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Compassion Fatigue and Self-Care Strategies among Addiction Professionals: A Qualitative Study

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Compassion Fatigue and Self-Care Strategies among Addiction Professionals:

A Qualitative Study

by

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Abstract

Addiction is a prevalent disorder and is on the rise. Addiction has serious symptomology and can negatively impact an individual's life in several areas. Not only can the person addicted become negatively impacted, but the addiction professional that treats this disorder can become negatively impacted as well. Because there is often a high co-occurrence of addiction and trauma among addiction clients, this intensifies the clinical profile of such clients which compounds the risk for addiction professionals. It is the addiction professional's response to this combination of addiction and trauma that can cause these professionals to experience compassion fatigue.

Research has been done to examine compassion fatigue among a variety of populations, but there has been limited research specifically with addiction professionals. This study aims to add to the literature by focusing on addiction professional's experiences with compassion fatigue and associated symptomology, and to explore the participant's training and their self-care strategies in relation to compassion fatigue.

Seven addiction professionals in the Tampa Bay area participated in in-depth interviews that focused on their experiences with compassion fatigue, training, and self-care. The data collected was analyzed qualitatively using thematic analysis. Results indicated compassion fatigue was present among six out the seven participants and that there was a lack of training among these participants. All of the participants shared several self-care strategies they use to address compassion fatigue. The study concludes by providing implications of the research, limitations, and recommendations for future research.

Chapter 1: Introduction

Addiction is a devastating illness and a major medical and mental health issue affecting

the United States. Those addicted may struggle with alcohol or other drugs or have a co-

occurring addiction in which they struggle with both substances. Compounding the issue is how

alcohol and drug addiction can coexist with other mental conditions such as: depression, suicide,

bipolar, chronic pain, anxiety, and trauma (Gold, 2011). In fact, it is estimated that 8.9 million

individuals in the United States struggle with both an addiction and a mental health disorder

(Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.).

Because addiction is severe and chronic, the disorder requires treatment. That treatment

is supplied by addiction professionals who are specifically trained to treat addiction. Although

these addiction professionals have specialized training, that training is surprisingly varied among

each professional. Many times, these professionals have not received any specific training

geared toward treating the co-occurrence of addiction and other mental conditions such as

trauma (Bride, Hatcher, & Humble, 2009; Deighton, Gurris, & Traue, 2007). Not having

specific training regarding how to treat addiction and trauma is an issue because addiction

professionals may not be prepared for the possible negative reactions they may experience due to

dealing with the traumatic stress of their clients (Knight, 2010). As a result, the lack of proper

training, coupled with challenging clientele, places addiction professionals at risk for developing

compassion fatigue.

Compassion fatigue can be defined as "a combination of physical, emotional, and

spiritual depletion associated with caring for patients in significant emotional pain and physical

distress" (Lombardo & Eyre, 2011, para. 1). More specifically, it develops from working with traumatized clients (Figley, 1995). Traumatized clients are clients who have experienced an event or situation that was physically or emotionally harmful in which it negatively impacted their level of functioning (SAMHSA, 2012).

Compassion fatigue can be personally and professionally devastating as it has an impact physically, emotionally, and spiritually. One component that has been shown to mitigate a counselor's vulnerability to compassion fatigue is self-care (Craig & Sprang, 2010). Self-care involves engaging in activities that promote overall wellbeing by addressing an individual's physical, emotional, mental, and spiritual health (American Holistic Nurses Association, 2014). Despite the high risk of developing compassion fatigue, addiction professionals may not be employing self-care to help lessen and/or eliminate the impact.

Background of the Problem

The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2008) conducted a national epidemiologic survey examining the prevalence of alcohol and drug addiction in the United States. According to the survey, 8.5% of the adult population met the criteria for an alcohol use disorder, 2% met the criteria for a drug use disorder, and 1.1% met the criteria for both (NIAAA, 2008). The statistics illustrate a high prevalence of addiction in the United States.

When reviewing the prevalence of addiction and other mental disorders, Grant et al. (2004) found that 20% of individuals suffering from a substance use disorder also met criteria for one or more mood disorders and 18% met criteria for an anxiety disorder. Through further analysis, Stinson et al., (2005) examined the prevalence of personality disorders, mood disorders, and anxiety disorders among three separate groups: alcohol only, drug only, and both alcohol and drugs. Those findings showed in the drug only group there were approximately 44% personality, 28% mood, and 24% anxiety disorders. In the drug and alcohol group there were approximately 51%

personality, 35% mood, and 27% anxiety. Finally, the alcohol only group found 25% personality, 16% mood, and 16% anxiety disorders (Stinson et al., 2005).

It is equally important to note many individuals may not meet the full criteria for a specific mental disorder, but have experienced some form of trauma. Trauma is defined as, "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 1). Events that may contribute to someone becoming traumatized are: physical abuse, sexual abuse, emotional abuse, neglect, combat, natural disaster, grief, domestic violence and more (National Child Traumatic Stress Network [NCTSN], n.d.)

In fact, according to Fahy (2007), 56.2% of clients who are in an inpatient substance abuse program report a lifetime history of trauma and 42.5% report active PTSD. Bride (2007) provides, "among treatment-seeking substance abusers, 60 percent to 90 percent have a history of physical or sexual abuse, and 30 percent to 50 percent meet the criteria for a diagnosis of post-traumatic stress disorder (PTSD)" (p. 63). The statistics clearly show a very high prevalence rate of co-occurring disorders and traumatic experiences among the addiction population. These co-occurring disorders only exacerbate an already troubling situation.

Without question, addiction is costly to a person. Those costs can be physical, emotional, spiritual, familial, and legal in nature. Physical costs may include cardiovascular disorders, sleep disorders, gastrointestinal issues and more (Gold, 2011). Familial costs may include marital strain, weakened relationships with children, financial strain, and an overall disconnect among family members (Gold, 2011). Legal costs may include alcohol and drug related arrests and attorney fees. There may also be societal costs such as: health care costs; productivity costs; criminal justice system costs; social welfare services; and motor vehicle crashes (National

Institute on Drug Abuse [NIDA], n.d.). Per the Substance Abuse and Mental Health Services

Administration (SAMHSA, n.d.), the cost of alcoholism in the United States is 235 billion

dollars annually and other drugs account for another 193 billion dollars each year. These

tremendous costs show a need for addiction treatment. By individuals entering in treatment, it

can lessen the overall personal and societal costs of addiction.

Statistics reveal a high demand for people seeking addiction treatment. For example,

considering alcoholism alone: "In 2007, 7.8 percent of persons aged 12 or older (an estimated

19.3 million persons) needed treatment for an alcohol problem in the past year" (SAMHSA,

2009, p. 1). Sadly, there is also a growing trend in treatment needs for the young adult

population. Specifically, in that population, ages 18-25, treatment needs are two to three times

greater than that of other populations (SAMHSA, 2009). In addition, under the Affordable Care

Act, those needing and seeking treatment for addiction could double (Join Together Staff, 2013).

The new law mandates addiction treatment as a necessary health benefit for insurance companies

(Join Together Staff, 2013). In fact, "four million people with drug and alcohol problems will

become eligible for insurance coverage" (Join Together Staff, 2013, p.1). This increases the

demand for addiction treatment and will likely cause strain to the addiction treatment system,

which will include increased demands on and for addiction professionals.

With such a demand, it has become very important to explore the role of addiction

professionals and how they are affected during the treatment process. Addiction professionals

are trained with a combination of specialized education and supervised work experiences.

Currently, it is estimated that there are 76,000 addiction professionals in the workforce (National

Association of Alcoholism and Drug Abuse Counselors [NAADAC], 2013). Addiction

professionals are involved in intervention, prevention, treatment, education, and the like

(NAADAC, 2013). They are employed in settings like hospitals, private or public substance abuse facilities, private practice, prisons, juvenile detention centers, halfway houses and more (NAADAC, 2013).

Addiction professionals face their share of challenges in the treatment process. Just as addiction presents costs to the addicted individual and society at large, treating the addicted may come at a cost to the addiction professional. These costs are unique to addiction professionals. It is important to understand these professionals work with difficult clientele; they often have low workplace support and practice with limited procedural guidelines (Duraisingam, Pidd, & Roche, 2009). Moreover, in many instances their salaries are low, they have low self-efficacy, and they have high caseloads with staff shortages (Duraisingam et al., 2009).

As mentioned previously, another challenge facing addiction professionals is the variability of their training. For starters, addiction professionals may be formally or informally trained. The formal route includes collegiate training and entering the field through a variety of avenues such as: social work, psychology, marriage and family therapy, or mental health counseling (Linton, 2012). Other addiction professionals may rely on certifications they have acquired in their professional training such as certified addictions professional or certified alcohol and drug addiction counselor (Linton, 2012). Addiction professionals, who take the informal route, simply enter the field through their own personal experiences with recovery.

Irrespective of the route chosen, there are many different forms of training within each path. As a result, this causes an overall lack of uniform training. This lack of uniformity can negatively impact a professional's overall preparedness in treating this complex disorder. In fact, research has shown that individuals without a master's level education are at higher risk for developing compassion fatigue (Perkins & Sprang, 2013). Sadly, the lack of uniformity also

makes it difficult to determine whether or not addiction professionals are even taught about compassion fatigue or the importance of self-care. Equally troubling is that research has shown addiction professionals are not prepared to treat addiction coupled with trauma (Bride et al., 2009). Consider the study conducted by Bride et al. (2009) wherein researchers found in their sample of 225 members of the National Association of Alcohol and Drug Addiction Counselors that, "most substance abuse counselors are not being prepared for practice with traumatized populations in their formal academic training" (Bride et al., 2009, p. 96).

It is safe to say addiction professionals face unique challenges in their treatment of addiction and may be at risk of developing compassion fatigue. Compassion fatigue develops when individuals in "helping professions" such as addiction professionals, become physically, emotionally, and spiritually depleted due to working with traumatized clients.

A similar construct to compassion fatigue is burnout. Burnout is defined as, "a psychological syndrome that develops in response to chronic emotional and interpersonal stress" (Thompson, Amatea, & Thompson, 2014, p. 58). Burnout develops gradually and is a result of a counselor's response to the interpersonal stress of dealing with clients as well as their work environment (Thompson et al., 2014). This differs from compassion fatigue because compassion fatigue can have a sudden onset and develops more specifically as result of one's response to working with traumatized clients (Bride & Walls, 2006; Thompson et al., 2014). Although these constructs have some similarities, this research is focusing specifically on compassion fatigue.

Without question, addiction professionals help clients who, as described above, are dealing with extremely complicated issues. These professionals are responsible for helping clients process a variety of painful emotions on a daily basis. Unfortunately, while helping clients, the process can negatively impact the addiction professional. These professionals often

believe they can handle any amount of negative intensity, but in reality they are vulnerable to the effects of compassion fatigue (Cummins, Massey, & Jones, 2007)

When compassion fatigue is identified, the concept of "counselor self-care" has been shown to mitigate the initial vulnerability and then the more enduring effects of compassion fatigue on these professionals. Self-care is well documented in the literature as a critical and necessary aspect of counselor wellness (American Counseling Association, 2010; Cummins et al., 2007; Richards, Campenni, & Muse-Burke, 2010). The goal of self-care among counselors is for counselors to balance caring for their clients while caring for themselves. The challenge is counselors often put their clients first at the expense of their own well-being. A necessary part of their training requires counselors to convey empathy and compassion toward their clients, but in many respects, they fail to convey the same amount of empathy and compassion to themselves. It is the combination of treating clients with severe issues, having inconsistent training practices, coupled with the empathic demands required of counselors, and no self-care that generally leads to compassion fatigue (Figley, 2002).

Statement of the Problem

With the prevalence of addiction increasing along with the need for client services, addiction professionals are an important population to examine. Addiction not only impacts the person addicted, but it can also impact clinicians who treat these clients. Addiction has very serious symptomology and often co-occurs with trauma making it a difficult population for clinicians to treat. Clinicians may repeatedly hear traumatic stories, which often increases and contributes to the development of compassion fatigue.

To date, there is an abundance of research exploring compassion fatigue among professionals treating traumatized clients (Fahy, 2007). The focus of this research, however, has

primarily been with clinicians in settings such as crisis centers, and child welfare agencies (Bride et al., 2009; Fahy, 2007). Although this is important research, it has left several gaps to fill. There has been little attention placed in the area surrounding the unique stressors affecting addiction professionals, particularly licensed mental health counselors (LMHC) and certified addiction professionals (CAP), who treat addiction and their risk of developing compassion fatigue (Bride & Walls, 2006; Fahy, 2007). The literature is also overly broad in trying to understand compassion fatigue and focuses mainly on the prevalence of compassion fatigue among a variety of populations. There are few studies that narrowly focus on addiction professionals experiences with compassion fatigue. Furthermore, while it is understood self-care is necessary for counselor wellness as a mechanism to help protect against compassion fatigue, there are few documented strategies developed for how it can be used by addiction professionals.

Significance of the Study

The need for addiction treatment services continues to increase, and in turn, requires more addiction professionals (Duraisingam et al., 2009; Fahy, 2007). Currently, the demand for addiction professionals far outweighs the supply (Duraisingam et al., 2009). From 2010 to 2011 the National Survey on Drug Use and Health (NSDUH) reported that 21.6 million individuals who were 12 years old and older needed treatment for a drug or alcohol problem (SAMHSA, 2013).

In sum, research has confirmed an overwhelming need for treatment services, and unfortunately, that same research has made it clear there are not enough addiction professionals to meet that need. In fact, it is projected that 5,000 addiction professionals are needed per year to replace those that leave this field of work (Fahy, 2007). Further, of the 477,000 jobs in the field of social work only 95,000 identified as having a substance abuse role (Fahy, 2007).

According to SAMHSA (2013) the shortage is viewed as a workforce crisis caused by, "high turnover rates, worker shortages, an aging workforce, stigma and inadequate compensation" (p.3). Compassion fatigue may be another contributing factor for why frontline mental health workers, including addiction professionals continue to leave the field (Bride & Kintzle, 2011; Ray, Wong, White, & Heaslip, 2013).

In order to help address the ongoing dynamic of an increasing addiction problem and a smaller group of individuals trained to help, it is important to focus on those currently remaining in the profession, and as Fahy (2007) stated: "listening to addiction counselors and workers may be an important direction for researchers interested in exploring compassion fatigue and related conditions" (p. 203).

There are several benefits of exploring compassion fatigue and self-care among addiction professionals. First, addiction professionals' experience with compassion fatigue is limited in the literature; as a result, there is a large void that needs to be filled. New, ongoing research specific to addiction professionals is likely to provide a wealth of previously unconsidered and valuable information.

From that research, we know that compassion fatigue can present on a continuum from acute to chronic and can affect helping professionals in several areas such as: performance at work, cognitively, emotionally, spiritually, and physically (Bush, 2009). If similar research is conducted with addiction professionals and the symptomology is identified, we can begin to look at the impact compassion fatigue has on an addiction professional's overall well-being and how it impacts their ability to provide optimal care to their clients.

The second benefit of this research is that it may identify issues with current training practices. In addition, it may uncover what role training plays in relation to compassion fatigue.

A third benefit of this research is how it will ultimately help educate addiction professionals about the risks they face due to the nature of their profession. It can help addiction professionals understand the high rates of trauma which exists among the addiction population and it can also help them understand that this combination may lead to negative emotional responses.

A fourth benefit of this research is it can also help addiction professionals identify symptoms of compassion fatigue they may be experiencing. Addiction professionals may be suffering with symptoms of compassion fatigue, but not know what to attribute the symptoms to. By learning that compassion fatigue exists and they have symptoms of it, this can help normalize the feelings associated by realizing they are not alone in this process.

Finally, a benefit of this research is it may help addiction professionals understand that compassion fatigue is a predictable condition that can be treated (Bush, 2009). This is great news for professionals because it means they do not have to leave the field, but rather seek help for their symptomology. Because counselor self-care has been shown to be one of the treatment strategies for compassion fatigue, understanding its role among addiction professionals is critical. Understanding self-care strategies that have worked for others in the addictions field may provide helpful tips for those who are currently struggling and looking for helpful solutions.

The cost of not exploring compassion fatigue within the addiction professional population is great. Left unexamined, there is a possibility that more addiction professionals will leave the field (Fahy, 2007). This would have a huge negative impact on addiction clients who need help. Most troubling is the fact that without bringing to light the impact of compassion fatigue, addiction professionals could continue to suffer in silence with symptoms of compassion fatigue that negatively impacts them personally and professionally.

Purpose of the Study

The purpose of this study is to gain an in-depth understanding of addiction professionals' experience with compassion fatigue and self-care, which will also shed light on their current training practices. There is little research on this topic specific to addiction professionals, making this research even more significant.

Objectives. The objectives for this study include:

1. Learning about addiction professionals' experiences with compassion fatigue and associated symptomology.

2. Understanding how training influences the prevalence of compassion fatigue among addiction professionals.

3. Understanding addiction professional's self-care strategies and their role in relation to compassion fatigue.

Research questions. The research questions guiding this inquiry are:

1. What are the experiences addiction professionals have with compassion fatigue?

2. What role does training play in relation to compassion fatigue?

3. What self-care strategies are being used currently by addiction professionals to address compassion fatigue?

Study Assumptions

The study assumptions are as follows:

1. Addiction professionals will acknowledge seeing a high co-occurrence of addiction and trauma clientele, as well as, report hearing traumatic stories on a frequent basis.

2. It is likely that addiction professionals will have experienced compassion fatigue during their career.

3. Addiction professionals will experience comparatively low workplace support, high caseloads, staff shortages, and low salary.

4. There will be inconsistency among the addiction professionals regarding how they were trained to treat addiction and trauma.

5. There may be a lack of education and training regarding compassion fatigue and self-care among the addiction professionals.

6. Addiction professionals will be able to provide helpful self-care strategies that may benefit other addiction professional.

Conceptual Framework

The conceptual framework for this study is based primarily on Bertalanffy's Systems Theory. The relationship between an addiction professional and client is a system. A system is defined as, "an interacting set of units, parts, or persons that together make up a whole" (Gladding, 2011, p. 4). Systems theory is based on the idea of wholeness (Bertalanffy, 1950). Further, from a systems theory perspective, a system is greater than the sum of its parts and it can only be as strong as its weakest part (Gladding, 2011). Systems can be open or closed (Bertalanffy, 1950). For example, a living organism would be an open system as there is continual change occurring with ongoing transferring of materials. In opposition, a closed system does not have any materials entering or exiting the system. Next, all systems are organized in a certain manner; with boundaries that are more or less penetrable based on the organizational structure (Gladding, 2011). Finally, all systems work to regulate themselves, strive for homeostasis and balance (Gladding, 2011).

The relationship between an addiction professional and client rests on the notion of circular causality as opposed to linear causality (Weinberg, 2012). Linear causality is the idea

that everything is moving in one direction with each action causing the next action, A----→B----→C (Weinberg, 2012). Circular causality is, "the idea that actions are part of a causal chain, each influencing and being influenced by each other" (Gladding, 2011, p. 428). Circular causality implies A←------→B←------→C (Weinberg, 2012).

A therapeutic system is a system whereby the counselor and client both influence one another with the transfer of materials; therefore it is often circular in nature (Weinberg, 2012). This system strives for homeostasis and requires a counselor to be empathic, warm, and genuine. While these are necessary ingredients in fostering a strong therapeutic alliance, they are also the very same qualities that provide a pathway for the transfer of traumatic stress from the client to the therapist (Cramer, 2002; Figley, 2002). The transfer of traumatic stress onto the counselor can increase the counselor's risk of developing compassion fatigue symptoms (Cramer, 2002).

For instance, the circular dynamic between an addiction professional and client can work this way: the more empathetic, warm and genuine the addiction professional is, the more likely the client will feel safe to discuss their addiction and trauma experiences; the more the client discusses their addiction and trauma; the more empathic, warm and genuine the addiction professional is. Of course, an addiction professional wants to foster a reciprocal counselor-and-client dialogue, but it ultimately comes with some risks.

Once a client feels safe to discuss their addiction and painful stories, they can do so without limitation thereby increasing a counselor's exposure to traumatic stories which only fuels compassion fatigue. Other components that may influence the system and fuel the development of compassion fatigue are poor counselor training practices, (Deighton et al., 2007) and a lack of education regarding compassion fatigue (Bride & Kintzle, 2011). In contrast, using self-care strategies has been shown to be a protective factor against compassion fatigue (Cummins et al.,

2007; Figley, 2002). In addition to these external factors increasing the risk of developing compassion fatigue, there are individual factors that can increase one's risk of developing compassion fatigue. For instance, having a personal history of trauma and high levels of distress can contribute to the development of compassion fatigue (Deighton et al., 2007). Although there are personal risk factors that increase one's risk for developing compassion fatigue they will not be focused on in this study.

Once compassion fatigue develops, the results create disharmony in the addiction professional/client system. That will result in some serious consequences. For example, addiction professionals may begin to avoid discussing painful and traumatic topics with their clients, or even worse begin to avoid-clients all-together (Perkins & Sprang, 2013). In addition, the addiction professional may not be able to convey the appropriate amount of empathy, warmth, and genuineness; at that point, the addiction professional has become emotionally depleted. The addiction professional may also lose objectivity with their clients, dread going to work, develop anxiety, and more (Lombardo & Eyre, 2011). All of this amounts to a disservice to the addiction professional, client, and the profession.

Figure 1 depicts the therapeutic relationship of the client and addiction professional. The lines going between the client and addiction professional represent the circular transfer of material. The addiction professional is conveying empathy toward the client as the client is discussing their traumatic experiences. The more empathy that is conveyed, the more likely the client is to discuss their traumatic experiences. Furthermore, as the client continues to discuss their traumatic experiences, this increases the addiction professional's exposure to trauma, thereby increasing their risk of developing compassion fatigue.

