# THE COST OF CARING: COMPASSION FATIGUE AMONG COMMUNITY MENTAL HEALTH SOCIAL WORKERS

Chanel M Mitchell, M.S.W., LCSW

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COMMITTEE IN CHARGE OF CANDIDACY:

Associate Professor Monica Matthieu,
Chairperson and Advisor

Associate Professor Michael A. Mancini

Associate Professor Vithya Murugan

Associate Dean of Research, Professor Michael Vaughn

Associate Cara Wallace

## DEDICATION

I dedicate this dissertation to my ancestors and parents Michael and Carolyn Mitchell. Thank you, for all the support, provision, strength, and words of encouragement throughout my life and during this doctoral program. We can do all things through remembering our linage, who we are, and what we were meant to do on this Earth.

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## DEFINITION OF TERMS

The following section lists and defines the terminology used throughout the study.

**Burnout:** a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations and results from long-term non-supportive work environments.

**Compassion Fatigue (CF):** "the natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995).

**Community Mental Health Clinics (CMHC):** agencies that are community-based and provide a variety of mental health services to those in need acting as an alternative to care that hospitals provide (Title II section 401 C).

**Post-Traumatic Stress Disorder (PTSD):** a stress related mental health diagnosis resulting from direct exposure to a range of potentially traumatic experiences.

**Vicarious Trauma:** the emotional residue of exposure individuals can retain from working with trauma survivors as they hear their trauma stories and become witnesses to the pain, fear, and terror that their clients have endured (McCann & Pearlman, 1990).

# CHAPTER 1: SPECIFIC AIMS

Compassion fatigue is the emotional and physical exhaustion helping professionals experience during their work with others. Compassion fatigue, often coined "the cost of caring," is defined as a natural consequence some feel from helping or wanting to help a traumatized or suffering person (Figley, 1995). It is a normal, preventable, and treatable condition. Signs and symptoms of compassion fatigue may develop rapidly or over time (Figley, 1995). Compassion fatigue has received more attention of late due to the tremendous strain of COVID-19 on the workforce and is a common work-related stressor. However, for the past decade, it has been mostly studied in the nursing profession (Sweileh, 2020). Most scholars have focused on resolving the condition from a self-care perspective. Scholars have also highlighted the limited organizational interventions (Cocker & Joss, 2016; Rauvola et al., 2019) for addressing compassion fatigue. The literature calls for identifying the factors organizations need to implement interventions for compassion fatigue. No studies have focused on organizational culture to address compassion fatigue and how this workplace information can contribute to developing interventions. Therefore, this research will:

1. Identify how community mental health social workers identify, manage, and prevent future occurrences of compassion fatigue.
2. Explore the role of organizational culture in social workers' perceptions of compassion fatigue.
3. Identify social workers' needs to minimize compassion fatigue.

To fulfill these goals, this study used a qualitative approach. The researcher recruited a snowball sample of 14 participants, including licensed and non-licensed community mental health (CMH) social workers who have experienced compassion fatigue. The study excluded social

workers who work outside community mental health agencies or have reported no experiences with compassion fatigue. The study had three key goals: (a) document community mental health social workers' experiences, (b) identify how CMH social workers manage and prevent reoccurrences of compassion fatigue and (c) explore if and how organizational culture influences social workers' experiences of compassion fatigue.

The findings will contribute to the social work profession and the literature on organizational workplaces due to the number of social workers in these workplace settings. In addition, the study may provide practical tips for mitigating social workers' compassion fatigue in workplace settings. Community mental health agencies may benefit from the results from this study and potentially use findings to curate organizational interventions for their staff.

**The purpose of the study**

Community mental health agencies have gained popularity in the United States over the past several years. CMHCs are facilities that provide services for the prevention or diagnosis of mental illness, care and treatment of mentally ill patients, or rehabilitation of such persons, wherein services are provided principally for persons residing in a particular community or communities in or near where the facility is situated (Title II section 401 C). These agencies offer services to uninsured Americans, increase access to mental health treatment in community settings, and provide additional services for individuals with chronic and persistent mental illness outside of the traditional healthcare system. CMHCs are vital community-based organizations currently providing a large percentage of mental health treatment to Medicaid and Medicare recipients, as well as those without an insurance safety net (NAMI, 2021). Although frequently criticized for being of inferior quality of care compared to inpatient (Dean et al., 1993; Mason et

al., 2004; Fisher et al., 2016), community mental health services are far more accessible, prompt, efficient, and equitable (Institute of Medicine, 2001).

Research has shown that CMHCs are experiencing a crisis of increased demand yet have a substantial provider shortage, specifically regarding social workers (Hoge et al., 2013; Wishner & Burton, 2017). Social workers in CMHCs provide most of the direct services (Hamm et al., 2020), such as case management, psychoeducation, and crisis prevention. In addition, more CMHC social workers are starting to openly discuss the mental health crisis, which, combined with the provider shortage, affects the psychological wellbeing of these employees (Conway, 2016; Søvold et al., 2021).

The setting is another stressor that emerges while working with clients with chronic and persistent mental illness. Specifically, CMHC's, where funding, resources, and staffing are scarce, is a taxing setting in which to work for the staff. These environments have intractable, continuous demands for productivity. They also have frequent high-stress cases, and leadership support is limited. Due to these factors, CMHC staff are stretched beyond their limits, reducing their ability to be empathic and compassionate. Compassion fatigue is often seen as the norm in practice and inevitable over time (Figley, 1995). Burnout, while different conceptually from CF due to the concept focusing on the stressful workplace environment, also occurs in CMHC settings.

The literature shows that compassion fatigue and burnout are linked to employee turnover rates (National Academics of Science Engineering and Medicine (NASEM), 2019). Organizational interventions and an understanding of CMHC as a setting for occupational hazards should be included in the literature (Rauvola et al., 2019). In recent years, a few studies

have examined prevention strategies among CMHC staff to minimize such conditions (Cocker & Joss, 2016).

CMHC social workers are essential to these organizations. However, if compassion fatigue among social workers- a preventable condition- is not being addressed, and if there is little understanding of their needs, the high turnover rate in the CMHCs will continue. This turnover presents new challenges and opportunities organizationally for CMHCs. More in-depth understanding of the effects of compassion fatigue from the perspective of CMHC social workers is needed to identify what organizations are doing to mitigate this problem. The study focuses on the needs of CMHC social workers and seeks to learn from their compassion fatigue experience within this organizational setting.

**Significance**

Compassion fatigue in social workers can present in myriad ways, including detachment, isolation, absenteeism, turnover, and decreased morale (Adams et al., 2006; Peinado & Anderson, 2020). If unaddressed, these symptoms of compassion fatigue can adversely impact the organizational culture and diminish the quality of client and patient care (Cocker & Joss, 2016). According to the World Health Organization (WHO, 2020), 93% of countries have shown increased demand for and use mental health services. More people are requesting treatment to address bereavement, isolation, the loss of income, and a fear of triggering or developing additional chronic mental health conditions or worsening existing ones. COVID-19 has caused unprecedented hazards to mental health globally. Social workers face increased caseloads and transformative changes in practices (Ashcroft et al., 2021), heightening the risk of compassion fatigue in the workplace. Thus, compassion fatigue has increased in frequency and in severity as an occupational hazard. One research strategy to develop interventions for addressing compassion

fatigue starts with exploring social workers' strategies for managing and preventing its reoccurrence and explore the effects of organizational culture on compassion fatigue.

The study is relevant to the social work profession because compassion fatigue has affected many social workers. Many social workers have left their jobs or remained in the profession feeling defeated and withdrawn due to compassion fatigue. Figley and Figley (2017) noted that compassion fatigue has negative consequences and is the cost of caring. The COVID-19 pandemic fueled provider shortages and negatively affected health care costs due to the need to retrain or restructure organizations to deal with shortages. The study's framework and perspectives focus on compassion fatigue within the context of the environmental circumstance during the time of the COVID-19 pandemic. However, prior researchers' findings provide an inadequate base for addressing compassion fatigue among social workers. There is a need for more research on organizational interventions designed with the input of the individuals who use those services (Cocker & Joss, 2016; Rauvola et al., 2019).

In addition, understanding compassion fatigue and social workers' needs may help organizational leaders support social workers to combat compassion fatigue. Organizational culture is vital to employees' well-being; therefore, a lack of organizational interventions for compassion fatigue worsens the condition. Some social workers have adapted to manage compassion fatigue efficiently, while others may lack the knowledge and understanding needed to address the condition. Social workers should share their stories of compassion fatigue, and organizational leaders must get involved and take responsibility for mitigating it in the workplace.

## Organization of the study

This dissertation is organized into five chapters, per the structure meeting Saint Louis University (SLU) requirements. Chapter One provides the reader with an introduction to the topic, including background information, key themes from the literature review, methodological assumptions, and definitions for terms. Chapter Two includes a comprehensive review of existing literature. This chapter is intended to provide information about compassion fatigue, organizational culture, conceptual models and training, professional hazards in the social work profession, and organizational culture's impact on employees' psychological well-being. Chapter Three describes the methodology, research design, rationale for the qualitative study, and the researcher's positionality. This chapter also includes participant criteria, data collection, and procedures for data analysis. Chapter Four provides an overview of the findings from the study. Lastly, Chapter Five discusses the results, implications for community mental health agencies and social workers, limitations of the study, and future research recommendations.

## CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this dissertation is twofold. It is first and foremost: (1) a qualitative study capturing community mental health social workers' experience of managing compassion fatigue and secondly, (2) proposes the importance of exploring the impact of organizational culture in the development of compassion fatigue. We first start with a literature review to provide background information on compassion fatigue and organizational culture. However, the literature is sparse regarding the relationship, impact, and/or effect between the two phenomena of compassion fatigue and the workplace setting. This section aims to 1) add to the literature the importance of understanding compassion fatigue and 2) to glean practical organizational tips from the literature that may be helpful to leaders assisting social workers in managing compassion fatigue.

The premise of this dissertation is that community mental health social workers experience compassion fatigue given their role as a provider, and their organizational culture influences their personal and professional experience. Thus, community mental health agencies need to understand how social workers experience, manage, and prevent reoccurrences of compassion fatigue and their needs from the agency to help mitigate the condition. The gap in the literature provides evidence that this topic is important and relevant to the social work profession and to the organizational leadership in their workplaces. To the researcher's knowledge, no current studies explore the two phenomena together from a qualitative perspective nor focus on the community mental health clinic workplace setting.

Extensive research on compassion fatigue has examined risk factors and steps individuals can take independently to rectify the condition. However, literature addressing organizational involvement or how environments affect individuals' responses to compassion fatigue is nascent.

This literature review addressed themes and subthemes related to community mental health centers (hereafter referred to as CMHC) social workers' challenges when dealing with compassion fatigue.

The overarching research question for this study was what strategies community mental health social workers use to manage and prevent reoccurrences of compassion fatigue. The research centered around three key questions and sought to: a) understanding how CMHC social workers describe their experience of compassion fatigue, (b) understand what strategies CMHC social workers use to manage and prevent reoccurrences of compassion fatigue, and what success the social workers have with utilizing the strategies, and (c) identify organizational needs to best support their psychological wellbeing.

The literature review utilized three databases: Google Scholar, EBSCO, and PsychINFO with the latter two searched using Academic Search Premier within Saint Louis University Library. When using Google Scholar, a search was performed using the keywords “compassion fatigue,” “social workers,” or sentences like “compassion fatigue in mental health professionals” or “Social workers experience with compassion fatigue.”. When using EBSCO and PsycINFO databases within the Saint Louis University library, keywords such as “compassion fatigue,” “secondary traumatic stress,” “prevention,” and “community mental health centers” were used in the search. All searches included the request for only “Peer review” articles, dissertations, and research to be included. All three databases were set with a request for a daily email list so that when a new research study was published, it was automatically sent to an email address. All studies were collected, outlined, and organized in a spreadsheet.

This literature review consists of eight sections, each addressing a major theme relevant to the study. The first section discusses the history and background of compassion fatigue and the theoretical framework. The second will explain the theoretical framework of the compassion

fatigue stress model. The third section will examine the history of CMHC and the connection between these settings and compassion fatigue. The fourth section will explore the organizational culture and the relationship between compassion fatigue, explain how organizational culture functions, how it impacts workplaces, and ends reviewing the social work code of ethics. Finally, the fifth section identifies the literature gap and explains the need and basis for the study. The final chapter will review the selected methodology.

**History of compassion fatigue development**

Joinson, a nurse educator, first introduced compassion fatigue (Chachula & Ahmad, 2022). She explained the concept as the loss of one's ability to provide a nurturing environment in emergency nurses. The nurses described feelings of being emotionally exhausted, tired, depressed, angry, detached, and feeling ineffective at performing their responsibilities (Joinson, 1992). Joinson considered compassion fatigue synonymous with burnout. Researchers suggested a need for more detailed theoretical rationale underpinning the concepts and a need to conduct research to define and to establish a causal relationship between the two concepts (compassion fatigue and burnout) (Sinclair et al., 2017).

Figley (1995), a then Florida State University professor, later developed the theoretical conceptual model to define compassion fatigue. Figley (1995) reported that trauma workers, particularly allied health professionals, appeared to be vicariously affected by the trauma work done with clients. The term compassion fatigue was then used to describe the phenomenon of stress resulting from the exposure to traumatized clients rather than the provider's response and exposure to the trauma itself, which included the provider's exposure to traumatic events that included physical or psychological abuse and natural disasters (Figley, 1995).

**Theoretical definition of compassion fatigue**

At the start of the conceptualization of compassion fatigue, scholars argued that the definition was too narrow (Sinclair et al., 2017). Scholars felt there were hidden and overlapping constructs with other stress-related disorders that are occupational hazards such as burnout and vicarious trauma and that compassion fatigue lacked conceptual clarity (Sinclair et al., 2017). Many in the field credit Sabo (2006) for introducing and discussing empathy and compassion in relation to compassion fatigue. According to Sabo (2006), Figley argued that compassion fatigue is an inevitable experience for those who work with individuals who are suffering or in pain due to the empathic response occurring in their daily interactions and therapeutic relationships. However, Sabo (2006) pointed out that empathy has many definitions and argues that Figley failed to articulate how empathy interacts within the conceptualization. Sabo (2006) referenced several definitions of empathy and detailed how the term varies depending upon the context in which it is used. Kunyk and Olson (2001) defined empathy as

1. a human trait, innate rather than taught;
2. a professional state (learned communication skill comprised of behavioral and cognitive elements);
3. caring (an understanding and need to act because of that understanding); and
4. a special relationship that involves reciprocity (Kunyk & Olson, 2001).

Others use the term empathy to mean an individual's ability to enter someone else's world. Empathy in this context means to perceive and to understand one's feelings and emotions while correctly conveying the information back to the individual. Sabo argued that Figley's model, which consisted of eleven variables to predict the onset of compassion fatigue (Figley, 1995, 2002a), was fatalistic and allowed for no opportunity for the individual to halt the progression of compassion

fatigue through effective means of coping, hope, and resilience. Also, Sabo argued that the model used compassion fatigue as a positive outcome within the therapeutic relationship (Sabo, 2011). While Figley argues that empathy is the core component to explain compassion fatigue, others have proposed it as a disruption in empathy or causing of empathic strain between the provider/ caregiver and client/patient.

Since 1995, there have been several frameworks developed to explain compassion fatigue (Rauvola et al., 2019). Some researchers argue that different concepts may influence compassion fatigue and that is separate from empathy. To date, Figley's model is the most cited and referenced theoretical model used to explain compassion fatigue.

**Compassion fatigue stress model**

Figley's (2002a), theoretical model of compassion fatigue draws on a stress-process framework (Adams et al., 2006; Sabo, 2006). Figley proposed that the antecedent of compassion fatigue is empathy. The multi-factor model of compassion fatigue assumes that empathy was a prerequisite for compassion fatigue. Figley states that empathy is necessary to build a therapeutic rapport to provide care (1995). His model is based on the three key elements: empathic ability, empathic response, and residual compassion stress, which assumes that empathy and emotional energy are critical elements needed to build a therapeutic rapport and have an empathic response (Figley & Figley, 2017). The model is depicted as a series of events that begin with the exposure to a patient's pain, suffering, or traumatic event. One's empathic concern and empathic ability, which has been defined as "the aptitude of the psychotherapist to notice the pain of others" (Figley, 2002a, p.1436)", may result in compassion stress, which is referred to as the residuals of emotional energy.

In human services, professionals must remain compassionate and empathetic when engaging with clients. Compassion fatigue develops when a provider is unable to assist clients with meeting their needs, is unable to detach from clients' situations and experiences, or experiencing a lack of satisfaction (Figley, 2002a) (see Figure 1).

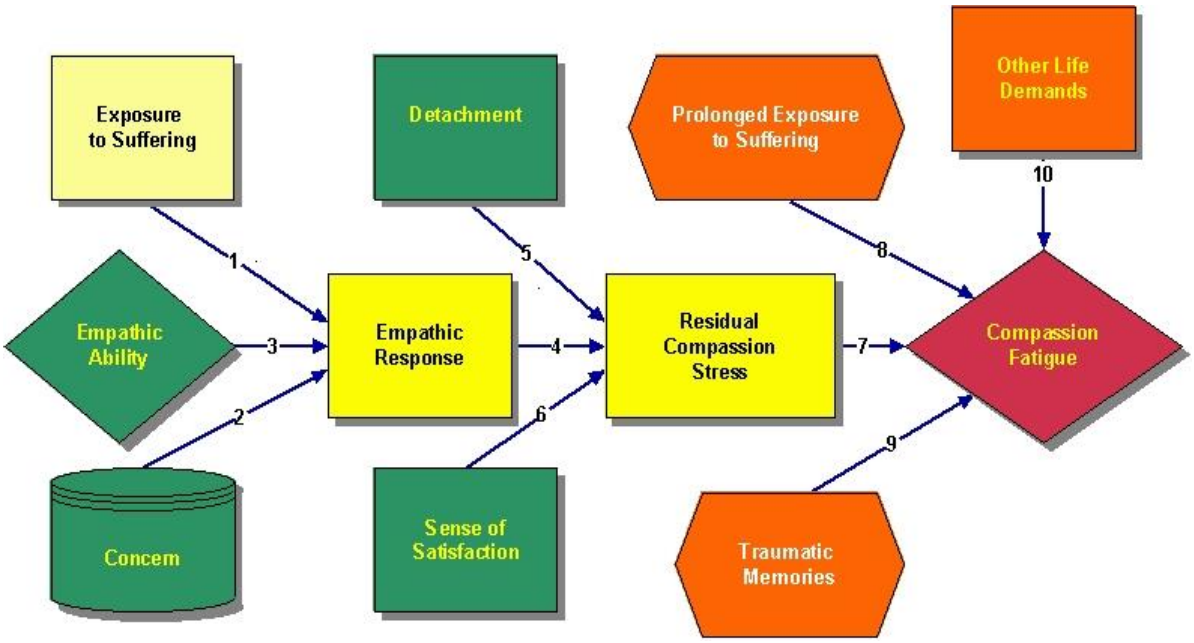


**Figure 1.** Compassion Fatigue Process
**Note.** See Appendix G. Copyright permission from Day & Anderson (2011). From "Compassion Fatigue – An Introduction," by C. R. Figley, 2001. http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html

Figley (1995) identified compassion fatigue as "the natural and disruptive by-product of working with traumatized and troubled clients" (p. 7). It is a condition caused by an unchecked buildup of caregivers' reduced capacity or interest in empathy. Scholars have studied compassion fatigue among individuals in various caregiving professions, including nurses and midwives, geriatric workers, emergency service workers, chaplains, physicians, psychologists, and social workers (Ledoux, 2015; Turgoose & Maddox, 2017). Although not a psychiatric diagnosis, compassion fatigue causes physical and emotional exhaustion that can adversely affect an individual's ability to feel empathy and have compassion for others. Compassion fatigue can harm

health care providers' personal health and professional effectiveness and, consequently, impact patient care (Cocker & Joss, 2016).

**Symptoms of compassion fatigue**

Compassion fatigue has many symptoms classified as physical, behavioral, psychological, and spiritual (Figley & Stamm, 1996). In addition, compassion fatigue can have a global impact on a provider's identity, well-being, and self-understanding (Huggard et al., 2017; Mathieu, 2018). The symptoms of compassion fatigue include continuously worrying about recounted traumatic events, reduced frustration tolerance, avoidance, and numbing. Other symptoms are feelings of dread in working with specific clients, a decreased sense of purpose, a lowered functioning threshold, and feelings of impotence. Identifying these symptoms can be a challenge, and symptoms can emerge suddenly without warning (Sinclair et al., 2017). Symptoms can have detrimental effects on a social worker's cognition, emotions, and behaviors. Table 1. provides a description of compassion fatigue symptoms.

**Table 1.** Compassion Fatigue Domain and Symptoms

| | | | |
|---|---|---|---|
| Headaches | Losing things | Mood swings | Loss of purpose |
| Muscle tension | Withdrawn | Restlessness | Disinterest in introspection |
| Digestive problems: diarrhea, constipation, upset stomach | Hypervigilance | Irritability | Slighted judgment |
| Sleep disturbances: inability to sleep, insomnia, oversleeping | Snippy/sarcastic/dark humor | Oversensitivity | Decreased discernment |
| Cardiac symptoms: chest pain/pressure, palpitations, tachycardia | Appetite changes | Anger and resentment | Questioning meaning of life |
| | Negative coping (smoking/alcohol/ substances/shopping) | Anxiety/depression | |
| | Increased outbursts of anger | Poor concentration | |

The various symptoms of compassion fatigue can, when unaddressed, have severe consequences. Compassion fatigue could lead to decreased self-esteem, apathy, and thoughts of harming oneself or others. In a systemic review of compassion fatigue and substance and alcohol use, Huggard et al. (2017) found that individuals experiencing compassion fatigue reported increased use of alcohol or drugs, absenteeism, and anger, a finding Williamson (2019) also noted. In addition, caregivers with compassion fatigue could experience feelings of powerlessness, guilt, fear, and survivors' guilt (Day & Anderson, 2011; Mathieu & Cameron, 2007).

Historically, people have dismissed symptoms of compassion fatigue, such as marked agitation, irritability, sadness, and moodiness, and instead viewed them as warning signals. However, learning about and recognizing these symptoms could reduce the risks of compassion fatigue. Failing to address the symptoms of compassion fatigue can affect providers' ability to provide adequate care. Consequently, the unaddressed symptoms of compassion fatigue could lead providers to question their ability to remain ethically sound under distress.

**Differentiating compassion fatigue from other work-related stress constructs**

Compassion fatigue is a term often used interchangeably with other work-related stress conditions, such as burnout, secondary traumatic stress (Bride et al., 2007), and vicarious trauma (McCann & Pearlman, 1990). Since 1995, Figley (compassion fatigue), Stamm (secondary traumatic stress), and Pearlman (vicarious trauma), have all worked extensively on the topic. Some have attempted to argue that the terms are different by distinguishing specific differences between the names and the constructs. However, others have argued that the findings have been unsuccessful in their attempts to identify real differences that would separate the three concepts (Baird & Kracen, 2006). After decades of research, scholars have identified the differences (Rauvola et al., 2019). Regardless of terminology-taxonomy, the topic has matured and been

used across multiple cultures and disciplines to bring language to traumatic events' experiences. In addition, the research has been useful in helping organizations' to better understand how to sustain and support workers across their careers (Rauvola et al., 2019). The following sections will provide an in-depth description of each concept identifying their differences.

