TREATMENT OF COMPASSION FATIGUE WITH INTERNET-DELIVERED COGNITIVE BEHAVIOURAL THERAPY

A Research Practicum Report

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By

Kimberly Larson

Regina, Saskatchewan

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Abstract

Compassion fatigue is a phenomenon regarding the psychological impact of bearing witness to the ongoing suffering of clients when working in a helping profession. Compassion fatigue, secondary trauma, professional burnout, and vicarious trauma are terms used interchangeably to explain this phenomenon. Compassion fatigue is the unique experience of those working in helping professions as it combines the emotional impact of secondary trauma exposure but also the frustrations and burnout related to the limitations to helping. Left untreated compassion fatigue can result in mental health conditions like depression and anxiety. The Online Therapy Unit is a psychology lab at the University of Regina for research, education and service delivery. The Wellbeing Course is an online transdiagnostic treatment course based on cognitive behavioural therapy for the treatment of anxiety and depression offered by the Online Therapy Unit. The purpose of this research project was to recommend specific adaptations that could be made to the current course, such as inclusion of specific trauma content and self-care strategies, that make the course a viable treatment option for helping professionals experiencing anxiety and depression stemming from compassion fatigue. Psycho-education about the components of compassion fatigue would make the course an appropriate treatment option. This research project is a qualitative exploratory study and includes a literature review, findings from experiential learning, content analysis of the Wellbeing Course and analysis of secondary data.

Keywords: compassion fatigue, vicarious trauma, secondary trauma, burnout, helping professional, internet-delivered cognitive behavioural therapy, self-care, resilience
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Chapter 1 Introduction

Compassion fatigue, secondary trauma, professional burnout, and vicarious trauma are terms used interchangeably in the literature when discussing the emotional impact of working with trauma survivors. All of these terms refer to the symptoms experienced by the helping professional as a result of bearing witness to the trauma of clients. The American Psychological Association (n.d.) website defines helping professions as those “that provide health and education services to individuals and groups, including occupations in the fields of psychology, psychiatry, counseling, medicine, nursing, social work, physical and occupational therapy, teaching, and education.” Practitioners in these fields will have different areas of specialization, knowledge and techniques but are united by the emotional investment required to establish a relationship with those in receipt of their services (Skovholt & Trotter-Mathison, 2016). Helping professionals often experience symptoms that parallel those of post-traumatic stress disorder (Geoffrion et al., 2019; Gil & Weinberg, 2015). This research project explored compassion fatigue, which is one term that is used to refer to the negative emotional impact on individuals who work in the helping professions (Caringi et al., 2017). The term compassion fatigue provides a framework for understanding this condition that includes both the impact of professional burnout and the impact of secondary trauma. Left untreated, compassion fatigue can result in anxiety, depression and suicidal ideation (Figley, 2002a; Martin-Cuellar et al., 2018). This condition is of particular importance to the field of social work as it impacts on the retention and wellbeing of workers in the profession.

The purpose of this research project was to develop an in-depth understanding about compassion fatigue and identify what therapeutic measures may effectively treat the symptoms of this condition. This project was situated within the Online Therapy Unit for Service,
Education and Research, which is a research lab within the Department of Psychology at the University of Regina. This research project assessed the potential use of an existing internet-based therapeutic program called the Wellbeing Course offered by the Online Therapy Unit that may be effective in providing treatment for the symptoms of anxiety and depression caused by compassion fatigue in professional helpers. The methods used to perform this research included an in-depth literature review, ascertaining themes that emerged and completing a content analysis of the Wellbeing Course based on the identified themes. Experiential learning was used to inform this project and secondary data analysis was completed to examine the efficacy of the course for helping professionals.

1.1 Online Therapy Unit Background

The Online Therapy Unit was established in 2010 in order to conduct research and provide education on, and service delivery for, evidence-based care for anxiety, depression and co-occurring disorders (Online Therapy Unit, n.d.). From the onset, the mission of the Online Therapy Unit was to develop and manage a website for professionals and students from various professional fields to use for the purpose of providing therapist assisted internet delivered cognitive behaviour therapy (Hajistavropoulos et al., 2011). The Online Therapy Unit provides an online program called the Wellbeing Course, which is a trans-diagnostic program designed to provide treatment for a range of anxiety and mood symptoms. This form of treatment was initially developed in Australia at Macquarie University’s eCentreClinic, which is internationally recognized for its scientific precision in the development and evaluation of online treatment for mental health conditions (Mindspot Clinic, n.d.). The Wellbeing Course consists of five online lessons and additional resources such as stories and do-it-yourself guides. The Online Therapy Unit’s programs are supported by trained therapists (or guides) who are graduate students or
professional mental health service providers (Online Therapy Unit, n.d.). Therapists and participants are assigned unique log in credentials allowing them access to the secure site. An interested applicant seeking mental health services will apply for access to the course online and complete a screening phone call with a member of the Online Therapy Unit staff. Once accepted, the individual is assigned a username and password allowing access to the course content. The individual can work on the program content and can exchange weekly messages with their assigned therapist using the website’s internal messaging system (Hajistavropoulos et al, 2011). The e-therapists have a different view of the course content on the secure system, and access to different functions, including a note-keeping function to document additional contact with the client (i.e. phone contact when required).

Participants of the Wellbeing Course can access online treatment at no financial cost and, in exchange, are asked to complete treatment questionnaires and outcome measurements. The collected data is used for research purposes to further assess effective treatment delivery options. The Online Therapy Unit is funded by both research grants and public funding from the Saskatchewan Ministry of Health which allows for the provision of online mental health services at no cost to consumers (Online Therapy Unit, n.d.). Due to the current funding scheme and research scope, the Online Therapy Unit limits its services to Saskatchewan residents over the age of 18 years experiencing depression and anxiety. The Online Therapy Unit continues to explore the implications of expanding the service area to include other provinces and additional specific populations, such as individuals experiencing chronic conditions, spinal cord injury or substance misuse (Online Therapy Unit, n.d.).
Anxiety and depression

Anxiety and depression are reported to be the most common mental health disorders with the highest prevalence over all other mood and substance use disorders (Hadjistavropoulos et al., 2016; Katzman et al., 2014; Zhang et al., 2018). The symptoms from these disorders affect people of all ages and socio-economic backgrounds. Kessler et al. (as cited by Hadjistavropoulos et al., 2011) indicate that approximately 16% of adults will be affected by a major depressive disorder at some point in their lifetime and close to 28% will receive an official diagnosis for an anxiety disorder. Anxiety and depression disorders encompass a myriad of symptoms that range from distorted thinking patterns, physical symptoms and maladjusted behaviours. These symptoms can be chronic, reoccurring and impact various facets of an individual’s life (Hadjistavropoulos et al., 2011). The prevalence of depression and anxiety disorders are greater than that of other common medical illnesses (Zhang et al., 2018) and so the treatment of such conditions in countries like Canada, where there exists publicly funded healthcare, is also a considerable consideration for policy makers. In addition to the personal cost of these conditions, there is also a financial cost to the healthcare system. Kroenke et al. (as cited by Singh & Gorey, 2018) reported that in the United States the cost of treating anxiety disorders is estimated to be around 40 billion dollars per year. Anxiety and depression are prevalent and disabling conditions but often go under-treated (Hadjistavropoulos et al., 2011; Hadjistavropoulos et al., 2014; Hadjistavropoulos et al., 2016; Katzman et al., 2014). Given the prevalence of depression and anxiety disorders, internet interventions are being examined as a way to increase access to services and bridge the gaps created by stigma, scheduling or accessibility. The low cost and accessibility are just two of many reasons why people choose to participate in internet-delivered therapy versus traditional face-to-face therapy. Stigma associated with mental illness, scheduling
conflicts which make in-person services less accessible, inaccessibility of in-person services for those living in rural or remote locations, or personal beliefs about seeking support are additional factors that make this form of therapy desirable (Hadjistavropoulos et al., 2011; Hadjistavropoulos et al., 2014; Hadjistavropoulos et al., 2016; Spence et al., 2011). The Online Therapy Unit was created in Saskatchewan as a treatment option for individuals experiencing depression and anxiety.

As discussed previously in this chapter, left untreated, compassion fatigue may result in symptoms of depression and anxiety (Figley, 2002a; Martin-Cuellar et al., 2018). Stebnicki (2007) explains that there is a physical and emotional cost to the sympathetic arousal that occurs when activating empathy due to the secretion of glucocorticoids released in the body which are a marker for anxiety and depression disorders. As discussed in the previous paragraphs, the Online Therapy Unit aims to fill a gap in current service delivery for depression and anxiety by offering courses that are evidence based. Research completed by the Online Therapy Unit has determined that internet-delivered cognitive behavioural therapy is generalizable (Hadjistavropoulos et al., 2016). With that in mind, the Wellbeing Course could be an appropriate treatment option for people (helping professionals) experiencing compassion fatigue; however no research has been identified that has directly examined this possibility. This research project aimed to address this gap and inform future research on the efficacy of providing internet-delivered services to helping professionals identified as experiencing compassion fatigue. I will now turn to the discussion of my research practicum learning goals, as well as identify activities that were part of this project. I will also discuss how the Online Therapy Unit helped to facilitate my learning and completion of this research project.
1.2 Learning Objectives and Activities

In preparation for the research Practicum, I had the opportunity to be trained in the Wellbeing Course and went on to provide therapeutic support as a student to participants completing the Wellbeing Course. In this role I was able to interact with many clients with different presenting concerns and I learned how the Wellbeing Course benefits individuals who are experiencing symptoms of anxiety and depression. I observed that there is a portion of clients accessing this service for treatment of anxiety and depression symptoms who identified as working in a helping profession. What I observed was that the symptoms of depression and anxiety become the focus of intervention for these helping professionals, with little focus on the work experiences that possibly contributed to the onset of symptoms. Administrators of the Online Therapy Unit had presented the opportunity for me to engage in a research project focused on determining if the current Wellbeing Course could be more trauma-informed, specifically for those who work in the helping professions. This research project was intended to help to understand what, if any, changes might be made to the current Wellbeing Course to provide effective service support to those who are experiencing depression and anxiety symptoms that result from compassion fatigue.

The first objective set out for this research practicum was to learn how helping professionals experience compassion fatigue and what evidenced-based approaches exist for treating the condition. In order to achieve this objective I first conducted a literature review to develop an in-depth understanding of the signs and symptoms associated with compassion fatigue, its impact on helping professionals, and what approaches are recommended in the literature to address symptoms of compassion fatigue. I participated in experiential learning
opportunities to increase my knowledge of compassion fatigue and other therapeutic approaches used in trauma treatment.

The second learning objective of this project was to research specific measures and changes that might be incorporated into the Online Therapy Unit *Wellbeing Course* to support treatment of compassion fatigue encountered by helping professionals. In order to achieve this goal I analyzed the feedback collected from previous course participants who listed a profession I considered to be a helping profession. Next I reviewed the *Wellbeing Course* content for the purpose of recommending additional resources or changes to content that might make the *Wellbeing Course* more trauma focused.

No participants of the Wellbeing course were directly interviewed so all of the activities of this research practicum were conducted within the parameters of the existing University of Regina Ethics Certificate of Approval granted to the Online Therapy Unit for Service, Education and Research. The development of the aforementioned learning objectives at the Online Therapy Unit is inspired by my prior work experiences that exposed me to compassion fatigue, which I discuss in the next section of this chapter.

**1.3 Situating Myself in this Research**

An insider perspective informed this project because I am a helping professional in the field of social work and I have experienced compassion fatigue. The strengths of this lived experience include having a good understanding of the type of work done by helping professionals, as well as the work demands. I know what I had to overcome to develop resiliency
and, I am aware of the barriers helping professionals face in efforts to overcome compassion fatigue.

“Burnout” and “self-care” are terms that I have come to know as a result of my work providing front line service in the field of social work. My undergraduate education provided an overview of the importance of self-care practices when working as a social worker. Upon reflection, I realize that I really had no idea what exactly was in store for me while working on the front line. The self-care activities I identified during my undergraduate education, such as having a relaxing bath or taking a walk, were not sufficient to manage the emotional implications of the work. Like so many of my university peers, I came into the field of social work because I wanted to create meaningful and positive change in the world. As Newell and MacNeil (2010) suggest, I had no frame of reference for the personal cost involved for those who work in the caring professions. When I finished my Bachelor of Social Work degree, I accepted a position working in child protection, where I would remain for almost five years. I had no intention of working in that specific area of social work practice while I was doing my undergraduate degree, but as life would have it, that work became the first chapter in my story of front line social work practice.

It turned out that I loved working in child protection and came to be very passionate about the work. I learned a lot about the myriad of social issues that impact people and the systemic issues that create barriers for change. I believe that my Bachelor’s degree provided me with an important foundation to begin working in social work, but did not provide me with the necessary tools to be emotionally equipped to deal with all of the pressures that social workers face when working with complex cases and complicated systemic policies. As the years wore on, I began to experience increasing frustration with what I felt was my own inability to do enough.
A lack of resources and policy limitations also contributed to my frustration regarding the struggle to fully support families involved in the Child and Family Services system. As a result of the emotional impact, I lost interest in doing personal leisure activities; I was often exhausted, and I felt a general sense of frustration and hopelessness. My perception of how everyday interactions between a parent and child could harm the child was heightened. I would see an unsmiling child that looked disheveled and wondered if they were being mistreated. My work had also heightened my awareness of signs of maltreatment and caused me to look at all children with concern. I struggled to manage large caseloads. I felt a sense of inability to complete the required paperwork. Regularly, I would compare myself to my colleagues in terms of my effectiveness and caseload management. At the same time, I became frustrated with policies that I felt impeded my ability to do effective case planning with families such as limitations to what services could be supported financially. I became irritated with my supervisor and with agency management, feeling that they no longer understood the pressures of being “on the front line”. Eventually this work experience took a toll on my personal relationships and my emotional wellbeing. Two months shy of five years, another professional opportunity arose in the area of Victim Services and I began the next chapter in my social work career.