Therapeutic System
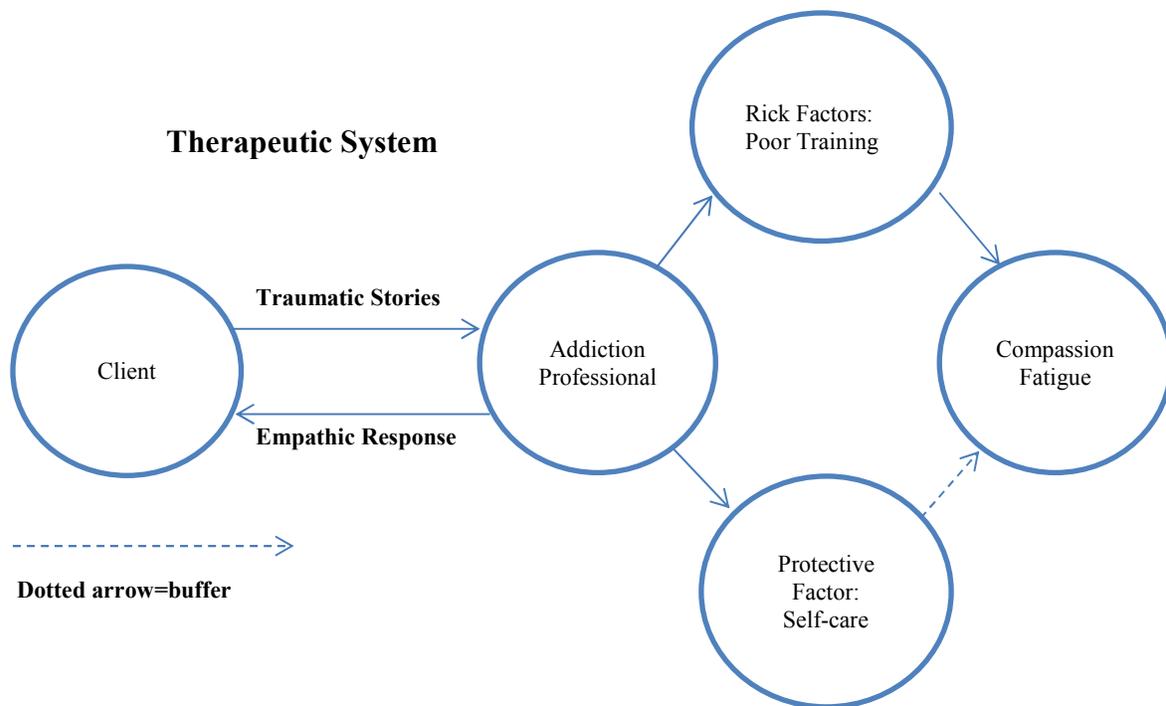
Figure 1: **Therapeutic system and factors impacting compassion fatigue.**

There are risk factors and protective factors of compassion fatigue. One of the risk factors for developing compassion fatigue is poor counselor training which is represented by the solid arrow pointing toward the compassion fatigue symbol. On the other hand, there are protective factors for developing compassion fatigue. One of the protective factors for the development of compassion fatigue is using self-care strategies. This is represented by the dotted line which shows a buffer going from the addiction professional to the compassion fatigue symbol.

Definition of Major Terms

Addiction/Substance abuse. Per the American Society of Addiction Medicine, addiction is defined as, "… a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social

and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors" (ASAM, 2014, p. 1).

Addiction professional. "An addiction professional is a person who possesses and utilizes a unique knowledge and skill base to assist substance abusers (persons affected by problems related to addictions) and the public for whom the prevention of addiction is a primary concern" (Florida Certification Board [FCB], 2014, p.1). For the purposes of this study an addiction professional will be operationally defined as a person who is a Licensed Mental Health Counselor (LMHC) and/or Certified Addiction Professional (CAP) and who has been practicing in the field of addiction for at least one year.

Burnout. Burnout is defined as, "a psychological syndrome that develops in response to chronic emotional and interpersonal stress" (Thompson et al., 2014, p. 58). It involves three tenets of emotional exhaustion, depersonalization, and feelings of ineffectiveness (Thompson et al., 2014).

Compassion fatigue. Compassion fatigue is defined as, "a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress" (Lombardo & Eyre, 2011, para 1). Compassion fatigue and burnout are similar in that they are responses to stressful interpersonal reactions (Thompson et al., 2014). They differ, however, in that compassion fatigue is a response to working specifically with traumatized clients, while burnout is a response the stressors of helping clients as well as organizational stress (Thompson et al., 2014). Compassion fatigue can have a sudden onset which is in contrast to burnout, which develops over time (Thompson et al., 2014).

Co-occurring disorder. Co-occurring disorders are defined as individuals having, "at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may

interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other" (SAMHSA, 2002, p. 1)

Secondary Traumatic Stress (STS). Secondary traumatic stress was the term originally used to describe compassion fatigue symptomology (Figley, 1995). Secondary traumatic stress and compassion fatigue are used interchangeably throughout the literature (Figley, 1995; Bride & Walls, 2006). Figley (1995) stated, "compassion fatigue is identical to secondary traumatic stress disorder (STSD) and is the equivalent to PTSD" (p. xv).

Self-care/wellness. Involves taking care of oneself physically, emotionally, mentally, and spiritually by engaging in activities that promote overall wellbeing. This is especially important when caring for others (American Holistic Nurses Association, 2014).

Trauma. Trauma is defined as, "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 1).

Scope and Delimitation of the Study

Participants in this study will be limited to licensed mental health counselors and certified addiction professionals who have been practicing in the field of addiction for at least three years and who currently work at an agency that treats addiction. These professionals counsel clients who struggle with addiction. Licensed mental health counselors, specifically those experienced in treating addiction, in contrast to licensed clinical social workers, have received little attention in the professional literature regarding their exposure to and the effects of compassion fatigue; which is why they were chosen as participants.

Chapter Summary and Overview

Chapter 1 provided the background of the problem, statement of the problem, and the significance of the study. Then, the purpose of the study, objectives, and research questions were discussed. Next, the conceptual framework was presented. Chapter 1 ended with a definition of major terms as well as the scope and delimitation of the study.

Chapter 2 will reintroduce the topic, discuss an overview of addiction and the addiction professional, and provide a historical background on compassion fatigue. A review and critical evaluation of the literature will then follow. The chapter will end with a discussion on self-care/wellness. In Chapter 3, the topic will be reintroduced and the research questions along with the research design will be presented. Then, a description of the participants, sampling procedures, and instruments will follow.

Thereafter, data collection procedures, a description of the researcher, and the procedures used to increase the trustworthiness of the findings will be discussed. Finally, the data collection procedures will be explained.

Chapter 4 will begin by describing the process used to analyze the data. It will then present the participants' demographic characteristics, followed by presenting the emergent themes that address the participant's experience with compassion fatigue, training, and self-care strategies. The results were intended to address the questions guiding the inquiry. Chapter 5 will further discuss the results of this study. This chapter will discuss the participants' demographic characteristics as well as the types of clients the participants treat. The emergent themes of the study will be discussed at length in terms of risk factors and protective factors. Then, the benefits that the addiction professionals experience when working with their addiction clientele will be shared. This chapter will conclude by presenting the implications of this

research for counselor educators, as well as, limitations of this research, and recommendations for future research.

Chapter 2: Literature Review

Chapter 2 will reintroduce the topic, discuss an overview of addiction and the addiction professional, and provide a historical background on compassion fatigue. A review and critical evaluation of the literature will then follow. The chapter will end with a discussion on self-care/wellness.

Reintroduction to the Topic

Individuals' struggling with addiction is escalating, which then causes an increased need for addiction professionals. Unfortunately, the demand for addiction professionals far outweighs the supply (Duraisingam et al., 2009). The lack of addiction professionals is at the crisis level (SAMHSA, 2013). Multiple factors have contributed to the crisis, including: poor compensation, stigma, workplace stress, an aging workforce, and possibly compassion fatigue (SAMHSA, 2013). Treating individuals struggling with addiction is complex and comes with unique stressors. One of the unique stressors is it often co-occurs with trauma. Addiction alone has very serious symptomology, but coupled with trauma, it makes for a more difficult disorder to treat (Fahy, 2007). Because of the co-occurrence of addiction and trauma, addiction professionals are at a greater risk for developing compassion fatigue.

We do know that a mitigating factor to developing compassion fatigue is self-care. As a result, how self-care is taught, and used by treating professionals has become very important. Along those same lines, providing uniformity in training for these addiction professionals has become equally important.

Addiction

Alcohol and drug addiction is a national problem and they are devastating illnesses (Anton, 2010). Not only do they impact the person addicted, but a variety of other systems like family, mental health, criminal justice, welfare systems and more (Hsr, Longshore & Anglin, 2007). Some individuals can experiment with alcohol and/or drugs with it never becoming an issue, but for others they become dependent on the substance (Hsr et al., 2007). For an individual to be clinically diagnosed with alcohol/drug addiction a certain criteria must be met. For example, according to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V) (2013), the criterion for alcohol use disorder is as follows:

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a twelve month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:

    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

    b. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal. (American Psychiatric Association, 2013, p. 490-491)

The number of symptoms an individual has determines the severity of their condition. For example, the presence of the two to three symptoms indicates a mild condition; and four to five symptoms indicate a moderate condition, whereas six or more symptoms indicate a severe condition (American Psychiatric Association, 2013). The criterion for drug addiction is very similar to alcohol addiction, but varies slightly according to the drug.

The reality is alcohol and drug addiction is chronic, progressive and fatal. Left untreated, individuals often find themselves in jails, institutions and in many cases, death. While alcohol and drug addiction are serious disorders, there is treatment available. The treatment is multifaceted, and includes the client working with a trained addiction professional.

Addiction Professional

This study will explore addiction professionals who have the credentials of Licensed Mental Health Counselor (LMHC) and/or Certified Addiction Professional (CAP). The requirements to become a LMHC in the state of Florida are: Master's degree from an accredited mental health counseling program which includes at least three credit hours specific to substance

abuse, 1,000 university sponsored field work hours, two years post-masters supervised experience, pass the national clinical mental health counseling examination, and complete an eight hour laws and rules course, two hour medical error prevention course, three hours HIV/AIDS course, and a two hour domestic violence course (Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, 2014).

The requirements to become an addiction professional in the state of Florida are: Bachelor's degree, 6,000 hours of direct addictions field experience, 300 hours of supervision or master's degree, 4,000 hours of direct addictions field experience, 200 hours of supervision, 350 hours of specified training, three professional letters of recommendation, pass the Florida Specific Exam, and sign the code of ethics statement (FCB, 2014).

As indicated above, when treating those addicted to drugs and/or alcohol, the treatment is multifaceted, and therefore the role of an addiction professional is also multifaceted. Addiction professionals are trained to provide substance abuse assessments, provide professional counseling, help clients engage in the counseling process, provide counseling to the substance abuser's family members as needed, and refer out when deemed necessary (FCB, 2014).

As mentioned earlier, addiction professionals face their share of challenges that set them apart from other counselors. Addiction professionals work with challenging clients on a daily basis (Jones & Williams, 2007). Often, a client struggling with an addiction may also be struggling with other mental health issues, as well as, financial, legal, housing, medical, and family issues (Jones & Williams, 2007). Therefore, an addiction professional is not only treating the addiction, but is also assisting with the ancillary issues the client is facing. Further, an addiction professional may be employed in an agency setting that lacks resources which is not uncommon in the addictions field. With the high demand for services and a low budget, the

addiction professional is impacted by having high caseloads, low salary, and low levels of work-place support (Jones & Williams, 2007).

Another issue addiction professional's face is the variability of training and unclear career path (Jones & Williams, 2007). Some agencies require addiction professionals to possess certain credentials and degrees, while others only require the individual to have field experience treating addiction. This variability leads to frustration among addiction professionals because it isn't clear the proper steps they need to take to further themselves within their profession (Jones & Williams, 2007). To address this issue, "standardized positions and uniform requirements would help those working in the profession understand what steps are necessary to attain specific positions. With clearer guidance, more addiction professionals may be motivated to seek additional education and training" (Jones & Williams, 2007, p. 10).

To further compound the issue of variability in training, it is not uncommon for addiction professionals to enter the field through their own personal experiences with addiction. In fact, a national study conducted in 1999 surveyed addiction professionals in 400 treatment programs, and found 60% were in recovery themselves (Jones & Williams, 2007). There are several benefits of an addiction professional being in recovery such as the increased ability to relate to the client, insight, and empathy, but there are risks too (Jones & Williams, 2007). The recovering addiction professional is at risk for relapse and must be extra vigilant about their personal recovery and not use their career as their recovery program (Jones & Williams, 2007).

The challenges discussed above illustrate the empathic demand addiction professional's face. Not only do they deal with a multitude of client issues, but they consistently deal with client relapse as well as client death. All of these components place addiction professionals at an increased risk for burnout and compassion fatigue (Jones & Williams, 2007).

It is important to note that, to date, much of the literature regarding the stressors of working in the addictions field has been termed "burnout." This term started being used in the literature around 1978 and, almost immediately it was adopted by addiction professionals (Fahy, 2007). Burnout has been defined as, "a psychological syndrome that develops in response to chronic emotional and interpersonal stress" (Thompson et al., 2014, p. 58).

In an article by Fahy (2007), she described personal accounts of her struggles with burnout while she was treating individuals struggling with addiction. Fahy (2007) outlined how in the 90's she and her colleagues recognized addiction clients were becoming more difficult to treat and how these clients were entering treatment with more drug and alcohol combinations than ever before. This combination further complicates the disorder.

One of the popular ways to treat addiction was the 12 step philosophy, however, at that time, more and more clients were rejecting that type of treatment (Fahy, 2007). She described how she was becoming hardened to the realities of the profession. She went further, stating she would see clients repeatedly coming in and out of treatment, and also seeing client's die from addiction. Through all of that, she had become numb (Fahy, 2007).

What Fahy (2007) described in the 90's, a pattern of working hard and coming home exhausted was summed up as burnout. As a result of this "burnout", counselors were trying to find ways to escape their reality, and in doing so, began abusing substances, and developing depression. As this went on, many addiction professionals left the field and the others who continued "became more and more rigid with the unmet expectations of our work" (Fahy, 2007, p. 201).

While similar, burnout does differ from compassion fatigue. Specifically, burnout is more of a gradual, progressive process whereas compassion fatigue has a rapid onset (Newell &

MacNeil, 2010). The term burnout is considered a broad term, and over time, began to carry a negative connotation. It was thought that if you identified yourself as burnt-out then you couldn't recover professionally (Fahy, 2007). In contrast, compassion fatigue, which is a newer term coined by Charles Figley, is a solution-focused concept that places high value on professionals having discussions with one another about the stressors of the helping profession (Fahy, 2007). Furthermore, the concept of compassion fatigue supports the idea that social service workers can get help for compassion fatigue and continue to have healthy and successful careers in the helping field.

In addition to Fahy (2007) recounting her personal experience with burnout, she also recounted her personal experience with compassion fatigue. That was triggered when she learned about the childhood abuse one of her addiction clients had suffered. Fahy (2007) described how she woke up every night for one week with a vivid picture of what the client had described. These vivid images caused her agitation and created a sense of fear for her own family. At that time, Fahy (2007) didn't understand what affects her client's story had on her until much later when she learned about the construct of compassion fatigue. After being educated about compassion fatigue, Fahy (2007) recognized the true impact of hearing her client's traumatic stories and then sharing in that pain with her client.

Fahy's (2007) description of both burnout and compassion fatigue, very clearly illustrate the unique stressors addiction professionals face. For instance, addiction professionals are often referred to as professionals who work on the front lines (Fahy, 2007). This means that they are working directly with their clients while at the same time having huge caseloads with chronic clients. Not only do they have mountains of work, with difficult issues, but they are doing this work under poor supervision, and with inadequate working conditions. Moreover, there is an

unfortunate culture in the field of addiction whereby advancements in treatment and research is neglected, and that leaves treating professionals to use dated policies and organizational procedures (Fahy, 2007). All of these conditions increase the risk of compassion fatigue and contribute to the poor retention of addiction professionals in the field.

Addiction and Trauma

Trauma has been defined as, "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 1). Some examples of trauma include: physical abuse, sexual abuse, emotional abuse, neglect, combat, natural disaster, grief, domestic violence and more (NCTSN, n.d.).

Individuals who experience trauma may or may not go on to develop full blown PTSD. However, among individuals seeking treatment for addiction, it is estimated that 60%-90% have had exposure to some form of trauma (Fahy, 2007). Even more severe, it is estimated that these individuals are four to 10 times more likely to meet the criteria for PTSD (Fahy, 2007). In fact, it is estimated that 21.6%-43.0% of individuals suffer from a substance abuse disorder concurrently with PTSD (Fahy, 2007). Whether individuals develop full blown PTSD or not, the reality is they are a vulnerable population and often have poorer treatment outcomes (Benton, Deering & Adamson, 2012). In fact, the combination of trauma/PTSD and addiction, "is marked by a more severe clinical profile and significantly greater impairment on a wide range of variables, including interpersonal and medical problems as well as motivation for treatment and treatment adherence" (Benton, et al., 2012, p. 30).

Fahy (2007) discussed being posed with the question about the co-occurrence of trauma and addiction and its impact on her personally and professionally. Specifically, she recalled being asked about how many of her substance abuse clients had trauma. Her response was simply: "…try all of 'em." (Fahy, 2007, p. 202). Fahy (2007) reported working with substance abuse clientele coupled with trauma was exhausting; exhausting to the point it was impacting her ability to go home and be present with her children. At that time, Fahy (2007) disclosed she didn't fully understanding what compassion fatigue was, but knew that she had symptoms of it.

It is reported that clients who struggle with addiction, and also have a history of trauma, tend to have a fragile treatment relationship, and can be difficult clients (Benton et al., 2012). This also tends to cause negative emotional reactions by counselors (Benton et al., 2012). Furthermore, Cramer (2002) previously reported clients with co-occurring trauma and addiction are often slower to complete treatment, are hospitalized more frequently, and experience more setbacks in both disorders. Moreover, during addiction treatment, PTSD symptoms often become exacerbated, especially at the beginning of treatment (Benton et al., 2012). Additionally, "substance abuse can mimic, mask or exacerbate psychiatric problems" (Cramer, 2002, p. 196). Because of the intensity of this clinical profile, a strong therapeutic alliance becomes necessary (Cramer, 2002). A strong therapeutic alliance requires a counselor to convey empathy, warmth, and genuineness. These qualities help counselors see the world from their client's perspective (Figley, 2002). While these qualities are critical and necessary, they are the very qualities that provide the pathway for the transfer of traumatic stress from the client to the therapist (Cramer, 2002; Figley, 2002).

Unfortunately, many addiction professionals who are trained to treat addiction are not, at the same time, trained to assess and treat trauma. This puts these addiction professionals at a

disadvantage because of the high rates of co-occurrence of the two disorders and the severe clinical profile they create. As a result, these addiction professionals are more prone to compassion fatigue.

Compassion Fatigue

Charles R. Figley began studying people who had suffered trauma in the 1970's, primarily Vietnam War veterans (Figley, 2002). He later expanded his trauma work to a variety of populations. Through his research he realized that not only were those who directly experienced trauma exhibiting negative symptomology, but so were their family members. He started to discover the contagion effect of trauma. Then, in the 1980's, Figley identified a theme occurring where several of his colleagues were leaving the counseling field due to "the toxicity of the work" (Figley, 2005, p. 1). He began to understand what he was witnessing was not burnout, but rather, what is now known as compassion fatigue.

While Figley was conducting his trauma research, a major accomplishment was occurring in the counseling field which was the development of the Diagnostic Statistical Manual of Mental Disorders (DSM) (Figley, 2002). It was published in 1980 and included the diagnosis of PTSD. The diagnosis not only included individuals directly exposed to trauma, but it also included people who were indirectly exposed to trauma. This included family members, close friends as well as the professionals involved in helping those who suffered trauma (Figley, 2002). Between Figley's extensive trauma research, and the development of the DSM that included criteria for those indirectly exposed to trauma, the concept of compassion fatigue was crystalized.

Compassion fatigue is defined as, "a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress"

(Lombardo & Eyre, 2011, para 1). Compassion fatigue can impact people in a variety of careers such as, first responders, chaplains, nurses, counselors, psychiatrists, emergency room personnel and more which all have the common thread of addressing trauma (Lombardo & Eyre, 2011). It is now clear that one's indirect exposure to trauma can cause emotional, behavioral, and cognitive changes in counselors who treat individuals who are experiencing traumatic situations (Craig & Sprang, 2010). When looking specifically at the counseling profession, counselors work with clients who are suffering enormous pain and the work is intense, and it is done every day (Cummins et al., 2007). This process requires the counselor to "consistently summon the energy to engage with another human's emotions" (Cummins et al., 2007, p. 1).

It is well established that a person's risk of developing compassion fatigue increases the more they are on the front lines treating trauma (Craig & Sprang, 2010). From that vantage point, compassion fatigue can have a rapid onset of symptoms, coupled with a sense of confusion and helplessness (Figley, 2002). Compassion fatigue symptomology also falls on a continuum ranging from mild symptoms to more severe symptomology of PTSD (Bride & Walls, 2006). Compassion fatigue has also been associated with experiences of feeling disconnected from peers and support systems (Figley, 2002).

Figley (2002) stated, "The very act of being compassionate and empathic extracts a cost under most circumstances" (p. 1434). The cost of compassion fatigue has been shown to include cognitive, work-related, physical, spiritual, and emotional symptoms. These work related symptoms include avoiding working with certain clients, the reduction in the ability to feel empathic toward clients, increased use of sick days, and an overall dread of going to work (Lombardo & Eyre, 2011). A person suffering from compassion fatigue may also develop physical symptoms including headaches, tension, fatigue, digestive issues, and sleep problems

(Lombardo & Eyre, 2011). That same compassion fatigued person also tends to suffer from emotional symptoms including anxiety, depression, mood swings, impaired concentration, irritability, restlessness, objectivity impairment, and anger (Lombardo & Eyre, 2011).

From his research, Figley (2002) identified eleven variables that help predict compassion fatigue. The variables are: empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, trauma recollections, life disruptions (Figley, 2002).

There are certain identifiable factors that have been shown to put a person at a greater risk of developing compassion fatigue. These risk factors include: age, gender, specifically, being a female, increased exposure to clients with trauma, occupational stress, personal history with trauma, length of time involved in trauma counseling, high caseload, social isolation, being overly optimistic or cynical, lack of self-awareness, and being in recovery (Craig & Sprang, 2010; Killian, 2008; Perkins & Sprang, 2013).

Not only have risk factors been identified, but research has also identified protective factors. Those protective factors include: good supervision, training, a perception of the ability to cope, clinical experience, self-care strategies, and having a support system (Craig & Sprang, 2010). Having a proper understanding of and being properly trained to identify these risk factors are a very important step for a counselor to take to help mitigate compassion fatigue. Equally as important to a counselor is to surround themselves in a work environment that acknowledges and protects counselors from compassion fatigue, but also encourages counselors to be proactive in their own personal lives and training to combat compassion fatigue (Bride & Kintzle, 2011).

One of the few qualitative studies done exploring compassion fatigue among counselors was conducted by Killian (2008). Although the study was not done specifically with addiction

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professionals, it highlights some of issues related to compassion fatigue among therapists working specifically with trauma survivors. The participants included 20 therapists who worked with survivors of childhood sexual abuse (Killian, 2008). All twenty therapists indicated they identified their stress through their bodily symptoms. They experienced muscle tension, headaches and lack of energy. One female therapist stated, "I get physically, emotionally, and mentally exhausted, and I also become emotionally shutdown and I am not as emotionally responsive to people" (Killian, 2008, p. 35). When discussing compassion fatigue symptoms, one female therapist described how she would lose track of time to the point she would forget what day of the week it was. She also reported being overwhelmed at work to the point of becoming disconnected from her own environment (Killian, 2008). Other symptoms of compassion fatigue experienced by the therapists included sleep disturbances, intrusive thoughts, along with anxiety, agitation, and panic (Killian, 2008).

There are only three studies to date that have examined compassion fatigue specifically among substance abuse counselors (Bride et al., 2009; Bride & Kitzle, 2011; Perkins & Sprang, 2013). First, Bride et al. (2009) were interested in exploring the prevalence of secondary traumatic stress among substance abuse counselors. The researchers were also interested in exploring trauma training practices among these professionals, but that portion of the study will be discussed in the next section of this paper.

