COMPASSION FATIGUE AND BURNOUT WITHIN A MENTAL HEALTH CLINIC A CONSTRUCTIVIST APPROACH

Leonard Pinto

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A CONSTRUCTIVIST APPROACH

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

Leonard L. Pinto

June 2020

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ABSTRACT

Compassion Fatigue and Burnout are two very familiar problems in the field of mental health that can harm both the provider and the client if untreated and left unresolved. Past research efforts have found prevention methods and ways to recover from both problems, from an individualized approach. These issues appear to possibly occur on an organizational or agency level, but very little research has been centered around this. Furthermore, this research has explored the differences to be found in experience across different scopes of practice within a mental health clinic.

From the constructivist approach, this research has gathered quantitative data, primarily using in-person interviews and purposive sampling to gather participants for this study. Information from the interviews was transcribed into electronic documents, then filtered and sorted using the Atlas.ti software. Data gathered from each participant then formed constructions, and was later used to create a joint construction and deeper understanding of the concepts through an in-depth discussion with all participants (known as a hermeneutic dialectic circle).

Findings from this study, may aid in the creation of new practices for agencies and organizations to prevent the conditions of Compassion Fatigue and Burnout, or provide a way to recover faster and more efficiently from them. The research may have also found that the two concepts are experienced differently depending on the type of service provider in the mental health clinic.

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CHAPTER ONE

ASSESSMENT

Introduction

The focus of this research study was to understand the symptoms and

relationship of Compassion Fatigue and Burnout in a mental health clinic,

outcomes across different disciplines, and the role they play in the environment.

This study utilized the constructivist paradigm to develop a joint construction

within the study site, to gain a better understanding from the key players

involved. A review of the literature revealed the symptoms and effects of

Compassion Fatigue and Burnout on individuals, comparing and contrasting the

two phenomena in some cases. Among the theoretical frameworks in social

work, social learning theory served to provide the best approach. This research

may benefit future social work with providers of mental health and further along

the current understanding of Compassion Fatigue and Burnout.

Research Focus

There is a general understanding and plenty of research to support the

importance of helping others and how it is beneficial for one's health in multiple

ways. While there are physically, mentally and spiritually benefits, there also

exists the potential for harm to the one providing the assistance or care in some

common circumstances. In the field of mental health care, harm to a provider can

often come in two forms: Compassion Fatigue and Burnout.

Compassion Fatigue is an emotional withdrawal of those providing care "for sick or traumatized people over an extended period of time" after experiencing bodily or psychological exhaustion" (Compassion Fatigue, 2018). Compassion Fatigue is commonly found among professionals treating people with illness, diseases, or victims of trauma. Mental health professionals are perhaps more susceptible to this than a number of other professions and the results of developing this issue are harmful to both the person and those they are caring for. "Burnout [is] an emotional and behavioral impairment that results from the exposure to high levels of occupational stress, has been described as a combination of three factors: emotional exhaustion, depersonalization and personal accomplishment" (Van Mol et al., 2015). Professionals in the mental health field can find this to be a common occurrence as the use of self, the caseload demand and the demands of businesses and agencies are placed upon them.

Previous research has been conducted to examine Compassion Fatigue and Burnout in certain roles (especially in nursing) and those roles in working with specific populations. However, it is difficult to find substantial research that focuses on how Compassion Fatigue and Burnout vary from one line of work to the next (if a difference exists at all) in a mental health clinic and the overall result they can create in a work environment. There are very few studies that evaluate the potential for Compassion Fatigue and Burnout to have a relationship themselves. The focus of this research project was to examine the symptoms

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and effects that both Compassion Fatigue and Burnout have in a mental health clinic across the various levels of providers (health care professionals: nurses, therapists and doctors), how it effects the clinic on a larger scale, and what measures and resources can be taken to prevent Compassion Fatigue and Burnout from continuing in that clinic. This research was important as neither Compassion Fatigue nor Burnout are desirable outcomes in a mental health care provider, as it is harmful to their own wellbeing and their clients. This study has gained insight into the experience of providers across the different levels of care and identify successful methods of prevention.

<div align="center">Paradigm and Rationale for Chosen Paradigm</div>

Using a research approach through the constructivist paradigm appeared to be the best fit in the way this topic needed to be addressed. The constructivist approach addresses areas in which subjective data is of high importance and assumes that there are multiple "constructions" (versions or understandings) that hold equal importance. The constructivist approach draws these constructions from sources identified as key players and engages throughout the research process with them. While the definitions of both concepts have been developed, research shows the terms have evolved over time. Additionally, the understandings and experiences of Compassion Fatigue and Burnout are subjective, in that it may be observed and felt differently between individuals. It may also not be perceived as detrimental to some as it does to others and the ability to prevent in from occurring may also be subjective to personal belief.

To develop a clearer understanding of these phenomena, a hermeneutic dialectic was needed. The hermeneutic dialectic circle is a joint construction involving the key players. In this circle, the constructions from one are shared with others and vice versa, for the purpose of creating one shared construction from multiple perspectives. Stakeholders and gatekeepers are identified and asked to participate in the hermeneutic dialectic circle. Through the constructivist paradigm the researcher gains qualitative data to develop the shared understanding through the collaboration and dialogue of the key players in the study. Constructivism also allows the key players to develop actions to take to reduce and prevent Burnout and Compassion Fatigue from occurring in their practice along with their colleagues.

Literature Review

The literature review process revealed that there is often confusion between terms used by healthcare professionals, most commonly Burnout and Compassion Fatigue. Though they may look the same outwards, they are very much different and have different consequences. The literature spoke thoroughly into the symptoms and effects of Compassion Fatigue and Burnout. There were also other factors to consider in this study that vary from others. Lastly, there was a need to talk about prevention and what that looks like.

Compassion Fatigue Versus Burnout

One of the most commonly mistakes made is thinking that Compassion Fatigue and Burnout are one in the same. Burnout and Compassion Fatigue can

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share many of the same symptoms as each other and may even have a few of the same results. However, they are definitely not one in the same. Van Mol et al., (2015), best state the difference as:

> Although [Burnout] is closely related to [Compassion Fatigue], the underlying mechanism most likely differs. Burnout is believed to be related to occupational factors, such as workload, autonomy, and rewarding, rather than personal relationships. In contrast, an inability to engage, or enter into a caring relationship, is considered to be the core of Compassion Fatigue. (p. 28)

Burnout is exhaustion, physical and/or emotional, when a worker is experiencing stress or little to no satisfaction in their work, and can be found in almost an occupation. Whereas, Compassion Fatigue indicates that the ability to feel compassion by the worker has been lost and they are unable to recover naturally. "Compassion Fatigue differs from Burnout in that the latter evolves gradually and is a result of emotional exhaustion. In contrast, Compassion Fatigue can emerge suddenly" (Cetrano et al., 2017).

<u>Symptoms and Effects</u>

With Compassion Fatigue and Burnout, the dangers are that the symptoms can be hidden. If seen, the symptoms can be thought to be other issues instead of the overall issue. Working is stressful environments can easily affect emotional stability, where Burnout becomes easily possible (Khan, Khan & Malik, 2015).

Compassion Fatigue is often referred to as the cost of caring for people

with emotional pain, and its detrimental effects can include exhaustion, an

inability to focus and a decrease in productivity, as well as unhappiness,

self-doubt, and loss of passion and enthusiasm. It often occurs quickly and

can go undetected by the healthcare professionals who experience it.

(Lester, 2010, p. 43).

