Understanding the Experiences of Compassion Fatigue Among Counselors in Private Practice: A Phenomenological Approach

by

Brie-Anna Michelle Willey

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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Abstract

The purpose of this interpretative phenomenological analysis was to understand the experiences of compassion fatigue and help-seeking and coping strategies among counselors in private practice. The theories guiding this study are the transition model and the transactional theory of stress and coping. The research questions included an OARQ What are counselors in private practice's experiences of compassion fatigue? Two SQs were also used (SQ1) What are counselors in private practice's experiences of help-seeking behaviors? (SQ2**)** How do counselors in private practice make sense of coping with compassion fatigue? Participants were selected using purposive and snowball sampling methods. Data collection included semistructured video interviews through the lens of a double hermeneutic. The interviews were recorded and transcribed. The transcripts were used to identify personal experiential themes and group experiential themes to study the unique experiences of counselors in private practice. The researcher also kept a personal journal of the process. The sample consisted of seven counselors in private practice. Three main themes were identified in this study: *I'm Overwhelmed on Every Side, I Don't Know What to Do,* and *I Grew from It.*

Keywords: interpretative phenomenological analysis, compassion fatigue, counselors, private practice, stigma

Dedication

This is dedicated to all the counselors in private practice who have struggled with compassion fatigue. I also want to dedicate this to my loving husband Blake. Thank you for your support and to my loving family. I also want to dedicate this to the Lord who inspired me to help people in the first place.

Acknowledgements

I would like to thank my dissertation committee including Dr. Tanisha Sapp, Committee Chair, and Dr. Fred Volk, Committee Member. Thank you for all of your tremendous help and support in helping me complete the dissertation process.

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List of Abbreviations

American Mental Health Counselors Association (AMHCA)

Compassion fatigue (CF)

Compassion satisfaction (CS)

Council for Accreditation of Counseling and Related Programs (CACREP)

Counselors in private practice (CPP)

Countertransference (CT)

Institutional Review Board (IRB)

Interpretative phenomenological analysis (IPA)

Licensed clinical professional counselor (LCPC)

Licensed mental health counselor (LMHC)

Licensed professional counselor (LPC)

Licensed professional clinical counselor-supervisor (LPCC-S)

Secondary traumatic stress (STS)

Vicarious trauma (VT)

World Health Organization (WHO)

Chapter One: Introduction

According to a recent study, up to 40% of counselors may be experiencing a form of burnout (O'Connor et al., 2018). Several studies have addressed counselor impairment and their coping and help-seeking behaviors (Beaumont et al., 2016; Gonzalez et al., 2019; Kalkbrenner et al., 2019; Maslach & Jackson, 1981; Mullen & Crowe, 2017; O'Sullivan & Bates, 2014; Tabaj et al., 2015; Wallace et al., 2010; Williams et al., 2012). However, limited research has described experiences of counselors in private practice (CPPs; Harrington, 2013), their risk for impairment, and help-seeking strategies (Savic-Jabrow, 2010). This chapter describes the background of this problem, the purpose and significance of the study, the theories chosen for this study, the research questions, definitions of terms, and a summary.

Background

Clinical errors such as ineffective treatment and inaccuracies in decision-making or ethics can negatively impact patient care for counselors (Brennan, 2013; Carney & Jefferson, 2014; Salyers et al., 2015). Furthermore, burnout levels can affect the quality of counselors' work with clients (Salyers et al., 2015). According to Morse et al. (2012), burnout prevalence is difficult to pinpoint. But O'Connor et al. (2018) conducted a meta-analysis of 62 studies concerning burnout impairment in mental health professionals, including doctors, nurses, social workers, psychologists, occupational therapists and counselors. They uncovered that feeling emotionally exhausted occurred at a 40% rate, depersonalization prevalence was at 22%, and experiencing a lack of accomplishment was at 19%. Burnout levels for CPPs, who represent 16% of the counseling workforce, are unknown (U.S. Bureau of Labor Statistics, 2021). According to the Health Resources and Services Administration (2018), the counselor labor force will likely increase 13% between 2021-2031; however, demand may range from 18% to 25%. In a sample

of 460 mental health providers in public and private agencies including psychologists, social workers, and case workers, Acker (2012) found that 56% experienced emotional exhaustion and 50% considered leaving the job. This combined data suggests that counselor training programs, researchers and supervisors need to remain vigilant in understanding and preventing compassion fatigue (CF) among counselors to help them stay in the field and remain healthy while working. The background concerning the problem is described in the following section, including historical, social, and theoretical applications.

Historical

Many researchers and theorists have worked to develop an understanding of stress in helpers over time. According to Lazarus and Folkman (1984), stress has been viewed throughout the last few centuries as the weight of difficulties that people experience when facing a challenging situation. Wolff (1953) described the reactions to stress as involving occurrences reminiscent of their past run-ins with danger, and the response may be more threatening than the actual catalyst. Freudenberger (1974) depicted this stress in terms of impact on helpers and described burnout as occurring when the weight of the stressors exhausts the individual physically and emotionally. McCann and Pearlman (1990) developed the constructivist self-development theory to explain vicarious trauma (VT) as the depth of impact of the client's experiences on the therapist as well as their mental health processes. Joinson (1992) was one of the first to highlight the risk of CF among nurses and also described how it can impact other helping professionals. Joinson (1992) urged helpers to consider four reasons to build awareness around CF, such as it can be emotionally damaging and that CF sources were possibly unavoidable. Joinson (1992) emphasized the value of training and understanding to building recognition and stated that certain personality factors were more sensitive. Similarly,

Freudenberger (1975) described helpers who had few boundaries with their work and were therefore more susceptible to burnout. Furthermore, secondary traumatic stress (STS) was identified in some helpers working with traumatized clients where the helper developed similar trauma symptoms, including reexperiencing and intrusive symptoms (Figley, 1995; Stamm, 2010). However, Stamm (2002) revealed that not every person exposed to trauma develops trauma symptoms.

According to Stamm (2010), CF was viewed as having two parts—STS and burnout. Stebnicki (2007) found empathy fatigue occurred when a counselor was physically, emotionally, and mentally worn out, which impacting their work when the counselor was reminded of their own traumas through hearing about similar traumas from their clients. Burnout includes struggling with a lack of hope and striving to manage workload (Stamm, 2010). Burnout was is the mental impact from continued sources of stress in the work environment (Maslach, 2003; Maslach & Jackson, 1981). Additionally, awareness is growing concerning the need to help the helpers, as Yang and Hayes (2020) pointed to the addition of burnout as a diagnosis in the *International Classification of Diseases*. According to the World Health Organization's (WHO, 2022) *International Statistical Classification of Disease and Related Health Problems*, the updated definition includes the description of burnout as unmanaged symptoms that develop following consistent stress with work. Burnout has three parts—exhaustion, withdrawing emotionally or mentally from the job or feeling pessimistic regarding the job, and perceiving that one's work does not make a difference or lack of attainment (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022). Maslach (2003) described difficulties with studying treatment options for burnout, stating the current solutions involve changing the individual. Examples include behavioral solutions such as leaving a job instead of altering the weight of agency

stressors (Maslach, 2003), which leads to a discussion of CF's impact as perceived by counselors and CPPs and potential coping strategies.

Social

Overall, there is much research on impairment in counselors but limited data regarding impairment in CPPs. Harrington (2013) found that information about CPP's has not been widely researched. Research relating to the impact of burnout and CPPs support needs was also lacking (Savic-Jabrow, 2010). According to Bercier and Maynard (2015), there is little research regarding STS and effective treatment options for mental health workers. Brauner (2015) described drawbacks related to private practice with social workers in that they may lack the needed business knowledge to run a practice and are on call for their practice. Freudenberger (1975) argued the importance of boundaries between work and life, which may include taking vacations. However, CPPs may have difficulty taking vacations if they are on call and may not have a backup counselor on staff or the ability to pay someone to fill in for them.

Brauner (2015) and Harrington (2013) depicted the financial stressors of private practice, ranging from salary inconsistency, payments from insurance companies, and the weight of managing the finances and administration. Another factor is stress that comes from asking for payment from financially strained clients (Moore et al., 2020). Furthermore, both agency counselors and CPPs may experience increased stress and trauma, which may impact their professional quality of life, and specifically their ability to cope effectively during the COVID-19 global pandemic (Litam et al., 2021). Brennan (2013) described the importance of CPPs realizing that they must function as their own supervisors and diligently self-monitor ethics, laws, paperwork requirements, and overall client care. Furthermore, CPPs must understand their

strengths and weaknesses, which can be explored in supportive personal therapy, consultation, or supervision (Brennan, 2013).

Though the need is recognized, some CPPs may not be seeking the help required due to barriers such as difficulty asking for help (Savic-Jabrow, 2010) or isolation (Brauner, 2015; Carney & Jefferson, 2014; McCann & Pearlman, 1990; Salyers et al., 2015; Savic-Jabrow, 2010). There is limited data and conflicting information about the amount of help-seeking CPPs request or require. In terms of perceived stigma, Negash and Sahin (2011) reported counselors are unlikely to request help due to fear of others' perceptions. Mullen and Crowe (2017) found that help-seeking in school counselors was hindered by stigma concerning mental illness. Conversely, help-seeking reduced stress and burnout, whereas burnout and stress reduced life satisfaction (Mullen & Crowe, 2017). Neukrug et al. (2017) evaluated human service professionals and determined barriers to attendance in counseling included the fit or trust with the personal counselor, the stigma of help-seeking, and the value placed on counseling. Of the participants, 28% were practitioners, 66.4% of practitioners had attended counseling, but it is unknown if any were in private practice. Kalkbrenner et al. (2019) inquired into stigma and attendance in personal counseling for counselors and found that 90.3% had attended counseling and 27% were attending at the time of the study. Savic-Jabrow (2010) found that 100% of the private practice respondents sought help from their supervisors, 80% pursued peer support and only 35% used personal counseling.

In terms of coping strategies, Coaston (2017) argued that to thrive in private practice, a counselor needs to use self-care and coping, including managing physical, emotional, and spiritual health along with applying SC. Likewise, SC and mindfulness are protective for counselors (Beaumont et al., 2016; Finlay-Jones et al., 2015) and rehabilitation counselors

(O'Sullivan & Bates, 2014). Skovholt (2012) described steps for coping—managing self-care, boundaries, compassion satisfaction (CS), taking breaks, and vacations. Other authors considered CS a protective factor in building resilience in helpers; however, they did not focus on private practice (Gonzalez et al., 2019; Tabaj et al., 2015). Wallace et al. (2010) did not evaluate CPPs but found that active coping strategies moderated workload stress and burnout in counselors. It was also recognized that elevated wellness protects against burnout (Lawson & Myers, 2011) and VT (Foreman, 2018) in both agency counselors and CPPs.

Savic-Jabrow (2010) discussed other strategies to create boundaries around time, which can be helpful to the private practitioner as well as self-care, including spiritual involvement, relaxation, exercise, and further training. For Hardiman and Simmonds' (2013) sample of 89 counselors (70 CPPs), existential well-being was related to reduced emotional depletion, less dissociation, and increased self-esteem. Brennan (2013) and Brauner (2015) highlighted the positive aspects of private practice, such as making one's schedule, which may reduce stress. Harrington (2013) described some freedom regarding income and whether to offer a sliding scale, time to attend training, choice of work location, and determining when to accept new referrals. Increased understanding is needed regarding the experience of CF and CPPs and understanding their help-seeking and coping behaviors.

Theoretical

Philosophies of change, transition, and developmental theories have evolved over time. Anderson et al. (2011) examined three types of developmental theories—facing and resolving crises, change over the lifespan, and identity-related changes over time. They reviewed contextual theories concerning environmental factors, work, family, socioeconomic status, age, goals, and other factors.. In the constructivist approach, people build their views based on their

experiences, perspectives, and personal meaning rather than an observable, objective reality (White, 1996). A third view involved a study into the lifespan and how adapting to change occurred based on variations in context and leading to different routes in life (Anderson et al., 2011). The fourth viewpoint was the theory of transitions and addressing the constancy of change and the process for adapting to this change (Anderson et al., 2011; Schlossberg, 1981). The application of Schlossberg's (1976) transition model is described below.

Schlossberg's (1976) transition model started as a rudimentary understanding of adults and the impact of change and transformation and a focus on giving clients back some control and assisting with decision-making. The theory grew as a deeper understanding of the individuals' place in time while experiencing the transition (Schlossberg, 1981). Schlossberg (1981) described the transition model as expected transitions can be prepared for and unexpected occurrences cannot (Anderson et al., 2011). The transition model was further developed into three parts: approaching transition; taking stock of coping resources with the four S system of assessing situation, self, supports, and strategies; and taking charge (Anderson et al., 2011, 2021).

In a qualitative study, Ensher et al. (2017) identified the impact of transitions with career change. The 18 participants had 97 career-defining moments, with 69 unexpected and only 18 expected. These career-defining moments consisted of expected and unexpected occurrences, personal wisdom gained, the value of relationships, and wisdom gained from spirituality. Six participants reported struggling with work versus a personal life issue, and three experienced burnout. Eight received guidance from a role model, eight from a mentor, others from a family member or third party, and eight from their higher power. Hudson (1991) analogized these transitions to river rafting with unpredictable waters and the excitement involved in describing

transition theory. This analogy is reminiscent of the transactional theory of stress and coping, which was described as understanding the potential harm or loss, threat, and challenge associated with stressors (Lazarus & Folkman, 1984). Anderson et al. (2011) also referred to the transactional theory of stress and coping and the cognitive appraisal of coping with a stressor by altering the environment or reducing the associated anguish (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) constructed the transactional theory of stress and coping to describe stress as involving a threat, harm, loss, or challenge and stated that personal interpretations or the primary appraisal might mediate responses. The secondary appraisal consisted of the steps needed to respond to the event, including coping responses. Further development of this theory included the expansion of the concept of coping as including both positive and negative emotions and acknowledging that there may also be meaning-focused coping that results from the reappraisal of ineffective coping in terms of hardship (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). Thompson et al. (2014) used this theory to evaluate counselor stress and coping, with 32% of the 213 counselors were in private practice. Viewed their work environment as positive this reduced CF and burnout for CPPs. Thompson et al. did not report if the number of work hours was associated with CF or burnout, but maladaptive coping and perceptions of their work conditions did predict CF. Mindfulness and CS were negatively associated with burnout, and mindfulness was negatively associated with CF.. Thompson et al. found that viewing work conditions more positively was associated with less impairment. Also, emotion-focused coping, in which religious support was part of the measurement, was associated with less burnout. Negative coping strategies and views concerning the working environment were associated with CF, but Thompson et al. did not compare differences between CPPs and agency counselors.

Moore et al. (2020) conducted a qualitative study on understanding agency counselors and CPP stressors by applying the transactional theory of stress and coping (Lazarus & Folkman, 1984) to interpret counselor stress responses. They found that client characteristics, relationship dynamics, counselor response, and personal versus professional self were present. Regarding client characteristics, unpredictable behaviors, aggressive behaviors, manipulation, boundary violations, and resistance to change were part of counselor stress. Regarding relationship dynamics, countertransference (CT) and reminders of past events, perceived mismatch of counselor–client, intensity of the counseling work, outside forces such as the perceived ability to pay for services, parent or guardian interference, stage of the relationship, and tension were stressful. Concerning counselor response or perception of the client, decision-making and responses, counselor emotional reactions, questioning ability, and coping in and out of the session were part of their stress reactions. Finally, the personal versus professional self coincided with the transactional theory of stress and coping reappraisal process and interpreted meaning with client and counselor interactions. Counselors reported struggling with managing their own needs, personal safety challenges, and responsibility toward clients as they struggled with destructive choices (Moore et al., 2020). In considering the transitions, strengths, and struggles of CPPs, the background and involvement of the researcher in the study are described below.

Situation to Self

I discuss my personal, professional, and philosophical background and how this study relates to me and vice versa. Smith and Nizza (2022) described interpretative phenomenological analysis (IPA) researchers as insiders who may share in the phenomenon they are investigating. I am part of several Facebook groups that support agency counselors and CPPs and some exclusively serve part-time or full-time CPPs who are building private practices and trying to

navigate the stressors in private practice. Concerning my own coping and emotion management, I have had to monitor and seek help with CF, including burnout and STS. I often seek strategies and guidance to help me stay in the counseling field and improve as a counselor. I continue to add boundaries to increase my counseling effectiveness, to connect with other counselors and network, and find out what others are doing to make private practices more sustainable.

As stated, I have participated in personal counseling and sought assistance from consultants to help me with cases and to learn new treatment modalities, which have helped me maintain interest and grow my business. I have seen significant improvement in my work with clients as a result. For instance, a few years ago, I learned how to provide eye movement desensitization and reprocessing, which has helped me grow as a counselor and increased my counseling effectiveness. I also cofounded a local Facebook group for counselors to help combat isolation and build networking opportunities. Through this study, I hope that by understanding CPP experiences of CF and help-seeking and coping behaviors, I can add to the body of knowledge to increase counselor employment longevity and prevent CF.

My personal and professional experiences and the meaning derived from those experiences, paired with my philosophy, guided this study. I approached this research with an ontological philosophy, acknowledging multiple sides to an issue and numerous realities (Creswell & Poth, 2018). The paradigm of social constructivism, which holds people search for comprehension and meaning in their world and are grounded in their experience and the meaning in their lived experiences, guided this study (Creswell & Poth, 2018). I am interested in better understanding the unique experiences of CPPs who have faced the problem of CF and coped through it as well as the meaning they found in their help-seeking behaviors.

Problem Statement

The problem is that CPPs who are stressed from their work (Brauner, 2015) may experience CF (Thompson et al., 2014). Counselors who are not using coping effectively may be at greater risk for experiencing STS (Litam et al., 2021). There may be moderate levels of burnout in the counselor population (Acker, 2012; O'Connor et al., 2018). CPPs may experience stress from CT (Moore et al., 2020) and the strain of managing the many moving parts of private practice (Brauner, 2015; Harrington, 2013). CPPs may also tend to isolate (Brauner, 2015; Carney & Jefferson, 2014) and may encounter barriers with help-seeking (Kalkbrenner et al., 2019; Mullen & Crowe, 2017; Neukrug et al., 2017), which can increase the risk of errors such as ineffective treatments, errors in clinical decisions, and poorer client outcomes (Brennan, 2013; Carney & Jefferson, 2014; Salyers et al., 2015).

Few studies have explored the struggles with a focus on CPPs (Harrington, 2013) or their strategies for managing burnout (Savic-Jabrow, 2010). Explorations of CPPs experiences with CF and coping often occur through discussing or analyzing struggles and proposed strategies, such as Brennan (2013), Brauner (2015), Carney and Jefferson (2014), or Harrington (2013). This focus suggests a gap in the literature concerning CPPs and CF experiences, help-seeking behaviors, and coping strategies. Further study concerning the experience of CF could help identify CPPs' help-seeking and coping behaviors, which could contribute to the knowledge base to help future CPPs remain in the field.

Purpose Statement

The purpose of this phenomenological study was to understand the meaning CPPs found in experiences of CF, and their help-seeking and coping behaviors. CF is composed of burnout and STS (Stamm, 2010). Burnout is defined as having negative feelings and hopelessness about

one's work (Stamm, 2010) with exhaustion, withdrawing emotionally, and feeling like one's work does not matter (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022). STS was defined as secondary exposure to traumas through working with clients and subsequent symptoms, including intrusive symptoms, sleep problems, and avoidance of similar triggers (Figley, 1995; Stamm, 2010). Help-seeking behaviors include reaching out for help from others, such as seeking personal counseling (Kalkbrenner et al., 2019; Savic-Jabrow, 2010). Counselor coping behaviors can consist of multiple strategies, such as self-care and wellness, boundaries, and vacations (Skovholt, 2012). The theories that guided this study were Schlossberg's transition model to understand the transition of CF and Lazarus and Folkman's (1984) transactional theory of stress and coping to understand counselor stress from CF. Both theories address using resources through help-seeking behaviors and coping with the stress from transitions. Both approaches also include reappraising resources as needed. This information was significant as there is a need for counselors to remain in the counseling field. The particulars concerning the significance of the study will be explained in the next section.