Near the end of my time working in child protection, conversations were starting to emerge about a concept called “compassion fatigue”. I was selected to participate in a committee that was formed to look at workplace culture and attend a workshop about compassion fatigue. Unfortunately, I was replaced at the last minute and was unable to participate in the committee’s work so that I could focus on my filing and paperwork backlog. The information my colleagues later shared with me about the workshop planted a small seed that later became my area of research focus in the completion of my MSW degree.
In the years following, I saw articles on social media and from various social work groups I followed, on this very topic. It seemed that social workers across the globe were experiencing the same pressures as I was experiencing, and this term “compassion fatigue” was becoming more familiar. There were open discussions with my peers at staff meetings about caseload demands and how to manage increasing pressures associated with front line practice. As a result of the position I was in during this time with Victim Services, I also started to learn about trauma and the impact that trauma has on individuals. I started to understand how helping professionals are emotionally impacted by their work with traumatized individuals.

By the time I decided to pursue my Master of Social Work Degree, trauma and compassion fatigue were two topics I had become very interested in, and passionate about. As a part of my personal journey I had reconciled that my experience in the area of child protection was not a reflection of personal failure, and that my experience was shared by many people who work in the helping professions. I had been witness to trauma and the emotional toll was unrecognized by the leadership at the time. My learning in my graduate courses taught me that this topic is important on a macro level as it impacts policy and service delivery. One standout moment during my graduate course work occurred while reading my textbook for a policy class and the authors highlighted that policy development and implementation are impacted by whether front line staff are experiencing burnout. I came to learn this is one of the components that contribute to compassion fatigue. McKenzie and Wharf (2015) point out that front line workers, although seen as having a lot of power by clients, see themselves as oppressed without any power to influence the policy process. It was at that moment that I felt I was able to link what I perceived as a clinical issue to social work policy. As I continued to move through the MSW Program, I chose to focus my graduate research papers on compassion fatigue whenever
possible. I have witnessed many of my colleagues experience similar emotional impacts as a result of working in the field of social work, and this fueled my passion to learn more in the hope of being able to one day provide service specifically in this area.

1.4 Organization of this Report

This report consists of five chapters. This first chapter provided information on my research practicum setting at the Online Therapy Unit, as well as my learning objectives and a discussion about my own location in this research project. Chapter two will present a literature review focused on existing research about compassion fatigue and related terms; as well as cognitive behavioural therapy and internet-delivered cognitive behavioural therapy. Chapter three discusses the methodology and theoretical perspectives that guided this project. In chapter four I present the findings of this research project, and discuss the relevance of these findings and limitations of the project. Chapter five concludes this report and will review the implications for the field of social work and directions for future research, along with my closing remarks. Since this project initially began the global pandemic of COVID-19 happened, and I would be amiss to not offer some commentary on information that emerged as a result.

In the next chapter I present a literature review focused on compassion fatigue and related terminology, as well as signs and symptoms of the phenomenon. The following chapter also outlines why compassion fatigue is an important issue to the profession of social work. The literature review also includes information relating to cognitive behavioural therapy and internet-delivered cognitive behavioural therapy.
Chapter 2 Literature Review

In this chapter I will discuss the literature that I reviewed to develop an in-depth understanding about compassion fatigue and related terminology. I reviewed literature on the topics of compassion fatigue, vicarious trauma and burnout. Reviewing literature in research is important for the purpose of identifying and defining terminology that goes beyond common language (Creswell & Creswell, 2018). I also reviewed literature regarding trauma, trauma-informed practice, cognitive behaviour therapy and internet delivered cognitive behaviour therapy.

2.1 Nomenclature

In this section I will summarize the terminology I discovered in the literature that refers to the emotional impact of working in a caring profession. It is necessary to understand each term and the differences between them in order to identify what coping skills may be most effective. The terms that will be focused on in this section are: vicarious trauma, burnout, secondary trauma, secondary traumatic stress, empathy fatigue and compassion fatigue. These constructs are used interchangeably in the literature (Adams et al, 2006; Bride et al, 2007; Canfield, 2005). Learning the terminology, signs, symptoms and risk factors is the first step in developing understanding about the topic of compassion fatigue. The interchangeability of terminology does make research on this phenomenon more challenging (Owens-King, 2019). I discovered this challenge in performing my own literature review, in trying to narrow the scope of my search. A future direction for research may be an inquiry of the most widely accepted terms, to unify the research and discussion.

What these constructs have in common are similar symptoms, which impact the cognitive, emotional, and physical functioning of the helping professional. Cognitive symptoms
could include decreased concentration, apathy, intrusive thoughts or imagery, and cognitive distortions while emotional symptoms can include guilt, anger, fear, irritability and a hopeless perspective on the world (Harr et al., 2014). Compassion fatigue is also associated with physical symptoms like sleep disruption, changes in appetite, or hypervigilance (Figley, 2002a). Similarly, intrusive imagery, avoidance, negative alteration in mood and cognition, and alterations in arousal or reactivity are all symptoms of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013). These symptoms also result from working in a helping profession, such as social work, where the use of compassion and empathic engagement are essential to the provision of services. Left untreated in helping professionals, these symptoms can result in mental health issues such as depression or anxiety. These feelings can negatively impact the individual’s relationships with co-workers, clients, personal relationships and self-esteem (Harr et al., 2014). According to Bride et al. (2007) there is an understanding at a clinical level that exposure to the trauma of others involves “an inherent risk of significant emotional, cognitive and behavioural changes in the clinician” (p. 155). Figley (2002b) argues that a comprehensive overview about compassion fatigue is the first step in treating it, so understanding the interchangeable terminology used is important in creating this foundational knowledge. According to the website for the Compassion Fatigue Awareness Project, the first step to wellness “begins with one small steps: awareness” (2020).

**Vicarious Trauma**

The work of McCann and Pearlmann (1990) is cited in the literature in reference to a condition called “vicarious trauma” (Aparicio et al, 2013; Cunningham, 2004; Finklestein et al, 2015; Way et al, 2004). Vicarious Trauma (VT) is similar to compassion fatigue in that it refers
to the emotional impact of being exposed to the traumatic experience of another person. It differs in that the focus is on the disruption of cognitive schemas specific to therapists who work with trauma survivors. Compassion fatigue is a term intended for a broad range of caring professionals and encompasses not only exposure to traumatic material, but also organizational factors such as caseload numbers.

Personal schemas are the ways in which we process information that is used to create our values and beliefs. McCann and Pearlman (1990) suggest that whichever cognitive schema is more important to the helping professional is likely to be the schema that memories of the victim’s story will attach to, producing intrusive and persistent imagery for the professional. This is not unlike what happens with Post Traumatic Stress Disorder (PTSD), except that the memories are planted by the story of another and not directly experienced. Vicarious trauma is the alteration of one’s own beliefs about the world and others (McCann & Pearlman, 1990). When exposed to the traumatic experience of another individual, the therapist must find a way to process this information in an appropriate way. Much of McCann and Pearlman’s work focuses on defining and establishing criteria for the phenomena. Coping strategies are suggested and include awareness of personal schemas. Trauma can negatively impact these cognitive schemas and therefore can change how the individual perceives events or people. There are five psychological needs that are primarily affected by trauma: safety, dependency/trust, power, esteem and intimacy (McCann & Pearlman, 1990). Vicarious trauma is proposed as a normal experience as a result of the work that therapists do, and therefore the focus should be on preparing for it and developing healthy coping strategies to reduce the likelihood of long-term effects rather than avoiding it. Secondary trauma and VT are used interchangeably in literature; however, the difference according to McCann and Pearlman (1990), is that the effects of working
directly with trauma survivors differs from working with other vulnerable groups, because the helping professional is exposed to all of the details of a traumatic event.

**Secondary Traumatic Stress**

Secondary traumatic stress (STS) is the emotional response to hearing shocking material (Canfield, 2005). The key difference between STS and vicarious trauma is that one is an emotional response while the other is a more deeply embedded change to the professional’s cognitive schemas. Both result from hearing details of another individual’s trauma; however secondary traumatic stress can be expected as a normal emotional response to hearing upsetting material. Emotional support, specifically empathic engagement, is a part of doing caring work and when details of a client’s trauma results in symptoms in the caring professional related to the client’s traumatic event, this is referred to as secondary traumatic stress (Adams et al, 2006). If STS is not dealt with appropriately it can lead to a prolonged disorder known as Secondary Traumatic Stress Disorder (Canfield, 2005). According to Figley (1995) STS is one of the components of compassion fatigue and will affect every professional at some point in their career; simply because they care. The profession of social work has, at its core, altruistic values of helping and concern for the well-being of people (Canadian Association of Social Workers, 2005). Based on my review of the literature, there is a very thin line differentiating secondary traumatic stress and vicarious trauma.

**Burnout**

Burnout is the term I heard most frequently during my undergraduate degree. Burnout refers to the lack of resources needed to do one’s job effectively and the resultant feelings of “professional insufficiency” (Brown, 2020). Burnout is a gradual process whereby feelings of hopelessness, emotional and physical depletion, along with feeling ineffective to do one’s work,
develop over time (Brown, 2020). This can be the experience of any working person and is not limited to those working in the helping professions (Canfield, 2005).

Literature dating back to 1981 defined burnout as “a psychological syndrome involving physical depletion, feelings of helplessness, negative self-concept and negative attitudes towards work, life and others” (Wilkinson et al., 2017, p. 18). Valent (2002) explains that burnout is linked to “assertiveness-goal achievement” which is a survival strategy (p. 26). Burnout symptoms such as poor work performance, irritability or difficulty concentrating happen as a result of the inability to achieve work related goals (Valent, 2002). According to Newell and MacNeil (2010), burnout is often the result of organizational factors such as high caseloads, feeling a lack of control or influence over policies and procedures, feeling there is unfairness in organization structure and discipline, a lack in professional support, and a lack of professional development or training. Newell and MacNeil (2010) state that “the single largest risk factor for developing professional burnout is human service work in general” (p. 59). It is less a question of “if” someone will experience burnout, and more so a fact that helping professionals will experience burnout at some point in their career.

When we consider the history of social welfare in Canada, burnout is more clearly understood. Economic constraints have changed the ideological approach to social welfare issues in Canada over the last several decades. There have been cuts in funding to social programs and a streamlining of social services to reduce costs; and yet the number of social issues in society has not reduced. Mathieu (2015) states that “the economic downturn further strained an already fragile, overtaxed system, and as a direct result, human service staff is now struggling more than ever” (p. 4). There is no shortage of work for social workers, but there is a shortage of time to accomplish the amount of work that exists. The pressures and frustrations that come as a result of
this shortage of time can lead to burnout. Neville and Cole (2013) suggest that burnout is an outdated term and does not accurately depict what is the result of longitudinal impacts of working in situations marked by sadness and despair. They suggest therefore, that *compassion fatigue* is a more accurate term and should replace the term *burnout*.

**Empathy Fatigue**

Brene Brown (2007) claims that empathy is the most powerful tool of compassion, and that compassion is an emotional skill which allows us to respond to other people in a meaningful way. Stebnicki (2007) states that compassion is a desirable and healthy human emotion and differs from empathy which is a specific skill that transcends beyond listening, attending, observing or responding with unconditional positive regard. If we understand empathy as a skill, then it stands to reason that over-use of a skill can lead to fatigue. The possession and use of this important skill is what makes a helping professional competent to do good work. This concept is somewhat limiting in that it would suggest that a helping professional whose empathetic skill is less developed would be less impacted by the exposure to traumatic or distressing experiences of clients. In this vein, less developed empathetic skills would serve as a protective factor to professional fatigue, but that is not supported by the literature.

**Compassion Fatigue**

Compassion is defined by Goetz et al. (2010) as the “the feeling that arises in witnessing another’s suffering and that motivates a subsequent desire to help” (p. 351). Compassion fatigue has come to be defined as “the cost of caring” based on the work of Dr. Charles Figley (2002a, p. 2). Specifically, Figley (2002b) defines compassion fatigue as “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing or reminders persistent arousal (e.g. anxiety) associated with the patient” (p.
Figley (2002b) suggests that compassion fatigue is the combination of exposure to secondary traumatic stress and burnout. Compassion fatigue results from, not only exposure to secondary trauma, but also due to the lack of resources to do one’s job. This is why compassion fatigue is unique to those working in caring professions (Owens-King, 2019). Compassion fatigue affects the caregiver’s ability to effectively do caring work (Bride et al., 2007). This occurs because the caring professional begins to experience the negative emotional and physical impacts of trauma firsthand. Compassion fatigue is the physical and emotional exhaustion that specifically affects a caring professional’s empathetic approach to working with clients (Brown, 2020). An individual can be affected in all aspects of their being by compassion fatigue. I have created the following figure to illustrate some of the symptoms that characterize this experience.