Compassion Fatigue, therefore, can often be confused with depression and a

variety of other diagnoses. But the consequences for Compassion Fatigue can

be much costlier than expected. Howard et al., (2017), state that "Compassion

Fatigue is likely to result in problems such as misjudgments, clinical errors and

poor treatment planning, all serious issues for effective care". In the field of social

work, this would be a violation of several of the ethical principles in the National

Code of Ethics.

<u>Other Considerable Factors</u>

Based on how much information is attainable surrounding both

Compassion Fatigue and Burnout, there is a need to account for a few other

relevant findings that may pertain to this study. As key players in this study will

be both male and female, Thompson, Amatea and Thompson (2014) found that

gender had no significance in predicting Burnout nor Compassion Fatigue. They

also found that the length of field experience and age carried no predictive

relevance, as well. On the contrary, Craig and Sprang (2010), found that

"younger professionals reporting higher levels of burnout", yet no difference in

Compassion Fatigue. They concluded that Compassion Fatigue requires much stronger preventative factors; "The utilization of evidence-based practices predicted statistically significant decreases in compassion fatigue and burnout, and increases in compassion satisfaction."

There has also been a focus on determining the prevalence of both Compassion Fatigue and Burnout within inpatient settings versus outpatient, and those within the community versus privatized. Lent and Schwartz (2012) concluded that outpatient providers for community mental health centers experienced higher rates of Burnout than both private health centers and inpatient. As this study examined an outpatient mental health clinic that is privatized, it may be important to note that the rate of Burnout will not match other facilities that are inpatient and/or community-based.

<u>Possibility of Recovery and Prevention</u>

Multiple sources identify Compassion Fatigue as being something that is "the cost of caring", "natural" and a "side-effect" of being invested. Most articles and documents discussing Compassion Fatigue address how to handle Compassion Fatigue once it has already manifested in a person. However, Thompson et al., (2014), explain that there are steps a mental health provider can take to reduce the chances of undergoing Compassion Fatigue. Using mindfulness techniques, self-monitoring along with practice of positive coping mechanisms significantly reduce the chance of it. Although job stress mostly corresponds to Burnout, it also plays a part in developing Compassion Fatigue.

From Beaumont et al., (2016), higher levels of self-compassion and well-being indicated being subjected to less burnout and compassion fatigue.

Most notably, social support and physical activity were found to strongly reduce the factors associated with developing Compassion Fatigue (Whitebird et al., 2013). Being able to connect with coworkers, both inside the work environment and outside of it allowed the reduction of stress in the workplace. Along with exercising, social support promoted self-care, continuously finding meaning in the work and using positive/healthy coping mechanisms. Compiling data from multiple studies, Cetrano et al., (2017), found that in order "to provide adequate mental health services, service providers need to give their employees adequate ergonomic conditions, giving special attention to time pressures. Building trustful relationships with management and within the teams is also crucial." They also found improvements to care can be made if "insecurity about the future" is removed and work-life conflicts are reduced.

Summary of the Literature

In this study, the literature was a strong element and was used as one of the constructions in the joint construction that will be developing. It is important in this construction to understand the similarities and differences between Compassion Fatigue and Burnout. Where they both can have damaging effects on the provider and the clients in their care, as well as result in poor employee work ethic if unmanaged. Burnout is a cumulative result of stress and workload, and Compassion Fatigue can occur in an instant or cumulatively from exhaustion

emotionally and/or physically from working with those who have trauma. Where

Compassion Fatigue can lead to hopelessness, lack of pleasure, anxiety and a

variety of other poor mental health outcomes. It is also important to understand

that gender and age have not been found to favor one side of either spectrum

over the other and that all providers are subject to these constructs. Finally, it is

important to note that both are preventable and recoverable, and there are

different ways to achieve this, but early engagement in positive evidence-based

practices are highly encouraged. This literature did not incorporate what

Compassion Fatigue or Burnout look like on an organizational level, if they exist

on that level, or how they may be connected. This was the understanding that

this research sought to uncover.

Theoretical Orientation

There were several theoretical frameworks that would be worth the

exploration for this research. However, for this study, the understanding that was

needed was best seen from a social learning theoretical framework. Albert

Bandura describes social learning theory in the following way, "…most human

behavior is learned observationally through modeling: from observing others one

forms an idea of how new behaviors are performed, and on later occasions this

coded information serves as a guide for action." (Bandura, 1977)

Compassion Fatigue and Burnout exist with individuals, but there is a

possibility that it exists on an organizational level due to the others witnessing

how a colleague or multiple colleagues deal with the situations they are in. The

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development of coping skills and general attitudes could potentially come into existence as an individual interacts with their work environment. Where Burnout and Compassion Fatigue truly exist on an organizational level, those involved in this study were able to shed some light as to how it comes into play and how it persists in the work environment.

In assuming that human behavior is learned, this study found that the key players have observed negative coping mechanisms and negative attitudes that align with Burnout or Compassion Fatigue in discussion with their colleagues. They retained it and reproduced what they have heard in their own sessions and dealings with clients, or even in their personal lives. Where continual practice reinforces their behaviors and reshapes their practices and attitudes altogether. However, Social Learning Theory also assumes that new behaviors can be learned. Thus, key players working together to exhibit better practices and positive behaviors towards clients and themselves may have positive implications.

Potential Contribution of the Study to Micro and/or Macro Social Work Practice

Understanding the seriousness of Compassion Fatigue and Burnout is highly important for social workers, as it is in the interest of all in the field to protect the well-being of each client. The potential from this research serves to uphold three of the five ethical principles of social work. Increasing their knowledge on the issue at hand will better the social worker's service to a client and display a higher level of competency. Removing negative emotions and

biases that result from both of these concepts demonstrate the social worker's value of the dignity and worth of the person. Understanding Compassion Fatigue and Burnout as they pertain to an organization is as important as it may be more difficult to prevent and eradicate, and the degree to which individuals in that organization experience looks different than an individual practicing on their own.

Summary

This research project explored the symptoms and effects that Compassion Fatigue and Burnout have in a mental health clinic across the different disciplines of providers (health care professionals: nurses, therapists, psychologists and doctors), how it effects the clinic on a larger scale, and what measures and resources can be taken to prevent Compassion Fatigue and Burnout from continuing in that clinic. This subject was approached through the constructivist paradigm to develop a joint construction in a mental health clinic. The current literature explained the symptoms and effects on the individual, as well as comparing and contrasting the two phenomena. Social learning theory provided the most appropriate theoretical framework for this research study. This research can benefit both the clients that are served in the mental health field as well as assist the well-being of every mental health care provider.

CHAPTER TWO

ENGAGEMENT

Introduction

This research study relied heavily on the ability to engage effectively with the key participants as this is done through a Constructivist approach. It was highly important for the researcher to utilize the relationships and connections of those at the site of study. In saying that, the researcher was connected to a mental health clinic, which is part of a larger system of healthcare in Southern California. For the purposes of this research, the name of the clinic will be held in confidence to protect the providers and the organization's interest. In addition, the term "patients" will be used interchangeably with "clients", as this clinic is connected to a larger hospital organization. Strategies for how the engagement process occurred included addressing the gatekeepers of this clinic, while issues regarding diversity, politics and ethics are discussed.

Study Site

The study site offers services primarily geared towards behavioral health and psychiatry. Clients are referred internally through visits with their primary care providers and other specialty services with medical care providers, or they can self-refer themselves and receive screening after calling into the Department of Psychiatry. Clients are often referred for experiencing symptoms of anxiety,

depression, grief/loss, anger and more, but can easily also range to presenting diagnoses with severe impairments and impacts of daily functioning.