Significance of the Study

The significance of the study is that additional knowledge concerning CF and the help-seeking and coping behaviors of CPPs may be valuable to current and future CPPs to build further understanding of the prevention and management of CF. The findings included the lived experiences of participants and how they approached stressors and transitions of CF in terms of a threat, harm or loss, or challenge and coping responses. Lived experiences included environmental and work-related tensions (Brauner, 2015; O'Sullivan & Bates, 2014; Thompson et al., 2014) and financial stressors (Brauner, 2015; Harrington, 2013). The struggles of managing CT have been documented, including understanding the challenges with boundaries

and the negative impact on the helper (Moore et al., 2020), experiencing isolation and withdrawal as well as help-seeking and coping (Brauner, 2015; Salyers et al., 2015). Other struggles include identifying barriers to and support for help-seeking (Kalkbrenner et al., 2019), barriers to coping (Barton, 2020; Freudenberger, 1975; Moore et al., 2020; Tabaj et al., 2015), and coping strategies (Coaston, 2017; Freudenberger, 1975; O'Connor et al., 2018; O'Sullivan & Bates, 2014; Patsiopoulos & Buchanan, 2011; Savic-Jabrow, 2010; Skovholt, 2012; Thompson et al., 2014). Managing stressors, transitions, seeking help, and coping may also help other CPPs find meaning in this process. In conclusion, this dissertation could add to the knowledge base concerning how to help CPPs stay in the field and help them flourish personally and professionally. The problem, purpose and significance of this study are condensed into the research questions.

Research Questions

This phenomenological research study sought to answer one OARQ and two SQs:

OARQ: What are counselors in private practice's experiences of compassion fatigue?

Qualitative research concerning counselor experiences of CF met Smith et al.'s (2009) requirements for IPA in that CPPs meaning and experience was recorded and interpreted. This research question was targeted to gather the overall experiences CPPs have with CF. Schlossberg's (1981) transition model and Lazarus and Folkman's (1984) transactional theory of stress and coping were applied when considering CPPs' experiences of CF transitions and stress and the meaning of those experiences.

SQ1: What are counselors in private practice's experiences of their help-seeking behaviors?

This question explored the meaning of CPPs lived experiences in terms of help-seeking by acknowledging that the participants were the experts on the phenomenon (Smith & Nizza, 2022). This experiential expertise relates to the updated transactional theory of stress and coping includes meaning-focused coping involved with stress (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). This question also explored stigma attached to help-seeking for CPPs (Carney & Jefferson, 2014; Malikiosi-Loizos, 2013; Neukrug et al., 2017).

SQ2: How do counselors in private practice make sense of coping with compassion fatigue?

This question also met IPA requirements of interest in identifying lived experiences (Smith et al., 2009; Smith & Nizza, 2022). Schlossberg's (1981) transition model and Lazarus and Folkman's (1984) transactional theory of stress and coping address coping strategies and reappraising of coping strategies. This question also explored meaning-focused coping with stress (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). Therapists who counsel while impaired could pose harm to clients (Brennan, 2013), including ethical risks (ACA, 2014; Brauner, 2015; Brennan, 2013). However, self-monitoring may assist CPPs in managing these risks (Brennan, 2013).

Definitions

1. *Burnout*—Stamm (2010) defined burnout as involving hopelessness and feeling ineffective in one's work. Burnout has three parts: exhaustion, withdrawing emotionally or mentally from the job, feeling pessimistic regarding the job, perceiving that one's work does not make a difference, and lack of attainment (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022).

2. *Compassion fatigue*—Stebnicki (2017) described CF as empathy fatigue that negatively impacting the mind, body and spiritual self. CF has two parts: burnout and STS (Stamm, 2010). Burnout includes the hopelessness, exhaustion, and lack of effectiveness in one's work (Maslach, 2003; Maslach & Jackson, 1981; Stamm, 2010; WHO, 2022). STS is secondary exposure to traumatic experiences (Stamm, 2010).
3. *Compassion satisfaction*—Stamm (2010) defined CS as positive emotional benefits from performing one's work well.
4. *Countertransference*—Yalom and Leszcz (2005) defined CT as the responses a therapist has to their clients, including objective CT, which is about helping the client, and subjective CT, which is about the therapist
5. Secondary traumatic stress—STS was defined as secondary exposure to the practitioner in terms of working with people who have been through stressful and traumatic experiences (Figley, 1995; Stamm, 2010).
6. Self-compassion—According to Neff (2003), SC is defined as self-kindness, common humanity, and mindfulness.
7. Vicarious trauma—McCann and Pearlman (1990) described VT as the depth of impact of the client's experiences on the therapist as well as altering their mood and view of the world. The more the counselors are exposed to trauma, the greater their risk of developing VT (McCann & Pearlman, 1990).

Summary

This chapter underscores the problem that CF may be difficult to manage for CPPs. Few studies have provided ideas for supporting CPPs (Savic-Jabrow, 2010). CPPs may be isolated (Brauner, 2015; Savic-Jabrow, 2010) and under stress (Brauner, 2015; Thompson et al., 2014).

They may experience difficulty setting or managing boundaries (Freudenberger, 1975; McCann & Pearlman, 1990; Moore et al., 2020). It is unknown how many are attending counseling to help with risk, but it may range from 35% (Savic-Jabrow, 2010) to 66.4% (Kalkbrenner et al., 2019). Acker (2012) reported that 56% of the sample experienced moderate to high emotional exhaustion, and 50% considered leaving their positions. There is a high demand for counselors (U.S. Bureau of Labor Statistics, 2021), and every effort should be made to maintain and add new counselors. The purpose of this study was to understand CPP's unique experiences of CF, including their help-seeking and coping strategies.

Chapter Two: Literature Review

The purpose of the study was to build further understanding concerning CPPs' experiences of CF and the meaning found in help-seeking and coping behaviors. Chapter 2 is divided into three sections: the theoretical framework, related literature, and summary. First, it explores CF through the lens of the transition model and the transactional theory of stress and coping. Next, it reviews the existing literature synthesizing concepts addressing the transitions, stress, impairment, coping strategies, and help-seeking behaviors of counselors (Foreman, 2018; Gonzalez et al., 2019; Lawson & Myers, 2011; Skovholt, 2012). The chapter illuminates the gap in the literature relative to the study and concludes with a summary of the literature.

Theoretical Framework

The theoretical framework that guided this study consisted of concepts from Schlossberg's (1981) transition model and Lazarus and Folkman's (1984) transactional theory of stress and coping. As revealed in the literature review section, some transitions in the lives of counselors can produce stress. The transition model describes the effects of transitions on counselors and how they can be managed through coping and reassessing resources (Schlossberg, 1981). The transactional theory of stress and coping steered the study's exploration of counselors' experiences and coping with the stressors from CF (Lazarus & Folkman, 1984).

Transition Model

In this section, the theory is reviewed, changes and updates to the theory, and studies that support its use as well as criticisms, and its application to CPPs. Schlossberg expanded the transition model and associated concepts over time. Schlossberg's (1976) earlier writings supported helping people who were facing role transformations and changes in adulthood. The first task for counselors is to help give clients back a sense of control through psychoeducation

concerning the decision-making model (Tiedeman & O'Hara, 1963). Based on this model, there are two steps in the decision-making process: anticipation and implementation. Anticipation involves exploring options, and implementation involves the process of change (Tiedeman & O'Hara, 1963). Schlossberg also considered the importance of counselors supporting clients who run into barriers by stating a counselor has three functions: counseling clients, building programs that expand constituency, and encouraging change through social action. The second task for a counselor is to obtain insight into the stages of adult development. Going through a crisis of role transformation, such as with career, intimacy, family life, community, and inner life, may involve existential awareness. People undergoing this process might find comfort in knowing that others share similar life experiences. Wisdom gained from understanding adult transitions can aid a counselor in attending to clients with a "third ear" or better understanding (Schlossberg, 1976, p. 35). The third task in understanding adult transformations is preventing age bias and helping clients through this existential process while working through their own existential feelings (Schlossberg, 1976).

Schlossberg (1981) elaborated on the theory and described an increased interest in understanding adult development because people constantly change and grow throughout their lives. These changes can lead to new social connections, alterations in behaviors, and new self-understanding. Schlossberg initially theorized individual differences with response to change; one person may thrive with a new experience, whereas another may be halted emotionally or physically. Schlossberg indicated that studying a person's unique characteristics and external influences and happenings are part of the study of transitions. A transition itself is not necessarily the focus; rather, the focus is the person's place in time and unique characteristics. The types of transitions are anticipated, unanticipated, chronic hassles, or nonevent (Schlossberg, 1984).

Anticipated transitions are events that are part of the life cycle, such as getting married or starting a career. Unanticipated transitions and unexpected happenings such as crises and chronic hassles include mismatched temperaments at work, home maintenance, and other mild, consistent difficulties. Nonevents include events that the client hoped would happen but did not occur, such as not having a child. The theory initially consisted of three factors that impact adaptation to a transition: transition characteristics, the pre- and post-environmental characteristics, and the individual's characteristics. These three factors then influence the result that an individual either adapted to or failed to adapt to (Schlossberg, 1981).

As stated, the transition model was originally developed with counselors and other helpers in mind and in terms of their support of clients (Anderson et al., 2011). The theory was later explained as involving three parts: approaching transitions, taking stock of coping resources, and taking charge (Anderson et al., 2011, 2021). Approaching transitions consists of transition identification, which assesses the type of transition, such as an event or an event that failed to occur, and the level of preparedness and the impact on a client's life. The second part of approaching transitions was the transition process and involves looking at where a client is on the continuum of the transition process, whether in the beginning, middle, or end. Taking stock of coping resources includes potential assets and liabilities of the four S system, such as the individual's unique situation, self, support, and strategies that contribute to the variety of coping. The third part is taking charge, which consists of strengthening resources and adding tools and techniques to manage a transition (Anderson et al., 2011, 2021). A transition period can bring bewilderment that signals awareness that something is wrong. When a person in transition can look at all angles of it and discover that they had options, they are more likely to cope and work it out (Anderson et al., 2011). Brach (2003) pointed to a coping strategy for the anxiety and stress

from perfectionism, including acceptance-based thinking. Radical acceptance is not based on avoidance, resignation, or passivity but on actively working toward the acceptance of imperfection (Brach, 2003). Through describing transitions and the impact on an individual, Anderson et al. (2011) also pointed to the growth that can occur through the process of loss and coping according to the writings of Miller and Harvey (2001).

Concerning defining a transition and identifying types of transitions, the expected or anticipated events and transitions may be somewhat easier to plan for because a person has a chance to mentally prepare (Anderson et al., 2011). However, unanticipated transitions such as crises or losses, natural disasters and the like, may be more difficult to prepare for because of a lack of notice (Anderson et al., 2011). It could be that CPPs who hear about traumas and unexpected events may experience their own symptoms because they begin to see the world as an unfriendly or unsafe place. Van Der Noot Lipsky and Burk (2009) noted how feeling helpless and hopeless can be a symptom that helpers experience in feeling like they cannot be effective, and according to Knight (2013), they may start to see the world as unsafe.

I have not located any articles documenting CF and Schlossberg's (1981) transition model in terms of counselors or CPPs. However, Barclay (2015) discussed applying the transition model to career transitions. Studies were also conducted with medical doctors (Browne et al., 2018) and leaders in various fields, such as higher education, medicine, banking, law, and service industries (Ensher et al., 2017). Hopson (1981) and Musamali (2018) offered concerns and criticisms of the transition model.

Barclay (2015) considered the process of applying Schlossberg's (1981) transition model in career transitions. In applying the four Ss to career transitions, regarding the situation the counselor would help the client explore the transition, the stress, and the meaning found while

assisting them in identifying and connecting with resources. In considering the self, the counselor could help the client explore interests with interest inventories and values exploration activities. Regarding support, the counselor would assist with helping the client identify their life and career roles and social support. Last, in terms of strategies, the counselor would assist the client in identifying their current coping abilities and additional coping (Barclay, 2015). In considering CPPs going through transitions with their employment, this information could be helpful to the counselor seeking personal counseling and the counselor assisting them.

Browne et al. (2018) conducted research into the career transitions of medical doctors into educators. They applied Schlossberg's transition model and evaluated the data from three focus groups studying doctors who transitioned from medical practice to teaching. They identified four themes in the Schlossberg model—self, situation, support, and strategies. Concerning the self, the doctors' values aligned with their work as a medical educators, which helped with the transition. For their situation, their sense of control over their next steps was a strong contributor. All participants confirmed that they relied on resources such as mentors and networks to help with the career change. Finally, the participants also identified multiple strategies, such as learning more, requesting help, and networking (Browne et al., 2018).

Ensher et al. (2017) conducted semistructured interviews with leaders in higher education, medicine, law, retail, cosmetics, banking, and the automotive industry. They used a thematic analysis with the interviews to identify different transitions ,and then to capture more information they used a grounded approach to identify themes. They recognized five themes in terms of career-defining moments: anticipated transition events, unanticipated events, insight experience, relationship experience and spiritual experience. External events ranged from positive, such as an opportunity to be on a board, to negative, such as a loss of a loved one.

Furthermore, some events had both positive and negative aspects. Another theme involved internal insights, such as when they recognized a critical time in their career. Meaningful relationships could involve a connection with a loved one, a mentor, a role model, or a supervisor. Moreover, the theme of spirituality, including an encounter with the divine, was an unexpected part of career-defining moments. Conclusions were drawn that providing support concerning career-defining moments can be helpful because this was a common experience. They also connected prior literature that proposed that help from mentors and supervisors can help with coping (Ensher & Murphy, 2005; Thomas, 2008). The above studies can be tied to the current research in that CPPs experience of CF is a form of a career transition and could prove helpful in supporting CPPs.

However, there have also been criticisms of the transition model. Hopson (1981) criticized Schlossberg's use of the word "adaptation" and suggested using "responses to transitions" instead as it opens the possibilities of different reactions, both positive and negative (p. 37). Other critiques include adding "predictable-unpredictable" to the transition variables (Hopson, 1981, p. 37). However, in reiterating questions on how to help adults in transition Schlossberg (1981) stated that responses and adaptations to transitions varied widely and asked how counselors can help adults encountering "inevitable but nonpredictable transitions of life." (p. 3). However, the later version of the theory included anticipated and unanticipated transitions (Anderson et al., 2011, 2021; Schlossberg, 1984). Musamali (2018) compared Schlossberg's transition model, which only focused on adults in transition, with Bridges (2003) model, which focused on both organizations and individuals. Another critique involves limitations in addressing particular interventions for struggling through transitions (Hopson, 1981; Musamali, 2018). In considering the strengths and limitations of Schlossberg's transition model, an

additional theory is also referenced in this study, the transactional theory of stress and coping by Lazarus and Folkman (1984), which further addresses stress and coping.

Transactional Theory of Stress and Coping

In this section, the theory is reviewed along with additional revisions, support for using this theory with CPPs, and criticisms of the theory. Lazarus and Folkman's (1984) transactional theory of stress and coping proposed the terms *stress* and *anxiety* represented similar concepts, and stress can be viewed as measuring various parts of the situation and person. There are variations in how each person responds to stress, and one's thoughts and interpretations may mediate their responses. The primary appraisal involves assessing the stressor and subsequent impact, and the secondary appraisal concerns the person's response to the stressor (Lazarus & Folkman, 1984).

In considering the primary appraisal, the perception of the event and the individuals' surroundings was key to how a person interpreted a situation as either inconsequential, neutral leaning positive, or stressful (Biggs et al., 2017; Lazarus & Folkman, 1984). Stress was then broken down into three parts: harm or loss, threat, and challenge. Harm or loss was defined as something that has already happened, such as trauma (Lazarus & Folkman, 1984). The second stress response—threat—is the potentiality of trauma reoccurring. The final stress response was the potential for viewing it as a challenge, which involves positive emotions such as excitement for potential growth. Although these responses occur independently of one another, Lazarus and Folkman (1984) also stated that two reactions could coincide, such as a threat and a challenge like a promotion. The transactions between the person and the environment were bidirectional; interactions between the individual and the environment may produce stress (Biggs et al., 2017; Lazarus & Folkman, 1984).

The thinking processes with coping, for this primary appraisal, can change how the person views a stressor, such as thinking negatively and more myopically versus thinking more positively and seeing their options (Lazarus & Folkman, 1984). Through this process, demands from the stressor and resources can be identified (Biggs et al., 2017; Lazarus & Folkman, 1984). Lazarus and Folkman (1984) purported that with a transaction, an individual brings their unique viewpoints, which preps the encounter with emotion to certain trigger points. They defined these as "personal values, goals, and commitments, as well as beliefs about oneself and the world," which determine the level of connection to the incident and one's subsequent emotional responses (p. 272). The person's interpretation of the occurrence is part of whether they experience emotional reactions. An individual's thoughts about their present as well as their past and future impacts their emotional response (Lazarus & Folkman, 1984).

The secondary appraisal concerns the steps the individual should or could take and the interpretation as to whether there is a threat to their welfare (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) pointed to attribution theory originated by Heider (1958) as involving the examination of causality such as attributing success to external factors such as luck and internal factors, such as talent. However, in the secondary cognitive appraisal, a person would take this a step further by examining the meaning of the attribution and impact to the individual's well-being, the coping strategies available to the person, and the ability of those resources to manage the situation (Lazarus & Folkman, 1984). Coping was described as dynamic cognitive and behavioral responses to environmental or internal pressures that are appraised as being beyond their current resources. Coping is constructed with numerous appraisals and reappraisals. Emotion-focused coping is depicted as strategies used to reduce emotional distress, such as avoiding and blocking, focusing on certain aspects of the situation, reframing, and finding the

positives (Lazarus & Folkman, 1984). Problem-focused coping was defined as problem-solving, finding more information about the situation, looking at alternatives, the cost versus benefits, selecting a decision, and then acting on the decision (Lazarus & Folkman, 1984). Next, the selected coping method yields a result that is then reappraised as having worked or found ineffective, and ineffective coping is reevaluated (Biggs et al., 2017; Lazarus & Folkman, 1984). Biggs et al. (2017) pointed to the fluidity of this process in that the primary and secondary appraisals are connected and may occur together. Further, the process of managing stress involves trying to return to homeostasis after encountering a stressor (Biggs et al., 2017; Lazarus & Folkman, 1984).

There has been some revision of the theory. Biggs et al. (2017) pointed out that Lazarus and Folkman (1984) initially described coping as reducing emotional distress from negative transactions. Later research indicated the presence of both positive and negative emotions in this process (Folkman, 1997; Folkman & Moskowitz, 2004). The theory was then revised to include a caveat explaining that coping that proves ineffective with resulting hardship that can lead to meaning-focused coping (Biggs et al., 2017; Folkman, 1997, 2008; Folkman & Moskowitz, 2004). Meaning-focused coping can lead to constructing positive emotions and evaluating those appraisals, which then are applied to the response by building further coping, and motivation toward problem-focused coping (Folkman, 2008). Meaning-focused coping was further described as connecting with appraisal-based coping, wherein an individual uses their beliefs, values, and existential goals to build and maintain coping and well-being during a stressor (Folkman, 2008; Park & Folkman, 1997). Five types of meaning-focused coping were identified, including seeing the positives, reminding self of the positives, making a plan and problem-solving, self-reflection to see a different perspective, and searching for the positives (Folkman,

2008; Folkman & Moskowitz, 2007). Benefit finding includes purposeful cognition in remembrance of the positives of the stressor (Folkman, 2008; Folkman & Moskowitz, 2007; Tennen & Affleck, 2002). Adaptive goal processes could include simple goals established for the day or goals that involve one's purpose (Folkman, 2008; Folkman & Moskowitz, 2007; Park & Folkman, 1997). There may also be a reordering of priorities as a result of the meaningful reflection (Folkman, 2008; Folkman & Moskowitz, 2007), and persons may infuse ordinary events with a positive meaning, such as with a word of kindness or watching a sunset (Folkman, 2008; Folkman & Moskowitz, 2007; Folkman et al., 1997).

Studies have been conducted that support using this theory to understand counselor stress (Folkman, 1997; Moore et al., 2020; Thompson et al., 2014). The theory has also been criticized (Folkman & Moskowitz, 2004; Hobfoll, 1989). In consideration of using supportive resources, coping was studied longitudinally in caregiving partners of men with acquired immunodeficiency syndrome (Folkman, 1997). Meaning-focused coping was used, including a positive reappraisal and search for meaning, revised goals, and application of spiritual beliefs (Folkman, 1997). Furthermore, Moore et al. (2020) applied consensual qualitative research to investigate the stress experienced by counselors in applying the transactional theory of stress and coping. They acknowledged that the most common forms of work stress for counselors were counselor burnout, CF, and STS. Five of the 13 participants were in private practice, and the remainder worked in other settings. They defined stress for the study as the emotional stress rooted in the problematic aspects of counseling clients. Of the participants, 10 reported they sometimes experienced stress; one stated they experienced stress often, and another said they experienced it very often. Counselors identified points of stress, including aggressive behaviors from clients, high-risk clients, boundary problems, decision-making, considering responses to

clients and interpretations of clients, and counselor trauma responses and CT. Many counselors also used coping strategies and help-seeking behaviors to manage the stressors. The personal versus professional self represented the struggle with maintaining the personal and professional parts in reaction to reviewing the stressors and their responses (Moore et al., 2020). In terms of considering this personal versus professional self, this aligned with the reappraisal process in terms of analyzing the meaning of the communications with challenging clinical situations (Lazarus & Folkman, 1984; Moore et al., 2020).