According to Figley (2002b) there are 11 variables that create “a causal model that predicts compassion fatigue” (p. 1436). These eleven variables are: empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement,
disengagement, prolonged exposure, traumatic recollection, life disruption, and compassion fatigue (Figley, 2002). The figure above illustrates the complexity of compassion fatigue, which is a key consideration in the discussion regarding effective treatment interventions that will come later in this report. Compassion fatigue impacts the whole person and not just one area of an individual’s life. According to the Compassion Fatigue Awareness Project (2020) “compassion fatigue is a set of symptoms and not a disease.”

In his earlier work, Figley (1995) described secondary traumatic stress as the result of helping traumatized individuals. Gentry, Baranowsky and Dunning (2002) explain that the cumulative stress associated with caring work eventually affects the resilience of the caring professional, leaving them vulnerable to compassion fatigue. Compassion fatigue affects not only one’s ability to perform to the best of their professional abilities, but it also affects personal relationships, emotional health and physical health. According to Wharton (2008), 48% of social workers in the United States experience high levels of personal distress as a result of the work they do. Robust health and balanced time use are two factors that contribute to an individual’s overall wellbeing according to the Canadian Index of Wellbeing (2016). The literature indicates that these are two areas negatively impacted by compassion fatigue.

Although a variety of terms exist and all relate to the shared experience of working in caring professions, compassion fatigue is the term used for the purpose of this project. Compassion fatigue encompasses both burnout and secondary trauma, providing a holistic approach to the experience. This is echoed by Turgoose and Maddox (2017) who argue that compassion fatigue is not specific to those who work with trauma and can apply more broadly to a variety of helping professionals. This research project is not focused on one single experience nor one single factor that results in a cumulative negative impact. It is focused on the regular use
of empathy, stressful working conditions, lack of resources and likely exposure to traumatic material that together results in symptoms of compassion fatigue. It is important to be aware of the complexities of caring work and how the professional can be affected in order to understand what interventions will be effective for that person. The provision of case management is common in various areas of social work practice. When carrying out the duties of a case management plan, social workers often attend the homes of the clients they are working with. Seeing a client in their home can expose the social worker to seeing distressing conditions first-hand. Owens-King (2019) refers to this as seeing a client’s distress “in the moment” and that at times, case management activity also requires social workers to be the bearers of bad news or impose sanctions which makes social workers vulnerable to an additional type of secondary trauma.

The next part of this chapter will outline what trauma is and why it has such an impact on the work of caring professionals. Individuals and families who find themselves seeking the services of social workers are quite often traumatized (Harr et al., 2014). According to the Mental Health Commission of Canada (2013) trauma is often at the root of many socio-economic conditions including poverty, homelessness, violence, mental health and addictions, as well as physical and chronic illnesses. These are human conditions that social work aims to ameliorate and provide service delivery for.

2.2 Trauma Informed Care

Trauma informed care is a practice approach that underpinned this research project. A key assumption about compassion fatigue is that exposure to secondary trauma is a contributing factor to its development. Trauma informed care is a practice approach to service delivery that aims to understand the impact of trauma on the cognitive and emotional functioning of an
individual who has been exposed to a traumatic experience (Levenson, 2017). In order to accomplish this, an in-depth understanding of trauma is required and without this understanding, those who access supportive services can be re-traumatized by the very systems meant to help.

**What is trauma?**

Trauma is the emotional response that persists beyond, and stems from, the lived experience of a distressing event and can impact a person’s sense of safety, self, ability to regulate emotions and navigate relationships (CAMH, n.d). Trauma results from exposure to an actual or threatened death, serious injury or sexual violence (American Psychiatric Association, 2013). According to the Mental Health Commission of Canada (2013), trauma effects changes to the brain, increases both physical and mental stress, causes compromised immune systems, decreases trust, causes attachment difficulties and conflicted relationships, causes hyper arousal and hyper-vigilance, and causes rigid or chaotic behaviours. According to the Mental Health Commission of Canada (2013) the three components of a trauma are: 1) it is unpredictable; 2) it is not preventable; and 3) it is inescapable. A traumatic event triggers the flight, fight or freeze response and what is important to know is how our body stores traumatic memories. Neuro-scientific research has revealed that trauma is stored in our nervous system, which affects our thinking, our senses and our survival instincts (Levenson, 2017). Trauma changes how we think and how we view the world.

**Post-Traumatic Stress Disorder**

As indicated previously, symptoms of post-traumatic stress disorder (PTSD) include intrusive imagery, avoidance, negative alteration in mood and cognition, and alterations in arousal or reactivity (American Psychiatric Association, 2013). The most recent edition of the Diagnostic and Statistics Manual of Mental Disorders V (DSM V) has recognized PTSD in a
new chapter, separating it out from its previous inclusion in the chapter on anxiety disorders. According to Pai et al., (2017) “research has demonstrated that PTSD entails multiple emotions (e.g., guilt, shame, anger) outside of the fear/anxiety spectrum, thus providing evidence inconsistent with inclusion of PTSD with the anxiety disorders” (p. 2). The move to a separate chapter allows for more attention on what constitutes a traumatic event and pays more attention to the behavioural symptoms (American Psychiatric Association, 2013).

**How trauma impacts helping professionals**

Amerigan et al. (2008) conducted a study on PTSD in Canada and out of a random sample of 2991 participants from across the country over the age of 18 yrs., 76% reported exposure to at least one traumatic event which would qualify for a PTSD diagnosis. The results of this study have an implication on those working in the caring professions. A vast majority of service recipients will have experienced trauma at some point in their lifetime. This means that caring professionals will experience repeated exposure to traumatic stories. This repetitive exposure to stories of trauma is the foundation of the development of secondary trauma, one of the key elements of compassion fatigue.

Cunningham (2004) states that given the prevalent rates of trauma, social workers in various practice settings will provide services to clients who have experienced trauma. Stebnicki (2007) shared a Native American teaching that “each time you heal someone, you give away a piece of yourself until, at some point, you will require healing” (p. 317). According to Figley (2002b) the very nature of compassion is to “bear suffering” (p. 1434). The ability to demonstrate compassion is an important characteristic required to work in social work. According to Newell and MacNeil (2010) “the single largest risk factor for developing professional burnout is human service work in general” (p. 59). In order to provide care, the
social worker may learn about the trauma experienced by the client. There is neuroscience focused on the use of empathy when exposed to the traumatic material of another. Emotions involve physiological responses and the regulation of this autonomic nervous system requires energy; when a helping professional is constantly mobilizing this energy there is a physical and emotional cost to persistent sympathetic regulation (Stebnicki, 2007). The very nature of trauma is significant sympathetic nervous system arousal, so understanding this sympathetic nervous system is a crucial component of being trauma informed, not only to understand how trauma has impacted the client, but also understanding how secondary exposure and regulating that response impacts the helping professional.

Trauma informed care differs from providing trauma therapy in that it is not one specific therapeutic model, but rather a way of viewing client issues within the context of their trauma history (Levenson, 2017). According to the Mental Health Commission of Canada (2013) trauma is at the root of many socio-economic issues including poverty, addictions, mental health, chronic illness, and more. Helping professionals, specifically social workers, provide service in all areas of the human experience. As a result, service recipients in all of these areas may have experienced at least one trauma during their lifetime. The impact of trauma can be pervasive and there is a lot of research that has been done on the impact that childhood trauma can have on an individual (Ameringen et al., 2008; Levenson, 2017; Mental Health Commission of Canada, 2013). Trauma informed care calls on service providers to foster an understanding of the myriad of ways in which trauma can affect an individual. Social work practice “focuses on the person within their environment” (Canadian Association of Social Workers, 2020, p.1). This perspective involves cultivating an understanding of the various systems that affect one person, from families and relationships; to service delivery systems and political ideologies. Trauma informed care
involves integrating knowledge of trauma and recovery into service delivery. Training in theories of trauma and its impact are suggested as one of the key ways to reduce the negative impacts that caring work has on the professional (Cunningham, 2004). Helping professionals will be in routine and repeated contact with individuals who have experienced trauma; therefore, having the tools to provide effective service delivery can result in decreased compassion fatigue.

In a study by Hernandez-Wolfe et al. (2014), it is suggested that having the proper constructionist framework to work with traumatized individuals can result in vicarious resilience for the helping professional. The proper framework requires having the proper training and tools in order to focus on the resilience of the client as well as the strengths of the intervention process (Hernandez-Wolfe et al., 2014). Canfield (2005) found that there are not many studies that focus on the more positive transformative processes of working with trauma survivors. Subthreshold PTSD refers to individuals experiencing clinically significant symptoms of PTSD but that do not meet the full diagnostic criteria (Bergman et al., 2015). This condition is also linked with significant impairment but there is less research on this population and therefore less is known about the trajectory and stability long term (Bergman et al., 2015). This is significant to trauma-informed care because it recognizes that not all traumatized individuals will have a formal diagnosis. Also of relevance to this research project was the consideration of how many caring professionals might be experiencing subthreshold PTSD. Cukor et al. (2010) found that 29% of disaster recovery workers involved in the 9/11 World Trade Center work met the baseline for subthreshold PTSD, and two years later 25% of those individuals continued to meet the criteria (as cited by Bergman et al., 2015). Subthreshold PTSD is very relevant in the discussion on compassion fatigue.
Emotional regulation and changes to cognitive schemas are key symptoms of those experiencing compassion fatigue. In order to reduce the impacts of compassion fatigue, appropriate trauma training is important in order to enhance the professional’s adaptive responses and diminish maladaptive responses (Valent, 2002). Levenson (2017) explains that trauma impacts self-regulation because it affects one’s ability to regulate emotions and affects cognitive schemas. As discussed previously in this chapter, recipients of services that are provided by social workers are likely to have experienced trauma. Social workers will therefore have repeated exposure to stories of trauma, and having proper trauma training will reduce the impact of secondary traumatic stress, thus protecting against compassion fatigue. Unfortunately even with this training compassion fatigue is inevitable for caring professionals at some point in their careers. The next section of this chapter will review additional ways to protect against the impacts of this experience and how to treat this condition once it occurs.

2.3 Interventions to Prevent and Treat Compassion Fatigue

Compassion Fatigue is an important phenomenon because left unidentified, the experience of compassion fatigue is very isolating. Figley (2002) makes a bold statement that “the conspiracy of silence among the profession about this compassion fatigue is no different than the silence about family violence, racism and sexual harassment in the past” (p. 1440). It is important to feel understood by colleagues who share the same experiences first hand (Grady & Cantor, 2012). Due to the similarities between the symptoms of PTSD and compassion fatigue, the inference is that treatment methods for PTSD can be incorporated into the treatment of compassion fatigue. Metcalf et al. (2016) found four popular emerging interventions for treating PTSD: acupuncture, emotional freedom technique, mantra-based meditation (MBM) and yoga. One of the key elements these interventions share is that they are theoretically connected to
mind-body practices (Metcalf et al., 2016). The literature on compassion fatigue highlights mindfulness as an effective intervention in addressing the symptoms of compassion fatigue and building resilience (Decker et al., 2015; Gregory, 2015). Cunningham (2004) argues that further studies are needed in order to determine exactly how resilience can be measured and developed. Similarly, there exists promising research regarding the use of internet delivered cognitive behavioural therapy for PTSD, but further research is needed (Spence et al., 2011).

The term “treatment” refers to the means used to address the symptoms negatively impacting someone’s health. The World Health Organization (2014) defines health as “a state of complete physical mental and social well-being and not merely the absence of disease or infirmity” (p. 7). Keeping this definition in mind, the following sections review treatment considerations to mitigate the impact of compassion fatigue that emerged from my review of the literature. Cognitive skills, resilience, self-care and supervision were the recommendations I found repeated in the literature I reviewed.

**Cognitive skills**

Empathy is understood to have four dimensions, one of which is cognitive (Wilkinson et al., 2017). The cognitive skills required to engage empathetically are what is required to understand what a client is expressing. The behavioural dimension is then necessary to express an understanding, which is imperative for developing a meaningful helping relationship (Wilkinson et al., 2017). This framework helps in understanding why cognitive skills are important in the treatment of compassion fatigue. The ability for helping professionals to engage empathetically with clients is what allows for therapeutic relationships to foster change.

Compassion fatigue impacts the ability to continue to express empathy and this is one of the reasons why compassion fatigue is an important topic relating to social work. Not only is
understanding compassion fatigue important to the wellbeing of the individual helping professional, but also to the attrition of professionals in the field of social work.

Another important element of the client-social worker relationship is the ability to bear witness to the traumatic material that clients have experienced. It is important to develop specific cognitive skills to process traumatic material. Cox and Steiner (2013) argue that the term “self-care,” which is so common in the helping professions, has not been fully explored in research and suggest that it falls short of highlighting the cognitive strategies that are needed to help professionals cope with chronic exposure to client hardship and trauma. Katzman et al. (2014) indicate that cognitive restructuring helps to reduce emotions such as anger or guilt which are a natural response when bearing witness to the suffering of others. Canfield (2005) concludes that there is a need for adaptive coping strategies to reduce the negative impact on helping professionals exposed to secondary trauma.