The clinic hosts classes to teach and help clients/patients gain the knowledge to help them reduce or increase certain behaviors, as well as group therapy available. Clients are able to attend nurse visits and receive psychiatric medication administration through the clinics LVNs and RNs. As it is difficult for the clinic to keep up with the demand of client request to see their psychiatrists frequently, the nursing staff helps fulfill the requests and serve as liaisons between the patient and the psychiatrists. Individual therapy with Licensed Clinical Social Workers (LCSW) and Marriage and Family Therapists (MFT). Each provider brings specific specialties and practices, such as Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, cultural and diversity issue backgrounds, Trauma-Focused Therapy, to name a few. Clients also have access to disability evaluations and psychiatric testing by Psy.D.'s and Ph.D.'s when clients feel they may have a disability rendering them incapable of returning to work. Medical consultations are available with psychiatrists for clients who wish to receive treatment with the assistance of prescribed medication. Psychiatrists in the clinic offer routine visits with their patients for management of psychotropic and psychiatric medications. Clients also have access to an On-Duty therapist during the clinic's hours of operation for any crisis; including but not limited to suicidal and homicidal ideation,

experiencing anxiety/panic attacks, family members seeking assistance with a distressed client and inability to cope with stressful situations.

All providers were board certified with the Board of Behavioral Sciences and are licensed in the state of California. The study site was located in Southern California, under the county of Los Angeles, and main location is held in West Covina. The client population is diverse, with about three-quarters of the clients identifying as Hispanic, with about a fifth identifying as Asian, and Caucasian, Black, other races and two or more races composing the remaining percentage, according to the 2016 census. The average household income matches that of the state of California, around $65,000. Clients who have a specified health plan can attend services through this clinic, with the healthcare plans offered through employers, the affordable healthcare option (Covered California), Medi-Cal and certain out of state healthcare plans. The organization prides itself in accepting members of all backgrounds and diverse groups, including promoting acceptance of all differences.

Engagement Strategies for Gatekeepers at Research Site

As the researcher was working for a mental health clinic, the ideal location for this study was at that specific clinic. Gaining access to the study site of choice did not appear to be an obstacle for this research subject. Strong rapport had already been established with the gatekeepers of this clinic and the key players of the study. Prior to the study, the agency had been subjected to a variety of paralleled symptoms to that of compassion fatigue (high rates of employee

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absenteeism, resistance to change, negativity towards management). This warranted even more cause for the gatekeepers to allow the study to occur, as the study could provide a better understanding and results that may benefit the gatekeepers in assisting the areas of concern.

All of the information for this study was kept confidential and the gatekeepers were aware that the names and any identifying information from the employees of this agency would hold in full confidence, as well. An area of concern was that one of the gatekeepers is the researcher's direct supervisor. However, the researcher was fully prepared to engage in conversation about the difference in roles between the researchers position in the workforce and that of the researcher role. Establishing the difference allowed the research tasks to be completed with little to no interference.

This researcher explained to the gatekeepers of this research site the various benefits that could come forth from this research study. The study may have resulted in identifying ways to prevent and reduce both Compassion Fatigue and Burnout for providers, and perhaps create a difference in culture for the agency with the study's direction. Gatekeepers noted that findings of this nature could result in less callouts from employees, better client care, fewer client complaints, a reduction in employee turnover rates, a faster rate of successful termination for clients, and more which are all implications for financial benefits in the clinic. The gatekeepers of this clinic were also interested in creating a more

positive atmosphere, where the wellbeing of their employees was also prioritized. This study aimed to accomplish that goal in addressing different ways to do so.

Self-Preparation

The researcher prepared for the possibility of issues presenting themselves before, during and after the data collection with participants. Those issues included, but were not limited to diversity, ethics and politics. The first step was to gain more information from the gatekeepers as far as what issues had the potential to come up during the study, especially politically. This researcher also gained a clear understanding of the agencies policy as it pertained to each discipline of practice (i.e. nurses, therapists, etc.). In addition, any biases held by researcher were addressed prior to the start of the research process and discussed with mentors or school faculty external to the research environment when found during the study. Furthermore, the researcher established a clear line of communication with their research advisor and the gatekeepers in the occurrence of an unexpected issue arising.

The researcher went into the research process removed from the employee role and assume the role of facilitator. For this process, the researcher drafted a statement and presented it to the gatekeepers to explain the role differences and how the study would be conducted outside of the work hours for the researcher as an employee. Discussion was held to address any specifics the gatekeepers wished to clarify or modify, and the final version was agreed upon by the gatekeeper and researcher prior to the study taking place.

The researcher was conscious of how long each interview would approximately take and planned accordingly with the participants to be respectful of their time and keep participants engaged. A practice run of the interview questions with someone external to the study (such as a peer or advisor of the researcher) was conducted to determine the estimated time needed. The researcher composed a standard statement to present to each participant in the study, to address the time commitment that would be asked of them and to allow the participant to respond with how they could or could not meet the request. Adjustments and accommodations were made as situations developed.

Finally, the researcher prepared for data gathering. In this process of preparation, interview questions were generated based on knowledge from literature. The researcher gained familiarity of the technology/software prior to needing to use it when compiling information and had all materials needed ahead of time before going into interviews (such as printed materials and recording devices).

Diversity Issues

Although Compassion Fatigue and Burnout could be experienced by anyone regardless of background, and the literature revealed these concepts were not correlated more or less with any select background or population of people, diversity was still considered. The researcher attempted to gain a diverse group of participants and would note in discussion of any biases or issues that were related to poor representation of a specific group.

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There was the possibility of the researcher running into several problems pertaining to diversity with participants. Given that the providers' ages range from five to fifty years above the researcher's age, the researcher may have been subject to discreditation or participants could have been unable to view the researcher in the given role. This researcher identifies as a male with a mixed ethnic background and this could have caused possible participants with various identities to be uncomfortable or uninterested in working with the researcher. The researcher prepared himself to be mindful of the differences in age, gender, experience, ethnicity and address each of them individual with each participant prior to the interviews. This helped create a deeper understanding for the purpose of the study and the researcher noted the importance of the unique impact each participant could bring with their personal background and identities. The researcher was also prepared for participants who may have already begun participating to exit the study of their own will, should the participant have found a conflict they did not wish to handle with the researcher.

Ethical Issues

The number of ethical issues to address with this research topic were minimal. Most participants were likely to ask that their responses remain in the fullest possible confidence, to be free of any possible repercussions from their management stemming from the answers they provide. The researcher took many measures to preserve the confidentiality for all participants. These measures consisted of refraining from speaking in the workplace about who was

participating and their responses, asking all participants to respect the confidentiality of those they discover are involved, to coding all interview responses and omitting identifying information whenever possible, and holding all interviews in a secure and protective environment. Data collected in the interviews had interviewees given pseudonyms to protect confidentiality of the participants. The member check meeting had participants easily able to identify one another in the group and at that time all participants were reminded of their agreements and expectations with the research.

Political Issues

The most notable political issue that existed within the clinic was the question of who had the lead role with a client between multiple providers. At the time of the study, between therapists, psychologists and doctors there were situations in which a patient being treated could be told something is necessary for their care, but would be refuted by another discipline. So as to keep the patient from harm, doctors were given the final say, but tension between the disciplines had grown over the last several years. Having the various levels of providers working together would have been difficult if those issues had come up. If the issue came up in discussion, the researcher would have redirected the attention back to the research topic and advised the participants to discuss the issue with their administration.