Thompson et al. (2014) also applied Lazarus and Folkman's (1984) transactional theory of stress and coping in their study of mental health counselors' experiences with stress and coping. Of the 213 counselors, 32% were in private practice, 41% reported working 36–40 hours per week, 12% worked 20–25% per week, 9% worked 26–30 hours, 9% worked 31–35 hours (Thompson et al., 2014). Furthermore, 29% of the participants reported working 41 or more hours per week. The participants experienced impairment such as burnout and CF when their coping ability was overwhelmed. Increased time and experience as a counselor were associated with reduced CF and burnout. Maladaptive coping was associated with increased burnout. Mindfulness, emotion-focused coping, and CS were related to reduced burnout. Thompson et al. suggested that counselors who did not have enough support would need to increase support by enhancing their coping strategies. Further, counselors' work environment and viewpoints regarding their coping strategies impacted their level of impairment. They concluded if counselors viewed their work conditions as positive, they experienced less CF and burnout. Thompson et al. suggested further study to explore how counselors respond to stressors and determine if they are using adaptive or maladaptive coping. Some of the studies in support of

using this theory in understanding counselor stress have been addressed and the criticisms of the theory in general are discussed next.

There have been critiques of the transactional theory of stress and coping concerning the use of some forms of emotion-focused coping, such as escape avoidance however, the author noted that distancing might be helpful in some situations (Folkman & Moskowitz, 2004). Furthermore, Hobfoll (1989) criticized various stress theories, including the transactional theory of stress and coping and described this theory as one of the models where stress occurs based on perceived demands and resources, not on objective demands and resources. According to Hobfoll, balance models are lacking compared to stimulus-based models. Hobfoll explained that a balance model is redundant and circular in that demand is balanced by coping ability. Another critique was that the demand and resource response was observed after it occurred, and it would be difficult to predict whether the resource could be used again. Also, by ignoring objective demands, Hobfoll emphasized that it is difficult to quantify a demand as some people respond so well to demands they do not notice, whereas others respond in the opposite. It is also difficult to measure with stress balance models because one would need to compare the number of coping resources versus demands (Hobfoll, 1989).

Taken together, understanding stress and coping were addressed and supported by some articles (Folkman, 1997; Moore et al., 2020; Thompson et al., 2014) and mildly criticized by others (Folkman & Moskowitz, 2004; Hobfoll, 1989). The transactional theory of stress and coping (Lazarus & Folkman, 1984) and the transition model (Anderson et al., 2011; Schlossberg, 1981) are discussed in the following sections. Combining these theories' strengths helped guide this dissertation in building an understanding of CPPs experiences of CF and the meaning behind their help-seeking behaviors and coping strategies.

Related Literature

A synthesis of the literature is included in the following sections through review of studies concerning counselors' experience of CF and the meaning found in help-seeking behaviors and coping strategies. According to Stamm (2010), CF involves burnout and STS. Burnout symptoms include exhaustion, emotional withdrawal, and feeling like one's work has little impact (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022). STS was characterized as secondary exposure to traumas through working with clients and the experience of symptoms such as intrusive symptoms, sleep problems, and avoidance (Figley, 1995; Stamm, 2010). Stressors in a counselor's work environment can contribute to the experience of CF (Thompson et al., 2014) while mitigated by coping strategies (Wallace et al., 2010). Experiencing CF without applying successful coping could pose an ethical risk to working with clients (Brennan, 2013) and could lead to risk for errors such as ineffective treatment, errors in decision-making and discerning ethics, and poorer client outcomes (Brennan, 2013; Carney & Jefferson, 2014; Salyers et al., 2015). The following sections apply Schlossberg's transition model to the study of CF in CPPs through seeking to understand their various transitions while also applying Lazarus and Folkman's transactional theory of stress and coping. A description of CPP stressors, impairment, and ethical implications follows. Both theories point to coping strategies or resources and were used in terms of considering CPP help-seeking and coping strategies in subsequent sections.

Counselor Transitions

Approaching transitions involves determining the type of transition and impact as well as where the individual is at concerning the process of the transition (Anderson et al., 2011; Schlossberg, 1981). Furthermore, Lazarus and Folkman (1984) described the transactional theory

of stress and coping with stress involving three types: harm or loss, threat, and challenge. There is a description of counselor transitions and an attempt to differentiate their different forms. The first topic encompasses counselor experiences of CT (Apostolopoulou, 2013; Connery & Murdock, 2019; Lu et al., 2017; McCann & Pearlman, 1990; Moore et al., 2020; Stebnicki, 2000; Williams et al., 2012). Then comes a discussion of the transition of counselor isolation (Brauner, 2015; Carney & Jefferson, 2014; McCann & Pearlman, 1990; Salyers et al., 2015; Savic-Jabrow, 2010). The transition of the stigma with help-seeking (Carney & Jefferson, 2014; Mullen & Crowe, 2017; Negash & Sahin, 2011) is considered, which may be related to views regarding the level of helpfulness in personal counseling (Kalkbrenner et al., 2019). Finally, transitions in private practice are reviewed (Apostolopoulou, 2013; Darcy & Abed-Faghri, 2013; Reese et al., 2013).

Countertransference

CT was defined as the responses the therapist experiences when working with clients, including objective CT, which is about helping the client, and subjective CT, which is about the therapist (Yalom & Leszcz, 2005). Moreover, having a history of personal trauma may be a risk factor for impairment in counselors. Williams et al. (2012) evaluated community mental health therapists' personal childhood trauma, wellness levels, ability to work with their supervisor, happiness with their work and workload, and VT and then provided training on coping. The results were that counselors who had gone through trauma in their earlier life were more likely to experience VT (Williams et al., 2012). This conclusion aligns with the transactional theory of stress and coping, which defines stress as occurring with harm or loss and a description of the term *threat* as the potential it could happen again (Lazarus & Folkman, 1984).

Moore et al. (2020) conducted a qualitative study on counselor stress and reported that seven counselors identified CT-related stress regarding relationship dynamics. Some recounted that the reminders of unprocessed past events were especially stressful. Eight participants experienced stress from feeling like the client-counselor relationship was not a good fit, and four of these perceived a cultural mismatch. Seven counselors relayed that the intensity in terms of the in-depth work of the counselor-client relationship was stressful. Outside influences such as parents, guardians, and the stress of asking for money from financially strained clients were also perceived as stressful. Also, nine counselors in the study reported that testing of the therapeutic relationship was stressful, especially if rapport was not strong enough. First, and last sessions were also perceived as stressful (Moore et al., 2020).

Connery and Murdock (2019) pointed to Bowen's differentiation of the self (Kerr & Bowen, 1988), which they related to how counselors manage CT. In describing this aspect of the theory, Kerr and Bowen (1988) described during early development a child is entirely dependent on the mother. However, according to family systems theory, every person has an individual life force that drives them to develop unique ideas, feelings, and perspectives over time. Additionally, a togetherness life force draws people to remain connected. The levels of emotional separation managed by people as they separated from their families of origin refer to the differentiation of self (Kerr & Bowen, 1988).

In considering differentiation of self and the counseling field, Connery and Murdock (2019) defined overinvolved feelings as increased closeness, being a client's friend, overhelping, and unneeded self-disclosure. Underinvolved reactions include too much distance, colder behaviors, and not showing interest in the client's stories (Connery & Murdock, 2019). In their study of 262 therapists, 42.7% were licensed at the master's or doctoral level, the rest of the

sample were prelicensed, and there were no indications of whether any participants were self-employed. Connery and Murdock inquired concerning counselors' levels of separateness and boundaries with clients. Randomly assigned therapists were then shown one of two types of videos, one with a hostile client and one with a lower demand or friendly client and CT was measured. They discovered that counselors tended to be overinvolved with the more submissive client. They also found that less differentiation of self was associated with increased overinvolvement and vice versa. In relation to the hostile client, there was an elevation of underinvolved feelings; however, having increased differentiation of self was associated with less under involvement (Connery & Murdock, 2019). There was an interaction in that differentiation of self was associated with overinvolved or underinvolved CT (Connery & Murdock, 2019). However, differentiation of self was not found to be significantly associated with boundary-balanced responses (Connery & Murdock, 2019). Further, counselors in training tended to select the correct responses compared to licensed counselors and suggested continued peer support (Connery & Murdock, 2019).

In the same vein, McCann and Pearlman (1990) and Stebnicki (2000) argued that CT might be related to the development of CF. Lu et al. (2017) evaluated eight students from a doctoral program in counseling regarding their personal experiences with trauma clients and found the students struggled with their own emotions and knowing where to put their own clinical boundaries. Furthermore, considerations and struggles with setting private practice fees may also lead to CT, especially during difficult economic times for both counselor and client (Apostolopoulou, 2013).

Hayes et al. (2011) described that CT was viewed at first as a weakness when discovered by Freud and determined unmentionable, and some still view it as having no benefit. However,

CT can be managed and used as Yalom and Leszcz (2005) highlighted the value of CT as a tool to aid therapy. Regarding CT management, Robbins and Jolkovski (1987) stated that two levels of CT involve feelings and behaviors and indicated that it is acceptable and inevitable that counselors will have feelings; their actions are scrutinized. Yalom and Leszcz suggested attending training and self-reflection to aid in determining the difference between objective CT, which can help the client, and subjective CT, which is about the therapist. Hayes et al. (2011) reviewed 11 studies concerning CT management and deduced that managing CT enhances psychotherapy outcomes.

Pertaining to gaps in the research in understanding CT, Connery and Murdock (2019) and Williams et al. (2012) studied counselors in general, and Lu et al. (2017) provided information concerning counselor students. Moore et al. (2020) included CPPs in the study but did not provide information about the differences between the types of counselors. Apostolopoulou (2013) focused on CPPs in terms of providing information but did not conduct a study. It was also suggested that successful management of CT could be beneficial in therapy (Hayes et al., 2011; Yalom & Leszcz, 2005). Further study into this construct could be helpful with determining how the transition of CT impacts CPPs. Taken together, it is agreed that CT can increase the risk for CF if not managed but if managed could be used a tool in therapy. This suggests that help-seeking behaviors such as peer support, consultation and supervision could aid in the management of CT as opposed to working on CT in isolation.

Counselor Isolation

Schlossberg (1981) described responses to transitions with three factors: transition characteristics, pre- and postenvironmental characteristics, and individual characteristics. These three factors then influence the result that a person can either adapt to or fail to adapt to

(Schlossberg, 1981). In applying this line of thinking, if a CPP fails to ask for help when this is needed, it can lead to failure to adapt, which could lead to more CF and impairment. Isolation is one of the markers of burnout (Freudenberger, 1975; Maslach, 2003; Maslach & Jackson, 1981). Also, McCann and Pearlman (1990) agreed that isolation could be challenging for the mental health professional. Savic-Jabrow (2010) researched the particulars regarding the strengths and the struggles of counselors who work in private practice and noted that isolation was problematic for CPPs. Savic-Jabrow reported they had a meager response rate to the survey (Savic-Jabrow, 2010). Salyers et al. (2015) described reports of isolation in their sample and that 58% of their sample testified that burnout negatively impacted work quality. Brauner (2015) and Carney and Jefferson (2014) also described isolation as problematic for the CPP.

In considering criticism of isolation as a maladaptive coping strategy, Skovholt (2012) suggested that using isolation could be beneficial for recharging, such as taking time to focus on oneself through exercise, recuperating through sleep and relaxation techniques, which may or may not involve others. Other suggestions for managing burnout and using self-care include solitary activities, such as Coaston (2017) discussed many types of self-care, including journaling about feelings, practicing mindfulness, spending time in nature and exercising, and spiritual self-care. Bradley et al. (2013) also described using self-care strategies, some of which involved contemplation and creativity, such as with the scrapbook journaling activity. Moreover, a balanced view may be helpful in considering time in isolation for recharging activities while also involving help-seeking activities with colleagues and mentors.

Regarding gaps in the research, only Savic-Jabrow (2010) concerned CPPs exclusively. The other articles were informational (Brauner, 2015; Carney & Jefferson, 2014) or involved various types of counselors (Salyers et al., 2015), suggesting that further research is needed to

understand isolation and the CPP. Furthermore, Savic-Jabrow (2010) discussed that the isolated private practice therapist might have difficulty asking for help.

The Stigma of Seeking Help

Another transition barrier for CPPs includes the stigma of help-seeking. Mullen and Crowe (2017) surveyed 333 school counselors to understand burnout, perceived stress, satisfaction with life, help-seeking, and stigma in the population. School counselors who had trouble reaching out for assistance tended to have viewpoints that hindered them from asking for help. Sources of support options regarding help-seeking included reaching out to an intimate partner, friend, parent, family member, counselor, helpline, medical doctor, religious support or no one. Stigma was found to be low in their sample, and help-seeking was moderate. Self-stigma of mental diagnoses negatively affected help-seeking; conversely, help-seeking prevented stress and burnout, whereas stress and burnout negatively impacted life satisfaction. This outcome means that higher self-stigma indicated less help-seeking and elevated help-seeking reduced stress and burnout. Elevated stress and burnout showed lower satisfaction with life in school counselors. The most frequently used sources of support were an intimate partner, followed by a mental health professional, then a friend, parents, and a doctor (Mullen & Crowe, 2017).

Carney and Jefferson (2014) described how avoidance of seeking help might lead to clinical errors by CPPs. Negash and Sahin (2011) in looking at marriage and family therapists discussed the development of stress by counselors as associated with working with clients with severe symptoms. They explained that counselors were unlikely to reach out for help because of worry about others' perceptions of their receipt of therapy. Other barriers to attending therapy included the risks of exploring sensitive content in the counselor and financial concerns (Malikiosi-Loizos, 2013).

Neukrug et al. (2017) investigated the participation rate in counseling for persons in human services. Only 28% of their sample identified as practitioners; they were recruited from the National Organization of Human Services, and it is unknown if any were in private practice. Neukrug et al. found that 69.6% of the 355 survey responders had participated in at least one counseling session as a client. They reported that 66.8% of students, 66.4% of practitioners, and 76.9% of instructors had participated in counseling and concluded that there was a high rate of attendance in counseling for human service professionals. Barriers or factors of influence were identified that impacted whether participants attended counseling, such as fit, stigma, and value. Fit concerned the level of comfort one identifies in therapy and their level of trust toward counseling effectiveness. Stigma was defined as a therapist's shame and worries about others' perceptions in their attendance of counseling. Value considered the cost versus the benefits of attending their own counseling (Neukrug et al., 2017).

Kalkbrenner et al. (2019) investigated counselors' views helpfulness of therapy and negative feelings associated with attendance. Out of the 312 participants, 90.3% of their sample participated in their own counseling in the past, and 84.2% were licensed counselors. Counselors' views on the level of helpfulness occurring in therapy impacted their attendance. Kalkbrenner et al. encouraged supervisors, other therapy organizations, and advocates to continue this discussion thus suggesting further research is needed.

Taken together, there was a high rate of attendance in counseling for participants in both studies (Kalkbrenner et al., 2019; Neukrug et al., 2017), indicating that stigma may or may not be a problem for counselors suggesting further study is needed. Neither study provided data on whether participants were in private practice. Malikiosi-Loizos' (2013) sample concerned therapy trainees, and Mullen and Crowe (2017) did not report any information about CPPs.

Negash and Sahin (2011) as well as Carney and Jefferson (2014) provided informational articles. Further study into the experiences of CPPs in terms of the stigma of help-seeking could help determine barriers to help-seeking. Additional transitions that may uniquely impact CPPs are discussed in the next section.

Transitions Into Private Practice

The transition into private practice can be a complicated and risky process from which CPPs may benefit from instruction. The U.S. Small Business Administration (2016) defined a small business as an independent business with less than 500 employees. It was reported that 45.4% of small businesses starting in 2006 survived the first 5 years and 51.4% of those started in 2011 survived 5 years. Also, they reported that about one third remain functional for 10 years (U.S. Small Business Administration, 2016). Reese et al. (2013) stated that counselors might need training to help them transition into private practice. They described that the Council for Accreditation of Counseling and Related Programs (CACREP) standards from 2009 did not require that counseling students be trained in understanding private practice and how to run a business. The CACREP (2016) standards described in the introduction that graduates would be ready to work in various fields, including private practice. Section 5.B.2.a, regarding career counseling, has a learning objective for career counselors preparing to work in the private or public arenas. In Section 5.A.2.m concerning addiction counseling, there is a description of training in "record keeping, third party reimbursement, and other practice and management considerations" (CACREP, 2016, p. 20). Similar phrases are used for clinical mental health counseling in section 5.C.2.m, clinical rehabilitation counseling in section 5.D.2.m and with marriage, couple, and family counseling in section 5.F.2.p (CACREP, 2016). However, there is no other mention of preparation for working in private practice.

Bradley et al. (2013) conducted a study with five participants to understand self-care in counselors and at least one participant was in private practice and reported being ill-prepared for being self-employed and managing self-care. Reese et al. (2013) set out to correct the problem of ill preparation and noted how many counselor training programs provide instruction in running a business is unknown. If 16% of the counseling workforce is in private practice (U.S. Bureau of Labor Statistics, 2021), then as Reese et al. suggested, it would be essential to include business training in counselor education to increase their chances of succeeding. They created a graduate-level elective course in entrepreneurship for master's and doctoral training programs, and they wrote the article to help instruct the replication of this class for other universities. In the course, as Reese et al. recommended assisting students to create a business plan, including a mission statement, identified niche, studying the market for viability, understanding competitors, legal structure, financials, and other important business concepts. They provided the course to university students, and Reese then created qualitative interview questions following the completion of the course. Overall, the students reported benefiting; however, they reported that business concepts were unfamiliar compared to counseling concepts and requested the concepts be broken down further. They also reported anxiety when thinking about facing entrepreneurship in their careers. The experience of students struggling with their thoughts promoted growth and the grade received was less important than the experience. Having guest speakers who worked in private practice or coaching was also beneficial (Reese et al., 2013).

Fee setting and providing a sliding scale is another business consideration of running a private practice. Apostolopoulou (2013) discussed the struggles of CPPs with fee setting during difficult economic times. Influences come from a CPP's theoretical model, potential CT difficulties, transference from the client, and the ethics of the profession. According to

Apostolopoulou, consideration of clients' financial needs in terms of payment for therapy services is suggested. This is confirmed in the American Counseling Association (ACA, 2014) *Code of Ethics,* which suggested under A.10.c adjusting fees or referring clients to more affordable providers. Further, there can also be a disparity between licensure types in terms of payment and inconsistent payments from insurance companies for CPPs (Darcy & Abed-Faghri, 2013).

In terms of understanding the gaps, some gains from working in private practice include that CPPs can manage their own time boundaries (Brauner, 2015; Brennan, 2013). They may experience reduced stress (Brennan, 2013), reduced burnout risk, and an increase in CS (Lawson & Myers, 2011). There can also be financial freedom for CPPs (Brauner, 2015) and freedom to choose according to the management of their practice (Harrington, 2013). However, CPPs may be ill-prepared for managing self-care in private practice (Bradley et al., 2013) and fee setting stressors (Apostolopoulou, 2013), and they would benefit from specific training in running a private practice (Reese et al., 2013). However, few additional articles have studied private practice transitions, and further research would be helpful (Savic-Jabrow, 2010). The transitions in private practice and the weight of these changes and decisions can lead to counselor stress.

Counselor Stress

Counselors face positive and negative effects of transitions. This section describes the literature about counselor stressors. CPPs may experience stress in a variety of areas in their personal and professional lives such as employment-related stress (Brauner, 2015; Tabaj et al., 2015; Thompson et al., 2014), and they may have poor boundaries (Litam et al., 2021; Puig et al., 2012; Sweifach et al., 2013). Employment-related stress can be examined through the viewpoint of the transition model in that the impact of the transitions with employment sparks

the need to respond with coping or reassessing coping and adjusting (Anderson et al., 2011, 2021; Ensher et al., 2017; Schlossberg, 1981). Lazarus and Folkman's (1984) transactional model of stress and coping can also be applied here to determine if the stressor presents harm, threat or challenge and appraise coping and resources.