**Resilience**

Newell (2020) found that there is no universally agreed upon definition of the term “resilience” in the collective literature on this topic, but as a broad construct it can be understood as “an adaptive response to stressful external stimuli” (p. 2). Baskin and Bartlett (2021) found that when stress overpowers resilience, work performance is negatively impacted. Resilience is achieved through the use of coping skills. Professional resilience, compassion satisfaction, self-compassion and vicarious growth are terms identified in the literature as possible concepts to increase resilience and reduce the impact of compassion fatigue. Resilience is the protective mechanism that fosters the continued use of empathy required to provide social work services. Having a high level of internal resources is related to lower levels of distress and PTSD symptoms (Gil & Weinberg, 2015). One important factor for developing resilience is taking into
consideration the personal trauma history of the helping professional (Luthar et al., 2000).

Having overcome personal hardships can be a strong motivating factor attracting people to the profession of social work. Having overcome personal hardship can increase the risk of counter-transference which is the term used to describe the personal emotions of the professional that arise in response to working with someone with a similar past (Martin-Cuellar et al., 2018). Bonanno (2004) challenges the concept of resilience as differing from recovery whereby the focus is on the ability to maintain a stable equilibrium as opposed to a deficit model that connotes a trajectory where normal functioning gives way to psychopathology. In relation to compassion fatigue, resilience is the ability of a helping professional to rebound to their personal baseline following a work-related incident, a highly stressful event, or a professional setback (Figley & Figley, 2017). Ostadhashemi et al. (2019) suggest that promoting resilience in professional development could enhance social workers’ skills and facilitate retention.

**Self-care**

Coping skills and stress management are central in the discussion on compassion fatigue. This is commonly referred to as self-care. Dorociak et al. (2017) define self-care as a “multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being” (p. 326). The literature differentiates between personal self-care versus professional self-care, and in ignoring this difference, superficial reference to “self-care” does not adequately protect against compassion fatigue (Martin-Cuellar et al., 2018; Owens-King, 2019). Professional self-care is the specific process of addressing the needs of one’s professional self and includes activities such as attention to workload, professional development, and time management (Martin-Cuellar et al., 2018). Newell (2020)
suggests a model of self-care that is holistic, addressing both personal and professional 
behaviours in order to promote resilience.

Empathy is key to providing competent professional services but compassion fatigue 
results when an individual’s ability to be empathetic becomes overtaxed and exhausted (Gentry 
et al., 2002). Finding ways to replenish one’s emotional reserve is important to the continuation 
of doing caring work. Dombo and Gray (2013) suggest that meditation and mindfulness practices 
are tools to support self-care in order to replenish that reserve. Lewis and King (2019) argue that 
self-care strategies need to be woven into a daily practice to mitigate the risk of compassion 
fatigue. Some of these strategies include eating a well-balanced diet, and getting enough rest and 
physical exercise. Stebnicki (2007) states that when we are constantly mobilizing energy as 
required to demonstrate empathy, we need to have energy stored to draw from. Willis and 
Molina (2019) suggest that regularly participating in wellness activities in the physical, 
psychological-emotional, spiritual, leisure and professional realms is a more comprehensive 
approach to self-care. Participants in one study found that the coping strategies they used initially 
were not sustainable in the long run, such as smoking or having an alcoholic beverage (Lewis & 
King, 2019).

Grady and Cantor (2012) suggest a model of self-psychology as an alternative approach 
to caring for the self. Self-care requires knowledge of how psychological resources can act as a 
protective mechanism (Grady & Cantor, 2012). As discussed previously, in my own experience I 
initially thought that having a bubble bath or watching a movie was considered self-care. Valent 
(2002) suggests that stress management and understanding stress symptoms is important. Having 
an understanding about stress-management techniques requires understanding how stress impacts 
the body and the mind. According to the World Health Organization (2014), self-care is defined
as “the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider” (p. 15). Glennon et al. (2019) argue that more emphasis is required on real-time techniques that can be used while providing services; not only outside of work. They suggest a “dual awareness” approach whereby the professional is both aware of what the client is sharing while also monitoring one’s own emotional reactions to that information. This is a skill that must be developed because “being a naturally empathetic or caring person is not enough” (Glennon et al., 2019, p. 51).

While self-care can be understood in a few different ways, what is clear is that regular practice of caring for oneself using a holistic approach is necessary to reduce the negative impact of secondary trauma and burnout. Being aware of what one has control over in life is a central element in the care of self (Stebnicki, 2007). Establishing, or re-establishing, control is one of the important goals of trauma treatment and therefore would apply for treatment of secondary trauma exposure experienced by helping professionals. There are a variety of barriers to self-care that are important to understand given it is the seemingly obvious answer to preventing compassion fatigue. A lack of time, organizational support, appropriate practice environment, work conditions, as well as a lack of social supports, are some of the barriers that impede the implementation of self-care strategies (Brown, 2020). Neville and Cole (2013) studied health promotion as a strategy to reducing compassion fatigue and burnout, and increasing compassion satisfaction, and found that this did not reduce compassion fatigue although it did reduce burnout. There was moderate positive association between engaging in health promotion and compassion satisfaction (Neville & Cole, 2013). Compassion satisfaction stems from the positive aspects of working in a caring profession (Stamm, 2010). Newell (2020) argues that professional
self-care fails to acknowledge that this is a holistic practice involving both the personal and professional domains. Much of the literature focuses on the implementation of self-care practices as a preventative approach rather than treatment noting that once an individual is experiencing compassion fatigue, professional help should be sought (Brown, 2020). Self-care is a skill that must be taught at the undergraduate level and early during a social worker’s career (Brown, 2020; Cunningham, 2004; Klein et al., 2018; Lewis & King, 2019; Martin-Cuellar et al., 2018; Newell, 2020; Shepherd & Newell, 2020). One of the most vital elements to developing this skill is adequate mentorship and supervision.

**Supervision**

In addition to having peer support, supportive leadership is one of the most commonly cited mitigating factors to reduce the impact of compassion fatigue (Adams et al., 2006; Clarke-Walper et al., 2020; Figley & Ludick, 2017; Harr et al., 2014). The importance of education and preparation to reduce the impact of trauma work on the social worker are recommendations that emerged in the literature on compassion fatigue. Aparicio et al. (2013) suggest that the connection between exposure to traumatic material and distress can be moderated by professional support. They suggest that education and professional support are predictive in the development of resilience (p. 29). Figley (2002b) argues that without a greater level of awareness of the risks associated with compassion fatigue there will be a detrimental impact on clients and decreased retention of caring professionals. Seeing compassion fatigue as an inevitable experience rather than something to be avoided, is one of the most common recommendations that emerge in the discussion on prevention. Leaders within human service agencies and organizations must recognize this fact in order for the cultural shifts to occur that would be required to foster supportive working environments.
Figley (1995) suggests that training is important to enhance adaptive stress responses and diminish maladaptive responses. According to Mathieu (2015), research shows that self-care alone cannot prevent compassion fatigue in helping professionals, but rather the most effective interventions are linked to workload, a reduction in trauma exposure, feelings of effectiveness associated with success in work, improved social support and, finally, engaging in a serious examination of the systemic problems that affect service delivery. Absenteeism is noted as a common symptom of compassion fatigue, which has both an economic and productivity impact for organizations and agencies. Mathieu (2015) states that “on the road to burnout, we lose compassion for one another as staff members” (p. 8). A lack of understanding about compassion fatigue results in a lack of support or understanding amongst colleagues and supervisors.

Bride et al. (2007) argue that social workers who are experiencing compassion fatigue will be more likely to make errors in professional judgment, treatment plans, or to mistreat clients. If one forges on, despite suffering the effects of compassion fatigue, they are not able to maintain the delivery of quality service. Social work service is a public service and as such unethical practice can negatively reflect upon the profession. According to the Mental Health Commission of Canada (2013), “Mental health problems and illnesses account for approximately 30% of short and long-term disability claims and are rated one of the top three drivers of such claims by more than 80% of Canadian employers” (p. 2). Compassion fatigue is a serious risk for those working in caring professions and compassion fatigue affects the mental health of the individual. When the individual is no longer able to cope with the mental health symptoms, disability is one very real possibility. Some workers will find another job, a suggestion that is often a common recommendation made when someone expresses their difficulties with a supervisor or manager. Wharton (2008) stresses that this response is not the solution to
addressing compassion fatigue. While and Clark (2021) emphasize the important role leaders play in creating a workplace culture that legitimizes self-care and self-compassion. According to the World Health Organization (2005) “there is increasing evidence that both the content and context of work can play a role in the development of mental health problems in the workplace” (p. 2). Research has identified a direct correlation between organizational factors and the risk of mental illness in social workers.

Cognitive skills, resilience, self-care and supervision are four treatment consideration that emerged in my literature review of the key factors to treating the symptoms of compassion fatigue. Left untreated, compassion fatigue will negatively impact the mental health of the helping professional. Once there are mental health symptoms, internet-delivered cognitive behaviour therapy (ICBT) is a treatment option. Symptoms of depression and anxiety can result from compassion fatigue. ICBT is an evidenced based approach to treating anxiety and depression.

2.4 Internet-Delivered Cognitive Behaviour Therapy

Cognitive behaviour therapy (CBT) is a psychotherapy that was developed in the 1960s by Aaron Beck (Beck, 1997). CBT is based on the theory that cognitive and behavioural factors influence emotions and that problems result from the biased processing of stimuli which distort an individual’s experience, creating a reality filled with cognitive errors (Singh & Gorey, 2018). Cognitive errors lead to symptoms of depression and anxiety. CBT aims to change these cognitive errors in order to improve mood or reduce anxiety, and has been empirically validated as effective in treating depression and anxiety. Advancements in research have revealed in the
field of neuroscience a connection between negative beliefs and severe loss of serotonin which contributes to a greater understanding between the mind-brain relationships (Beck, 2005).

According to Hajistavropoulos et al. (2011) advancements in technology and the widespread availability of the internet make this an affordable and accessible treatment alternative. Internet-delivered cognitive behavioural therapy (ICBT) is a treatment approach where psycho-education, cognitive, and behavioural strategies are presented to clients through structured modules on the internet, presenting strategies to change thinking patterns, reduce physical symptoms, and effect behavioural changes, thereby reducing symptoms of anxiety and depression (Allen et al., 2016; Hadjistavropulos et al., 2011; Hadjistavropoulos et al., 2014). ICBT first began to be offered in the late 1990s and more than 200 trials have been published establishing the efficacy for the treatment of anxiety and depression along with co-concurring disorders (Carlbring et al., 2018). The advantages of ICBT have been well established: improved access to mental health services, convenience for scheduling, privacy to access services which may reduce stigma, and cost effectiveness (Hadjistavropoulos et al., 2011; Sztein et al., 2018). According to Katzman et al. (2014) research has shown that ICBT is more effective than waitlists or supportive care control strategies in reducing symptoms of anxiety and depression. This therapeutic approach can be therapist assistance or unguided, and there appears to be minimal difference in treatment outcomes between these two variations (Olthuis et al., 2015). Additionally, research has shown that ICBT is as effective as in-person cognitive-behavioural therapy in the treatment of depression and anxiety (Carlbring et al., 2017; Hadjistavropulos et al., 2011; Sztein et al., 2018).

Research has not found many disadvantages to ICBT when accessed by those who are willing to participate in this therapeutic delivery method. Some disadvantages do include the cost
in developing and managing the online programs, the requirement for both the user and therapist to be computer literate, difficulties for therapists to manage crisis if presented, and the potential for miscommunication with clients (Hadjistavropulos et al., 2011). Additional potential challenges include ensuring confidentiality and secure access, recruiting skilled practitioners and the lack of financial structure for reimbursement when a cost is associated with the online service (Sztein et al., 2018). The *Wellbeing Course* relies on the use of standardized screening tools such as the PHQ-9 and GAD-7 to measure changes to the intensity of depression or anxiety symptoms while clients are participating in treatment. Relying on these measures alone could be a disadvantage in treating anxiety and depression caused by compassion fatigue. The following section reviews a tool called the professional quality of life scale that would be useful to ICBT treatment related to compassion fatigue.

### 2.5 Professional Quality of Life Scale

The professional quality of life scale (ProQOL) is a screening tool that measures compassion fatigue and compassion satisfaction (see Appendix). This measure is a 30 question self-rating scale that measures both the positive and negative aspects of working in a caring profession. The positive aspects are considered “compassion satisfaction” while the negative factors are referred to as “compassion fatigue” (Stamm, 2010). Together these factors equate professional quality of life. The ProQOL is the most commonly used measure in research on this topic, and combines the work of Figley and Stamm who have been researching in the area of compassion fatigue and secondary traumatic stress since 1995 (Stamm, 2010). The measure scores compassion satisfaction, burnout, and secondary traumatic stress and is intended for use with those who, either through paid or volunteer work, are potentially exposed to the traumatic experiences of another person (Stamm, 2010).
While the ProQOL is mentioned extensively in literature, the validity of the measure itself is debated. Heritage et al. (2018) found construct validity of the compassion satisfaction scale but argue that there is a lack of evidence to support construct validity of the measure’s secondary traumatic stress scale and burnout scale. Their research, however, was specific to use of the measure in the profession of nursing. Alternatively, the findings of Geoffrin et al. (2019) supported construct validity of the ProQOL and recommended it as an appropriate instrument for helping professionals, specifically child protection workers. The strength of the ProQOL is that it provides the helping professional with a tangible resource to assess the positive and negative aspects of the helping work. Possibly incorporating this tool can offer validation as well as concrete observations of areas that could use improvement in the life of individuals impacted by compassion fatigue.