The Role of Technology in Engagement

Technology had a limited role in engagement with the participants and stakeholders. In terms of communication, emails and phone calls were needed to initiate the discussion with individuals in agreeing to participate and when and where to interview. The majority of conversation was held in person, however. Recording both voice and video capabilities were sought, but was determined on the comfortability and permission of the participants. Finally, the coding used for the data collection and analysis was done electronically by a coding software.

Summary

The researcher's place of employment became the study site for this research project. The researcher and gatekeepers had established strong rapport with each other, and no obstacles existed in completing the research at the study site. Self-preparation occurred before the interviewing process took place, where the researcher was fully prepared to gather data. In addition, the researcher planned for possible issues that could have presented themselves before, during and after the research process that included diversity, ethics and politics within the agency. A research advisor and the gatekeepers were utilized as needed for assistance as unexpected issues potentially came about. Technology was used in respect to communicate with participants and data gathering, and limited otherwise.

CHAPTER THREE

IMPLEMENTATION

Introduction

In a constructivist approach, the main objective is to develop a joint construction. A key piece in doing so is to have a continuous process of data collection and analysis. The collection of data primarily comes from study participants and their understandings, while other data will mostly stem from observations and social artifacts. Study participants were selected in a purposive method, combining maximum variation and snowball sampling. In gaining different sources of information, or constructions, an analysis was conducted after each as soon as possible. The analysis of each interview allowed this researcher to check for understanding and identify units of information to include in the joint construction. After each unit of information was collected, they were sorted into specific categories and then gathered into one larger joint construction. This joint construction was presented before the interviewees and involved members of the hermeneutic dialectic circle, in what is referred to as the "member check meeting". This member check meeting was a furthering of the analysis process, in which the joint construction was explored and evaluated by the group.

Study Participants

The researcher selected multiple members of each type of provider: nurses, therapists, case managers and psychiatrists, all from the mental health clinic where the researcher currently is employed. As each group/discipline has a culture formed, input from each was most necessary in trying to build a joint construction.

Participants were asked to be honest at all times, open to the ideas and opinions of others, have a willingness to shift with the research if the research focus shifted and to help preserve other participants' right to confidentiality. Participants were from different backgrounds, such as religious beliefs, ethnicities, educational institutions, etc. At this study site, there were about 100 providers between nurses, therapists, case managers, psychologists and psychiatrists. All providers had received their licenses through the state of California and were certified through the appropriate governing boards. All providers had achieved at least a bachelor's degree from a university, but nearly all had completed graduate level degrees and some with doctorates. A majority of providers were of Asian and Caucasian backgrounds, but the population of providers at this clinic had individuals from many various ethnicities. Other diversifying information pertaining to religious backgrounds were unknown. However, it is important to note that all the providers at this clinic typically received the highest salaries in their corresponding job titles in comparison to the rest of the state of California.

Selection of Participants

The nature of a constructivist study is to gain as many different perspectives and constructions, with the intent of forming one joint construction. In order to obtain these perspectives, purposive sampling is needed. In this method, the researcher searched "for study participants who will give the most complete data about the study focus" (Morris, 2014). To further the selection process and gain the necessary data, the researcher utilized "snowball sampling", where participants helped identify the next key participant. In conjunction with snowball sampling, this research also utilized maximum variation sampling. Maximum variation sampling helped gather various ranges of experiences surrounding the research concept, while providing strong details for any unusual experiences and identifying commonalities or patterns found in multiple unique experiences. Morris (2014) mentions that in combining the methods of snowball and maximum variation sampling, we can expect "a diverse set of perspectives and develop the sample by means of recommendations of interviewees". For the purpose of studying compassion fatigue and burnout, participants were asked to address another individual who my have experienced, may have been experiencing or actively worked to prevent it. The researcher gathered participants from all forms of diverse backgrounds, including but not limited to age, professional experience, education and theoretical orientations. Initially, the first participant was drawn from the gatekeeper's suggestion and it

began "snowballing" from that first participant until all constructions were collected.

Prior to any initial interview and after the primary gatekeeper had allowed entrance to the research site, a stakeholder was recommended by that gatekeeper to start the process. This set in motion the creation of a hermeneutic dialect circle that was essential in gathering the data for this project. As there were at least three areas of care (nurses, therapists and psychiatrists) that could have been affected by Compassion Fatigue and Burnout, the sample aimed to gather as many participants from each area/discipline as possible. The researcher obtained a list of all providers within the clinic from the gatekeeper, and asked each participant to point out a name or names from the list that may have had a different perspective or background regarding the topic.

Data Gathering

The majority of data in this study was collected through interviews, though any reports or documentation that could have given insight into this topic were considered as a possible construction as well. Before discussing the interview process, there are two constructions that need to be considered. The first construction was this researcher's own construction of what compassion fatigue and burnout are, how it affected different disciplines and the larger entity (such as a clinic), and how it could be prevented. The second account that was considered was the construction the current literature created surrounding the same topic. Reflecting on the current knowledge that had been published about

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the issue incorporated the construction of experts in the subject into account indirectly.

The researcher was also interested in collecting information outside of interviews through studying documents and social artifacts that are present in the clinic. Although this writer was unable to identify what those artifacts would be prior to entry to the site, there were also no artifacts and documents found by the gatekeeper and participants surrounding the topic. Thus, this research project had several avenues of data gathering, with the hope that all would be possible, but the research remained heavily centered on interviews.

Preparation Stage

The interview process began with a preparation stage before any initial interviews. For the constructivist approach, the understanding is that the interviewer is the instrument in gathering data. Therefore, it was imperative that this researcher established a mindset prior to interviewing that is geared to seeking a clear comprehension from the interviewee and his or her perspective, free from personal biases and self-interpretations of compassion fatigue. As an interviewer, this researcher needed to be open to any response and alert at all times in each interview. It was also be important to understand how to utilize all of the applicable senses and own intuition as needed for the conducted interviews. Lastly, the interviewer recognized the importance of learning the terms and phrases surrounding compassion fatigue to better communicate with each participant.

<u>Beginning Interviews</u>

Each interview needed to have a default set of questions, that ultimately aimed to gain the basic information this research sought. The questions asked in the interviews were similar to: What is your definition of compassion fatigue and burnout? What are your experiences with these concepts? What similarities or differences exist between them? What do you believe to key component in conquering/overcoming this? How do compassion fatigue and burnout affect the organization or clinic that you are working for? How would being able to prevent it make you feel? What are things you see and hear regarding this topic? What is your background? See Appendix A for questionnaire.

Ideally, all initial interviews were to be conducted in person, face-to-face, to fully engage with the gatekeeper. This allowed the interviewer to examine body language and facial expressions of the interviewee, which prompted further questions and, in a few cases, altered the course of questioning for the purpose of gathering more of the interviewee's perspective. An in-person interview also allowed for trust to be built between the researcher and each participant in the face-to-face interview. There were some limitations to this data gathering method as it could have with any other paradigm; being that the interviewees may have provided answers they thought the interviewer was seeking, rather than being completely honest. Fully honest answers may have also been limited by a feeling of shame that this topic could have brought about for the interviewee, so it was this researcher's role to provide informed consent and create rapport with the

interviewee to bring about the notion of being able to speak freely without judgment.