Employment Related Stress

In this section, literature concerning employment related stress and the impact on CPPs is discussed. In applying Lazarus and Folkman's (1984) transactional theory of stress and coping with 213 mental health counselors (32% CPPs), unhelpful coping, such as substance use and negative self-statements, were associated with burnout (Thompson et al., 2014). Negative coping strategies and perceptions of their work environment were also associated with CF (Thompson et al., 2014). Brauner (2015) described some of the negatives of working in private practice for social workers. Drawbacks to private practice included the need to understand business practices, which is often not part of the curriculum in social work education. Reese et al. (2013) sought to correct this lack of education for counselors. Another disadvantage is being on call for one's practice every day of the week, including holidays, and isolation (Brauner, 2015). Stress comes from not having a consistent and stable flow of income, from problems with payments from insurance companies, (Brauner, 2015), ever-changing delivery of these services by various organizations, and changes in managed care and technological advances (Harrington, 2013). The overall weight of financial decisions and liabilities, overhead costs, and unpredictability with funding are other negatives (Harrington, 2013) related to CPP private practice.

Freudenberger (1975) analyzed employment stress and noted that risk factors for impairment included helpers who overcommit, caseloads with limited successes and varied needs and unreasonable expectations from the supervisors. The nurse or mental health worker may

push themself to their limits or put their needs last, increasing the risk for burnout. This finding contradicts Sinclair et al. (2017), who used a meta-analysis with a primary focus on nurses and stated that limitations exist in symptoms evidenced in one type of health professional are probably not applicable to another type of health professional. This suggests that further research is needed in each unique field, including CPPs, in order to better understand experiences in CF and coping strategies needed.

Research concerning work-related stressors for CPPs is rare. Tabaj et al. (2015) reported that burnout and CF phenomena were associated with a lack of attendance with professionals working with vocational rehabilitation (VR). The sample included 98 participants who were employed by VR in a variety of jobs such as psychologists, doctors and social workers and 20 were rehabilitation counselors. Aspects that increased stress included monotonous work duties, struggling through difficult choices, financial matters, and feeling underrated. Elevated stress was also associated with morale and the employment setting. In another study, burnout was linked to increased caseload size for VR counselors (O'Sullivan & Bates, 2014). When considering persons in small businesses, Schonfeld and Mazzola (2015) found little research concerning stressors and the impact on mental health. Their sample consisted of 54 people in 50 different careers, two of whom were therapists. They found that ambiguity in finances, working many hours, and the pressures of finding health insurance were factors impacting stress. They considered some aspects of Lazarus and Folkman's (1984) theory in terms of coping and noted that problem-focused coping was used more than emotion-focused coping in their sample (Schonfeld & Mazzola, 2015).

Regarding gaps in the research, Thompson et al. (2014) did not report differences between those who work for agencies versus private practice. Schonfeld and Mazzola (2015)

said there were only two therapists in their sample. Tabaj et al. (2015) provided data concerning VR counselors and others employed for VR, including social workers but did not contribute to the knowledge base concerning stressors in private practice. Other articles were informational and provided analysis of the literature, the problem, and suggestions but did provide any additional research concerning employment-related stressors (Brauner, 2015; Freudenberger, 1975; Harrington, 2013). Furthermore, in addition to financial and work-related stressors, boundary problems can negatively impact the CPP.

Poor Boundaries

This section examines literature concerning CPPs' struggles with establishing or maintaining boundaries and the contribution to their stress levels. Boundary violations were identified as a point of stress for agency counselors and CPPs (Moore et al., 2020). Tabaj et al. (2015) confirmed that boundary problems with employment and private life contributed to negative responses. New counselors may also face boundary challenges. For instance, for counselors beginning in the field, balancing education, work, and family life can be difficult for marriage-and-family therapists (Negash & Sahin, 2011). Puig et al. (2012) studied burnout, boundaries with work, self-care and wellness. Their sample included 129 mental health professionals—29.5% mental health counselors, 14.7% psychologists, 8.5% in counselor education, 7% marriage and family counselors, 1.6% social workers, and .8% rehabilitation counselors. Employment types included 42.6% employed in K–12 schools, 23.3% in postsecondary schools, 17.1% in outpatient settings, and only 10.9% worked in private practice. They discovered that job burnout predicted levels of personal wellness in the counselors. Furthermore, exhaustion, which is part of burnout, was negatively related to wellness, such as the creative self, physical self, and coping self. They observed a sort of cycle in which counselors

become too tired to exercise because of exhaustion, which leads to unhealthy decisions and possibly more stress (Puig et al., 2012).

Freudenberger (1975) likewise found that not maintaining boundaries between work increased and private life increased the risk for burnout. Other risk factors included increased control, taking on too much, failing to delegate, and not making time for socialization, recreation, and hobbies. There is also the potential of systemic burnout, where leaders overcommit and then fail to attend, which can impact the whole system. There is also a risk for burnout when professionals, including therapists and doctors, work full days and then volunteer (Freudenberger, 1975).

Furthermore, Anderson et al. (2011) claimed that unexpected transitions, such as natural disasters, can be impactful. Litam et al. (2021) assessed 161 counselors, of whom 52 were in private practice, concerning the impact of the COVID-19 global pandemic on the professional counselor. They found that professional quality of life was significantly predicted by posttraumatic stress, coping responses, resilience, and perceived stress. Counselors were likely experiencing increased stress and trauma symptoms that influenced their professional quality of life during the pandemic (Litam et al., 2021). Sweifach et al. (2013) used a qualitative inquiry with 14 semistructured focus groups concerning social workers from hospitals and agencies and their responses following disasters. They looked at emotional and thought responses and noted a dichotomy in some social workers. For example, they had difficulty with going through the trauma and keeping a professional distance, whereas others experienced few problems with boundaries. They observed other reactions, such as the social worker experiencing emotional difficulties when clients were overly self-focused through the disaster, but then opposite feelings when clients were much more other-focused. Some could block off their emotions whereas

others experienced difficulty. They found three common behavioral reactions; displaying good boundaries between their emotions and their job; experiencing more difficulty with professional responses, and a third group could perform the nuances of their job but intermittently acknowledging their own feelings (Sweifach et al., 2013).

However, some CPPs may maintain good boundaries and experiencing positive effects. Potential positives associated with managing boundaries in private practice include that CPPs have the ability to make their own schedules (Brauner, 2015; Brennan, 2013). CPPs may also experience less stress (Brennan, 2013), reduced burnout risk, and increased CS (Lawson & Myers, 2011). There is a potential for increased income, freedom to offer a sliding scale, and to attend trainings based on their interest (Brauner, 2015). Harrington (2013) discussed additional gains from working in private practice, such as having choices with decisions, work location, choice with theories used, and when to accept new clients.

Concerning gaps in the research, research was conducted where some participants were in private practice, but the researchers did not report differences between the groups (Litam et al., 2021; Moore et al., 2020; Puig et al., 2012). Other studies did not indicate whether participants were in private practice or not (Sweifach et al., 2013; Tabaj et al., 2015). Lawson and Myers (2011) did provide data for CPPs who experienced reduced burnout and increased CS. Data provided by other researchers was informational (Freudenberger, 1975) and some reported the concerns of private practitioners (Brauner, 2015; Brennan, 2013; Harrington, 2013). In terms of the transition model, the above studies represent expected occurrences, such as work tasks and unexpected circumstances concerning boundary struggles, and natural disasters (Anderson et al., 2011; Schlossberg, 1981). There is a description of stressors that may produce harm, threat, or challenge in considering the transactional theory of stress and coping. A helper's

ability to respond to a possible threat or challenge such as a boundary challenge, appraise the situation, cope, and reconsider strengths represents the application of both theories. When stressors outweigh resources and coping responses, counselors can consider asking for help and yet some helpers isolate and withdraw or fail to ask for help (McCann & Pearlman, 1990; Salyers et al., 2015; Savic-Jabrow, 2010). This tendency to isolate or withdraw may be linked to stigma with help-seeking, which could increase the risk for impairment.

Counselor Impairment

This section describes the literature in terms of the problem of counselor impairment, the types of counselor impairment, and the ethical implications. Counselors who provide care in an impaired state when experiencing burnout or CF could bring harm to a client (Brennan, 2013) including ethical risks (ACA, 2014; Brauner, 2015; Brennan, 2013). CF consists of burnout and STS (Stamm, 2010). Burnout includes symptoms such as withdrawal, isolation, and physical symptoms (Freudenberger, 1975; Maslach, 2003; Maslach & Jackson, 1981). STS symptoms may appear similar to PTSD (Figley, 1995; van Dernoot Lipsky & Burk, 2009). Furthermore, Merriman (2015) in describing supervision for counselor interns stated that additional information needs to be added to the knowledge base concerning the prevention of CF. It is unknown exactly how many counselors work in private practice, but they may make up 16% of the counseling workforce (U.S. Bureau of Labor Statistics, 2021). Understanding CPPs experiences with CF is important to understand how to help them reduce impairment symptoms and remain in the counseling field.

Harrington (2013), in conferring with an employee of the American Mental Health Counselors Association (AMHCA) described that the majority of the “nearly 7,000” counselors who were part of the AMHCA were in private practice (p. 189). Harrington reported that when

searching articles, research regarding private practice appeared infrequently and noted that there does not seem to be much incentive for mental health counselors to participate for research studies. The individualized nature of private practice makes it difficult to pinpoint the exact number of licensed professionals in private practice (Harrington, 2013). Researchers also noted that the prevalence of burnout was challenging to identify for mental health professionals as research to date had not looked at frequency throughout the occupations (Morse et al., 2012). Wardle and Mayorga (2016) evaluated master's-level counseling students. They reported that 86% of the sample of 35 were working while going to school, and 85.72% of were experiencing some level of burnout. This high level indicates that tendencies toward burnout and coping patterns may develop early in a counselor's career, which training programs may need to address.

O'Connor et al. (2018) used a meta-analysis to determine the factors involved with burnout and its prevalence in mental health professionals. They estimated that the prevalence of emotional exhaustion was 40%, depersonalization levels were 22%, and low personal accomplishment was 19%. Elevated age was associated with depersonalization and personal accomplishment. Higher caseloads or workloads were also associated with burnout, yet having choice and autonomy with one's work was found to be protective. Role conflict was related to emotional exhaustion, and role ambiguity was related to higher emotional exhaustion, however, supervision was found to be protective (O'Connor et al., 2018).

Acker (2012) inquired into emotional exhaustion, role stress, severe mental illness caseloads, workplace support, and intent to quit with 460 mental health providers, including social workers, psychologists, and case managers. Acker reported that 56% of the sample experienced moderate to high emotional exhaustion, and 50% considered leaving their positions.

Acker did not report exact figures for participants working in private and nonprofit organizations but stated emotional exhaustion was greater with those working for public agencies. Estimates of the prevalence of CF, burnout, and STS are challenging to determine among CPPs. However, understanding information concerning CPPs who are in the workforce or who may join the workforce could help determine how much CF training is needed.

According to the U.S. Bureau of Labor Statistics (2021), 319,400 people were employed as substance abuse, behavioral disorder, and mental health counselors; 19% were employed in outpatient centers, 16% in individual and family services, which may represent private practice, 10% in hospitals, 10% in residential facilities, and 8% in the government. The job outlook is very good for this occupation and is expected to grow 25% from 2019 through 2029 (U.S. Bureau of Labor Statistics, 2021). This promising outlook indicates that there will also be an increase in counselors working in various settings, including private practice. This increase in the growth of the counseling profession may then increase the risk for burnout. Suppose up to 56% (Acker, 2012) of CPPs who comprise 16% of the counseling workforce (U.S. Bureau of Labor Statistics, 2021) are experiencing burnout. In that case, understanding of counselor experiences of CF must be improved.

Types of Counselor Impairment

It is essential to understand both the stressors and the impact of these stressors to support an individual through the transition (Anderson et al., 2011; Schlossberg, 1981). For CPPs this support concerns the management of CF through supporting their building of resources, including coping or help-seeking. Burnout and STS are described as components of CF (Stamm, 2010). Stamm (2010) defined burnout as building gradually and involving hopelessness and an impact to effectiveness on the job and can also be linked to feeling ineffective, increased

workload and lack of support in the work setting. STS was defined as being related to one's job with secondary exposure to people who have gone through severely stressful and traumatic incidences (Figley, 1995; Stamm, 2010). The subsequent impact to the helper may be sleep changes, intrusive effects, and avoidance (Figley, 1995; Stamm, 2010). A few authors and researchers looked at CF among counselors (Lawson & Myers, 2011; Stebnicki, 2007, 2017; Thompson et al., 2014); however, much more data exists concerning burnout and counselors as will be described.

Van Dernoot Lipsky and Burk (2009) discussed the link between STS and CF and found that STS symptoms could include difficulty feeling empathy due to the vast amount of trauma a helper has absorbed. A helper may also experience numbing, leading to a risk of maladaptive coping, including substance use (van Dernoot Lipsky & Burk, 2009). Stebnicki (2007) further described CF as empathy fatigue, which can hinder a counselor from moving forward and impacts the mind, body, and spirituality. Stebnicki (2017) authored a book about counseling persons with trauma histories. The chapter on compassion or empathy fatigue described how counselors might start experiencing symptoms similar to their clients. Concerning spiritual impact, counselors may begin to question their own spirituality after seeing the dichotomy of healing and death in their client's stories. Errors were identified in that counseling training programs have often not encouraged their trainees to understand their self-care needs when working with clients. CF can hinder counselors from being fully present in meetings, and they may miss important data. Stebnicki (2017) pointed to research about physiological changes in the counselor while treating clients, which could be fatiguing for helpers. In the study, Stebnicki (2017) mentioned Marci et al. (2007), who measured skin conductance during therapy sessions

and noticed, while compared to an assessment on their interpretation of counselor empathy, that there were physiological changes in the therapist and client.

Regarding definitions and understanding of this subsection of CF, Freudenberger (1975) described burnout as a struggle in managing one's own feelings and experiencing the weight of the problems in the world while balancing the needs of those reaching out toward the helper. Freudenberger described how the symptoms involve emotional depletion, depression symptoms, as well as physical symptoms, including stomach problems or other pains. Isolation was a sign of burnout as well as changes in personality, feeling on edge, irritability, and quick-tempered reactions. Burnout may include paranoia, such as worry that one is a target, the dichotomy of risk-taking, and invincible feelings fueled by thinking one has encountered most things. Helpers may experience fatigue, stuck and negative thoughts, and there is a risk of substance use. Burnout can accelerate to the point of losing the reason and motivation for working in the field, which is difficult to regain (Freudenberger, 1975). In an informational article, Skovholt (2012) noted that providing support to others with a lack of reciprocal support is part of counselor exhaustion. This formula is helpful to the client but takes a tremendous amount of effort for the counselor, and yet they may experience benefits such as the rewards of seeing a client grow and heal (Skovholt, 2012).

Maslach and Jackson (1981) contributed seminal information toward understanding and defining burnout and measuring its prevalence. Helpers exhausted in their emotions and bodies may be at increased risk of neglect of impairment and neglecting client duties. Maslach and Jackson studied burnout, worker levels of depersonalization, and exhaustion in 605 individuals in various jobs, such as counselors, other mental health professionals, first responders, doctors, and administrators. They found three parts of burnout: emotional exhaustion with work,

depersonalization as an aspect of burnout connected to a lack of empathy toward clients or patients, and lower scores on personal accomplishment, which measures pride in one's work and successes.

Many researchers have investigated burnout in counselors (Gutierrez & Mullen, 2016; Hardiman & Simmonds, 2013; Lawson & Myers, 2011; Litam et al., 2021; Maslach & Jackson, 1981; Mullen & Crowe, 2017; Puig et al., 2012; Salyers et al., 2015; Thompson et al., 2014; Wallace et al., 2010) as it is a term that is often referred to in the literature to describe impairment. A few are highlighted here, and others are described throughout the literature review. Wallace et al. (2010) evaluated 232 counselors to determine mediating factors with burnout and found that workload, role conflict, role ambiguity and lack of use were associated with counselor burnout. . Wallace et al.'s study is further discussed in terms of coping strategies later in the chapter. Knight (2013) depicted burnout as resulting from the weight of stressors in the counseling practice and reviewed a case study of a counselor in private practice who was experiencing STS and intrusive symptoms.

Salyers et al. (2015) obtained a sample of 123 clinicians providing mental health treatment from the Veterans Affairs medical center, social services, or community mental health centers; 53% of their sample were at the master's degree level, and 18% were at the doctoral level. Burnout negatively impacted work quality for 58% of their sample. Participants also experienced isolation, reduction in patience, fatigue, poor communication and listening, worse client outcomes, and negative views from colleagues and clients. In the open-ended questions, helpers reported taking it out on their families, yet some reported positive impacts, such as connecting with colleagues. Also, in the open-ended questions, 87% identified that burnout impacted their work with clients, and 93% reported it affected their work with colleagues. They

found that participants with increased depersonalization were more likely to describe an impact on clinical work, and those with elevated emotional exhaustion were less likely to report an impact on client outcomes (Salyers et al., 2015).

The second part of CF is STS (Stamm, 2010), which occurs when a helper learns about a traumatic event happening to someone they care about and the subsequent stressful impact of this knowledge on the helper (Figley, 1995). Figley (1995) compared this stress to PTSD symptoms and called these STS disorder symptoms. STS was further described as when trauma happens to the client only, and the helper may reexperience these occurrences through memories, dreams, and triggers (Figley, 1995). The helper may also avoid similar situations or reminders and may withdraw. They may also experience on-edge feelings, insomnia, hypervigilance, and other physical symptoms (Figley, 1995). Van Dernoot Lipsky and Burk (2009) echoed that STS symptoms in helpers may include feelings of helplessness, hypervigilance, difficulties with managing complex situations, reduced creativity, dissociation, and avoidance. McCann and Pearlman (1990) also described VT as the impact of the client's experiences on the therapist and their emotions, and viewpoints toward the world and explained that more exposure includes increased risk for VT development. Knight (2013) relayed experiences with counseling trauma survivors and the potential impact on one's worldview, such as seeing the world as unsafe and needing to stay vigilant. Knight noted that a gap in the literature includes that research often describes STS, CT, and burnout as the same concept when they are different and reported that the definition of indirect trauma is lacking. Furthermore, counselors who struggle with CF and other symptoms may have difficulty treating clients effectively, leading to ethical implications.

Ethical Implications of Counselor Impairment

CPPs need to hold themselves accountable to ethics and laws; as Brennan (2013) stated, they are their own supervisors and need to remain diligent. For instance, Brennan emphasized the importance of self-monitoring, where client autonomy is respected, and giving clients information so they can make informed choices. Maintaining beneficence, where the client's good is considered when providing treatment, is also crucial. Brennan described fidelity examples as arriving to appointments on time, being present, listening, and providing records when requested. Counselors are to treat all clients fairly and not discriminate, which are essential aspects of justice. Nonmaleficence involves determining whether a client is deteriorating because of treatment and ensuring the counselor is not causing harm. Brennan also reviewed important aspects of working with insurance and best practices with paperwork, such as providing informed consent and Health Insurance Portability and Accountability Act information. Failure to keep current with client paperwork, including notes, can open the door to errors. Brennan also recommended monitoring through continued self-assessment and emphasized self-examination regarding counselors' strengths and weaknesses, personal experiences, and how this impacts counseling performance. Self-analysis of character traits such as introversion, avoidance of conflict versus overly assertive behaviors were also underscored (Brennan, 2013).

Professional responsibility was highlighted in section C of the ACA (2014) *Code of Ethics* in that counselors should prioritize self-care, including focusing on their physical, spiritual, and emotional health to provide quality care. In this same section, the ACA recommended self-evaluation to determine if counselors are impaired and to request help from other professionals to prevent injury to clients (ACA, 2014, C.2.g). To address counselor impairment, the ACA *Code of Ethics* required counselors to help colleagues and other

professionals to recognize if they are impaired. If counselors notice colleagues or other professionals are impaired, the counselor should offer assistance or consultation to prevent potential harm to clients (ACA, 2014, C.2.g).

On the topic of consultation, Carney and Jefferson (2014) noted little research was completed concerning the receipt of consultation for CPPs. It was acknowledged that the counselor may not know the ethics concerning consultation or may not understand the steps involved. Other problems may include isolation, over-self-reliance, lack of referral sources, and lack of understanding or stereotyping of different related professions. They may have experienced difficulty noticing their errors or may wait excessively before seeking help (Carney & Jefferson, 2014).

