adequate benefits and advancement opportunities that make workers feel like they are valued and can improve in the agency. Sharing with employees the effects compassion fatigue can have, instilling humor into the daily atmosphere and encouraging individual actions are also important steps that agencies can take (Figley, 2002).

## Decisions

- First think about possible approaches to the problem:
  - Individual
  - Group
  - Organization
- Think about what you could do
- Then take action!!!




<http://confusedcartoon.blogspot.com/2012/08/confused-cartoon-man-face-was-thinking.html>

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When thinking about what to do about compassion fatigue, think about what level something can be done at to help cope with it. Measures taken don't have to be limited to just one or two strategies; maybe multiple strategies are needed to solve the problem. For example, maybe more self-care strategies are needed. Maybe there is a group you can join or a training you can attend. Maybe it is that you need to adjust your caseload, so talking to your supervisor is necessary. Perhaps your supervision needs to address your caseload with their supervisor, and the organization becomes involved.

**Cases**

- **Please get into groups of around 5 students**
- **As you read through the cases, think about what you have learned in the workshops**
- **Discuss some of the questions with your group and be ready to report on your case**



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Now we are going to look at some cases and see if we can think about what compassion fatigue might look like in the workplace and brainstorm some strategies of what you might be able to do if you find yourself in these situations.

Estimate how much time you think they will have given how long the lecture portion took. Make sure to leave at least 20 minutes for the survey at the end. This section should take approximately 15-20 minutes.

Note: Divide into groups; pass out case studies; have them discuss; then have some groups share with the larger group.

**Cases**

Asher

Sylvia

Anna

**N** University of Nevada, Reno

Jill Mant, MSW

Let's talk about what you came up with in each case.