There were times that it was difficult or nearly impossible to conduct individual interviews, especially as this research was conducted with employees who worked similar hours. Attempting to capture many individuals at separate times during the workday proved tedious and the next best approach was to conduct the interview by telephone. A telephone interview allowed the interviewees to have the interviews conducted in a place where they feel most comfortable and meet without a time restriction. There were a few limitations to this method as well. The topic of compassion fatigue could have made some interviewees uncomfortable at times, especially when it came to areas of concern when practicing in the midst of it, it would be important for the interviewer to capture the interviewee's body language, but that was not possible through telephone conversation.

Maintaining Focus and Direction During Interviews

During the interviews, there was room for tangents to have occurred. This was not necessarily discouraged in the interview process, as it could have led to much more deeper-rooted issues and different perspectives. This researcher created prompts as needed for the interviewee to return to the topic, but also respected the interviewee's determination to state what they needed to regarding the topic of compassion fatigue and burnout. In moments where the interviewee was unable to answer a particular question or had run out of information to

provide, the interviewer attempted to utilize backup questions already prepared.

In the instances where nothing more could have been shared; the interviewer

asked the participant if there had been anything overlooked by the interviewer of

if he/she had any concerns. The researcher lastly asked the interviewee to help

identify another stakeholder who may have held a different opinion or had

something different to offer than they did.

<u>After the Interviews</u>

After gathering all the initial interviews' responses, a first draft was created

and presented to the interviewees prior to the member check meeting. This

meeting served multiple purposes, but the ultimate goal was for the stakeholders

to establish a joint construction. This hermeneutic dialect ensured this research

was credible, as well as helped determine what information was agreed upon,

disagreed on amongst its members, and which issues warranted action to be

taken. The member check meeting was held at an agreed upon location and time

that best served the majority of participants. All members were asked to be open

and respectful of the other members and their perspectives, as they were each

supported by this effort to question this joint construction and assist in clarifying

the understandings. Through this process, the result was a shared understanding

and joint construction of the topic by all the members. The researcher presented

constructions that were presented from various members, commented on

similarities and areas of disagreement. Participants of the member check

meeting were asked to respond to these constructions and voice what the final

construction should hold, as well as to help develop an action plan.

Data Recording

Qualitative data was collected from each interview. Before each interview,

the researcher asked the participant if it will be permitted for the interview to be

voice recorded. From the voice recordings, the researcher accurately transcribed

the interviews into electronic documents/transcripts. The researcher transcribed

the recording immediately after each interview, with a highly structured format

(such as creating a new paragraph when the speaker changes, when a new topic

is introduced, etc.). Every word was captured into the transcript, as well as the

nonverbal communication recalled from each interview. The voice recordings

and transcripts were kept secure in the possession of the researcher. During the

member check meeting, the researcher sought out the permission of all

participants to video record, as too many voices may have been confusing on the

voice recording to gain the full understanding upon playback. Similar to a post

positivist approach, the constructivist study has a need for the researcher to

create two research journals. The first journal held records of all the processes

and encounters from the beginning of the research process until the joint

construction has been finalized. The second held the researcher's own thoughts

and experience as the data is gathered. This was of high importance in

discussing and reflection for this study, as the study could have taken a much

different path than expected and the researcher's own experience factored into the joint construction.

Data Analysis

After each summary and analysis of an interview and observation, the researcher identified units of information. Units of information are essentially pieces of information that do not need to be expanded or given further explanation to be understood and they would pertain to the knowledge of compassion fatigue or action to be taken. A few possible examples of units for this research could have been labeled as: "compassion fatigue and burnout as necessary for growth", "burnout experienced, not compassion fatigue", "strong connection between concepts" and "techniques for prevention". From there the units of information were processed into a coding program and chart. To be most effective with the amount of data anticipated to be collected, a computer-assisted qualitative data analysis software (CAQDAS) was used in coding and sorting the qualitative information received. For this research project, Atlas.ti is the software that was utilized as it was easily available for this researcher to use. This program allowed for information to be sorted by (but not limited to) the source of information, the date and time the information from the source was collected, the type of source and the location.

The following step was to start grouping the different units of information, for the purposes of consolidating data into categories. Each unit was assessed for whether it seems or looks like it belongs to another category or not. This

became a process of building units of information upon each other to deepen the understanding of the categorized topic. With the creation of each grouping or category, a number was assigned. Once all the units of information were slowly grouped together, the category started to become more defined and have specified criteria to include some units and exclude others. In advancing the research, the researcher focused on finding a bridge between categories if possible. Finding a bridge included gathering information from the interviewees and other sources of information, as the joint construction benefitted from having a deeper understanding of the subject.

With the development of each unit and bridge, patterns and similar units started coming together creating a more developed construction and understanding. In the member check meeting, these developed constructions revealed, as well as the opposing constructions to find resolution and areas to further explore.

Termination and Follow Up

The member check meeting took place toward the conclusion of the research, but it was also the moment in which the analysis was validated and/or invalidated by the members of the hermeneutic dialectic circle. Within this member check meeting, the researcher presented the categories identified and started to facilitate the conversation surrounding the joint construction on the subjects of compassion fatigue and burnout. The researcher explored the areas of agreement and disagreement with the members for each category,

considering each perspective and attitude. Each participant was encouraged to help in this analysis, as this research was a product that needed their contribution to become whole. Finally, the hermeneutic dialectic circle had a final decision to reach; what action is needed. In the case of this study, the researcher gained understanding on the issue of compassion fatigue and burnout, and how it affected various positions/disciplines, as well as how it affected the larger entity. In comprehending the issue better, the researcher in conjunction with the participants developed an action plan in reducing, resolving, and/or eliminating the problem in the future.

<div align="center">Communication of Findings and Dissemination Plan</div>

Preliminary findings were addressed with all those who participated in the final member check meeting. However, as the member check meeting built on the information presented, the final results were determined shortly after that meeting and compiled by the researcher. In the meeting, the participants worked with the researcher to develop an action plan. The results and action plan were distributed to all the participants and gatekeepers. Information from there was disseminated as appropriate by the agency. Participants and stakeholders were given contact information for the researcher in case anything had been left unanswered or needed to be made clear. The gatekeepers were asked to follow up on the action plan for the clinic, as they were the ideal distributors of information and of the action plan.

Summary

Implementation included interviewing participants from the study site and

using purposive sampling, specifically "snowball sampling" with maximum

variation sampling to further the interviewing process while gathering the

necessary and diversified data. The researcher prepared for the interviewing

process, and the process itself had at least three stages (a beginning, during and

an after). Data was gathered via voice and video recording, with handwritten

notes as needed. Data was sorted and analyzed by CAQDAS through the Atlas.ti

software. The member check meeting brought the participants together to finalize

a joint construction and develop an action plan. The researcher provided the

participants and gatekeepers with the findings, where it was disseminated as

needed by the gatekeepers.

CHAPTER FOUR

EVALUATION

Introduction

This section of the research addresses the noteworthy findings from the reported experiences with Compassion Fatigue (CF) and Burnout (BO). It begins with an outline of demographics from participants, followed by a deciphering of the constructions surrounding CF and BO from unit categories and the connections found between them. Those constructions bridged together created joint constructions and were addressed for accuracy in the member check meeting. Finally, this evaluation addresses the implications for future social work practice on macro and micro levels. Participants were randomly assigned numeric values to preserve the confidentiality of their identities.