There have been mixed results concerning what aids or hinders counselors in preventing burnout. Bercier and Maynard (2015) completed a meta-analysis pertaining to treatment for STS. They struggled to find research that involved controlled and experimental designs where at least half of the participants were mental health workers. They described this lack of representation as another research gap in the data and stated that most of the research they examined provided descriptions of STS but did not describe effective treatment. Impairment, including prevalence, risks, ethics, and aspects of CF were discussed. The next section describes protective factors, including help-seeking behaviors of CPPs and coping resources.

Counselor Help-Seeking Behaviors

In this section, the topic of counselor help-seeking behaviors and related literature is described. Help-seeking is considered seeking support in terms of Schlossberg's transition model (Barclay, 2015). Counselors are advised to seek supervision and guidance with their caseloads (Brennan, 2013) due to the protective aspects of being able to turn to one's supervisor (O'Connor

et al., 2018). Help-seeking behaviors include CPPs seeking personal counseling (Kalkbrenner et al., 2019; Savic-Jabrow, 2010), and seeking supervision (Carney & Jefferson, 2014; Finklestein et al., 2015; Knight, 2013; Mullen & Crowe, 2017; Savic-Jabrow, 2010). Help-seeking for counselors also includes seeking peer support (Connery & Murdock, 2019; Darcy & Abed-Faghri, 2013; Moore et al., 2020; Savic-Jabrow, 2010; Stebnicki, 2000) and seeking spiritual support (Barton, 2020; Coaston, 2017; Davis et al., 2012; Hardiman & Simmonds, 2013; Skovholt & Trotter-Mathison, 2016; Thompson et al., 2014).

Seeking Personal Counseling

Personal counseling is a valuable resource for supporting counselors through the stressors in their own lives and with working with clients. The ACA (2014) *Code of Ethics* under Professional Responsibility and Impairment describes how counselors need to take steps to prevent impairment and seek help when needed for physical, mental, or emotional problems and, if impaired, cease counseling clients during that time in (C.2.g). Researchers have found that there may be increased help-seeking behaviors with counselors (Kalkbrenner et al., 2019; Neukrug et al., 2017), and elevated help-seeking can reduce levels of stress and burnout (Mullen & Crowe, 2017). Savic-Jabrow (2010) described that 35% of participants received personal counseling. Kalkbrenner et al. (2019) calculated stigma and attendance in counseling with student counselors and found that 90.3% had attended counseling. However, views regarding the level of helpfulness of the counselor's therapist can impact whether they attend appointments (Kalkbrenner et al., 2019).

Moore et al. (2020) described the struggle of the counselor in maintaining the personal and professional self in terms of the transactional theory of stress and coping. Further, Bennett-Levy (2019) considered the importance of acknowledging the personal and interpersonal

qualities of a therapist as well as the importance of personal practice to achieve growth. Bennett-Levy (2019) pointed to the development of the personal practice model developed by Bennett-Levy and Finlay-Jones (2018). Bennett-Levy and Finlay-Jones acknowledged three of the most researched personal practices: personal therapy, meditation programs, and self-practice or self-reflection. The personal practice model consists of acknowledging the two selves in the therapist, including the personal self and the therapist self. Four kinds of motivation were identified: personal problems, personal growth, self-care, and therapist skill development. The five identified outcomes include primary outcomes of personal development and wellbeing, self-awareness, interpersonal beliefs/attitudes/skills, reflective skills and a secondary outcome of conceptual/technical skills. The three parts of the reflective process included personal self-reflection, therapist self-reflection and reflective bridge. Bennett-Levy and Finlay-Jones argued that focusing on personal self-reflection and therapist self-reflection could facilitate personal and professional growth.

Regarding self-reflection and the dichotomy of the therapist as a person and a therapist, Gutierrez and Mullen (2016) surveyed counselors and marriage counselors on emotional intelligence and burnout and found that those with elevated emotional intelligence exhibited reduced burnout. Counselors had increased understanding of the management of feelings compared to the general population and exhibited medium to low levels of burnout.

Some barriers to counselors seeking their own counseling include stigma around help-seeking (Kalkbrenner et al., 2019; Mullen & Crowe, 2017; Neukrug et al., 2017). Malikiosi-Loizos (2013) discussed the benefits and drawbacks of attending personal therapy for counselors and counseling psychologists. Further, the psychoanalytic, existential-humanistic, cognitive behavioral orientations suggest personal therapy to understand oneself. Malikiosi-Loizos pointed

to other benefits such as personal and professional growth and progress toward self-actualization as claimed by Abraham Maslow and Carl Rogers and noted that this self-exploration could open a counselor to the pain-filled process of self-exploration, which might impact mood and bring confusion. Other hindrances include there may be concerns about confidentiality and impact to finances (Malikiosi-Loizos, 2013).

Regarding gaps in the research, neither Gutierrez and Mullen (2016) nor Kalkbrenner et al. (2019) identified whether any of the counselors in their samples were in private practice. Savic-Jabrow (2010) focused on CPPs; however, the sample was small. Bennett-Levy and Finlay-Jones (2018) also recommended further research to explore whether personal practice improves reflective skills and further study into personal practice. Another form of help-seeking included seeking supervision from other, more experienced counselors.

Seeking Supervision

In addition to personal counseling, some respondents revealed that connecting with other counselors through continuing education, consultation, and other meetings were helpful, and 100% of respondents relayed that they received assistance from their supervisor (Savic-Jabrow, 2010). Furthermore, 80% of subjects described thinking and contemplation strategies as recharging (Savic-Jabrow, 2010). Fundamentally, reaching out for assistance was associated with decreased risk for burnout (Mullen & Crowe, 2017). Furthermore, Knight (2013) recommended identifying and expressing feelings and receiving support from supervisors and colleagues to prevent and manage STS. Benefits of consultation for mental health professionals include improved work, advocating for clients and the mental health field, building skills, and ethics, and building their businesses (Carney & Jefferson, 2014).

Finklestein et al. (2015) researched trauma symptoms and VT in 49 social workers working in a war-exposed area in the Gaza Strip and 50 working in Sderot. They recorded the level of assistance they received from colleagues and their belief in their professional abilities. They also rated the rocket fire they were subjected to, related trauma symptoms, and CF. Gaza Strip counselors were more educated, and Sderot counselors experienced more trauma symptoms, including PTSD and VT. PTSD symptoms were influenced by professional experience, subjective exposure, and views of professional abilities. VT was related to professional experience, subjective exposure, professional support, and views of professional abilities. Finklestein et al. interpreted the results to mean that professional support may be helpful with VT, and their experiences may build strength. They also reported that further training in understanding trauma and VT might be protective.

Falender and Shafranske (2012) pointed to the importance of the supervisor engaging the supervisee in competent supervision to aid in the longevity of successful outcomes in therapy. However, Ellis et al. (2014) argued that incompetent and harmful supervision can impact both the supervisee and the clients negatively and lead to harm, and pointed to the gap concerning the limited definition of the constructs. They conducted two studies, with the first pertaining to a sample of 34 clinical supervision experts where 68.7% of their sample had obtained a doctorate, 28.4 a master's degree, and 23.5% were in private practice. Their purpose was to identify harmful supervision descriptors in preparation for the second study. The following study consisted of 363 supervisees, of whom 45.3 % were training in psychology; 32.6% were studying mental health counseling, social work, or substance abuse; and 12.8% were studying school psychology or school counseling. Self-identified inadequate supervision concerns where the participant looks at the definition and identifies their supervision as lacking. De facto

inadequate supervision occurs when the supervision fails to meet the minimum competency, and the participant has identified those behaviors. Of the participants, 61.4% identified either past or present inadequate supervision, and 90.1% of participants' supervisors exhibited de facto inadequate supervision (Ellis et al., 2014).

Considering the gap, most of the studies in this section refer to counselors without a particular focus on private practice (Ellis et al., 2014; Finklestein et al., 2015; Mullen & Crowe, 2017). The exceptions were Savic-Jabrow (2010), who focused on CPPs but admittedly obtained a small sample which was a limitation. The other articles, however, were primarily informational (Carney & Jefferson, 2014; Knight, 2013). Further study into the benefit of supervision for CPPs could be helpful. Another form of help-seeking for CPPs involves seeking peer support.

Seeking Peer Support

Skovholt and Trotter-Matheson (2016) described therapists as often cultivating one-way caring relationships due to the nature of therapy and their natural abilities. They stated that this relationship tendency occurs even in their personal lives. Balanced relationships were encouraged and peer support was identified as a way to develop those relationships. According to researchers, seeking peer support is rated as a common help-seeking behavior for counselors (Moore et al., 2020; Savic-Jabrow, 2010). Sweifach et al. (2013) proposed connecting social workers with an accountability person for the provision of individual support and recommended additional study. Stebnicki (2000) proposed ideas for counselor management of personal trauma symptoms, such as participating in support groups with space allotted for discussing feelings, monitoring and managing caseloads to build connections and express feelings, and sharing self-care psychoeducation. Connery and Murdock (2019), in their study about the differentiation of self and CT, found that counselors in training were more likely to maintain healthy boundaries

with their clients and may have invested more emotionally than licensed counselors,. They suggested continued support from peers to help manage these boundary dilemmas .

In a study of characteristics concerning licensed mental health counselors (LMHCs) in New England, 55 responded to the survey (Darcy & Abed-Faghri, 2013). Darcy and Abed-Faghri (2013) reported that 65% of the sample worked in independent private practice or for a private agency, and the majority of 95% were satisfied with their jobs. Concerning strategies to build a successful practice, 67% received peer support from coworkers, 54% accepted peer support from outside the work setting, and 31% participated in supervision in the practice. Regarding paid supervision and professional association membership, 15% reported receiving this and 8% reported no professional support.

Peer support carries some limits. Many Facebook networking groups exist to provide peer support for counselors by helping them build their businesses, networking, and consultation. Most of these groups prohibit counselors from providing identifying information about clients; however, it can be challenging to moderate thousands of counselors and other helpers. For instance, Kaplan et al. (2011) highlighted an ethics scenario in which a counselor had erroneously posted information about diagnoses and appointments and pointed to the ACA *Code of Ethics* recommendations to have a written policy about the rules for the agency. Bratt (2010) reported that there was little study into counselors and social media at the time, and the importance of being careful with self-disclosures was stressed. The value of maintaining confidentiality in terms of technology and social media was also emphasized in the ACA (2014) *Code of Ethics* (ACA, 2014, H.2.b, H.6.d).

In consideration of gaps in the research, some research exists concerning the benefits of seeking peer support for CPPs (Darcy & Abed-Faghri, 2013; Savic-Jabrow, 2010). However,

most did not focus on the particular needs of CPPs and concerned counselors in general (Connery & Murdock, 2019; Moore et al., 2020; Sweifach et al., 2013) and further research into peer support and CPPs would be beneficial. An additional help-seeking behavior for CPPs includes seeking spiritual support.

Seeking Spiritual Support

Seeking spiritual support can be a valuable resource for CPPs. In applying Schlossberg's theory, Anderson et al. (2021) described spirituality as a resource in coping with transitions. Myers and Sweeney (2005) also described the essential self, which includes spirituality as an important part of wellness. Similarly, Lawson and Myers (2011) found that counselors and CPPs with elevated wellness levels rated spirituality highly in terms of career-sustaining behaviors. Coaston (2017) also described the importance of spiritual self-care and combining it with spending time in nature and grounding strategies. Hardiman and Simmonds (2013) studied burnout, spiritual well-being, and existential well-being in Australian counselors; 70 worked in private practice, and 19 worked for agencies. Counselors provided face-to-face client work hours from a few hours a week to up to 60, with the median at around 20 hours per week. A significant number of participants, 81, reported having worked with clients who had experienced significant trauma. They wrote that 68 counselors did not participate in spiritual activities, and 21 did participate. Reduced levels of burnout were identified in the sample. Also, increased caseload and gender were not related to burnout, which differed from prior studies. Those who worked in the field longer experienced lowered depersonalization aspects of burnout. Additionally, they found that religious well-being was not correlated with burnout. However, existential well-being was related to a reduction in emotional depletion, decreased dissociation and an increase in

esteem. Burnout may impact interest in religious activities, and they recommended further study to look into this possibility (Hardiman & Simmonds, 2013).

In an IPA study, Barton (2020) reported that all five counselor participants reported the importance of spirituality and communicating with God, and one said they prayed for guidance before sessions. Thompson et al. (2014) also found an association between counselors who viewed their work conditions more positively and reduced CF and burnout. Further, Thompson et al. evaluated emotion-focused coping and noted that religious support was part of this construct, which was associated with reduced burnout. They found that feeling expression activities, including "emotional support, humor, and religious beliefs," were protective factors (pp. 65, 72). Davis et al. (2012) reported that rehabilitation counselors wondered if they had put their best efforts into the work with the client who passed away. They later constructed existential realizations and understood they put in their best effort and would continue to improve upon doing so, and found the concept of veracity and reconnecting with why the counselor entered the field could prove helpful. Skovholt and Trotter-Mathison (2016) surmised that counselors are witnesses to traumas, the world's difficulties and clients' existential struggles. A counselor who pursues individual spiritual or religious endeavors may find understanding or meaning in those realities (Skovholt & Trotter-Mathison, 2016).

There was some additional ambiguity in the helpfulness of spirituality for counselors. Lizano et al. (2019) studied work engagement, burnout, spirituality, and wellbeing in 133 social workers and other human service providers, of whom 38.3% worked in mental health. Workload was related to emotional exhaustion and depersonalization. They also found that spirituality was not related to emotional exhaustion or depersonalization, which are aspects of burnout that was an unexpected result (Lizano et al., 2019).

In contemplating gaps in the research, Hardiman and Simmonds (2013) did not provide information particular to CPPs in terms of spirituality. Lawson and Myers (2011) included CPPs in their sample, and counselors with elevated wellness also reported increased spirituality. Further, managing existential aspects of existence was found to be helpful (Davis et al., 2012; Hardiman & Simmonds, 2013), but spirituality did not help reduce burnout (Hardiman & Simmonds, 2013; Lizano et al., 2019). Thompson et al. (2014) discovered an association between decreased burnout and CF and emotion-focused coping, which involves a religious component, and CPPs were part of the sample; however, little information was provided explaining religious beliefs and how they may help counselors. It may be beneficial to further explore CPPs' experiences with spirituality as a help-seeking behavior. Spirituality was also listed as an aspect of wellness which can be a coping strategy as well (Myers & Sweeney, 2005)

Counselor Coping Strategies

Both the transition model and transactional theory of stress and coping address the importance of coping strategies and resources to help the individual through the change or stressors such as CF. In continuing the discussion on managing CF, Skovholt (2012) discussed 10 steps toward coping for counselors. The first is to protect oneself through building self-care skills and boundaries. The second is to determine what recharges the counselor and focus on giving energy to that. The third is enjoying the rewards of therapy, and Step 4 consists of balancing empathy levels and setting appropriate emotional boundaries. In Step 5, Skovholt discussed the value of working diligently and balancing it with accepting that counselors have only partial control over client outcomes and the remainder of the work rests with the client. Step 6 involves creating a healthy work environment and acknowledging that in working for organization as an employee that they may have limited control in that environment. Step 7

comprises help-seeking behaviors such as including and maintaining socialization in balanced relationships to off-set the one-sided nature of counseling. Step 8 concerns focusing on physical health in enhancing positive energy through exercise, adequate sleep, healthy diet, relaxation techniques, and cultivating loving and affectionate relationships. Step 9 urges counselors to focus on professional growth by increasing counseling skills to revitalize the practitioner. Step 10 describes the importance of the counselor concentrating on fun and enjoyment in their lives (Skovholt, 2012).

Wallace et al. (2010) evaluated 232 counselors who worked in facilities treating sexual abuse and substance abuse and measured burnout levels compared to the mediation of coping strategies. They discovered that workload, or quantitative aspects of work, role conflict—including perceived mixed messages from the employer, role ambiguity or not knowing how to complete one's job, and lack of utilization or feeling underused concerning one's education, were all affiliated with burnout in counselors. They also found nine mediators, including adaptive and maladaptive coping, correlated with the predictor of job stress. These included self-distraction, active coping, denial, substance use, use of instrumental support, behavioral disengagement, planning, humor, and self-blame. All of these except active coping and instrumental support were found to be significant predictors. They observed complete mediation with job ambiguity and its relation to counselor burnout as these were not related if a counselor coped using self-distraction or behavioral disengagement. The results were in support of the job demand resource or job demand control models in that job demand components from the job stress increased levels of burnout whereas coping strategies reduced the pressures and burnout levels with these counselors (Wallace et al., 2010).

In this section, additional coping strategies for CPPs are explored, including building understanding concerning the use of self-care (Beaumont et al., 2016; Bradley et al., 2013; Foreman, 2018; Gonzalez et al., 2019; Lawson & Myers, 2011; Litam et al., 2021; Myers & Sweeney, 2005; Thompson et al., 2014; Williams et al., 2012). Boundary setting is another important coping strategy for counselors managing stress (Brauner, 2015; Brennan, 2013; Davis et al., 2012; Lawson & Myers, 2011; Harrington, 2013; Skovholt, 2012; Skovholt & Trotter-Matheson, 2016). Furthermore, SC (Barton, 2020; Beaumont et al., 2016; Coaston, 2017; Finlay-Jones et al., 2015; O'Sullivan & Bates, 2014; Patsiopoulos & Buchanan, 2011) and mindfulness (Barton, 2020; Coaston, 2017; Hayes et al., 2004; Patsiopoulos & Buchanan, 2011; Thompson et al., 2014) will also be explored.

Counselor Self-Care

Understanding the self-care behaviors of CPPs may prove helpful in preventing CF. Counselor self-care may involve wellness, CS, and purposeful strategies for self-care. Regarding components of self-care, Myers and Sweeney (2005) described the indivisible self and the importance of maintaining wellness, which is divided into five parts, the essential self, the creative self, the coping self, the social self, and the physical self. The essential self consists of identity components such as spiritual and existential factors, self-care processes, how one views their gender, and cultural schemas. The creative self involves the interactions of feelings and cognitions, perceptions of one's ability to control their environment, and the ability to add humor and work. The coping self is derived from views of oneself, how one manages stress, confidence in their abilities and the ability to relax completely. The social self and its components consist of community, family, friendships, and love which protects from loneliness and stagnation. The fifth part, the physical self, concerns how one cares for their body through movement and

consumption. Myers and Sweeney discussed the importance of context, such as family and the adjacent community, structures such as local governments and schools, places of employment, and global concerns that can impact the individual and their place in time and developmentally.

Self-care may be a protective factor for CPPs. The effects of VT were found to be mitigated by coping and well-being for community mental health counselors (Williams et al., 2012). Lawson and Myers (2011) surveyed 506 counselors, of whom 39.3% were in private practice, to understand wellness, career-sustaining behaviors, and professional quality of life. In the study, participants shared that 35% of their clients experienced some form of trauma, and 15.5% on their caseload were often in crisis. Counselor wellness was associated with being in private practice versus working at a school or agency and having a reduced caseload of high-risk clients. Concerning career-sustaining behaviors, counselors reported high ratings toward spending time with family, humor, balancing work, and home life, retaining self-awareness, pondering positive occurrences, remaining unbiased with clients, and retaining their professional character. CPPs exhibited elevated CS and less burnout than counselors in agency or school settings. These results suggest that coping strategies, help-seeking behaviors, and managing stress can protect CPPs from burnout (Lawson & Myers, 2011).

Skovholt (2012) highlighted that the rewards of providing therapy or CS could also be a helpful coping strategy. This helpfulness may be related to the coping self (Myers & Sweeney, 2005) or how one manages stress. In Gonzalez et al.'s (2019) sample of crisis responders, 81.4% obtained certifications or licensure, and their degrees ranged from the associate to the doctoral level. Of the 70 respondents, 24 worked in the public or government sector, 12 worked in community mental health, and 15 were in other sectors. No differences between men and women were reported, and crisis responders who displayed coping skills of managing adversity exhibited

elevated CS. A negative correlation was found between resilience with professional quality of life compared to burnout and STS. In other words, resilience and CS were found to be protective from CF and burnout. Thompson et al. (2014) also found that increases in CS reduced burnout risk. In terms of agency work at VR, this construct of CS may change over time (Tabaj et al., 2015). According to Tabaj et al. (2015), in the beginning of their tenure, VR counselors experienced CS, and tapered off toward their eighth year of employment. Naghavi and Salimi (2018) found in their qualitative study following a small sample of rehabilitation counselors, participants reported experiencing emotional difficulty following hearing trauma stories, although they experienced positive effects as well, such as posttraumatic growth.

