Pivotal Events: "I'm Not a Normal Person Anymore"—Understanding the Impact of Stress among Helping Professionals

Heather Howard and Nicole Navega

To assess the impact of high-stress work on helping professionals, three major constructs have been employed throughout the past two decades: secondary traumatic stress, compassion fatigue, and occupational burnout. Applied together, these constructs provide powerful tools to recognize the debilitating effects that trauma care can have on helping professionals' quality of life.

The objective of this mixed-methods study was to understand coping strategies that helping professionals use to manage stressful working environments within a transactional stress and coping theoretical framework and structural empowerment model. The two major qualitative themes were systemic oppression on the professional side and intrinsic empathy on the personal side. Participants identified a pivotal event that impacted both their personal and professional lives.

The use of this conceptual framework with helping professionals is promising as an emerging practice. Cultural shifts in host environments could create spaces for formal debriefing, wellness trainings, and decreased stigma related to help-seeking behaviors.

Key words: *empowerment, professionals, stress and coping*

The psychological, physical, emotional, and relational impact on helping professionals working in high-stress environments and with trauma survivors has been extensively researched for more than two decades (Newell & MacNeil, 2010; Sprang, Craig, & Clark, 2011). Often used interchangeably, the three major constructs studied are secondary traumatic stress (STS), compassion fatigue (CF), and occupational burnout (Figley, 1995). Secondary traumatic stress results from helping a traumatized person (Figley, 1999). Researchers have observed that people who come into continued close contact with trauma survivors may also expe-

Heather Howard, MSW, PhD, LICSW, is assistant professor, Florida Atlantic University, Boca Raton. Nicole Navega, MSW, LICSW, is a doctoral student at Florida Atlantic University, Boca Raton.

rience emotional disruption, becoming indirect victims of trauma (Figley, 1995). By comparison, STS is a condition, and CF is a process that happens over time to unsupported workers (Radey & Figley, 2007). Indicators of CF may include sleep disturbances and fluctuations in emotional states (Sansbury, Graves, & Scott, 2015). Occupational burnout is defined as a response to prolonged exposure to demanding interpersonal situations and is characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). What these constructs share, from condition to process to outcome, is a debilitating effect on quality of life of the helping professional.

This mixed-methods study explores the impact of stress, trauma, and coping among helping professionals. For purposes of this study, helping professionals are defined as police, firefighters, rescue workers, acute medical professionals, and social workers exposed to trauma and acute stress. The study included sixteen participants and was approved by the Wheelock College institutional review board. Data collection took place between January and June 2017. The objective was to understand coping strategies used to manage stressful working environments within a transactional stress and coping theoretical framework and structural empowerment model as an emerging practice.

Background

Figley, a pioneer in STS research, looked at growing concerns about the impact of critical events on emergency personnel, such as firefighters and police officers, stating that they are at higher risk for psychological disorders and substandard work performance than the general public (1995). According to Figley (1999), STS or occupational burnout is the main reason why many mental health professionals leave the direct-care field. These professionals are more likely to experience psychological effects due to the nature of their employment. The inevitable consequence for some professionals who lack coping or external supports creates tension within their personal relationships because it is difficult to disconnect themselves emotionally and cognitively from these traumatic work-related experiences (Sorenson, Bolick, Wright, & Hamilton, 2016).

In 2015, van Mol, Kompanje, Benoit, Bakker, and Nijkamp (2015) conducted a systematic review of emotional distress among intensive care unit (ICU) health care providers. Prevalence rates varied among the 14,770 respondents as follows: CF (7.340%), STS (0–38.5%), and burnout (0–70.1%). Because previous research has produced varying results, van Mol and colleagues (2015) asserted that further inquiry is needed to assess the authentic prevalence of such concerns within professions that manage crises.