The researchers ultimately surveyed a total of 242 members of the National Association of Alcohol and Drug Addiction Counselors. Unfortunately, while 1,000 members were sent the survey, there was only a 24% return rate (Bride et al., 2009). To assess the prevalence of secondary traumatic stress, the participants were given the Secondary Traumatic Stress Scale (STSS).

The Secondary Traumatic Stress Scale (STSS) is a 17 item self-report scale that encompasses three subscales: intrusion, avoidance, and arousal. The three subscales mirror the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV-TR) criteria for PTSD diagnosis (Bride et al., 2009). This scale has demonstrated convergent, discriminant, and factor validity along with internal validity (Bride et al., 2009).

The results of the STSS revealed that 56% of counselors met at least one diagnostic criteria, 28% met two diagnostic criteria, and 19% met all three of the core diagnostic criteria (intrusion, avoidance, arousal) for PTSD (Bride et al., 2009). More specifically, of the intrusion symptoms, substance abuse counselors most frequently reported (43%) they thought about their work with trauma clients without meaning to. Of the avoidance symptoms, 27% endorsed detachment from others, 30% endorsed emotionally numbing, and 36% of the substance abuse counselors indicated that they have avoided these types of clients (Bride et al., 2009). Of the arousal symptoms, sleep disturbances (26%) and irritability (30%) were indicated the most. This study revealed the rate of PTSD among substance abuse counselors who are indirectly exposed to trauma is high (Bride et al., 2009).

Next, Bride & Kitzle (2011) explored the relationship between secondary traumatic stress, job satisfaction, and turnover among substance abuse counselors. Although there is a high turnover rate among substance abuse counselors, little research has been done exploring the relationship between secondary traumatic stress and turnover (Bride & Kitzle, 2011). There were 216 substance abuse counselors that participated in the study.

Participants were administered the Secondary Traumatic Stress Scale (STSS) and the Professional Quality of Life Scale (ProQOL). The results found that 56% of the participants met at least one of the core diagnostic criteria for PTSD (Bride & Kitzle, 2011). Furthermore, the

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results showed that the substance abuse counselors who scored high on the STSS, reported lower job satisfaction and occupational commitment (Bride & Kitzle, 2011). In addition, job satisfaction, "fully mediated the relationships effects of STS on occupational commitment" (Bride & Kitzle, 2011, p. 25).

Finally, in a study by Perkins & Sprang (2013), they examined compassion fatigue, burnout, and compassion satisfaction among substance abuse counselors working with offenders. The participants consisted of twenty substance abuse counselors and they were administered the Professional Quality of Life Scale-IV (ProQOL, IV), The General Empathy Scale, and participated in a qualitative interview (Perkins & Sprang, 2013). Nine of the substance abuse counselors scored high on the compassion fatigue subscale on the ProQOL-IV. Of those nine participants, two themes emerged from the qualitative interview: the participants found working with women challenging and having a family member with an addiction or being in recovery themselves increased their risk of compassion fatigue (Perkins & Sprang, 2013). Almost half of the participants scored high on the compassion fatigue subscale indicating compassion fatigue is certainly present among this population.

The next section will present the literature found that explores training practices in the areas of addiction, trauma, and compassion fatigue and self-care.

Training

Addiction training. Research suggests, "current training and education of helping professionals in the addictions may be inadequate" (Morgan, Toloczko, & Comly 1997, p. 1). As mentioned earlier, not only is there variability regarding how addiction professionals enter the field, there is variability within each path too. For instance, research has shown that

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prerequisites, course curriculum, and teacher qualifications are variable within addiction training programs (Morgan et al., 1997).

Because of this variability, the Council for Accreditation of Counseling and other Related Educational Programs (CACREP) was interested in exploring addiction training in counselor education programs. Morgan et al. (1997) interviewed 70 CACREP-accredited counselor education programs. The researchers conducted a brief interview with each program and asked them to provide a syllabus for each addiction course offered. There were 57 programs that provided their addiction course syllabi (Morgan et al., 1997).

Results showed that 21 of the programs required courses in substance abuse. Of those programs, 19 required one substance abuse course; one required two courses and one program required three substance abuse courses in their program (Morgan et al., 1997). Participants were also asked whether they thought it was necessary for counselors to receive training in substance abuse treatment. Results showed that 52% thought it was very necessary; 27% moderately necessary; 18% somewhat necessary; and 3% probably unnecessary (Morgan et al., 1997).

This study provides a glimpse of the variability in training among CACREP- accredited counselor education programs as well as program's perspective on the need for offering substance abuse training for counselors.

Trauma training. It is clear how important it is for addiction professionals to become properly educated to recognize the risk factors associated with compassion fatigue. This educational process must start early in a career, as research has shown even practicum students are at risk for developing compassion fatigue (Knight, 2010). Knight (2010) was interested in studying the prevalence of secondary traumatic stress (STS), vicarious traumatization (VT) and compassion fatigue (CF) among social work practicum students and field supervisors.

Specifically, the researcher wanted to learn about the role the educational and supervisory relationship plays in helping or hindering the effects of indirect trauma (Knight, 2010).

The study consisted of 81 undergraduate students who were enrolled in their field practicum placement and 72 field supervisors. A total of three instruments were used: Professional Quality of Life Scale (ProQOL), Trauma and Attachment Belief Scale (TABS), and a questionnaire focused on background details and demographic information (Knight, 2010).

In total, 51.8% of the students completed the research surveys and 70.8% of the field supervisors completed the research surveys. Results revealed 40 students and 50 field supervisors experienced some negative reactions in working with their clients (Knight, 2010). The study also revealed students showed more signs of indirect trauma as compared to the field supervisors. The students' scores were also higher than trauma therapists from previous studies (Knight, 2010). Going further, the results showed white, female students exhibited more signs of VT and CF. Both students with limited experience and field supervisors with limited experience showed more signs of VT (Knight, 2010). These findings clearly highlight the risk of VT and CF facing practicum students very early on in their careers.

The results did not reveal a relationship between a client's history of trauma and indirect trauma among the students or field supervisors (Knight, 2010). In addition, no relationship was found between difficult to engage clients and CF and STS among students or field supervisors (Knight, 2010). There was a relationship, however, between working with mandated clients and expressing signs of VT among the students as well as a relationship between working with aggressive clients and increased risk of CF among students (Knight, 2010).

Finally, students who felt underprepared by their education exhibited more signs of VT and CF (Knight, 2010). That was consistent with the field supervisors, who also exhibited more

signs of VT when they reported feeling underprepared by their education. Overall, these findings showed the majority of participants felt their educations underprepared them for the negative reactions they may experience during their careers (Knight, 2010).

As mentioned in the previous section of this paper, Bride et al. (2009) were not only interested in exploring the prevalence of secondary traumatic stress among substance abuse counselors, but they were also interested in trauma training practices among these professionals. Bride et al. (2009) discussed the high rates of co-occurrence between substance abuse and PTSD/trauma, but hypothesized that PTSD/trauma were not being assessed, diagnosed, or treated in most substance abuse treatment facilities. Regardless of whether PTSD/trauma was being specifically addressed in substance abuse treatment facilities, it was clear that addiction professionals were treating substance abuse clients who had suffered trauma (Bride et al., 2009).

There were 242 members of the National Association of Alcohol and Drug Addiction Counselors surveyed and they were given thirteen specific questions designed to assess the trauma portion of the study (Bride et al., 2009). The thirteen questions were developed to explore counselor's trauma assessment and treatment strategies along with their referral practices (Bride et al., 2009). Specifically, the questions were designed to explore how often counselors assess trauma/PTSD; how often counselors incorporated trauma issues onto their client's treatment plan; and how many of their clients they referred for trauma-specific services, while continuing substance abuse counseling or discontinuing substance abuse counseling (Bride et al., 2009).

Within the responding counselors, it was estimated that more than half of their substance abuse clients had experienced some form of trauma (Bride et al. 2009). Although there were high estimates of co-occurring substance abuse and trauma symptomology, sadly the results

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demonstrated these substance abuse counselors were not adequately trained to treat such. In fact, only 39% of the substance abuse counselors received any academic training for treating trauma and only 19% completed an internship specific to the treatment of trauma (Bride et al., 2009). While these numbers are disheartening, the good news is it appears substance abuse counselors are recognizing this deficit and are voluntarily seeking out additional training after graduation (Bride et al., 2009). Results showed 82% of the substance abuse counselors engaged in continuing education training for specific trauma treatment (Bride et al., 2009).

Despite an overwhelming lack of education and training, "approximately half of counselors reported that they address trauma or traumatic stress on clients' treatment plans or in individual counseling" (Bride et al., 2009, p. 102). While it is encouraging that some counselors recognize the importance of treating trauma, the testing also reveals that the other half of counselors are not addressing trauma.

These findings clearly indicate the need to improve training practices for professionals when they are the treating within the substance abuse population that also have experienced trauma. Unfortunately, the lack of training becomes a disservice to clients, but it also harms the counselors because of their increased risks for developing compassion fatigue (Deighton et al., 2007).

In a study by Sprang, Clark, & Whitt-Woosley (2007), the researchers were interested in compassion fatigue, compassion satisfaction, burnout among 1, 121 mental health practitioners in a rural setting in the south. The researchers were also interested in how the participant's trauma training practices influenced compassion fatigue. Trauma training practices were measured by asking participants to self-identify if they had specialized training in treating trauma. With the goal of controlling for overconfidence bias, the researchers compared the

participant's responses to the guidelines of using empirically-based methods (Sprang et al. 2007).

Results showed that specialized trauma training reduced the level of compassion fatigue and

increased the levels of compassion satisfaction (Sprang et al., 2007). This suggests that,

"knowledge and training might provide some protection against the deleterious effects of trauma

exposure" (Sprang et al., 2007, p. 272).

In a similar study, researchers were interested in examining compassion fatigue, burnout,

and compassion satisfaction among workers employed at four Italian community-based mental

health facilities (Rossi et al., 2012). A total of 260 individuals completed the ProQOL, the

General Health Questionnaire, and a socio-demographic questionnaire. The study consisted of

the following occupations: psychiatrist, psychologist, social worker, rehabilitation therapist,

psychiatrists in training, and healthcare support workers (Rossi et al., 2012). The research

questions included whether having traumatic life events would increase the risk of compassion

fatigue and burnout and whether training was a barrier in developing compassion fatigue and

burnout (Rossi et al., 2012). Results showed psychiatrists (16%) and social workers (24%)

experienced the highest levels of compassion fatigue. In addition, individuals who experienced a

negative life event within the past 12 months reported higher compassion fatigue scores than

those did not experience such events (Rossi et al., 2012).

The hypothesis that training would be a barrier in developing compassion fatigue and

burnout was not supported. However, the hypothesis may not have been supported possibly,

because of a methodological issue as to how the questions were worded. Specifically,

researchers broadly asked if staff members attended "any" training events. Such a question is not

specific enough to truly target the intended research question. This is an example of why

research needs to be more focused in order to obtain helpful information regarding the actual impact training has on compassion fatigue.

Evidenced-based practices and compassion fatigue. Craig and Sprang (2010) conducted a study exploring the impact of utilizing evidenced-based practices on compassion fatigue, burnout, and compassion satisfaction. Using the 2003 National Association of Social Workers and the American Psychological Association roster, 2000 practitioners who self-identified as having trauma specialty were sent the survey for this study. Of the 2000, 532 trauma specialists responded. Of that sample, 47% had master's level training and 52% had doctoral level training. The sample was also 34% males and 65% females ranging in age from 27 to 83 years (Craig & Sprang, 2010). Reportedly, 98% of the participants indicated they had clients within their caseloads suffering from PTSD (Craig & Sprang, 2010).

The 30-item Professional Quality of Life Inventory III (ProQOL-III) was used to measure rates of compassion fatigue, burnout, and compassion satisfaction (Craig & Sprang, 2010). The 19-item Trauma Practices Questionnaire (TPQ) (Craig & Sprang, 2010) was used to examine evidenced and non-evidenced based practices. This questionnaire evaluates six evidenced-based approaches including EMDR, cognitive therapy, behavioral therapy, psychodynamic therapy, eclectic therapy, and solution-focused therapy (Craig & Sprang, 2010).

Because evidenced-based practices have manualized treatment and interventions (Craig & Sprang, 2010), it makes using this approach user-friendly and easy to follow. In addition, evidenced-based practices have undergone rigorous testing and have been shown to be efficacious with a variety of populations (Craig & Sprang, 2010). If counselors are trained in evidenced-based practices for the treatment of trauma this would likely lead to an increase in their self-efficacy within that population. It was believed that by increasing self-efficacy in

treating trauma such a practice could help to reduce the risks of developing compassion fatigue (Craig & Sprang, 2010).

The results of the study "indicated that evidence-based practices reduce burnout and compassion fatigue and increase compassion satisfaction" (Craig & Sprang, 2010, p. 334). More specifically, through the hierarchical regression employed, it was found that having an increased number of clients diagnosed with PTSD on one's caseload and not utilizing evidenced-based practices were predictors of compassion fatigue (Craig & Sprang, 2010). These findings further illustrate the need for addiction professionals to obtain specific training for the treatment of trauma to better help their addictions clients and lower their risk of developing compassion fatigue. In addition, having evidenced-based training may help the addiction professional provide a more coherent theoretical framework (Craig & Sprang, 2010). This framework would then help to lessen confusion between counselor and client about the direction of therapy and at the same time help to maintain clinical focus (Craig & Sprang, 2010). Since empathy is the primary way traumatic stress is passed onto a counselor, evidenced-based training may help regulate addiction professionals' empathic output by providing them more confidence and establishing stronger boundaries (Craig & Sprang, 2010).

Compassion fatigue and self-care education and training. To date, there is no research that explores whether addiction professionals are being taught about compassion fatigue and self-care or to what extent. Bride & Walls (2006) published an article calling attention to the need for educating addiction professionals about the risks of compassion fatigue with the goal of better preparing them for the profession. Since that article, no research has followed up exploring if addiction professionals are being taught about compassion fatigue and self-care or to what extent.

Critical Analysis

Research clearly illustrates compassion fatigue is prevalent among professionals who focus their careers on helping others (Bride et al., 2009; Craig & Sprang, 2010; Killian, 2008; Knight, 2010; Rossi et al., 2012). In fact, research is showing that social work interns are impacted by compassion fatigue at the onset of their careers (Knight, 2010). Half of the social work interns that took part in that study reported negative reactions to their clients (Knight, 2010). In one of the studies that focused on substance abuse professionals, 19% indicated they experienced PTSD symptoms of intrusion, avoidance, and arousal (Bride et al., 2009). The other study that focused on compassion fatigue among substance abuse counselors found that almost half of the participants scored high on the compassion fatigue subscale (Perkins & Sprang, 2013). Finally, social workers and psychiatrists in Italy not only corroborated those prior results, but showed even higher rates of compassion fatigue at 24% and 16% respectively.

Research is providing a better understanding about compassion fatigue, what causes it, and who is affected by it. Research is also bringing to light how much training, and in this situation, the lack of training, can impact the effects of compassion fatigue. Consider the social work interns reporting that they did not feel prepared for the negative reactions they were experiencing toward their clients (Knight, 2010). Those who felt underprepared showed more symptoms of compassion fatigue (Knight, 2010). Social work interns are not alone; substance abuse counselors previously reported feeling underprepared by their education (Bride et al., 2009). These professionals acknowledged the high co-occurring rates of addiction and trauma but only 39% reported being educated about how to treat trauma. Social workers and psychologists acknowledged the need for education and training on how to treat trauma. They identified training in evidenced-based practices for the treatment of trauma as being helpful in

reducing the risk of compassion fatigue (Bride et al., 2009). It is helpful that studies are examining trauma training practices among counselors and addiction professionals, but none have examined how addiction professionals are being trained and educated about compassion fatigue and self-care. This study will expand our understanding of training practices by asking the addiction professionals how they were educated and trained about compassion fatigue and self-care. This will hopefully provide useful information about addiction professionals training in the area of compassion fatigue and be a platform for future research.

The existing literature provides a global view as to how prevalent compassion fatigue is among a wide range of helping professionals. Since we know compassion fatigue exists on a rather large scale effecting a large population, it has now become important to gather more research on specific experiences these professionals have with compassion fatigue. Only one article has provided an in depth account of therapists personal experiences with compassion fatigue (Killian, 2008). While this one study does help expand our understanding of compassion fatigue, more qualitative studies are needed.

It is also apparent the majority of the existing literature focuses on compassion fatigue and training practices among social workers and psychologists (Craig & Sprang, 2010; Killian, 2008; Knight, 2010; Rossi et al., 2012). With such an abundance of information that is useful to help these professionals, it is important to expand our understanding of compassion fatigue and training practices to other helping professionals. This study will expand the professionals previously studied, and focus on addiction professionals with the specific credentials of licensed mental health counselor (LMHC) and certified addiction professional (CAP). Qualitatively exploring addiction professional's personal experience with compassion fatigue will help,

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"access the richness and detail of subjects' narratives and ways of making meaning" (Killian, 2008, p. 34).

Self-Care Strategies/Wellness

The counseling field is not for the faint of heart. It can create physical, psychological, and spiritual distress if counselors are not vigilant about practicing self-care. Although there is a plethora of literature discussing the importance of self-care, the reality is many counselors still neglect themselves (Killian, 2008; Patsiopoulos & Buchanan, 2011). One of the reasons for this may be as Sapienza & Bugental (2000) stated:

> Many of us have never really learned how to take the time to care and to nourish ourselves, having been trained to believe that this would be selfish or that there is no time for this when there is so much else to handle. Nor have most psychologists taken the time to develop compassion for themselves, and compassion for their own wounds. (p. 459)

> Often counselors are busy conveying compassion toward their clients while neglecting compassion toward themselves (Sapienza & Bugental, 2000). This increases their risk for developing compassion fatigue.

It is believed that "one of the most important skills counselors can learn in guarding against impairment is the regular practice of self-monitoring and self-care activities" (Lawson & Venart, 2005, p. 244). Self-care involves physical, psychological, and spiritual components (Richards et al., 2010). Physical self-care refers to the importance of incorporating exercise into one's daily life. There are many benefits to exercise, including maintaining one's physical health, along with improving one's emotional health. Exercise has been shown to reduce symptoms of depression and anxiety and improve one's overall quality of life (Richards et al., 2010). Psychological or emotional self-care encourages counselors to seek their own

professional counseling. By doing so, it can improve one's personal as well as professional life (Richards et. al, 2010). Personally, the counselor gets to engage in a one hour session dedicated to helping them find direction, clarity and more. Professionally, it can help with understanding one's boundaries, limitations, and assist with learning ways of practicing self-care (Richards et. al., 2010). Spirituality can include a variety of beliefs such as meditation, religion, yoga, prayer etc. Studies have shown that a spiritual connection is beneficial to one's mental health and can improve one's quality of life (Richards et al., 2010). Because of this, spirituality is an important component to one's self-care and is an encouraged strategy for improving one's overall well-being.

The importance of counselor wellness and practicing self-care to prevent impairment became so critical that in 2003 the American Counseling Association (ACA) formed a task force specific to the topic. ACA recognized the importance of having healthy and psychologically present counselors as they are better equipped to help their clients as compared to counselor's suffering from compassion fatigue (Killian, 2008). With this understanding, the task force focused their efforts at fostering awareness of counselor impairment and developing prevention and intervention strategies to deal with such impairment. The taskforce outlined personal risk factors for impairment and challenged counselors to consider the following questions: How prepared do I feel doing this work? What is my training, education and experience? What are my current stressors and/or changes in my life? What is my coping style? Do I have a personal history of trauma? Would I be able to ask for help if I needed it (American Counseling Association, 2005)?

Without question, self-care in the counseling field has become a necessary ingredient to an ethically sound practice. In fact, the ACA established a code of ethics that serves as a guide

for counselors to follow with the goal of promoting human dignity, doing no harm, and enhancing the overall counseling profession (ACA, 2005). As part of that code, the ACA made it a point to include sections about counselor wellness and self-care. Those include, sections C.2.d Monitoring Effectiveness, C.2.g Impairment (counselor), and F.5.b Impairment (student). These codes require counselors to monitor their effectiveness with their clients and take necessary steps to improve when needed (ACA, 2014). In addition to monitoring effectiveness, the ACA code insists that counselors and counseling students monitor themselves for signs of physical, emotional, or mental impairment. If an impairment is detected the counselor or counseling student should refrain from providing services until the impairment is addressed (ACA, 2014).

After the ACA put a spotlight on this issue, there has been a movement in favor of pursuing and engaging in self-care for counselors. This new movement has helped counselors understand risk factors of impairment and challenged counselors to practice self-awareness (Richards et al., 2010). Once the deficiency of counselor self-care was highlighted, new assessment tools were designed to examine counselor's self-care strategies, stress reactions, burnout, compassion fatigue, and secondary traumatic stress. These assessment tools have made it easier to detect compassion fatigue.

Since the importance of self-care is undisputed, it is never too early in a counselor's training to introduce this topic (Yager & Tovar-Blank, 2007). Introducing self-care early is important because of the unique qualities of counseling training programs. In contrast to other professions, counseling students not only need to demonstrate the cognitive knowledge they've obtained through their coursework, but they must also demonstrate interpersonal counseling skills and learn how to address client's emotional difficulties (Yager & Tovar-Blank, 2007).

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Learning interpersonal skills and how to address clients' emotional difficulties can trigger intense and uncomfortable emotional reactions for the counselor in training. Because of this, "effective learning of counseling skills must occur within the context of an ongoing effort to develop counseling students' personal wellness" (Yager & Tovar-Blank, 2007, p. 143). Several strategies were developed by Yager & Tovar-Blank (2007) regarding ways training institutions can teach about counselor wellness.

They recommend introducing the topic of wellness directly and discuss the personal and professional growth that will occur while in training (Yager & Tovar-Blank, 2007). One student stated, "I know you had told me before I began that there would be self-evaluation, self-awareness, and self-growth in virtually every class in the counseling program. But even with that awareness, I was still surprised by how much I have been stretched, molded, and remodeled as a person" (Yager& Tovar-Blank, 2007, p. 144).

Not only should the topic of wellness be introduced directly, it should be discussed consistently and regularly throughout a student's training (Yager & Tovar-Blank, 2007). Counselor educators should also model wellness for their students and remind the students that wellness is an ongoing process (Yager & Tovar-Blank, 2007). Furthermore, wellness should be presented as a way of life for counselors and counselor educators should encourage personal counseling as a means of support for the counseling students (Yager & Tovar-Blank, 2007). It is also important to review the ACA code of ethics viewpoint on wellness and counselor educators should develop ways to refocus students' attention to wellness. Finally, counseling students must be taught about client resiliency, positive psychology, wellness, and strengths perspective to counteract client pathology (Yager & Tovar-Blank, 2007).

Self-care/wellness literature. In a study by Collins and Long (2003), they explored compassion fatigue and self-care strategies among 13 caregivers who were working with individuals who were traumatized by the Omagh bombing on 15 August 1998. The participants reported supervision being helpful both personally and professionally. Humor was found to be helpful as well as rest, relaxation, and exercise. Specifically, participants found walking, swimming, football, reading, movies, and massage to be beneficial self-care strategies that helped them deal with their trauma work (Collins & Long, 2003). Unfortunately, "participants did not avail themselves of these strategies often enough" (Collins & Long, 2003, p. 24).