Beaumont et al. (2016) found that student counselors who were kinder to themselves, experienced more well-being and CS and reduced CF and burnout. Litam et al. (2021) found that CS was significantly predicted by posttraumatic stress, coping responses, resilience, and perceived stress. They found that increased resilience was related to increased CS and asserted that relationship might arise from a greater sense of purpose in terms of helping people during a pandemic. Perceived stress and resilience were strong predictors of burnout. Elevated stress was associated with increased burnout, and increased resilience was associated with reduced burnout. Posttraumatic stress, coping responses, and resilience significantly predicted STS, and Litam et al. commented on the possibility that counselors who were not able to cope effectively experienced these trauma symptoms.

Foreman (2018) described how wellness tiers and trauma exposure affect VT. In their pilot study and sample of 68 counselors, about 27% were in private practice. They found that exposure to trauma stories did not reduce wellness and that the higher the amount of wellness, the lower the VT impact. They pointed out that their findings might contradict those of McCann

and Pearlman (1990), who posited that the more exposure to trauma, the higher the risk of experiencing VT. CPPs reported personalized self-care strategies included religious activities, calming strategies, and workouts, and 77% of participants used reading and education, 52% reported other relaxation techniques such as massage (Savic-Jabrow, 2010). Mayorga et al.'s (2014) hypothesis was supported in that counseling students' self-care levels were negatively correlated with stress such that if self-care decreased, stress increased.

Under Professional Responsibility in section C of the ACA (2014) *Code of Ethics*, counselors are urged to prioritize self-care to maintain their emotional, physical, and spiritual health. Also, in the CACREP (2016) standards under Section 2.F.1.l, self-care was listed as part of the curriculum under professional counseling orientation and ethical practice. All five of Barton's (2020) participants reported after attending training in the British Association for Counselling and Psychotherapy ethical framework that directions for self-care implementation were ill-defined. One participant in private practice reported not receiving enough preparation for self-care practice. Bradley et al. (2013) concurred that the term *self-care* was not well defined by those who require it and pointed out a failure to guide its implementation. They also criticized the literature that attempted to define it but lacked specificity (Bradley et al., 2013).

Bradley et al. (2013) provided some suggestions about self-care strategies, such as using creativity to reduce burnout and CF, and provided steps and support to using such mediums. They suggested three strategies for building self-care. The first is to celebrate subtle changes and successes with clients, write these on a slip of paper, make them colorful, or write on different colored pieces and place them in a jar. When feeling down or overwhelmed, the counselor could review these to remember that even small changes are making a difference and if they choose to share the success with a colleague or peer support. The second strategy was imagining and

drawing oneself, the counselor, as a plant and imagining the needs of the counselor. Then the counselor writes a set of instructions for self-care for oneself. Bradley et al. also suggested solution-focused strategies such as noting effective strategies, what needed improvement and defining recognition of growth. Finally, they recommended scrapbook journaling using art supplies while expressing emotions, reflecting on responses, and improving mood. The author recommended further research with the use of creative self-care strategies (Bradley et al., 2013).

Some researchers have addressed self-care among agency counselors and CPPs (Barton, 2020; Litam et al., 2021; Thompson et al., 2014). In terms of gaps in the research, others did not look specifically at CPPs (Gonzalez et al., 2019; Naghavi & Salimi, 2018; Tabaj et al., 2015; Williams et al., 2012) or focus on counselor trainees (Beaumont et al., 2016). Although Foreman's (2018) sample included CPPs, characteristic differences between types of employment and self-care or wellness were not reported. Lawson and Myers (2011), however, identified some differences for CPPs such as elevated wellness and CS and reduced burnout; however, they did determine the leading to these outcomes but only recommended further study into elements that help counselors cope. Some counselors, including CPPs, report that self-care is ill-defined and that they need further instruction on how to implement it, which suggests further research is needed to support them (Bradley et al., 2013). The next section provides a description of boundary setting as another coping strategy to support CPPs.

Boundary Setting

Boundary setting is another essential coping strategy for managing a successful private practice. Having good boundaries may be protective for CPPs (Brennan, 2013; Lawson & Myers, 2011), and boundary setting can help a counselor manage their energy more productively (Skovholt, 2012; Skovholt & Trotter-Matheson, 2016). Freudenberger (1975) provided

additional strategies for building good boundaries to prevent burnout: improving the interview process for volunteers, varying tasks, limiting excess hours, rest and vacations, expressing feelings, professional development activities, maintaining exercise routines and building boundaries between life and work. In terms of successful practice management, setting good time boundaries around sessions could also be effective (Savic-Jabrow, 2010). Setting boundaries to allow time for professional growth could also prove helpful. Respondents acknowledged that better preparation and training for potential traumas could prove helpful (Sweifach et al., 2013). Likewise, additional training could include reveal the impact of the grief process on the rehabilitation counselor and the nuances of how best to relate to a deceased loved one's family (Davis et al., 2012). Savic-Jabrow (2010) also reported that one respondent found that setting aside time for reading, short courses, and study was helpful. Also, CPPs may have more freedom to set boundaries, such as with their time (Brauner, 2015; Brennan, 2013) and with overall practice management (Brauner, 2015; Harrington, 2013).

CPPs need to be vigilant in maintaining good boundaries while also maintaining balance. Skovholt and Trotter-Matheson (2016) described that a balance of self-care and other care is important for the counselor or other helpers. The definition of depersonalization in terms of burnout was defined as a lack of empathy toward clients (Maslach & Jackson, 1981). A lack of empathy could lead to not being fully present in sessions, leading to potential errors (Stebnicki, 2017). According to Tan (2011), some therapies are more about techniques that could increase the risk that a client feels dehumanized, which could also be viewed as having boundaries that are too firm. Tan described other therapies, such as existential therapy, to allow the therapeutic relationship to be a point of healing for clients. Yalom and Leszcz (2005) called this connection

the corrective emotional experience. Maintaining boundaries is important to protect the counselor, but being too distant in therapy may not be beneficial to the client.

In considering gaps in the research, there is much written about theory and analysis of the literature in terms of boundaries and CPPs (Brauner, 2015; Brennan, 2013; Harrington, 2013) or boundaries and other coping strategies for counselors and other helpers (Skovholt, 2012; Skovholt & Trotter-Matheson, 2016; Stebnicki, 2017). Davis et al. (2012) and Sweifach et al. (2013) regarded counselors in general, and Lawson and Myers (2011) focused at least partially on differences between CPPs and other counselors. The fourth study, however, had a small sample size (Savic-Jabrow, 2010). In conclusion, there is little information concerning boundaries and CPPs and how maintaining these boundaries is helpful for this population, so further study would be beneficial. In discussing counselor coping strategies, another important strategy involves SC.

Self-Compassion

SC and mindfulness are useful as coping strategies for CPPs. According to Neff (2003), SC involves being kind to oneself, viewing oneself as part of collective experiences with others or common humanity, and mindfulness, which was described as balanced awareness of feelings. Coaston (2017) provided support for SC by outlining its protective effects in terms of burnout. However, Patsiopoulos and Buchanan (2011) reported that little research exists concerning SC and counselors and provided a narrative inquiry into SC and the counselor. Concerning employment types for their 15 participants, three worked in private practice, eight worked for community agencies, two were employed in private and community agencies, and two in higher education. Researchers noted three main themes: *Counselors' Stances in Session*, *Workplace Relational Ways of Being,* and *Finding that Balance Through Self-Care*. Strategies included in

Counselors' Stances in Session incorporated stances of acceptance and not knowing, kindness to self with inner dialogue, mindfulness, setting aside time for self, and acceptance of fallibility. The theme *Workplace Relational Ways of Being* included working with a compassionate work team and speaking truth to self and others. *Finding that Balance Through Self-Care Strategies* examples included having a self-care plan including time for leisure, which was stated most often. Other ideas for self-care included exercise, sleeping enough, nutrition, meditation, massages, and socialization (Patsiopoulos & Buchanan, 2011).

Beaumont et al. (2016) reported that counselor students with elevated SC experienced increased well-being and CS and less CF and burnout. Finlay-Jones et al. (2015) indicated that greater SC helped psychology clinicians improve emotional management and improvement in facing their individualized challenges. Rehabilitation counselors' views of their overall life achievements and their perceptions of their relationship with clients were negatively correlated with burnout (O'Sullivan & Bates, 2014). O'Sullivan and Bates (2014) indicated that a counselor's optimistic view of themself and their abilities could be a protective factor for burnout. Coaston (2017) argued that SC is being kind to oneself and validating one's feelings instead of denying them, which provides an opportunity to grow in one's practice.

Barton (2020) conducted an IPA with five counselor trainees from an MA counseling training program. They each had at least 8 years of experience in counseling and all reported being Christians. Four main themes were identified. The first was *Perceptions of Challenges of Working as a Therapist*. This theme concerned the demands of the job and the challenges of difficult clients and client issues. For example, assessing risk and considering breaking confidentiality increased anxiety for a participant. The second theme included *Perceptions of Inadequate Preparation for Self-Care*. For example, the participants attended the British

Association for Counselling and Psychotherapy ethical framework, which emphasized self-care but provided little instruction on how to implement self-care, and participants noted personal struggles with self-care. *Perceptions of Growth* for the third theme included personal growth, growth of self-awareness, learning limitations and resilience. The fourth theme consisted of *Perceptions of Caring for Self*, including prioritizing self-care and SC, which to one participant meant being kind to themselves and spending time in a garden. Another part of self-care included relational care with balanced relationships (Barton, 2020).

If counselors do not practice SC in their work and lives, they may be open to self-critical behaviors. Neff (2003) discussed that developing SC helps reduce self-critical judgments and helps counselors cope emotionally and connect with others. Skovholt and Trotter-Matheson (2016) described counselors with disproportionate views on their ability to help, such as thinking they could change the world, may leave the field early. Over time they may learn that these beliefs are overzealous and not realistic as well as perfectionistic and grandiose (Skovholt & Trotter-Matheson, 2016). Acceptance and SC can help the counselor to develop more realistic plans in helping clients while sharing responsibility with them for their progress (Skovholt, 2012; Skovholt & Trotter-Matheson, 2016).

Concerning gaps in the research, few studies examined SC with counselors or SC with CPPs except Patsiopoulos and Buchanan (2011) and Barton (2020), who provided qualitative research into private and agency counselor experiences of SC. Additionally, Coaston (2017) provided a review of the literature and suggestions for self-care and SC for agency counselors and CPPs. Other authors focused on counselors in general in terms of coping strategies (Skovholt, 2012; Skovholt & Trotter-Matheson, 2016). Other researchers focused on student counselors (Beaumont et al., 2016), rehabilitation counselors (O'Sullivan & Bates, 2014) and

psychologists (Finlay-Jones et al., 2015). I located no studies that countered the positive effects of SC except there are criticisms of mindfulness, as seen in the next section (Goldberg et al., 2016; Van Dam et al., 2018). Further, as described in the following section, Neff (2003) found that mindfulness is also a part of SC.

Mindfulness

Some researchers described mindfulness as a positive coping strategy that may help prevent CF (Barton, 2020; Coaston, 2017; Hayes et al., 2004; Patsiopoulos & Buchanan, 2011; Thompson et al., 2014). Neff (2003) defined *mindfulness* as accepting emotions and thoughts without identifying with them too closely. In considering the transactional theory of stress and coping concerning the interaction of stress and thoughts (Lazarus & Folkman, 1984), SC and mindfulness strategies (Neff, 2003) may be helpful with counselor management of their emotions and cognitions. It was found that increased mindfulness predicts reduced burnout in agency counselors and CPPs (Thompson et al., 2014). In addition, Hayes et al. (2004) studied stigmatizing attitudes and burnout in substance abuse counselors, of whom 55% were in private practice. In comparing three treatment modalities for substance abuse counselors, acceptance and commitment therapy, which includes mindfulness, appeared to reduce burnout in participants in the post- and 3-month follow-up, and multicultural training reduced burnout in the post assessment (Hayes et al., 2004).

In developing a plan of action for self-care, Coaston (2017) discussed the importance of physical health and exercise or relaxing activities, mindfulness, attending trainings and learning to prevent stagnation, and expressing emotions with creative journaling. In an IPA study, Barton (2020) reported that participants emphasized the importance of caring for themselves mindfully and holistically under the theme of *Perceptions of Caring for Self*. Examples of mindful

interventions from participants included walking or exercising, spending time in nature, creating and cooking, art, holidays, and taking breaks (Barton, 2020). Also, Patsiopoulos and Buchanan (2011) reported that their sample of agency counselors and CPPs also found mindfulness and prayer as a way of life and a valuable coping strategy.

Critics of using mindfulness as a coping strategy claimed little consensus exists on the definition of mindfulness (Van Dam et al., 2018). Goldberg et al. (2016) studied mindfulness in 130 participants enrolled in a health and well-being study to evaluate a self-report measure of mindfulness across three conditions: a mindfulness-trained group, a health-awareness-trained group, and a control group. They noted that mindfulness traits increased in the health management condition of which participants had no training in mindfulness, thus putting into question its discriminant validity and adding questions concerning definitions of mindfulness.

In terms of gaps in the literature, several articles offered support for mindfulness with agency counselors and CPPs (Barton, 2020; Coaston, 2017; Hayes et al., 2004; Patsiopoulos & Buchanan, 2011; Thompson et al., 2014). However, it may be an ill-defined concept (Goldberg et al., 2016; Van Dam et al., 2018) and thus difficult to implement for CPPs. Further research into defining mindfulness and understanding the particular benefit of CPPs would be beneficial.

Summary

The problem is that CPPs are experiencing stress from their work (Brauner, 2015), including experiencing CF (Thompson et al., 2014). Many studies addressed the impairment of mental health professionals, including counselors (Beaumont et al., 2016; Connery & Murdock, 2019; Davis et al., 2012; Gonzalez et al., 2019; Finklestein et al., 2015; Gutierrez & Mullen, 2016; Kalkbrenner et al., 2019; Mullen & Crowe, 2017; Naghavi & Salimi, 2018; O'Sullivan & Bates, 2014; Sweifach et al., 2013; Tabaj et al., 2015; Wardle & Mayorga, 2016; Williams et al.,

2012). However, there are gaps in the literature regarding support for CPPs as few studies focus on the stress from their work, the help-seeking or coping strategies used, or the needs of CPPs (Harrington, 2013; Savic-Jabrow, 2010). CF consists of STS and burnout (Stamm, 2010). Burnout is defined as having an emotional impact, hopelessness, and withdrawal and feeling that one's work is meaningless (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022). Further, STS includes symptoms similar to PTSD (Figley, 1995; van Dernoot Lipsky & Burk, 2009). In this dissertation CF in CPPs was studied through the lens of the transition model (Anderson et al., 2011; Schlossberg, 1981) and the transactional theory of stress and coping (Lazarus & Folkman, 1984). This study could add to the knowledge base concerning the experience of CF in CPPs as well as the help-seeking behaviors and coping strategies used. Help-seeking behaviors are defined turning to people or resources for support, such as personal counseling (Kalkbrenner et al., 2019; Savic-Jabrow, 2010). Counselor coping strategies are defined as how CPPs cope through relaxation strategies, taking a vacation, focusing on CS or wellness, and self-care (Gonzalez et al., 2019; Lawson & Myers, 2011; Savic-Jabrow, 2010; Skovholt, 2012).

Chapter Three: Method

As described in Chapter 2, there is a gap in the literature regarding stress and coping strategies used by CPPs (Harrington, 2013; Savic-Jabrow, 2010). The purpose of this phenomenological study was to better understand the meaning CPPs found in experiences of CF, and their help-seeking and coping behaviors. The information provided in this study added to the knowledge base to improve the picture of CF in CPPs as well as their help-seeking and coping behaviors. This chapter outlines the research design and research questions and provides an overview of the participants, data collection methods and data analysis for the study. Last, ethical considerations and trustworthiness are explained, followed by a summary of the chapter.

Design

The type of study was qualitative, and the research design was phenomenological. The specific type of design used was IPA, and the specific approach applied included hermeneutics. The reasoning behind choosing qualitative research was to obtain information about the experience and meaning of experiencing CF, which aligns with qualitative descriptions (Creswell & Creswell, 2018; Creswell & Poth, 2018). Phenomenology was used to identify the common meanings for participants who have experienced the same phenomenon (Alase, 2017; Creswell & Poth, 2018; Smith et al., 2022; Smith & Nizza, 2022). Creswell and Poth (2018) pointed to the origin of phenomenology as based on Husserl, which was further developed by Heidegger, Sartre, and Merleau-Ponty. Smith et al. (2009) recognized that Husserl's works focused on psychological processes whereas Heidegger focused on understanding existence. Alase (2017) pointed to Moustakas (1994) and van Manen (1990) as having expanded phenomenology to align with present qualitative methods. Van Manen (2014) wrote of phenomenology as inquisitive thinking through encompassing oneself with understanding meanings as opposed to seeking

answers. Grounded theory was not selected as the data were psychological and discursive approaches were not selected as there is not necessarily a focus on language use (Smith et al., 2022). A narrative approach was not chosen as this tends to focus more on the stories of participants, whereas IPA focuses on meaning (Smith et al., 2022).

According to Smith (2011), IPA is a well-recognized and commonly used qualitative method in psychological research. Creswell and Poth (2018) pointed to Smith et al. (2009) as the leaders of IPA's development. Smith et al. (2009) credited Smith (1996) as a founding article describing IPA as established in the qualitative, experiential, and psychological. Further, in using IPA, a researcher examines the personal awareness and experience of a phenomenon (Smith et al., 2022; Smith & Nizza, 2022; Smith & Osborn, 2003). It is categorized as an experiential method grounded in the three theoretical pillars of phenomenology, hermeneutics, and idiography (Smith et al., 2009, 2022; Smith & Nizza, 2022). Through an IPA perspective, a researcher focuses on idiography or the particulars of the person living with cognitive, psychological, philological, and physiological aspects (Smith & Nizza, 2022; Smith & Osborn, 2003). A researcher using these methods understands that the participants' words, cognitions, and emotions are linked (Smith & Nizza, 2022; Smith & Osborn, 2003).

This IPA research philosophy aligns well with the main theories used in this study. The first is the transition model (Anderson et al., 2011; Schlossberg, 1981), a theory about processing expected or unexpected transitions and includes the four S system (Situation, self, support, and strategies). The second was the transactional theory of stress and coping (Lazarus & Folkman, 1984), a theory about stressors and the interpretation of the participant in terms of cognitions, emotions, and coping. As stated, the approach was also hermeneutic. Hermeneutic theorists evaluate what is meant in order to interpret and pinpoint original meanings in context to history

and present life (Smith et al., 2009; Smith & Nizza, 2022). Smith et al. (2009) described Heidegger as a hermeneutic phenomenologist and hermeneutics as originally developed to understand biblical writings and later other documents. A researcher using these methods does get close to the research, and there are two steps to the hermeneutic where the participant is perceiving and interpreting their world and the researcher is perceiving and interpreting the participant's process of perceiving and interpreting their world, which is also called a double hermeneutic (Smith et al., 2009, 2022; Smith & Nizza, 2022; Smith & Osborn, 2003). Additional parts to this process involve empathic hermeneutics where the researcher tries to understand participants experiences and questioning hermeneutics where the researcher questions the process and the phenomenon to better understand it (Smith et al., 2009, 2022; Smith & Osborn, 2003). There is also the hermeneutic circle in considering the parts and the whole and vice versa (Smith et al., 2009, 2022). The investigated phenomenon (Creswell & Poth, 2018) included inquiring into CPPs experiences with CF and the meaning found in their help-seeking behaviors and coping strategies.

Research Questions

OARQ: What are counselors in private practice's experiences of compassion fatigue?

SQ1: What are counselors in private practice's experiences of their help-seeking behaviors?

SQ2: How do counselors in private practice make sense of coping with compassion fatigue?

Setting

This section provides an overview of the setting for this study. The setting for this study involved multiple counseling networking groups on Facebook, a counseling association in a Southeastern state, and the counseling department of a university in a Southeastern state. Kosinski et al. (2015) described Facebook as an important research tool providing access to a

diverse pool of potential participants. The rationale was that CPPs often network and gain insight into the process of managing a private practice from other counselors through Facebook networking groups and other organizations. The Facebook groups the researcher used for participant recruitment included national support groups that assist CPPs managing insurance contracts and credentialing, and groups that support counselors and other mental health professionals running their private practices.

Likewise, the counseling association and their associated Facebook group that the researcher used to recruit participants supports counselors in the Southeastern area where the researcher was located. Due to a low response from participants, the researcher received institutional review board (IRB) approval to add an additional site. The researcher concluded participant recruitment at a university counseling department in a Southeastern state. The counseling department consists of faculty members who are licensed counselors and may have a private practice.