Another study that explored CF in mental health workers found that 97.8 percent of respondents reported that their patients had experienced trauma, and 88.9 percent reported that they address trauma-related concerns as a function of direct practice (Bride, 2007). Emergency personnel and mental health workers who manifest STS report negative impacts on their overall work experience such

as CF, occupational burnout, and rapid staff turnover (Garman, Corrigan, & Morris, 2002).

Additionally, a study of 491 acute care registered nurses found that a lack of meaningful recognition was a significant predictor of burnout. This lack of meaningful recognition, correlating with poor job satisfaction, affects nursing retention and quality of care (Kelly, Runge, & Spencer, 2015). Other studies have demonstrated a higher risk of poor professional judgments, such as misdiagnosis, poor treatment planning, or abuse of clients, for those experiencing secondary traumatization (Rudolph, Stamm, & Stamm, 1997).

There is a paucity of research about how to address the potential of STS, CF, and occupational burnout and how to promote emotional and physical well-being for helping professionals. Flannery (2015) suggested further research on the physical, intrusive, and avoidant symptoms of trauma among helping professionals. He concluded that there are barriers that may impede further research, including the stigma associated with seeking help.

A few recent studies focused on protective factors to prevent STS, CF, and occupational burnout in helping professionals. These studies suggested some best practices to address these concerns, such as increasing education in social work curricula as a first-line preventative measure for inexperienced social workers and emphasizing agency-based trainings for social workers already in the field (Newell & MacNeil, 2010). One study explored variables that influenced how firefighters and law officers react and manage stress and discovered that involvement in an emotionally significant relationship was a protective factor (Shaffer, 2010). Another study of 213 mental health professionals found that counselors who reported less maladaptive coping, higher mindfulness attitudes, and more positive perceptions of their work environments also reported less CF and burnout (Thompson, Amatea, & Thompson, 2014).

The impact of STS, CF, and occupational burnout among helping professionals can be addressed through policies, practices, and procedures that are aimed at reducing these conditions and increasing overall well-being. In this study, we explored the role of coping in trauma-exposed helping professionals and sought to understand how positive coping might sustain these helpers within transactional stress and coping and structural empowerment models.

Conceptual Framework

The conceptual framework utilized was a transactional stress and coping theory in addition to a structural empowerment model. Lazarus and Folkman (1984) defined stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 21). Coping is defined in terms of the "cognitive and behavioral efforts someone makes to manage (i.e., master, reduce, or tolerate) a troubled person-environment relationship" (Lazarus & Folkman, 1984, p. 141). Transactional stress and coping provides a theoretical basis for

studying experiences related to stressful work environments from a systemic perspective and has been utilized in a study examining predictors of CF and burnout in mental health counselors (Thompson, Amatea, & Thompson, 2014). It is therefore important to understand whether the organization offers employees support, training, and resources in order to mitigate psychological harm without stigma or repercussion.

The transactional stress and coping framework interconnects with the structural empowerment model. Both theories emphasize the relationship between people's perceptions of their work environment and the support that is actually offered. One study utilizing the structural empowerment model found that individuals who feel empowered in their place of employment tend to experience less emotional exhaustion and reduced rates of burnout (Gilbert, Laschinger, & Leiter, 2010). This conceptual framework highlights the significance of strengthening organizational support and the perceived empowerment of helping professionals within their organizational structure.

Methodology

Research Objective

The objective of this study was to understand coping strategies utilized by helping professionals to manage stressful working environments within a transactional stress and coping theoretical framework and structural empowerment model.

Sample and Recruitment

We used a purposive sample of helping professionals who self-identified as being exposed to trauma in their work environments and who work in high-stress environments. The participants were recruited from our professional networks.

Data Collection

A semi-open interview guide (see appendix) was utilized as well as the Professional Quality of Life Scale (ProQOL), a thirty-item self-report scale of the positive and negative aspects of caring that measures compassion satisfaction, STS, and occupational burnout (Stamm, 2010). Yardley's (2000) four broad principles for assessing the validity of qualitative research—(1) sensitivity to context, (2) commitment and rigor, (3) transparency and coherence, and (4) impact and importance—were applied to assess the qualitative inquiry.