2.6 Summary

I completed an extensive literature review on compassion fatigue and the related terms used to describe the emotional impact of working in a helping profession. Compassion fatigue, vicarious trauma, burnout, secondary traumatic stress and empathy fatigue are the different terms most frequently found in the literature referring to this experience. Trauma-informed care is a best practice approach to service delivery whereby the profession takes into consideration the past trauma of the client, to reduce the chance of the client being re-traumatized while accessing services. In order to practice from this approach, the professional must have an understanding of how trauma impacts a person from a holistic perspective, and this approach leaves the professional vulnerable to being repeatedly exposed to the traumatic material of those they work with. This best practice approach to service delivery in a helping profession then has the potential to contribute to the development of compassion fatigue. There emerged from my
literature review four specific interventions recommended to treat compassion fatigue and reduce its impact on the helping professional. These interventions are cognitive skills, resilience, self-care and supervision. Left untreated compassion fatigue can result in mental health concerns like depression and anxiety. Depression and anxiety have been found to be effectively treated through internet-delivered cognitive behavioural therapy. The following chapter will look specifically at the research I conducted in order to analyze one specific ICBT program called the Wellbeing Course to explore whether that course could be used to treat anxiety and depression resulting from compassion fatigue.
Chapter 3 Research Methods

This chapter will outline the frameworks that guided this project and the research methods used to collect data. This research project was a qualitative exploratory study. The methods used to conduct this project included a literature review and ascertaining themes that emerged in the literature review. A content analysis of the Wellbeing Course based on the identified themes using a research software program was completed and the final method was the analysis of secondary data.

3.1 Frameworks

This research project is a qualitative exploratory study that relied primarily on the analysis of secondary data. This project was framed by qualitative design because I used multiple sources of secondary data that I organized, reviewed and interpreted (Creswell & Creswell, 2018). Specifically, the project aimed to determine whether or not the Wellbeing Course could be used in the treatment process of compassion fatigue. This exploration was based on the data collected through my literature review, the establishment of themes emerging from the literature, use of those themes to complete an analysis of the current Wellbeing Course content, and inferences made based on analysis of secondary data of previous course participants who worked in a helping profession.

Inductive analysis was used to capture the themes that I believe emerged from my literature review. The inductive process involves building from the data, in this case literature, to establish themes (Creswell & Creswell, 2018). My research goal was to learn about the phenomenon of compassion fatigue and what treatment approaches have been proposed in existing literature. According to Creswell & Creswell (2018) “one of the chief reasons for conducting a qualitative study is that the study is exploratory” (p. 27). There was no pre-existing
data within the Online Therapy Unit regarding use of the *Wellbeing Course* for helping professionals and so this project was intended to figure out “the lay of the land”. The methods used in the project included a literature review, experiential learning, analysis of secondary data previously collected by the Online Therapy Unit and thematic content analysis of the *Wellbeing Course*.

The *Wellbeing Course* has been established as a trans-diagnostic treatment program and so this study aimed to determine the feasibility of running a future trial of the *Wellbeing Course* that would be more trauma focused and specific to those working in a helping profession. Cognitive behavioural therapy (CBT) is the therapeutic approach I examined through my literature review. Based on the research and data collected by the Online Therapy Unit, the assumption at the onset of my project was that CBT is effective in treating the symptoms of depression and anxiety. There is a large quantity of research supporting the effectiveness of CBT in treating depression, anxiety and PTSD (Spence et al., 2011). There is evidence that CBT is more effective in the treatment of PTSD than non-trauma focused psychological treatments, and that self-directed interventions have demonstrated reduction of anxiety symptoms (Katzman et al., 2014). This suggests that CBT may be effective in treating the symptoms of anxiety, regardless of what caused the manifestation.

### 3.2 Literature Review

The literature review presented in the previous chapter of this report is the result of an examination of academic literature related to compassion fatigue. The purpose of a literature review in research is to share the results of previous studies that related to the current project, to examine the current project in the context of the larger ongoing dialogue, attempt to fill information gaps within the current project, and frame the importance of the current project
(Creswell & Creswell, 2018). The literature review of this project was the principal research method that guided all of the learning activities.

I tried to limit the scope of my review to research completed in the western countries because of similarities in social issues, practices and policies. I started my literature review by performing a “quick find” search of the University of Regina Library database using the words compassion fatigue, vicarious trauma and burnout. I limited my search to academic journal articles available online and from the year 2000 forward. I also expanded my review by searching for the articles or authors referenced in my initial findings. Finally, I requested that the Saskatchewan Health Authority library complete an evidence search on the topic “Evidenced based approaches to treating emotional trauma – PTSD” and I received 22 results. It was noted that much of the literature on PTSD applies to military veterans. I then completed an additional evidence search request titled “Compassion fatigue in social workers” which generated 46 results.

While these topics can affect professionals in all caring professions, for the purpose of this project I tried to focus my review on literature related to the profession of social work. When I was initially exploring a research practicum on the topic of compassion fatigue, I had discussions with one counselling agency where it was agreed that compassion fatigue is a condition that affects a vast number of professionals. There are some professionals that would not readily come to mind who might share the experience of compassion fatigue such as funeral home professionals or highway personnel responsible for cleaning up the highway after a tragic accident. This fact is echoed by Figley and Ludick (2017) who suggest that trauma researchers, health science librarians, and short-term insurance claim workers are also amongst professionals who may experience secondary traumatic stress due to the nature of their work. I chose to focus
on literature related to social work as it is the profession I am situated in and the area of study that this research project is purposed for. I also noted that most of the literature on the topic of compassion fatigue is focused on professionals in specific areas of practice, such as counsellors or healthcare social workers in a specific service area.

The results of my literature review revealed that the treatment of compassion fatigue has not been extensively researched and, as such, there exists a gap in the literature that this project seeks to fill. Compassion fatigue does not have an established set of symptom criteria and so I was drawing from what the literature indicates in that the symptomology parallels that of PTSD, depression and anxiety. This resulted in reviewing the literature on cognitive behavioural therapy and more specifically on internet delivered cognitive behavioural therapy.

3.3 Experiential Learning

One of the learning activities of this project was to participate in experiential learning opportunities to deepen my understanding of trauma and compassion fatigue. Qualitative research is interpretative and involves the researcher in an intensive way (Creswell & Creswell, 2018). Typically this involvement is with participants of a study, but given the exploratory nature of this particular project, experiential learning was deemed to be appropriate. Experiential learning can foster a deeper conceptual understanding and there has been over 20 years of research supporting this form of learning, especially in higher education settings (Morris, 2020). The experiential learning model first conceptualized in 1984 by David A. Kolb is founded on theory that places conscious intentional action on a subjective experience as the center of the learning (Kolb & Kolb, 2009).

The goal of the experiential learning opportunities as part of this research project was to explore correlation between treatment recommendations in the literature and application to
practice. I completed an eight-week local Mindfulness-Based Stress Reduction course first, followed by a two-day Trauma-Informed Expressive Arts Therapy Level 1 certification course, and finally, I completed an online Compassion Fatigue Specialist Training course. These learning opportunities reflected my early findings in the literature about strategies that could reduce the symptoms caused by compassion fatigue.

**Experiential learning #1: Mindfulness-Based Stress Reduction**

The first of these opportunities was an eight-week Mindfulness-Based Stress Reduction course (MBSR). MBSR is a well-established, cost-effective program (Shapiro et al., 2005). MBSR is based on the work of Jon Kabat-Zinn and offered by Joanne Frederick at the Prairie Centre for Mindfulness in Regina. In some of my early reading on trauma and compassion fatigue, I noticed that mindfulness was often referred to as a tool for building resilience. Asensio-Martínez et al. (2019) state that there is a link between resilience, mindfulness and self-compassion which are health-assets that improve stress management. Mindfulness-based stress reduction was specifically listed as one common intervention in the treatment of PTSD in a study completed by Metcalf et al. (2016). The goal of mindfulness training is to increase awareness of thoughts, emotions, and maladaptive ways of responding to stress in order to better cope with stress (Bishop et al., 2004).

I did not have any previous knowledge or experience on mindfulness practice, and so I felt that this course would be beneficial not only for my academic learning but also for personal growth. I had the assumption that meditation was emptying one’s mind of all thoughts and blocking out all distractions which was not something I could successfully practice. My participation in this course introduced me to a variety of meditation practices and provided me with an understanding of the term *mindfulness*, which is about being present and aware in the
moment, and as I continued my research this understanding grew. I have been able to identify why mindfulness is important in developing resilience, which protects against the symptoms of compassion fatigue. Meditation practices are tools to achieve this end.

During the MBSR course, participants meet and are guided through different meditation practices each week. These practices facilitate learning how to be present with one’s own thoughts, emotions and body which aids in improved stress management. Some of the practices introduced were walking yoga, a body scan, sitting meditation, and teachings on how to be present. There was also teaching on the physiological responses to stress. Mindfulness is important in order to recognize the emotions one is feeling in the moment and how that stimulates certain physiological responses, or why one is having a particular behaviour response.

This course was very beneficial because it expanded my understanding of meditation. I learned about the notion of “not striving” and allowing what thoughts appear to pass, being inquisitive rather than critical. I also learned how to pay attention to my own physiological responses to thoughts, sights, sounds, smells and situations. I am glad that I had the opportunity to participate in this course at the very start of my research practicum because it helped me to understand, in a more meaningful way, the concepts presented in the literature, as well as in the Wellbeing Course.

Mindfulness and meditation training increase self-awareness (Posluns & Gall, 2019). Self-awareness is an important first step in mitigating the impact of compassion fatigue. Thielemann & Cacciatore (2014) found that greater levels of mindfulness are protective factors against compassion fatigue and that mindfulness is a teachable strategy. These findings support the idea that mindfulness-based stress reduction practices could be incorporated into a trial of the Wellbeing Course for helping professionals. MBSR is further appropriate to the Wellbeing
Course because there is research to suggest it is effective for the prevention of relapse of depression (Teasdale et al., 2000).

Experiential learning #2: Trauma-Informed Expressive Arts Therapy Level 1

The second learning opportunity I participated in was a two-day certification in Trauma-Informed Expressive Arts Therapy Level 1. Expressive arts therapy was pioneered by Natalie Rogers, daughter to famed psychologist Carl Rogers (Malchiodi, 2020). According to Rogers (1993) expressive arts therapy is a process of self-discovery, using any art form, that comes from a place of deep emotion and whereby the process of expression is not to produce art but let go and release. There is a growing body of literature that supports the use of art therapy in the treatment of PTSD (Foa et al., 2008; Metcalf et al., 2016). Trauma is a subjective experience that affects the mind and body, and traumatic experiences can be difficult for people to express with words alone (Malchiodi, 2020; Collie et al., 2017). The correlation between trauma and compassion fatigue was intriguing to me; I was interested in learning if art therapy could be used as a therapeutic intervention for compassion fatigue. In May 2016, I participated in a two-day expressive arts therapy workshop facilitated by Dr. Cathy Malchiodi who is an expert in the area of expressive arts and trauma therapy. This workshop was an overview of how art therapies such as music, art, movement and more, can allow survivors to develop self-regulation and heal from trauma. Estrella (2003) explains that expressive art therapy is a specialty because of the multimodal approach that is not limited to only one art form but rather using arts in sequence, simultaneously or with thoughtful transition from one to another in a single session.

According to Malchiodi (2020, p. 52) there are seven components of trauma-informed expressive arts therapy:
1. Neurodevelopment and neurobiology inform the application of expressive arts and play therapy to trauma informed intervention;
2. It is focused on supporting self-regulation;
3. Expressive arts therapy can help identify and improve the body’s experience of distress;
4. It is used to establish and support a sense of safety, positive attachment and relationships;
5. It is strength-based and it increases resilience;
6. It respects the client’s preferences for self-expression; and
7. It provides meaning-making experiences and opportunity to develop a new post-trauma narrative.

I learned from participating in this workshop that expressive arts therapy could be an effective intervention in reducing symptoms of compassion fatigue. The main lesson for me was that art therapy is a tool to help people develop self-regulation, which is required in order to process and eventually articulate a traumatic experience. I could identify from my own personal experience that over-arousal is a significant anxiety symptom. Prior to participating in this workshop I had enjoyed using an adult colouring book, finding that it was an effective relaxation practice. My personal experience, combined with the various examples from Dr. Malchiodi’s workshop, helped me to develop a solid understanding of the holistic benefit expressive art therapies can have on trauma treatment. At the conclusion of the training, I felt that art therapy could be used in the treatment of compassion fatigue, a thought confirmed by Martin et al. (2018) who found that creative arts therapies are an innovative way to prevent stress and improve stress management.
Expressive art therapy activities could be incorporated into the *Wellbeing Course.* Research on the use of expressive arts therapy delivered virtually was completed as early as 1998 (Collie & Ćubranić, 1999). Weinberg (2020) recommended the use of imagination and movement to enhance embodiment, presence and engagement in online therapies. Visual images are easily transmitted electronically, which can aid in bridging the physical distance between participant and therapist (Collie et al., 2017). As will be addressed later in this report, since this project began the COVID-19 pandemic struck. As a result, online service delivery has become a much more common way of life and there is a great deal of emerging research on the use of expressive arts therapies through online service delivery (Williams, 2022).

**Experiential learning #3: Compassion Fatigue Specialist Training**

The third experiential learning opportunity I chose to participate in was an online course through the Traumatology Institute called “Compassion Fatigue Specialist Training (CFST)”.