**Secondary traumatic stress/ compassion fatigue**

According to Figley, compassion fatigue is "identical to secondary traumatic stress disorder (STSD/STS) and is the equivalent to post-traumatic stress disorder" (PTSD (Figley, 1995, p. xv). Within the literature, compassion fatigue is known and used interchangeably with secondary traumatic stress (McCann & Saakvitne, 1995; Newell & MacNeil, 2010). However, STS is one of the lesser well-known and used terms. STS refers to a set of psychological symptoms that mimic post-traumatic stress disorder but is acquired through exposure to individuals suffering the actual effects of trauma (Baird & Kracen, 2006). Post-traumatic stress disorder (PTSD) happens following a potentially traumatic event or series of events that directly impacted an individual or witnessed and been involved in a traumatic event (APA, 2013). STS occurs when a person in a helping role or profession is repeatedly exposed to others' traumatization and develops symptoms similar to those with PTSD.

Figley used the term compassion fatigue instead of secondary traumatic stress because he felt it would be more socially acceptable amongst clinicians who in fact had experienced the symptoms (Sinclair et al., 2017). Thus, compassion fatigue describes the overall experience of emotional and physical fatigue that human service workers experience due to the chronic use of empathy when treating individuals who are suffering (Figley, 2002a). Compassion fatigue - STS, has been documented in various helping professions, including ER doctors, nurses,

psychologists, therapists, social workers, and first responders like police officers, ambulance personnel, and firefighters (Greinacher et al., 2019).

Compassion fatigue has been described as a convergence of burnout and secondary traumatic stress that causes physical and mental exhaustion by depletion and the inability to cope with one's everyday environment (Cocker & Joss, 2016). In the literature, Figley and Stamm agreed to use the term interchangeable (Newell & MacNeil, 2010). According to Stamm (2002), burnout and secondary traumatic stress are related; however, they have distinctively different outcomes. STS has been found to arise from failed survival strategies. While burnout surfaces from a failed attempt of an individual reach their individual assertive-goal achievement and in return becomes frustrated and experience a sense of loss of control, increased willingness, and diminished morale (Cocker & Joss, 2016). On the hand, STS stems from a rescue-caretaking response, wherein the individual cannot save the other individual from harm, which results in internal conflicts, such as guilt and distress.

**Vicarious trauma**

Vicarious traumatization (VT) is defined as the "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with client's trauma material" (Pearlman & Saakvitne, 1995, p. 31). It is the emotional residue of exposure that professionals witness from working with clients who have experienced trauma and suffering. VT is described as a more pervasive and longer lasting shift in the individuals inner experience that results from disrupted beliefs about themselves, relationships, and the world, all of which separates this concept from the more acute phenomena of compassion fatigue (Rauvola et al., 2019).

Similar to compassion fatigue, VT has been distinguished from burnout. VT is a state of tension and preoccupation with the stories/trauma accounts and experiences described by clients.

This tension and preoccupation have been said to be experienced by professionals in several ways, including avoiding talking or thinking about what the trauma-affected client(s) have been talking about, expressing numbness, or being persistent in arousal state. VT is different from burnout. Burnout is related to being overloaded emotionally secondary to the client's problems, whereas VT reactions are related to specific traumatic experiences (Trippany et al., 2004). Like the other stress-based concepts, VT can impact a provider's professional performance and functioning, resulting in errors in their clinical judgment and mistakes.

Similar to compassion fatigue, vicarious trauma conceptualization involves empathy as a contributing factor to its development. Also, like compassion fatigue, the model acknowledged that there are other factors involved in the development of vicarious trauma, which includes the providers professional's history of trauma and substance abuse, inadequate training, or inexperience.

While compassion fatigue refers to the profound emotional and physical destruction that occurs when caregivers/providers are unable to refuel or regenerate themselves after prolonged exposure to trauma. Vicarious trauma refers to a whole worldview shift that occurs in those individuals. In vicarious trauma, the providers or caregivers notice that their fundamental beliefs about the world are altered and possibly damaged due to the repeated exposure to traumatic material (Pearlman & Saakvitne, 1995).

In the end, both terms are much more complicated than just being tired of providing therapeutic support and being overworked. There is a conflict between the individuals' core values and beliefs and the provider/caregiver's work. Vicarious trauma may affect the worldview and beliefs on concepts like aging, diseases, or similar things. Simultaneously, compassion

fatigue causes a provider/ caregiver to not stop thinking about the individual they provide compassionate care for, which causes an increase in empathic distress.

## Burnout

Burnout was first introduced by Freudenberge (1974) who noted that it occurred in responses to prolonged work tension and stressors. In 1993, Pines reported burnout: "happens most often among those who work with people and results from the emotional stress that arises during the interaction with them" (p. 387). Later, Maslach and Jackson (1981) defined burnout as a syndrome of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. In depersonalization, a sense of detachment and social distancing occurs, usually at the expense of personal and professional relationships. Pessimistic or unsympathetic responses to others, mainly those served, are additional features. Historically, burnout has been rooted in the understanding of the interpersonal context of a job. More particularly, the interaction between the care recipient and the caregiver, as well as the values and beliefs which the caregiver endorses (Maslach et al., 2001; Sabo, 2011).

Burnout is now defined by the World Health Organization (WHO) as a syndrome brought on by ongoing work-related stress that has been unsuccessfully managed and resulted in confusion (WHO, 2019). Factors that lead to burnout have been connected to personality characteristics (Aronsson et al., 2017). Research has hypothesized that three personality traits contribute to burnout: avoidant behavior, problem-solving, and confrontation (Maslach & Leiter, 2016). Traits also include neuroticism, openness to experience, and agreeableness. Results show that certain traits tend to occur in the grouping of many individuals, which has increased their risk of developing burnout. Other factors contributing to burnout include work-life issues involving personal job mismatch, work overload, lack of control, lack of reward, lack of

community and collaboration, lack of fairness, and value conflict (Leiter & Maslach, 2004; Leiter & Spence Laschinger, 2006). Recent studies have found that burnout results from prolonged interpersonal stressors (Maslach & Leiter, 2016).

Since the origin of the construct of burnout, scholars have operationalized and measured burnout differently from compassion fatigue. Because burnout is a phenomenon in the occupational context, it does not apply to describing or explaining experiences in other areas of life. Although burnout is closely related to compassion fatigue, they have different core mechanisms. Burnout pertains to concepts focused on work rather than personal relationships, such as workload, autonomy, and reward (Whitebird et al., 2013). In contrast, compassion fatigue focuses on an individual's inability to engage with others at and outside of work. Table 2 summarizes the differences between the concepts.

**Table 2.** Compassion Fatigue Versus Burnout & Vicarious

| **Compassion fatigue** | **Secondary Traumatic Stress** | **Burnout** | **Vicarious Trauma** |
|---|---|---|---|
| Feelings of indifference and inability to cope with one's environment | Stress reaction following exposure | Feelings of cynicism and detachment from the job | Worldview shifts after trauma exposure by client |
| Impaired engagement with others | Similar PTSD like behaviors | Impaired engagement with work | Cognitive disruption |
| Psychological and emotional stressor | Arise from failed survival strategies | Environmental and organizational stressors | Thought processes change how one engage with clients |

Note. Descriptions of burnout from Burnout: The Cost of Caring, by C. Maslach, 1982. Copyright 1982 by Prentice Hall.

The main distinguishing feature between compassion fatigue and burnout is the emphasis on psychological and emotional stressors instead of environmental and organizational stressors, respectively (Morse et al., 2012). Compassion fatigue is a preventable condition with early symptom recognition (Cocker & Joss, 2016). Unlike burnout, compassion fatigue has a rapid

onset and fast recovery when recognized and managed. In contrast, burnout has a slow, progressive onset that lasts over an extended time (Morse et al., 2012). Although similar in symptomology, compassion fatigue and burnout differ significantly in circumstances. The mislabeling of these two conditions can cause confused symptom recognition, which, in turn, can result in a lack of appropriate intervention. The following section will review the history of community mental health centers and the connection to compassion fatigue.

**CMHC setting and its connection to compassion fatigue**

Community mental health centers are highly stressful environments that may cause stress for social workers (Slade, 2009; Thornicroft et al., 2016). Section 204 of Title II describes Community Mental Health Centers as a mental health services program under a unified system of care. The goals of CMHCs are to: a) provide a varied and comprehensive range of services near the patients' homes, b) provide these services to all persons in the community regardless of their ability to pay, c) permit a patient to transfer easily from one type of service to another as his/her needs change (continuity of care), and d) strengthen community resources for the prevention of mental illness (Public Law 88-164, Section 204). The centers provide various mental health services and sometimes serve as an alternative to the care that mental hospitals provide (APA, 2015). CMHCs were developed to deinstitutionalize the large state hospitals and move long-term patients identified as mentally ill that lived in group homes, nursing homes, and other institutions into the community. CMHCs attempt to address various healthcare gaps in services by providing access to care for individuals who are eligible for publicly funded mental health services.

The Act of 1963 represented the fundamental change in social and governmental attitudes regarding where and how individuals with mental illnesses are treated in the United States (U.S.) (Mental Retardation Facility and Community Mental Health Centers Construction Act, 1963). The

guidelines stated that essential services must provide or include to some degree: 1) in-patient and outpatient services, 2) partial hospitalization (daycare or night care), 3) emergency services providing 24-hour care, and 4) consultation and educational services available to community agencies and professional personnel. The section of PL: 88-164 also describes that the CMHC provides comprehensive community care to those who cannot otherwise afford it. Centers must reside in residential districts of the community and must be easily accessible.

CMHC supports social justice by addressing the needs of traditionally underserved individuals and populations, such as ethnic minorities, homeless individuals, children, adolescents, and immigrants. The services offered in a CMHC not only focus on an individual's deficits and disability but also on their strengths, capacities, and aspirations (Thornicroft et al., 2016). The goals of CMHC are to enhance the individual/family unity and the ability to develop a positive identity, restructure their illness experience, be self-managed with support, and pursue a valued social role (Slade, 2009). Other goals of CMHC include reducing access to care and barriers to care and offering continuity follow-up for those with long-term disabilities. The function and structure of CMHCs are to reduce or manage environmental adversities and strengthen families, external social networks, communities, and organizations that engage individuals who experience mental health issues (Slade et al., 2014). However, these agencies are often short-staffed, underfunded, and lacking resources to address the complex clients' needs in the community. Consequently, increasing workers risk of developing compassion fatigue.

**Social workers in CMHCs**

Community mental health centers (CMHCs) various service delivery models exist for the delivery of community-based mental health services. Care delivered in the community is often done through a community mental health team (Malone et al., 2007). Community Mental Health

Teams (CMHTs) are often multidisciplinary, including professionals such as nurses, psychiatrists, psychologists, and social workers (Malone et al., 2007), peer supports (trained individuals with a diagnosis of severe mental illness) may also work in CMHTs. These professions' combined expertise and teamwork practices enable service users to receive more holistic care addressing their medical, mental, and social needs.

Typically, psychiatrists and other primary care providers are contracted as affiliates of these agencies and provide care to Medicaid/Medicare recipients. In CMHCs, social workers play a prominent role within CMH's and provide the most direct services (Hamm et al., 2020). According to Zippia (2022), the demographics of mental health workers in the U.S. reviewed and verified by the U.S. Bureau of Labor and Statistics (2022) census found that 61.7% of all mental health workers are women, 34.0% are men. Most employees in the field identified as White (80.9%), followed by Hispanic/ Latino (9.1%) and Black or African American (6.7%) (Zippia, 2022). When looking specifically at the social work profession in CMH, 41% of social workers are bachelor-level degree recipients (Salsberg et al., 2017).

Although other professionals work in CMHC's, scholars and even social workers have found the role of a social worker to be complex and hard to explain, and involves several responsibilities, especially in CMHC settings (Morriss, 2017). Segal and Baumohl (1981) define community social workers' core functions as assessments and high-risk screenings, crisis intervention, short-term counseling, care planning, patient advocacy, and continued care. They also identify patient and family education and support, community resources and coordination, post-hospitalization counseling and care management, research, and substance abuse treatment. Research has highlighted the high levels of stress among community mental health workers in multidisciplinary teams. For example, Prosser and colleagues (1997) found staff have higher levels

of depression and anxiety and are more 'emotionally exhausted' than hospital inpatient, day-care, or outpatient staff. Job satisfaction among staff is related to having team role clarity and identification with the team (Ruch et al., 2018).

More specifically, social workers face multiple challenges and barriers interfering with their ability to provide care and sometimes competing responsibilities to care for themselves and clients' needs, given the work with vulnerable clients and their needs. Morriss (2017) interviewed social workers in CMHTs and found that participants struggled to positively articulate their role, describing it as 'operating in the gaps left by other professions' (Morriss, 2017, p. 1348). Abendstern and colleagues (2022) explored social workers' experiences with their multidisciplinary colleagues on CMHTs in England. Results indicated that when social workers are absent from CMHTs, there were delays in recognizing social needs, leading to less timely service delivery and diminished service user involvement. Also, the study found that more restrictive practices were causing a loss of rights and impacting social justice. Such a finding aligns with other research that points to the valued perspective of social workers in promoting the social model of caring for mental health, promoting least restrictive practices, and advocating for person-centered care (Penhale & Young, 2015; Abendstern et al., 2022).

In addition, Abendstern and colleagues (2022) found that participants felt that social workers in CMHT were vital to supporting people in achieving long-term recovery. The findings provided detailed evidence of social workers' unique and needed contributions to CMHTs. Specifically, they add distinctive value for service users and their colleagues (Abendstern et al., 2022). These findings are congruent with studies that define the role of a social worker in the USA (Abendstern et al., 2016). For example, Hackbrath's (2015) overview of funding of CMHC discussed how providers in CMHC tend to have more regular contact with clients than medical

providers because of their role and involvement in direct care. Social workers build extensive rapport and learn valuable information about the clients they serve. Given their role and position in their clients' lives, social workers support many individuals and families with limited internal and external support.

As policy requires, CMHCs are to provide a continuum of coordinated services and support, including rapid response 24/7 crisis services in supportive settings, peer and family support, targeted case management and clinical assessments and interventions. These types of services and the level of care are emotionally taxing. Recent epidemics, such as the opioid crisis and COVID-19, highlight community mental health centers' challenges, such as the lack of providers and funding challenges. During the Affordable Care Act expansion, scholars have reported a shortage of mental health providers (Hoge et al., 2013), specifically social workers (Lin et al., 2016 Mann et al., 2016;) and increase the risk of experiencing compassion fatigue.

**Compassion fatigue among social workers in the mental health workforce**

Social work professionals, educators, and students in training are often unaware or fail to acknowledge the severity of compassion fatigue (Harr et al., 2014). It is an occupational hazard for helping professionals (Rauvola et al., 2019). According to research, more than 70% of social workers experience some level of compassion fatigue (Mathieu, 2012). It affects between 40% to 85% of helping professionals (Mathieu, 2012). According to a systemic review by Singh and colleagues (2020), 19.8% of mental health professionals report compassion fatigue to some degree. Additionally, recent studies found that 10 to 74.1% of mental health professionals are affected by compassion fatigue (Laverdière et al., 2019; Xie et al., 2020; Koutra et al., 2022).

Other studies have explored compassion fatigue among mental health professionals in intensive care unit settings. Studies estimate that the prevalence rate of compassion fatigue

among mental health professionals ranges from 7.3% to 40% for professionals (van Man et al., 2015). This study found that this rate rises from 25% to 70% among inexperienced mental health professionals. The rationale includes a lack of training to help combat work stress. Studies indicate a higher prevalence of compassion fatigue is often seen in health professionals exposed to, witnessing, and caring for people after trauma (van Man et al., 2015).

Franza and colleagues (2020) evaluated stress levels in 102 workers recruited in different departments (psychiatric and multidisciplinary) in healthcare. The sample included 30 clinical social workers. Across all disciplines, increased stress was experienced in burnout, compassion fatigue, and hopelessness. Their findings noted significant compassion fatigue and burnout in several groups. When looking specifically at social workers, participants reported that 30% were affected by compassion fatigue and 31% by burnout. Findings noted that individuals who reported a higher educational level reported lower fatigue and burnout, which reduced their risk of developing high levels of work stress.

Another study examining social workers examined posttraumatic stress, grief, burnout, and secondary trauma experienced by employed social workers in the United States. With a sample of 181 social workers, Holmes and colleagues (2021), found that a quarter (26.21%) of social workers met the diagnostic criteria for PTSD and 16.22% reported severe grief symptoms. While 99.19% of the participants reported average to high compassion satisfaction, 63.71% reported average burnout, and 49.59% reported average secondary trauma. The authors highlight the importance of employers and organizations providing the resources for both immediate and ongoing support for the psychological well-being of their employees. This study, however, did not focus specifically on identifying where social workers work, but rather grouped individuals as first responders who were employed in the social work field and had either a Bachelor of

Social Work (BSW) or a Master of Social Work (MSW) degree. Holmes and colleagues (2021) acknowledged the need to discuss shared or collective trauma in the workplace, although their study did not measure it.

Scholars have pointed out the importance of educating social workers early in their training about compassion fatigue. For example, Harr and Moore (2011), examined compassion fatigue and compassion satisfaction among social work students in their field placement compared with those individuals employed as human service professionals. Findings found that social work students reported lower levels of compassion fatigue and higher levels of compassion satisfaction, consistent with the national sample of employed human services professionals. However, one rationale for this finding was that this sample had inexperienced students who did not uphold full responsibilities and exposure to the social work roles compared to an employed human service professional. Also, the study noted that compassion satisfaction serviced as a protective factor against compassion fatigue. This finding is consistent with other research studies. The study highlighted differences between MSW concentration students compared to foundation students entering the MSW program. MSW concentration students reported lower levels of compassion satisfaction. The difference may be due to the knowledge obtained in the later stages of social work education. Harr and Moore (2011) stress the importance of teaching and educating students about compassion fatigue in undergraduate programs and to ensure that their education endeavors to prepare them for the work field. Discussing compassion fatigue early in a career trajectory can help future social workers increase awareness of the risks and costs of working in the helping profession. In addition, educators need to teach and reinforce the importance of implementing healthy coping skills focusing on self-care and compassion fatigue prevention.

With an increase in the prevalence of compassion fatigue among mental health providers, it is necessary to explore how organizations are structurally addressing the problem. The behavioral health workforce is experiencing a national shortage (Andrilla et al., 2018), and mental health providers have a high turnover rate, estimated at 40%. Specifically in the community mental health sector. However, it is common to notice trends and rates of 70% (Brabson et al., 2020). Rates of turnover in the mental health workforce are chronically high, with detrimental effects on the agency and the mental health providers' psychological well-being. The helping professionals' nature of work endorses the use of compassion, which creates a natural susceptibility to professional suffering (Figley, 2002).

Given the current climate in social services, recent studies have found that social workers are leaving their positions for jobs outside of the social service field because of occupational stress and other workplace demands (Torpey, 2018). Studies have cited compassion fatigue and burnout as known influences that cause professionals to leave the field (National Academics of Science Engineering and Medicine (NASEM), 2019). In one National Academies report (NASEM, 2019), the authors warn health care systems that they are failing to protect their employees from occupational stressors, including compassion fatigue and burnout. Research shows that the pre-pandemic compassion fatigue for mental health care professionals was significant, between 25% and 70% percent (van Mol et al., 2015; Thapa et al., 2020).

To combat this, research suggests early prevention and intervention strategies to minimize the risk of developing compassion fatigue. Early education and detection of symptoms and signs of compassion fatigue can help reduce the impact on the helping professional. As a result, research needs to address contributing factors and identify effective prevention and intervention strategies to combat compassion fatigue.

**Consequences of social work shortage in CMHC**

It has been widely cited that the social work profession, with lower-paying jobs, contributes to compassion fatigue, burnout, and high turnover rates in nonprofit agencies (Quinn et al., 2019). According to the Bureau of Labor Statistics (BLS), the median annual pay for social workers in 2021 was $49,470. This amount varies depending on an individual specialty, location, and employer. BLS (2022) reports that social workers' starting salary begins above $56,000 and goes up depending on location in a medical setting. The average income median salary in CMHC is $44,000 in certain areas (BLS, 2022). These reports are congruent with previous workforce studies (Salsberg et al., 2017). The Council of Social Work Education's (CSWE) (2017) Profile Social Work Workforce report noted the highest paying social work positions are federal or medical (inpatient- medical social work) positions. Compared to other helping professions, studies show that social workers make far less money than teachers and nurses (Salsberg et al., 2017). Specifically, when comparing salaries to registered nurses, social workers make 30% less than the comparable figures for registered nurses (Lerner & Pollack, 2022).

COVID-19 has also highlighted the growing crisis of healthcare worker shortage, barriers to access to care, and treatment disparities among minorities in America. Before the pandemic, during previous epidemics, such as the opioid crisis and suicide, there were state and federal orders and grants to stimulate the workforce and improve access to care. For example, the Center for Medicare & Medicaid Services (CMS) implemented over 50 provisions to the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities ACT of 2018, also called the Support Act of 2018. This Act amended the Controlled Substance Act, expanded the conditions providers must meet to provide medication-assisted treatment, and expanded options for a provider to be considered a qualified provider

(Public Law 115-271/ 21 USC 301). Also, initiatives in community care sought to increase access and programs geared towards co-occurring treatment modalities to address the rise in opioid use.

The provisions of this Act aimed to increase operations to treat beneficiaries with substance abuse disorders, including opioid use, redefine and strengthen medical providers' prescribing behavior, improve access and treatment of acute and chronic pain, and heighten safety protocols to educate the public and share prescribing data. Before the opioid crisis, the concern about health professional workforce shortage predated the coverage of the Affordable Care Act (ACA); the increased demand for care exacerbated expansion of services. Before passing the ACA, economists, and policymakers requested leadership to increase efforts to hire more staff, including advanced practiced practitioners, improve access to care in rural areas, and expand mental health services (Hoge et al., 2013; Wishner & Burton, 2017).

Currently, the National Alliance of Mental Illness (NAMI) (2021) reported that nearly 50% of the 60 million adults and children live with a mental health condition in the U.S. without receiving treatment. The research found that 134 million people live in a designated Mental Health Professional Shortage Area (NAMI, 2021). Regarding psychiatric care, 55% of U.S. counties do not have a single practicing psychiatrist (NAMI, 2021). These findings are in line with previous research. For example, a study found that before the pandemic, it was estimated that nearly half of youth with a psychiatric diagnosis were not receiving treatment (Whitney & Peterson, 2019). One of the barriers was access to care and the limited number of specialty mental health providers (e.g., child psychiatrists) available (Whitney & Peterson, 2019).