Killian (2008) conducted a study where twenty therapists were asked about what self-care meant to them. In general, the therapists shared how self-care is an important part of professional development and how practicing self-care is healthy modeling for their clients (Killian, 2008). The therapists also mentioned that self-care is a proactive way to prevent compassion fatigue and it is an opportunity to take personal time. The twenty therapists reported using the following self-care strategies and finding them beneficial: debriefing and processing, quality time with family and friends, exercise, and spirituality (Killian, 2008). The same counselors mentioned that despite how important self-care is, "it had rarely been addressed in their clinical training or in continuing education" (Killian, 2008, p. 36).

In an article that discussed the prevention of counselor impairment and wellness strategies, Lawson and Venart (2005) conveyed the importance of counselors designing a holistic self-care program. They encouraged counselors to practice cognitive restructuring that would help counselors identify negative thoughts that were preventing them from implementing self-care strategies. In addition, the following strategies were identified as beneficial for trauma counselors: discussing cases with co-workers, attending workshops, time spent with family and

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friends, travel, vacation, hobbies, debriefing with colleagues between sessions, exercise, socializing, limiting case load, spirituality and supervision (Lawson & Venart, 2005).

Finally, because of the unique stressors addiction professionals face, a self-care guide was created specifically for this profession (Jones & Williams, 2007). The guide was intended to help the addiction professional identify stressors and provide self-care strategies (Jones & Williams, 2007). The most beneficial strategies included nutrition, exercise, mental wellness, and recovery management (Jones & Williams, 2007).

First, nutrition is important because eating healthy keep us well and feeling good. Typically, especially in an agency setting, the work day for an addiction professional is fast paced. As a result, it is easy make unhealthy food choices just to save time. While these choices save time, they will ultimately lead to health consequences, lethargy, and decreased motivation (Jones & Williams, 2007). The self-care guide challenges addiction professionals to learn about nutrition; become cognizant of what food they are eating, consider portion sizes, and recruit co-workers in eating healthfully (Jones & Williams, 2007).

After considering nutrition, it becomes a logical extension to move onto exercise. Exercise is proven to promote overall wellness and prevent future health issues. Not only are there numerous health benefits of exercising, but it is also a great way to reduce stress, anxiety and depression (Jones & Williams, 2007). The guide encourages addiction professionals to start slow, find a partner to work out with, and to choose an activity of great interest (Jones & Williams, 2007).

Then, after considering the body, the next piece to consider is mental wellness of addiction professionals. As stated by Jones & Williams (2007), "Addiction professionals work in a demanding and stressful environment, and in order to provide optimal services to clients,

they must be mentally healthy" (p. 26). The self-care guide encourages addiction professionals to set boundaries with their clients, perform self-assessments regularly, engage in personal rituals that promote clarity and focus, take breaks between clients, practice relaxation, make time for fun activities outside of work, maintain a support network, and seek professional support (Jones & Williams, 2007).

Finally, since it is estimated that 60% of addiction professionals are in recovery themselves, it is important to focus on recovery management (Jones & Williams, 2007). Too often recovering addiction professionals blur the lines between their professional work and their personal recovery program which increases the risk of relapse (Jones & Williams, 2007). It is recommended to look for signs of relapse, to be vigilant about one's personal recovery program, and to remember, "working as an addiction professional does not constitute a program of personal recovery" (Jones & Williams, 2007, p. 33).

In sum, self-care is vital in preventing compassion fatigue and impairment, practicing ethically, and maintaining balance both personally and professionally. Unfortunately, despite knowing how important it is to practice self-care, not all counselors do it. The reality is, "the care that counselors provide others will be only as good as the care they provide themselves" (Lawson & Venart, 2005, p. 245).

Chapter Summary and Overview

Chapter 2 presented an overview of addiction and the addiction professional, and provided an historical background on compassion fatigue as well as a review and critical evaluation of the literature. The chapter concluded with a discussion on self-care/wellness.

Chapter 3 will reintroduce the topic and will present the research questions, research design, and a description of the sample. Thereafter, the sampling procedures, instruments, and

data collection will be discussed. This will be followed by a description of the researcher and

procedures used to increase the trustworthiness of the findings. Finally, the data collection

procedures will be explained.

Chapter 3: Methods

In Chapter 3, the topic will be reintroduced and the research questions along with the research design will be presented. Next, a discussion of the sampling procedures, instruments, and data collection will be discussed. Following that discussion, a description of the researcher and procedures used to enhance the trustworthiness of the study will be presented. The chapter will conclude by sharing the data collection procedures used in this study.

Reintroduction to the Topic

The purpose of this study is to gain an in-depth understanding of the addiction professionals experience with compassion fatigue and self-care and to use this information to review their current training practices. With addiction problems on the rise, there is an increasing need for healthy addiction professionals to be of service. Unfortunately, there is a shortage of these addiction professionals. A contributing factor to this shortage may include compassion fatigue.

Compassion fatigue is the result of the empathic demand counselors' face while working with complex clients (Fahy, 2007). Counselors ultimately want to reduce the suffering of others and do so by providing empathic understanding and empathic responses, but it is through this process that a client's traumatic stress can be transferred onto the counselor (Figley, 2002). Complex clients include those struggling with addiction. To compound the issue for addiction professionals, clients with addiction have often experienced trauma. The addiction professional's response to this combination of addiction and trauma can cause addiction professionals to exhibit serious symptomology of compassion fatigue.

Suffering from compassion fatigue can have a tremendous negative impact on their lives, both personally and professionally. Making matters even more complicated is the underlying problem that addiction professionals may not be receiving proper training or education to treat addiction coupled with trauma or about the risks of compassion fatigue. Moreover, addiction professionals may not be receiving appropriate education about self-care being a useful strategy to help address the symptoms and avoid the risks associated with compassion fatigue.

Research Questions

There are three basic questions that are guiding this inquiry. They are the following:

1. What are the experiences addiction professionals have with compassion fatigue?

2. What role does training play in relation to compassion fatigue?

3. What self-care strategies are being used currently by addiction professionals to address compassion fatigue?

Research Design

This study used a qualitative design and semi-structured interviews to gather the data. The qualitative design was chosen because it generates both in-depth and detailed information. More specifically, semi-structured interviews, during which each participant is asked similar questions, were used to make comparisons across participants (Bernard & Ryan, 2010). An interview guide provided the topics and list of questions that were covered (see appendices D and E for the interview guide). Along with the questions, a variety of probes were used. These probes included a silent probe, an echo probe, an uh-huh probe, and a tell-me-more probe (Bernard & Ryan, 2010).

Description of the Sample

  Inclusion criteria. In order to be included in this study the participants had to be LMHCs and/or CAPs with at least three years of addiction counseling experience. In addition, the participants had to be employed at a community agency that treats addiction.

  Exclusion criteria. The credentials of Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Mental Health Counselor Intern (IMH) were excluded from this study as the focus is solely on Licensed Mental Health Counselors (LMHC) and certified addiction professionals (CAP).

Sampling Procedures

  There were two types of nonprobabilistic sampling techniques used in this study: purposive and quota sampling. Purposive sampling was chosen because of the predetermined criteria needed for inclusion into this study and quota sampling was chosen because of the three distinct credential categories of interest, four LMHC's, four CAP's, and four LMHC and CAP's (Bernard & Ryan, 2010). In order to reach thematic saturation, recruiting 12 participants was the goal (Guest, Bunce & Johnson, 2006). While 12 participants was the goal, the final participant sample was seven. A reason for this may have been that the addiction professionals contacted had too much on their plate to be able to participate in this study. It is possible that if the addiction professionals were currently experiencing compassion fatigue that they may not have wanted to engage in study focusing on that subject. It is important to note that even though the sample was seven, it seems thematic saturation was reached based on the fact that new themes were not emerging by the end of the final interview (Bernard & Ryan, 2010).

  The sample was recruited by email through Psychology Today website, LinkedIn, and through my relationship with colleagues at various community agencies (see Appendix A for

recruitment email). Each participant signed a consent form to participate as well as to consent to be audio recorded (see Appendix B for informed consent form).

Procedures

The study was granted approval from the Institutional Review Board (IRB) from the University of South Florida (see Appendix C for IRB approval letter). Once approval was granted, recruitment emails were sent to potential participants who matched the inclusion criteria. Those who responded to the recruitment email indicating they would like to participate were then contacted by the researcher to schedule the interview. The interview participants each received a $5.00 Starbucks gift card for their participation.

Data Collection Procedures

I conducted all seven interviews. Interviews lasted from 30 minutes to 50 minutes with the average length of the interviews being 40 minutes. Some of the participants went into more detail with their responses and shared stories which contributed to some of the interviews being longer in length. Each interview started with the participant signing the consent form. Before beginning the interview, all participants were asked to confirm their consent on an audio recorder. At the beginning of each interview, a definition of compassion fatigue was discussed and a copy of the definition was placed in front of each participant. The purpose of this procedure was to help the participants stay focused on the construct of interest, compassion fatigue (see Appendix F for compassion fatigue definition).

The data were transcribed by a transcription service that maintained confidentiality. The data were kept on password-protected computer in a secure location. All data (electronic and paper) were kept in a locked filing cabinet in the researcher's office and will remain there for

five years, per USF policy. Thereafter, it will be destroyed by the researcher; physical records will be shredded and electronic records will be erased.

I was present in the office where the data were kept on a daily basis and was the only person who had access to these files. The same is true for electronically kept data, as I was the only individual who had access to the password protected computer.

Pilot testing. The interview protocol was pilot tested with two addiction professionals, one LMHC and CAP, and one CAP. The first two people who agreed to participate in the study were chosen for the pilot test, and their data were included in the final analysis.

The two participants were asked to evaluate the interview protocol based on the following criteria: Was the interview protocol easy to understand? Were the questions clear? Did the interview guide flow appropriately? During the interviews, I evaluated the questions and flow as well.

Pilot Test 1. From the first pilot test, it was determined that question 19: "What helps you the most in your work as an addiction professional?" lacked clarity and was confusing to the participant. Through discussion with the participant, it was decided that I would clarify the question by adding it as a probe to question 18: What are the ways you de-stress?
Probe: Of those ways you mentioned, what has helped you the most in your work as an addiction professional?

Pilot Test 2. The second pilot test participant reported that the interview guide was easy to understand, the questions were clear, and that the interview guide had a nice flow to it. The participant did report that it may be helpful to have more in-depth discussion about the differences between compassion fatigue and burnout at the beginning of the interview. From that feedback, I included a reference table that included the differences between the two

constructs and discussed it at the beginning of the remaining interviews (see Appendix G for reference table). The IRB granted approval to amend the changes to the interview guide based on the pilot interviews (see Appendix H for the IRB amendment letter).

Description of the Researcher and Clarification of Researcher Bias

I am the researcher and primary investigator (PI) conducting this study. I am a Doctoral Candidate in a Counselor Education Program, and I am a licensed mental health counselor as well as a certified addiction professional. I have been co-teaching at the master's level in counselor education programs since 2011. In addition, I am trained at the doctoral level in both quantitative and qualitative methods. Prior to this qualitative research, I conducted a quantitative study exploring student's perception of academic performance and life satisfaction among high school students.

This topic was chosen based on my extensive work in the field of addiction. The first six years of my career was spent working in addiction treatment facilities. During that time I witnessed compassion fatigue as seen through my supervision with my supervisees and began to understand the extreme need for self-care strategies to help manage it. Although compassion fatigue was clearly affecting the addiction professionals, it was also clear it was not being readily discussed and self-care strategies were not being used. It is possible that self-care strategies weren't being used because during this time the organization had low staff which forced each counselor to carry a higher than average caseload and created more work overall for each counselor. Because of this, the counselors may have found it difficult to find the time to implement self-care strategies.

Not only did I witness compassion fatigue among my supervisees, I also experienced compassion fatigue while working in the addictions field. This experience taught me the value using several self-care strategies to deal with the compassion fatigue.

Because I hold the credentials, LMHC and CAP, which are the same credentials that are of interest for this study, there is a risk of perceptual bias. However, in order to ensure trustworthy results, I continually discussed the study's research methods and interpretations of data with committee members as well as took field notes and used peer debriefing after each interview.

Trustworthiness

Generally speaking, establishing trustworthiness helps to determine how beneficial the research will ultimately be (Lincoln & Gabu, 1985). According to Lincoln and Guba (1985) enhancing trustworthiness in qualitative research involves establishing credibility, transferability, dependability, and confirmability. I will discuss each of these concepts briefly beginning with credibility.

Credibility. Credibility refers to the, "confidence in the truth of the findings" (Cohen & Crabtree, 2006, p. 1). I used peer debriefing and member checking to ensure that I represented the participant's information in an accurate manner.

Peer debriefing is a credibility strategy that, "contributes to confirming that the findings and the interpretations are worthy, honest, and believable" (Spall, 1998, p. 280). Peer debriefing sessions were scheduled after each participant interview. This helped the researcher maintain perspective about the process of the research and allowed the researcher the ability to process any feelings or stress associated with the interviews.

The interview data was verified using member checking (Lincoln & Guba, 1985). The member checks allowed the participants the opportunity to assess the accuracy of their interview transcript and to correct any errors detected (Lincoln & Guba, 1985). Once the interviews were transcribed, each participant was contacted via email and asked to review their transcript (see Appendix I for member check email). Four participants responded to the email and reported their transcripts were accurate. It is assumed that the three participants who did not respond to the member check email did not detect any errors in their interview transcripts either

Transferability. Transferability is a, "process in which the researcher and the readers infer how the findings might relate to other situations" (Denscombe, 2010, p. 189). Transferability is used in qualitative research as an alternative to generalizability as seen in quantitative research. Generalizability differs from transferability in that the findings are, "measurable, testable and checkable" (Denscombe, 2010, p. 189).

The researcher aimed to provide ample detail about the main characteristics of the participants as well as detailed information about the constructs being discussed through thick descriptions (Denscombe, 2010). The goal in providing this detail was to enhance the probability that the findings could be transferred to other addiction professionals with similar characteristics (Denscombe, 2010).

Dependability. Dependability is established by showing that the findings are, "consistent and could be repeated" (Cohen & Crabtree, 2006, p. 1). I chose to use field notes as my primary strategy to ensure the dependability of my findings. Field notes are, "an essential part of all qualitative data collection" (Bernard & Ryan, 2010, p.46). I kept field notes during each interview in order to note the content being discussed, feelings, and non-verbal cues from

the participants (Tessier, 2012). Field notes were used in conjunction with an audio recorder, which also enhances the dependability of this study (Bernard & Ryan).

Confirmability. Confirmability is concerned with ensuring that the research findings are the result of the participant's information provided and their experiences rather than because of the biases of the researcher (Shenton, 2004). I used an external auditor to help enhance the confirmability of this research and reduce researcher bias. The purpose of an external audit in qualitative research is to, "evaluate the accuracy and evaluate whether or not the findings, interpretations and conclusions are supported by the data" (Cohen & Crabtree, 2006, p. 1). An external auditor examined the process of this research study and examined the accuracy of the themes identified. This is an important step as it aids in validating the research study.

Data Analysis Procedures

After the interviews were conducted and recorded, a transcriptionist transcribed the data verbatim. At that point, thematic analysis was used to analyze the data. I created a codebook that included a priori and emergent codes. A priori codes often come from professionally agreed upon definitions in the literature, local constructs, researchers' values, and personal experiences (Bernard & Ryan, 2010). Emergent codes are discovered after analyzing the transcripts (Bernard & Ryan, 2010).   The a priori codes were: distressing memories, avoidance, irritability, pre-occupation, difficulty separating personal and professional life, evidenced-based practices, and support.

After analyzing all of the data, I decided to conduct a follow-up interview focusing on the participants training practices as they relate to compassion fatigue. The IRB granted approval to conduct the follow-up interview (see Appendix J for IRB approval letter for follow-up interview). This information did not emerge from the original data; therefore after consultation

with one of my committee members I formulated three more questions that targeted this information and would aim to more accurately answer research question 2 (see appendix K for follow-up questions). Only emergent codes were used in analyzing this data.

Chapter Summary and Overview

This chapter presented the research questions along with the research design used in this study. Next, a description of the sample, sampling procedures, and data collection procedures were discussed. Following that discussion, strategies employed to increase the trustworthiness of the findings were presented. Finally, a description of the researcher and data analysis procedures were explained.

Chapter 4 will begin by describing the process used to analyze the data. It will then present the participants demographic characteristics, followed by presenting the emergent themes that address the participant's experience with compassion fatigue, training, and self-care strategies. This chapter will conclude by sharing the participant's advice to other addiction professionals regarding compassion fatigue.

Chapter 4: Results

This chapter will begin by describing the process used to analyze the data. It will then present the participants demographic characteristics, followed by presenting the emergent themes that address the participant's experience with compassion fatigue, training, and self-care strategies. The results aimed to answer the following questions:

1. What are the experiences addiction professionals have with compassion fatigue?

2. What role does training play in relation to compassion fatigue?

3. What self-care strategies are being used currently by addiction professionals to address compassion fatigue?

This chapter will conclude by sharing the participant's advice to other addiction professionals regarding compassion fatigue.

Data Analysis

The seven participant interviews were audio recorded. Each participant was given a pseudonym to ensure confidentiality. The recorded interviews were then transcribed verbatim by a transcription service. Once transcribed, I organized the data into meaningful sections. Meaningful sections were determined based on the research question under which the data most appropriately fit. Once this was accomplished, I used a color coding system to identify a priori and emergent codes. The a priori and emergent codes were then entered into an Excel spreadsheet, which included the code definition along with the participant's exact words that corresponded to the specific code. From there, the final themes were determined. In the results

section, next to each theme, you will notice a number out of seven that indicates how many of the participants made up each theme.

Results

  Participant demographics. Table 1 presents the participant's demographic characteristics, which consists of their credentials, age, gender, time spent in the field of addiction counseling, and ethnicity.

Table 1

Participant Demographics

Name	Credentials *(n=07)*	Age	Gender	Time in Field	Ethnicity
Gail	LMHC, CAP	33	Female	Eight Years	Caucasian
Matt	CAP	43	Male	Six Years	Caucasian
Dave	LMHC, CAP	46	Male	Ten Years	Caucasian
Molly	LMHC	32	Female	Six Years	Caucasian
Paige	LMHC	65	Female	Thirteen Years	Caucasian
Sally	LMHC	58	Female	Twenty-one Years	Caucasian
Elaine	LMHC	29	Female	Five Years	Caucasian

  The participants consisted of five females and two males, and they all identified as Caucasian. The participants had the following credentials: four were LMHC's, two were LMHC and CAP's, and one was a CAP. Their ages ranged from 29 to 65 years old. The mean age was 44. Time spent in the addiction field ranged from 5 years to twenty-one years. The mean

number of years in the field was 10. Matt, Sally, and Elaine identified their work role as being

therapists; Gail, Dave, and Molly identified their role as being clinical director; and Paige stated

that she coordinates and facilitates an outpatient program within an agency setting.   Finally,

Matt, Dave, and Paige referenced personally being in recovery.

      Clinical practice characteristics. This section will discuss the clinical practice

characteristics identified that placed the participants at greater risk for compassion fatigue. Table

2 will present the percentage of addiction clientele seen by the participants, percentage of

addiction and trauma clientele seen by the participants, and the frequency in which the

participants reported hearing traumatic stories from their clients.

Table 2

Clinical Profile of Participant's Clientele

Participant	% of addiction clients	% addiction & trauma clients	Frequency of hearing trauma
Gail	60%	60-70%	Daily Basis
Matt	100%	30-40%	30-40%
Dave	100%	100%	Regularly
Molly	100%	100%	Once a day
Paige	100%	60%	All the time
Sally	60-70%	80%	Everyday
Elaine	75%	50%	Sometimes

Four out of the seven participants reported their clientele was 100% addiction clientele,

and the other three participants saw addiction clients 60-75% of the time.

Similar to previous research findings, all seven participants reported a high co-occurrence of addiction and trauma among their clientele (Bride et al., 2009). Two of the participants believed 100% of their addiction clientele have suffered some form of trauma and the other five participants believed their addiction clientele suffered trauma 30-80% of the time. In addition to the high co-occurrence of addiction and trauma, the participants reported hearing traumatic stories from their clients on a frequent basis.

Five out of the seven participants reported hearing the traumatic stories: daily, all the time, or regularly. Because the participants reported frequently hearing traumatic stories from their addiction clientele, they are at risk for the transfer of traumatic stress from their clients (Burke, Carruth, & Prichard, 2008; Cramer, 2002). The more risk for the transfer of traumatic stress, the more risk for compassion fatigue (Cramer, 2002).

Another factor identified that places these participants at risk for compassion fatigue is that they work with challenging clientele (Perkins & Sprang, 2013).

Theme I: Challenging clientele (7/7). The participants identified four major characteristics that made their clientele challenging. *Denial, minimization, lying, and resistance to treatment* were the characteristics that made the work they do with the addiction population challenging. When posed with the general question about challenges faced in their profession, most of the participants spontaneously laughed and responded that the challenges of the profession are many. This laughter illustrates that the difficulties of the job and clientele are so widespread and well known to those in the profession that there seems to be a sense of camaraderie about the subject.

One of the main goals of an addiction professional is to change their client's thinking process and mindset about drugs and alcohol, but it is often met with difficulty. Examples of this type of thinking process that can be difficult to change are illustrated in the following excerpts.

Gail

"There are a lot of challenges, but there are some like the mindset of marijuana is safer than alcohol, or with alcohol, the argument that it is legal; Prescribed medications, that they are legal. It's hard to get passed that mindset."

Molly

"Not connecting that perhaps if you would stop selling crack or stop using heroin, you would not find yourself in front of the judge. And the faulty mindset of, "well, clearly I have to stop shooting oxy's, but I can totally smoke pot or I can totally drink."

Two participants reported struggling with getting their addiction clients to understand that getting well includes more than just abstaining from drugs and alcohol.

Dave

"Like I said earlier is this idea of, 'well if I just stop drinking or if I stop drugging, everything is going to get better'."

Paige

"Most clients who suffer from addiction tend, at least initially, to believe that if they can just abstain from using substances that their lives will get better. They don't see the implications of addictive behavior, addictive thinking, or even what we call process addictions, which means peripheral addictions like overeating, gambling, workaholism is a big one, that kind of thing. Things that don't involve substances that keep them locked in the addiction cycle."

Changing this type of thinking is difficult because most of the time the individual doesn't believe they have a problem, and they are in denial about their addiction. A characteristic that can accompany denial is lying. Dave said,

"Denial, I mean that's the biggest deal. They don't even realize, they don't even know "I am lying" kind of thing. That's what the acronym for denial is, 'don't even know I am lying'."

Dealing with a client's denial system and dishonesty is hard because addiction professionals want to help their clients, but are limited based on how forthcoming the client is. Elaine stated,

"Like I said before, I only know what they client tells me. I never know how truthful they are being in what they are saying. You get a lot of manipulation and there's also a lot of minimization and denial that goes on."