Data Analysis

Data were analyzed using the qualitative software program Dedoose. We utilized a constant comparative method of content analysis designed to establish patterns and themes (Marshall & Rossman, 2011). In addition, the quantitative data from the ProQOL were analyzed using descriptive statistics.

Results

Participant Characteristics

There were $N = 16$ helping professionals who met inclusion criteria to participate in an individual interview utilizing an interview guide. All helping professionals had worked in their discipline between ten and twenty-five years. Table 1 displays the number of participants by occupation and gender identification. Table 2 shows the results of the ProQOL.

Themes

Major themes or subthemes were defined when 50 percent or more of the participants referred to a topic. Participants shared that they attempted to keep work and home life separate. Hence, the major themes are separated between professional and personal life. It was evidenced in the data, however, that the themes were interconnected and fluid (see figure 1). The two major themes were systemic oppression, encompassing the professional side, and intrinsic empathy, encompassing the personal side. Participants identified a pivotal event that impacted both their personal and professional lives. Hence, the experience of a pivotal event is central to both the participant's intrinsic empathy and experience of systemic oppression. The subthemes for systemic oppression were workplace coping, organizational support, and formal debriefing; subthemes for intrinsic empathy were personal coping, symptoms, and growth.

In the following subsection, quotes about pivotal events demonstrate each theme.

Two quotes demonstrate an example of a pivotal event. It is the pivotal event that is permeating and fluid and interconnects with the two major themes and subthemes. An emergency room nurse said, "I had been in emergency services at that time about, oh, I don't know, fifteen, sixteen years, and everybody that does this has that one call that changes them, and that was mine. That took me a long

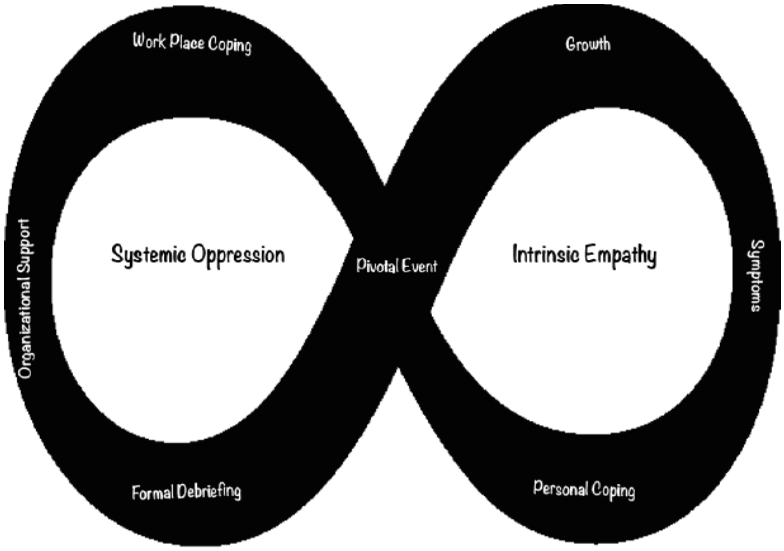
Table 1 Participant occupation and gender identification

Police	Emergency medical services	Nurse	Physician	Social work	Firefighter
3 males	1 male	1 male 4 females	1 male 2 females	4 females	
$N = 3$	$N = 1$	$N = 5$	$N = 3$	$N = 4$	$N = 0$

Table 2 Final scores on the ProQOL: compassion satisfaction, STS, and burnout

Rating	Compassion satisfaction	STS	Burnout
High	62.5%	0%	6.25%
Average	37.5%	37.5%	50%
Low	0%	62.5%	43.75%

Figure 1 Conceptual map of themes and subthemes



time to get through." After a deadly shoot-out in the community, a police sergeant said, "I had seen dead people before, and I had seen, you know, shooting victims before; but I think this might have been the first time that I watched somebody, basically their life functions come to an end. Right in front of me."