Data Analysis

This study had a total of ten participants. The ages of participants ranged from 29 to 51 years, with the average around 40 years of age. 60 percent of the population interviewed identified as female and 40 percent as male. Among the participants, 50 percent identified as Asian, 20 percent identified as Caucasian, and 30 percent as Hispanic. In this study, different levels of providers and backgrounds were also desired. Four different provider levels were interviewed; two psychiatrists with degrees of M.D., one psychologist with a degree of Psy.D., five therapists with three MFTs and two LCSWs, and two nurses with one as an

RN and the other as an LVN. All participants had attended at least one university within the Southern California region towards their educational backgrounds. Though they identified various educational experiences and early degrees such as criminal justice, psychology, medicine, substance use, and grant writing, every individual has been in the field of behavioral health for a minimum of five years. Participants in this study further reported the number of years they had worked with their current agency, which ranged from 1 to 22 years, with an average of 6 years of service. All participants currently see patients in the same outpatient mental health clinic. With the exception of the nurses, the rest of the participants have established caseloads of patients.

This data analysis helped in understanding individual constructions with CF and BO while also helping to develop join construction with the definitions of Compassion Fatigue and Burnout, the relationship between CF and BO, causes for both to occur within a clinic, the effect on individuals and the workplace culture, and preventative measures that can be taken.

Joint Constructions

A major objective of this study was to understand the perspectives of providers surrounding CF and BO as a collective. To understand the perspectives as a whole, the researcher first needed to know how the participants defined the two topics.

Compassion Fatigue. Participants in this study had somewhat similar personal definitions of Compassion Fatigue. Participant #1 noted that it is "when

your empathy tank is tapped out, low, feeling depleted. It starts to become

increasingly difficult to be empathetic and non-judgmental especially with difficult

patients" (personal communication, February 2020). Participant #6 stated that his

definition included "the inability to have empathy or sympathy for others; where a

provider becomes too tired to experience or feel compassion for others"

(personal communication, February 2020). In the member check meeting,

Participants collectively made sure to include the mention of "feelings of

desensitization", "secondary traumatic stress", "barriers" and "uncontrolled

engagement" (personal communication, March 2020). Thus, the final joint

construction agreed upon the group was that compassion fatigue is a

phenomenon that can occur with any service provider who becomes

overwhelmed or exhausted through direct exposure with patients suffering from

traumatic experiences, in which the provider feels emotionally, physically, and

spiritually depleted rendering them desensitized or unable to show compassion

and empathy for others.

Burnout. As it would seem to be an everyday term used across the board,

some participants had interestingly different responses and views. Participant #5

explained that "burnout is a reaction to work-related stress that can lead to

mental, emotional and physical exhaustion, as well as a negative attitude

towards the work we do, and even questioning whether this is something we

want to continue doing" (personal communication, February 2020). Meanwhile,

participant #6 stated that it is "a statement exhaustion related to the response

that an individual can have towards their career, commitments, lifestyle and experiencing the exhaustion to the point of relinquishing commitments and duties" (personal communication, February 2020). Where some participants felt that Burnout was directly linked to work, others felt that it could stem from any dimension of their life and start to conflict with their work responsibilities. Others, such as participant #9 believed Burnout to be "the inability to deal with everyday stressors" (personal communication, February 2020). Whereas, participant #3 remarked that it is "the loss of passion for one's work" (personal communication, February 2020). This was a lengthily debated topic in the member check meeting, and it was finally determined that, "Burnout experienced in the mental health field primarily relates to the feelings of mental, emotional, spiritual and/or physical exhaustion from work-related stress".

The Relationship Between Compassion Fatigue and Burnout. Slightly less than half of the participants explained that they had fortunately never experienced Compassion Fatigue in their careers, but still had witnessed it among friends and/or colleagues. Still, for all participants, they reported that they believed there can often be a direct connection or correlation between CF and BO. The most shared view of this relationship is reflected in participant #1's statement, "I think they share similar symptoms and I think often they come hand-in-hand. Compassion Fatigue can lead to Burnout and Burnout can lead to Compassion Fatigue" (personal communication, February 2020). More interesting were the ways in which participants of this study felt the very separate

terms were related. Participant #9 shared that she believes "Care and compassion toward others should come from an overflow of compassion towards oneself. Compassion fatigue can really only occur if the person has burnout or is ignoring one's own needs" (personal communication, February 2020). Participant #5 outlined that "Compassion Fatigue can lead to burnout, if we continue to carry the burdens of our patients to the extent that it is affecting our own emotional well-being" (personal communication, February 2020). The joint construction presented to the member check meeting and agreed upon for this topic was that the two concepts are "reinforcing of one another", in that Burnout from lead to unhealthy practices and create easier openings for Compassion Fatigue to occur. Likewise, untreated Compassion Fatigue can lead to Burnout in the workplace and trickle into other areas of a mental health professional's life (personal communication, March 2020).

Reported Causes of CF and BO in Mental Health. In almost every interview and in the member check meeting, participants voiced that they were sure that their definitions of Compassion Fatigue and Burnout explained the causes of both concepts. However, participants were quick to add that the causes for both Burnout and Compassion Fatigue are often a result of poor boundaries and poor selfcare. Participant #4 explained,

> I can honestly say that in the beginning of my career – when I was much
> younger – Compassion Fatigue and Burnout were a direct result of the
> lack of boundaries I set with my job and myself. I was working long hours

overextending myself, saying 'yes' to more clients and projects just so I

could help more people. (personal communication, February 2020).

In addition to that, participant #3 shared that she experienced both previously

from "unfair work environment, poor leadership, coworker strain, little to no

improvement in patient's status, unrealistic workloads, and lack of

communication in the workplace" (personal communication, February 2020). This

furthered the conversation in which participants #7 and #10 explained that their

experiences of CF and BO were often linked to unrealistic workloads and

demands to meet all their clients'/patients' needs during times of higher caseload

numbers. Participant #5 voiced that the causes she has experienced as a mental

health professional are different than what colleagues in other fields have

experienced as she has pressure from leadership and the organization while also

having to meet the needs and demands from the patients she serves. She

described this as feeling similar to "having to serve multiple masters" and not

knowing which one would be the end of her career. The member check meeting

participants all accepted this response as part of their joint construction for the

main cause of both their experiences with Compassion Fatigue and Burnout

(personal communication, March 2020).

The Effect of CF and BO on Individuals. Even as participants had clearly

defined the two terms as separate concepts, the effects they experienced were

quite similar and often overlapped, such that participants continuously combined

the effects of both terms into one answer or rephrased their answers during

interviews when they released it could be applied to both CF and BO. While the inability to express compassion and demonstrate empathy are obvious effects, there were notable other effects reported. Participant #1 explained that she would "notice that when they occurred, I would start getting irritable and short with patients, sometimes lashing out or becoming more aggressive than appropriate" (personal communication, February 2020). Participant #6 voiced that he experienced "a shortage of patient and a significantly less willingness to help others in any capacity" (personal communication, February 2020). Participant #2 stated that, "I had experienced fits of depression, feeling like a book with no substance…completely empty inside as I went through both Compassion Fatigue and Burnout together. It interfered with my personal and home life very poorly" (personal communication, February 2020). Together, the group established that there were no limits or shortage of negative personal effects from Compassion Fatigue and Burnout.

The Effect on the Workplace's Culture. Out of the 10 participants, 7 agreed that there was clear evidence the culture of their clinic had been affected negatively by Compassion Fatigue and Burnout. Participant #8 expressed:

There are so many service providers here are easily identifiable as burned out and fatigued. Unless they are addressed, the culture here will worsen, and we will no longer have high caliber providers here because they will simply quit or move on to other fields that aren't so stressful to prevent

their own burnout and compassion fatigue from occurring. (Personal

communication, February 2020).