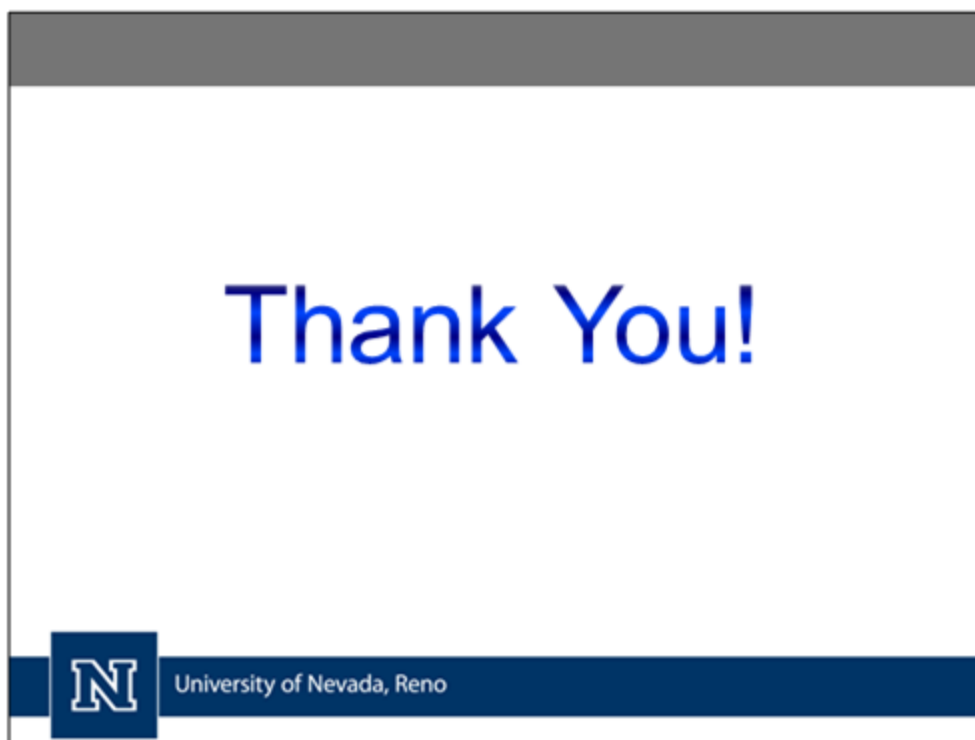
**Questions?**



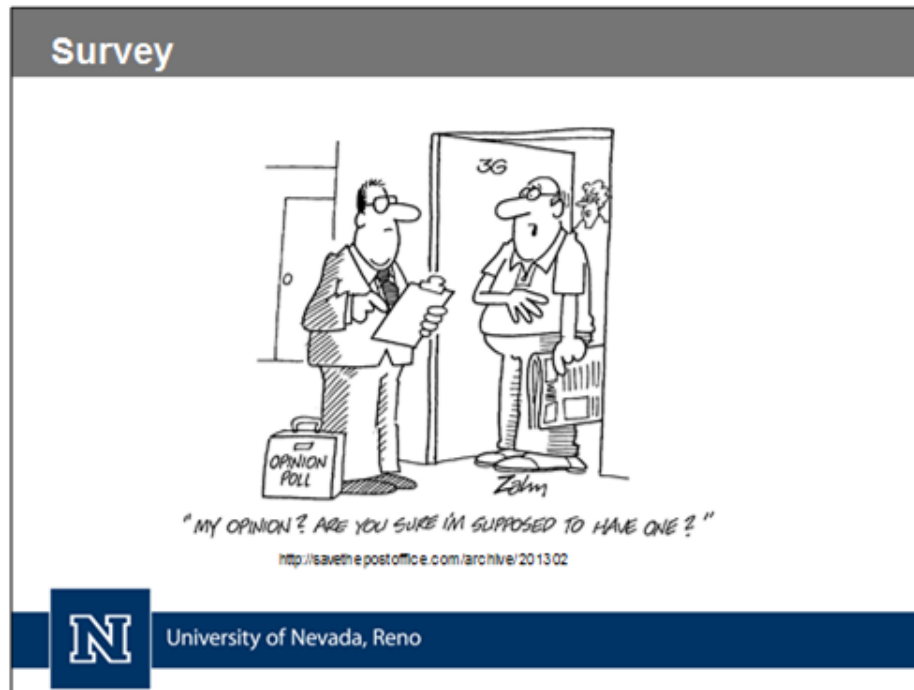
[http://washingtontote.com/definitively\\_no/](http://washingtontote.com/definitively_no/)

**N** University of Nevada, Reno

Does anyone have any questions about anything that we have covered in any of these workshops?



Thank you for participating in these workshops.



We are now going to finish up with a survey. Parts of the survey will be familiar and some will be completely new. Please be as honest and as accurate as possible as any feedback you could provide will be extremely helpful. The school of social work would like to implement this survey again and will make changes based on your feedback.

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University of Nevada, Reno

## Case Studies

### Case Study: Asher

You are a social worker at a local psychiatric inpatient hospital that provides acute care to adults. While some outpatient services are provided, the primary mission of the hospital is to stabilize patients with the goal of discharging them into another level of care. Late one night a client comes in for an assessment and presents with suicidal ideation. You conduct your assessment as usual and the client is admitted to the hospital willingly. That night, for some reason, you find yourself thinking about that client. Something special about them struck a chord with you.

A couple days later at work, you go and talk to a nurse to check on him. After flipping through the paperwork, the nurse says, "Sorry, I really don't remember him. It looks like he was discharged a couple of days ago." Shocked, you respond, "You don't remember him? Do you even take a minute out of your day to get to know your patients or are you too busy checking off your lists?" You continue, "Let me guess, it was the billing department that recommended discharge because his insurance ran out, right? Isn't that always the case? You know, if people around here did their job instead of just moving patients through like cattle, then maybe I wouldn't be seeing so many of them land back in assessment over, and over, and over, and over, again." Looking at the stunned nurse, you turn and walk away.

### Case Study: Sylvia

You are a social worker at a local child welfare agency. You work in the "assessment unit," which is responsible for investigating allegations of child abuse or neglect. Recently you noticed there is a social worker named Sylvia has been making inappropriate jokes. Sylvia has been in the assessment unit for about 4 years, following her field practicum as a student there. She has always been the "joker" on the team, but you have noticed her jokes growing more inappropriate. Also, she has appeared to have lost her ability to censor them around new workers or when talking in public places. She also seems to be joking about most of her investigations instead of just a few. You have also noticed that she keeps bringing up frustration about the fiscal climate of the state. She mentions frequently that she only has a few more years in the County system and is concerned that "they" are going to take her retirement away from her.

Concerned about Sylvia, you reflect on what you know about her... You know that Sylvia has been married for a long time, but she doesn't comment about her relationship. She has a sister that she was very close to, but you heard her mention that they got in a big fight and they have not spoken in a while. Also, she used to go on lunchtime walks with some of the other social workers, but lately has commented that she would rather get her notes done so she doesn't have to think about that at night.

### Case Study: Anna

You are a social worker at a local family resource center (FRC). Your primary role is to facilitate the groups and provide case management services for the clients and families. You are currently supervising an MSW student who has a Bachelor degree in Psychology and this is their first field practicum experience. Currently the student is working at the Food Bank where they work primarily with volunteers.