Systemic Oppression

Fifty percent of the participants expressed disillusion in their professional lives with the work environment as a major contributor to CF, occupational burnout, and STS. An attending neonatologist stated:

> I think the hospital has very little mentorship within my division. It doesn't exist. And without getting into too much detail, it not only doesn't exist, it—there's not an interest in how we are coping and what our stress level is. . . . It doesn't exist, and there's not an interest in wanting to explore that aspect of things. I think a good number of people who are in this profession think that this conversation you and I are having is not necessary.

A city police officer shared:

> I think that it's the internal stuff. It's the interdepartment stuff. That's the worst. That's worse than anything, unfortunately. That's worse than the external stuff. But I think most —I think most police officers would tell you that it's the internal stuff that pushes it over the edge. You deal with

> something bad on the street, and then the supervisors are going to second guess how you handled it, and they're going to tell you should have done . . . . I would rather deal with the stuff on the street and not have to deal with the internal stuff. Because the internal stuff is always worse.

Subtheme: Organizational Support
A nurse manager in an emergency room explained:

> A nurse may say, "I can't do a sexual assault exam right now. I've reached my limit." And that's OK, we don't stop it, we just give it a break, work through it, and then come back. You might have had a fetal demise, and you just reached your limit. And you can't do [it]—and if you have a good team, you can just turn and say, "Tag, it's your turn this time, I just can't."

An emergency medical technician endorsed shared values and the use of humor as a positive work support strategy:

> If you have a good partner, you can kind of joke around with them . . . that helps a lot. Having somebody else there. Because they're literally experiencing the same exact trauma that you are at that time. . . .we had the same kind of sense of humor, and the same values.

A police sergeant recognized the bond with fellow officers as a major work support: "the great thing about our profession . . . we know we all put that uniform on, and . . . we bleed the same blue . . . you help each other get through it . . . there's that brotherhood in our profession."

Subtheme: Formal Debriefing
A flight nurse shared that the formal debriefing is not a typical practice or formal policy:

> Through the emergency room, we can request a formal debrief. . . . I've been in this institution for nine years, as a nurse; and I've actually only had one formal debrief. And it was a three-year-old drowning. . . . Everyone that was involved in the trauma room . . . [the] State Police to the EMS program that brought her in—everyone was there. And it was wonderful. But that was really the only time that that's officially happened.

A police sergeant encouraged formal debriefing:

> We talk about it amongst ourselves . . . but there wasn't any, like, formalized [debriefing]. I think our department has gotten so much better in recent years of . . . formalizing the process when somebody experiences a potentially traumatic event . . . and actually mandating people to go speak to our

> department psychologist, or something—or, you know, offering services should somebody want it.

Subtheme: Workplace Coping

Table 3 demonstrates how various helping professionals practice workplace coping during their workday.

Intrinsic Empathy

The major theme within the participants' personal life was intrinsic empathy and the three subthemes were symptoms, personal coping, and growth.

A postpartum nurse described empathy as a large component of her nursing practice:

> My take on all of it—and a lot of people don't think this way—is you have to try and understand another person's perspective. You have to try and place yourself in another person's shoes. They didn't grow up just like you. They may not have had the same experiences as you; and so you have to try and just understand where people are coming from and just be empathetic and don't judge.

A city police officer explained that he experiences a decrease in empathy when he is experiencing CF: "In the end, you try to do—hopefully you do the right thing every time. You just may have less patience, less empathy sometimes. Especially if you're dealing with the same people and the same situations."

Subtheme: Symptoms

The participants shared their experiences of the work environment; exposure to secondary trauma contributed to a variety of physical, emotional, and psychological symptoms. Several of the participants described experiencing pervasive thoughts.