In a like manner, participant #4 shared,

I have seen several therapists and doctors here decline in their selfcare,

isolated, taking excessive days off work, and become irritable. Some have

completely changed career avenues, and I've seen colleagues look into

different avenues for helping others to switch things up. And then there

are some who have developed horrible coping habits and even turned to

alcoholism. (Personal communication, February 2020).

The majority of participants in interview responses believed that the culture in the

workplace was being affected and that the effect was negative on the clinic. In

the member check meeting, some voiced that they believed it was more than the

clinic that has been affected, but that the issue is truly systemic. Participant #8

stated:

On a macro level, society as a whole doesn't care about mental health,

and doesn't have respect for our field. Most of the places I've worked,

including this one, are setup to overwork and underpay their staff. I think

we are not trained to challenge the system because we ourselves are

double blinded by compassion and good will. Because we're in a helping

profession, I think we make ourselves believe we have to keep giving and

not ask about what we get in return. In the long run, we are the one that

are worn out. (Personal communication, March 2020).

This could not be included in the joint construction, however, as nearly half of the group did not share in this belief that the issue extends beyond the workplace and is systemic in nature. Opposing viewpoints held that they had been in environments where this was not the case, and that in this specific workplace they have not appropriately utilized the resources at their disposal such as the union and labor partnerships.

Preventative Measures To Be Taken. During the interviews and the member check meeting, participants were asked to provide their recommendations for prevention or recovery solutions if this was an agency-wide experience. Participants shared several methods of prevention which include various forms of selfcare for individuals. Participant #9 revealed that providers in the clinic would benefit from:

Strengthening our physical health along with our mental, emotional and spiritual health can help prevent Compassion Fatigue and Burnout. I know that when I was in distress, I was not taking good care of my body and mind. I started exercising, eating healthy, taking time to rest and recover after difficult work shifts, spending more time with family and friends, praying more, reading and meditating on God's word so that my internal foundation would be stronger and as a result, I was able to function more effectively in my personal life and at work. (Personal communication, February 2020).

Others shared their personal physical selfcare methods, such as participant #1's

where she "cope[s] with both with lots of selfcare. By doing a lot of physical

fitness from Zumba, Orange Theory to CrossFit. I need intense HIIT type

exercise to manage stress" (personal communication, February 2020). When

asked to generalize more or expand on a macro level in the member check

meeting, participant #10 stated that:

> There can be more wellbeing and selfcare education to help us identify
>
> early signs of both Compassion Fatigue and Burnout, with additional
>
> resources to address recovery. We should also ask to be provided with
>
> more resiliency training such as relaxation techniques and stress
>
> reduction. But most importantly, we have to be willing to talk about these
>
> sensitive issues openly and be available to help others experiencing these
>
> conditions. (Personal communication, March 2020).

In a final joint construction, the members agreed that the organization needs to

change on several levels to prevent these two concepts from occurring within

and to provide resources to allow providers to recover. The members noted that

in prevention, some of the meeting times should dedicate to check-ins, some

socialization, and education on these topics on occasion. They also agreed that

leadership in the organization should take measures to reduce the demands from

high caseloads and fast-paced discharge to focus on providing better quality of

care and provide mental health professionals time to recover.

Data Interpretation

This research effort found that Compassion Fatigue and Burnout may have some unique characteristics across various mental heal professionals' definitions, but ultimately are and can be understood to withhold the same conceptualization. In addition, the study found significant relationships between CF and BO, causes in which both can occur, an understanding on how individuals and the agency's culture can be affected, and a collaborative approach to prevent it from occurring and recovery for those experiencing them. These results were gained from a sample of providers in a mental health clinic in Southern California ranging across different levels of service which included psychiatrists, a psychologist, therapists, and nurses.

The findings from this study corresponded to the findings in many of the reviewed literature pieces and other studies surrounding both Compassion Fatigue and Burnout. For starters, the participants from this study matched the definition of Burnout according to Van Mol et al. (2015), where they found BO to be related to workloads and other work-related factors. This research findings expanded on it to incorporate that exhaustion occurs in different or a combination of mental, emotional, spiritual, and/or physical forms. Similarly, participants unknowingly and collectively expanded upon the literature's definition of Compassion Fatigue. Where Cetrano et al. (2017) found that CF is emotional exhaustion and the inability to feel compassion for others, participants in this

study found that to be true, but that the exhaustion extends beyond just emotional states.

Cetrano et al. (2017) and Van Mol et. al (2015) both also looked at the clear and distinct differences between CF and BO, but did not draw many similarities between the two concepts beyond that they are often confused with one another. The data from this study helped uncover that the reasoning for this confusion is that many factors between the two overlap, not to mention that they can lead from one to the other and vice-versa. The findings were an understanding that the effects can look very similar in behavior and negative responses, with CF and BO acting as reinforcers for each other.

The findings from Thompson, Amatea and Thompson (2014) uncovered that gender played no significance in which of the two would be more likely to experience CF or BO. That data is congruent with this research effort as all participants explained they had experienced Burnout at some point in their careers, and nearly an equal amount of males and females in this study had experienced Compassion Fatigue at least once. More over, this research did not see race or ethnicity holding a significant difference with CF and BO experienced. Some participants, such as participant #4, had stated that they had experienced much of their BO in the early stages of their careers or post-graduate jobs in the field; aligning with the data found by Craig and Sprang (2010) where they determined that BO is experienced at higher rates with professionals of younger ages.

Lastly, Thompson et al. (2014) and Beaumont et al. (2016) suggested the best roads to prevention and recovery from both CF and BO are to engage in selfcare practices including mindfulness, well-being and self-compassion. Participants in this study agreed and were able to explain their needs from the agency to resolve these issues affecting the workplace culture, which include education, reduction in stressors, and socialization.

Implications of Findings for Macro and/or Micro Practice

The findings from this study were focused on both a micro and macro level practices in the field of mental health service. Micro practitioners, such as case managers, social workers, and the varying types of mental health professionals included in this study can benefit by understanding the definitions of CF and BO in an applied metal health clinical setting. This information will also provide them with the understanding of the risks of both in not seeking resolution and treatment for them, as well as ways to prevent and recover from the phenomena.

Macro practitioners and mental health agencies would do well to use these findings in determining the roles, responsibilities, and expectations they establish for their providers. As many participants voiced concerns of overwhelming workloads, large caseloads, and excessive demands from their employers, considerations for restructuring or resolution should always be kept in mind. Some participants explained feeling the pressure from the organization, leadership, and the clients they serve, which adds to the likelihood of BO. Management and organizations can use this takeaway to find ways to empower

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mental health providers or consider reducing the amount of pressure and expectations they hold. Finally, agencies and organizations can use these findings to better understand the ways in which CF and BO negatively affect individuals the employ, as well as the workplace culture, in order to prevent high turnover rates and low performance issues.

Limitations to this study were identified in several ways. A major limitation was that this study was conducted in only one mental health clinic and time could not permit additional clinics to participate in the study. The size of the sample was rather small and only accounted for about 10 percent of the clinic's number of mental health professionals. As this was a qualitative approach, interviews and the member check meeting were also time consuming, where participants also voiced the research may have gained more data if surveys were utilized instead. Future research on this topic may wish to consider a larger number of participants, additional numbers of clinics, and potentially a quantitative approach.