Matt stated,

"Oh, God. I think the biggest challenge for me was to just accept the fact that they're going to lie to you every single time. Most of them don't want to be here, most of them don't want to do it, so they are very treatment resistant no matter what they say. They are going to lie a lot so you get lied to your face. Just not taking that personally is probably the most difficult and challenging part of the job."

This is where addiction professionals often use confrontation and other therapeutic techniques to break through the denial system and address the lying. If clients do believe they have a problem, it is often minimized. Because of this minimization, clients do not see a need for treatment; therefore, addiction professionals are met with treatment resistance.

Based on the fact that the participants acknowledged having a high percentage of addiction and trauma clientele, hearing a large number of traumatic stories from their clients, and reported working with challenging clientele, it is not surprising that six out of the seven participants reported experiencing compassion fatigue during their careers.

The next section will focus on answering research Question 1 by sharing what participants had to say about their experiences with compassion fatigue. First, specific experiences that six of the participants have had regarding compassion fatigue will be presented. Following that presentation, themes that emerged regarding the participant's experiences with compassion fatigue symptomology will be discussed.

Research Question 1: What are the Experiences Addiction Professionals have with Compassion Fatigue?

Participant's experiences with compassion fatigue (6/7). This section will share participants' stories about a time when they experienced compassion fatigue. It is noteworthy that only one of the participants did not report experiencing compassion fatigue.

Gail

> Gail shared how she remembers a specific time when compassion fatigue surfaced in her life.

Gail recalled how a client stopped her before leaving for work one day and said, "your day might end at 5:00, but my life-I'm living this." The client was meaning that Gail could go home to her family and turn everything off, but the things that were going on in her head happen 24 hours a day.

Gail reported that this situation began to affect her personal life as evidenced by being at home thinking about what was going on with that particular client. This is a situation that Gail reportedly still thinks about regularly.

Dave

Dave reported experiencing compassion fatigue as recently as the day before the interview. He reported having his third session with a challenging client who is on the autism spectrum and reportedly very close-minded. Dave stated he was trying very hard to help the client see things from a different perspective and to see that there is a different way to live life, but nothing was working. Dave was fighting the client's denial system and feeling emotionally depleted. Dave ended the session early and asked the client to leave his office. Dave found himself irritable and frustrated. Dave reported that he talked to someone immediately after the session because he was having doubts about many things such as: his patience, tolerance, and understanding with this client. Dave sought support from others who helped support him in his feelings and normalize what he was experiencing.

Sally

Sally shared that her compassion fatigue experience was with a few clients from a long time ago. Sally did not mention the specific client situation that caused such a strong reaction, but shared that she remembers feeling completely overwhelmed and like she couldn't talk to another person. She also stated that she couldn't hear another traumatic story and wanted to go to bed and be in a dark room. She reported that these feelings lasted about 24 hours.

Molly

Molly shared that she has experienced compassion fatigue experience several times during her career. Although she didn't report one specific incident, she did share that her

compassion fatigue experiences led her to express the following: avoiding clients and co-workers; didn't want to hear people, and wanted to be left alone in her office. She reported that she was able to address these symptoms by either taking a long weekend or taking a more extended break. Molly mentioned how important it is for her to take a break from work when she is having these symptoms of compassion fatigue because she knows that she isn't functioning appropriately to be at work.

Matt

Matt shared that it is distressing when he hears a client talking about their childhood abuse or trauma. He mentioned that it bothers him alot because it's difficult to hear, not because it was his own trauma, just because of his own belief structure that he has to keep separate. Matt shared that when this type of compassion fatigue situation occurred, he was lucky because people he worked with brought it to his attention and forced him to take some time off and talk about it.

Paige

Paige stated that she has absolutely experienced compassion fatigue during her career. Paige did not mention a specific incident, but shared how she doesn't think you can do this for a living and not have it occur throughout time. Paige stated it is all about how you problem-solve the situation; recognize it for what it is, and take appropriate measures such as self-care and boundary setting.

Compassion fatigue symptomology.

Theme II: Emotional impact (6/7). The participants acknowledged experiencing an emotional impact because of the traumatic stress of their clients. It seems that witnessing clients going through their own emotional turmoil and hearing their client's traumatic stories creates an

emotional response from the addiction professional. Six of the seven participants shared the following.

Matt

> "You see people cry, you see people sad. They're at the low point in their life and that's difficult over time to deal with, especially when you watch them make bad choices after bad choices. That's difficult emotionally. It is more difficult to maintain emotional balance in dealing with clients like that. You got to do a lot more to take care of yourself. You got to be aware of yourself and where you're at a lot more, I think, than when you're just bopping around life and not having to deal with the traumas of others. It used to be very difficult early on when I first started, but now, it's not as bad. The best way to describe it, early on, it was much easier to take on other people's stuff and to think you could really do something to help them get out of it. You kind of get lost in where your place is at in the counseling thing."

Sally

> "There have been times when I have just felt really like overwhelmed and like I've wanted to cry and if I hear one more sad thing, then I'm just going to fall apart. So, I think that there may be some emotional shutting-down that happens at times."

Some participants reported noticing an emotional impact when their client's traumatic stressors resonated with them personally in some way. For instance:

Dave

> "I guess what traumatizes me the most in my everyday life is the stuff that I was traumatized with as a child that I haven't really worked through as an adult, but most of that I've taken care of. I'll tell you, when I find myself getting – this is where I struggle

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with. This area with the family stuff, I do one on one fine. I work with the addicts but if I'm working with the addict's family and the family is talking about their personal trauma with the addict. That's when I can get into my own emotions in that place. So I shy away from that kind of work. [Laughter] I don't really like to do the family work."

One participant did not notice an emotional impact because of the traumatic stress of her clients but did notice the risk of being directly traumatized due to some of the unfortunate realities of the addiction profession. Molly said,

"I wouldn't say because of it (emotional impact because of traumatic stress of addiction clients), but there was an incident two years where we had a guy, we caught him with drugs in the facility. He knew he was getting discharged. He told us, 'I'm not going back to prison.' He hugged his counselor goodbye and four days later, we found him dead of an intentional overdose. That was really traumatic for the entire staff."

Theme III: Distressing memories (4/7). Distressing memories about the traumatic events that clients experience was identified as a theme among the addiction professionals. It seems these memories can occur frequently or occasionally, and they occur on a random basis. Gail said,

"Yes, regularly, I think about those things. I mean I think about things all the time. Currently, I don't have an active case load but I am always thinking about things that people have told me about the trauma that they've experienced, flashbacks that people tell me that just occur randomly. I'll think about the time they saw their mother get murdered or going home and never knowing when they were going to get abuse by somebody sexually or physically or psychologically. I think about those stories all the time."

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When Gail mentioned the powerful memories that surface for her I was thinking about the intense nature of being an addiction professional and acknowledged the stress that can come from hearing such stories. Since Gail acknowledged having such powerful memories that occur regularly, my hope is that she has strong coping strategies for when they surface in order to protect her mental health.

Sally

"Occasionally. I don't know. When somebody has a particularly horrendous story, sometimes I will think about that. It will come back to me. Maybe very occasionally, intrusive memories about it. I don't know I would put it to a flashback to that extent. But random times where something - someone has said may come in to my mind and I'll think about it."

It seems that Sally's distressing memories occur less frequently than Gail's distressing memories. Since Sally has been practicing in the addictions field several years longer than Gail that may play a role in why Sally reported experiencing fewer distressing memories.

Elaine

"Again, it leaves a footprint in my mind. I'll get a mental picture of the event happening when they describe it in great detail, the father coming into the shower, that kind of thing, and just thinking about how that must feel for them to be so vulnerable as a little girl trying to take a shower and having that be so disrupted and having that be so traumatic for them. If anything, it kind of makes me feel grateful that I can take a shower without having to think about those memories and be traumatized myself just by everyday life."

Theme IV: Avoidance of thoughts/feelings (2/7). It seems that addiction professionals avoid thoughts and feelings associated with hearing their client's traumatic stories in two ways:

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consciously or automatically. Although only two participants mentioned this type of avoidance of thoughts and feelings, I thought it was necessary to include in order to illustrate how this avoidance may surface in different ways.

For example, Gail found herself using a conscious approach to avoid certain thoughts and feelings. She said,

"I used to (avoid thoughts and feelings associated with hearing client's traumatic stories). I used to put a lot of effort into making myself focus on things outside of work, but it doesn't bother me anymore."

In contrast, Sally found that this avoidance occurred as more of an automatic response. She stated,

"Yes. I don't think I consciously say, 'Oh, you know I don't want to go there,' [laughter] but I think there are times when I'm aware of feeling myself internally, kind of taking a step back.

Theme V: Irritable behavior (4/7). After hearing traumatic stories from addiction clients, four of the participants noticed experiencing irritable behavior. The participants seemed to be very aware of this feeling of irritability and reported using strategies such as self-talk and talking with others as a way to work through the irritable feelings. Matt reported,

"Yes. When I hear something like that, that is traumatic either for them or would trigger something in me, it just takes a little while to kind of rebalance myself, to adjust. It's just you're off kilter a little bit. Then, it just takes you a little while to kind of think your way through and get to the other side."

Dave

"Yes. I'm usually generally pretty aware of them (irritable feelings) right away. It's stuff I don't like feeling. So when it comes up for me, I know automatically start to think, "Okay, where's this coming from? Talk to somebody about it," maybe get some insight in what's going on. Mostly just figure out how to take care of myself in that place and then I'll just be conscious about it and for whatever reason I may be irritable mostly at home with my partner sometimes coming home and just try to change that behavior."

Another participant shared that she noticed the irritability surface in specific circumstances that involve men making inappropriate comments. Sally reported the following,

"Yes. Well, the times that I have been aware of it (irritability) are when I have been around men who have been making inappropriate comments, whether it be sexually or relationship-wise about women and I have had a particularly difficult trauma session recently, and then I have found myself being very angry [laughter] and wanting to lash out verbally." [Laughter]

It seems irritability can surface when someone's trauma triggers something in us that we may not be able to pinpoint or it can happen in specific circumstances. Either way, it is important to develop strategies to deal with the irritable behavior so that it doesn't linger long-term. A strategy that may be beneficial is to talk to someone as soon as the irritability surfaces in order to process through the feeling and gain perspective on the situation.

Theme VI: Preoccupation with clients (6/7). It appears there are certain clients that demand our attention more so than others. An interesting revelation was that the participants were very aware of the type of clients and circumstances that seemed to ignite this preoccupation.

The participates reported the preoccupation occurs when working with the following clients: young male clients, problematic clients, clients who are in the midst of intense trauma work, clients with safety issues, and clients who experienced extreme traumas.

Here is what two of the participants shared,

Paige

"Certain clients who are in the middle of their trauma work do take more of my mental attention, but I also have boundaries around that."

Elaine

"Yes. I would say that the ones who have had some of the most extreme traumas, like I said, I feel that closeness with where it just makes me want to help them even more and do anything that I can for them and especially in a residential setting where it doesn't end after that session's over. You're still around them for the rest of the day and then like I said, it is something that - I still think about clients who have had very extreme traumas and all. I'll think about what they've told me and feel badly for them, but I wouldn't see it's something that I necessarily obsess about or that have intruding thoughts or something."

Theme VII: Difficulty separating personal life from professional life (6/7).

All but one of the participants said that they have struggled with separating their personal life from their professional life. They find themselves checking their phones, wondering about work issues or a particular client while at home, and if they are going through something on a personal level, it makes keeping that separation more challenging.

Gail

"In some ways it is because I always want to be accessible, I think more than what is expected for my job. I always have my phone with me. I'm always checking. If I wake up in the middle of the night, I check my phone to see if something happened at work. So, I think yes, a little bit anyway."

Molly

"I will say being a manager in a community agency is extremely time-consuming. My schedule has changed so many times. I'm always at the mercy of the program. If there's an emergency at 12:00 PM or 12:00 AM, I am expected to respond. I am on call 24/7. When I take a vacation, I leave an entire page of delegated responsibilities and call lists. That gets really overwhelming. [Laughter] It was less so as a counselor. It's more in a management role that I find that to be like, "Oh my god.""

Sally

"At times, depending on what's going on in my life. When I was going through a divorce, working with family members, working with couples was a little more challenging. So, I didn't work with them then." [Laughter].

It seems that maintaining this separation may be more challenging early in one's career. Two participants reported struggling with this in the past, but seem to have learned from that time period and set boundaries in order to keep a distinct separation between their personal and professional life.

Matt

"Not anymore. It used to be, absolutely. Early on, not thinking about work when you're at home, not thinking about what you needed to do or what you should have done or what you could have done differently, or what you need to do the next day with any given

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client or family member. Also, setting the boundaries that people aren't calling you, letting you know what was going on at work while you're not at work, so just kind of setting the difference between work and home life."

Paige

"No, not now. So I've made mistakes in the past where I've kind of been over-involved, or in a management, or an on-call position, but not now. It interfered with my own sleep patterns. I was probably irritable because of the interrupted sleep - and I'll tell you, the main clue for me is I am a healthy person and I was starting to break out in rashes and stuff like that, and that's when I just called a halt to the whole thing. I said, 'I am doing too much and I'm not living like this."

Difficulty separating personal from professional life is a boundary issue that six of the seven participants seem to experience. This type of boundary issue is common for all human service providers, but there are strategies to address this issue. I would suggest that if you are in a management role that you explore ways that you could share some of the after-hours responsibility with another management professional in order to alleviate some of the burden that comes from being on-call 24/7. Two of the participants reported this type of boundary issue was more challenging at the beginning of their career; therefore I would also suggest personally determining what boundaries are important for your overall wellbeing and to set them at the beginning of your employment.

Employment risk factors. Table 3 presents the participant's experiences with the following employment risk factors: high caseloads, staff shortages, low salary, and low workplace support. Research suggests that these employment risk factors can increase one's risk

of developing compassion fatigue (Craig & Sprang, 2010; Jones & Williams, 2007; Killian, 2008; Perkins & Sprang, 2013; Van Hook & Rothenberg, 2008).

Table 3

Employment Risk Factors

Participant	High Caseload	Staff Shortages	Low Salary	Low Workplace Support
Gail	Yes.	Definitely	Yes, Absolutely	No
Matt	Currently no. In the past, yes.	Absolutely	Yes, of course [Laughter]	No
Dave	Not anymore, but I have in the past.	Yes	Well, yes [Laughter]	Yes
Molly	Yes. [Laughter]. All day, every day.	Oh my God. Like you wouldn't believe	Yes	No, not at all
Paige	Occasionally.	No. We embrace a lot of interns	Yes	No
Sally	No.	Not as a general rule	No	No
Elaine	In the past, yes.	Yes	Yes	No

Note. *n*=07

Four risk factors cited in the literature that are most closely related to compassion fatigue were noted among the participants. When asked about these risk factors there was, again, laughter from the participants signaling that these factors seem to be well known and prevalent in the addiction field. It was found that most of the participants either currently had a high caseload or carried one in the past. One of the reasons for the high caseloads is often because of staff shortages which five out of the seven participants acknowledged occurred at their place of employment. In addition to the participants acknowledging high caseloads and staff shortages, the participants overwhelmingly reported having low salaries. Paige said,

"Well, we all know that addiction is like the lowest paying thing you could possibly do in the counseling realm. I'm sorry, but it just is. It comes with the territory. You can't go into it expecting anything different, I don't think."

Interestingly, while most of the participants acknowledged having high caseloads, staff shortages, and low salaries, this did not seem to negatively impact their workplace support. In fact, six out of the seven participants reported that they had good workplace support. I was surprised by this finding and would have assumed that if the participants were experiencing high caseloads, staff shortages, and low salary that their workplace support would have been low as well. It seems that although the workplace conditions may not be favorable, agencies are working hard to provide a supportive environment to their employees.

The next section will aim to answer research question 2 by focusing on themes related to the participants training practices and how training relates to compassion fatigue.

Research Question 2: What Role does Training Play in Relation to Compassion Fatigue?

Research has shown there is variability among addiction professionals regarding how they enter the addictions field as well as variability within each path of entry. Research also suggests that having a master's degree can be a buffer against compassion fatigue (Perkins & Sprang, 2013). The purpose of asking the participants about their formal and informal training was to explore how variable it was among this particular sample and then to determine if the variability may influence compassion fatigue. My assumption was that those who had formal training such as a master's degree may experience less compassion fatigue.

Theme I: Variability of addictions training (7/7). Variability of training for treating addiction emerged as a theme from the participants. This is consistent with previous research regarding addiction training (Bride et al., 2009; Lee, 2013; Linton, 2012). All seven participants

reported being trained to treat addictions in a variety of ways: One participant mentioned having one class in their master's program; two participants mentioned personal recovery; two participants mentioned on-the-job-training including CEU's and supervision; and two participants mentioned trial and error. The following are examples of what some of the participants' shared regarding each path:

Substance abuse class.

Molly

"Well, we got one class in graduate school; one where they pretty much tell you to refer them out. I was actually talking about this with a friend the other night who's in the counseling field. She was like, 'I just don't understand why so many people are so afraid of dealing with substance abuse. The population is so great. They're so fun.' I said, 'Yes, but you got to think about it. For people that don't go into the field, it's this looking thing that nobody knows what to deal with and you literally get one class.' I got one class and then thrown into my internship."

Molly's experience is similar to what I have heard other addiction professionals express about their substance abuse classes. In my personal training, I took two substance abuse classes. I do not recall being urged to refer them out, but I do remember the classes were primarily an overview about the history of addiction and an overview of drugs and alcohol. A critical component that was missing was the clinical and practical component of how to treat addiction.

Trial and error.

Gail

"By reading stuff. I don't know, trial and error?"

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Molly

"My internship supervisor really kind of believed in trial by fire. So, I just got thrown

right into groups, "Here's the curriculum, go do a group.""

Unfortunately, I believe the trial and error approach is a very common way that addiction

professionals are being trained to treat addictions. It may be because agencies are often

understaffed and overworked making it difficult for them to provide appropriate on-the-job

training. While this seems to be an accepted route of training it is not ethically sound and is a

disservice to the addiction professional and their clients.

Personal recovery.

Matt

"CEU's, supervision, and then being an addict myself."

Dave

"First of all, I did a whole lot of group therapy on my own."

Research has shown that a large percentage of addiction professionals are in recovery

themselves. In fact, a national study that was conducted in 1999 surveyed addiction

professionals in 400 treatment programs and found that 60% were in recovery themselves (Jones

& Williams, 2007). There are certainly benefits to being an addiction professional that is also in

recovery. For instance, the ability to relate to their clients and their empathic ability is strong

because these professionals have often been through similar situations and know firsthand the

struggles that can result from addiction. Just as there are benefits, there are also challenges such

as risk for relapse and boundary issues (Jones & Williams, 2007).

Theme II: Lack of school training for treating trauma (6/7). The participants

reported they did not receive adequate training on how to treat trauma in school, yet it seems

these participants took the initiative to educate themselves regarding trauma treatments in other ways. I wanted to ask about their trauma training because trauma is the core aspect of compassion fatigue and it seems that if one hasn't received proper training on how to deal with their client's trauma, they would be at an increased risk for developing compassion fatigue.

Two participants revealed that they received training in the Seeking Safety curriculum; two received EMDR training and one participant is pursuing EMDR certification currently; and one participant reported that he was trained to treat trauma by engaging in regular supervision. The Seeking Safety Curriculum is, "a present-focused treatment for clients with a history of trauma and substance abuse." (National Registry of Evidenced-Based Programs and Practices (NREPP), 2015, p. 1). It can be used with men and women as well as individually or in a group format and the curriculum focuses on coping skills and psychoeducation (NREPP, 2015). EMDR stands for Eye Movement Desensitization and Reprocessing Therapy. EMDR is an, "information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies" (EMDR Institute, 2011, p. 1). The Seeking Safety Curriculum and EMDR are common approaches to use for the treatment of trauma among the substance abuse population.

Seeking safety.

Gail

"How were you trained to treat trauma? Through Seeking Safety. I wouldn't say there was any formal training other than learning about that manual."

Molly

"We have a Seeking Safety curriculum and we started as an agency doing trauma informed care trainings, but I can tell you that my particular training was they handed me

this Seeking Safety book and said, "Go do a group." So, that's not the appropriate training for that. I'm not going to lie. It's been very similar training for everyone after me because I was never trained appropriately."

EMDR.

Sally

"I use EMDR and you know, again, I think it was on-the-job training (regarding how to treat trauma)."

Supervision.

Matt

"We have had several trainings. We do the annual trainings on it. Most of my training has been going and asking supervisors for help on how to handle the situation and what to do and then practicing it and doing it all over again."

Theme III: Lack of school training about compassion fatigue/self-care (6/7).

Six of the seven participants reported a lack of school training about compassion fatigue and self-care. These participants shared that they learned about compassion fatigue and self-care through conferences and continuing education trainings, and even then, the training had been limited. I found it surprising that six of the seven participants denied having school training regarding compassion fatigue and self-care. This finding warrants further exploration to determine if this is typical among master's level counselors.

Gail

"I wouldn't say I've experienced any formal education or training other than going to conferences."

Matt

"Formal? Not a whole lot other than the annual required trainings on it. That's an hour or

two each year as far as trainings go. That's all I've received."

In contrast to six of the participants, one participant shared that she did receive adequate

school training in relation to compassion fatigue and self-care. Elaine stated,

"That was something we talked about a lot through my master's program at USF."

Theme IV: Supervision on compassion fatigue and self-care (6/7). Training via

supervision on compassion fatigue and self-care was a theme that was revealed. It seems that

while the participants did not report receiving much training on compassion fatigue and self-care

in their school programs, the topic is frequently discussed with their on-site supervisor once

employed. Supervisors appear to be doing a great job of discussing the importance of these

topics with their supervisees.

Gail

"Yes, very much. Supervision talked about compassion fatigue and self-care."

Molly

"Yes, we talk about that a lot as a management team. Mostly as it relates to our

employees, but also as it relates to each other. Probably in July, we started talking about

the holidays and planning time off and making sure people actually take their time off.

So, we really try to instill in the team, "You know, this is part of your bonus as an

employee. This is part of your pay. You earned this. If you are not taking it, you're

shorting yourself." We really try to encourage taking time off as a form of self-care and

work-life balance."

Theme V: Use of evidenced-based practices (4/7). In the last several years the use of evidenced-based practices has been on the rise, especially in agency settings (Addiction Technology Transfer Center Network [ATTC], 2009). Evidenced-based practice refers to a manualized and rigorously studied set of interventions used to treat a variety of disorders (Craig & Sprang, 2010). Four of the seven participants reported using at least one of the following evidenced-based models: Seeking Safety curriculum, CBT, REBT, EMDR, and motivational interviewing.

Gail

> "This agency is really big on everything that we do, as much as possible, we try use stuff that is evidenced-based. As far as trauma, we use Seeking Safety and rely on that heavily."

Sally

> "We use CBT, Motivational Interviewing."

Elaine

> "With Tampa Crossroads we go with choice theory, REBT, and SMART recovery type model."