Table 3 Examples of workplace coping practices

Professional	Coping behavior
Oncology nurse	45-min lunch; leave building and walk. Work with a partner; autopilot.
Sexual assault nurse	Code Lavender: meditative relaxation for 10 min; one thing at a time until it is completed.
Flight nurse	Talk to your peers, share ideas, or take a mental health day if needed.
NICU physician	Put things in boxes to get through the day.
Emergency room (ER) nurse	File it away and move on to the next patient.
Sexual assault physician	Put up a barrier.
ER nurse manager	Reactive mode, decompress, and evaluate later.

For example, a sexual assault nurse shared:

> College rapes—I have a 21-year-old daughter. It makes me very—not nervous, but makes me sweat a lot—when my kid's telling me that she's going out for the day and going to a party or something. . . .That causes me probably the biggest anxiety as a mother worrying about your daughter with the sexual assaults. . . .The problem with me is, coping—I don't cope. I don't think about it. I only think about it when my kid tells me she's going out for the night.

A city police officer said:

> I know it's affected me. . . . I live and work in the same city, I'm sometimes reminded of things, just driving around. Drive past places where you go to calls and where things happened, and you just kind of get those—the memories come back. And you see the same things that you saw there. . . . I thought of them as intrusive thoughts. I'm not a normal person anymore. Absolutely not a normal person any more.

Many of the participants described physical complaints. An oncology nurse shared:

> I told my primary care doctor, asking, "I think I might need something to take for sleep. I've been taking Benadryl, and I don't really think that's what I should take long-term.". . . So I do have a prescription for sleep medicine . . . . I take it home and I'm like, OK, did I do this right? Did I do that right? I should have done this. Maybe I should have done that better.

One of the attending physicians said, "I internalize my stress a lot, and that manifests probably mostly in my headaches. I get migraine headaches." A mental health worker talked about avoidance of work as a symptom:

> I think it's hard to go to work the next day after you've experienced something really traumatic. It's hard to face it. . . . I just kept reliving it, and didn't want to—really wanted to avoid coming in the next day. . . . So, that feeling of not wanting to go work, which I rarely feel, is a major trigger for me in terms of burnout and secondary trauma. Any avoidance of the work, I know I've got to get some support or figure out how I'm going to feel better.

A neonatal intensive care unit social worker reflected:

> I think the hard part is it wasn't a place I could walk away from at the end of the day and forget it. I always brought it home. . . . I decided to make a

change to leave, because I started to feel that it would literally take five years off my life if I didn't leave. I would do work at home a lot of times. Constantly dream about work. Still dream about work. . . . It was hard for me to leave it behind. So, it would definitely affect my relationship with my husband.

An ER nurse shared that a traumatic case affected her:

I didn't sleep for three days. Talking it through with coworkers and people, we had a debriefing like a day later with a state team that came in, but I thought at that point I was fine. I'm good. And then—about three, four years—ooh, let's see, about five years later, it started manifesting itself in other things: sleepless nights, restlessness, pain, physiological pains, anxiety, stress, anger, to the point where I needed to start seeing a therapist.

An emergency medical technician (EMT) described symptoms like this:

Some anxiety at work and out of work. Definitely PTSD. I know when I first started as an EMT, it was a lot worse. I would have some calls where people died, and I couldn't sleep for days, or I'd have nightmares for weeks; and then it's strange, but your mind just adapts to it. And then it's not that you don't care, it's just that you're able to kind of stuff it in and just work past it. Because you know that you tried your best, and you just move on to the next patient.

Subtheme: Personal Coping

Following are participants' statements about strategies for personal coping.

I would say alcohol has definitely come up as a way to release tension, at the end of the day. Hot yoga is a huge, huge coping skill of mine. Talking with other clinicians. Luckily, I have a couple in my family. Watching TV, and getting out of my own head is one of my skills. A big one for me is having something to look forward to, whether it's a trip, or something fun that I'm going to do, or travel (trauma therapist).