The Facebook groups, counseling association, and a university counseling department were selected as they have licensed counselors in attendance and CPPs, which increased the odds of recruiting participants who met the inclusion criteria. Participants were also welcomed to recommend other participants for the study, a process called snowballing, as described in the next section (Kosinski et al., 2015; Smith & Nizza, 2022). The researcher was a member of the Facebook and association groups and contacted the group administrators and the university for approval before posting any recruitment letters. The participant was instructed to attend the online interview in a closed room in their home or their office. The rationale for providing interviews online was to make it easier for the participant to attend (Bolderston, 2012) and to reduce the risk for the participant and researcher as there was an ongoing pandemic.

Participants

In this section, a description of the participants, sample size, type of sample and sampling procedures is provided. A total of seven participants were selected for this study, allowing for detailed case-by-case analysis of the phenomenon (Smith & Nizza, 2022; Smith & Osborn, 2003). Smith et al. (2022) suggested that six to 10 participants could be sufficient for doctoral-level studies as quality is emphasized. The researcher sought participants through snowball sampling, which helped identify persons who wanted to participate (Alase, 2017; Creswell & Poth, 2018; Kosinski et al., 2015; Moore et al., 2020; Smith et al., 2022; Smith & Nizza, 2022) from various social communities including CPPs who are members of counselor-focused private-practice Facebook groups and a university. Additionally, the interview questions were piloted with a CPP colleague before implementing the interviews (Moore et al., 2020; Smith & Nizza, 2022). Purposive sampling or selecting participants with a special understanding of the phenomena (Smith & Osborn, 2003; Smith et al., 2022; Smith & Nizza, 2022) was also used to determine qualification for participation in the study.

Table 1

Participant Demographics

Participant pseudonym	Age in years	License type	Years in private practice	Racial identification	Gender identity	Clients seen per week	Clients experienced trauma	Currently seeing a therapist?
Cheryl	26–35	LPC	5–9 years	White	Female	21–25	11–15	Yes
Jody	36–45	LCPC	10+ years	Prefer not to answer	Female	16–20	11–15	No
JoJo	56+	LPC	10+ years	White	Female	16–20	6–10	Yes
Margaret	46–55	LPC	10+ years	White	Female	21–25	16–20	No
Mary	46–55	LPCC-S	5–9 years	White	Female	11–15	11–15	No
Ruby	56+	LPC	5–9 years	Black	Female	16–20	11–15	Yes
Veronica	26–35	LPC	2–4 years	White	Female	16–20	16–20	No

Regarding years in private practice, one participant worked 2–4 years, three worked 5–9 years, and three have been in private practice 10+ years. Concerning racial identification, one participant preferred not to answer, one reported they were Black, and five reported they were White. All participants reported they were female. One participant reported seeing between 11–15 clients per week, four participants saw between 16–20 clients per week, and two participants saw between 21–25 clients per week. Of the clients seen per week, one participant reported that 6–10 of their current clients experienced trauma, four participants reported that 11–15 of their current clients experienced trauma, and two participants reported 16–20 of their current clients experienced trauma. Also, three of the seven participants were seeing a therapist at the time of the interview.

Procedures

This section provides detailed information concerning the procedures used in the study. The researcher sent the Permission Request Letter (Appendix A) through email or Facebook Messenger and obtained permission from the Facebook group administrators, association leadership, and the university to post the study advertisement. After receiving IRB approval, the researcher posted the Recruitment Template: Social Media (Appendix B) to the approved Facebook groups and the Participant Recruitment Letter (Appendix C) to the counseling association's forum. Last, after receiving approval from the department chair of the university counseling department, the researcher sent the participant recruitment letter to the department chair to disseminate to their faculty. Those interested in participating were directed to click the link in the recruitment post or letter to participate and were taken to the Prescreening Questions and Demographic Questionnaire (Appendix D).

When the participant went to the link in Qualtrics, inclusionary and exclusionary criteria were listed at the beginning of the Prescreening Questions and Demographic Questionnaire. The first screening question required that eligible participants were 18 years old or older. If the potential participant stated they were under 18 years old, they reached the end of the questionnaire. If they were over 18 years old, they proceeded to the next questions. The researcher also screened participants for active license type, and if they said yes to being a LMHC, licensed professional counselor (LPC) or state equivalent they proceeded to the next questions. If they said no to this type of license, they reached the end of the questionnaire and did not proceed to the study. Another screening question inquired if the participant currently worked in private practice. If they said yes, the survey branched to the next question. If they said no to this question, they reached the end of the questionnaire and did not proceed to participate in the study. The branched question inquired if they had an active client caseload. If they said yes, they proceeded to the next questions. If they said no, they reached the end of the questionnaire and did not participate in the study. Another screening question inquired as to how many years they worked in private practice, if they chose 2 or more years, they proceeded to the next question, if they selected 1 year or less, the survey ended. A definition was then provided concerning CF, and if the potential participant denied experiences of CF in the last 2 years, they reached the end of the questionnaire. If they responded yes to current or past CF they proceeded to the next questions. The remaining questions inquired into their racial and gender identification, number of years in private practice, number of clients seen per week, number of clients who have experienced a traumatic event, and whether they were seeing a therapist or not.

After completing the Prescreening Questions and Demographic Questionnaire, prospective participants that met the inclusion criteria were presented the Consent Form

(Appendix E) in Qualtrics and asked to review and sign the form digitally. The consent form contained information that explained the purpose of the study, the risks and benefits of the study, the inclusion criteria, and guidelines for confidentiality to be considered while participating in the online interview. For participants who met the inclusion criteria, completed the Prescreening Questions and Demographic Questionnaire, and signed the consent form via Qualtrics were sent the confirmation email and invited to schedule the online audio and video interview. Before collecting the data, the researcher piloted the Interview Questions (Appendix G) with a counselor colleague in private practice who met the criteria for participation in the study (Moore et al., 2020; Smith & Nizza, 2022).

IPA requires an audio recording mechanism for conducting interviews (Smith & Nizza, 2022; Smith & Osborn, 2003). Therefore, the researcher conducted the audio and video interviews online using Microsoft Teams. To ensure confidentiality, prior to the interview, participants were instructed to verify they were in a private location in their home, office, or another private room. The researcher conducted the interviews in her home office and used headphones and a noise cancellation machine to further protect the participants' confidentiality. Once the interview concluded, the researcher saved the audio and video interview files in a password-protected folder on her password-protected computer. After the interview, the researcher emailed the participants the Resources Document (Appendix H) and an Amazon gift card.

Then, the researcher transcribed the interviews. Once the transcription was complete, the researcher reviewed each transcript for accuracy and sent the transcript to the participants to review for accuracy through member checking (Creswell & Poth, 2018; Lincoln & Guba, 1985). All seven participants confirmed the accuracy of the transcripts, and one provided corrections.

Participants were provided with pseudonyms to protect participant privacy and confidentiality. Identifying information was kept in a separate password-protected file from the pseudonyms to maintain participant confidentiality.

The data analysis commenced after the interview process and included listening to the transcripts, writing notes to begin to identify themes and repeating this process through every interview (Smith et al., 2009; Smith & Osborn, 2003; Smith & Nizza, 2022). In the first step the researcher read and reread the transcript for the first case (Smith et al., 2022). Next, descriptive, linguistic, and conceptual observations or exploratory noting were written while the researcher reviewed the transcript (Smith et al., 2009, 2022; Smith & Nizza, 2022). Following this, experiential insights and exploration of meaning commenced (Nizza et al., 2021; Smith & Nizza, 2022). The themes were further identified by typing them out and putting them on a bulletin board regarding the participant to search for connections across experiential statements (Smith et al., 2009, 2022; Smith & Nizza, 2022). The next step involved typing up the themes for the participant in a table in a Word document to identify personal experiential themes (PETs). Subsequently, these steps were followed to develop the PETs for each participant. The final step involved searching for experiential themes across cases to identify the group experiential themes (GETs; Smith et al., 2009, 2022; Smith & Nizza, 2022). The GETs with the overall details of the themes and subthemes that emerged during data collection can be found in Table 2 located in the results section of Chapter 4.

The Researcher's Role

In this section, the researcher's role as an instrument is described, including the unique experiences and biases that may have influenced the study. The researcher as an instrument helps meet the double hermeneutic aspect of IPA in that the participant is making sense of the

phenomenon while the researcher is also making sense of participant making sense of the phenomenon (Smith et al., 2022; Smith & Nizza, 2022). The researcher is an LMHC, certified rehabilitation counselor, and qualified supervisor who runs a group private practice. The researcher has experienced CF, including burnout and STS symptoms. The researcher sought help from a therapist, and a consultant and has constructed resources and coping strategies to manage CF. The researcher was interested in identifying and understanding the unique experiences of other CPPs who have successfully coped with CF and to learn the impact of this transition upon CPPs. Learning how CPPs who are currently experiencing CF are coping and seeking help was of interest to the researcher. The researcher was aware of personal and professional biases, including frustration with insurance companies who often audit counselors and yet pay low rates for services. Other biases include the personal knowledge of difficulty in knowing when to ask for help and struggling with finances, which impacts that decision. Additional biases include the researcher's personal and professional knowledge of risk factors, coping, resources, and help-seeking, which may have influenced the interviews and results. However, any biases might have served as part of the empathic hermeneutic (Smith et al., 2009, 2022; Smith & Osborn, 2003) in that the researcher as a counselor understands some of what the participants were going through, which is an important aspect of conducting IPA.

From the researcher's perspective, job demands are different for a counselor in private practice than for agency counselors. CPPs may experience less burnout than those who work for agencies (Lawson & Myers, 2011). However, the types of stress they experience are different (Brauner, 2015). Also, from a researcher's perspective, there can be concerns regarding managing one's time, financial and personal resources and difficulties with managing and creating policies. There can also be stress from balancing work and life boundaries and

managing large amounts of incoming messages. A counselor's phone may ring throughout the week, sometimes late at night and on weekends. If a counselor does not have a separate business line or other workers who can help, this could interrupt their ability to rest. There can be stress in determining which tasks to delegate if one has an assistant and which tasks need to be completed by the owner. There can be stress overall from running all parts of the business, including administration, financial management, payroll, insurance billing, managing employees, and being on call. Furthermore, if the clinician falls behind and cannot work due to impairment, the business may fail, and the income that one's family relies on will end, which can bring a tremendous amount of stress to the CPP.

The researcher understood that her viewpoints and experiences might have differed from other self-employed counselors. The researcher approached the research with an ontological philosophy (Creswell & Poth, 2018) in acknowledging that other CPP realities and experiences, as well as knowledge and coping, were likely different from hers. The researcher sought to measure these phenomena to see if there were themes that researchers, counselor educators, and other counselors could use to assist current and future CPPs to thrive in their professions. The researcher interpreted the information obtained through the interviews with CPPs in IPA with a double hermeneutic and observed these phenomena to see if there were themes that could help CPPs to thrive in their professions.

The researcher conducted this IPA study to build an understanding of CPPs experiences of the phenomenon of CF, as defined by Stamm (2010). The researcher explored the impact of the counselors' stressor(s) and observed the appraisal of the impact of the stressor(s) and appraisal of the resources that were used (Anderson et al., 2011; Lazarus & Folkman, 1984; Schlossberg, 1981).

Data Collection

In this section, the data collection strategies are discussed, including explanations concerning the use of the Prescreening Questions and Demographic Questionnaire and interviews. The data were collected through a demographic questionnaire and semistructured interviews. The Prescreening Questions and Demographic Questionnaire was used to determine the work setting and individual characteristics to ensure the participants qualified for the study. A semistructured interview was used to inquire about the participants experiences with CF and the meaning they derived from those experiences. An advantage of using video interviews was that it is closely likened to traditional research interviews (Bolderston, 2012). Semistructured interview questions allowed specific questions to be asked and modification based on the communications between the researcher and interviewee (Smith et al., 2009, 2022; Smith & Osborn, 2003). The researcher followed the recommendation of preparing an interview guide to provide some structure and provided the in-depth interviewing in similarity to having a conversation (Smith et al., 2009, 2022, Smith & Nizza, 2022). The questions were open and expansive to allow the participant to freely elaborate on the meaning of the experience (Smith et al., 2009; Smith & Nizza, 2022). There was an attempt to establish rapport, the researcher also followed curious areas of inquiry, and respondents' interests were explored (Smith & Osborn, 2003). The semistructured interview offered guidelines of questions to ask but allowed freedom to closely investigate the world and the unique impact of the phenomenon on the participants (Smith et al., 2009; Smith & Osborn, 2003). The questions were asked, and then if the respondent had any difficulty answering or data was halted, the researcher encouraged more discussion (Smith et al., 2009, 2022; Smith & Osborn, 2003; Smith & Nizza, 2022).

Questionnaire

A demographic questionnaire was provided through Qualtrics in order to exclude participants who did not meet the studies' inclusionary criteria and in order to obtain information concerning gender, age, racial identification, years in private practice, number of clients seen per week, number of clients with trauma histories, license type and to inquire if they were seeing a therapist. Participants did not move past the first four questions if they did not meet all of the criteria. Eligibility criteria required participants to be 18 years old or older, be an LPC/LMHC (or state equivalent), work in private practice actively seeing clients, and identify as having experienced CF in the last 2 years while working in private practice. The demographic questions were designed to obtain information about the person of the participant and their work environment. A definition was provided concerning compassion fatigue in order to help the participant identify if they are experiencing this.

Prescreening and Demographic Questionnaire

1. What is your age?
    - 18–21 years old
    - 22–25 years old
    - 26–35 years old
    - 36–45 years old
    - 46–55 years old
    - 56 years old or older
    - Under 18 years old

2. What nonrestrictive counseling license do you hold?
    - LMHC
    - LPC
    - State equivalent (specify)_____
    - Other mental health discipline (LMFT, LCSW, psychologist, etc.)
    - I am not currently licensed
3. Do you currently work in a private practice?
    - Yes
    - No

    a. If yes, do you currently see clients (have an active client caseload)?
        - Yes
        - No”
4. How many years have you worked in private practice?
    - 1 year or less
    - 2–4 years
    - 5–9 years
    - 10 + years
5. Review the following definition of “compassion fatigue” as defined by Stebnicki (2017):

“Compassion fatigue is empathy fatigue that negatively impacts the mind, body and spiritual self, broken into two parts: burnout and secondary traumatic stress.

Burnout—counselors’ feelings of hopelessness, exhaustion and lack of effectiveness in your work.

Secondary traumatic stress—counselors secondary exposure to trauma experienced by clients.”

In considering the above definition of compassion fatigue, in the past 2 years have you experienced compassion fatigue (burnout and/or secondary traumatic stress) while working in private practice?

- Yes
- No”

6. What is your racial identification? Check all that apply.
    - Black
    - African American
    - Latinx/Latin American
    - Native American
    - Asian American/Pacific Islander
    - Asian
    - White
    - Arab American
    - African
    - Not listed (please specify)_____
    - Prefer not to answer
7. To which gender identity do you most identify?
    - Female
    - Male
    - Gender diverse
    - Non-binary
    - Non-conforming

- Not listed
- Prefer not to answer

8. How many clients are you currently seeing per week?
    - 1–5
    - 6–10
    - 11–15
    - 16–20
    - 21–25
    - 26+
9. Of the clients you are seeing per week, how many have experienced a traumatic event?
    - 1–5
    - 6–10
    - 11–15
    - 16–20
    - 21–25
    - 26+
10. Are you currently seeing a therapist?
    - Yes
    - No

Interviews

A semistructured online interview was conducted through Microsoft Teams to interview the CPPs. First there was a greeting and introduction and explanation of the process of the interview such as that the researcher was inquiring about experiences and viewpoints in private

practice and with CF. The interviews were conducted from the researcher's home office and privacy was ensured. The participants were instructed on the consent form to ensure privacy either in a room in their home or their office.

Standardized Open-Ended Semistructured Interview Questions

1. Please describe the population of clients you work with in your private practice.
2. Please describe the stressors experienced in your personal and professional life.
3. What stressors have you experienced while working in private practice?
4. What were some of the unexpected stressors you experienced?
5. Can you describe how you came to experience compassion fatigue?
6. What did compassion fatigue feel like?
7. What did it mean to you when you recognized you were experiencing compassion fatigue?
8. What did you do once you noticed your symptoms of compassion fatigue?
9. What strategies did you use to help you cope with compassion fatigue?
10. Please describe your process of coping with compassion fatigue.
11. What coping strategies did you find most beneficial?
12. What are your beliefs about counselors who experience compassion fatigue?
13. How do you believe compassion fatigue could be prevented?
14. What do you believe may have prevented you from asking for help, if anything?
15. Is there anything else you would like to share about your experiences that I have not addressed?

The interview questions were open to allow participants to expand on the topic (Smith et al., 2009, 2022). Question 1 explored the caseload of the participant and the potential influence

on CF and related to the OARQ. Freudenberger (1975) noted that limited success with caseloads posed a risk. In the questionnaire, caseload size was also requested. A high caseload size has been linked to burnout (O'Connor et al., 2018; O'Sullivan & Bates, 2014) along with severe symptoms (Negash & Sahin, 2011). Counselor wellness was associated with having a smaller caseload in terms of high-risk clients (Lawson & Myers, 2011).

Question 2 addressed the notion that balancing work, family, and education may be challenging (Negash & Sahin, 2011). Questions 2 through 4 concerned the OARQ and some of the stressors, experiences, or transitions with CF that may include difficulties with managing CT (Apostolopoulou, 2013; Connery & Murdock, 2019; Lu et al., 2017; McCann & Pearlman, 1990; Moore et al., 2020; Stebnicki, 2000), and isolation (Brauner, 2015; McCann & Pearlman, 1990; Salyers et al., 2015; Savic-Jabrow, 2010). There may also be employment-related stress (Brauner, 2015; Freudenberger, 1975; Harrington, 2013; O'Sullivan & Bates, 2014; Tabaj et al., 2015; Thompson et al., 2014) and poor boundaries (Freudenberger, 1975; Litam et al., 2021; Moore et al., 2020; Negash & Sahin, 2011; Puig et al., 2012; Sweifach et al., 2013; Tabaj et al., 2015).

Questions 5 through 8 concerned the OARQ and the meaning of the experience of CF for the participants, including feelings and associated meanings. Concerning signs of CF, there may be symptoms of burnout and STS symptoms (Stamm, 2010) such as fatigue, withdrawal, or pessimism about work and one's ability to make a difference (Maslach, 2003; Maslach & Jackson, 1981; WHO, 2022). There may be intrusive symptoms, difficulty sleeping, and avoidance of triggers (Figley, 1995; Stamm, 2010).

Questions 9 through 11 asked about the meaning behind help-seeking and coping behaviors of CPPs and pertained to SQ1 and SQ2. Help-seeking behaviors included talking to an

intimate partner, friend, parent, or doctor (Mullen & Crowe, 2017) and seeking personal counseling (Gutierrez & Mullen, 2016; Kalkbrenner et al., 2019; Savic-Jabrow, 2010). Counselors might also pursue supervision (Carney & Jefferson, 2014; Finklestein et al., 2015; Knight, 2013; Mullen & Crowe, 2017; Savic-Jabrow, 2010), or peer support (Connery & Murdock, 2019; Darcy & Abed-Faghri, 2013; Moore et al., 2020; Savic-Jabrow, 2010; Stebnicki, 2000). CPPs may also seek spiritual support (Coaston, 2017; Davis et al., 2012; Hardiman & Simmonds, 2013; Skovholt & Trotter-Mathison, 2016; Thompson et al., 2014).

Coping strategies of CPPs include self-care practices such as wellness behaviors (Bradley et al., 2013; Foreman, 2018; Lawson & Myers, 2011; Myers & Sweeney, 2005; Savic-Jabrow, 2010; Thompson et al., 2014; Williams et al., 2012) or focusing on the rewards of therapy or CS (Beaumont et al., 2016; Gonzalez et al., 2019; Litam et al., 2021; Skovholt, 2012; Stamm, 2010; Thompson et al., 2014). CPPs can also attend to an increase in boundaries (Connery & Murdock, 2019; Freudenberger, 1975; Savic-Jabrow, 2010; Skovholt, 2012), including setting aside time to attend further training (Skovholt, 2012; Sweifach et al., 2013). Furthermore, SC (Coaston, 2017; Finlay-Jones et al., 2015; Thompson et al., 2014) and mindfulness (Coaston, 2017; Hayes et al., 2004; Thompson et al., 2014) are additional coping strategies that CPPs might utilize.