Overall, the data revealed three overarching themes: variability in addiction training, a lack of formal trauma training, and a lack of formal training about compassion fatigue and self-care. After analyzing the initial data, it was clear that there were no emergent themes about the role training played in relation to compassion fatigue. Because of that, I conducted a follow-up interview with six of the seven participants to target that information and to better answer research Question 2.

The follow-up interview consisted of three questions:

1. What role do you think addiction, trauma, and compassion fatigue training plays in regard to compassion fatigue?

2. From the data, I have found there's variability in addiction training, a lack of formal training for the treatment trauma, and a lack of formal education on compassion fatigue and self-care. Would you say that is on track?

3. How do you think having training in these areas would help with compassion fatigue?

Conducting the follow-up interview afforded me the opportunity to, not only ask additional questions, but to verify some of my results related to the training among these participants. I asked the participants if they thought the findings regarding variability in addiction training, lack of formal trauma training and lack of formal compassion fatigue and self-care training was on track. All of the participants stated "yes" they felt these findings were accurate.

Now, I will present the themes that emerged from the follow-up data.

Importance of Training in Relation to Compassion Fatigue

Theme VI: Prevention of compassion fatigue (6/6). All six of the participants reported that they thought training is important in preventing compassion fatigue. The following are representative participant comments on the importance of training in preventing compassion fatigue.

Dave

"Getting good training is essential. We will be less likely to get compassion fatigue. It won't be so emotionally draining if we have proper training."

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Matt

"Better training would definitely be helpful. The learning curve wouldn't be so steep,

especially with having no formal school training like myself."

I was inspired to hear that all six participants viewed training as a critical piece in

preventing compassion fatigue. I place a high value on proper training, and from my own

experience, see the benefit of good training as it relates to preventing compassion fatigue. If I

have proper training I will feel more equipped to face the challenges of the addiction profession.

Of the five participants who experienced compassion fatigue during their career, they all

shared that they believe their training or lack thereof played a role in their personal development

of compassion fatigue.

Matt

"Since I didn't have formal school training in any of these areas, it made it much more

likely for me to develop compassion fatigue and for it to happen quicker than it would it

have otherwise. You don't even know what you're looking at or for and just hope

someone will kinda point it out. And that becomes the training right there."

Dave

"I think it impacted me (lack of training). I was new in the field and not so trained and

had a lot of stress. I didn't feel equipped to deal with all the stressors I was facing."

Theme VII: Awareness and confidence (6/6). All six of the participants thought that

training protects individuals from acquiring compassion fatigue in two main ways: *Promoting*

awareness and increasing confidence. Training promotes awareness by providing a roadmap for

professionals regarding what to look for in reference to compassion fatigue and also what they

need to do if compassion fatigue is detected. In reference to how training helps promote

awareness, Erin said,

> "It (training) gives you something to watch out for. Awareness is the key. Very
>
> beneficial."

Matt
> "Better training in compassion fatigue would help with being able to identify it was going
>
> on more quickly and be easier to address."

Participants reported that they also felt training promoted self-confidence which helped

prevent compassion fatigue. Having proper training provides addiction professionals with the

necessary tools they need to do their jobs effectively. If an addiction professional has these tools

they will feel more confident and better equipped to do their jobs, thereby lessening the effects of

compassion fatigue.

Dave

> "Training will help promote confidence within the individual. It will help addiction
>
> professionals have better skills and strategies to deal with addiction and trauma. Having
>
> better training can help counselors stay rejuvenated and effective. We need good
>
> educators, take internships, ceu's etc."

Paige

> "The more competent you feel, the less stress you will feel too. And you will better know
>
> where your boundaries are. It promotes more confidence. It doesn't seem that educators
>
> are keeping up with the trends in the field."

I would like to end this section by sharing what participants found to be most beneficial

in their training that helped prepare them for treating the addiction population. The number in

parenthesis to the right indicates how many of the participants reported the following:

- Seeking safety curriculum (2).

- Time and experience in the field (2).

- Learning from others who have been in the addiction field for a long time (2).

- Personal recovery (1).

I was surprised to hear that only two participants found a particular training most beneficial in preparing them for treating the addiction population, especially when six of the participants shared how important they thought proper training is. I am curious to learn if this is because they lacked proper training, therefore they were forced to find benefit in other areas or whether they just found the other areas more beneficial.

This next section will aim to answer research Question 3 by discussing the self-care strategies addiction professionals are currently using to address compassion fatigue.

Research Question 3: What Self-Care Strategies are being used by Addiction Professionals to Address Compassion Fatigue?

Theme 1: Physical exercise (6/7). Physical exercise was a main theme that emerged from the participants as a form of self-care. It was clear the high value they place on engaging in exercise and they were quick to identify this strategy as something they found extremely beneficial. Participants specifically enjoyed going to the gym, exercising outdoors, running, yoga, walking, and swimming.

Dave

"I'm usually in the gym everyday right after I get out of work. I'm in a totally different place in my mind. I'm able to let so much of it go.

Molly

"I work out. I love my gym. I try to hit the gym before I go to work as often as I can.

Elaine

"I have some little weights here and I have my yoga mat over there. I try to stretch and I do a lot of exercising outside of work and that just helps so much.

Theme II: Mental escape activities (6/7). A mental escape activity refers to any activity in which individuals can mentally tune out the stressors of their daily life and find relaxation. Participants enjoyed engaging in the following mental escape activities: sitting at a coffee shop, looking at a phone, reading magazines, reading novels, watching T.V., going to the gym, getting massages, cooking, baking, being outside and staying in touch with nature, going to the beach, shopping, and hanging out with grandchildren.

Gail

"I like to just like zone out and read a magazine, sit at a coffee shop and read or sit with my phone. So, I like to just tune out."

Sally

"Go to the beach. The beach is the place. The beach fixes everything for me. I do escape things like reading novels and going to movies."

It seems that being carefree is something that is helpful to some of the participants too. Finding activities that promote a carefree attitude seems to be helpful given the challenges and stressors of working as an addiction professional. It is another way to relax and de-stress.

Dave

"When I'm done with the gym I take my dogs for a walk. At night in bed with my partner and puppies, watching T.V., just being carefree in what we watch."

Paige

"I cook. I hang out with my grandchildren because young people are so carefree and refreshing. I like to be outdoors."

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Theme III: Transitions (4/7). The participants identified that having a transitionary activity between work and home is extremely helpful. This transitionary activity seems to help the participants emotionally and physically shift from their work day mindset to home life. It is a great way to practice separating personal life from professional life.

Gail

"I would give myself that drive, like I would tell myself, I have this hour to figure out what to do with these feelings, but then as soon as I get home, it has to be done.

Matt

"I leave work every day and go take a shower. It kind of mentally and physically washes the day from me. That's the first thing I do. You just wash. You take off your clothes. You go get in the shower and you wash. You physically wash off the entire day. You put on a new set of clothes and then you can go do whatever instead of walking around with all the stuff on you. I know it's more psychological than anything else, but it works.

Dave

"So I go home, change. In the past, I would just go right to the gym from work and after that work out.

Molly

"Usually, I'll just listen to music on my drive home. By the time I get home, I've left all my clients in the building.

Theme IV: Basic needs (4/7). Basic needs in this context refer to what addiction professionals seem to need to achieve basic mental and physical health. Participants reported the following basic needs as being helpful self-care strategies: *Nutrition, sufficient sleep, and*

strategic scheduling. Table 4 will present specific examples of what participants do that helps

them meet their basic self-care needs of nutrition, sufficient sleep, and strategic scheduling.

Table 4

Basic Needs

Nutrition	*Sufficient Sleep*	*Strategic Scheduling*
Packing lunch	Getting 8 hours	Not scheduling clients back to back
Keeping snacks at office		Taking bathroom break
Taking lunch break		Taking time off from work
Eating healthy		Taking a vacation

Below are a few specific comments from the participants about their basic needs.

Dave

"Getting enough sleep, making sure I take time to use the bathroom, to get something to

eat. I don't schedule my clients back to back one after the other so that boom I'm done

with one and haven't even shed all that energy from that one client and allow myself to

reset for the next experience that I'm going to have with this other client. Then I give

myself time away from work: plan a vacation, long weekends, taking days off.

Elaine

"I have a snack stash over here. Eating healthy helps and having a good night sleep.

Theme V: Personal support to deal with compassion fatigue (5/7). Personal support,

which included support from family and friends, was reported as an important component of the

participant's overall well-being. Most of the participants reported having personal support was a

way that helped them deal with compassion fatigue.

Matt

> "Family that do not have anything to do with addictions or this field in general. I spend a lot of time with them and with other friends, too.

Dave

> "My family and my kids, and by my kids, I mean dogs. I stay connected and supported by others on a regular basis. I have people in my life daily, I'm not isolating, I talking and telling them what's going on with me. I'm being emotionally honest with people.

In contrast to the above statements, two participants shared how they have struggled getting support from their husbands and close family regarding the work they do as an addiction professional.

Gail

> A personal challenge that I've had is that my friends outside of work, they don't understand. They don't understand why these people that I don't know personally, like why they affect me. So, like talking to my husband is difficult because he can't support me the way that I want him to, or my close friends or my mother. All the people who support me in other ways, it has been a challenge that they are not able to help me with this particular topic.

Molly

> My husband is not an empathetic person. He's a military contractor and his empathy skills are about that of a cup of coffee. They're occasionally warm and somewhat satisfying but not terribly lasting and a little bit superficial.

Theme VI: Professional support to deal with compassion fatigue (7/7). All participants reported professional support being critical to their wellbeing as addiction professionals. Professional support included supervisors and co-workers.

Gail

> Definitely co-workers. Co-workers are very helpful. The supervisor I had for my license who was also a teacher for our master's program. He knows me very, very well and I reach out to him occasionally.

Molly

> My boss is very supportive. It helps that we have a tremendously supportive team. My team is like a family. We know each other's spouses. We know each other's birthdays. We eat lunch together. We'll go out on the weekends. So, we constantly laugh. We are super supportive and we pay attention. When someone is in their office with the door closed all day, we check in. We don't let that go unnoticed. We ask them, "Do you need me to cover your group?" "What do you need from me today?" "Is there something I can help you with?"

Theme VII: Supervision/Consultation (7/7). Participants reported seeking supervision/consultation for difficult clients and finding this essential in remaining balanced and keeping perspective as an addiction professional.

Matt

> "Yes, absolutely. You get a different perspective on somebody. That's always good, I think. For me, the most important part is it keeps me grounded with the client. If I think I am the only one that can deal with them (the client) or the person that knows best on what's going on then I'm in a bad place with that person."

Molly

"All the time. Thankfully my boss has an open door policy. Not just for me, but also for my team….I try to demonstrate this as much as I can for my team, Just go consult. There's nothing wrong with that. Someone may have a brilliant idea that had not yet occurred to you."

Sally

Yes. It's helpful to have other people to bounce ideas off of, to get suggestions from other people about maybe things I haven't thought of, or to get validation that I've done x, y, and z and that's what other people would have done. I am also a member of a supervision group that meets once a month. So, if there are difficult cases or self-care or transference issues, then I have a place where I can go that's delineated for that.

Theme VIII: Importance of maintaining boundaries (4/7). Boundaries were referenced several times throughout the interviews and seemed to be an invaluable strategy for taking care of oneself. The participants shared about how they set boundaries with their clients as well as their employer.

Matt

I've set very clear boundaries with the people that I work with that I don't get phone calls about work. If it can wait until tomorrow, then it will wait until tomorrow. You have to work on that.

Sally

I think part of that is also being able to set good boundaries with clients.

Elaine

Setting boundaries with your employers about not taking too high of a caseload and

things like that.

Of the many self-care strategies addiction professionals are using to prevent and address

compassion fatigue, I asked each participant to share what self-care strategy helped them the

most. Table 5 illustrates the participant's top choices.

Table 5

Most Helpful Self-Care Strategies

Participant	Strategy
Matt	Shower
Dave	Support from others that are privy to what I experience as a therapist.
Molly	Gym
Paige	Staying in touch with nature
Sally	Beach
Gail	Exercise
Elaine	Having a good support system

Advice to Other Addiction Professionals

I would like to end Chapter 4 by sharing the participant's advice to other addiction

professionals who may be struggling with compassion fatigue. Their recommendations fall into

three broad categories: normalization, importance of self-care, and attention to boundaries.

The following are illustrative comments.

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Gail

To understand that those feelings are normal. We want counselors to feel something to able to make a connection, but without going too far. Then, just get some help right away.

Matt

That it is real. You are going to have to learn how to take care of yourself. It's going to happen to you, there's no question about it. It's just when you are going to be willing to acknowledge it and take care of yourself.

Molly

Just watch for it. If you are not taking care of yourself, it will come through. You may not notice it, but the clients will…..I think compassion fatigue is something we don't look at enough in the field. It's something all counselors go through, especially in the addictions field. Once you normalize it and you educate on it, people will start looking for it, but we don't talk about it enough for people to know.

Dave

Work on your own stuff…If you aren't willing to do that, you are not going to be able to survive.

Paige

Get some boundaries around it.

Sally

Taking care of yourself is imperative. It isn't optional. It's something that you have to do and I think part of that is also being able to set good boundaries with clients.

Elaine

I talk about boundaries all the time and that they are a daily work in progress. It is

something I work on every single day….It's for the sake of not hurting the client and for

the sake of benefiting them.

Chapter Summary

The results of this study illustrate several themes about compassion fatigue, training and

self-care among the seven addiction professionals interviewed. In Chapter 5, the themes will be

discussed in detail under each research question. Following the detailed discussion of the

themes, implications of this research for the field of counselor education, limitations, and

recommendation for future research will be presented.

Chapter 5: Discussion

The results of this study indicate that compassion fatigue is present among addiction professionals. This chapter will discuss the participant's demographics as well as the types of clients the participants treat. Next, the emergent themes will be discussed at length in terms of risk factors and protective factors. Then, the benefits that the addiction professionals experience when working with their addiction clientele will be shared. This chapter will conclude by presenting the implications of this research for counselor educators, as well as, limitations of this research, and recommendations for future research.

Demographics

It does not seem that gender or age impacted whether or not the participants experienced compassion fatigue. It does appear, however, that length of time working in the addictions field may play a role in relation to compassion fatigue. Being in the field longer seems to be a protective factor against compassion fatigue. This was realized based on the fact that the participants shared that many of their compassion fatigue experiences were from earlier in their career, and they reported that their compassion fatigue symptomology was more pronounced at the beginning of their careers. This finding was surprising to me as I thought that if an addiction professional has been in the field a long time with a lot of trauma exposure that the individuals would experience more compassion fatigue situations. It may mean that as addiction professionals progress in their careers, they learn better strategies to effectively deal with clients as well as effective strategies to practice self-care, thereby lessening the risk of developing compassion fatigue.

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Clinical Profile of Clients

When looking at the clinical profile of the types of clients the participants treat, my assumption that the participants would treat a high number of addiction and trauma clients was confirmed. The participants reported that they believe their addiction clients have also suffered some form of trauma at least 30%-100% of the time. Accordingly, because of the reported high co-occurrence of addiction and trauma, it is not surprising that the participants reported hearing traumatic stories from their clients on a frequent basis which confirmed my second assumption. This frequent exposure to traumatic material increases the risk of developing compassion fatigue among these participants (Cramer, 2002). This risk is made clear given the fact that six out of the seven participants acknowledged experiencing compassion fatigue during their career. The next section will discuss the participant's experiences with compassion fatigue.

Experiences with Compassion Fatigue

Six out of the seven participants shared a specific compassion fatigue experience they have had during their career. Through their stories it was revealed how compassion fatigue can express itself in a variety of ways. For instance, Gail shared how when she experienced compassion fatigue she had difficulty separating her personal life from her professional life. Dave mentioned that he felt irritable and his patience and tolerance level was low. Furthermore, Molly reported avoiding both her clients and co-workers and feeling like she didn't want to hear anyone. This is similar to what Sally shared in that she too wanted to avoid people and not talk to anyone. Sally also mentioned how she felt so overwhelmed and couldn't stand to hear another traumatic story. Finally, Matt shared that childhood abuse is a trigger for him in developing compassion fatigue and this was identified when a co-worker pointed it out to him.

When Paige shared about her experience with compassion fatigue she did so in terms of how she addressed it. Paige mentioned the importance of recognizing compassion fatigue for what it is and being willing to take appropriate measures, such as boundary setting and practicing self-care, to address it.

Emerging Themes

Compassion fatigue symptomology/risk factors. Fahy (2007) maintained that while addiction alone has very serious symptomology, coupled with trauma, it makes for a more difficult disorder to treat. In addition, the participants shared that addiction can be a difficult disorder to treat because the clientele are challenging. They reported that addiction clientele are challenging because they often present with the characteristics of *denial, minimization, resistance*, and *lying*. The addiction professionals found it difficult to address their client's denial system and to deal with their client's minimization of their drug and alcohol use. In addition, they reported difficulty in dealing with their client's dishonesty and resistance to treatment.

The emergent theme of denial being most challenging isn't too surprising because according to Bishop (1991), "denial is perhaps the most striking psychological feature of chemical dependency" (p. 199). Denial is challenging to face because it, "is the force that supports the addictive process and distorts reality for the user, preserving the progressive and fatal relationship with the chemical" (Bishop, 1991, p. 199). Because denial distorts one's reality this leads clients to minimize their drug and alcohol use and they are often resistant to treatment because they don't believe they need it. Denial is also said to be challenging because it is a difficult construct to grasp and understand (Bishop, 1991). Because of the unique characteristics of denial, confronting this system on a regular basis can take its toll on addiction professionals.

According to Mathieu (2007), working with clients who have suffered a lot of trauma increases one's risk of compassion fatigue. It has already been established that the participants hear traumatic stories on a regular basis. This frequency may have led the participants to experience an emotional impact due to dealing with their client's traumatic stress. This emotional impact reportedly can impact one's personal life and create feelings of sadness. In addition, the emotional impact can lead to an emotional shutting down and feeling overwhelmed.

Hearing traumatic stories can also lead to experiencing distressing memories, avoidance of thoughts/feelings associated with hearing about the trauma, irritable behavior, and preoccupation with clients. The more exposure to traumatic stories, the higher the risk of developing compassion fatigue (Burke et. al., 2008). According to Sabo (2011) the risk of compassion fatigue increases when an emotional response is elicited due to having memories of a client's trauma. Four out of the seven participants reported experiencing distressing memories about their client's trauma. It was reported that the memories were intrusive and would occur randomly. This is similar to what Bride et al. (2009) found in his research with substance abuse counselors. In fact, 43% of the substance abuse counselors reported they thought about their work with their trauma clients without meaning to (Bride et al., 2009). Furthermore, the risk of compassion fatigue may increase based on how someone processes the distressing memories when they occur (Sabo, 2011).

According to Figley (1995), avoidance or numbing of the memories, thoughts, or feelings of the traumatic event is a symptom of compassion fatigue. Two out of the seven participants acknowledged avoiding thoughts or feelings associated with hearing their client's traumatic stories. One participant shared that early in her career she put a lot of effort into avoiding these types of thoughts and feelings by focusing on things outside of work. The other participant

shared that she did not consciously avoid these thoughts and feelings, but instead, did so as more of an automatic response.

Irritability is another symptom of compassion fatigue (Mathieu, 2007). Four out of the seven participants reported experiencing irritable behavior as a result of hearing their client's traumatic stories. The participants reported experiencing the irritability for about a couple of hours at the most. One participant reported he recognizes this feeling of irritability quickly and tries to take care of it by talking to someone about it and processing his feelings. This finding of addiction professionals experiencing irritability is similar to what Bride et al. (2009) found where 30% of substance abuse counselors also reported experiencing the symptom of irritability in their work with their addiction clientele.

Preoccupation with clients was reported from six out of the seven participants. It was reported that preoccupation occurred in the following situations: when working with difficult clients; working with clients in the midst of trauma work; working with younger clients; working with clients with safety risks, and working with clients with extreme traumas. One participant reported she does not currently find herself getting preoccupied with clients, but it happened frequently in the past. Another participant maintained that although she may get preoccupied with a client, she has boundaries up that keep her safe. Preoccupation with a particular client is a warning sign/symptom of compassion fatigue that clinicians need to be aware of and pay attention to (Figley, 1995). Preoccupation with clients can lead to re-experiencing the traumatic events, avoidance/numbing, or arousal (Figley, 1995). By having awareness, boundaries, and talking to someone about the preoccupation, it seems this can reduce the risk of developing compassion fatigue.

Difficulty separating one's personal and professional life is another symptom that could lead to or signal compassion fatigue (Figley, 1995). Six out of the seven participants reported struggling with the separation between personal and professional life at some point during their career. For two of the participants, maintaining this separation was more challenging at the beginning of their careers, rather than currently. Furthermore, it seems that being in a management role makes maintaining this separation more challenging. One participant mentioned always having her phone with her and wanting to be accessible for work which makes keeping the personal and professional life separation challenging. Similarly, a participant shared that being a manager is very time-consuming and part of her job is being on-call 24/7. And finally, a participant shared that, in the past, when she was in a management role or an on-call position that it took its toll on her health and she began breaking out in rashes. She believes that the lack of sleep due to being on-call contributed to the health issues. Once her health issues started to surface, she stopped the on-call position and made the decision to not live that way anymore.

In addition to being in a management role creating some challenges with keeping one's personal and professional life separate, one participant reported she found it difficult to maintain this separation when she was going through a divorce. It seems that when one's personal life is in flux it can spill over and impact one's professional life and vice versa.

Among the participants, several employment risk factors for compassion fatigue were identified. I chose to explore the addiction professional's experience with high caseloads, staff shortages, low salary, and low workplace support. The reason for this decision was because previous research has indicated that these are common workplace stressors that may contribute to the development of compassion fatigue (Craig & Sprang, 2010; Fahy, 2007; Jones & Williams,

2007; Killian, 2008). In addition, I personally experienced these workplace stressors while working in an agency setting. For instance, it was the norm to carry a high caseload due to staff shortages. Unfortunately, due to financial constraints, the agency was unable to hire new employees to help lessen the burden of carrying a high caseload. Along the same lines, since there were financial constraints, staff salary was generally low. Although these concerns were expressed to the management team regarding these workplace issues, there was a lack of adequate workplace support. Experiencing these employment risk factors in addition to working with addiction and trauma clientele made the risk for compassion fatigue that much greater. These types of employment stressors can lead to psychological and physical health issues among employees and they often lead to high rates of employee turnover (Duraisingam et al., 2009). This seems to be a trend in the addictions field where these types of employment risk factors are the norm, rather than the exception (Broderick, n.d.; Duraisingam et al., 2009; Jones & Williams, 2007). It is surprising that such a trend exists considering how important the profession is to those who are addicted, as well as their families, and the community. This may be because the addictions field is still trying to legitimize itself and be recognized for its important contributions. The variability of training among addiction professionals may contribute to the field not receiving the recognition it deserves.

Similar to previous literature (Broderick, n.d; Duraisingam et al, 2009; Jones & Williams, 2007), the majority of participants reported having high caseloads at some point during their career, staff shortages, and low salary. Six out of the seven participants laughed when asked about having a low salary and seem to have resigned themselves to this fact. In a CNN report examining stressful jobs with low pay, substance abuse counselors appeared on that list (CNN Money, 2015). The report stated the median pay for a substance abuse counselor was $32, 400

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and 71% respondents stated that their job was high stress (CNN Money, 2015). Experiencing these employment risk factors can increase one's risk of developing compassion fatigue (Jones & Williams, 2007; Perkins & Sprang, 2013).