Before COVID-19, scholars voiced that the U.S. mental health system was severely inequitable and leaving many Americans without accessible and affordable care (Altiraifi &

Rapfogel, 2020). Disparities exist among those who identified as people of color and marginalized gender identities (Kugelmass, 2016). For example, before COVID-19, racial groups had been highly discriminated against such as African Americans, American Indians, and Alaska Natives who used mental health services less than white Americans (U.S. Dept, 2001; McGuire & Miranda, 2008). The American Psychological Association highlighted these racial differences at the beginning of the pandemic, which led to the organization making a public address and issuing an apology for the lack of access and care to the Black Indigenous People of color (BIPOC) communities (DeAngelis, 2021).

As studies continue to highlight the shortage of providers and the difficulty Americans have accessing a mental health provider (34%) (NAMI, 2016), CMHC settings continue to serve in this gap. CMHCs provide care via social workers who provide clients with the most direct services (Hamm et al., 2020). This high utilization of providing direct care in turn increases social workers' exposure to clientele with traumatic backgrounds, increasing their risk of developing compassion fatigue and eventually burnout. More attention is needed to focus on the health, quality of life and occupational exposures experienced by community mental health providers. Some argue that less attention is paid to social workers in the community (Lerner & Pollack, 2022). It has been cited that social workers' play a critical role in the mental and behavioral health infrastructure in the United States (CSWE, 2014). Social workers' roles include providing clinical and social caring to clients in the community. Along with other CMHT members, they attempt to manage the shortage in health professions by ensuring that people are connected to services in the community to minimize hospitalizations and other crises, such as the increase in substance use and suicide attempts.

In 2019, the Substance Abuse and Mental Health Service Administration reported that by 2025, the United States would have a shortage of 10,000 mental health professionals. Specifically, they posited that the nation will experience a total shortfall of over 195,000 social workers, with the most severe shortages occurring in the western and southern regions of the United States (Lin et al., 2016). Shortages are more likely to occur in rural areas due to a lack of funding and infrastructure. Social workers are the largest and fastest growing professional providers of mental health services in the United States (NASW, 2018; Bureau of Labor Statistics, 2018). They are the backbone of the mental health system (Mann et al., 2016), yet research shows that fewer social workers are available to meet the growing demand in the country following COVID-19 and future epidemics that are sure to follow.

While there is extensive research on the topic of occupational stressors and related topics, such as providers' distress about the social work profession (Kuip, 2016; Lynch & Forde, 2016) and compassion fatigue (Adams et al., 2006; Figley & Figley, 2017), they do not focus and provide a current perspective from CMHC social workers. This study focuses on CMHC social workers due to limited research from their perspectives and the increased turnover rate in the profession. The next section social workers ethical stance to addressing compassion fatigue.

## Social worker code of ethics

Social work is a helping profession. To ensure that professionals are doing no harm to others, professionals take an ethical oath to practice and to provide services that improve the quality of life of their clients. According to the National Association of Social Work (2017), a foundational premise and the "core of social work" is professional ethics (pg. 2). The NASW outlines the ethical standards and values all social work professionals and agencies uphold. The primary responsibilities of the NASW Code of Ethics and state licensure boards are to be

accountable to the public and protect citizens (NASW, 2008). The NASW Code of Ethics may also be used by organizations or human service agencies that employ social workers as a reference point for ensuring ethical practices.

All social workers are required to uphold professional ethics as it pertains to their own well-being. The National Association of Social Work Code of Ethics expresses the importance of social workers attending to their personal and professional well-being to prevent professional impairment (NASW, 2008). There are several sections of the Code of Ethics of the social work profession that apply. Section 4.05 on impairment states that social workers are not to allow their personal problems, psychosocial distress, legal problems, or mental health difficulties to interfere with their professional judgment and performances. It also indicates that it is the social worker's responsibility to take appropriate corrective action, seek assistance, or decrease workload to protect clients and others. According to this section, when a social worker becomes aware of any impairment of any kind, whether it be psychological distress related to job responsibility or experience, it is the professional's responsibility to seek help. It is unethical to allow personal distress to impact job performance, as it has the potential to put the client and their work environment at risk.

The NASW Code of Ethics (NASW, 2008) also speaks to social workers and organizations taking the necessary measures to reconcile concerns of impairment. The Code discusses the importance of ensuring that the workplace environment is healthy and conducive to providing quality services. For example, in Section 3.07 on administration states that social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision (NASW, 2008). Other responsibilities of the organization to ensure social workers are effective and ethically sound

involve continuing of education and staff development. Per Code 3.08 on continuing education and staff development, social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics (NASW, 2008). Scholars often remind social work educators and agencies employing social workers that they have an ethical responsibility to provide adequate knowledge and support because of their various roles and responsibilities as social worker (Harr et al., 2014).

By upholding these core values and ethical guidelines outlined by the NASW, professionals and organizations are responsible for ensuring workplaces are safe and can sustain their employees. However, compassion fatigue in the literature continuously references that individuals are responsible for addressing the problem. Many risk factors of compassion fatigue are known but are not limited to individuals leaving the profession prematurely and potential risk of ethical and boundary violations. Scholars reported that the most crucial risk is the potential harm to clients due to a professional's inability to make informed ethical decisions, of which they are unaware due to the impact of compassion fatigue (Adams et al., 2006; Voss Horrell et al., 2011). Hence, social workers' experiences managing and preventing reoccurrences of compassion fatigue and how organizational culture impact their experiences as a CMHC employees is imperative to understand. The following section will review the literature on integrating organizational culture to better explain compassion fatigue among social workers.

**Competing values: organizational culture framework**

Organizational culture is a cognitive framework consisting of the assumptions and values the members share. It is essential in shaping the workplace context, providing stability, and

modeling for employees how to respond and cope. Additionally, organizational culture provides an identity, helping bind the staff's individuality and actions to the workplace. Therefore, organizational culture influences behavior (Bass & Avolio, 1993; Greenberg & Baron, 2011), which aligns with the social work perspective that environments influence people and their behaviors.

Human service organizations, such as CMHC, create a social context for the services they provide; this context, in return, affects the quality and outcomes of the services in various ways. Social contexts are identifiable, interpersonal networks of individuals characterized by stable, predictable patterns (e.g., routines, norms) that prompt, direct, encourage, and constrain individual behavior (Katz & Kahn, 1978; Rogers, 2003). The social contexts in which individuals are rooted and interact frame their perceptions, behaviors, and attitudes (Rogers, 2003). In this case, mental health services are provided in various organizational contexts, including community-based treatments facilities, inpatient hospital settings, or primary care practices that serve adults and children with mental health needs (Gilsson et al.,2008).

A decade of research in various organizations provides evidence that an organization's social context affects whether new core technologies, such as programs or policies, are adopted, how they are implemented, and whether they are sustained and effective. Therefore, an organizations' culture and climate impact and influence the quality of services, outcomes, and employees. According to Hemmelgarn and colleagues (2006), there is a difference between culture and climate. They state that organizational climate is considered a surface observation of the workplace environment. Organizational culture is defined as the patterns of norms and attitudes shared and established by the members and given groups (Hemmelgarn et al., 2006).

Business and social science literature present various organizational cultures and frameworks. The competing value framework indicates how organizational culture can differ along two sets of opposite values: (a) valuing flexibility and discretion instead of stability, order, and control and (b) valuing internal affairs instead of what is occurring in the external environment (Cameron & Quinn, 1999; Quinn & Rohrbaugh, 1983). Originating as a management theory for identifying the indicators of organizational effectiveness, CVF is a way to examine organizational focus and organizational preference for structure.

Together, the two CVF dimensions form four quadrants of organizational culture: clan-collaborate, adhocracy-create, hierarchy-control, and market-compete. Hierarchy-control is an internally focused culture emphasizing stability and control for employees and processes. Adhocracy-create is a highly flexible and externally focused component; organizational leaders fostering this type of culture are experimental and constantly assess future requirements for survival. The market-compete culture focuses on competitiveness, productivity, and bottom-line results. Clan-collaborate centers around sustainability and togetherness in organizations via shared values and networking. Collaborate requires cohesiveness and the remaining four in the organization to exist.

The CVF is a multidimensional framework for connecting various interest levels from individual leadership to organizational competency to organizational outcomes. The CVF model is useful for organizing and understanding various topics and areas related to organizational effectiveness and other areas.

Organizational culture is an important predictive factor of organizational effectiveness (Greenberg, 2003). It guides employees' words and deeds, clarifying what they should do or say in a given situation, and creates stable behaviors within the workplace. Organizational culture has

three primary functions: (a) developing a sense of identity, (b) demonstrating a commitment to the organization, and (c) clarifying and reinforcing behavioral standards (Greenberg, 2003). Organizational culture is the overarching personality that indicates the core values shared throughout the organization and how employees respond to, adapt to, and address work-related problems. With a person-in-environment approach, organizational culture provides the opportunity to understand the impact of workplace stressors that can result in the development of compassion fatigue. The following sections present the integration of the two frameworks.

## The interaction of compassion fatigue and organizational culture

The literature is extremely limited in studies on how mental health providers, specifically social workers, are impacted by organizational culture and/or climate when experiencing compassion fatigue. Literature on compassion fatigue has mostly been cited in nursing (Sweileh, 2020). While organizational culture can be used to understand its influence on employees and their level of compassion fatigue, Choi (2011), noted minimal research has examined the relationship between compassion fatigue and organizational culture.

Organizational culture can be seen as shared learning experiences that lead to shared, taken-for-granted assumptions held by a group or organization (Schein, 2010). No recent research discusses the relationship between organizational culture and how it relates to compassion fatigue. Although much research has explored the protective and risk factors associated with compassion fatigue, more information is needed on how organizational characteristics and workplace variables contribute to compassion fatigue in social workers. Previous research on organizational factors and the connection between compassion fatigue is dated and only focused on protective factors (Condrey, 2015; Bell, Kulkarni, Dalton, 2003).

Townsend and Campbell (2009) explored organizational factors that led to compassion fatigue among nurses working as sexual assault nurse examiners. Their study found that when organizations had diffused goals, nurses were more likely to report symptoms of compassion fatigue. Other studies have acknowledged that certain ergonomic factors like having a comfortable physical work environment, comfortable furniture (Bell et al., 2003), private meeting locations, and offices (Neumann & Gamble, 1995) can prevent compassion fatigue.

Hernandez and colleagues (2014) examined job embeddedness and job engagement in the social work field. Their study findings concluded that organizational culture is a factor that led to employee disengagement and burnout in social work occupations. Their study concluded that most cases of reported burnout, which one can propose are the end products of compassion fatigue, were the result of organizational culture rather than specific types of social workers. Their study recommended that managers and leaders increase their employee engagement in job embeddedness, which consists of positive working relationships and maintaining open communication with employees, to reduce burnout and disengagement by employees. These suggestions are helpful with other job-related stressors that are closely related to burnout.

More recently, examining compassion fatigue and organizational culture/climate has been documented mostly in doctoral dissertations. Condrey (2015) conducted a quantitative study exploring the relationship between compassion fatigue and organizational culture. The study used the Professional Quality of Life Scale and Organizational Culture Profile to measure the relationship. The setting of the organizations selected was predominately inpatient. For example, the seven locations were a mix of inpatient psychiatric units, chemical dependency units, and an active military unit. One setting was an outpatient mental health center that provided services to recently discharged inpatient clients.

This study found that individuals who reported high levels of obtaining rewards were at a higher risk of developing compassion fatigue. Organizations with less decisiveness and high variability in their organizational value ratings scores showed more participants reported compassion fatigue. Organizational value is based on eight organizational factors: innovation, attention to detail, outcome orientation, aggressiveness, supportiveness, emphasis on rewards, team orientation, and decisiveness. Also, findings noted that organizational aggressiveness significantly predicted individuals' compassion fatigue. Per the organizational culture profile (Cable & Judge, 1997), aggressiveness is defined as a characteristic of organizational culture where group members are expected to be assertive or easygoing to compete with other companies in the marketplace. Organizations with an aggressive culture value being competitive and desire to outperform others at all costs.

One area for improvement in this study was the need for more description and specific demographic information regarding the participants. The study did not compare the differences in the level of compassion fatigue based on participants' job titles, responsibilities, and length of time at the organization. Nor did the study, given its quantitative approach, provide an in-depth discussion on the individual's perspective of compassion fatigue to provide further contextualization of the findings. The study did contribute to the limited current research studies on the topic, highlighting the need for employers to educate staff on the risks of compassion fatigue and the need for employers to acknowledge it exists. In addition, Condrey (2015) points out the need for employers to recognize staff accomplishments and effectiveness as a form of motivation to decrease the risk of the development of compassion fatigue. Condrey (2015) also stresses the importance of addressing organizational policies and staff support to decrease aggressiveness and minimize the risk of compassion fatigue. Conversely, it would be advantageous for providers in

social work and social service and healthcare organizations working to reduce turnover to understand how compassion fatigue and organizational culture and climate may impact their work with clients experiencing chronic pain and trauma.

Condrey (2015) recommended further research studies examine implementation of policies to advocate for changing organizational culture. They also recommend the exploration of policies and procedures to determine how culture impacted levels of compassion fatigue. One limitation of this study was that did not acknowledge nor differentiate what would exist when working in an outpatient, non-profit organization compared to inpatient- hospital-based environments. Other studies note significant differences when comparing an inpatient–hospital setting to a community mental health setting (Quinn et al., 2018).

As a result, this dissertation aims to focus primarily on community mental health social workers. By obtaining knowledge about social workers' perspectives on how organizational culture affects compassion fatigue, the researcher notes that this is the first step in beginning to address workplace impacts. Hopefully, this line of research leads to organizations that employ social workers developing system-wide interventions, increasing financial spending on well-being, focusing on employee satisfaction, reducing turnover rates, and improving the quality of care and outcomes for clients. The next section will review the gaps in the literature.

**Gaps in the literature**

Research regarding compassion fatigue outside of the medical field is nevertheless sparse. More recently, the topic has gained attention outside of the nursing profession. However, few qualitative studies are used to address this research gaps. As mentioned above, most studies discussing compassion fatigue have explored and identified protective and risk factors associated with and linked to the development of compassion fatigue.

Historically, the research literature has indicated that individuals experiencing compassion fatigue are mostly responsible for resolving their experiences via self-care practices (Mathieu, 2012). Other scholars have argued that more research is needed to address the gap in organizational interventions to mitigate the condition (Cocker & Joss, 2016). Empirical inquiry to date has primarily focused on the symptomology of compassion fatigue and addressing interventions at the micro or individual level (Sabo, 2011; Cocker & Joss, 2016). Most of the research focuses on the provider's experience and less on leadership dynamics to mitigate compassion fatigue. Few studies have examined the relationship between compassion fatigue, work environment, and self-disclosure or organizational culture impact to reduce compassion fatigue. Scholars have encouraged the focus on experiences of compassion fatigue from a leadership perspective in managing employees to expand the current literature. From the provider's perspective, more literature can provide an accounting for the complex ways compassion fatigue affects provider's well-being.

Cocker and Joss (2016) conducted a systemic review that examined the effectiveness of interventions used to reduce compassion fatigue in health care emergency and community service workers. Results indicated few studies and few workplace interventions are available to combat compassion fatigue. Also, Cocker and Joss (2016) noted the need for more studies to find new ways to mitigate compassion fatigue. Most of the studies on compassion fatigue interventions use a cognitive behavioral therapy approach from the individual level, with limited exploration or implementation at the organizational level.

A study by Rauvola and colleagues (2019) conducted a qualitative review on compassion fatigue. According to the authors, there has been extensive research on empathy-based stress and adverse reactions among helping professionals. They argue that the extent of reviews on

compassion fatigue, vicarious trauma, and other work-related stressors is non-comprehensive and/or out of date. Their findings recommend a new research agenda that focuses on compassion fatigue as an organizational hazard, supported by the research recommendations from Cocker & Joss (2016). Rauvola and colleagues (2019) also recommend that qualitative studies be included in future research agendas to study different forms of empathy-based strains, such as compassion fatigue, is needed. Furthermore, the authors argue that a more representative sampling technique is needed when conducting qualitative studies to improve the diversity of the participants.

Cavanagh and colleagues (2019) conducted a systemic and meta-analysis review on compassion fatigue. The study findings indicate that the prevalence rate among health care providers varies. Similar to the meta-narrative review conducted by Turgoose & Maddox (2017), demographic factors like years of experience, age, sex, religion, and specialty in the field were not statistically significant nor appear to influence compassion fatigue consistently. Cavangah and colleagues (2019) note that further studies are needed to mitigate compassion fatigue.

Turgoose & Maddox (2017) conducted a meta-narrative review on the common correlates and predictors of compassion fatigue in mental health professionals. From 32 quantitative studies, Turgoose and Maddox (2017) found that professionals' own trauma history, certain types of empathy, and a high caseload were significant factors that predicted compassion fatigue amongst mental health providers. On the other hand, empathy and mindfulness practices were protective factors against compassion fatigue. Their future directions suggested studies exploring adaptive coping skills, longitudinal studies, and large-scale studies to examine compassion fatigue more broadly and over time with specific affected subgroups.

Also, systematic reviews have encouraged further studies exploring experiences of compassion fatigue among different helping professions, such as social workers, psychologists,

teachers, and police officers, and the problems they face in overcoming compassion fatigue (Ondrejková & Halamová, 2022). They argue that such exploration would answer the question of whether there is a general form of compassion fatigue experienced similarly by all helping professions or whether it is a profession-specific phenomenon.

Previous literature recommends the implementation of wellness in the workplace to combat work-related stress. Although wellness in the workplace is an $8 billion industry in the United States, recent literature has found that it does not resolve work stress conditions like compassion fatigue or burnout (Weiss, 2020). Employers have offered yoga, meditation classes, and other wellness services, however, the research indicates these efforts need improvements. A 2019 study shows that workplace wellness programs had no impact on overall health, sleep quality, nutrition choices, health markers, or health care usage, failing to move the needle on the very issues that they claimed to address. The programs also needed to improve basic workplace outcome metrics such as absenteeism, performance quality, and retention of key employees. Weiss (2020) recommends that organizations take a systematic approach and involve stakeholders in identifying effective ways to resolve work-related stress conditions such as compassion fatigue and burnout. Like Rauvola and colleagues (2019), Weiss (2020) stresses that these conditions are organizational hazards that must be addressed to sustain the workplace. Failure to address such issues will continue to result in high turnover rates, low workplace morale, and increased comorbid health disparities among employees.

**Summary**

In conclusion, there has been extensive research on compassion fatigue. Scholars have acknowledged several gaps, such as the examination of organizational interventions (Cocker & Joss, (2016) and the exploration of how different factors may play a role in the development of

CF within community mental health populations before they enter the workforce—also, further exploration of predictors and contributors of compassion fatigue outside of the health care setting environment. The literature review findings indicated that studies focusing on community mental health social workers were rarely reported. Additionally, most studies offer ProQOL score data with little further investigation into the respondents' experiences, utilizing qualitative measures to enrich the findings. Furthermore, most research is conducted in a healthcare context where the functions of a social worker differ from those of a community mental health clinician (Sweileh, 2020).

More qualitative studies could be explored to further expand the understanding of compassion fatigue. Several authors have acknowledged a need for qualitative studies exploring the concept to improve personal and organizational interventions to avoid or prevent compassion fatigue developing and aim at creating a set of social workers' best practices to prevent compassion fatigue. Finally, given that measures of compassion fatigue exist, quantitative studies dominate what is known about individual level factors. Less is known about compassion fatigue in the workplace. Therefore, this dissertation adds to the literature by conducting a qualitative study and exploring organizational culture's impact on compassion fatigue among a professional group embedded in CMHC. Investigating compassion fatigue and the impact of organizational culture may provide managers with a better understanding of burnout and interventions that can reduce rates be developed. The following chapter discusses the research methodology for the study.

# CHAPTER 3: METHODOLOGY

This qualitative research study explores experiences among community mental health social workers who provide services to individuals with chronic and persistent mental health diagnoses. This study aims to fill the gap in the literature by understanding the characteristics and challenges experienced by community mental health social workers (Cocker & Joss, 2016; Figley & Figley, 2020). This study examined the similarities and differences in the strategies used by community mental health social workers to resolve issues related to compassion fatigue. Also, this study sought to identify social workers' needs and provide systematic intervention strategies to combat compassion fatigue in a community mental health setting.

Chapter 3 will review the methodology used in this study. An overview of the use of the sample population, data collection, study design, and qualitative approach will be discussed. This section will also review the sources of the data. Also, this chapter will outline key aspects of trustworthiness, ethics, and research integrity. The study utilized Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, & Craig 2007).

The following research questions guided this qualitative study about compassion fatigue and how community mental health social workers manage the condition and prevent recurrences.

RQ 1) What are community mental health social workers' experiences of compassion fatigue?

RQ2) How did social workers manage and prevent a reoccurrence of compassion fatigue in community mental health settings?

RQ3) How do social workers perceive the organization, barriers, and needs to mitigate and prevent reoccurrences of compassion fatigue among social workers in community mental health settings in the USA?

## Sample and procedure

Community mental health social workers experience several stressors that complicate their work in the community and work with vulnerable and marginalized populations (Ruiz- Fernandex et al., 2021). Social workers in the community setting are in constant contact with the suffering experienced by the most vulnerable individuals. Due to these factors, community mental health social workers were selected for this study. Originally, the target population was master's-level community mental health social workers in the USA. Missouri was chosen because the Missouri Department of Mental Health reports a provider shortage, leading to them working long hours, having extended waitlists, and consolidating their services (Shoyinka & Lauriello, 2012; Weinberg, 2021). These conditions add stress on the employees, specifically social workers, to meet the increased demand. However, due to limited recruiting yield in Missouri, the study expanded to other United States, including voluntary participants from Georgia, Florida, North Carolina, and Washington state. The sample also includes licensed and non-licensed participants because they share the experience of compassion fatigue and working in community mental health centers.

## Study design

The study design used an exploratory qualitative approach analyzed with thematic analysis. This approach allowed the researcher to identify and generate themes from interview responses. Data were gathered from two sources, an online questionnaire via Qualtrics software (Qualtrics, 2020) and semi-structured interviews conducted via Zoom (Zoom Video Communications, Inc., 2022) with master's level community mental health social workers in the United States. The total sample for the questionnaire screened for the study included 18 participants, and a subsample of 14 participants responded to the interviews.

## Sampling and recruitment

IRB-approved flyers were posted on social media platforms, including Facebook, Instagram, and Twitter, inviting potential participants to participate and share the recruitment materials. Emails were also forwarded to the researcher's colleagues and professional peer networks, with attachments including the IRB-approved recruitment statement, approved flyer, and a media posting statement requesting emails be dispersed to their own professional network. Recruitment information was posted daily on all social media platforms. Permission was also requested to post materials in the social work groups that targeted community mental health social workers.

Recruitment was planned for one month. However, the recruitment process was extended due to minimal responses with few completed questionnaires. The recruitment statement was posted at the start of the online questionnaire. Before beginning the recorded interview, the researcher also reviewed the recruitment statement and information that defined the terms and conditions for participating in this research study. Verbal consent was obtained before proceeding with the interview.

The inclusion criteria for the study asked that participants to acknowledge that they:

1. actively worked in a community mental health agency in the United States,
2. had a terminal degree of a Master of Social Work, and
3. had at least some experience with compassion fatigue.