Police officers, firefighters, EMTs, dispatchers, things like that, they're all, they've got kind of a twisted sense of humor. Because if they don't, then you know, you'll lose your mind. They taught me coping mechanisms, taught me techniques, how to deal with, how to—and even to be a help for others . . . . I eat—don't always make the healthiest of options, but eating has been a source of fulfillment because it's easy, it's quick, and it's satisfying. There's a long time . . . pornography was also that same outlet for a long time, which still raises its ugly head every once in a while, but more the food. It took me about five or six years to finally realize that I needed somebody to talk to (ER nurse).

A city police officer stated, "there's been times where I've drank more than I should've," whereas a NICU social worker echoed this way of personal coping: "I'd say alcohol. I don't think that I ever abused alcohol, but I definitely think that that would be one thing. Like at the end of the day, it would be like, 'Oh, you need a glass of wine.'"

Subtheme: Growth

Most of the participants shared their personal growth as helping professionals. The social worker in health care, whose patient and her partner were charged with infant homicide, shared that she reflects on and evaluates her practice:

> I felt I should have prevented it, I should have asked more about the father of the baby. I should have talked about Shaken Baby Syndrome. So now I asked myself, "What can I change?" And I do at the end talk about it, and all my postpartum clients I see I talk about it. I tend to process things and let it go.

An ER nurse, while describing one transformational experience with a patient, said, "Someday we're all going to be in that situation. We're all going to be that person and —I pray that there's somebody that will take care of me compassionately, and that my family will understand when enough is enough." An EMT reflected on his mortality:

> It makes you more conscious of decisions I make in my life about my health or my diet. Or just anything. I don't drink anymore. I watched people in their thirties that were going home on hospice, because they couldn't get a liver transplant, or people on dialysis. So it's kind of eye opening, in a good way.

Discussion

The interconnection of the helping professionals' personal and professional lives was an overarching theme. This was explained by a flight nurse:

> Sometimes things really hit you. And in this profession you just can't help but beat yourself up sometimes. Sometimes that call will stay with you when you come home. And you try to have that separation of work and home life. I'm fortunate enough that my husband is in a similar profession, and so he understands it. And so he's been a good sounding board, to be able to debrief things with him.

Although many participants expressed the objective of maintaining the work-life balance, it was apparent that the two parts of the helping professional's life, professional and personal, were fluid, and the professional side of life strongly influenced the participants both negatively and positively. Participants related a

pivotal event in exquisite detail that strongly impacted their professional and personal lives as if it had occurred recently, despite having taken place a decade prior in some cases. It was as if the researcher were bearing witness to the work experiences that transformed these participants' lives. They used phrases like "it still feels raw," "it has always stuck with me," "I had no one to share it with," and "that one call" that changes them to describe witnessing a death or hearing a story of horrific sexual violence and physical abuse.

Kanter's (1977) structural empowerment model explains the relationship between levels of support in the workplace and emotional exhaustion. The model posits that individuals with access to power (e.g., lines of information, support, and resources) and opportunity (e.g., a chance to advance and access to professional development) can accomplish the tasks needed to achieve organizational goals. For example, Sarmiento, Laschinger, and Iwasiw (2004) conducted a study involving nurse educators (N = 89) and demonstrated that higher levels of empowerment were associated with lower levels of burnout and greater work satisfaction. If individuals have access to power and opportunity, they are more likely to be motivated and able to motivate and empower others.

Conversely, many participants considered organizational hierarchy far more difficult than stressful work demands. Work was considered stressful, as expressed by phrases like "due to the work environment," "toxic," and "internal stuff is always worse than the external stuff." A participant said that the "system has been broken for a while." Many experiences conveyed by the respondents demonstrated this major theme of systemic oppression, such as inadequate support; supervisor's lack of interest in how someone was coping; little recognition for job dedication; feeling unheard; and a belief that, despite the respondents' best efforts to make positive changes, administrators made decisions regardless of their suggestions.