This course was designed for helping professionals or students in pursuit of a master’s degree to develop an in-depth understanding of compassion fatigue and the Accelerated Recovery Program (ARP). ARP was the only comprehensive recovery model specifically for compassion fatigue that I found in the literature, a fact echoed by the Arizona Trauma Institute (n.d.) which indicates that the ARP is the only evidenced-based treatment protocol for compassion fatigue in the world. ARP was developed in 1997 under the direction of Dr. Charles Figley with the goal of assisting helping professionals regain functioning in areas that have been compromised due to compassion fatigue (Gentry et al., 1997). After clinical trials were completed, the ARP was presented at the International Society for Traumatic Stress Studies (ISTSS) in Montreal, Canada, and the developers were approached by an official with the American Federal Bureau of Investigation (FBI) to train staff (Gentry, 2002). The ARP was subsequently developed into a standardized
treatment model and evolved into a “train the trainer” model; the CFST (Gentry & Baranowsky, 2013). The CFST has been used to treat helping professionals experiencing compassion fatigue all over the world (Gentry, 2002).

The ARP is centered on the notion that helping professionals often fear seeking treatment for compassion fatigue due to fear of judgement or ridicule, and these fears contribute to silencing response, a series of assumptions that affect the caregiver’s ability to attend to the story of the client effectively (Gentry et al., 2002). The silencing response and ineffective service to clients is one of the ultimate costs of compassion fatigue in helping professions. The ARP is a holistic approach to treating compassion fatigue by focusing on the symptoms and resolving both the personal and professional impacts.

There are five primary treatment areas that the ARP focuses on. Those are: resiliency skills, skills acquisition, self-care, internal conflicts and connection with others (Gentry & Baranowsky, 2010). Gentry et al. (2002) claim that cumulative stress from working with clients with complicated needs affects caregivers’ resilience. This leaves the helping professional vulnerable to compassion fatigue. The ARP is a model that builds on the strengths of the helping professional and teaches them how to increase self-awareness by identifying compassion fatigue symptoms and triggers. Awareness is a key factor to effective self-care (Posluns & Gall, 2019). The final step of the ARP model is to master arousal reduction and develop grounding techniques. Cognitive restructuring, a process of changing cognitive distortions, is the psychological process used in the program. Cognitive distortions are thoughts that lack validity and are based on errors in logic (Chand et al., 2021). The ARP is delivered in five sessions. The first session is to assess the needs and history of the helping professional. The second session focuses on allowing the caregiver to tell their story by providing a narrative from past to present.
In the third session the caregiver chooses one to three negative memories which will then be used in exercises for desensitization and reprocessing. In the fourth session the goal is to develop more positive self-affirmation and the ability to manage stress; and finally there is a session for wrap up and goal evaluation.

This course reinforced what I found in the literature about the importance of learning how exposure to secondary trauma and stress impact a helping professional. The course was conveniently delivered online and there was a wealth of materials provided to use in practice. The use of online materials is extremely relevant to this research project given that the Wellbeing Course is an online treatment program. Additionally, the use of psycho-education to achieve positive treatment outcomes is central to both the ARP and Wellbeing Course. The treatment areas of the ARP parallel content found in the Wellbeing Course such as exploration of symptoms, developing coping strategies for improved self-regulation, focus on cognitive skills and normalizing difficult emotional experiences. Like the Wellbeing Course, the ARP also uses self-reported symptom rating skills which could easily be incorporated into a helping professional specific Wellbeing Course. Finally, the Wellbeing Course that I analyzed for this project was therapist assisted which pairs well with the ARP format. Self-guided activities between sessions are an important component of the ARP, which is similar to the format of the Wellbeing Course. Overall I found the ARP very comprehensive in regards to the phenomenon and treatment of compassion fatigue, of which techniques could be incorporated to a pilot Wellbeing Course for helping professionals.

3.4 Induction of Themes from the Literature Review

Using inductive reasoning, I identified five themes from my literature review that are relevant to the phenomenon of compassion fatigue. The purpose for identifying themes was to
explore what the literature recommends to treat compassion fatigue and examine if those recommendations connect to the treatment approaches offered in the Wellbeing Course. The five themes that emerged were: compassion fatigue awareness and prevention; cognitive skills, coping skills, professional support, trauma training, and education.

**Theme #1**

The first theme that emerged was the importance of compassion fatigue awareness and training. This theme encompasses the importance of understanding all of the various terms and labels that are used in the literature interchangeably in reference to the personal toll that working in a helping profession has on the professional. Gentry (2002) suggests that becoming more informed on the phenomenon of compassion fatigue, vicarious trauma and secondary traumatic stress is an important first step for someone who suspects that they, or a colleague, are experiencing symptoms of compassion fatigue.

**Theme #2**

The second theme that emerged was the importance of specific cognitive skills required to work in a helping profession. Cognitive skills included references to survival strategies, processing information, specific techniques to minimize the impact of stress, or low mood. It emerged that developing specific cognitive skills to process traumatic material is required to overcome compassion fatigue. The literature is unanimous regarding the importance of developing resilience in order to work in a helping profession and protect against the symptoms of compassion fatigue.

**Theme #3**

The third theme that emerged in the literature was the need for coping skills. Coping skills encompass such things as stress management skills, work-life balance and healthy lifestyle
habits. There is not a definitive set of coping skills that are recommended, but instead the term refers to overall strategies to tend to one’s own wellbeing. Coping skills included any reference to specific skills such as mindfulness, meditation, humour, counselling, grounding techniques or self-care.

**Theme #4**

The fourth theme that emerged was the importance of training specific to trauma. Information specific to what is considered trauma, the symptomology of trauma, impact of trauma and how to reduce symptoms is also key information in trauma training. Trauma training and education was a broad category and included general information about what trauma is, how it affects a person, specific reference to skills training or reference to the term *trauma informed*. The literature revealed that this understanding is paramount in developing an understanding of compassion fatigue and that the symptoms of compassion fatigue parallel PTSD. The importance of education and preparation to reduce the impact of trauma work on the helping professional are recommendations that emerged in my review of the literature on compassion fatigue.

**Theme #5**

The final theme that emerged during my literature review was the importance of professional support. References to supervision, debriefing, healthy work environment or peer support were coded as professional support. The literature pointed to the need for both adequate supervisor support, debriefing and peer support. This professional support is important in developing resiliency skills. The skills are important protective factors against compassion fatigue as well as overcoming the symptoms.
3.5 Thematic Analysis of the *Wellbeing Course* Content

The identified themes were then used to perform a qualitative content analysis of the *Wellbeing Course*. The main focus of this research project was to evaluate if the *Wellbeing Course* could be used to treat the symptoms of compassion fatigue. I used QSR International Pty Ltd (2017) Nvivo (Version 11) software to complete a thematic analysis on the course content. Nvivo is a qualitative data analysis software program and was readily available to me through the University of Regina. This software program is regularly used in the research conducted by the Online Therapy Unit. The themes I had identified were used as codes in the software program and the content analysis revealed the number of instances the codes appeared in the course content. The content analysis revealed that the existing *Wellbeing Course* does contain information relevant to compassion fatigue.

Previous research confirms the *Wellbeing Course* has positive outcomes in the reduction of symptoms of depression and anxiety (Hadijstavropoulos et al., 2016). Available data within the Online Therapy Unit informed me about whether or not previous participants of the course worked in a helping profession, and whether the *Wellbeing Course* was effective in improving symptoms of depression and anxiety. This information could contribute to the work of the Online Therapy Unit providing direction for future clinical trials specifically targeted to helping professionals experiencing compassion fatigue. In the next sub-section, I will briefly explain the focus of each of the current *Wellbeing Course* lessons.

*Wellbeing Course Lessons*

There are five lessons included in the *Wellbeing Course*. Each of the lessons in the *Wellbeing Course* contains a slide show presentation on the material for that lesson, a do-it-yourself guide, and stories of fictional characters to illustrate the application of the content to real
life experiences. The order of the lessons reflects the structured approach of cognitive behavioural therapy.

Lesson one of the *Wellbeing Course* presents psycho-education regarding depression and anxiety. The lesson provides an overview of causes and presents the therapeutic framework of cognitive behavioural therapy. The first lesson normalizes depression and anxiety as common experiences amongst adults in Canada. The goal of the first lesson is to illustrate how thinking can trigger particular physiological and behavioural responses.

Lesson two explores in more detail the cognitive process. The goal of the lesson is to develop the ability to identify unhelpful thoughts that trigger low mood, physical symptoms associated with depression and anxiety, or unhealthy behaviours. This lesson teaches the skill of cognitive reprocessing by recognizing unhelpful thoughts, analyzing the thought and doing something helpful to replace or change the thought.

Lesson three examines under-arousal and over-arousal associated with physical symptoms of depression and anxiety. The lesson reviews “fight or flight” responses when faced with certain triggers, explaining that the physiological responses are normal and can be controlled. The lesson offers suggestions on how to overcome under and over arousal by planning for enjoyable activities each day during the week.

Lesson four presents the therapeutic concept known as “graded exposure.” This concept involves setting goals to address unhelpful behaviours. Avoidance and safety behaviours are presented as the common responses to depression and anxiety, and these responses include isolating, avoiding places or situations, procrastination or substance use. Graded exposure is the process of identifying goals and associated tasks, ranking the tasks from easiest to more
challenging and then executing the tasks to build confidence. By gradually overcoming fears the individual builds confidence and their capacity to cope with worry and fear.

The fifth and final lesson of the *Wellbeing Course* is focused on relapse prevention and ways to manage setbacks. The lesson reminds participants that setbacks are a normal part of the process and managing anxiety and depression symptoms. Participants are encouraged to identify potential risks and signs of increasing symptoms, followed by determining what skills to use and how to manage symptoms to keep from spiraling.

### 3.6 Secondary Data Analysis

As part of this project, I also examined secondary data previously collected by the Online Therapy Unit and, using a software program called Qualtrics, I examined pre- and post-treatment scores and satisfaction outcomes of selected participants that completed the *Wellbeing Course* between January to December 2015. At the time when I completed this project, Qualtrics was the web-based survey and reporting software used at the Online Therapy Unit. The data was based on identifying participants who previously completed the *Wellbeing Course* and whose demographic information reflected work in a helping profession. The subjective criterion used in the selection process was whether the participant indicated working with people in a health setting, first responder, social work or policing and corrections. This list was composed under the supervision of my Professional Associate and the results yielded data focused on 49 individuals. The data I reviewed was the pre- and post-treatment symptom scores each selected individual reported, as well as their satisfaction outcome scores. Based on this secondary data, I could then infer if the *Wellbeing Course* could be useful in treating anxiety and depression that stems from compassion fatigue. The findings of my secondary data analysis will be reviewed in the next chapter of this report.
3.7 Summary

This project was a qualitative exploratory study. I reviewed literature on compassion fatigue and associated terms, along with relevant literature on online therapy and cognitive behavioural therapy. I further enriched my understanding of specific treatment strategies found in the literature by participating in three different experiential learning activities. I applied inductive analysis to establish five themes that emerged in the literature and used these themes to complete a thematic analysis of the current Wellbeing Course. The thematic analysis was focused on examining how much relevant information to compassion fatigue the current Wellbeing Course contains in order to infer its feasibility in treating symptoms of anxiety and depression in helping professionals experiencing compassion fatigue.
Chapter 4 Findings and Discussion

In this chapter I will summarize the findings of the analyses I completed and discuss the importance of my findings in this context, and the contributions that can be made to the consideration of changes to the current Wellbeing Course in order to make it applicable to those individuals experiencing compassion fatigue. The identified themes from the literature reviewed and presented previously (compassion fatigue awareness and prevention; cognitive skills; coping skills; professional support; trauma training and education) were coded to complete the content analysis of the existing Wellbeing Course. The purpose of the content analysis was to determine how much relevant information to compassion fatigue is in the existing Wellbeing Course. The analysis of secondary data previously collected by the Online Therapy Unit allows inferences to be made about changes to the current Wellbeing Course that would equip it to be a viable treatment option for helping professionals experiencing anxiety and/or depression symptoms resulting from compassion fatigue. This chapter will conclude with a discussion of the limitations of this research practicum project.

4.1 Findings

Wellbeing Course content analysis

The content analysis revealed 187 references relevant to the theme of compassion fatigue awareness and prevention. References in the Wellbeing Course to specific trauma symptoms, risk factors, awareness of symptoms, and normalization of symptoms were all categorized under the topic of compassion fatigue awareness and prevention. These references were specific to symptoms of anxiety and depression, awareness of symptom presentation and manifestation, the effects of symptoms on cognition and behaviour and the benefit to addressing symptoms. Included in the theme of awareness and education was specific teaching on risk
factors to development and exacerbation of symptoms. These findings suggest that this theme is the most relevant in existing course lessons. Lessons one and three contained the most references to this theme but it was fairly consistently identified throughout the entire course.

Next, I found presence of 64 references coded to the theme of **cognitive skills**. These references would be primarily attributed to the number of times there is information included about thinking. The bulk of the references to this theme are found in lesson two which is the lesson that focuses on identifying unhelpful thoughts and reframing. Additional references to beliefs were coded given that beliefs are cognitive. This finding was not surprising given that the *Wellbeing Course* is based on cognitive behavioural therapy.

There were 51 references to the theme of **coping skills**. Any reference to breathing exercises, behaviour or actions were coded under this theme. Lessons one and two, not surprisingly, contained no references to this theme given those lessons are an overview of symptoms and emphasis on thought.