The questionnaire and informed consent document can be found in Appendix B

## Sample strategy

A snowball sampling approach, defined as a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects (Parker et al., 2019), was used for recruitment. The snowball approach was used to aid in recruitment as it is

assumed that involved participants would be able to locate and encourage other potential participants to engage in the study that had the necessary characteristics to be eligible to participate in the study. According to Shaghaghi and colleagues (2011), snowball sampling and face-to-face interviews help generate the trust scholars claim is required to gain referrals. Although interviews were conducted virtually, video cameras were on to help provide comfort for the interview, with only the audio recorded. Vogel (2013) reported that using telecommunication with snowball sampling techniques has helped reduce barriers and improve the quality of interviews. For semi-structured interviews, studies conducted using Skype, a videoconference program similar to Zoom, are beneficial in using telecommunication to reduce barriers and reach and increase respondents (Vogel, 2013).

**Setting**

The study was conducted virtually with community mental health social workers. The researcher was in a secure private location within a home with no other individuals or subjects in proximity to hear the interview. Participants' locations varied from their private home offices to workplace offices. No other non-participants were present during the virtual interviews/zoom audio recordings.

**Ethical considerations**

Before any data collection, the Institutional Review Board (IRB) from Saint Louis University approved the researcher to conduct this study, monitor the data collection and protect the privacy of the participants. Throughout the data collection, participants were reminded that the study was voluntary and that they could withdraw from the study at any time. Upon completion, participants were given a $25.00 electronic Amazon gift card for participating in the research study.

## Protection of participants

Community mental health social workers work with vulnerable populations. To ensure that ethical considerations were upheld, the researcher protected participants' confidentiality, name and locations of employment, and private information of clients' personal information. Interview questions were designed to limit the sharing of identifiable information between clients and the name of their workplace. Although anonymity cannot be assured, participants were informed that the information provided would be kept confidential. The individual's personal information was not queried in the interview. Throughout the transcribing process, all names were removed to protect the participants' identities. All data was saved without identifying information. A random number was assigned, and all information participants gave was coded based on their understanding of compassion fatigue and themes from how they resolved compassion fatigue. Due to the nature of the topic, at the end of the interview, the researcher completed a debrief-check to ensure safety. Participants were offered to debrief and reflect on their feelings about the research topic and the interview. A contact number for SAMHSA's National Helpline was made available for participants.

## Data collection

Once the participant completed the online questionnaire, if participants were interested in completing the interview phase of the study, participants were asked to provide an email address (Appendix copy of the online survey document approved by IRB). Once the questionnaire was completed, the researcher downloaded each response from Qualtrics software and saved the document to her computer. The researcher looked at the last question on the questionnaire to see if the participant was interested. If they clicked "yes," the researcher reviewed the ProQOL scale scores to ensure they met the criteria for having compassion fatigue, which was a score average

above 13. The researcher then emailed the participant requesting their availability to schedule the interview. The email included an overview of the study, the participant's requirements, the link to the study, whether the participant had previously emailed the researcher, and available times to complete the interview. Participants who agreed to participate in the study were emailed a personalized Zoom link with the date and time mutually agreed upon for the interview. Figure 2 shows the process of recruitment the researcher used to complete the audio-recorded interview (see Figure 2). The following section reviews the source of the data and instruments used for the study.

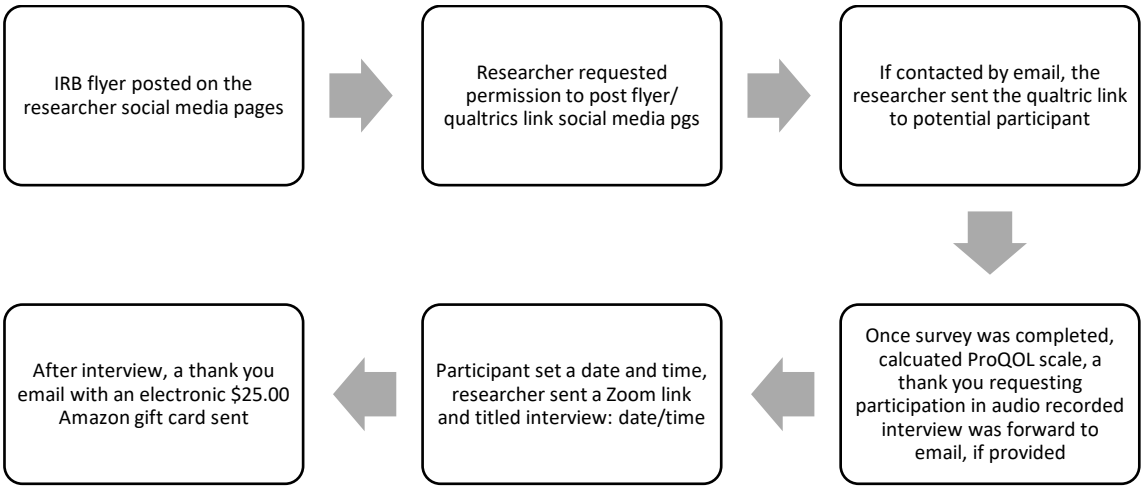


**Figure 2.** Process of Recruitment

Qualitative research concerns how participants derive meaning from their experiences and reality in different situations (Merriam & Tisdell, 2016). In basic qualitative research, interviews are the most common method used to collect data for interpretation. This study used interviews as the primary source of data, using surveys as additional information to add additional perspective to answer the research questions. All data collection processed will be discussed in detail in this section, starting with an illustration of the data collection that occurred with each participant. Data collection and analysis occurred concurrently throughout the study, and recruitment continued

until achieving thematic saturation. Further clarity of the data collection process is provided in Figure 3 to be analyzed.

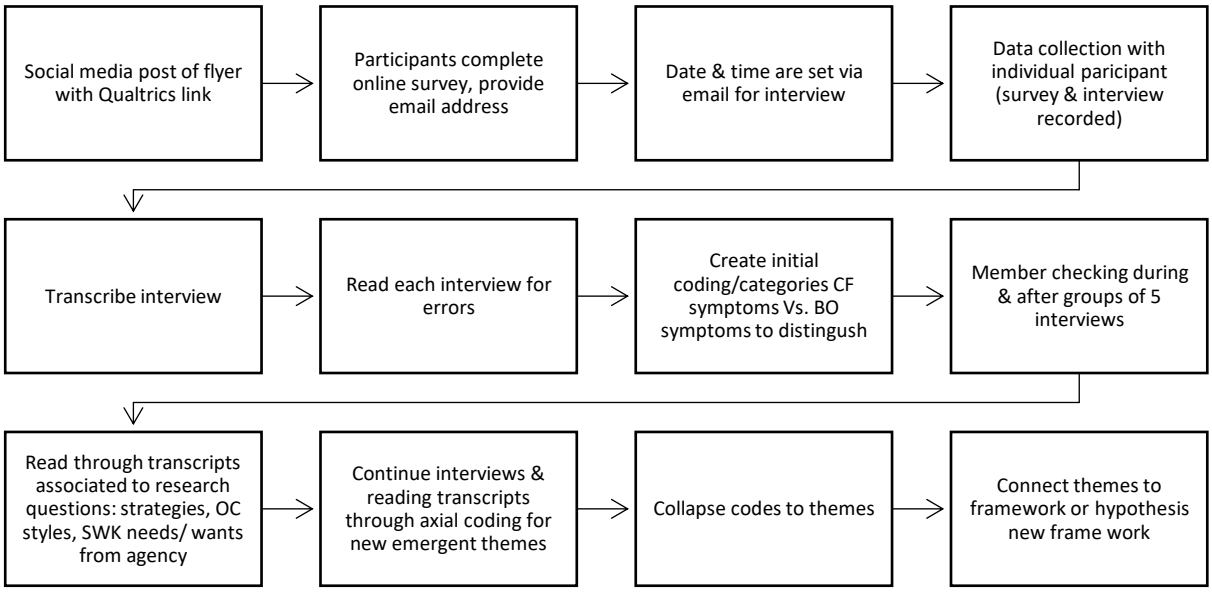


**Figure 3.** Data Collection Flowchart

Note. Figure 3. Data collection flowchart for the study. This figure describes the order of recruitment, data collection, and analysis for the study.

## Analytic Approach

The theoretical framework for this study was the Compassion Fatigue Process Model. The theory brought forth an understanding of how compassion fatigue is developed and factors such as detachment or compassion satisfaction from work resolve or influenced the condition (Figley, 2002a). Figley's (2002) compassion fatigue process model uses the concept of compassion and empathy. According to Figley (2002a), when there is a decrease in compassion and empathy and prolonged exposure to the pain and suffering of others, individuals with limited protective factors or satisfaction, support, or appropriate coping skills increase the risk of developing compassion fatigue.

## Rationale for Qualitative Method

This study utilized qualitative research methodology. Qualitative methods for this study best given that the study explored how community mental health social workers describe their experiences with compassion fatigue and the strategies used to mitigate and prevent such conditions. Understanding lived experiences has been used mostly through a qualitative method, and qualitative research designs employ analysis through interviews, document analysis, and observation (Merriam & Tisdell, 2016). This method also focuses on understanding specific variables within a context, such as perceived situations and a smaller sample population (Bengtsson, 2016). This study describes and discusses how community mental health social workers describe strategies, tools, and actions implemented in their lives to combat compassion fatigue. Also, it explored how their experiences could help to identify what more organizations can do to assist social workers with reducing compassion fatigue.

Merriam and Tisdell (2002) states there are three characteristics to qualitative research: (a) how people attach meaning to their experiences; (b) the researcher as the instrument (compared to the use of surveys and questionnaires used in quantitative methods); and (c) the analysis of findings are rich and descriptive. Using a qualitative methodology allows an understanding of an individual's belief system, perspectives, and experiences. Therefore, this study focused on the first-hand experiences of compassion fatigue as social workers describe strategies to combat the condition.

As experiences are not easily translated into quantifiable data, and much would be lost in the translation (Oxley, 2016), the use of this kind of research applies when the goal is thorough and in-depth descriptions and interpretations of a specific phenomenon, without modifying it

from its natural occurrence (Sousa, 2014). The study focused on how community mental health social workers describe the nature of the condition and strategies used to mitigate compassion fatigue and their perceived thoughts on what organizations need to implement to address compassion fatigue. Qualitative research supports the concept of interest as the individual experiences in its natural environment (Sousa, 2014), including specific people's experiences under specific circumstances (Leedy et al., 2016).

A quantitative method would be used when the knowledge is based on quantification, confirming rather than exploring, and explaining rather than describing (Creswell, 2007; Sousa, 2014). The quantitative methodology would not fit this specific research study because the researcher wishes to capture the experience, accounts and stories, behaviors, personal descriptions, and perspectives of the participants working in community mental health to provide a better understanding of the experience regarding compassion fatigue (Barnham, 2015). As a result, a qualitative approach using thematic analysis was selected because it aims to understand compassion fatigue among community mental health social workers and identify their organizational needs as it relates to their past experiences (Creswell, 2007).

**Rationale for design**

Once the researcher determined that the qualitative methodology was the best fit, it was necessary to define the design used for this study. Each design differentiates in its purpose, analysis, and data collection. This study needed to utilize a design that answered the study's problem statement and appropriateness to address compassion fatigue among community mental health social workers as the unit of observation and analysis. This study considered several designs, such as narrative, phenomenological, and descriptive. An exploratory design was selected.

The exploratory qualitative approach design focuses on understanding a concept, thoughts, or experiences without making a hypothesis, making predictions, or getting any meaning or implication from the results (Austin & Sutton, 2014). This approach involves conducting in-depth interviews with participants of interest and asking open-ended questions. Based on these characteristics, an exploratory qualitative research design represented an optimal choice for in-depth conversation regarding community mental health social workers. Utilizing a qualitative design allows the participants to share their experiences of compassion fatigue while working in community mental health settings. The qualitative approach also supports using quotations and statements to explain and support participants' experiences. This design supported data collection utilizing reflexive thematic analysis for discovering repeated patterns and themes of the unit of analysis, which is the participants' strategies used to combat the phenomenon.

## Data analysis

### Instrumentation

The Professional Quality of Life Scale -5 (Stamm, 2010) was used as a prescreening tool. This scale measures burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction for individuals in helping professions (Stamm, 2010). The Professional Quality of Life Scale (ProQOL) developed by Stamm (2010) has good construct validity. Construct validity results, which refer to the survey accurately measuring what should be measured, have been confirmed and supported during many meta-analysis studies (Morse et al., 2016). This instrument has been widely used in studies among therapists, counselors, social workers, and psychologists and has been reported in over 2000 published articles (Stamm, 2010).

There are three subscales: the burnout subscale, the secondary traumatic stress subscale, and the compassion satisfaction subscale. By looking at the scores on each subscale, the scale produces an overall measure of the professional quality of life for those in the helping professions. The ProQOL uses a 5-point Likert scale (1 – never to 5 – very often) with 30 items in total. Respondents are asked to read each statement in relation to their current work situation and select the number that reflects how frequently they have experienced these occurrences in the last 30 days (Stamm, 2010).

This study focused on the scores from one of the three subscales - the secondary traumatic stress/compassion fatigue subscale. To measure reliability, which refers to the consistency of an instrument over time and different studies (Creswell & Creswell, 2018). In quantitative research, Cronbach's alpha (a) is used to demonstrate a scale's internal consistency, and the value ranges from 0 to 10 (Creswell & Creswell, 2018). The degree of internal consistency is considered good if it is .75 or above (Crano et al., 2015). Stamm's (2010) secondary traumatic stress subscale, which has ten items, was used for this study. The Cronbach's alpha (a) was .85, thus good reliability.

At the beginning of the qualitative data collection, the survey collected geographical information about the participants. The study included a demographic questionnaire (see Appendix A). The demographic questionnaire included questions about age, race, and gender. It also included education questions such as the highest level of graduate training, length of time in the social work field, and current place of employment.

**Analytic methods: Quantitative data analysis**

The quantitative analysis was completed using IBM SPSS Statistical Software Version 26 (IBM, SPSS, 2021). Sociodemographic information was collected using a Qualtrics survey,

outlined in Appendix A. It was collected at the beginning of the questionnaire process. This internet-based data collection platform enables the transfer of data to SPSS Statistical software. The researcher then reviewed demographic responses, created a table with the variables, and calculated the sum, mean, median, and minimal and maximal scores of the secondary traumatic stress subscale.

**Qualitative data analysis**

The study also employed a thematic analysis. The thematic analysis focuses on identifying relevant themes generated from the data concerning the phenomenon being studied (Braun & Clarke, 2006). Braun and Clarke (2006) explain that thematic analysis is a methodology for identifying, analyzing, and reporting patterns/ themes within the data. The researcher-maintained reflexivity through the analysis and writing by recording, discussing, and challenging established assumptions. Following Braun and Clarkes' (2019) reflexive thematic analysis approach, the researcher acknowledged her subjectivity in the research process as she has a history of working in community mental health and had previous experiences of compassion fatigue. As a result, her experience shaped and guided this research study. Braun and Clarke's (2019) approach to reflexive thematic analysis was used for data analysis. The six-phase reflexive thematic analysis was used to promote flexibility during the analytic process. This process is not necessarily linear and was used in the preparation and analysis of the data in this study (see Table 3). Data from this study was first coded by hand and utilized member checking as needed. The researcher followed the six phases.

**Table 3.** Phases of Reflexive Thematic Analysis

| Analytic Phase | Description | Actions |
|---|---|---|
| Data Familiarization | •Immersing oneself in the data<br>to understand depth and breadth of the content<br>•Searching for patterns and meaning begins | •Transcribing audio data<br>•Reading and re-reading data set<br>• Note taking |
| Initial Code Generation | Generating of initial codes to organize the data, with full and equal attention given to each data item | •Labelling and organizing data items into meaningful groups |
| Generating (initial) Themes | •Sorting of codes into initial themes<br>•Identifying meaning of and relationships between initial codes | •Diagramming or mapping<br>•Writing themes and their defining properties |
| Theme Review | •Identifying coherent patterns at the level of the coded data<br>•Reviewing entire data set as a whole | •Ensuring there is enough data to support a theme<br>•Collapsing overlapping themes<br>•Re-working and refining codes and themes |
| Theme Defining and Naming | • Identifying the story of each of the identified themes<br>• Fitting the broader story of the data set to respond to the research questions | • Cycling between the data and the identified themes in order to organize the story |
| Report Production | • Presenting of a concise and interesting account of the story told by the data, both within and across themes | • Writing a compelling argument that addresses the research questions<br>•Writing beyond the simple description of the themes |

Note. Table 3. Adapted from Braun & Clarke (2006). See Appendix G. for permission.

Codes were then combined, categorized, and analyzed to generate themes to illustrate the data's meaning related to the research questions. Familiarity with the data was done by constantly reviewing the transcripts. The researcher wrote notes during the interview and on the

transcript after transcription to identify preliminary codes (Braun & Clarke, 2006; Braun & Clarke, 2016; Braun & Clarke, 2021). Member-checking was completed as needed to ensure data was presented the way participants intended. Periodically through the interview, summaries were provided by the interviewer on what participants had stated and asked them to confirm writers' comprehension as an initial form of member checking. Below is a sample table showing how the initial codes were organized during steps one and two processes. Table 4 provides an example of the initial code table for the study.

**Table 4.** Example Initial Code Table

| **P# & Quote** | **Code Assigned** |
|---|---|
| P3: giving and continuing to give from an exhausted place giving from a place of because that's what your heart is that's what you know. | Exhausted |
| P8: my coworkers, not the organization, my coworkers I guess they make part of the organization, (but) my supervisor didn't even know that they did this. They made a food meal train… it was wonderful it was amazing | Social Support |
| P8: administration…people that do their jobs are kind of penalized in overworked and then the people that are. Not doing what they need to do, like everybody else is kind of like picking the slack up so. | Contributors |

The next step was coding. Coding required the researcher to identify transcribed interview content related to the research questions. The researcher looked for repeated patterns in the data, using color coding to keep track of possible patterns. Below is a table illustrating the researcher moving from codes to categories. While coding, the researcher focused on parts of the

data specific to the research questions. As a result, hand coding was used with color highlighters. For example, a yellow highlight was used to identify phrases and statements referencing the experience of compassion fatigue. A blue highlight indicated strategies or actions taken to combat compassion fatigue. Green highlights were used to identify barriers, and contributors' participants reported what caused or led to their experience of compassion fatigue. Pink highlights indicated suggestions or recommendations participants felt their community mental health agency needed to implement to resolve compassion fatigue. Table 5. below shows some initial codes, categories, and representative quotes.

**Table 5.** Sampling of Initial Codes, Categories, and Quotes: Steps One and Two

| Participants | Codes | Categories | Quotes |
|---|---|---|---|
| Participant 9 | Support-Debrief | Support System | "my boss is always like always available to debrief with anything… (when disclosing compassion fatigue) I talked to my boss about it… I can tell her anything like she's known me for 30 years." |
| Participant 7 | Negative Emotions | Guilt | "if I'm struggling this much and don't, I barely scratched the surface of being able to make… the burden of both experiencing that to some level and watching my clients struggle is a lot." |
| Participant 3 | Negative encounters | Relationship with others | "My family gets the brunt of it because I usually work during the day…seeing clients after work hours…completing tasks over the weekends…my son get the brunt of that because mom is in here doing sessions" |
| Participant 4 | Lack of Support | Administrative support | "feeling overwhelmed and overworked we have high caseload and low resources, I will also say, not having the leadership to be supportive. Of course, they are stretched thin as well, but they still have to make sure that people on the front line are healthy and have the resources that they need to complete their jobs." |
| Participant 2 | Strategies | Self-Care-physical activity | "I incorporate overall self-care techniques where it's going to the gym or making sure I'm eating or going to the park or whatever it is, kind of make sure my mental stays in good shape" |

Step 3 was searching for themes. After initial coding, the researcher began to group the codes into categories where codes shared a salient feature. The researcher collated the data into potential themes (Braun & Clarke, 2006). This process moves the researcher from a focused

analysis of codes to a broader analysis of themes (Braun & Clarke, 2006). By utilizing the tables, per Braun and Clarke (2006), the researcher could keep track of each theme, definition, and example and exert from the data. In step four, the researcher writes and reviews themes. The researcher ensured that data from the transcripts aligned and had ample enough context to support the formulated theme. Table 6 provides examples of the development of codes, definitions, and themes.

**Table 6.** Examples of Codes Into Themes

| **Theme** | **Codes/Related Codes** | **Definitions** | **Subtheme** | **In vivo Tx: example** |
|---|---|---|---|---|
| **Compassion fatigue knowledge** | Empathy<br>Compassion<br>Avoidance<br>Disconnection<br>Fatigue<br>Exhaustion | Statements that describe an understanding of compassion fatigue and differences regarding other work-related stressors | Knowledge about empathy and compassion<br><br>Participants make statements that indicate there is a difference/ differentiation between burnout | giving and continuing to give from an **exhausted** place giving from a place of because that's what your heart<br><br>just doing it because you know if no one else does it it's not going to get done, and so, then **you feel compelled** to keep giving to **keep doing it at the cost of yourself at the expense of yourself.** |

**Table 6.** Continued Examples of Codes into themes

| Theme | Codes/Related Codes | Definitions | Subtheme | In vivo Tx: example |
|---|---|---|---|---|
| **Burnout Knowledge** | Schedule<br>Time<br>Documentation | Result when individuals are exposed to trauma, fear or uncertainty, loss of economic security or position, and anger over diminished control or circumstances. | Administration<br>Workload<br>Salary | Work related factors described to indicate |

Next is step five: defining and naming themes. This process involves the development of a definition, refinement, and detailed analysis (Braun & Clarke, 2006). Braun & Clarke (2021) state that the researcher should be able to define each theme easily and articulate what is not part of the theme. Engaging in this process means that the themes identified can tell a story relating to the phenomenon, which are what themes are intended to do (Braun & Clarke, 2006).

The researcher used the pen, paper, and highlight method to help organize the data. The researcher cut out sections of transcripts to orchestrate the themes and compare the themes found during the hand coding process. In addition, cutting out sections, and identifying concepts in the selected quotes acts as a secondary coding process to ensure the researcher identified themes are consistent with the data. Finally, step six is to produce the report, which is the results section. To illustrate and organize the findings of the themes, the researcher used the Word smart art hierarchy feature to complete the mapping of the five categories formulated from the data analysis along with the subcategories identified.

**Audio recordings**

Interviews lasted about half an hour and were conducted via Zoom (Zoom Communication Inc, 2022). The researcher audio-recorded the interviews to provide for accurate transcription of data. Following each interview, the researcher updated a spreadsheet that allowed the researcher to keep track of the length of interviews, completion of questionnaires, how many were needed for the study, and how many were completed. In the spreadsheet, the researcher used email addresses and their responses from the online questionnaire to identify participants and their assigned participant ID to ensure that the researcher could identify the participant's consent forms and the audio recordings. A sample of the interview can be found in Appendix A.