Several participants stressed the importance of organizational support. For example, receiving positive affirmation and acknowledgment that the helping professional "did the right thing" were important. Colleagues' mutual aid was equally important, as was sharing emotional responses to stressful events at work, such as "feelings of helplessness," and creating an environment where one was able to "take a break" before attending to another patient or stressful case. There were a few participants who "checked in" after work hours with a coworker who was emotionally distraught over a case. As one of the police sergeants described:

> Some of my favorite things to do are highlight the good things that the officers do. My sole responsibility is to make sure that they're set up to succeed and to have all the resources that they need. When you frame your work that way, even when things become stressful, they're really not stressful, because it's all for a good cause. I've got a hard task to do, but it's for a good cause. It's to help somebody be better at their job. And so, by framing it that way, I've had more satisfaction in the last three-plus years.

Several participants seemed to define formal debriefing in the workplace as an important opportunity to express how they feel, yet their workplaces do not offer that opportunity as a best practice. One physician questioned whether attending physicians and other helping professionals can be in control of decision making and simultaneously be vulnerable. Similarly, one police officer said that formal debriefing "is not a popular thing." This may suggest the need for a cultural shift and a new way of framing formalized supports in the workplace for normalizing emotional responses to highly traumatic experiences that come with the job.

According to the transactional stress and coping model, coping involves a range of activities to deal with stressors and resulting distress (Lazarus & Folkman, 1986). The coping strategies are problem focused, emotion focused, or meaning focused (Provencher, 2007) depending on the context, psychological factors, and personal characteristics. The findings of this study demonstrated problem-, emotion-, and meaning-focused coping. Some of the participants coped by talking to their close family and friends; others decided to exercise and eat well. Although many reported that alcohol was a coping tool to address the symptoms of stress, none disclosed alcohol abuse. Many of the participants shared their experiences of physical, emotional, and psychological symptoms such as sleeplessness, anxiety, pervasive thoughts, headaches, and exhaustion. Some noticed a relationship between the symptoms and self-identifying with patients. This often negatively impacted their personal relationships because they did not have any emotional support available for their families. Additionally, there was often work avoidance if the stress at work was insupportable.

Although ProQOL results did not indicate any high scores of burnout or STS, the participants shared many difficult experiences, including a pivotal event that was easily recited with impeccable detail. These experiences of trauma exposure impacted the participants in a positive way. Figley (1995) explained the transactional relationship between a trauma subject and the helping professional and the reciprocal relationship this entails within the contextual work environment. For instance, one neonatologist realized that she is not responsible for every bad outcome with her patients. She also needed to recognize and accept her limitations. Another emergency health professional acknowledged how precious life is and offered compassionate care, reflecting that perhaps someday he might be on the receiving end. Finally, there is a profound connection between these professionals and the individuals they help because of their shared humanity with all its hopes, fears, and dreams. Although empathy is considered a risk factor (Figley, 1995) for developing STS, this study demonstrated that empathy and trauma exposure created opportunities for transformational growth in the helping professionals and enhanced work sustainability.

Conclusion

It is an ethical imperative to address CF, occupational burnout, and STS for helping professionals, both as a function of professional codes and as a moral duty to

others. The literature suggests that not attending to the emotional, physical, and psychological needs of the helper can induce harm to both the helping professional and the trauma subject. In addition, increased focus on this important issue by policy makers, researchers, and administrators may decrease negative coping, increase job retention rates, and prevent patient harm.

Although this exploratory study was limited by its small sample size and thus lacked generalizability, the conceptual framework as well as the use of the transactional stress and coping process within a structural empowerment model is promising. For example, trainings could be developed in various host environments to establish structures of opportunity and power. Future research could evaluate whether training and workplace focus on supporting helping professionals would decrease the negative impact on them. Areas of focus for cultural shifts in host environments could emphasize employee recognition and create spaces for formal debriefing, wellness trainings, and decreased stigma related to help-seeking behaviors.

References

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*, 63–70. doi:10.1093/sw/52.1.63

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 3–28). Lutherville, MD: Sidran.