In contrast to previous literature (Duraisingam et al., 2009; Jones & Williams, 2007), six out of the seven participants denied having low workplace support. It seems agencies are working hard to provide a supportive workplace considering the prevalence of high caseloads, staff shortages, and low salaries. Providing a positive work environment can help protect addiction professionals from developing compassion fatigue (Bride & Kintzle, 2011).

There are other risk factors such as age, gender, personal history with trauma, and being in recovery that also place addiction professionals at risk for compassion fatigue (Craig & Sprang, 2010; Killian, 2008; Perkins & Sprang, 2013). Among this sample, it does not seem that age or gender played a role in the development of compassion fatigue. One participant did mention having a personal trauma experience where he discussed being traumatized by what he put his family through due to his addiction. He shared that because of this experience he tries to limit the amount of time he spends working with family members because of the emotional reaction it triggers for him. Although this client mentioned this personal trauma experience it was not explored in greater detail and how it related to his experiences with compassion fatigue. Furthermore, three of the participants reported that they were in recovery themselves. These three participants did not share details about this aspect of their lives and it was not explored on a deeper level.

Training risk factors. Participants reported variability in training for treating addiction and lack of training in two different areas: treatment of trauma and compassion fatigue and self-care. First, variability of training for treating addiction will be discussed.

There is no question that to date there has been much variability in the training for addiction professionals (Bride et al., 2009; Lee, 2013; Linton, 2012). This variability has not only been identified in the routes offered to become an addiction professional, but also in how addiction courses are designed and taught (Lee, 2013). If someone chooses the formal school route at the master's level, and enrolls in a clinical mental health counseling program, these programs often only require one addictions course (Lee, 2013). If someone chooses a marriage and family therapy program or career-counseling program, an addiction course isn't typically even required (Lee, 2013).

If an individual chooses to pursue only a certification in addictions, they are required to have a bachelor's degree as well as 6,000 direct contact hours (FCB, 2014). This means they will likely not have had an addiction class at all as part of their training and rely heavily on on-the-job training and supervision. Research suggests that individuals without a master's level education are at higher risk for developing compassion fatigue (Perkins & Sprang, 2013).

Because of these issues, there is a need to have more uniformity regarding addiction training practices. Since having a master's level education reduces the risk of developing compassion fatigue (Perkins & Sprang, 2013) that might be the best form of entry into the field. In addition, mandating a series of addiction courses at the master's level would be helpful to ensure a more comprehensive approach to addiction training. Moreover, adding an addiction certification on top of one's master's degree can help demonstrate the professional's addiction specialty. Not only will this help addiction professionals be better prepared for their careers, it will help legitimize and strengthen the addiction professional's professional identity (Broderick, n.d.; Hagedorn, Culbreth, & Cashwell, 2014; Lee, 2013).

Similar to what research has shown regarding the variability in addiction training, the participants in this study acknowledged the same. Five of the participants chose the formal school route and completed their masters degree for counseling. Two participants entered the field through their own recovery and then one obtained their masters degree and the other obtained his certification in addictions. It seems that while entering the field through one's own recovery was the norm at one time, the addictions field has evolved and is requiring a higher level of education and training for those interested in working with the addiction population (Hagedorn et al., 2014). This new trend became evident when recruiting participants for this study.

Of the six participants who obtained their masters degree, four reported having only one class on addictions during their training and reported it wasn't very helpful in adequately preparing them for treating the addiction population. The participants also reported learning how to treat addictions via on-the-job training, reading information, CEU's, supervision, or through their own recovery. The term "trial and error" was mentioned twice by participants as a way to describe how they learned to treat addiction.

The good news is the Council for Accreditation and Related Education Programs (CACREP) has identified the variability of training for addiction professionals and recognized the need to solidify the addiction counseling profession. In 2009 CACREP revised their standards and acknowledged the importance of addiction education (Lee, 2013). The changes were as follows: Human growth and development courses were to now include theories and etiologies of addiction and clinical mental health counseling programs were required to implement more addiction-related requirements into their curriculum (Lee, 2013). In addition to those changes, there was the development of standards for a 60 hour addiction counseling

program (Lee, 2013). All of these additions are a step in the right direction for the addiction counseling field.

The participants reported a lack of formal school training in how to treat trauma. Six out of the seven participants reported this deficit. This is similar to the research conducted by Bride et. al. (2009) where the researchers found most substance abuse professionals were not adequately being trained in their respective academic programs to treat traumatized clients. This is unfortunate because as this study reveals, there is a high co-occurrence of addiction and trauma. This clinical profile of addiction coupled with trauma can make the treatment more challenging for addiction professionals and can also cause more negative emotional reactions by counselors (Benton et al., 2012). The negative emotional reactions may take the form of distressing memories, avoidance or numbing of thoughts and feelings, or irritability which, as discussed earlier, the participants in this study have experienced and are risk factors for compassion fatigue.

Finally, the participants reported a lack of formal school training about compassion fatigue and self-care. Six out of the seven participants reported not learning about compassion fatigue and self-care in their schooling, but learning about it at conferences and through continuing education opportunities. While counselor wellness is extremely important and advocates for self-care, it appears that, "only a handful of counselor education programs offer a wellness class" which aligns with what the participants reported (Roach & Young, 2007).

In a study conducted by Roach & Young (2007) the researchers assessed masters level counseling students' wellness levels at the beginning, middle, and end of their counseling programs. Of the 204 participants from three different accredited universities, they found that less than half of the participants reported having a wellness course offered (Roach & Young,

2007). Of the students who did have a wellness course, results indicated that those students had higher levels of Total Wellness (Roach & Young, 2007).

The preliminary data revealed issues with regard to the participant's training practices in three areas: addiction training, trauma training, and compassion fatigue and self-care training. Taking it a step further, three follow-up questions were conducted with six of the participants to explore how these issues in training related to compassion fatigue.

All six participants corroborated the results that there is variability in addiction training, a lack of formal trauma training, and a lack of formal compassion fatigue and self-care training among addiction professionals. Even the one participant who reported having a lot of good school training in these areas stated that although her experience was positive, she knows many colleagues that did not have such experience, and therefore, feels that the issues with training are more the norm rather than the exception.

Interestingly, the variability of addiction training found in this study is similar to what Morgan et al. found in their exploration of addiction training in counselor education programs back in 1997. The results regarding the lack of formal trauma training among the participants in this study is similar to what Bride et al. (2009) found when researching trauma training among addiction professionals. Bride et al. (2009) found that addiction professionals were treating a high percentage of clients with addiction and trauma, yet only a small percentage had actually received academic training on how to treat trauma. Furthermore, Bride et al. (2009) found that although the participants received little trauma training in their academic programs, the participants pursued continuing education opportunities and certifications in trauma training to address this deficit. This is similar to the addiction professionals in this study. Most sought training in EMDR and the Seeking Safety curriculum to lessen the deficit of not receiving trauma

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training in school. It is important to note that the one participant that reported receiving good school training in these areas was the most recent graduate from a master's program which may indicate counselor training programs are improving in these areas. Future research of counselor education programs regarding these training issues is warranted.

Not only were these training issues identified among the participants in this study, but it was also revealed that the participants believed training plays an important role in relation to compassion fatigue. The participants shared how they believe good training helps prevent compassion fatigue. Gail shared an interesting discovery she made in the past week with regard to training and compassion fatigue. She discussed witnessing well trained staff starting to take care of other staff members who weren't properly trained. She stated she sees a ripple effect and the strain that lack of training puts on the entire system and the compassion fatigue risks that come from it.

All of the participants reported how essential and critical they think proper training is and how it can help increase one's confidence level, lessen the emotional drain, improve boundary setting, and lessen the steep learning curve in the addictions field. The participants believe that all of these benefits of good training can help buffer the effects of compassion fatigue.

The participants seem to understand the role of training in relation to compassion fatigue because of their personal experiences with compassion fatigue. All of the participants who experienced compassion fatigue in the past reported that their training played a role in their development of compassion fatigue. For instance, Matt who entered the field through his own recovery reported how he didn't have any formal training on how to treat addiction, trauma, and had no understanding of what compassion fatigue and self-care was. Matt shared how this made the learning process of working in the addiction field very difficult and caused compassion

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fatigue to show up in his life earlier than it may have otherwise. He mentioned how he was lucky that a colleague came to him with their concerns about him struggling with compassion fatigue because he didn't know what it was or what to be looking for. Matt stated that this process of a colleague pointing it out to him became his training. Furthermore, Dave shared that when he was new to the field he was under a lot of stress. He mentioned that his training didn't prepare him for the stressors that he was facing, and that contributed to him developing compassion fatigue. Gail mentioned her lack of training influenced the development of compassion fatigue by her not knowing the emotional boundaries to have between her and her clients. For instance, Gail stated she made a commitment to herself early in her career to be emotionally invested in her clients and to be emotionally present with them along their journey. She reported knowing the importance of being emotionally present with her clients, but not realizing the risks that can come from such. In contrast, Elaine, who has not experienced compassion fatigue during her career, stated that she partially attributes that to the good training she received through her master's program.

Protective factors against compassion fatigue.

Training. Although the participants acknowledged variability in their training for treating addiction and a lack of formal school training in the areas of trauma and compassion fatigue and self-care, there were protective factors identified. First, even though the participants reported that their addiction training was quite variable; four participants stated they have learned to use evidenced-based practices such as CBT and motivational interviewing in their work with addiction clients. This is a protective factor against compassion fatigue because research has shown that using evidenced-based practices can reduce one's risk for compassion fatigue (Craig & Sprang, 2010).

Similarly, while the participants acknowledged a lack of school training for treating trauma, it seems they each recognized this deficit and took the initiative to seek out trauma training on their own. The participants reported being trained in EMDR, Seeking Safety curriculum, and utilizing supervision to learn about how to treat trauma. Because EMDR and Seeking Safety are evidenced-based this is another protective factor for the participants against compassion fatigue.

Next, even though six out of the seven participants shared they did not receive school training about compassion fatigue and self-care; they are receiving training on these topics through supervision with their work supervisors. This type of dialogue is critical to counselor wellness and can help a counselor feel safe to be able to discuss their feelings and receive guidance about compassion fatigue.

Finally, from the follow-up interview, the participants stated that having training in the areas of addiction, trauma, compassion fatigue and self-care would serve as a protector against compassion fatigue in the following ways: increased confidence and increased awareness. Dave, Paige, and Gail discussed how having good training would promote confidence within the individual and help addiction professionals feel better equipped and more effective in dealing with addiction and trauma, whereby reducing the risk of compassion fatigue. This is similar to what Craig and Sprang (2010) found in their study about the benefits of using evidence-based practices in treating trauma. The researchers maintained that using evidenced-based practices may reduce the risk of developing compassion fatigue because it increased the counselor's self-efficacy in treating the trauma population. It seems that having increased self-efficacy and self-confidence in treating addiction and trauma is viewed as a buffer against developing compassion fatigue.

Sally, Matt and Elaine mentioned how training promotes awareness. By having better training, Sally mentioned that it would help addiction professionals be more aware of the importance of self-care and also learn about specific ways to take care of themselves. Matt stated that having better training would assist with being able to identify signs of compassion fatigue early, and in turn, it would be easier to address. Elaine stated that awareness is key and having good training helps foster awareness so that you know what you are looking for in regard to compassion fatigue.

Self-care. The participants shared about several self-care strategies they find helpful in guarding against compassion fatigue. It seems these addiction professionals are aware of the importance of self-care strategies and use them on a regular basis to maintain their health.

Exercise. Exercise has proven physical and mental health benefits and is a highly recommended component of overall wellness (Cummins et al., 2007; Jones & Williams, 2007; Lawson & Venart, 2005; Richards et al., 2010). While counselors often recommend this strategy to their clients, counselors don't always take their own advice (Cummins et al., 2007). Roach & Young (2007) found that among the masters students they interviewed about wellness, only five of the 204 participants mentioned physical exercise or nutrition as part of their responses about wellness. The researchers theorized the low response may have been because of the student's intense workload as graduate students (Roach & Young, 2007).

Contrary to Roach & Young's (2007) findings, the addiction professionals in this study overwhelming reported understanding the importance of exercise and implementing this form of self-care regularly. In fact, two of the participants shared how they enjoy going to the gym after work as a way to help them de-stress from the workday. One participant shared how she keeps weights and a yoga mat in her office so she can exercise and de-stress while at work. Of the

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participants who mentioned exercise, they each lit up with a smile when they discussed the value they find in this self-care activity.

Mental escape activities. Another self-care theme that emerged was engaging in mental escape activities. Given the intense nature of the addictions profession, it seems the participants reported enjoying activities where they could briefly tune-out or mentally escape. This is helpful as it allows for a temporary shut-down of work related thinking. The participants reported several activities that helped them mentally escape which included sitting at a coffee shop, looking at phone, watching t.v., being carefree, and more. This is a balancing act because it is also important for addiction professionals to not mentally escape to a degree that it becomes unhealthy (Venart, Vassos, & Pitcher-Heft, 2007). It can become unhealthy when someone employs this form of escape to avoid thoughts and feelings as a long-term solution (Venart et al., 2007).

Two participants mentioned enjoying mental escape activities that promote feelings of being carefree. One participant specifically mentioned the benefit she finds in spending time with her grandchildren because they are carefree and refreshing. Previous research has confirmed this as a helpful self-care strategy and found time spent with children improves emotional health and wellbeing by "connecting counselors to positive feelings" (Venart et al., 2007, p. 54).

Transitions. Transitions were also found to be helpful among the participants. Transitions refer to an activity used to transition from work to home life. The benefit of using a transitionary activity is that it seems to help one mentally and physically leave the work day behind and to maintain a clear separation between work and home life. One participant reported showering or taking a bath as soon as he gets home to physically and mentally wash the day

away. He reported this is the most helpful self-care strategy he uses. The other transition

activities used by the participants were using the drive home to process through feelings,

listening to music on the drive home, or going to the gym between work and home.

Similarly, in a qualitative study with six Australian social workers, researchers explored

what helps social workers stay in the profession (Chiller & Crisp, 2012). All six participants

shared they have a transitional activity such as travel or exercise that helps them make the shift

from work to home (Chiller & Crisp, 2012). It seems that both social workers and addiction

professionals find this strategy helpful.

Basic needs. The participants shared they found nutrition, sufficient sleep, and strategic

scheduling as extremely helpful self-care strategies. It seems these strategies are the basic

elements that these addiction professionals need in order to function in a healthy manner. The

needs identified can be thought of in a similar way to Maslow's most basic physiological need.

In this sense, if addiction professionals fail to meet this most basic need, it is challenging to meet

their higher needs and function optimally.

First, nutrition will be explored. Research has shown the importance of proper nutrition

in combatting compassion fatigue (Cummins et al., 2007; Jones & Williams, 2007), but with

busy schedules and high pressured jobs, individuals can find it difficult to make healthy

nutritional choices. Four of the participants shared strategies that help them achieve their

nutrition needs: packing lunches, keeping snacks in office, and making the commitment to taking

their lunch break regardless of how busy the day may be.

Sufficient sleep was also mentioned by three of the participants as an important self-care

strategy. The reality is if a person is not getting adequate sleep it can negatively impact their

mental and physical well-being and can lead to a myriad of issues like making poor decisions

regarding nutrition, boundaries, and more. If one's sleep starts to suffer, it may signal an issue such as: increase in work stress, depression, or anxiety (Killian, 2008). Addiction professionals can use their sleep patterns as a marker for their overall well-being.

Finally, strategic scheduling in the form of taking time off of work, taking bathroom breaks, and taking breaks between clients was mentioned. By taking time off of work, it helps rejuvenate one's mind, body and spirit. All too often, people get busy and believe that they don't have the time to use their vacation hours or some agencies may discourage taking time off, but it is critical. Similarly, taking breaks between clients allows for one to decompress and recharge and is a great way to guard against compassion fatigue. This also allows for one to take a bathroom break and get centered before the next client. As Dave stated, "I don't schedule my clients back to back one after the other so that boom I'm done with one and haven't even shed all that energy from that one client and allow myself to reset for the next experience that I'm going to have with this other client."

Personal support. Personal support can be defined as, "relationships with spouse, companion, friends, and other family members" (Richards et al., 2010, p. 250). Killian's (2008) research with clinicians working with trauma survivors confirmed that personal support was a primary factor in protecting against compassion fatigue and promoting compassion satisfaction.

In this study, the participant's responses regarding personal support were mixed. Five participants shared they have personal support consisting of family members and close friends to help them deal with compassion fatigue and work-related stressors. One participant shared he values spending time with people not related to the addiction field and finds that helpful. Another participant shared that her friends are therapists; therefore they are empathetic and understanding to the elements of compassion fatigue.

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Two participants reported not having support from their husbands. They both mention they struggle getting understanding and empathy from their husbands regarding the work they do. The good news is, these participants seem to be aware of this deficit and have learned to garner their support elsewhere.

Professional support and supervision/consultation. Professional support can be defined as, "consultation and supervision from peers, colleagues, and supervisors and the continuation of professional education" (Richards et al., 2010, p. 250). Several studies have shown that having professional support is a protective factor against compassion fatigue (Cummins et al., 2007, Jones & Williams, 2007; Killian, 2008; Lawson & Venart, 2005; Richards et al., 2010), and the findings of this study supports that conclusion, as well.

All seven participants reported having a strong professional support system to help them deal with compassion fatigue. They referenced having supportive supervisors, co-workers, and colleagues that they can turn to for guidance and support. One participant stated,

"My team is like a family. We are super supportive and we pay attention."

Having a strong professional support system affords an individual the opportunity to confidentially process trauma material, confer with co-workers between sessions, brainstorm therapeutic interventions, obtain clinical suggestions, and get validation about the clinical direction you are pursuing (Killian, 2008; Lawson & Venart, 2005).

A component of professional support is supervision. Supervision is an ongoing process and, ideally, should continue throughout one's career. It is vital because it is a way of, "assessing and monitoring for prevention purposes" (Cummins et al., 2007, p. 42). Effective supervision involves a foundation built on trust where a person feels a sense of safety to share their feelings, anxieties, and more (Cummins et al., 2007).

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Jones & Williams (2007) maintain that one of the traits addiction professionals should exhibit is the, "willingness to use clinical supervision and peer assessments to gain insights into clinical performance, especially deficiencies" (p.15). This trait was found among the addiction professionals in this study. In fact, all of the participants reported they seek out and engage in regular supervision/consultation. Paige said,

"I still pass cases with problematic aspects of them by other staff members so that we can maintain a team kind of strategy instead of me arbitrarily acting on particular cases."

Maintaining boundaries. Boundary setting is not just a recommendation in the counseling field, but an ethical obligation (ACA, 2014). Walker & Clark (1999) stated that, "boundary crossings and violations may damage clients, clinicians' careers, agencies' reputations, and programs' credibility" (p. 1439). Therefore, boundary setting is intended to not only keep clients safe, but is also intended to keep counselors safe. Often, the clients who seek addiction treatment lack boundaries; therefore it is imperative that addiction professionals have the knowledge and skill base to effectively set boundaries and teach their clients about boundaries (Jones & Williams, 2007).

Four of the participants in this study found boundary setting essential for their self-care. The boundary setting the participants discussed took two forms: boundary setting with clients and boundary setting with employers. When specifically discussing boundary setting with employers, participants reported they have implemented the following boundaries and found it helpful: not getting work related phone calls after hours, keeping caseload down, not taking call, and only working four days a week.

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Interestingly, although boundary setting is an ethical obligation, only four participants referenced this as being important to their self-care. It is unclear why the other three participants did not reference boundary setting, but they may not see it as an important form of self-care.

Benefits: Positive Client Change

The final protective factor I would like to discuss is the benefits the participants found in working in the addiction field. Finding benefit is one's job can help protect against compassion fatigue (Smart et al., 2014). Five of the participants reported the benefit they derived from their profession was seeing their clients change in a positive way.

Gail

"There are quick changes, you are able to see it in their face immediately when they get it, when they find a coping skill that works, or the sense of pride when they run into someone that they used to use drugs with or they go into a situation where they had a craving or an urge, but they were able to get passed it. I like how it's quick. You can see changes very quickly with the population."

Matt

"It can be rewarding at times. It's very challenging. I guess that's a benefit, too. You never know what you are going to get when you walk in the door. Getting to know people, I do enjoy, but I also enjoy only getting to know them for a short period of time and then they move on to bigger and better things. I do enjoy that."

Dave

"Well, the benefits are that people can actually have a spiritual awakening, and all that is, is a change in the way that they interpret or perceive themselves, the world they live in, the people in it, their communities, and the closest people in their lives; usually with a lot

less hostility and a lot less fear. It's nice to see people kind of relax and maybe exhale for the first time in their lives and so I appreciate that."

Molly

'They come in just a hot mess, just an absolute hot mess. Sometimes they literally come in in paper clothing with no shoes because we get them straight from jail. They come in with nothing. Sometimes not even the shirt on their back. We're a six month program so by the end of six months, if they followed the program, and they get everything in place, they have their ID, they have their social security card, they have employment, they have housing. They've gone from being a detriment to society to a contributing tax payer. That to me is just an awesome shift to be able to watch."

Paige

"I think more so than other populations of people, addicts have negative consequences right in their faces, and so they're more willing to make changes and they see a reason for making changes."

Conclusion

The purpose of this study was to gain an in-depth understanding of the addiction professionals experience with compassion fatigue, training practices, and self-care. The goal was to answer the following research questions:

1. What are the experiences addiction professionals have with compassion fatigue?

2. What role does training play in relation to compassion fatigue?

3. What self-care strategies are being used by addiction professionals to address compassion fatigue?

This study aims to add to the literature by bringing attention to the addiction profession in general. As mentioned earlier, strides are being made in trying to strengthen addiction professional's professional identity and to legitimize the addiction profession. By listening to the voices of addiction professionals regarding this important topic, it aligns with those objectives. Focusing specifically on Licensed Mental Health Counselors and Certified Addiction Professionals experiences also aims to close the gap in the literature as these credentials have not been a primary focus.

In listening to the addiction professionals in this study, it was revealed that six out of the seven participants experienced compassion fatigue during their career. The one participant who has not experienced compassion fatigue reported she experienced burnout during her career. This isn't too surprising given the fact that the participants reported the following: High frequency of addiction and trauma clients, hearing traumatic stories on a regular basis, employment risk factors, and lack of training in several areas such as addiction, trauma, compassion fatigue and self-care. These are all factors that place an individual at risk for developing compassion fatigue. Additional risk factors/warning signs identified are as follows:

- Suffering an emotional impact due to their work;

- Suffering distressing memories;

- Avoidance of thoughts and feelings associated with their client's trauma;

- Irritability;

- Preoccupation with clients;

- Difficulty separating personal and professional life;

By identifying these risk factors/warning signs among the addiction professionals in this study, the hope is that other individuals in the addiction field may benefit from reading about their experiences and identify how they may relate to the experiences discussed.