The researcher sent an email reviewing the overview of the study and provided available times to schedule their audio-recorded interview. A zoom link with the scheduled interview time and a calendar invite attachment was sent to the participant. Per the IRB-approved process, the researcher deleted all research materials for this study until the completion of a manual transcript. For the interview transcription process, the researcher took an average of two and a half hours per interview transcript to complete. The researcher utilized Otter. Ai (2022) otter.ai website to transcribe the interviews. Otter.ai is a transcription website that generates notes from audio recordings. After completing this process, the researcher took an hour to start initial coding, underlying and highlighting content, and correcting spelling errors. Also, deleted repeated phases, participant stuttered and redacted any identifiable information during transcription. Content that had identified information was also removed, including coworkers' names, identifiable location information pertaining to participants' workspace, and participants'

personal identifying information stated during the interview. These were omitted to protect all participants confidentiality.

## Data saturation

The researcher made preliminary decisions about the number of participants and who was selected to participate in the study before data collection to get close to data saturation. According to Glaser and Strauss (1967), theoretical saturation is present when no additional data is found, nor can the researcher develop properties of new categories. It was recommended that the researcher aim to recruit 20 participants. After two waves of recruitment and difficulty securing appropriate participants, changes regarding geographical locations were made to widen the recruitment pool. As a result of the widening of recruitment, fourteen participants provided rich data about compassion fatigue. Braun et al. (2018) stated that qualitative studies do not have a maximum sample size. However, 20 to 30 participants typically comprise an adequate sample size for identifying a psychosocial process (Creswell, 2008). Participants' responses became similar to the point where the researcher felt that "gathering more data about a theoretical construct reveals no new properties nor yields any further theoretical insights" (Bryant & Charmaz, 2007, p. 611) about compassion fatigue. Thematic saturation was reached in August 2022.

## Enhancements to methodological rigor

The researcher reviewed the literature on enhancing qualitative research studies procedures before commencing the consolidated study criteria for qualitative research. The researcher pursued the analysis retrospectively to challenge some of the recommendations provided in the literature. The following section will discuss the researcher's approach to enhancements to methodological rigor.

**Interviewer characteristics**

The researcher is a female African American, who is the owner of a private practice social work business in Saint Louis, Missouri. She worked in community mental health for five years before moving to the private sector. She has experienced compassion fatigue as a case manager working in a community mental health agency. During her licensure as a clinical social worker, she would speak with her supervisor about her compassion fatigue experience and discuss frustration and barriers that interfered with her overcoming the condition. Responses from leadership and immediate supervisors often cited dated status quo explanations with limited solutions on how to challenge the norm. From her experience, she found an interest in exploring interventions and solutions to resolve compassion fatigue at both the individual and systematic levels. Before leaving the nonprofit sector, she worked with team leaders to improve workspaces for staff. To mitigate work stressors, she attempted to implement healthy wellness practices to promote self-care during the workday. Based on this background, her previous community mental health position provided an insider perspective for this research.

The researcher's personal experience also defined the target population and shaped the development of the problem statement and methodology selections. From her experience, people mentioned compassion fatigue and rarely discussed evidenced-based interventions to resolve the condition. As a result, this study aims to develop the foundation for future studies to identify or develop systematic interventions delivered in the community mental health workplace to improve social workers' experience of compassion fatigue.

The researcher's background with qualitative methodology includes graduate-level training and experience as a qualitative interviewer as a graduate assistant. The graduate assistant role included following research protocol, collecting data, and conducting interviews following

the interview guide. In addition, as a licensed clinical social worker, the researcher's responsibilities involve conducting psychosocial assessments and confirming information received during evaluations. For member checking, the researcher confirmed understanding from the participant throughout the interviews, such as periodically summarizing respondents' statements to confirm comprehension. The respondents would say phrases like "exactly" or "yes, that's it". Also, the researcher emailed each participant an overview of the themes emerging from the interviews, allowing participants to clarify or offer suggestions on the findings.

To minimize personal perspective and researcher experience, she also used triangulation of interviews to ensure the validity and trustworthiness of the data collection. Also, the researcher asked for examples and more information to capture the participants' perspectives to ensure clarity. The use of triangulation helped the researcher compare themes related to compassion fatigue. In addition, field notes were taken at the end of each interview as a journaling process to document her thoughts and reflections throughout the research process. Prompts in the field notes include reviewing the researcher's thoughts on how she connected or felt during the interview process.

Field notes were completed after each interview. Field notes functioned as a reflexivity journal throughout the data collection and analysis to facilitate an internal dialogue for understanding issues and analysis (Smith, 1999). The journals included critical reflection on the presence or absence of participants' voices, facial responses, or body language shifts represented in the interviews. Reflections included how the researcher's roles as a social worker and researcher provider, gender roles, investigator race, and personal biases influenced the interpretation of the interviews. The researcher's field notes consisted of four questions to answer, including researchers' overall impression of the interview, unclear questions or needing

additional probing, new probes to consider for future interviews, and observations about participants' interest motivation during the interview.

Overall, her perspective on compassion fatigue and her previous work history in community mental health contributed to the research. Compassion fatigue is a sensitive topic, often normalized as an experience in the social service field and used interchangeably with burnout. Throughout the process, she acknowledged working in the field as her background that brought her to want to study this phenomenon.

## Trustworthiness

Researchers use strategies to enhance the quality of their qualitative research and meet the standards of scientific rigor. Quantitative scholars can use statistical procedures to evaluate the level of reliability and validity of their research (Creswell, 2008; Lincoln & Guba, 1986). However, trustworthiness is used to measure reliability and validity in qualitative research (Lietz & Zayas, 2010). Lincoln and Guba (1985), who have the most-cited standards for evaluating qualitative work, note that qualitative studies should have trustworthiness and present the research participants' perspectives as closely as possible (Lietz & Zayas, 2010). Qualitative scholars evaluate trustworthiness based on the research's credibility, transferability, dependability, and confirmability. Another trustworthiness tool used was member checking, a technique used to establish the credibility of the participants' responses. Throughout the interview, the researcher summarized respondents for comprehension. Also, an email summary of preliminary themes was forwarded to participants for accuracy and to ensure the transcripts reflect their lived experiences (See Appendix E).

## Creditability

Credibility is the degree to which a study's findings reflect the participants' meanings (Lincoln & Guba, 1985). The objective of credibility is to remove researcher bias and ensure the authenticity of the participants' interpretations. According to Drisko (1997), researchers should engage in reflexivity and remain self-aware of their influence on the research to manage bias. Additionally, credibility requires the researcher to manage the risk of reactivity and bias. This proposed study will include an inconspicuous, transparent, and nonintrusive data collection process that includes informing the participants of the audio recording of their interviews. The interviews used neutral nonverbal and verbal language to reduce potential bias. In addition, the data analysis process will include highlighting sections from the transcripts and selecting statements that reflect the participants' experiences to provide rich, contextual documentation directly from participants for reduced deception and bias. This study included prescreening to ensure the participants have experience with the phenomenon under study (Lincoln & Guba, 1985; Nowell et al., 2017), thus enhancing credibility and transferability.

## Transferability

Transferability is the applicability or usefulness of the findings for theory, practice, and future research (Lincoln & Guba, 1985). However, this study might have limited transferability due to its focus on social workers' strategies to mitigate compassion fatigue, instead of a broader population of all community mental health professionals. Thematic analysis will analyze the data and seek to achieve confirmability. Thematic analysis allows the researcher to remain reflective and aware of biases and assumptions during the data analysis. Thus, the thematic reflexive approach is an appropriate strategy to reduce bias in this study. Finally, ensuring the trustworthiness of the research will entail making the data available upon request.

## Dependability

Like credibility, dependability is vital to a valid qualitative study. Dependability means the researcher has presented the study in such detail that other researchers could replicate every methodological and analytical decision the researcher made (Elo et al., 2014). Replication in qualitative research is unlikely. The researcher detailed each step and phase for transparency, which helped to establish dependability. The researcher employed additional steps to continue establishing dependability throughout the study.

First, the researcher engaged in reflective journaling after each data collection and debriefing with at least one committee member. Chowdhury (2015) recommends debriefing to increase the quality of the study. Talking with someone not involved in the study, walking through the researcher's process, and reviewing and discussing the development of codes and themes minimize biases and help establish dependability (Given, 2008). Second, the bracketing technique was implemented. This task allowed the researcher to identify personal beliefs on the topic to recognize them and limit thoughts from influencing data analysis (Creswell, 1998). Third, the audio was recorded and transcribed via Rev for transcription service. The researcher received the transcript and reviewed the document for accuracy, ensuring it was correct before proceeding with data analysis. Fourth, member checking was completed throughout the semi-structured interview process for each research participant. Consequently, it allowed the participants to review their understanding of the data as participants intended.

Lastly, as mentioned above, the researcher engaged in reflective journals, interview notes, and a codebook. Although Braun and Clarke (2020) do not require or advocate for a codebook for thematic analysis, the researcher finds that this lends itself to the study's dependability. It also helps to illustrate the analytical process for the data analysis. Interview

notes were used to help minimize researcher bias, which could threaten the study's dependability. The researcher employed these steps during pilot testing to ensure they were completed and successful.

## Confirmability

Confirmability focuses on the study's results. It refers to precision in the data interpretation. As a process, it explains if other researchers agree with the study results and the accuracy to meet a confirmability threshold (Elo et al., 2014). Researcher bias, if not acknowledged, poses a threat to confirmability. Hence, it is vital to mitigate researcher bias by engaging in the tasks noted earlier. Member checking, bracketing, and verifying participants' indented response also aid in data interpretation. Also, Braun and Clarke's (2020) six-step thematic analysis, shown in Table 4. outlines the researcher's steps and how the researcher concluded from the data, thus, building confirmability.

## Integrity

Qualitative research requires that research shows the integrity of its findings and the value of the research. Integrity refers to honesty and probity in the research process. The researcher's central ethical principle is to do no harm to participants, gain informed consent, and appropriately represent respondents' views as accurately as possible (Watts, 2008). To ensure that integrity was upheld in this study, participants were provided the informed consent signed electronically and reviewed during the beginning of the interview. The researcher reviewed the purpose of the study and asked for verbal consent before conducting the interviews. Throughout the interviews, the researcher completed member checking to verify the understanding of participants' statements. Also, participants were sent an email highlighting the study's findings

and offered the opportunity to correct or refute findings. Chapter 4 will review the results from Qualtrics and the interviews.

# CHAPTER 4: RESULTS

This chapter includes a discussion of the descriptive findings, data analysis procedures, and study results. There will also be an explanation of how the transcribed data was coded and how themes emerged from the data, and how the data was analyzed. Lastly, in this chapter the study results will be discussed, in text quotations, followed by a summary of the chapter.

Out of the multiple postings, 148 participants started the Qualtrics survey, 33 of the surveys had duplicated IP web addresses and were eliminated from the study. Thirty-seven of the surveys were incomplete, 60 were completed questionnaires with no email address to follow up, and 18 completed questionnaires with email addresses. Of the 18 eligible respondents who completed the online questionnaire, had a score above 13 on the secondary traumatic stress subscale of the ProQOL were sent an email. Eighteen participants responded to email follow up. Four attended the sessions, but after reviewing the criteria via zoom audio recording, it was determined the participants did not meet the criteria. As a result, 14 participants met criteria, replied, scheduled, and completed the semi-structured interview. Descriptive data were obtained from the online questionnaire and the semi-structured interview. The following section describes the descriptive data for each interview.

## Participants' profile

There were a total of 14 participants, ranging in age from 25-58. The populations that participants worked with included adult, homeless population, substance abuse, and comorbidity dual diagnosis. There were 12 female and two male participants. Seven participants identified as African American, six as Caucasian, and one Asian, Caucasian- mixed participant. For marital status, seven reported being married, six single/ never divorced and one divorced participant. See Table 7 for participants demographic characteristics.

**Table 7**. Participants Demographic Characteristics

| | n=14 | Mean | Median | SD |
|---|---|---|---|---|
| Age | | 40 | 39 | 11.22 |
| Marital Status | | | | |
| Single | 6 | | | |
| Married | 7 | | | |
| Divorced | 1 | | | |
| Race/Ethnicity<br>Black | 6 | | | |
| Caucasian | 7 | | | |
| Mixed, Bi-racial | 1 | | | |
| Gender | | | | |
| Male | 2 | | | |
| Female | 12 | | | |
| Years at Agency | | 6.85 | 4 | 8.14 |
| Years in Field | | 12.78 | 9 | 9.40 |
| Geographic | | | | |
| Saint Louis | 8 | | | |
| Other | 6 | | | |

**Descriptive findings**

A total of 14 participants contributed completed data collection instrument for the analysis. Qualified participations were over the age of 18 and either licensed or non-licensed social workers. The ProQOL (Stamm, 2010) instrument was used as a screening recruitment qualifier for this student to protect participants anonymity and encourage sufficient participants meet their criteria for this study. Summary statistics were calculated for secondary traumatic stress (Table 8). The following section will review the results from the interviews.

**Table 8.** Descriptive Statistics

| Variable | M | SD | Min | Max |
|---|---|---|---|---|
| Secondary Traumatic Stress | 27.28 | 6.37517507 | 18 | 40 |

Note. Variable: Secondary Traumatic Stress measured by the ProQOL-V (Stamm, 2010).

## Qualitative interview findings

Qualitative data from 14 community mental health social workers were coded and analyzed to answer each research question. Five major themes emerged from the data:

1. Emotional distress, such as guilt, strained relationships, and feelings of ineffectiveness were the most commonly reported feelings associated with compassion fatigue among community mental health social workers. The theme of psychological distress explored how participants defined and described their experience with compassion fatigue. It also discussed the experience's impact on their interactions and relationships with others.
2. BIPOC social workers' ethnicity and gender identity factors are additional burdens that complicate the management and prevention of compassion fatigue.
3. A lack of organizational support, systematic barriers, and unrealistic expectations and demands were identified contributors of compassion fatigue experienced by community mental health social workers.
4. A multidimensional (e.g., physical, mental, and spiritual) self-care approach is the most used strategy to prevent reoccurrences of compassion fatigue, including arranging time off, having social support, and conducting debriefing sessions.
5. Creating safe spaces to debrief and address compassion fatigue in organizations is needed for social workers employed in community mental health organizations.

The subthemes highlighted some commonalities and differences reported by participants as they described their experience with compassion fatigue (see Figure 4).

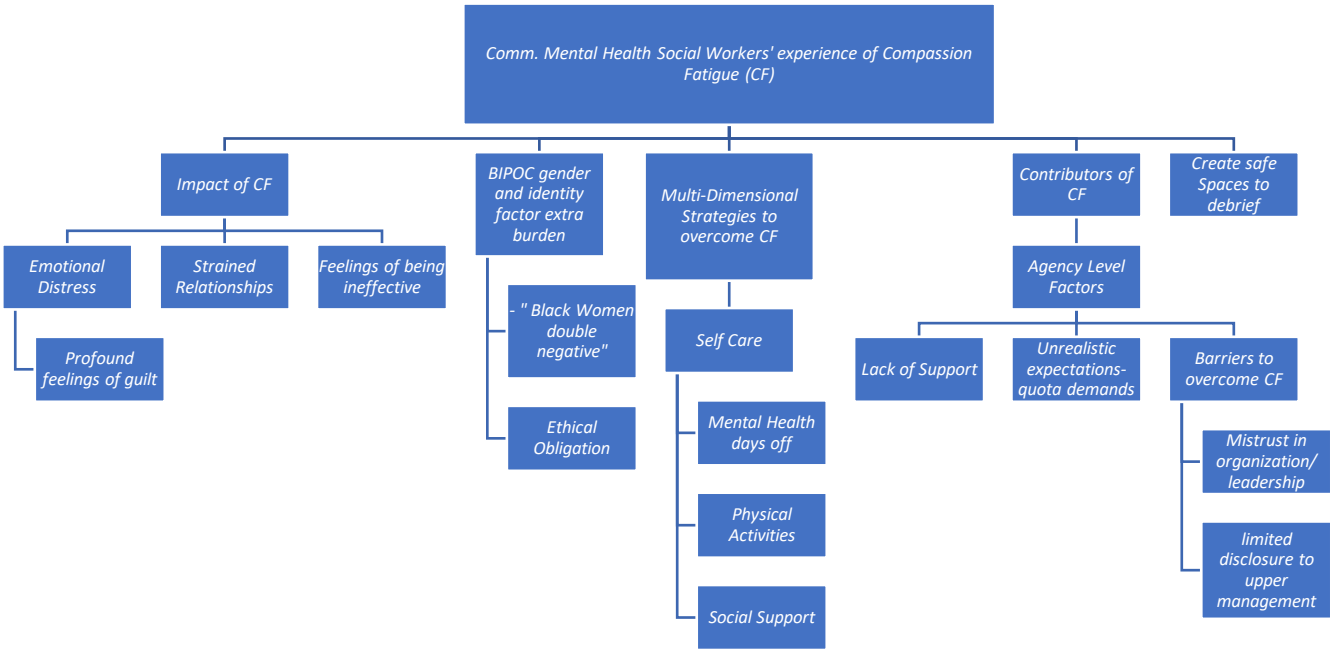


**Figure 4.** Thematic Mapping of Themes

Note. Figure 4. A thematic map illustrating the five categories illuminated from thematic data analysis and subcategories -themes of community mental health social workers' experience of compassion fatigue.

The results are organized based on the research questions and thematic categories. Figure 4 displays the five major themes and the subthemes- categories emerging from data. The following section reviews the research question and results and development of the themes.

**Results Research Question One**

The first research question was developed to gain insight into community mental health social workers experience of compassion fatigue. Two themes emerged from this research question. The first theme, Theme One, noted that CF leads to emotional distress. Two distinct subcategories emerged from the data. The majority of the participants had a) a strongly negative emotional (e.g., agitation, irritability, sadness) reaction to compassion fatigue and b) reported adverse/ unpleasant encounters with others during an episode with compassion fatigue. such guilt, strained relationships, and feelings of ineffectiveness were the most common reported

feelings associated with compassion fatigue among community mental health social workers. Theme Two noted that BIPOC social workers' ethnicity and gender identity factors are additional burdens that complicate the management and prevention of compassion fatigue.

**Theme one: Compassion fatigue leads to emotional distress**

Negative emotions are unpleasant, emotional reactions that express a negative effect. Negative emotions are described as the negative aspects of helping others, which results in symptoms of secondary traumatic stress (STS). Negative emotions, as discussed by the participants encompassed: frustration, helplessness, guilt, and inadequacy. Participants described compassion fatigue as a disruption in emotions and being exhausted. Most participants described emotional distress and depressive reactions to the symptoms. Participants described an inability to be present with others in a compassionate way. Several participants made statements such as “I do not have the emotional bandwidth” or “I do not have the emotional capacity to show up” to describe their inability to provide empathy and compassion for others.

Most participants shared that they noticed a lack of engagement with tasks that previously provided them with excitement. For example, one participant described doing things robotically and lacking excitement, or interest in completing the tasks or communicating with clients. Similarly, other participants commented on being disengaged and dreading going to work. One participant reported, “basically, when anyone has become so exhausted that they start to not be able to empathize with patients, they no longer care”. Also, the sentiment was echoed by another participant who stated, “during COVID-19, I was working from bed and not listening to respond to what was said, however, ensuring that safety was assessed and validating clients without exchanging or following the DBT treatment modality”. Finally, another participant shared similar feelings and reported,

> you start kind of getting numbing feelings around folks' circumstances. The things that you hear from people and see… you notice you should probably have a certain reaction to it and you just don't have the emotional bandwidth to let yourself process… it's like an active dissociation.

**Profound feelings of guilt and strained relationships during CF**

Guilt was an emotion frequently referenced to describe how participants perceived themselves as having compassion fatigue. Several participants commented that they felt sad and guilty for "saying this" while describing their experience with compassion fatigue. Several perceived themselves as being bad and had failed for developing the condition. For example, one participant reported,

> It sounds so terrible, but I feel like I just kind of expect it (compassion fatigue) to happen… I try my hardest to not let it (compassion fatigue) get as bad as it has been in the past. But in these jobs, we're dealing with lots of… sad things in the world, trauma, and mental illness, and substance… and lots of limited resources... To say that for the rest of my career I'm not gonna experience compassion fatigue, I couldn't say that because I know that I probably will. I just hope that I'm able to not let it get as bad as I have in the past.

Most participants with children described a phenomenon they described as mommy guilt. With CF they reported an ability to shut off emotions at work, manage and navigate metaphorical fires or crises at work while remaining completely calm and patient. However, they did describe being irritable, impatient, short, and yelling at children for trivial reasons while at home. Participants reporting feelings were blown "out of proportion," to the point where they felt like they were losing control.

The majority of participants reported that compassion fatigue had a negative impact on their interactions with themselves, family members, clients, and coworkers. Almost every participant expressed that their support system received the brunt end of their compassion fatigue. As a result of having compassion fatigue, some participants stated that they felt inadequate and incompetent as providers. Participants reported the impact of compassion fatigue

led them to feeling disconnected and disengaged from others. In particular, participants with children, reported their children could sense that work had stressed them out, which led to their children avoiding them. Those who did not have children reported that their friends had noticed a decrease in their social interactions.

Participants mentioned how their families have jumped into help with work-related tasks because work was brought home. For example, a participant shared, "(I) tell myself to not type notes in the morning...my family would like for me to be present…(husband) feel as if I don't really have time to complete my work and spend time with my family". More than five participants shared not having the social energy to engage or discuss issues with peers because they perform such tasks at work. For example, one participant stated, "after work I'd get on my phone to play games, but my mind just numbing, I'd just sat on my couch just unable to move.".

**Questioning one's effectiveness and abilities during CF**

Participants expressed that they questioned their ability to be effective during their CF experience. They felt that their clients did not receive their "best version". Many reported feeling inadequate as a provider and felt guilty for not being able to immediately resolve their symptoms. Many felt that compassion fatigue affected their ability to be empathic, by stating they felt that they had a reduced emotional capacity or compassion to provide care. Participants described being disconnected during sessions and unable to be mentally present, which increased participants having a negative belief of themselves and in their abilities. One participant shared that she believed that individuals who experience compassion fatigue can become insubordinate and non-compliant as a social worker. For example, one shared,

> I no longer had that capacity or energy to give or want to wake up every day and listen, provide the validation and empathy and all that came with being a good DBT (dialectical Behavioral Therapy) therapist… patients could kind of tell it wasn't working. I could lay in bed, take the phone call…specifically with DBT there was more to the therapy than

> just listening. The patient felt heard, but my job or part in the therapy was not there… I listened and you get it all out and now you feel much better than great we did a good job, but actually the therapy model is not set up that way.

Others described feeling disingenuous as a provider and reported feeling like they were checking boxes. For example, one participant stated they, " do things just to say things are done". Similar sentiments were shared by others of doing the bare minimum to ensure job responsibilities were met, but with less enthusiasm or interactions with others. Four participants noted disengaging in interactions with clients during bouts of compassion fatigue to preserve their remaining energy by not doing more than necessary. Participants noted that they do what is ethically required of them as a provider. Doing the bare minimum was a statement describing their bouts of compassion fatigue. For example, one participant stated,

> there are moments, where I could be present and say something, I might not have to be, but I do it, just to support my clients, but I don't challenge them, I don't point out something to reflect on just because I may not have the energy to do it. There's no conversation piece of it going back and forth for me being present in a way.