Flannery, R., Jr. (2015). Treating psychological trauma in first responders: A multi-modal paradigm. *Psychiatric Quarterly, 86*, 261–267. doi:10.1007/s11126-014-9329-z

Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction. *Journal of Occupational Health Psychology, 7*, 235–241. doi:10.1037/1076-8998.7.3.235

Gilbert, S., Laschinger, H. K. S., & Leiter, M. (2010). The mediating effect of burnout on the relationship between structural empowerment and organizational citizenship behaviours. *Journal of Nursing Management, 18*, 339–348. doi:10.1111/j.1365-2834.2010.01074.x

Kanter, R. M. (1977). *Men and women in the corporation*. New York, NY: Basic Books.

Kelly, L., Runge, J., & Spencer, C. (2015). Predictors of compassion fatigue and compassion satisfaction in acute care nurses. *Journal of Nursing Scholarship, 47*, 522–528. doi:10.1111/jnu.12162

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Lazarus, R. S., & Folkman, S. (1986). Cognitive theories of stress and the issue of circularity. In M. H. Appley & R. Turnbull (Eds.), *Dynamics of stress: Physiological and social perspectives* (pp. 63–80). New York, NY: Plenum Press.

Marshall, C., & Rossman, G. B. (2011) *Designing qualitative research* (5th ed.). Thousand Oaks, CA: SAGE.

Maslach, C. H., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, *52*, 397–422. doi:10.1146/annurev.psych.52.1.397

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health*, *6*(2), 57–68.

Provencher, H. L. (2007). Role of psychological factors in studying recovery from a transactional stress-coping approach: Implications for mental health nursing practices. *International Journal of Mental Health Nursing*, *16*, 188–197. doi:10.1111/j.1447-0349.2007.00466.x

Radey, M., & Figley, C. (2007). The social psychology of compassion. *Clinical Social Work Journal*, *35*, 207–214. doi:10.1007/s10615-007-0087-3

Rudolph, J. M., Stamm, B. H., & Stamm, H. E. (1997, November). *Compassion fatigue: A concern for mental health policy, providers and administration.* Poster session presented at the meeting of the International Society for Traumatic Stress Studies, Montreal, Canada.

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma*, *17*, 114–122. doi:10.1177/1460408614551978

Sarmiento, T. P., Laschinger, H. K. S., & Iwasiw, C. (2004). Nurse educators' workplace empowerment, burnout, and job satisfaction: Testing Kanter's theory. *Journal of Advanced Nursing*, *46*, 134–143. doi:10.1111/j.1365-2648.2003.02973.x

Shaffer, T. J. (2010). A comparison of firefighters and police officers: The influence of gender and relationship status. *Adultspan Journal*, *9*, 36–49. doi:10.1002/j.2161-0029.2010.tb00070.x

Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship*, *48*, 456–465. doi:10.1111/jnu.12229

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, *90*(6), 149–168.

Stamm, B. H. (2010). *The concise ProQOL manual: The concise manual for the Professional Quality of Life scale*. Pocatello, ID: ProQOL.org. Retrieved from http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf

Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*, 58–77. doi:10.17744/mehc.36.1.p61m73373m4617r3

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. *PLOS One*, *10*(8). Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0136955

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*, 215–228. doi:10.1080/08870440008400302

Appendix: Core Questions for Professionals Who Self-identify as Working with Traumatized Clients

Core Questions

1. How does your work impact your relationship with others?
2. Do you believe that your work has caused you to suffer from certain mental health symptoms?
3. Do you find that you are more easily frustrated or angry due to your work?
4. How does experiencing secondary trauma impact your work functioning?

Probing Questions

1. Are you being treated for depression, anxiety, or any other mental health issue that you believe is directly related to the trauma you experience at work?
2. Are you seeing a therapist and are you being prescribed any medication due to the trauma you experience at work?
3. Have you ever used drugs or alcohol to cope with the stress from experiencing trauma at work?
4. How do you cope with severe work stress?
5. Does your work stress and secondary and direct exposure to trauma contribute to a decrease in job satisfaction?
6. Does your organization have any processes to debrief or support the witnessing of traumatic events?