While there were several risk factors/warning signs of compassion fatigue identified, it seems the participants have a strong emotional self-awareness regarding the stress they experience from working with their addiction and trauma clientele. Emotional self-awareness aids in protecting against compassion fatigue by helping an individual detect when they are suffering symptoms of compassion fatigue and develop an appropriate course of action to avoid developing more pronounced symptoms of compassion fatigue (Killian, 2008). It seems the participant' emotional self-awareness has deepened over time as evidenced by statements about how much they have evolved since being a novice counselor. They have learned to be more in-tune with their emotions and have learned the value and necessity of self-care. This is evidenced by the many strategies identified and utilized by these participants. The following strategies were discussed:

- Physical exercise;

- Mental escape activities;

- Transitions;

- Basic needs;

- Personal support;

- Professional support and supervision;

- Boundary setting;

While it is clear the addiction profession is challenging on many levels, the participants in this study seemed to genuinely enjoy the work they do and derive a lot of benefit from

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working with the addiction population. The hope is this research can also present the positive aspects of working in the addictions field and inspire others about the importance and benefits of working with addiction.

Implications for Counselor Educators

Although six out of the seven participants acknowledged experiencing compassion fatigue during their career, the theme emerged that compassion fatigue is not something readily discussed by addiction professionals.

Matt

"Most people won't talk about it. It has to be pointed out to them that they are in a funk. I don't think they want to acknowledge that they have it quite frankly, because they think they either shouldn't have it or they think if they do have it, then they're not meant to be in the field, so they can't acknowledge it."

Molly

"We don't talk about it enough because everybody thinks that as counselors, we're this agent of change and we should be able to "heal thyself" which is crap because you can really only feel that when you are not at work. You need to get out of your office to do it. You need to go do something fun. You need to recharge your own batteries. That is not going to happen if you are just stuck in your 40 hour week, crying."

Additionally, six out of the seven participants reported not learning about compassion fatigue and self-care during their formal education experience. It is unclear if this is unique to this sample or if this is a trend across counselor education programs. If it is not being discussed, it will be important for counselor educators to begin discussing the concept of compassion fatigue at the beginning of counselor training as well as consistently throughout counselor

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training. When discussing the concept of compassion fatigue with counseling students, it will be important for counselor educators to do so in a non-shaming way and in a way that normalizes the construct.   By teaching about compassion fatigue in this manner, the hope is counseling students will feel comfortable bringing up the topic and asking for help if needed.

While CACREP is working to solidify the standards for addictions counseling, there is still work to be done. I would recommend that counselor educators find ways to incorporate addiction education into their respective course curricula. It may be helpful to provide an addiction component in courses such as: Human Development and Personality Theories, Group Counseling, Counseling in Community Settings, Multicultural Counseling, and Assessment and Appraisal.

Within the addictions courses offered, I would also recommend that counselor educators include course content regarding the high prevalence of the co-occurrence of addiction and trauma. Because dealing with trauma is a core component of compassion fatigue, it is important to educate students thoroughly on this topic with the hope of better preparing addiction professionals for this reality. Additionally, teaching students how to assess for trauma is needed so they have an understanding of what to look for regarding trauma among their clients and this will help guide the treatment process. It would also be important for addiction professionals to understand the effects of trauma and how trauma symptoms can influence addiction symptoms and vice versa. By understanding this process, the addiction professional can then educate their clients about this process which may help the client gain a better understanding of both their addiction and trauma conditions.

Limitations

There were several limitations in the study. First, the addiction professionals in the study practiced solely in the Tampa area. Because the geographic location was narrow in scope, the research may not be transferable to other addictions professionals in other geographic locations. Second, using a quota sampling approach, the goal was to recruit four LMHC's; four LMHC/CAP's; and four CAP's. This quota was not reached, and instead, the final sample consisted of four LMHC's; two LMHC's/CAP's; and one CAP. It is unclear how reaching the quota may have impacted the results. Also, four of the seven participants verified that their transcribed interviews were correct. It is assumed that the three participants who did not respond to the member check email did not detect any errors in their interview transcripts either, but this is not certain. Finally, six out of the seven participants agreed to participate in answering the follow-up questions regarding research question two. Since one of the participants did not participate in this component of the research it is not clear how their response may have changed the results.

Recommendations for Future Research

It is recommended that similar research be conducted with addiction professionals who are new to the field, possibly while in their two year internship experience awaiting licensure. Research has shown that social workers experience compassion fatigue at the onset of their career, and they reported experiencing negative reaction to their clients (Knight, 2010). Furthermore, in an exploratory study of compassion fatigue in novice counselors, it was reported that "novice counselors who work with trauma survivors commonly report experiencing a variety of feelings similar to those of their clients" (Exum, 2002, p. 11). Several of the participants in

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this study reported experiencing more pronounced symptoms of compassion fatigue earlier in their career.

The participants in this study had all been working in the addiction field for at least five years. This was intentional because I wanted to ensure that the participants had exposure to addiction and trauma clientele. It would be important to discover if addiction professionals, who are early in their career and with less exposure to client's traumas would still acknowledge experiencing compassion fatigue and associated symptomology. Results from this proposed study could further inform counselor educators and supervisors about the importance of compassion fatigue education and making it a topic that is discussed regularly with the goal of better preparing new addiction professionals for this important field. The research could also uncover how compassion fatigue symptomology may differ between novice addiction professionals and more seasoned addiction professionals.

While the topic of compassion fatigue and self-care are important topics to discuss in counseling programs, it is unclear the extent to which they are woven into counselor training coursework. Future research could examine how many counselor training programs are incorporating the topics of compassion fatigue and self-care in their training programs and to what extent. The more discussion, training and awareness of the topics of compassion fatigue and self-care, the more it can be normalized among counselors in training.

Since all of the participants in this study were Caucasian, it would be important for future research to focus on a more diverse sample. It would be helpful to explore how compassion fatigue symptomology may differ among individuals from different ethnic backgrounds.

Finally, research indicates that having a personal history with trauma and being in recovery can increase one's risk for developing compassion fatigue (Craig & Sprang, 2010;

Killian, 2010; Perkins & Sprang, 2013). One participant referenced a personal experience with

trauma and three of the participants mentioned being in recovery themselves. Although these

risk factors were mentioned, they were not explored thoroughly and warrant further exploration.

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Appendices

Appendix A: Recruitment Email

Dear   ,

My name is Amanda DePippo and I am working on my dissertation at the University of South Florida under the direction of Herbert Exum, Ph.D. Research indicates that compassion fatigue impacts a variety of helping professions and we are interested in its role among addiction professionals. This research has been approved by the IRB (#18768).

I am emailing you and inviting you to participate in this research study because you are a mental health professional (LMHC and/or CAP) who treats clients with addiction in the Tampa Bay area. If you decide to participate, I would then sit down and ask you about your experiences with compassion fatigue and self-care. The interview will take approximately 30 minutes of your time and will be audio-recorded. It is completely voluntary on your part, and you may stop at any time. All of your responses will be confidential.

If you are interested or have any further questions, please email me back at adepippo@mail.usf.edu.

Thank you for your help.

Amanda DePippo, LMHC, CAP
University of South Florida

Appendix B: Informed Consent

Informed Consent to Participate in Research
Information to Consider Before Taking Part in this Research Study

IRB Study # 18768_____

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study titled, "Compassion Fatigue and Self-care Strategies among Addiction Professionals: A Qualitative Study" that will be conducted by Amanda DePippo, Doctoral Candidate at the University of South Florida in the Counselor Education Department. This research project will be conducted under the guidance of my faculty advisor, Dr. Exum.

- ✓ Purpose of the Study: The purpose of this study is to learn more about compassion fatigue and self- care among addiction professionals.

- ✓ Why I am Requesting Your Participation: You are being asked to participate in this research study because you are an addiction professional in the Tampa Bay area.

- ✓ Why Your Participation is Helpful: To assist in learning more about your experience with compassion fatigue and your self-care strategies.

- ✓ What Participation Requires: If you participate in the study, I would then sit down and ask you about your experience with compassion fatigue and self-care. The interview will be audio-recorded. Completion is expected to take approximately 30 minutes. There are no right or wrong answers. Participation will occur during the fall of 2014.

- ✓ Total Number of Participants: 20

- ✓ Alternatives: You do not have to participate in this research study.

- ✓ Benefits: We are unsure if you will receive any benefits by taking part in this research study.

Appendix B: Continued

- ✓ Risks or Discomfort: This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

- ✓ Compensation: Participants will receive a $5.00 Starbucks gift card.

- ✓ Privacy and Confidentiality of Your Responses: Your decision to participate in this research study must be completely voluntary. Please note that you can stop at any time. There is minimal risk for participation in this research. I will be present during the interview in order to provide assistance if you have any questions or concerns. I will destroy all data after five years. All written data will be shredded. Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, the USF Institutional Review Board and its staff, and other individuals acting on behalf of USF may inspect the records from this research project, but your individual responses will not be shared with anyone other than myself and my doctoral committee. A pseudonym will be used instead of your real name to ensure confidentiality. Only we will have access to the locked file cabinet stored at USF that will contain all records.

- ✓ Voluntary Participation/Withdrawal: You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study

- ✓ What I Will Do with Your Responses: I plan to use the information from this study to promote awareness about compassion fatigue among addiction professionals. This research project is for my dissertation and the results of this study may be published. However, the data obtained from you will be combined with data from other people in the publication. The published results will not include your name or any other information that would in any way personally identify you.

- ✓ Questions? If you have any questions about this study, call Amanda DePippo, the Principal Investigator, at 850/519-7578. If you have questions about your rights as a person who is taking part in a research study, you may contact a member of the Division of Research Compliance of the University of South Florida at (813) 974-5638

Appendix B: Continued

Consent to Take Part in this Research Study
It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this letter and consent form for my records.

_____
Printed name

_____   _____
Signature of participant   Date
taking part in the study

Statement of Person Obtaining Informed Consent
I certify that participants have been provided with an informed consent form that has been approved by the University of South Florida's Institutional Review Board and that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

Appendix C: University of South Florida IRB Approval Letter

9/8/2014

Amanda DePippo, M.Ed.
L-CACHE - Leadership, Counseling, Adult, Career & Higher
Education 4202 E. Fowler Avenue
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**

IRB#: Pro00018768

Title: Compassion Fatigue and Self-care Strategies among Addiction Professionals: A Qualitative Study.

Study Approval Period: 9/7/2014 to 9/7/2015

Dear Mrs. DePippo:

On 9/7/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):

Protocol Document(s):

Compassion fatigue study protocol

Consent/Assent Document(s)*:

Informed Consent.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

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Appendix C: Continued

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Signature removed from online copy

John Schinka, Ph.D.,
Chairperson USF Institutional
Review Board

Appendix D: Interview Guide, Version 1

Demographic Questions:

As we begin, I'd like to ask you a few demographic questions.

- Male or female? [just mark]

- Age?

- What are your credentials?

- What year did you obtain your degree and/or certification?

- Number of years counseling?

- Number of years of working with addictions?

- Type of employment?

- What is your ethnicity/culture?

Let's talk a little bit about your experiences as a counselor. Keep in mind, you can choose not to answer a question at any time.

1. What brought you into the field of addiction counseling?

2. Tell me about the clients that you work with, and in general, about the work that you do as an addiction counselor?

3. What are the benefits of working with clients who are struggling with addiction?

4. What are the challenges of working with clients who are struggling with addiction?

Let's discuss the types of clients you treat.

5. What percentage of your clientele comes to you for help with an addiction?

6. What are the most common addictions you treat?

7. What other disorders co-occur with addictions?

Probe: What about trauma?

Probe: How would you define trauma?

Appendix D: Continued

If they need further clarification: "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

Probe: What percentage of your addiction clients suffered trauma too?

Probe: What are the most common traumas reported among your addiction clientele?

8. Do you hear traumatic stories from your addiction clientele? If yes, probe.

Probe: At what frequency?

Let's talk in more detail about your experiences with addiction counseling.

9. How have you been impacted by the traumatic stress of your addiction clients?

Probe: Have you had an emotional impact because of the traumatic experiences of the addiction

clients you treat?

    Probe: How so?

Probe: Do you ever have distressing memories about the traumatic events that you hear about

from your addiction clients?

    If yes, probe: Can you tell me more about that?

Probe: Do you have dreams or flashbacks about your addiction client's traumatic events?

    If yes, probe: Can you tell me more about this?

Probe: Do you try to avoid thoughts or feelings associated with the traumatic stories that your

addiction clientele shares?

    If yes, probe: How do you attempt to avoid such thoughts or feelings?

Probe: Do you feel like you've experienced the trauma of someone you've helped?

    If yes, probe: Can you describe that experience?

10. Do you ever experience the following symptoms as a result of hearing the traumatic stories

Appendix D: Continued

from you addiction clientele?

a. Irritable behavior

b. Reckless or self-destructive behavior

c. Hypervigilance

If yes, probe: How long would you say these symptoms last?

    Probe: Can you tell me more about these symptoms?

11. Do you ever feel preoccupied with one or more of your clients?

Probe: Can you tell me more about that?

12. Is it difficult to separate your personal life from your professional life?

Probe: In what ways is it difficult to separate your personal from professional life?

Probe: Do you feel it is more difficult to separate your personal from professional life working in

addictions versus regular counseling?

13. Have you experienced any physical symptoms as a result of hearing the traumatic stories

from the addiction clients you treat?

Probe: Can you tell me about that?

14. Do you experience any of the following through your place of employment?

a. Low workplace support

b. High caseload

c. Staff shortages

d. Low salary

15. Have you heard about compassion fatigue? Yes No

If yes: How would you define compassion fatigue?

If no: Compassion fatigue is a combination of physical, emotional, and spiritual depletion

Appendix D: Continued

associated with caring for clients in significant emotional pain and physical distress. In general, it can be thought of as the cost that comes from caring for our clients.

16. Have you experienced compassion fatigue?

Now, I'd like to ask you about your self-care strategies. If they have experienced compassion fatigue say, how do you deal with compassion fatigue?

17. How do you cope with the challenges you face as an addiction professional?

18. What are the ways you de-stress?

19. What helps you the most in your work as an addiction professional?

20. Do you have personal support to help you deal with compassion fatigue?

If yes, probe: what types of personal support do you have?

21. Do you have professional support to help you deal with compassion fatigue?

If yes, probe: what types of personal support do you have?

Probe: Do you seek supervision for difficult clients?

Probe: Have you found that to be helpful? In what ways has seeking supervision been helpful?

If they do not have compassion fatigue, probe:

What advice do you have for other addiction professionals struggling with compassion fatigue?

I have a few questions about your training.

22. How were you trained to treat addictions?

Probe: What about evidenced based practices?

23. How were you trained to treat trauma?

Probe: What about evidenced-based practices?

24. What did you find beneficial in your training that helped you prepare to treat the addiction population?

Appendix D: Continued

25. What formal education/training have you received about compassion fatigue and self-care?

Probe: What about education/training via CEU's?

Probe: What about training/education via supervision?

Closing questions:

As we wrap up, I have a few closing questions.

26. What advice would you give other counselors who work with addiction and trauma regarding

compassion fatigue and self-care?

27. Are there any other thoughts you'd like to share?

Thank you so much for your responses, they are most helpful.

Appendix E: Interview Guide, Version 2, Dated 9/30/2014

Demographic Questions:

As we begin, I'd like to ask you a few demographic questions.

- Male or female? [just mark]

- Age?

- What are your credentials?

- What year did you obtain your license and/or certification?

- Number of years counseling?

- Number of years of working with addictions?

- What is your ethnicity/culture?

Let's talk a little bit about your experiences as a counselor. Keep in mind, you can choose not to answer a question at any time.

1. What brought you into the field of addiction counseling?

2. Tell me about the clients that you work with, and in general, about the work that you do as an addiction professional?

3. What are the benefits of working with clients who are struggling with addiction?

4. What are the challenges of working with clients who are struggling with addiction?

Let's discuss the types of clients you treat.

5. What percentage of your clientele comes to you for help with an addiction?

6. What are the most common addictions you treat?

7. What other disorders co-occur with addictions?

Probe: What about trauma?

Probe: How would you define trauma?

Appendix E: Continued

If they need further clarification: "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

Probe: What percentage of your addiction clients suffered trauma too?

Probe: What are the most common traumas reported among your addiction clientele?

8. Do you hear traumatic stories from your addiction clientele? If yes, probe.

Probe: At what frequency?

Let's talk in more detail about your experiences with addiction counseling.

9. How have you been impacted by the traumatic stress of your addiction clients?

Probe: Have you had an emotional impact because of the traumatic experiences of the addiction

clients you treat?

    Probe: How so?

Probe: Do you ever have distressing memories about the traumatic events that you hear about

from your addiction clients?

    If yes, probe: Can you tell me more about that?

Probe: Do you have dreams or flashbacks about your addiction client's traumatic events?

    If yes, probe: Can you tell me more about this?

Probe: Do you try to avoid thoughts or feelings associated with the traumatic stories that your

addiction clientele shares?

    If yes, probe: How do you attempt to avoid such thoughts or feelings?

Probe: Do you feel like you've experienced the trauma of someone you've helped?

    If yes, probe: Can you describe that experience?

10. Do you ever experience the following symptoms as a result of hearing the traumatic stories

Appendix E: Continued

from you addiction clientele?

a. Irritable behavior

b. Reckless or self-destructive behavior

c. Hypervigilance

If yes, probe: How long would you say these symptoms last?

    Probe: Can you tell me more about these symptoms?

11. Do you ever feel preoccupied with one or more of your clients?

Probe: Can you tell me more about that?

12. Is it difficult to separate your personal life from your professional life?

Probe: In what ways is it difficult to separate your personal from professional life?

Probe: Do you feel it is more difficult to separate your personal from professional life working in

addictions versus regular counseling?

13. Have you experienced any physical symptoms as a result of hearing the traumatic stories

from the addiction clients you treat?

Probe: Can you tell me about that?

14. Do you experience any of the following through your place of employment?

a. Low workplace support

b. High caseload

c. Staff shortages

d. Low salary

15. Have you heard about compassion fatigue? Yes No

If yes: How would you define compassion fatigue?

If no: Compassion fatigue is a combination of physical, emotional, and spiritual depletion

Appendix E: Continued

associated with caring for clients in significant emotional pain and physical distress. In general, it

can be thought of as the cost that comes from caring for our clients.

16. Have you experienced compassion fatigue?

Now, I'd like to ask you about your self-care strategies. If they have experienced

compassion fatigue say, how do you deal with compassion fatigue?

17. How do you cope with the challenges you face as an addiction professional?

18. What are the ways you de-stress?

Probe: Of those ways you mentioned, what has helped you the most in your work as an addiction

professional?

19. Do you have personal support to help you deal with compassion fatigue?

If yes, probe: what types of personal support do you have?

20. Do you have professional support to help you deal with compassion fatigue?

If yes, probe: what types of personal support do you have?

Probe: Do you seek supervision for difficult clients?

Probe: Have you found that to be helpful? In what ways has seeking supervision been helpful?

If they do not have compassion fatigue, probe:

What advice do you have for other addiction professionals struggling with compassion fatigue?

I have a few questions about your training.

21. How were you trained to treat addictions?

Probe: What about evidenced based practices?

22. How were you trained to treat trauma?

Probe: What about evidenced-based practices?

23. What did you find beneficial in your training that helped you prepare to treat the addiction

Appendix E: Continued

population?

24. What formal education/training have you received about compassion fatigue and self-care?

Probe: What about education/training via CEU's?

Probe: What about education/training via supervision?

Closing questions:

As we wrap up, I have a few closing questions.

25. What advice would you give other counselors who work with addiction and trauma regarding compassion fatigue and self-care?

26. Are there any other thoughts you'd like to share?

Thank you so much for your responses, they are most helpful.

Appendix F: Compassion Fatigue Definition

Compassion fatigue is defined as:
"A combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress."

It develops from working with traumatized clients and has a rapid onset.

Appendix G: Reference Table: Burnout vs. Compassion Fatigue

Boyle, D. A. (2011). Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Issues in Nursing, 16*(1).

Table 3. Characteristics Differentiating Burnout From Compassion Fatigue		
Variable	**Burnout**	**Compassion Fatigue**
Etiology	Reactional: response to work or environmental stressors (i.e., staffing, workload, managerial decision making, inadequate supplies or resources)	Relational: consequences of caring for those who are suffering (i.e., inability to change course of painful scenario or trajectory)
Chronology	Gradual, over time	Sudden, acute onset
Outcomes	Decreased empathic responses, withdrawal; may leave position or transfer	Continued endurance or 'giving' results in an imbalance of empathy and objectivity; may ultimately leave position

Appendix H: University of South Florida IRB Amendment Approval Letter

10/2/2014

Amanda DePippo, M.Ed.
L-CACHE - Leadership, Counseling, Adult, Career & Higher Education
4202 E. Fowler Avenue
Tampa, FL 33620

RE: **Expedited Approval for Amendment**

IRB#:   Ame1_Pro00018768

Title: Compassion Fatigue and Self-Care Strategies among Addiction Professionals: A
            Qualitative Study.

Dear Mrs. DePippo:

On 10/2/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** your
Amendment. The submitted request has been approved for the following:

Revised Protocol, version 2, dated 09/30/2014
Revised Interview Guide, version 2, dated
09/30/2014

Approved Item(s):

Protocol Document(s):

Compassion fatigue study protocol revision

We appreciate your dedication to the ethical conduct of human subject research at the
University of South Florida and your continued commitment to human research protections. If
you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Signature removed from online copy

John Schinka, Ph.D., Chairperson
USF Institutional Review Board

Appendix I: Member Check Email to Participants

Dear Pseudonym,

Thank you again for participating in my dissertation research. As we discussed at our meeting, I am emailing you a copy of the interview transcript. Please review it for accuracy and email me any feedback you may have.

Sincerely,

Amanda DePippo

Appendix J: IRB Approval Letter for Follow-Up Interview

March 27, 2015

Amanda DePippo, M.Ed.
L-CACHE - Leadership, Counseling, Adult, Career & Higher Education
Tampa, FL 33612

RE: **Expedited Approval for Amendment**

IRB#: Ame2_Pro00018768

Title: Compassion Fatigue and Self-care Strategies among Addiction Professionals: A Qualitative Study.

Dear Dr. DePippo:

On 3/26/2015, the Institutional Review Board (IRB) reviewed and **APPROVED** your Amendment. The submitted request has been approved for the following:

Other Changes: addition of a new study instrument: "Follow-up Interview". Protocol Changes: to version #2 (study is closed to enrollment)

Approved Item(s):

Protocol Document(s):

Compassion fatigue study protocol revision

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Signature removed from online copy

John Schinka, Ph.D.,
Chairperson USF Institutional
Review Board

Appendix K: Follow-Up Interview Questions

1. What role do you think addiction, trauma, and compassion fatigue training plays in regard to compassion fatigue?

2. From the data, I have found there's variability of training for the treatment of addiction, a lack of formal training for the treatment trauma, and a lack of formal education on compassion fatigue and self-care.

    Would you say that is on track?

3. How do you think having training in these areas would help with compassion fatigue?