The fourth theme from the literature, which was **professional support**, was the least prevalent in the *Wellbeing Course*. With only two references which referred to accessing therapy, this is the recommendation for ameliorating compassion fatigue that is the least represented. This is not surprising given that the treatment of anxiety and depression is not relevant to professional support in the same way compassion fatigue is.

Finally, there were 13 references that are relevant to the final theme of **trauma training and education**. These references were connected to psycho-education on the arousal and under-arousal. The most references to this theme were found in lesson three, which focuses on the physical sensations related to depression and anxiety.
I created the following table to illustrate which lessons of the *Wellbeing Course* contain information that are relevant to the symptoms compassion fatigue. As mentioned previously, the literature review I completed revealed that there is no established symptom criterion for compassion fatigue but, as is the case of unresolved PTSD, left untreated compassion fatigue can lead to the conditions of anxiety and/or depression. The *Wellbeing Course* is effective in developing awareness of what the symptoms of anxiety and depression are, normalizing the existence of symptoms and identifying risk factors for developing or exacerbating symptoms.

**Figure 2**

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**Secondary data analysis**

The secondary data that I examined was based on the previous participation of 49 individuals identified as working in a helping profession. Participants of the *Wellbeing Course* are asked to complete a set of pre- and post-treatment questionnaires. My data analysis reviewed
the post-treatment results and satisfaction outcomes. Participants responded to the question “overall, how satisfied were you with treatment?” using a Likert scale. This scale ranged from 1 (very satisfied to) to 5 (very dissatisfied). Of the data I reviewed, 15 participants reported being very satisfied with the Wellbeing Course, 24 satisfied, 9 neutral, and 1 dissatisfied with the course. While the degree of change varied amongst all participants, the post-treatment results revealed a reduction of symptoms for all during the eight weeks of participation in the course.

In addition to answering on the rating scale, participants are also able to provide subjective answers. The one participant who rated their satisfaction as “dissatisfied” wrote that they did not enjoy the narratives used in the lessons. The responses indicated that all 49 individuals were satisfied or very satisfied with the quality of the lessons, with the exception of two people that indicated “neutral” satisfaction. Two participants indicated that they would not recommend the course to another person and the same two individuals indicated that participation in the Wellbeing Course was not worth their time and that they would have preferred in-person therapy. Of the feedback provided, 26 participants identified “thought challenging” as the most helpful skill introduced in the course. Nine others reported “graded exposure” and six identified breathing techniques as the most beneficial. The do-it-yourself guides were listed by 16 participants as beneficial, while ten others listed the “stories” as being beneficial. Three respondents did not provide feedback in this area. Of the feedback I reviewed, more contact with the therapist, inclusion of video lessons and changes to the stories were all identified by the participants as suggested changes to the course. More detailed or complex stories, more common experiences and more flexibility with survey responses were additional feedback that was given.
4.2 Discussion and Recommendations

The results of this project mean that the Wellbeing Course was overall an effective treatment option for reducing symptoms of anxiety and depression for past participants who worked in helping professions. These results correlate with what is found in the literature about the overall effectiveness of internet-delivered cognitive behavioural therapy treatment. The results of this research practicum project also confirm that the current Wellbeing Course contains information relevant to the overall phenomenon of compassion fatigue and some of the concepts important to the treatment of compassion fatigue. The most obvious gap between the existing Wellbeing Course and a version specifically tailored to compassion fatigue is in the absence of specific trauma content and information relevant to professional support.

My secondary data analysis revealed that there are people who work in a helping profession that have participated in the Online Therapy Unit Wellbeing Course for the treatment of depression and anxiety. Mood disorders and anxiety symptoms result when compassion fatigue is not adequately addressed. There is empirical evidence that the Wellbeing Course is effective in reducing the symptoms of anxiety and depression; we can thus infer that, with the addition of specific materials related to compassion fatigue, the Wellbeing Course would be effective in improving these symptoms for helping professionals whose symptoms of anxiety and depression stem from compassion fatigue. Adaptations to the Wellbeing Course have been made to meet the needs of other specific client groups such as maternal wellness, cancer survivors and individuals living with chronic pain; the randomized trials that followed have also proven successful in reducing symptoms of depression and anxiety in those specific participant groups (Alberts et al., 2017; Hadjistavropoulos et al., 2018b; Pugh et al., 2014). Based on my secondary data analysis, experiential learning and examination of the literature, I have identified
recommendations about adaptations that could be made to the *Wellbeing Course* specifically for individuals experiencing depression and anxiety symptoms caused by compassion fatigue. The following recommendations are organized based according to the themes developed through the literature review.

**Recommendation #1: Trauma training**

Specific content defining trauma, including the signs, symptoms and causes, would need to be woven throughout the *Wellbeing Course* if adapted for use by individuals experiencing compassion fatigue. Secondary trauma exposure is a fundamental factor underpinning compassion fatigue. Adaptations to each lesson would require trauma specific learning. In lesson one information about how trauma exposure can result in symptoms of anxiety and depression would be required, as well explanation about the similarities and differences between these symptoms and trauma responses. This lesson contains information about the physiological and behavioural responses to anxiety and depression, and so adaptation to include an overview of the neuroscience of trauma would be appropriate. Lesson two would further the trauma teaching by including how the use of empathy requires cognitive skills. A specific recommendation about content that could be added to this lesson will be discussed below, under the theme of cognitive skills. Lesson three would further learning on the physiological response to secondary trauma exposure. In this lesson teaching on the connection between trauma and the sympathetic nervous system would be important to enrich the understanding of the helping professional on the physical cost to empathy use. Some adaptations in lesson four using more trauma specific language and references could also be included. Overall, this is the lesson that would likely see the least amount of change relevant to the theme of trauma. Other themes will be more relevant to adaptations to this lesson which will be presented below. The final lesson of the course has
opportunity to specifically address how to manage ongoing secondary trauma exposure as it is an essential component to remaining in a helping profession. It would be important that adaptations in this lesson celebrate the work of the helping professional and highlight that despite ongoing exposure to traumatic material, compassion satisfaction is possible.

One of the tools used by the Online Therapy Unit to deliver course content are vignettes featuring characters whose experiences are meant to be reflective of course participants. With each lesson there is a vignette of how the characters apply the skills presented in the lesson. Previous research indicates that participants of ICBT find the stories helpful (Hadjistavropoulos et al., 2018a). This would be one area that adaptations could be made to disseminate specific trauma content for helping professionals. The characters of the stories would reflect the experience of working with clients, hearing traumatic stories and being impacted by that as a professional. Additionally, inclusion of content on the neurological impact of trauma would be important and would fit in well in lessons one and two of the current Wellbeing Course.

An additional resource that should be added to the adapted version of the Wellbeing Course would be on the topic of trauma-informed care. This additional resource would review what trauma-informed care is and how it is implemented to practice. While this approach to practice is becoming more commonly adopted by agencies and incorporated into practice policies, it would be still a relevant addition to the course. This additional resource would aid in normalizing for the participant secondary trauma exposure based on the statistics of the prevalence of trauma amongst clients and importance of this practice approach for effective service delivery. Information regarding the silencing response could also be included as part of this resource to explain the consequence of untreated compassion fatigue.
**Recommendation #2: Cognitive skills**

This theme is already strongly incorporated in the *Wellbeing Course*, and so few adaptations would be required specific to this. Cognitive skills are relevant to compassion fatigue treatment because they are necessary to the helping professional to process their emotional responses to secondary trauma. My recommendation for these adaptations also stems from my experiential learning with the Accelerated Recovery Program (ARP), which incorporated teaching on the process of cognitive restructuring. Empathic engagement is a professional skill, and so deconstructing how that is a cognitive skill versus an emotion would be important. The primary change I would recommend is that examples in the lessons should pertain to being a helping professional.

**Recommendation #3: Coping skills**

If adapting the current Wellbeing Course to be more specific and relevant to individuals experiencing compassion fatigue, it would be important to differentiate between specific coping skills to reduce the impact of compassion fatigue and coping strategies for the symptoms of anxiety and depression. This difference hinges on the understanding that self-care practices increase resilience; resilience stems from the use of coping skills when exposed to secondary trauma and stress. Mindfulness activities increase resilience, and resilience can be achieved with regular self-care practice. The adaptations I would recommend for the *Wellbeing Course* rely heavily on my experiential learning as part of this research practicum.

The mindfulness-based stress reduction course I completed taught me a multitude of meditation activities. An introduction to mindfulness would incorporate well into lesson two of the *Wellbeing Course* as a method to restructure unhelpful thoughts by shifting positive or pleasant stimulus. This can be further explored in lesson three with meditation practices that
increase awareness of physiological reactions to stimulus. A guided meditation could also be added to this lesson in the DIY resources.

An important component to the compassion fatigue specialist training I completed was making space for the helping professional to express their narrative from past to present. This helps in making the connection between how working in a helping profession has gradually led to the experience of compassion fatigue and how specific skills can both treat unwanted symptoms and act as a protective agent going forward. I think that this process could be assimilated to the *Wellbeing Course* not only through the written exchanges between participant and therapist, but with the incorporation of expressive arts therapy activities. A selected art activity could be built upon from week to week to reflect different elements of the CBT skills presented in the course lessons.

**Recommendation #4: Professional support**

The literature refers to the importance of professional support in the context of what is needed beyond the personal level to mitigate and reduce the impact of compassion fatigue. This theme would be the least adaptable to the *Wellbeing Course*. There is opportunity to add content to lesson 3 regarding how physiological responses to stressors often impact helping professionals, and this could include information from the literature specific to burnout. Burnout is the other component that leads to compassion fatigue and, as discussed in chapter two of this report, stressors such as case load size, feelings regarding policies or procedures, lack of professional support and lack of training can stem from working in a helping profession like social work. Psycho-education on the physiological symptoms of stress would make lesson three better adapted to treating anxiety and depression resulting from compassion fatigue. This information would then flow well into lesson four by providing insight to maladaptive coping
strategies that are a common to compassion fatigue. Lesson four presents the concept of graded exposure which is intended to resolve behaviours like avoidance, isolation, procrastination or substance misuse, which were also referenced in literature as consequences of compassion fatigue (Figley, 2002a; Harr et al., 2014). The final adaptation, and where this theme would best be reflected, is in lesson five in discussion about how to manage wellness ongoing. The ongoing need for professional and personal self-care plans would be important adaptations to this final lesson, which was also how the accelerated recovery program concluded.

The final adaptation I would recommend would be the addition of the ProQOL scale. This scale is used in the accelerated recovery model, and the use of standardized self-reported screening tools is already an element to the Wellbeing Course. These screening tools provide the participant visual evidence to support symptom change. The ProQOL is the only tool that has been researched for the screening of symptoms related to compassion fatigue.

4.3 Limitations of Project

One of the primary limitations of this particular research practicum project is the use of secondary data. The data analysis could not determine whether the symptoms of past participants were actually the result of their work in a caring profession. While the literature is fairly conclusive that, regardless of external factors helping professionals cannot be un-impacted by repetitive exposure to traumatic material, other factors do merit some consideration. Personal history, family history and additional life stressors can all impact an individual’s experience of depression and anxiety. The extent to which other factors impact the development of anxiety and depression for those who seek out the Wellbeing Course would need to be considered in participant selection of a compassion fatigue specific trial study.
The selection criteria applied for decisions on the secondary data examined was subjective in that it included anyone who worked in a profession that provided care to other humans. The exact position the participant held, the length of time, and actual exposure to traumatic material was not known. This definition is vast and as such it limits the ability to examine the professional factors. Most of the literature focuses on the professions of social work, nursing or law enforcement. There are varying considerations and differing impacts amongst the caring professions and so, in order to produce more concrete data, a study involving participants in the same single profession would provide greater reliability.

The second limitation to this project is the scope of the literature search. Due to the number of terms and concepts used interchangeably to refer to the personal impact of working in a helping profession, it is possible that studies were missed if different terminology was used. Francoise Mathieu (2021) reports this specific limitation makes not only conducting a literature search on this topic challenging, but then also measuring and comparing incidence rates and offering evidence-based best practice recommendations becomes an impossible task. Harr et al. (2014) highlight this challenge regarding the interchangeability of terminology as what causes the difficulty in synthesizing research and creating evidence-based practice and training specific to this topic. Mänttäri-van der Kuip (2020) suggests that research suffers due to the lack of concept clarity. The variety in terminology and ever-new emerging terminology makes it very difficult to establish empirical data regarding risk factors, symptoms and treatment for the psychological impact working in a helping profession has on the individual. Compassion Satisfaction is another construct that relates to this area of study and that was not an area that was focused on exclusively in this research project, ergo more relevant research may exist under that umbrella. The concept of compassion satisfaction is closely related to compassion fatigue;
however the exact impact one has on the other has not been empirically clarified (Bride et al., 2007). Closer examination of the inter-connectivity of these two constructs in addition to concept clarity could further strengthen the research in this area.

The nomenclature limitation is not new; Stamm (1997) identified the primary focus of discussion was not about whether helping-induced trauma can happen, but rather what it should be called. Perhaps as a result of this dilemma, there has not been empirical research conducted specific to the treatment of compassion fatigue. This could be partly attributed to the fact that compassion fatigue is a concept that defines the overall psychological impact of caring work, but within the concept there are many different symptoms. The symptoms are similar to those of post-traumatic stress disorder; however, compassion fatigue is not a recognized diagnosis with an established set of symptom criteria to form diagnosis, and rather the negative impact of working in a helping profession. The result is treatment ambiguity. Moral distress, moral injury, professional fatigue syndrome or operational stress injury are additional concepts that have been used in literature relating to negative impacts of working in a specific or general caring profession. I also found that there continue to be new concepts emerging in a continued attempt to best label the phenomenon.