Summary

This section provided insight into the demographics of those who participated in this study. Individual and joint constructions were discussed, as well as the member check meeting, as this research followed the Constructivist paradigm model. The findings were compared to the research and findings from other studies. The section addressed the ways in which both macro and micro

level practices could benefit in the field of mental health. Lastly, the limitations of

the study were discussed in conjunction with considerations for future research.

CHAPTER FIVE

TERMINATION AND FOLLOW UP

Introduction

This study examined the differences found in experiences with

Compassion Fatigue and Burnout across different scopes of practice within a

mental health clinic. This last section discusses the termination of the study and

how it proceeded. Followed by an explanation of the communication of findings

to both the research site and the study participants. This section will also include

a brief discussion of ongoing relationships with study participants. Concluding

this research is the plan for dissemination of the research and its findings.

Termination of Study

Following every interview, the researcher verbally expressed appreciation

for the participants cooperation and time in providing his/her experience and

knowledge on the subject. The study participants present in the member check

meeting were also thanked for their contributions as a whole. The study's

termination at the study site terminated after the member check meeting. The

study itself concluded with the submission of the research paper to the

researcher's university.

Communicating Findings to Study Site and Study Participants

The findings from this study were submitted to the research site and to participants in an informational report. The researcher personally delivered the research to the site gatekeeper and explained the results of the study, as well.

Ongoing Relationship with Study Participants

Relationships with study participants terminated at the closing of interviews and the member check meeting. Relationships did not extend past the point of participants receiving the findings of the study.

Dissemination Plan

Dissemination of the research findings occurred through two platforms. The first was a presentation via a digital poster creation for Poster Day at Cal State University, San Bernardino. The second was the submission of the research paper to fulfil the graduate studies research project and become available for public viewing through CSUSB ScholarWorks.

Summary

This chapter reviewed the details pertaining to the termination of the study, with regard to the study site and the study participants. It outlined the communication of findings to site and participants, as well. The ongoing relationship with study participants was addressed. Lastly, the plan to disseminate the findings was noted.

APPENDIX A

DATA COLLECTION INSTRUMENT

Questionnaire

1. What is your age?

2. How do you identity yourself in terms of gender and racial/ethnic identity?

3. Can you briefly describe your education and clinical background?

4. How long have you been in your current position?

5. What is your experience with Compassion Fatigue (CF) and Burnout (BO)?

6. What is your definition of the two terms?

7. If you have or know someone else who has experienced them, what are ways to prevent or recover from them?

8. Do you think CF and BO are related? How?

9. What causes or contributes to the development of CF and BO?

10. How have you seen others deal with these concepts?

11. Do you see CF and BO affecting the culture here in this clinic? If so, can you explain?

12. If this were an agency-wide experience here, what could be done to prevent or help the agency recover?

13. What have you experienced with other places of employment surrounding this topic?

14. Is there anything else that you can share on the subjects of CF and BO that would be important to note?

*** Who might have a different perspective from you or have a different experience?

*Questionnaire created by Leonard L. Pinto

APPENDIX B

INFORMED CONSENT AND DEBRIEFING

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate is designed to examine the conditions of Compassion Fatigue and Burnout among providers in a Los Angeles County mental health clinic. The study is being conducted by Leonard Pinto, an MSW student under the supervision of Dr. Gretchen Heidemann-Whitt, research professor for the School of Social Work, California State University, San Bernardino. The study has been approved by the Institutional Review Board Social Work Sub-Committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to examine the conditions of Compassion Fatigue and Burnout among providers in a mental health clinic.

DESCRIPTION: Participants will be asked several questions regarding their understanding of and experiences with Compassion Fatigue and Burnout, especially as it relates to their current employment in a mental health clinic. You will be interviewed by a master's level researcher. The interview will be audio recorded with your consent. You will also be asked to participate in a follow up 'member-check' group.

PARTICIPATION: Your participation in the study is fully voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported in group form only. The research findings will not reveal your name or other possible identifying information in any reports.

DURATION: The interview will not exceed one hour in length. The subsequent "member check" group will not exceed one hour in length.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any immediate direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Gretchen Heidemann-Whitt at (909) 537-5501 or email: Gretchen.Heidemann@csusb.edu.

RESULTS: Results of the study can be obtained from the Pfau Library Scholar Works (http://scholarworks.lib.csusb.edu) at California State University, San Bernardino after December 2020

****
****
I agree to be audio recorded: _____ YES _____ NO

This is to certify that I read the above and I am 18 years or older.

_____   _____
Place an X mark here   Date

College of Social and Behavioral Sciences
School of Social Work

DEBRIEFING STATEMENT

This study you have just completed was designed to examine the conditions of compassion fatigue and burnout among various disciplines of providers in a Los Angeles County mental health clinic. We are interested in understanding compassion fatigue and burnout from an organizational level, and ways in which to prevent or recover from their occurrence. We are interested in your personal experience with these concepts as well as what you have observed. This is to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study, please feel free to contact Dr. Gretchen Heidemann-Whitt at (909) 537-5501 or email: Gretchen.Heidemann@csusb.edu. If you would like to obtain a copy of the group results of this study, please contact the ScholarWorks database (http://scholarworks.lib.csusb.edu/) after September 2020.

APPENDIX C

RECRUITMENT FLYER AND IRB APPROVAL

Faculty Reviewer: Armando Barragán   Due Date:

Student(s): Leonard Pinto   Return To:

Proposal Title: Compassion Fatigue and Burnout Within A Mental Health Clinic

Please review the attached IRB application for compliance with standards for protection of human subjects. A copy of the full proposal is in the "Students' Proposals" folder for reference, if necessary. If you will be supervising the project, please read it closely and return to the student with your comments.

- -

Proposal Should Be:

☑ Approved

☐ Resubmitted With Revisions Listed Below

☐ Forwarded To The Campus IRB For Review

Revisions That Must Be Made Before Proposal Can Be Approved:

☐ Faculty Signature Missing

☐ Missing Informed Consent   ☐ Debriefing Statement

☐ Revisions Needed In Informed Consent   ☐ Debriefing

☐ Data Collection Instruments Missing

☐ Agency Approval Letter Missing

☐ CITI Missing

☐ Revisions In Design Needed (Specify Below)

Reviewer Signature: A. B_____   Date: 10/7/19

REFERENCES

Bandura A. (2016). The power of observational learning through social modeling. In R. Stenberg, S.T. Fiske, D.J Foss (Eds.). *Scientists making a difference*, 235-239

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. *Counselling & Psychotherapy Research*, 16(1), 15–23

Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., … Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research*, 17, 755

Compassion Fatigue. (2018). Retrieved from http://www.compassionfatigue.org/

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping,* 23(3), 319–339

Khan, A. A., Khan, M. A., & Malik, N. J. (2015). Compassion fatigue amongst health care providers. *Pakistan Armed Forces Medical Journal*, 65(2), 286–289

Morris, T. (2014). Practice informed research methods for social workers. *Kindle Edition.*

Lester, N. (2010). Compassion fatigue. *Mental Health Practice*, 14(2), 11

Lent, J., & Schwartz, R. C. (2012). The impact of work setting, demographic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling,* 34(4), 355–372

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, 36(1), 58–77

Van Mol, M. M. C., Kompanje, E. J. O., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review.

Whitebird, R. R., Asche, S. E., Thompson, G. L., Rossom, R., & Heinrich, R. (2013). Stress, burnout, compassion fatigue, and mental health in hospice workers in Minnesota. *Journal of Palliative Medicine*, 16(12), 1534–1539.