The student hasn't had any problems with any areas where they have worked before. The student learns that even if a client has a lot of medical expenses, the bottom line is their income. The student reports to you that they were bothered by the limitations of the food program and felt bad for the elderly clients.

Lately, the student has had an unpredictable schedule. They report having doctor appointments, car troubles, and trouble at their apartment complex as reasons. You check in with some of the staff to see how the student had been doing lately and they report that the student started not wanting to work on some of their projects. They report feeling that the student thinks they are "above" that type of work. When you talk to the student about this, they mention growing up in the same community as the FRC stating that they never knew about the FRC or how many people need food. They mention that they have a friend in the Public Health program and that they were thinking about switching to that program instead of social work.

### **Questions for Case Studies**

1. In light of what you have learned in the workshops, what is your assessment of [social worker's name here]?
2. Is it your responsibility to address the situation? If yes, what steps would you take to address it?
3. What barriers might you encounter when trying to address the situation?
4. What personal factors for [social worker's name here] could be contributing to the situation?
5. What organizational factors could be contributing to this situation?

6. How would your strategy change if [social worker's name here] were your colleague and not your student?

7. What strategies could be employed at the organizational level to address the situation?

\*Cases adapted from Manit, Jones & Smith, 2013

APPENDIX H  
CDRGP Coding

CDRGP Code: \_\_\_\_\_

### CDRGP Code Instructions

For these workshops on compassion fatigue you are being asked to create a code. This five letter code is called a Context-Determined, Rule-Generated Pseudonym (CDRGP) code (Carifio & Biron, 1980).

Please read each statement below carefully and write the correct letter for each question on the left-hand line.

\_\_\_\_\_ First letter of your middle name (if no middle name, write “z”)

\_\_\_\_\_ First letter of the month you were born in

\_\_\_\_\_ First letter of your sex: Male or Female

\_\_\_\_\_ First letter of the name of your street

\_\_\_\_\_ First letter of your mother’s first name (if unknown, write “x”)

These five letters are your CDRGP code. This is the code you will use on the CDRGP code page at the front of each survey you fill out in each workshop. You will be the only one who knows that the code is yours.

## APPENDIX I

### Information Sheet and Consent to Participate

## Information Sheet about Research Study: Workshops 1 and 3

Title of Study: Compassion Fatigue and Social Work Students

Protocol Number: 608932-1

### Purpose

You are being asked to participate in a research study. The purpose of this study is to learn more about compassion fatigue, burnout, compassion satisfaction and self-compassion among social work students.

### Participants

You are being asked to participate in this study because you are an adult social work student at UNR who is in a social work field placement and who is participating in a mandatory workshop about compassion fatigue.

### Procedures

As part of this workshop you will fill out the attached Demographic Questionnaire which will ask about demographic information, the Professional Quality of Life Scale 5 about compassion fatigue, burnout and compassion satisfaction (here the terms “helper” or “help” refer to the work you do in social work field placement, a social service agency or the field of social work), and the Long Self-Compassion Scale which will ask about self-compassion, thus no additional time outside of this 50-minute workshop will be needed to participate in the study.

However, you may choose for your responses to be included in this research study or not included in this research study. The research responses will be confidential and the measures you fill out will only be connected using a CDRGP code (a code that you will create using personal information at the beginning of this study. You will be the only one who knows that the code is yours). You will not be personally identified on any of the measures or in any reports or publications that may result from this study. At the conclusion of this study surveys without demographic information (to maintain student confidentiality) will be returned to the social work department to evaluate the workshop.

### Risks/Benefits

The risks of participation in this study are minimal. You may chose for your responses not to be included as part of the research study in any of the workshops. There may be no direct benefits for your participation in this research study. However, this study will contribute to the literature regarding social work students, compassion fatigue, burnout, compassion satisfaction and self-compassion.

### Questions/Concerns

If you have any questions or concerns about this study, please contact the student researcher Miranda Smith at [smithm90@live.com](mailto:smithm90@live.com) or the principal investigator Gloria Messick Svare, PhD at [glorias@unr.edu](mailto:glorias@unr.edu). You may also call the Office of Human Research Protection if you have any concerns on the conduct of the study at 775-327-2368.

**Consent to Participate in Research: Workshops 1 and 3**

Please check one of the following responses:

Yes, I would like my responses to be included in this research study

No, I do not want my responses to be included in this research study.