**Theme two: BIPOC social workers gender and racial identity factors complicate CF experience**

The second theme identified was how BIPOC social workers have an extra burden to address while combating compassion fatigue. Across the data, there was a consensus among six participants that BIPOC social workers had a racial and gender identity factor that was not mentioned by White social workers in the sample that complicated their management and prevention of compass fatigue. Six of the six Black/ BIPOC social workers verbalized that their ethnicity and being a Black woman interfered with their willingness to disclose compassion fatigue with others. More specifically, they shied away from discussing their compassion fatigue with leadership. BIPOC participants stated they did not share as there was a lack of trust and a belief that the information disclosed would not be used against them in the future. Also, the BIPOC social

workers felt it was their duty to address and highlight the lack of attention being addressed surrounding the racial issues occurring in society in general, not specifically related to compassion fatigue or their organizational affiliation.

**Black women's experience is a double negative**

A common belief held and shared among Black-African American identified participants, who were primarily women, shared that their racial identity worsens their experience with compassion fatigue. Six BIPOC participants (6 of 6 BIPOC participants) shared that "being black and a woman is a double negative" and emotionally taxing. In contrast, seven Caucasian women did not mention their racial identity positively or negatively impacting their experience with compassion fatigue. Black women talked about feeling that they had to suppress their experience of compassion fatigue because they are often seen as strong and resilient. Some mentioned having to code switch and police their tone to minimize coming off as aggressive. Participants described having to censor and belittle their experience to receive support from others, specifically leadership, to accept their experience. Participants felt that if they displayed their raw emotions such as anger or aggression, participants felt they would later be targeted or unable to be seen as a leader in future promotions opportunities. For example, a participant shared,

Just being black is very difficult in this in this country because we are still considered a minority and people still look at us as being very resilient because of our race and so people expect for us to come back really quickly to get over it and sometimes it's not always the case…I have what they call is a double negative. I'm a black woman and so that just comes with a lot of personal stressors and then of course at work sometimes doctors can talk to me in ways that they would not talk to perhaps white women or white males and self-overcoming those barriers and work to gain people's respect and make sure that they are respecting you at all times can be very difficult.

Another participant shared having to overcompensate for her racial identity to prove that she is competent to reduce others from questioning their intellect. Another participant stated, “I feel like as a black woman we have to work thousand times harder to prove ourselves to prove it reduces smart to prove that we are just as qualified I feel like we have to hold ourselves to a higher standard there's almost like a push for perfection like to not make errors because you don't ever want to give anybody that satisfaction of saying that you did something or did something wrong. I just would equate it to me, it feels like pressure.”

For the other women that participated in the study, it was acknowledged that being a woman, held an expectation for them to be nurturing and caring. One participant stated, “being identified as female…there is this need that reflected in our society that you are going to be expected to be seen as lesser, so you have to do more to prove yourself”. This was echoed by other female identifying participants.

In comparison, the male participants shared indifferences on how gender impacted their experience of compassion fatigue. One participant felt that neither age nor gender impacted their experience of compassion fatigue. He described being open and willing to discuss their experiences with others. In contrast, the other participant stated that their gender interfered with their willingness to share. For example, participant shared,

> there's certain parts of (sharing information about compassion fatigue) that I don't always go into details... I do talk about it… I kind of have to measure how much I disclose to people... I'm much more likely to steer conversations with new introductions or somebody about what my wife does as a nurse because I know they what she does… (being a male) I think it sometimes impacts how willing I am to engage in some of those topics with other people.

**BIPOC have an ethical obligation to show up**

BIPOC social workers felt they held an obligation to engage in diversity, equity, and inclusion conversations. They noted their organizations lacked the infrastructure to discuss and

to challenge racial discrimination that clients and employees felt while working in community mental health. This perceived feeling of obligation contributed to their experience of compassion fatigue. For example, BIPOC social workers shared that White colleagues would praise them after meetings for challenging and bringing up issues during a meeting yet failed to acknowledge the stress or praise BIPOC experience in the meetings. Some also felt their White colleagues would reach out to discuss racial issues and disregard the additional burden placed on the BIPOC providers as the agency diversity, equity, and inclusion educator to discuss racial issues because they are accessible in the workplace. For example,

> [when] Mike Brown was murdered it was like the whole city was on fire was erupting in Ferguson…. I wanted to jump out and run to Ferguson, but also had to take care of my clients here ….and I'm like I need to be a stable for us here…. I also need to take care of my home… it's a tug and pull and there was like no rest and because I was one of the only black people working… leadership was like, "So what do we do "and i'm like, why is this what I'm the social worker…. Help us – we have to figure out how to manage all these emotions and We need your help to figure it out and they didn't explicitly say hey, you black woman in a room tell us what to do, over like at me, what do you think?

BIPOC social workers also felt it was their duty to "show up" for their BIPOC clients. They reported they endeavored to minimize their client's emotional distress during racially tense issues occurring in the news. They also worked to ensure clients could process the collective racial trauma occurring.

They often stated that they had to manage how they conveyed their frustration and anger to not appear as the "angry black woman." For example, participants shared that they had to be mindful of their tone and how they made statements while talking with non-BIPOC peers and managers. For example, a BIPOC participants stated,

> Within the Community and within the organization sometimes you have to be mindful of how you verbalize… Black woman sometimes like vocalizing our frustrations or just anything we're going through… have to be a little bit more tactful with our words and be more mindful and understand the ramifications if we do decide to speak up.

Several noted they felt colleagues believed the stereotype that Black women are strong and can endure pain, that they appeared resilient and capable of handling stress. However, peers lacked the ability to provide mutual support when the BIPOC social worker experienced distress. They often stated that they had to manage how they conveyed their frustration and anger to not appear as the "angry black woman.", which limited them from sharing their bouts of compassion fatigue.

**Research Question Two**

**Theme three: Multi-dimensional approach to prevent compassion fatigue**

The second research question explored what strategies and actions community mental health social workers took to manage and prevent reoccurrences of compassion fatigue. Theme three identified that the majority of the participants developed a multi-dimensional strategy plan to manage and prevent compassion fatigue. Three subcategories emerged from the data which included self-care, such as taking time off, therapy, engaging in physical activity, using support system and debriefing. The majority of the participants reported adhering to their agency's self-care recommendation and routinely scheduling mental health days.

Participants emphasized how important it has been to take days off and utilize support systems. Four participants highlighted personal skills of setting and enforcing boundary setting to minimize work stressors and overextending themselves. Nine participants shared that they used colleagues or a supervisor, to process their compassion fatigue. Some participants shared self-care practices such as taking a moment to be reflective and grounded. These practices were mentioned as tools used to help participants be present, refocus and rejuvenate themselves. For example, participant shared,

> (strategies used to combat compassion fatigue included) implementing self-care- self-care, know limitation and where you lack. Ask for help when you need assistance with

competency or skill competency. Just realizing that I don't have to do everything all at once and that it's okay to take a step back in asking for help is a huge thing.

**Arrangement of time off**

For the majority of the participants, self-care mostly consisted of taking time off of work. More than nine participants said they took time off work during compassion fatigue episodes to deal with the symptoms. Participants shared similar views on taking mental health days and "turning off" as a care provider. Some participants shared how they took extra steps to ensure they scheduled PTO days throughout the month or bi-monthly routine outings- vacations. Participants echoed a sense that it was their priority to take care of themselves as they felt their organizations did not care. A few participants described not being concerned about supervisors approving their request for time off. Participants also reported having "mental health days" after several encounters with compassion fatigue.

**Engage in physical mindfulness activities**

Physical activities strategies were also mentioned as a way to help manage compassion fatigue. Mindful activities helped participants release tension and physical exhaustion. Activities included working out, cooking, and eating and preparing healthy meals. Participants reported CF led to physical neglect. Many reported a loss of interest in pleasure activities that were considered a healthy routine. Participants shared finding non work related- mental health tasks to destress such as walking outside, being present with animals, or engaging in activities that are pleasurable.

**Engagement in therapy**

Many participants mentioned seeking therapy to address their symptoms during an episode of compassion fatigue. By attending therapy, participants shared that the therapeutic relationship helped them to develop boundaries, improve communication, and establish a healthy

work-life balance. It helped participants to compartmentalize and develop boundaries. Participants explained they could sort through their stressors from attending therapy to find what work-related issues contributed to symptoms such as depression and anxiety. For example, one participant reported therapy reminded them that they were human and that it was acceptable not to have all the answers or fix problems clients experienced. Another reported attending therapy during their lunch break. She stated, "I knew every Monday at two. I took a lunch break out of my car ...You practice what you preach, you know you tell your clients to go, and it's like I can't tell these people to go do all this stuff, and then I don't do it myself, you know kind of thing". Another participant shared,

> I have my own therapist, so we talked a lot about burnout first, thought was maybe a little bit of a person just dealing with the pandemic, so I don't know really exactly what it was until, he kind of broke id down to me…I do therapy just talking about like self-care I'm in putting my own personal boundaries in place so like after five o'clock I was not history, no mark email, I'll turn off my phone...tell my clients who maybe didn't always understand my own boundaries and what is appropriate and what's a crisis.

**Utilizing social support system**

Using a support system was another strategy for combating compassion fatigue. Several participants emphasized using internal supports, which included colleagues, supervisors, and directors, to process thoughts and emotions related to compassion fatigue. The majority reported that they preferred to talk with coworkers rather than supervisors. Participants expressed they felt more connected and validated by their colleagues. Overall, participants shared that their support, whether at work or outside, helped combat compassion fatigue.

Participants reported coworkers were the primary support system in their workplace. Colleagues with previous bouts of compassion fatigue openly offered advice and support. Three participants mentioned that their supervisors were their biggest support systems. For example, one participant shared that she had known her supervisor for most of her career, so there has

been an established relationship where she feels comfortable discussing problems beyond work with her supervisor. Some participants acknowledged having internal support to be a protective factor. One participant shared, “I’ve been fortunate where I did have people, the people who are my peers for the most part were like really supportive and helpful and sometimes admin were too, but I would say a lot of times peers.” Another participant shared that she has had two great supervisors in her life that checked in frequently after she shared experiencing compassion fatigue. She stated, “my supervisor is around my age, she's female, she's very kind and she's always doing check-ins. She makes me feel, it's very pleasant to talk, I never feel rushed. Others acknowledged their support systems outside of home, stating,

> I feel lucky that I got a great wonderful, lovely people in my life that supported me…. I’m not having collegial support so even within my system, some of the counselors are so burnt out…I get it, its (compassion fatigue) is complex, but not having enough collegial support, so I have had to seek that outside.

**Debriefing/check-ins are important**

Debriefing was described as a tool to help participants process and share their frustrations related to compassion fatigue symptoms while receiving helpful suggestions to improve. Those who shared with colleagues reported venting about their experiences while at work helped them leave work. During debriefing, participants described being able to highlight challenges and receive feedback on how to improve resolving problems. By engaging in debriefing, participants explained that peers highlighted strengths, which validated the participant—also provided options on handling areas of deficits. Furthermore, debriefing helped participants feel unjudged, supported, and competent. It also helped to normalize their experience and feel seen and validated. Four participants that worked in the same organization highlighted that they appreciated their organization's debriefing resource. Debriefing was mentioned several times throughout the interview. A participant shared,

> my boss is always available to debrief with anything…They (organization) also they started a grief group. I think it just helps because you know you are not alone and there's always someone with that sick-wrapped sense of humor, sometimes it's me, but you can sort of laugh about it. I find laughter so helpful for me, if I can laugh about it, it helps and I do this in the debriefing sometimes.

A participant reported that she valued that her supervisor often offered to debrief and welcomed participants to share on challenging workdays. She notes that through this debriefing process, colleagues often shout "boundaries" to help participants maintain healthy work boundaries with clients, so she does not overextend herself. Similar participants shared that debriefing helped them maintain healthy work boundaries when working with complex cases. Those in other organizations reported similar processes. For example, one participant shared,

> the mental health department that I work under, people can communicate with the doctors and social workers, you can communicate with any provider on teams... the providers are available to communicate with each other to check in about clients, but we're also able to communicate with each other… I feel like providers in the mental health clinic where I work do a good job of checking in with each other, especially if we are dealing with the same client and like something you know traumatic or stressful is going on.

**Results Research Question Three**

The third research question explored what were the perceive the organization, barriers, and needs to mitigate and prevent reoccurrences of compassion fatigue among social workers in community mental health. Two themes emerged from research question three. Theme four identified agency-level factors such as a lack of support and trust in leadership and unrealistic work demands as contributors to the development of compassion fatigue. Theme four identified CMH social workers needs for organizations to create safe spaces to debrief.

**Theme four: Agency-level factors contribute to CF**

The majority of the participants shared that agency level factors such as a lack of support and unrealistic demands as contributors to their experience of compassion fatigue. Barriers to managing CF identified were the need for more trust in leadership and willingness to disclose CF

experience. Participants felt management was disengagement and lacked insight into problems in the organization, which complicated their experience of compassion fatigue. For an example, one participant stated,

> I realized we are (social workers) replaceable… these people (leaders) don't care, like your organization, they care to a certain extent, or they say they do… I think administration (contribute to cf) ... people that do their jobs are kind of penalized and overworked. Then people that are not doing what they need to do, like everyone else is picking the slack up.

Another participant reiterated similar feelings about lack of support from leadership and shared,

> leadership, which is like our CEO, our CEO they have tried to implement (support) the best way that they can for everyone to be supportive of what are the other for us to be to have teamwork culture, unfortunately, it doesn't tickle down, and so my experience has definitely been I'm trying my best to meet the patient's needs. Unfortunately, there are several departments that don't feel the same way, for me, I can easily see myself falling back into compassion fatigue if, I don't have the support of my peers in my department.

**Unrealistic expectations and demands**

Participants felt their organizations had unrealistic expectations about productivity/ quotas that needed to be met. Participants stated that engagement expectations were unrealistic and challenging to meet the client's needs. Participants understood that organizations must make income; however, the demand for participants to chase the units became emotionally and physically taxing. For example, one participant shared,

> it was about…Money, what was it called engagement. Having those units and making sure that you know, at the end of the month, you had what you needed to so that you didn't have a conversation with your supervisor, and it was also a lot of you know, these are the rules, and these are, how they are. Simply because we need to make sure where we're in line for funding.

Other participants talked about how the tasks asked of them are nearly impossible to complete but expected. For instance, one shared, "leadership be like, just finish a job that needs

to get done, like do the impossible…like do these 50 million things that are you know that really shouldn't all be on a social worker because other agencies need to provide the missing services".

**Lack of trust/transparency.**

Several participants mentioned trust as a barrier preventing them from openly discussing their issues. Participants that were dismissing and unable to process situations felt it hindered them from recognizing and verbalizing symptoms. Participants felt management would conduct surveys and fail to review results. For example, a participant shared, "it sounds so terrible, but like most community mental health agencies I've worked in I really don't trust management". Others reported attending town hall meetings where they were encouraged to share thoughts but felt, "[there are] so many meetings that were supposed to come with our needs and suggestions to make the agency better, but I've never rarely seen anything change from those things". Another participant felt that management was too controlling and distrustful of them to be productive, sharing that,

> the biggest barrier is when managers tried to over control and they don't share and there's a lack of transparency and you don't empower people as much as possible…when it comes to managers feeling stressed, they become controlling… when anybody stressed out you want to control whatever you can control... Then you control things that really don't need to be controlled, which makes the stress worse… when management teams feel more under pressure and mor stress, they get much more controlling than that leads to people feeling less trusted, less than power.

**Limited Disclosure of CF to Upper Management**

Most of the participants shared that they discussed their experience of compassion fatigue with colleagues and external supporters. Several acknowledge disclosure being a barrier in their recovery. Few participants shared that they have spoken directly with a midlevel manager or direct supervisors. Participants acknowledged concerns and consequences of being targeted or removing their autonomy if they shared about their compassion fatigue. For most participants, it

was echoed that they felt comfortable sharing with individuals that would offer support or assist them with finding alternative ways to manage their stress.

Those who declined to disclose their experience of CF with management shared fears of being watched and loss of autonomy, which prohibited them from wanting to share. For example, a participant shared, "when you do say you need help, or if they're tracking your progress, or maybe they're noticing things, then it could be deemed as a like a negative thing". Others shared when they had shared with leadership, minimal actions were taken to assist participants with resolving their issues. For example, one participant stated, "not directly to management (disclosing to management) … mostly coworkers… because (management) don't care… when you tell them stuff…like I told my supervisor didn't like doing drug group…. She's like, I heard you say that; so, outside of that what else can I do to help… they don't resolve things".

A participant mentioned their lower-level position being a barrier in disclosing compassion fatigue experience. Participant stated, "my job title, maybe like my position coming from a CSS (community support specialist) … I feel like not being encouraged to voice back played a role in not disclosing".

**Theme five: Creating safe spaces to debrief**

Theme five illustrates how organizations need to allocate time and safe spaces in organizations to help combat compassion fatigue. Most participants suggested that management needed to conduct more check-ins or create shared spaces to process. Participants wanted their leadership to engage their staff more and discuss compassion fatigue. The design of their offices did not promote an environment that allowed them to be open and feel comfortable discussing issues. Some participants noted the office floor plans had changed to an open floor plan, which

limited privacy. Outside of team meetings, participants suggested allocating time specifically to check-ins and processing issues. For example, one participant reported that from past places of employment, jobs rarely made it a priority to check-in. Although she currently has this resource available, she noted it would be worth it for other community mental health agencies to implement check-ins. She shared,

> I wish there was time to have some sort of like check in with social workers or check-ins with counselors or check in with whoever -anybody that was struggling who attended meetings, to talk about these things (compassion fatigue), but there I don't think people have time to do it.

Another participant with a similar suggestion stated," (there should be) some type of team engagement, where you kind of get to be around others, there may be times you discuss certain things, find out that you're not the only one that's experiencing compassion fatigue… I think that's helpful. Overall, incorporating a culture where you know the workers feel comfortable expressing themselves is something that I think would be beneficial." Participants felt they did not foresee themselves not having a reoccurrence of compassion fatigue. However, setting boundaries and working within participants skill levels reduced their CF episodes.

**Summary**

The result of the study suggests that community mental health social workers have emotional distress that impacts their relationships and view of themselves, which include feelings of guilt and inefficacy when they experience compassion fatigue. However, BIPOC social workers report gender and ethnicity as additional factors complicating compassion fatigue management. Community mental health social workers use a multidimensional approach to managing and preventing compassion fatigue, such as taking time off, using internal and external social support to debrief, setting healthy boundaries, and engaging in extracurricular activities. Overall, across the community, mental health social workers believe that agency-level factors such as limited

support from their leadership and lack of debriefing processes contribute to compassion fatigue. Findings also suggest that CMH social workers would like their workplaces to develop emotionally safe spaces to share and discuss issues affecting their ability to do their job.

# CHAPTER 5: DISCUSSION

The study explored the issues of compassion fatigue among community mental health social workers. Community mental health social workers' strategies and actions to manage and prevent compassion fatigue were examined. Also, the study sought to explore the role of organizational culture in social workers' perceptions of compassion fatigue. Next, the study aimed to identify social workers' needs within community mental health centers to minimize compassion fatigue and better understand the tools used to combat the conditions. Lastly, the study sought to identify the needs among CMH social workers working in community mental health to minimize compassion fatigue systematically.

The study adds to the current literature on compassion fatigue strategies to prevent reoccurrences (Cocker & Joss, 2016). The findings from this study also help to identify organization-level strategies to assist community mental social workers with combating compassion fatigue (Cocker & Joss, 2016). Also, the findings are expected to assist in addressing the social worker shortages in the workforce by providing CMHC leadership with insight to assist social workers with minimizing CF. Findings were driven by data from the Health Resources and Services Administration's reports (Beck, Manderscheid, Buerhaus, 2018).

The results of this study generated five themes. Emotional distress, such as guilt and inadequacy, are the most common response to compassion fatigue among community mental health social workers. The second identified that BIPOC social workers find their ethnicity and gender as an additional stressor that complicates their experience of compassion fatigue. Theme three highlighted the self-care practices such as taking time off and setting personal and professional boundaries essential to minimizing compassion fatigue. The fourth theme identified agency-level factors such as a lack of support and trust in leadership and unrealistic work demands

as contributors to the development of compassion fatigue. Lastly, theme five showed how organizations need to allocate time and safe spaces in organizations to help combat compassion fatigue.

Overall, many findings were consistent with the literature surrounding common symptoms experienced from CF and how CF impacts the individual, the work environment, and support systems (Lombardo & Eyre, 2010; Harr, 2014). Findings also demonstrate how an organizational environment/culture functions in the manifestation of compassion fatigue. Lastly, CF prevention involves leadership involvement and how changing systematic practices can mitigate the condition. Some of the themes are somewhat interwoven with each other, for instance the theme CF leads to emotional distress and limited organizational support and unrealistic demands overlap causes CF. In this section, discussions will contextualize the literature related to the study findings following the themes and categories mentioned above.

**Theme one discussion: compassion fatigue causes emotional distress**

The concepts of emotional exhaustion and emotional distress in relationships were two issues widely recognized, both in the interviews and throughout the literature review. Community mental health social workers describe themselves as overwhelmed, drained, moody, irritable, impatient, and withdrawn when CF presents. Theme one is consistent with other literature (Mathieu, 2011). Identifying these symptoms can be challenging and emerge suddenly without warning (Sinclair et al., 2017), as working with clients who experience severe prolonged ailments depletes the emotional resources of the providers (Singh et al., 2020). Thus, further complicating caregivers' processing of their emotional distress. As a result of the emotional depletion, the client's chronic stress is transferred to the professional. Results from the study indicate that the stress from working with such clients often impacts relationships. Findings align

with other studies showing that a lack of empathy and feeling purposeless in their work negatively affects patient care and individual relationships with colleagues and patients/ clients (Lombardo & Eyre, 2010).

The study's findings on the feelings of guilt are in line with Papzology and Chopko's (2017) findings on empathy and guilt among law enforcement. They found that feelings of guilt and shame can accumulate among police officers who have been exposed to multiple morally distressing causing incidences. Following similar beliefs of Figley (2002), Papazoglou and Chopko (2017) propose that compassion fatigue is related to moral suffering experienced by first responders in the line of duty. This study's results suggest that feeling guilty is a common emotional response to working in social services and are social workers' personal reactions social workers experience that may contribute to the experience of compassion fatigue. Guilt can affect social workers' practice, potentially leading to social workers being overly involved and engaging in unhealthy behaviors to help, potentially leading to burnout.

Emotional distress and exhaustion and its effects on personal life were the most cited results of compassion fatigue on healthcare professionals (Mason et al., 2014; Menezes et al., 2013; Rice & Warland, 2013; Van der Wath et al., 2013; Yoon et al., 2010) and consistent with the study's findings. Regulating such emotional responses is important to psychological well-being. For helping professionals in community mental health settings with clinical roles, self-management strategies to improve social workers' mental health become even more essential. Findings suggest that social workers should acknowledge feelings of guilt and process them to minimize delaying recovery. As suggested by empathy researchers, managing personal distress for caregivers in the social service sector is important to help sustain them in social work (Thomas, 2013).

The study findings are consistent with the literature on the behavioral response of individuals with compassion fatigue (Figley, 2002b). The findings support the theoretical perspective proposed by Stamm (1995) and Figley (2002a) that symptoms of compassion fatigue can lead to behavioral changes in the individual. These behavioral changes can stem from emotional detachment, agitation, and lacking compassion and empathy for others.