The American Psychiatric Association (2020) released a COVID-19 “Pandemic Guidance Document” using the term “moral injury” to refer to the negative impact on healthcare workers who face extreme and excessive demands due to the global pandemic. Moral injury is indicated as a contributing factor to burnout but distinct for the other terminology reviewed as part of this research practicum project (The American Psychiatric Association, 2020). “Operational stress injury” is the term used in current research specific to public safety personnel which includes Canadian Border Services, Canadian Security Intelligence Service, Correctional
Officers, Correctional Workers, Dispatchers, Emergency Call Centre Operators, Emergency Medical Technicians, Firefighters (including volunteers), Municipal Police Officers, Paramedics (including Emergency Medical Responders), Provincial Police Officers, and Royal Canadian Mounted Police (Canadian Institute for Public Safety Research and Treatment, 2018). The nomenclature limitation is further problematic if different language is limited to only certain helping professions. Alternatively, social work is a generalist field and while there are global similarities regardless of specific population served, there are also differences specific to service areas. According to the International Federation of Social Workers (2014), the core concept of knowledge for the global definition of social work requires recognition of the uniqueness of social work research and theories that are co-constructed with service users in an interactive, dialogic process and therefore informed by specific practice environments. This statement is reflected in this research project focused on compassion fatigue because research should be inclusive of all the literature that exists using all of the applicable terminology in all of the practice areas.

A third limitation of this research practicum project was the use of insider perspective. Drawbacks of this perspective are the possibility of bias as a result of personal experience, as well as my passion for my profession. Social work is only one of several helping professions and there are unique challenges that may not be common within other helping professionals. There is the possibility of me having disregarding information gleaned during the research process that did not fit my experience. Consultation with my professional associate and peers was one of the ways I sought to reduce the influence of any personal bias. I also tried to review literature specific to other caring professions to ensure that information on the topics of trauma and compassion fatigue were consistent with the rest of the literature. Presenting my findings to my
professional and academic supervisors was another activity I incorporated in an effort to reveal any bias that may have permeated the research project.

**4.4 Summary**

The findings of this research practicum project are that the *Wellbeing Course* contains some information currently that is relevant to compassion fatigue, and that data from previous participants who worked in a helping profession reported favorable outcomes reducing symptoms of anxiety and depression upon completing the course. Of the five themes established from the literature review, cognitive skills are best represented in the current *Wellbeing Course* lessons. Professional support is the theme least represented, but adaptations to the theme of coping skills would be the most beneficial. Adaptations to the vignettes and do-it-yourself guides in each lesson would be required in addition to specific course content additions. Specific trauma content, and mindfulness activities would make the *Wellbeing Course* a treatment option better aligned with what is recommended in the literature for those experiencing compassion fatigue. Reliance on secondary data is one of the primary limitations of this study and further research should include running a trial of an adapted *Wellbeing Course* for helping professionals. Interchangeability of terminology is the second limitation of this project, making the scope of the research challenging.
Chapter Five Conclusion

5.1 Implications for Social Work

Compassion fatigue is a very real experience for those who work in the field of social work. The etiology of compassion fatigue is the act of caring, which is what draws people to the field of social work (Lewis & King, 2019). The profession of social work exists to provide services to those who are vulnerable. Most often individuals who are vulnerable have experienced trauma and part of the work that is done with these individuals involves hearing their stories. Stebnicki (2007) points out that empathy is a critical skill to using a person-centered approach which is a part of most training programs in western countries. Social work education involves learning about ways to engage with clients, theoretical frameworks within which service delivery is accomplished, the history of the profession and other fundamental knowledge required to work in the profession. While there is often discussion about the risk of burnout and the importance of self-care, there is a lack in the development of the cognitive skills required to compartmentalize and process all of the traumatic material that one will be exposed to working in this profession.

There is a dichotomy between what it takes to be an effective social worker, focusing on the needs of the client, versus focusing on self-care to protect against compassion fatigue (Glennon et al., 2019). This dichotomy is part of what makes the experience of compassion fatigue isolating. The term “self-care” makes self the central point, yet the very nature of social work is altruistic. Willis and Molina (2019) argue that “social workers are the most important players in the profession; without the server there is no service” (p. 83). They suggest that a major weakness with the National Association of Social Workers Code of Ethics is the emphasis on the wellness of client and minimal guidance regarding the importance of wellness for the ones
providing service. The Canadian Association of Social Workers mirrors this emphasis with the value of “service to humanity” which places the professional service above personal goals or advantages (Canadian Association of Social Workers, 2005). The correlation between a lack of recognition about compassion fatigue and high turnover rates in social work cannot be ignored (Grady & Cantor, 2012). Once affected by compassion fatigue, individual social workers tend to leave their job or the profession entirely with a belief that it was a personal failure. There is a stigma associated with mental health conditions in society, and caring professionals are not exempt from experiencing this stigma when they experience symptoms of anxiety or depression caused by compassion fatigue. This research practicum project highlights the important recognition that in social work there will be personal toll on the professional individual at some point in their career. When that happens, there needs to be appropriate support in place to overcome the impact of this toll. Identifying that this toll is not the result of a personal flaw, or lack of effort on the part of the individual, means naming the experience as compassion fatigue.

Social work is not the only caring profession affected by compassion fatigue. First responders, nursing and policing are only a few of the other caring professions identified in the literature on compassion fatigue. There even exists a body of research specific to clergy and compassion fatigue. Interestingly, seeking support from social workers is one of the recommendations for these other caring professions. This is ironic when one considers that social workers are also suffering from compassion fatigue (Andersen & Papazoglou, 2015; Jacobson et al., 2013; Neville & Cole, 2013).

5.2 Future Research

Existing research suggests that the symptoms of compassion fatigue are similar to those of PTSD; however, there is limited research specific to the treatment of compassion fatigue.
There is an opportunity for future research to test the validity of treating the symptoms of compassion fatigue with similar measures currently considered best practice in the treatment of PTSD. Future research would include running a trial of the Wellbeing Course specifically for those who work in a helping profession and are experiencing symptoms of compassion fatigue. While the Wellbeing Course successfully treats anxiety and depression, an adapted version for compassion fatigue would require additional resources that focus specifically on exposure to secondary trauma and ways to manage work stress. These resources would involve providing additional psycho-education regarding trauma and its impact, as well as more detailed information about the impact of stress. Consideration of factors outside of the individual’s control, such as caseload size, supervision and peer support would also be required to fully assess impacts and existence of compassion fatigue.

It is important to acknowledge the history of First Nation, Metis and Inuit people in Canada. Specifically, for social work, a profession dedicated to advocating for social justice and cultural competency, the history of abuse and systemic discrimination must be acknowledged. However, there is an absence of this specific acknowledgement in the research, particularly regarding how this harmful legacy correlates to compassion fatigue. The concept of wellness, as defined by the World Health Organization as “the optimal state of health of individuals and groups,” is vital to protective and healing components of compassion fatigue. Cornerstone to the discussion of wellness are the commonly understood standards of social determinants of health including such factors as income, physical environment, and social supports, as well as others. Dr. Cindy Blackstock (2021) identifies that these social determinants of health, however, do not recognize all of the needs of Indigenous peoples. As such, there is also an absence of recognition for the additional risks facing First Nation, Metis and Inuit helping professionals to experience
compassion fatigue, and a lack of recognition of how this trauma history impacts the work they do. Due to this striking lack of examination, future research should address the gaps in contemporary understanding of social determinants of health, the unique needs of Indigenous peoples, and the impact of systemic inequality on Indigenous helping professionals. There is no doubt that compassion fatigue negatively affects all helping professions and, in particular, those impacted by generations of trauma and continued systemic inequality. Therefore, future research regarding the prevention and treatment of compassion fatigue for those with intersecting vulnerabilities is crucial. This work must not only include Indigenous researchers and professionals but be guided by them. Social work research must make space and resources available for this important work to be completed – for the betterment of Indigenous helping professionals, the clients they serve, and Canadian society as a whole.

5.3 What We are Learning from COVID-19?

Since the conception of this research practicum project the global pandemic of COVID-19 began. The COVID-19 pandemic exacerbated challenges that already existed for helping professionals (Baskin & Bartlett, 2021). Professions that already had worker shortages prior to the pandemic risk having additional unmet needs as even students training in helping professions were experiencing adverse impacts associated with the COVID-19 pandemic (Evans et al., 2021). Workloads have increased during the pandemic which is expected to have impacted the wellbeing and mental health of staff (While & Clark, 2021). Increased workload and a myriad of stressors beyond those experienced as pre-pandemic work related stressors have brought renewed attention to the concepts of burnout, vicarious trauma and compassion fatigue. There is already an emerging body of literature that focuses on specific professions, namely medical professionals providing front line service during the pandemic. It has been found that
professionals on the front line during COVID-19 have reported reduction in sleep quality, increased stress levels, increased symptoms of depression and anxiety as well as trauma symptoms (Evans et al., 2021; Gray et al., 2021; Ralph et al., 2021). Following the 2003 SARS outbreak, research showed that those front line responders working in hospitals experienced a significant increase to rates of chronic stress, professional burnout, depression, anxiety, substance misuse and absenteeism (Maunder et al., 2008). Research stemming from that pandemic suggested that a shift was needed away from clinical interventions for mental health issues and that, instead of pathologizing helping professionals’ responses to distress caused by the work, fostering resiliency would be a more respectful approach (Maunder et al., 2008). This shift is consistent with my overall findings regarding compassion fatigue. Research stemming from previous pandemics foreshadowed what is now being revealed as the impacts of the COVID-19 pandemic (Gray et al., 2021).

Baskin and Bartlett (2021) completed a systematic review of current research related to the mental health impact of COVID-19 on helping professionals and concluded that, while the effects have been explored, other reviews did no measure resilience, which is cited as an important protective factor. This correlates with my findings from the overall literature on compassion fatigue and the themes in the emerging body of research also parallel what I found in the literature. Resilience, self-care and professional support continue to trend as the most often identified recommendations. Baskin and Bartlett (2021) state that it is imperative for leaders and healthcare institutions to both understand and apply that understanding to the broad range of effects associated with the work of helping professionals during the pandemic. While and Clark (2021) concluded that managers need to recognize the needs resulting from work-related stress and burnout in order to support staff in having a plan for recovery. Ralph et al. (2021) found that
better organizational and social supports reduce anxiety levels. The body of emerging research on the impact of COVID-19 thus far has not provided new treatment recommendations but continues to highlight the risks of working in a helping profession and dealing with crisis and trauma. The literature specific to the emotional impact of COVID-19 on helping professionals also continues to add to the ambiguity around terminology, as I found to be the case in the literature on compassion fatigue. Compassion fatigue was already a significant issue for helping professions; COVID-19 has only exacerbated this, and the long term effects are not yet known (Evans et al., 2021, Gray et al., 2021)

5.4 Closing Statements

Famed psychologist Carl Rogers (1995) once wrote, “I have always been better at caring for and looking after others than I have been at caring for myself” (p. 80). This quote summarizes my own lived experience both personally and in terms of what I have heard countless colleagues reiterate. According to traditional Indigenous teaching, the journey to becoming a Medicine Person requires an understanding that at some point in the journey the healer will also be wounded and require healing (Stebnicki, 2007). While there is a wealth of literature and various theories that have been offered regarding the emotional impact of working in a helping profession, none has been able to conclusively demonstrate the mechanism that accounts for this phenomenon (Gentry, 2002). Compassion fatigue must be seen as something that will happen during the career of a helping professional and not as the result of moral failure, but rather as the result of doing good work. In order to be an effective helper one must have highly developed empathetic skills. If it is a skill then not only must it be taught, but also kept up and refreshed. The use of this skill cannot exceed the ability of the caring professional to monitor their own emotional needs (Stebnicki, 2007). This skill development and maintenance exceeds
the basic teaching of “self-care”. Self-care implies that the burden for alleviating the psychological burden of caring work is solely the responsibility of the individual. While self-care is one important protective factor, intervention for compassion fatigue goes beyond the individual and requires the support of supervisors, educators and professional organizations.

I believe that as a result of the focus on the individual, compassion fatigue has been frequently misdiagnosed as anxiety and depression. While these mental health conditions can result if compassion fatigue is not addressed, that is not the appropriate way to frame the emotional impact of doing caring work. It is for this reason that this project was necessary. The greatest lesson that I have learned through this research practicum is that the treatment for compassion fatigue is more than basic self-care. Healing and balance of the helping professionals’ emotional, mental and spiritual wellbeing is required. As is the case with so many areas of social work practice, compassion fatigue is both a micro and macro level issue.

This research practicum project stemmed from my own personal experience but in the end, I have learned what a myriad of factors impact the experience of working in a helping profession. Social work programs and professional associations can play an integral part in expanding teaching and support on trauma-informed practices which will be a protective factor against, and in the treatment of, compassion fatigue. According to Gentry (2002), no one who chooses to work with trauma survivors is immune to the potential adverse effects of this work. Social workers consciously choose this meaningful work despite possible adverse effects. Thankfully, long, healthy, and fulfilling careers are absolutely possible.
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