Centrano and colleagues' (2017) examined indicators of quality of working life and their role on mental health professionals' levels of compassion fatigue, burnout, and compassion satisfaction found that mental health professionals were more concerned about work interference with their personal lives than the reverse. Mental health professionals attempt to reduce work impacting their personal life; however, the findings and literature show that due to the nature of their social work, ongoing and unresolved compassion fatigue impacts the individual relationship and the workplace (Harr, 2013). The literature encourages caregivers to learn the early warning signs of compassion to prevent compassion fatigue (Mathieu, 2011).

**Theme two discussion: BIPOC gender and racial identity complicate CF**

BIPOC social workers reported navigating additional stressors related to their gender and racial identity as factors that complicate the management and prevention of compassion fatigue. When CF is present and racial tension is increased in society, BIPOC participants reported taking on additional protective roles and feeling ethnically obligated to minimize their needs to shield clients from injustice and minimizing their need. BIPOC social workers reported challenges differently from their non-Black colleagues, including discriminatory practices against how they talk, facial expressions, and tone used to express disagreement. These results show that African American providers do not feel safe expressing themselves. Results indicate that non-White providers had to be mindful of self-disclosure about personal experiences and fear of being

denied a promotion because of challenging norms and policies within the workplace were consistent with the research (Roberts et al., 2018; Phillips et al., 2018). These findings are similar to that of other studies (Giordano et al., 2020).

BIPOC social workers' response to CF and withholding of personal information is a commonly shared belief some African American professionals hold about being Black in the workplace (Phillips et al., 2018). Studies have found that many African American professionals, specifically Black Women, feel their professionalism is constantly scrutinized and closely watched, on guard, and under increased pressure to perform. Research encourages workplaces to be mindful of tone policing marginalized groups when BIPOC employees voice their concerns using trauma-informed communication strategies (Asare, 2021). Also, work is needed to build relationships for BIPOC social workers to trust that workplaces are addressing racial discrimination and disrupt existing power imbalances.

The results from the study reinforce the importance of recognizing BIPOC struggles; discussing their CF experiences is key to opening dialogues with them and exploring tangible resolutions to help increase feelings of safety. Also, it encourages workplaces to acknowledge the burdens and dual roles placed on BIPOC social workers during racially intense moments by validating their experiences to lessen the emotional taxation experienced by BIPOC social workers potentially. Establishing safety in the workplace disrupts racial oppression by asking employees who have undergone racial trauma about their needs and for agencies to be receptive to the suggestions and honesty provided, along with self-reflecting on policies and procedures that may reinforce oppression (Giordano et al., 2020; Cooke & Hastings, 2023). The findings presented here offered insights into the extra burden experienced by BIPOC social workers whose voices and experiences are absent from the literature.

**Theme three discussion: multi-dimensional strategy plan to prevent compassion fatigue**

Engaging in a multi-dimensional self-care approach were referenced in coping strategies implemented to combat compassion fatigue. Self-care plans included obtaining emotional support from colleagues, family, and friends to process work-related issues, forming routines to arrange time off (Sheppard, 2016), and joining extracurricular activities, which align with previous findings (Leon, Altholz, & Dziegielewski, 1999; Pfiffering, 2000; Berger & Gelkopf, 2011). More specifically, social support can significantly determine a psychological adjustment in international relief personnel after trauma exposure or hearing about the traumatic event and act as a buffering mechanism (Figley, 1995; Sanchez-Reily et al., 2013; Figley & Figley, 2017; Sinclair et al., 2017).

Participants noted that internal organizational support can mitigate stress by having a healthy support system in the workplace. Participants who worked in the same organizations reported having adequate leadership support and felt their organization did a good job supporting their needs, such as offering unscheduled supervision to check in, reviewing cases, and acknowledging frustrations, leading to employees identifying unknown needs to improve workflow. Participants in other organizations reported relying on external support. Considering whom participants identified as social support is important to explore further as most participants described and relied on external supports such as nonwork-related peers (e.g., family/ non-social work peers) to help them mitigate their experiences. This study demonstrates that limited internal organizational support systems are available to social workers working in community mental health organizations.

Leadership can increase their presence in the workplace by engaging in open conversations and asking for employees' input, offering space to discuss needs or feedback about changes outside of scheduled employee satisfaction surveys. Organizational systems management can contribute

to occupational stress that increases and magnifies the stress experienced by working with clients or intentionally incorporate activities and attitudes that promote compassion satisfaction (Harr, 2013). For example, one strategy is acknowledging employees' successes when working on complicated cases. Employers can acknowledge and normalize employees' frustration and offer to find solutions to rectify problems. Social workers cannot avoid the job strain inherent to their professions. However, researchers have found that those with social support and great work relationships are better equipped to handle work demands (Van Hook & Rothenberg, 2009).

Utilizing a multi-dimensional approach to mitigate compassion fatigue is consistent with other studies, such as Gentry and colleagues' (2002) resiliency program and other research literature on combatting compassion fatigue. Gentry and colleagues (2002) proposed five components of a compassion fatigue resiliency model to mitigate compassion fatigue which included the following: (a) self-regulation: use muscle relaxation to activate the parasympathetic nervous system and learn to change negative perceptions into positive ones, thereby strengthening recovery ability, resiliency, and adaptability of stress; (b) intentionality: modify impulsive thinking and negative stress-related coping behaviors and cultivate the habit of thinking thoroughly before reorganizing oneself for work; (c) perceptual maturation/self-validation: change one's mood, relax when encountering stress, identify with one's own response to stressful events through self-talk, and format work-related negative feelings into normal requirements; (d) connection and support: cope with stress through interactions with an organization or support network; and (e) self-care and revitalization: balance physical and mental health by doing aerobic exercise, following appropriate dietary and sleep regimens, and strengthening professional abilities. These suggestions effectively mitigated compassion fatigue (Gentry et al., 2002) and were implemented by all of the participants in this study to manage and prevent reoccurrences of compassion fatigue.

However, Cocker and Joss's (2016) meta-analysis point out that most of these practices are individualized and do not involve or address workplace-system-wide strategies. Further research is needed to address from an organizational standpoint what leadership involvement and actions are to help combat compassion fatigue. Results from this study also suggest continued research agenda exploring organizational strategies to combat compassion fatigue, which will be discussed in the following sections.

**Theme four discussion: agency- level contributors of CF**

Both limited support and mistrust of leadership were highlighted in the literature as contributors to compassion fatigue (Figley,1995). Research has found that limited support is a key risk factor contributing to compassion fatigue (Killian, 2008). Social workers reported needing support from managers, colleagues, and family/friends. Examples included leadership offering to assist with finding coverage if participants wanted to take mental days off. Also, examples included colleagues and family, allowing social workers to vent and validate their emotions. Common workplace factors contributing to CF include job duties, such as delivering bad or uncertain news to patients and their families, and lack of perceived managerial support (Bernhardt et al., 2009), which is consistent with the findings from this study.

Leadership involvement is needed to help mitigate compassion fatigue (Figley, 1995). Figley (1995) states that it is the responsibility of management to help recognize, acknowledge, and address those experiencing signs and symptoms of compassion fatigue, stress, and burnout. Training for supervisors and administrators is important to help develop management, leadership communication, and conflict resolution skills (Figley, 1995). An interactive leadership style may fit today's emergency workers (Figley, 1995; Figley & Figley, 2020). However, organizations have moved towards utilizing wellness programs to address and improve employees' well-being.

Consequently, this shifts the responsibilities from leadership back to the employee rather than the organization-management to assist in resolving (Slatten et al., 2020; Weiss, 2020). Research encourages organizations to support human development, increase autonomy and empower and train employees to develop various skills to mitigate compassion fatigue.

Another concept that correlates with the research is that the need for leadership support and a sense of trust may reduce community mental health social workers experiencing compassion fatigue. Building trustful relationships with management and within teams is crucial (Centrano et al., 2017) and increases honesty. Support and trust would allow community social workers to be more vulnerable regarding the difficulties they are experiencing, share problems in work related processes, and ask for more assistance in rectifying problems. Empirical evidence has suggested that employees with adequate support, information, and resources experience lower levels of compassion fatigue (Adams, Boscarino, Figley, 2006). Craig and Sprang (2010) further explained that extensive trauma caseloads and prolonged working periods beyond a normal work schedule are associated with secondary traumatic stress. Participants shared the need for support from management to review cases and offer support of reassignment or cross-training would help mitigate compassion fatigue.

The findings suggest that costs are incurred when organizations and leaders fail to be supportive and engaged in rectifying problems and making it the employees' responsibility to resolve issues. Placing unrealistic demands on employees because of staff shortages profoundly impacts employees' work satisfaction. High demand for services from caregivers can create the buildup of unresolved daily stressors by human service members (Figley & Figley, 2017). These findings reinforce the importance of managers working to balance workload and establish trust for employees to be honest about their needs and challenges. Both social workers and

management must work together to identify solutions to meet the organizations' and clients' goals and needs while maintaining the social workers' psychological well-being. These results underline how crucial it is for managers to be engaged and help social workers find a balance between the workload and rectifying barriers or problems.

An important takeaway is that participants' lack of sharing their experience of compassion fatigue with the leadership hinders the organization from identifying effective strategies to mitigate compassion fatigue within the workplace. This behavior hinders leadership from implementing effective changes to policies and procedures to improve the work environment to minimize compassion fatigue. Failure to communicate and share their experiences may exacerbate symptoms of compassion fatigue and lead to burnout or retention issues within organizations. The findings suggest that employers need to develop/cultivate work environments that welcome more internal support for their behavioral health providers. This theme is consistent with the literature (Huxley et al., 2005; Rosen et al., 2018).

**Theme five discussion: creating safe spaces to debrief**

Safe spaces are environments where employees feel comfortable expressing their emotions and needs with others. Emotionally safe spaces allow for the freedom to openly express concerns, challenges and find a sense of acceptance and understanding from others (Banfield et al., 2022). Psychologically unsafe environments can lead to employees not speaking up about errors or shortcomings for fear of reprisals, which can result in mistakes and harm clients (Clancy, 2019). Participants described toxic workplace environments in which they felt isolated, unsafe, and vulnerable when sharing their CF-related experiences. Participants expressed the need for employers to cultivate an organizational culture that allows individuals and their teams to feel safe (Edmonson, 2018). Unsafe spaces can decrease emotional safety and trust between the therapist

and the client, re-traumatize clients, reduce client engagement in services, and interfere with successful treatment outcomes (Orpustan-Love, 2014).

Creating a safe place for employees is needed to create a cultural shift toward a healthier way of discussing CF in the workplace. The findings from this research illustrate the importance of management involvement in conversations on the health and well-being practices of employees in work settings, daily operations, and business practices. Also, reinforce the need for CMH agency leadership to put forth promoting a transformative vision of discussing CF as an organizational intervention (Cocker & Joss, 2016). Social workers' recommendation aligns with the literature's need for organizational interventions to combat CF (Sweileh, 2020). Participants' use of debriefing aligns with the literature on how to mitigate compassion fatigue by creating safe spaces. These suggestions also emphasize a broad interest in mental health promotion and healthy working and psychologically safe environments.

The literature suggests that leaders create a safe space with the shared belief that employees can speak up without the risk of punishment or humiliation (Herway, 2017). Leadership should ensure that accountability is fostered and reciprocated in the organization without creating unhealthy employee anxiety (Edmondson, 2017; Clancy, 2019). Safe spaces include promoting dialogue, building trust, willingness to discuss uncomfortable topics, promoting and fostering gratitude practices, promoting diversity and inclusion, encouraging freedom and individuality, and investing in leadership among employees (Herway, 2017). Research has found it to be a highly critical driver in helping promote high-quality decision-making, healthy group dynamics, interpersonal relationships, and effective executive execution in organizations (Edmondson & Mortensen, 2021). Safe workspaces increase empathic ability

and empathic response, which are protective factors that allow caregivers to locate and identify resources and external support to aid in reducing the suffering of the individual (Figley, 2002).

**Findings and connections to the theoretical framework**

In this study, the theoretical model used to conceptualize compassion fatigue was the etiology stress model proposed by Figley (1995). The model assumes that empathy and emotional energy are used to help those suffering. To do this requires an empathetic response. An empathetic response is an attempt to reduce a client's suffering by offering empathetic understanding (Figley, 2002b). CF model suggests that practitioners limit compassion stress, deal with traumatic memories, and effectively manage caseloads or effective ways to avoid compassion fatigue (Figley, 2002a). Compassion stress (CS) is the demand for action to relieve the suffering of others. Reducing compassion stress by increasing practitioner happiness by learning to disengage from job emotionally and physically is strongly encouraged. The findings from the studies on how to prevent reoccurrences and management of compassion fatigue are consistent with the literature and recommendation proposed by Figley (2002) to minimize CS which included stress management, self-soothing, and seeking professional help when needed.

Participants reported minimizing CF, by taking mental health days, setting emotional boundaries around their expertise and clinical limitations, these suggestions are consistent with the literature on how to reduce compassion fatigue for the individual (Mathieu, 2012). Other studies have found ways that managers can assist in mitigating experiences of compassion fatigue by reassigning patients, formal mentoring programs, employee training, and having a compassionate organizational culture (Slatten, Carson, & Carson, 2020). Slatten and colleagues (2020) argue that managers in both private and nonprofit settings should work to have balanced

caseload with mixed-balanced caseloads that include equal parts of clients with easy problems to challenging and difficult situations (Sprang et al., 2007).

Research studies encourage managers to incorporate training in holistic self-care activities (Slatten, Carson, Carson, 2020), which includes learning to recognize warning signs of compassion fatigue and developing interpersonal coping skills to help prevent and lessen the effects of compassion fatigue. Slatten and colleagues (2020) suggest the use of self-care to aid in helping healthcare workers restore and maintain a healthy balance in their lives. Activities like getting adequate sleep, good nutrition, exercise, and frequent mini vacations are recommended to develop healthy self-care routines to minimize compassion fatigue (Inbar & Ganor, 2003; Slatten, Carson, Carson, 2020). This suggestion was shared by current study participants and noted as their activities that are often revisited when recognizing early warning signs of compassion fatigue. In some cases, participants shared that they noticed that when these activities are withdrawn from their daily routine, participants reported an increase in re-experiencing compassion fatigue. Furthermore, Slatten and colleagues (2020) highlighted that it is both the individual and the managers' responsibility to encourage employees to tend to their physical health to mitigate compassion fatigue. They find that recommending a holistic self-care routine helps employees create specific boundaries and aids in separating work-life balance.

Slatten and colleagues (2020) suggestions are consistent with the participants' recommendations and reported needs from organizations. For example, participants shared that when managers are engaged and encouraged to take care of themselves and practice self-care, they reported a decline in reexperiencing compassion fatigue. It can be suggested from the results that management can assist in mitigating compassion fatigue by increasing their

conversations with employees surrounding hobbies and interests, and activities that are stress relievers in the office to act as a reminder for staff to have a work-life balance.

**Greenburg's organization culture (person in environment/ org culture impact) theory**

Greenberg's organizational culture posits that organizational culture has an essential role in shaping the workplace context, providing stability, and showing employees how to respond and cope. Additionally, organizational culture provides an identity helping bind the staff's individuality and actions. Therefore, organizational culture influences behavior (Greenberg & Baron, 2011). The findings from this study indicate that many participants felt their leadership and organization lacked a cohesive display of the organization's culture. Many participants felt that the organization's mission and actions did not translate across the organization. Many reported that lower management appears to have a collective teamwork culture. In contrast, upper management often focused on competing with other organizations and marketing themselves as the better organization against their competitors. For example, several participants who worked in the same organization shared how their office remodel focused more on aesthetics and how long a client is in the office than the work being done to reduce their suffering. Based on the competing values framework, results suggest that opposing behaviors confuse employees' understanding of the organization's culture and influence their experience of compassion fatigue.

According to previous studies, Inbar & Ganor (2003) and Radey and Figley (2007) agree that organizations can improve a workplace by promoting a culture where clinicians feel that they can depend on their colleagues in a time of need. Also, help develop managers for workers with leadership capabilities and style that promotes creativity, problem-solving, and collaborative vision. As mentioned above, Harr (2013) encourages leadership to take an active

role in creating opportunities and activities that help social workers take care of themselves. Such suggestions align with Greenburg's organizational culture theory and recommendations on creating a strong culture that has symbols and slogans, ceremonies and team-based interactions that help promote and reinforce the basic values and assumptions of the organization. These activities and skills help management engage actively with employees creating opportunities for dialogue and observation of how well employees are doing.

Social work functions within a holistic, person-in-environment approach to service users with more focus on prevention, care, and recovery than cure (Hick, 2006; Freeman, 2011; Payne, 2014), an approach that acknowledges that environmental factors are important. For caring professionals, the environment and organizational culture can serve as protective factor that decreases the risk of experiencing compassion fatigue. From the results, social workers stated improving the organization's culture, increasing support, being trustworthy and collaborative in problem-solving, and increasing law staff decision-making involvement can potentially reduce social workers' experience of compassion fatigue.

**Limitations**

This study has several limitations. The sample size was small and was a non-random sample. The transferability of findings is limited due to the inclusion of only social workers working and residing in the United States and English-speaking participants. While recruitment was broad, we did limit it to community mental health social workers in St. Louis then expanded to other states in the USA. Data for this study were collected via self-report. The self-report method was a function of choosing qualitative inquiry because the research sought to obtain a depth of information on a topic with limited literature evidence. While, for example, participants likely recalled experiences of encounters from past work experiences and factors associated with

compassion fatigue, this could not be confirmed. Despite several procedures to ensure rigor and trustworthiness, such as memo checking, confirming understanding of statements and phrases, and completing field notes, biases by the researcher who collected and analyzed the data may have influenced results.

Additionally, selection and availability bias were limitations. The sample was not selected randomly, and recruitment was primarily done via social media platforms. The researcher potentially missed potential participants who were not using social media which was one of the study's criteria. Also, with the interviews being conducted virtually, the researcher limited potential participants who would have preferred in-person interviews. Although virtual interviews increase access to potential participants (Vogel, 2013), zoom fatigue, a term used to describe the overuse of videoconferencing for work, increased during COVID-19 (Elbogen et al., 2022). Consequently, this potentially reduces interest in completing this study. For availability bias, participants may have been influenced by participating in recalling memories differently from how they occurred, potentially substantially and unconsciously influencing their belief, and inappropriately categorizing past events as compassion fatigue and possibly experiencing something else. Due to these limitations, results may differ significantly and are not generalizable.

Another limitation is social desirability bias. Participants may have tried to present themselves in the best possible light when asked about negative behaviors in clinical practice. Furthermore, participants were self-selected to volunteer. Participants who may have been actively expressing compassion fatigue might have declined to participate in the study due to their mental state of discussing work-related stress, which limits the generalizability of the results. Furthermore, snowball sampling also limits generalizability. However, snowball

sampling is designed as a recruitment method that offers a way to overcome many of the recruitment challenges associated with inviting difficult-to-reach communities to join social service and work-related research studies. Though this study intended to focus on a specific discipline, the majority of respondents identified as social workers, and most were women. Few male participants were engaged in the study, which is a noted barrier in social work research as women make up the majority of the workforce in the community sector. Lastly, the incentive to participate in completing an audio-recorded interview may have influenced the limited number of participants.

**Implications**

The data from this study add to the limited research examining the juncture of compassion fatigue and organizational culture's impact on community mental health social workers in the United States. This study has several implications for community mental health organizations and social workers in the public sector. Because community mental health is often understaffed with limited resources and high demand for services, community mental health agencies need to continue improving debriefing and mental processing for social workers working with complex cases. Also, work is needed to implement a system-wide initiative to encourage social workers to take care of themselves, such as workplace mindfulness activities, increase communication on compassion fatigue in the workplace, and increase programs for social workers to build resilience (Harr, 2013; Figley & Figley, 2017).

Compassion fatigue is preventable when measures are taken to ensure monitoring and early detection occurs by boosting protective factors, reducing risk factors, and enhancing resiliency. Other strategies for mitigating compassion fatigue include having organizational leadership support and involvement in addressing challenging cases and offering debriefing to

help social workers process the client and work-related stressors. Increasing collaborative work and team reflection processing in weekly or monthly workflow processes to minimize the accumulation of stress amongst social workers (Harr, 2013). When possible, social workers should be involved in decision-making or changes to work processes to receive input on how changes would affect workflow, services, and exposure to prolong pain and suffering.

Current trends in the United States show increased service utilization in community mental health centers (Tornicroft & Henderson, 2016). As a result, employees play a vital role in managing and ensuring that programs and services are running properly. Thornicroft and Henderson (2016) proposed that community mental health agencies should develop and evaluate methods to improve shared decision-making among healthcare staff and service users. Staff members and clients should be involved in decision-making processes consistent with the current research agenda for improving community mental health services. Research findings also suggest that organizations in the community mental health sector should also see practitioners/ providers as partners in an integrated system.

Other proactive self-care activities worthy of implementing in the workplace include mindfulness practices, joining professional peer groups, clinical supervision, or seeking therapy, which could demonstrate positive outcomes for Black mental health social workers or minority groups struggling with race-related stress (Giordano et al., 2020; Posluns & Gall, 2019). Recommendations for leadership to improve the workplace include encouraging a culture where compassion is expected, recognized, valued, and celebrated within the organization (Slatten et al., 2020). Organizations need to create safe spaces for employees to talk about their pain, frustration, and experiences to help assign meaning and identify future practical skills to implement to rectify problems that could lead to compassion fatigue. Furthermore, leadership

can help individuals make positive reinterpretations of negative thoughts. Engage and assist employees with reframing situations and finding solutions as a collective team unit to reduce shifting the burden and responsibility back onto the individual.

**Practice implication for minority -BIPOC social workers**

There are a few organizational policies on diversity, equity, and inclusion (DEI), as well as the hiring, retention, and promotion of individuals of color, that CMHC can implement to minimize CF for BIPOC social workers. Understanding the factors that lead to CF, specifically for BIPOC and marginalized social workers informs human resources efforts at the recruitment and rendition of community providers. The need for a racially diverse social service workforce and leadership is abundantly clear, yet social service agencies focus on promoting and recruiting BIPOC leaders often is dismissed (Miu & Moore, 2021). Given the recent attention to institutional racism in the workplace, more agencies have started to openly address their lack of diversity, equity, and inclusion for BIPOC communities. Often workplaces fail to acknowledge that BIPOC individuals experience cultural taxation in which BIPOC people generally are expected to serve as cultural brokers between the community, and White clinicians and administrators, while simultaneously experiencing microaggression and invalidation where their feedback on policy and system changes are ignored and dismissed (Padilla,1994).

Organizations must note when BIPOC professionals are doing institutional work on diversity, leadership should ensure adequate protected time for this work and appropriately recognize their efforts. Failure to support the work of educating others increases their risk of CF and other work-related stressors. Of note, the data collection for this study occurred when employers sought to initiate DEI initiatives to challenge institutional racism and address inequities in mental health access for the BIPOC communities. The findings focus on developing

workplace climates and implementing practices supporting BIPOC community providers. As workplaces consider how to develop effective recruitment and retention efforts to hire and support a more diverse social servant workforce, the findings affirm that organizational leadership must carefully consider the roles asked of BIPOC social workers in CMH settings.

Providing mentorship and training programs to develop social workers of all ethnicities is important; however, implementing practices focused on providing BIPOC women and all marginalized individuals opportunities for advancement into leadership positions is critical. BIPOC women, compared to other ethnicity and genders, face significant barriers to advance into leadership roles (McDowell, 2015; Washington & Roberts, 2019). Other ethnic groups are being promoted and advanced in their career at greater rates than BIPOC women (Orbe-Austin, 2021). The resiliency ability to overcome racial challenges for BIPOC women, coupled with the data showing that women in social work are more likely to have a positive impact on treatment outcomes, reaffirm organizations human resources personnel to make continuous efforts to promote BIPOC women in social work with the necessary support and tools to be successful.

**Implications for policy**

A workplace climate that includes openness to discuss CF and racial issues can be addressed through diversity, equity, and inclusion (DEI) policies. The findings suggest that the emotional exhaustion and lack of feeling safe experienced by CMHC social workers increase the risks of CF. Workplace cultural-environmental and DEI efforts have become a major focal point for many employers, with increasing attention paid to employees' mental health well-being policies (Novotney, 2022). As a result, discussing CF and racial differences is often expected to be brought up and resolved by the individual (Carter, 2007; Cocker & Joss, 2016; Shell et al., 2021). Leadership in CMHC must be willing to openly discuss and encourage conversation on CF and

offer support to social workers. Also, assist social workers with challenging barriers and improving clients' outcomes to reduce prolonged suffering for both the client and the social worker.

Leadership and administration teams should work to ensure that CMHC caseloads are appropriately balanced with the number of challenging cases. The finding indicates that during COVID-19, there was a demand for mental health care at CMCH, with clients experiencing prolonged unresolved trauma exacerbated by social and economic stressors. The public policy states that CMHC laws cannot refuse individual services if a person meets the criteria. Leadership must appropriately balance the number of high utilizers on caseloads to assist social workers with managing client care (Turgoose & Maddox, 2017). Leadership can implement and enforce consistent safety measures to protect employees and clients from being overly exposed to trauma by minimizing the number of clients with trauma history and balance caseloads with clients with acute stressors. CMHC must partner and collaborate with other agencies to help ensure that policies and procedures effectively meet clients' needs, so it is not solely the CMHC and social worker's responsibility.

**Future research**

During COVID-19, compassion fatigue research studies and publications increased drastically (Yi et al., 2022). Given that this study was completed during this time, the results of this study highlight several important areas for future research. A future qualitative study could seek to explore and focus on leadership and involvement with mitigating compassion fatigue amongst staff in community mental health settings could provide a rich context for the findings in this study. Since findings from this study were related to agency-level factors contributing to compassion fatigue. There is a need for research focused on work-related system-wide compassion fatigue interventions (Cocker & Joss, 2016). A future research agenda might

incorporate a pilot study developing and implementing a compassion fatigue intervention to ascertain if organizational/system-wide interventions reduce and mitigate compassion fatigue among social workers.

Additionally, future research studies need to examine how management and leadership play a role in compassion fatigue and the effectiveness of creating safe spaces to process CF. Findings indicate that to resolve mistrust in a workplace, organizations must have effective lines of communication that are made accessible to all, ensure confidentiality, and provide methods to help track concerns and resolve issues. Additional studies can examine the effectiveness of leadership implementation of CF organizational interventions, including having an effective system for reviewing, monitoring, auditing, identifying issues, and openly discussing plans to address ongoing problems. Said approach can assist leadership with helping social workers identify early warning signs of compassion fatigue symptoms through appropriate monitoring and evaluating issues presented (Figley, 1995; Gentry, 2002; Harr, 2013).

Sweile (2020) assessed and examined the research trends on compassion fatigue and burnout. Findings from the analysis indicated that one-third of the retrieved publications focused on nurses and nursing. The author suggested that future research specifically examining interventions and strategies to cope with coping skills. Sweilie (2020) highlighted approaches to managing burnout among healthcare providers. The strategies or interventions were targeted at the individual and/or organizational levels; however, few interventions specifically discussed compassion fatigue. Sweilie (2020) proposed that continued research on the topic be the focus for health policymakers, academics, researchers, and international health organizations to implement preventive strategies.

Results from this study suggest that future research should focus on examining leadership involvement in mitigating compassion fatigue among mental health professionals. Given the embodied and relational nature of resolving compassion fatigue, understanding how leadership assists and interpret employees' needs during those times will further inform organizations about the meaningful use of implementing organizational/agency-wide resources to help social workers. While data and studies have described what individuals with compassion fatigue do to mitigate their condition, there needs to be research exploring how leadership and management address and implement interventions across the agency to combat compassion fatigue (Cocker & Joss, 2016).

**Conclusion**

To conclude, community mental health social workers play a vital role in mental health services. This study explored how social workers combat and prevent reoccurrences of compassion fatigue. The study also explored their organizational needs to assist them in mitigating compassion fatigue. The effects and barriers to managing compassion fatigue were also explored. Most social workers reported a negative emotional response to compassion fatigue and described feeling guilt, shame, and inadequate due to compassion fatigue. Many participants felt agency-level factors continued and were barriers that complicated their recovery and prevention of reoccurrences of compassion fatigue.

Previous literature and the results from the study, it is imperative that research agendas focus on compassion fatigue and start to critically look at the impact of institutional and work-place factors that can influence a professional’s experience of CF. Leadership involvement in resolving and helping social workers minimize risk of developing compassion fatigue is necessary. Positive and engaged leadership is needed in organizations to help community mental health social

workers reduce compassion fatigue experiences. Kinjerski (2014) study encourage leadership to focus on supporting staff to achieve the organization's purpose and demonstrate behaviors that are consistent with the organization mission and philosophy, which can improve satisfaction and happiness in the workplace minimizing risk of experiencing negative emotions such as guilt and inadequacy among staff.

## APPENDIX A. INTERVIEW PROTOCOL

Researcher: Chanel Mitchell, M.S.W., LCSW

The Cost of Caring: Compassion Fatigue among Community Mental Health Social Workers

### Central Research Questions

RQ1: What are the stories of social workers in community mental health settings as they deal with compassion fatigue?

RQ2: How did social workers manage and prevent a reoccurrence of compassion fatigue in community mental health settings?

RQ3: How do social workers perceive the organizational culture, barriers, and needs to mitigate and prevent reoccurrences of compassion fatigue among social workers in community mental health settings in St. Louis, Missouri.

### Compassion Fatigue Interview Guide: CMH Social Workers

Thank you for taking the time for this interview. I expect it will be between 60 minutes. Do I have your consent to continue with this interview? May I have your permission to record this conversation?

[Turn on audio recorder]

The purpose of today's interview is to learn what strategies community mental health social workers use to reduce compassion fatigue.

Also, I hope to identify what you need to help you manage or prevent reoccurrences of compassion fatigue. I hope this interview will be useful to help develop future workplace interventions or start the conversations and potentially lead to system-wide changes to assist social workers with preventing compassion fatigue.

1) Can you describe to me what compassion fatigue means to you?
2) Describe for me a time when you felt you were experiencing compassion fatigue?
3) Describe for me the moment when you recognized that you were experiencing compassion fatigue?
    a. How many times have you experienced compassion fatigue?
4) In what ways do aspects of your identity (e.g., race, age, gender) affect your experience with compassion fatigue?
5) In what ways do you think your experience with CF has affected your work (e.g., with clients, interactions with colleagues, etc)?

Now, I would like to talk with you about the strategies and tools you use to manage and prevent reoccurrences of compassion fatigue**.**

6) Thinking back to the last time you experienced CF what strategies did you use to manage compassion fatigue?

a. How effective were these strategies?
b. Probe: what barriers/ obstacles or specific factors, if any, you have experienced while managing compassion fatigue?

7) What strategies have you implemented in your life to prevent a reoccurrence of cf?

Now, I'd like to shift gears, and would like to discuss how your organization addresses compassion fatigue.
Looking at organizational culture, which is simply described as "how things are around here".

8) Can you describe your organizational culture?
9) Does your organization culture impact your experience of compassion fatigue?
   a. Probe: yes, no
      i. If so, how- in what way?
10) In what ways has your work in this organization contributed to your experience with compassion fatigue?
   b. Probe: what role does the organizational culture play into your experience of compassion fatigue?
11) Have you ever shared that you had compassion fatigue with colleagues/ leaders/ lead supervisors, or team members, human resource, management?
      i. Probe: If yes, who did you share this information with?
      ii. What, what was their response?
   c. Probe: In what ways do aspects of your identity (e.g., race, age, gender) affect your likelihood of reaching out to your [organization/supervisor/colleagues] for support when experiencing compassion fatigue?"
12) Has your organization ever done anything to help you manage compassion fatigue?
   d. Probe: If yes, what has your organization done?
   e. Probe: what more needs to be done in your organization?
13) Are there specific tools or resources you recommend that your organization utilize to prevent compassion fatigue amongst staff?

Lastly, thinking about COVD-19,

14) Has your experience with compassion fatigue changed over the last three years?
   a. If yes, was that COVID-19 related?
      i. Probe: if so, how
   b. Probe: Was it your personal, emotional response to COVID-19?
   c. Probe: Was it the organizational response change to the delivery of CMH services (e.g. limited in person contact, telehealth, online/zoom meetings)

All right, that wraps up our interview. Thank you very much for your time. Have you had any epiphanies or thoughts about your experiences with compassion fatigue because of this interview? (Include this as the member check question follow up)

[Turn off video/ audio recording].

(Optional if needing more snowball recruitment): I am still looking to recruit additional social workers in this study. Is there another social worker you would recommend I reach out to for this interview? (Obtain email or phone to contract participant.)

We will be sending your gift card via email to the email address you provided in the survey. Does that still work for you? [Clarify and take note if this has changed.]

Once again, thank you. We will be in touch and share our findings in the future.

## APPENDIX B. INFORMED CONSENT

Dear Participant:

My name is Chanel Mitchell. I am a doctoral student at Saint Louis University School of Social Work. I am writing to ask for your help in completing an interview for my dissertation. The overall purpose of my study is to identify what strategies social workers working in community mental health agencies use to manage and prevent compassion fatigue. The data collected will be used for my doctoral dissertation and possibly professional publications and presentations. Criteria for participation in this survey include having at least a master's degree in social work. There is also a series of demographic questions. The survey should take no more than 60 minutes, although if you wish to elaborate time will be provided, it might take longer. There is a small risk you might feel discomfort recounting your experience with compassion fatigue by participating in this survey. You may benefit from participating in the study by reflecting on how you manage symptoms of compassion fatigue and its effects on you as a social worker. I hope that your participation will benefit organizations and future leaders to help others better understand and develop workplace interventions. There will be no compensation provided for participating in this study. I will remove all identifying information about respondents. The only people with access to the survey information besides myself will be my advisor and research committee at Saint Louis University.

Please note that no identifying information will be attached to your response. The data collected will be kept for up to 3 years, as required by the federal guidelines, and password-protected. Presented data will include no identifying information, and the use of illustrative quotes will merit careful consideration. Your participation in this study is voluntary, and you may discontinue your participation at any time without penalty. You may choose not to answer any questions you wish. If you have any questions or concerns, please contact me at Chanel.Mitchell@slu.edu or the Committee Chair of this dissertation study Dr. Monica Matthieu at monica.matthieu@slu.edu.

BY PROVIDING A VERBAL "I AGREE", YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

## APPENDIX C. RECRUITMENT LETTER

Recruitment Letter

Dear Social Work Providers,

Chanel Mitchell, LCSW, a doctoral student under the supervision of Dr. Monica Matthieu, Ph.D., at Saint Louis University is conducting a research study titled The Cost of Caring: Compassion Fatigue among Community Mental Health Social Workers. This letter is to request your participation in the study. The purpose of the current study is to explore and better understand social workers' experiences and strategies to manage and prevent compassion fatigue while working in a community mental health agency.

Your participation in this study will involve engaging in a video-recorded interview via Zoom. You will be asked nonidentifiable demographic questions and questions surrounding strategies you use to manage or prevent compassion fatigue. Your participation should take about 45 to 60 minutes.

As a participant in this study, the risks to you are minimal, such as loss of confidentiality. You will not provide your name or any identifying information to ensure confidentiality. The research team will only view your responses. Additionally, there may be questions about work-related stress that could make you feel uncomfortable. Please note that you are free to stop participating in this study at any time. In addition, you may skip any questions that make you uncomfortable. The social work profession and the St. Louis community may benefit from your participation by helping to identify ways in which workplaces can improve the environment to reduce compassion fatigue and burnout amongst mental health clinicians within the Midwest region.

The results of this study may be published in an academic journal, but your responses will remain anonymous. Again, you will be asked not to report any identifying information. Your participation is voluntary, and you may choose not to participate. If you have any questions regarding this study, please contact professor Dr. Monica Matthieu at 314-977-2752, or the primary investigator, Chanel Mitchell, at Chanel.Mitchell@slu.edu. If you have any questions regarding your participation rights, please contact the Saint Louis University Institutional Review Board at 314-977-7744.

We ask participants to sign up for an interview no later than June 1, 2022.

Thank you very much for your cooperation,

Chanel Mitchell
College of Public Health and Social Justice
Saint Louis University
St. Louis, MO 63108

## APPENDIX D. SOCIAL MEDIA POSTING/RECRUITMENT REQUEST

Social Media Recruitment

Dear _____,

We are contacting you because you are the administrator of this social media group. My name is Chanel Mitchell, and I am conducting a qualitative study on compassion fatigue among social workers working in a community mental health agency. The purpose of the current study is to explore and better understand how social workers manage and prevent compassion fatigue. I am requesting your permission to post the survey link in a post in this group. The IRB office has approved this interview at Saint Louis University. The informed consent can be forwarded along with the IRB-approved flyer upon request. Please let me know if you have any questions. Thanks in advance.

Best,

Chanel Mitchell
College of Public Health and Social Justice
Saint Louis University
St. Louis, MO 63108

## APPENDIX E. STUDY EMAIL FEEDBACK REQUEST

Dear Research Participant,

Thank you for your previous participation in the Research Study on the cost of caring: Compassion Fatigue among Community Mental Health Employees. Your insight on this subject was essential to understanding how mental health employees address compassion fatigue in community mental health agencies. I greatly appreciated your time spent sharing your expert knowledge on this subject. The following summarizes the preliminary findings from the analysis of the 14 interviews conducted for the study. Feel free to review them at your leisure; at the end, I provided an option for you to provide further feedback input or clarification on the topic.

An aggregation of the data shows four distinct themes:

1.Psychological distress and relational differences with three subthemes, including negative emotions and psychological distress (e.g., guilt and shame), negative impact on relationships, and service provision

2. Contributors of compassion fatigue exist at the organizational, system, and community/ population levels along with three subthemes, including lack of organizational support, systematic barriers, and unrealistic expectations and demands

3. Strategies and prevention of reoccurrences of compassion fatigue along with the following subthemes were arranging time off, having social support, and conducting debriefing sessions.

4.Creating safe spaces to debrief and address compassion fatigue in organizations is needed.

Across the four themes, widespread refrains of having safe people and spaces to share and discuss issues that impact community mental health social workers indicate that an overall sense of being heard, seen, and validated was essential to resolving symptoms related to compassion fatigue in a community mental health setting.

1) **Psychological distress and relational differences:** Participants found that working in community mental health is challenging and comes with several hardships that led them to lack compassion and empathy. Although working in CMH can be intrinsically rewarding and empowering, participants have experienced significant challenges.

Of the many challenges that participants described, the most significant centered on: (a) feeling negative emotions such as guilt and shame for having compassion fatigue, (b) compassion fatigue impact on their relationships with clients and their workplace, (c) needing space in their organizations to debrief. In particular, participants did not want to minimize their workload or ask for changes in job responsibilities; however, they struggled with the lack of organizational and leadership support to mitigate compassion fatigue symptoms. Participants found it challenging to trust that their organizations would support them if they disclosed and shared their compassion fatigue experiences. Participants found it challenging to engage with leadership about their negative experiences dealing with compassion fatigue due to the unhealthy work environment that fails to address systematic barriers. Lastly, participants found it challenging to believe that organizations would improve and help them resolve compassion fatigue episodes in the future.

2)**Agency-level contributors to compassion fatigue:** Participants identified several agency-level factors that contributed to their experience of compassion fatigue, which included a lack of leadership support, systematic barriers, and unrealistic expectations and demands. Several participants discussed how leadership appeared disconnected from the problems and often expected participants to find solutions to clients' needs while limiting the support and resources to assist. Participants also acknowledged that they experienced overextending themselves to meet clients' needs due to gaps in services and resources.

3)**Self-Care:** Participants stressed the importance of attending to their own mental, physical, and emotional well-being to prevent compassion fatigue. More specifically, participants were committed to the following:

a. Time off Physical wellness regimen
b. Utilizing social supports to debrief
c. Identify and implement healthy boundaries.
d. Engaging in activities that promote spiritual and emotional growth

**Self Care Development**: Participants made a commitment to upholding their own personal and professional development to lessen the effects of compassion fatigue by getting involved in activities that promote wellbeing as soon as they became aware of its symptoms and signs. They were committed to accessing their social supports and finding healthy ways to mitigate compassion fatigue by exploring new hobbies, requesting exposure to various projects in the workplace, and seeking advanced training to improve their skillset. They were committed to staying healthy by engaging in continuous reflective practices that promote self-awareness and growth.

4) **Safe Spaces**: Lastly, participants expressed a need for more safe spaces and opportunities to debrief with their colleagues and mid-level supervisors. Participants felt that the workspace needed more time to process stressful cases or barriers that interfered with their ability to work with their clients. As a result, participants felt they had to deal with stress and experience compassion fatigue while addressing clients and job responsibilities. Participants felt that workspaces needed a designated space to process and review processes and ways to minimize barriers in caring for others. Participants are not asking for a reduction in caseloads or work modifications but rather support validating their experiences and finding ways to rectify challenges. Participants shared that their job had to feel safe and comfortable to engage in such a process, which organizations sometimes do not present to be.

**Optional questions for additional feedback or clarification:**

1. Do these themes reflect your experiences?
2. Are there any themes that surprised you?
3. What is your reaction to these findings?
4. In your perspective, is there anything missing from the results?
5. After reviewing the results, is there anything additional you would like to add?

Thank you again for your support, expertise, and work you do in the community.

Reminder:  All Amazon gift cards were sent out via Amazon immediately following your interview. If for any reason you did not receive them, please let me know, and I will look into resolving this issue.

## APPENDIX F. QUALTRICS SURVEY QUESTIONNAIRE

CMH Social Work Sociodemographic Questions

1) What is your current age?
2) What is your current relationship status? (Codes: Single/never been married, married, widowed, divorced)
3) How would you describe your racial and ethnic identity? (Codes: White, Black or African American, Asian, Native Hawaiian or Other pacific islander)
    a. Probe: Ethnic Identity (codes: Hispanic or Latino, or White- non- Hispanic, Black or African American- non-Hispanic, Asian- non-Hispanic)
4) How would you describe your gender identity?
5) Number of years at current CMH agency?
6) Do you have a LMSW (yes/no)
7) Do you have a LCSW (yes/ no)
8) Number of years in your current position?
9) What is your current job title?
10) Can you describe your current job responsibilities in your current position?

**Section 2 of Questionnaire: Compassion Fatigue Measure**
Professional Quality of Life Compassion Fatigue Subscale (Stamm, 2007)

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

Please answer using the following scale:

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

2) I am preoccupied with more than one person I [help].
5) I jump or am startled by unexpected sounds.
7) I find it difficult to separate my personal life from my life as a [helper].
9) I think that I might have been affected by the traumatic stress of those I [help].
11) Because of my [helping], I have felt "on edge" about various things.
13) I feel depressed because of the traumatic experiences of the people I [help].
14) I feel as though I am experiencing the trauma of someone I have [helped].
23) I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
25) As a result of my [helping], I have intrusive, frightening thoughts.
28) I can't recall important parts of my work with trauma victims.

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

## APPENDIX G. PERMISSION TO REPRINT

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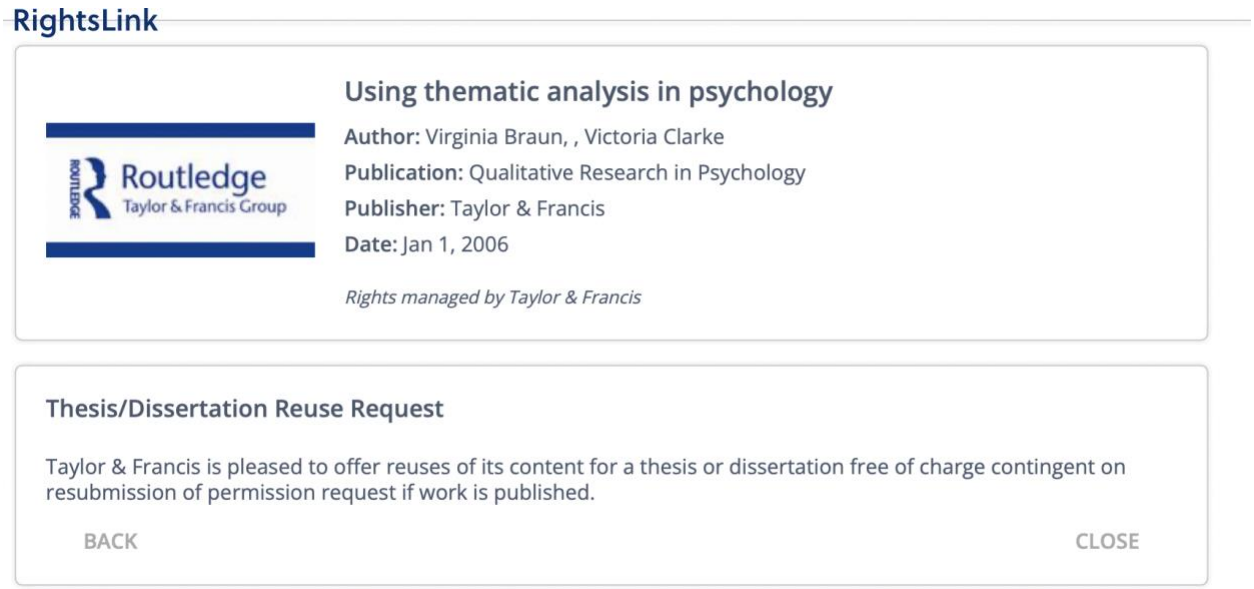
**Table 3.** Permission to reuse content for dissertation.



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## VITA AUCTORIS

Chanel M Mitchell was born and raised in Portland, Oregon. Before attending Saint Louis University, she attended Florida Agricultural and Mechanical University in Tallahassee, Florida, where she earned a Bachelor of Psychology and graduated summa magna cum laude in 2011. From 2011 to 2013, she also attended Saint Louis University, where she received a Master of Social Work.

While at SLU, Chanel participated in the Graduate Student Association. Chanel worked as a graduate assistant throughout the social work department. Currently, Chanel is a licensed clinical social worker and adjunct professor at Fontbonne University in Saint Louis, Missouri.