Questions 12 and 14 pertained to SQ1 and exploring hindrances to help-seeking, including stigma (Carney & Jefferson, 2014; Mullen & Crowe, 2017; Negash & Sahin, 2011) or negative views of the level of helpfulness of counseling (Kalkbrenner et al., 2019). This question also addressed stressors with self-exploration involved in personal therapy (Malikiosi-Loizos; 2013).

Question 13 asked the participants to draw the together how they believed CF could be prevented. This question pertained to the OARQ and two SQs, and it inquired into help-seeking

and coping as well as meaning-focused coping when they reappraised coping for more effective coping (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004).

Question 15 provided an opportunity for further exploration of the participants' experiences and meaning found in those experiences.

Data Analysis

This section describes the IPA data analysis process. The IPA data analysis process involved a challenging nonlinear procedure where the researcher drew on creativity and skill and allowed room for interpretation (Smith et al., 2009; Smith & Nizza, 2022). In IPA, the focus is on the participants and the meaning they derive from their experience as well as the researcher's interpretation of the thoughts of the participant (Smith et al., 2009; Smith & Nizza, 2022). This process involves a detailed analysis of what was said in the interview (Smith & Nizza, 2022). There is room for subjectivity, leading to only tentative statements concerning what was observed (Smith et al., 2009). The process involves reading and recording the evolving narratives of the participants, identifying themes in the interview and in between the sum of the interviews (Nizza et al., 2021).

First, the researcher read and reread each transcript and took exploratory notes. The researcher printed the transcript, listened to the interview, went through each question, and wrote notes in the margins of the transcript to begin to identify emerging themes and repeated the process (Smith et al., 2009, 2022; Smith & Osborn, 2003; Smith & Nizza, 2022). The researcher followed the Smith and colleagues suggestion and imagined the participant who spoke the words and kept in mind that the process and the researcher recorded ideas as they came (Smith et al., 2009; Smith & Nizza, 2022) while also avoiding making strong conclusions (Smith & Nizza, 2022). The researcher noted insights by making detailed notes in the margins and using sticky

notes (Smith et al., 2009). The researcher kept a journal to record additional insights made after each interview (Smith et al., 2009, 2022).

The researcher used descriptive, linguistic, and conceptual observations (Smith et al., 2009; Smith & Nizza, 2022). Descriptive comments involved noting objects the participant explained such as the face value items,important objects, events and experiences for the participant (Smith et al., 2009; Smith & Nizza, 2022). As the exploration of these comments continued, meanings were derived from the descriptors (Smith et al., 2009). The researcher used linguistic exploration by examining the words chosen to express meaning and paid attention to pauses, laughter, metaphors, similar statements, and repetitions (Smith et al., 2009; Smith & Nizza, 2022). Through conceptual commenting, the researcher identified the underlying theme the participant was expressing (Smith et al., 2009; Smith & Nizza, 2022). This observation process also drew from the researcher's professional, clinical, and life experiences to aid in identifying possible meanings (Smith et al., 2009).

Following this, the researcher reviewed the initial noting and made experiential statements, existential assertions and identified the emerging meanings behind the words (Nizza et al., 2021; Smith et al., 2022; Smith & Nizza, 2022). These statements were sometimes psychological due to the researcher's background and yet rooted in the concept of the experience described (Smith & Nizza, 2022). This process involved interpretation and reading between the lines selectivity in what was highlighted (Smith et al., 2022; Smith & Nizza, 2022). Overall, the researcher identified the participants' experiences and then interpreted the experience (Smith & Nizza, 2022).

The researcher identified themes through mapping, connecting and recognizing patterns in the transcripts and the wealth of experiential statements (Smith et al., 2009, 2022; Smith &

Nizza, 2022). This identifying was part of hermeneutics in taking apart the whole to identify the parts to be drawn back together (Smith et al., 2009). This process constructed a depth of understanding with the researcher's interpretations involving both the participant and researcher (Smith et al., 2009). The researcher searched for connections across emerging experiential themes and searched for theme connections in thinking of the research questions. The researcher then arranged the experiential statements on a bulletin board and placed experiential themes together to determine connections (Smith et al., 2009, 2022; Smith & Nizza, 2022).

Following the identification of themes, involved the process of bringing the parts into the whole (Smith et al., 2009) through naming the PETs and organizing them into a Word document for the participant (Smith et al., 2009, 2022; Smith & Nizza, 2022). The researcher added the experiential statements under the theme identified and listed the page in the transcript, which helped with internal consistency, relative broadness and specificity of each theme (Smith et al., 2009, 2022). The themes were listed with the PETs written in bold capital letters and subthemes written in bold (Smith et al., 2022). The experiential statements were written below the themes and subthemes followed by the corresponding participants statements and their respective page numbers (Smith et al., 2022).

The researcher used several tools to aid in identifying and understanding themes through abstraction, subsumption, polarization, contextualization, and numeration (Smith et al., 2009). Abstraction was used to identify similar themes and then to name the overall theme. Subsumption was employed when a theme was identified, and other themes were listed under this larger theme. Polarization was used to identify contradicting themes and opposites. Contextualization was also applied to draw together themes in the context of the person's life in terms of temporal, cultural and narrative themes. Numeration was used while observing the

frequency that a similar theme appeared in the interview. Finally, identifying the function of the themes in larger themes was also used (Smith et al., 2009).

Following this, the researcher repeated the prior steps through reading and rereading, initial noting, developing themes, and searching for connections across experiential statements and themes for subsequent cases (Smith et al., 2009, 2022; Smith & Nizza, 2022). In working with subsequent participant data, the researcher sought to identify individual themes; however, as Smith et al. (2009) predicted, the researcher was likely influenced by the prior data and yet attempted to look at the individual case separately as was possible.

In the final step, the researcher searched for patterns across cases by developing emerging GETs (Smith et al., 2009, 2022; Smith & Nizza, 2022). The researcher compared and reordered the data on a bulletin board as Smith and Nizza (2022) suggested. A master table of themes for the group was created (Smith et al., 2009, 2022). Additional levels of interpretation were used such as after analyzing the whole, and the researcher focused on important pieces of the transcript and further explored points of interest (Smith et al., 2009). The researcher worked to stay present in the context of the writings with interpretation and maintaining a balance of empathy and questioning in terms of hermeneutics (Smith et al., 2009). The researcher focused on building overall themes but also focused on the individual parts and delved into the deep meanings behind the words of participants (Smith et al., 2009). Following the deep analysis of themes, the researcher wrote up the findings in the results section.

Trustworthiness

In this section, the trustworthiness strategies used in the study included credibility, dependability and confirmability, and transferability. Creswell and Poth (2018) emphasized the importance of having trustworthiness in qualitative research methods. According to Lincoln and

Guba (1985) trustworthiness was defined as the ability to convince the readers that the findings are worth paying attention to, which includes truth value or credibility, establishing confidence in the findings, and applicability or transferability. The researcher focused on consistency or dependability to aid in future replication of the study. The researcher maintained neutrality or confirmability to build the findings in the experiences of participants and not on the researcher's biases (Lincoln & Guba, 1985).

Smith et al. (2009) presented an argument that the trustworthiness of IPA is enhanced when used correctly. Yardley (2000) provided principles for reviewing the quality of qualitative methods, including the application of sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. Sensitivity to context consists of grounding in knowledge found by prior investigators of the theory and in the literature, sociocultural considerations and participant perspectives as well as ethical considerations (Yardley, 2000). This study met the requirement for sensitivity to context in the application of purposive sampling, sensitivity through building empathy and rapport with the participant, and being sensitive in the interpretation of meaning while analyzing transcripts (Smith et al., 2009). According to Yardley commitment and rigor of meticulousness in the data collection process, analysis and reporting along with the researcher taking extra care to immerse themself in the topic. Commitment and rigor were also demonstrated in the sensible selection of participants and confirming that they met the research criteria along with maintaining sensitive engagement with the participants during the interviews (Smith et al., 2009).

Transparency and coherence concerned clarity and the strength of the argument, the quality of the narrative, coherence between the philosophy and the method used, and transparency through providing details concerning data collection (Yardley, 2000). These were

demonstrated through the application of IPA through the researcher's use of details or tables to describe the participants, the interview, and the analysis procedure (Smith et al., 2009). Impact and importance concerned the value of the data described in the qualitative research and whether it was interesting and of value to others (Yardley, 2000), and this researcher was seeking to provide interesting information (Smith et al., 2009) to aid current and future CPPs. Furthermore, in addition to the rigorous process of IPA, which leads to an increase in credibility, the researcher used several strategies to increase objectivity and reduce bias (Creswell & Poth, 2018; Smith et al., 2009) such as recording insights in a journal.

Credibility

Creswell and Poth (2018) suggested several strategies to follow to maintain credible qualitative methods, such as applying the researcher's lens, the participant's lens and the reviewer's lens. The reviewer's lens is described in the next section. The researcher's lens is the researcher's task of verifying the accuracy of the qualitative findings (Creswell & Poth, 2018). The first strategy used through the researcher's lens was corroborating evidence through triangulation of multiple data sources (Creswell & Poth, 2018; Lincoln & Guba, 1985). This involved substantiating information with the literature to expound on the identified themes (Creswell & Poth, 2018) as was described in the findings and implications sections. The researcher also used referential adequacy, which involves comparing statements to the phenomena described and is established through evaluating the videotape recordings after the meetings (Lincoln & Guba; Eisner, 1975). Through the procedures with IPA, the researcher recorded and transcribed the interviews, and later listened and reviewed the transcripts multiple times to ensure accuracy which also increased credibility.

Lincoln and Guba (1985) pointed to another strategy to increase credibility, negative case analysis. The researcher reported any disconfirming evidence, and negative case analysis with multiple data sources from the literature and using detailed descriptors to aid in replication and depth of analysis (Creswell & Poth, 2018). The researcher worked to describe insights while reading the transcripts without overly subjective opinions but also pulled from research, training and experience (Creswell & Poth, 2018; van Manen, 2014). However, this also involved using the self of the researcher as part of the process in IPA and hermeneutics which involves the person of the researcher observing the phenomena in the participant (Smith et al., 2009; Smith & Osborn, 2003).

Regarding the participant's lens, member checking was used, which is the participants checking the transcripts to ensure accuracy (Creswell & Poth, 2018; Lincoln & Guba, 1985). After checking the transcript for accuracy, the researcher sent a copy to the participants, and they updated the documents or approved the transcripts. All seven participants approved their transcripts. Lincoln and Guba (1985) described member checking as an important piece of building credibility and Alase (2017) confirmed the benefit of credibility as well as transferability in IPA.

Dependability and Confirmability

Dependability is defined as consistency and determining if the study could be repeated (Guba, 1981; Lincoln & Guba, 1985). Lincoln and Guba (1985) noted that establishing credibility helps with building dependability. Confirmability is defined as a form of neutrality and determining whether the findings are rooted in the participants' experiences (Lincoln & Guba, 1985). Dependability and confirmability can also be set through an audit trail (Guba, 1981). Concerning a reader's or reviewers' lens, a researcher provides detailed descriptors of

processes used so a third party would be able to follow and replicate the procedures (Creswell & Poth, 2018; Smith et al., 2009) to add to the knowledge base. The interviews commenced through Microsoft Teams and were recorded and transcribed. Transcripts were reviewed with analysis through detailed notes, which increases dependability (Creswell & Poth, 2018). The researcher reviewed the transcripts after the interviews to make sure they represented the interview, and the researchers' detailed notes concerning themes could also be reviewed by an auditor. According to van Manen (2014) phenomenological studies concern not comparisons and measurements, but if another researcher is to study the phenomena they will seek additional information, not necessarily replication.

Transferability

Transferability with qualitative methods consists of identifying patterns and in-depth descriptions as well as formulating ideas or themes (Lincoln & Guba, 1985). Other researchers can then review the information to determine if those ideas apply to their research (Lincoln & Guba, 1985). This qualitative researcher provided in-depth descriptions to aid the feasibility of further research (Lincoln & Guba, 1985). This IPA study involved a small homogenous sample who provided information about a perspective instead of a population (Smith et al., 2009). The importance of having a homogenous sample includes the ability to observe the experiences of the participants and any "convergence and divergence" that occurs (Smith et al., 2009, p. 50). Smith et al. (2009) described the significance of theoretical transferability in connecting the themes identified, their personal and professional experience, and the existing literature. Moreover, the process of IPA and the in-depth analysis involved seeking to understand the phenomenon through identifying themes in the transcripts and between participants (Smith et al., 2009; Smith & Nizza, 2022). Using in-depth descriptors aided transferability so other researchers could

replicate the research and follow the steps used (Creswell & Poth, 2018) or add to the data on the phenomena (van Manen, 2014). The information collected concerning CPPs' experiences of CF and their help-seeking behaviors and coping strategies added to the knowledge base about the participants' experiences, which may help present and future CPPs.

Ethical Considerations

In this section ethical considerations are described, including the process used for seeking approval for the study, the storage of the data, confidentiality, risks and benefits and referrals. Research did not commence until approval was received from Liberty University's IRB. Permission to advertise the study was requested from the approved Facebook group administrators, the association and the department chair of a university's counseling and family department. According to Microsoft (2022) data in Microsoft Teams is secure and encrypted. The interviews in Microsoft Teams were downloaded to a password-protected computer. All data for this study were stored in a password-protected folder on a password-protected computer. Any physical data such as Word documents and tables were locked in a filing cabinet. Identifying information was removed and pseudonyms were used to protect participant privacy and confidentiality. In the consent forms, it was disclosed that the study would consist of prescreening and demographic questions and that an interview would commence about participant experiences with CF, their help-seeking and coping behaviors. Risks were described such as that the discussion of CF may bring up distressing thoughts and feelings concerning the topic. Also discussing STS may bring up memories of this occurrence. Benefits were described as not helping the participant but helping other counselors and future counselors. The participants were informed through the consent form that they were free to withdraw from the study at any time. A list of referral sources was also provided as compiled in Appendix H.

Through the process of the interview, the researcher remained aware of the participants emotional status and checked in with them as needed to see how they were doing and if they were ok to proceed.

Summary

The purpose of the study was to understand CPPs experiences of CF and their help-seeking behaviors and coping strategies. Few researchers have inquired into the experience of CF with this population (Savic-Jabrow, 2010). After receiving IRB approval, the qualitative study commenced consisting of IPA with a double hermeneutic of empathic and questioning hermeneutics (Smith et al., 2009; Smith & Osborn, 2003; Smith & Nizza, 2022). Snowball and purposive sampling were used to determine a sample of seven CPPs. Risks and benefits for participation were described in the consent forms. A semistructured recorded interview of 15 questions was conducted with CPPs through Microsoft Teams and was transcribed at that time through Microsoft Teams. The transcripts were then analyzed through detailed notetaking and a researcher's journal for each individual and then themes were identified in the subject's narrative and then between participants. These were written up into tables. In terms of trustworthiness, the researcher worked to follow IPA and reduce unnecessary bias by reporting any disconfirming evidence, corroborating with multiple data sources, and using detailed descriptors for replication and depth of analysis (Creswell & Poth, 2018). In terms of ethics, a consent form was provided explaining risks and benefits as well as the option to withdraw and referrals were provided. Pseudonyms were used, and the research was password protected. In the following chapter, the findings of the research will be provided.

Chapter Four: Findings

The purpose of this phenomenological study was to understand the meaning CPPs found in experiences of CF, and their help-seeking and coping behaviors. This chapter provides an overview of the participants and the data collected. Following this, the findings are presented, including the three themes identified and each of their subsequent subthemes. The research question responses are then provided followed by a summary.

Participants

Seven participants participated in this IPA study. Each participant relayed their unique experiences of stress and their experiences of CF as well as coping and help-seeking they used in the last 2 years. In this section, background information about the participants is provided including age, licensure type, work setting, caseload information, coping, and supports.

Cheryl

Cheryl is a White female between 26 and 35 years old. She is an LPC and works as a contractor in a group private practice. She has been employed in private practice for 5–9 years and works with individuals and couples from adolescence through adulthood. Cheryl reported that she sees between 21–25 clients per week, and 11–15 of these clients have experienced trauma. She recently trained in *Accelerated Resolution Therapy* (ART) and relayed that this has been a great help in her practice and protects her from trauma stories. Cheryl also recognized that she has been experiencing CF over the last 2 years and questioned her purpose. She reported she is currently seeing a therapist and also feels supported by therapist friends. She expressed having faith in God which supports her in her practice.

Jody

Jody is between 36–45 years old, is woman, and chose not to answer concerning racial identification. She is an LCPC and has worked in private practice for 10 or more years and currently runs her own private practice. She reported she mainly works with adults between 20s and 50s and provides treatment for anxiety, depression, and some other diagnoses including grief, career, family difficulties. She sees between 16–20 clients per week and 11–15 of these experienced trauma. She said that she experienced CF within the last 2 years. She is not currently seeing a therapist but spends time with and consults with other therapist friends. She has a spouse and a family that she spends time with as well as friends. She spends some of her free time reading, journaling and doing yoga and reported she is somewhat introverted. She keeps a structured workweek and unstructured weekends to allow time with family and to complete errands.

JoJo

JoJo is a 56-year-old or older White woman. She is an LPC, currently works in private practice, and has been practicing for 10 or more years. She sees children and adults from 11 or 12 years old and up. She was previously employed as a public-school teacher. She sees between 16 and 20 clients per week, of whom six to 10 have experienced trauma. She stated she sees high functioning clients now but used to work with various types of clients. She identified experiencing CF in the last 2 years and stated she is seeing a personal therapist. She realizes that she and her husband are good a support for each other. She also has children she described she talks to and a son who lives nearby. She described a strong faith in God and reported she is a Christian. She reported she often turns to the Lord for guidance with her practice. She has been

working to separate her identity from that of a counselor and stated she realizes she will retire some day and that she needs to separate her self-confidence from this.

Margaret

Margaret is a White woman between the ages of 46–55 years old. She is an LPC and has been working in private practice for 10 or more years. She is the CEO and administrator of her group private practice and reported it became a nonprofit in 2017 and they own their building. While also managing staff, she also keeps a caseload of 21 to 25 clients per week and of these 16 to 20 have experienced trauma. She reported she experienced CF in the last 2 years and stated that seasonal darkness is a stressor for her. She reported that the closest practice is a long distance away, so her group practice accepts almost any type of complaint or diagnosis to accommodate client needs. She reported she experiences more stress from managing employees than working with clients. Margaret does not see a personal therapist at this time. She reported she spends her free time exercising and enjoys biking and running. She is also married and described her husband as supportive. She reported she has a strong faith as well and enjoys leading Bible studies.

Mary

Mary is a White woman between 46–55 years old and has a state equivalent license of LPCC-S. She runs her private practice and is also working to build a side project to provide psychoeducation. She has also provided supervision to interns. Prior to working in counseling, she worked in marketing. She has been in private practice for 5 to 9 years. She currently sees between 11 to 15 clients per week of whom 11 to 15 have experienced trauma. She reported she used to counsel children along with adults but now she mainly counsels adults and has worked in maternal mental health. She identified she experienced CF in the last 2 years. She is not currently

seeing a therapist, but she participates in a consultation group with other therapists that she highly values. She has reduced her client load to allow space for healing. She reported she is married and has a daughter and said that her personal life is going well but she experiences stress in her work.

Ruby

Ruby is a Black woman who is 56 years old or older. She is an LPC, runs her private practice and recently started a coaching business as well. She has been working in private practice for 5 to 9 years and sees between 16 to 20 clients per week, of whom 11 to 15 of these have experienced trauma. Her caseload consists of clients with trauma and addiction, and she only sees adults. She identified experiencing CF in the last 2 years. She provides caregiving to her mother and her husband and is currently seeing a therapist. She stated she is a Christian and has a strong faith in the Lord. She reported her husband is a good support and she also talks to a small group of other counselors. She enjoys watching rerun shows because people were kinder to each other, and she reported she appreciates spending time with refreshing friends. She also spends time exercising including walking. She thoroughly enjoys providing supervision to interns and loves giving back to other counselors.

Veronica

Veronica is a White woman between the ages of 26 to 35 years old. She is an LPC and currently works in private practice and is finishing up her doctorate. She reported she is an extrovert and is also working on additional odd jobs and teaching. She has worked in private practice for 2 to 4 years and stated that she started working in full time private practice in 2019. She enjoys providing trauma treatment and also treats severe dissociation. She said that she sees between 16 to 20 clients per week and all of these clients experienced trauma. She is not

currently seeing a therapist but has therapist friends and turns to a supervisor as needed. She enjoys sports, including running, tennis, volleyball, yoga, and reading. In the next section, the results and findings of this IPA study are described.

Results

The results from this IPA study are presented under theme development and research question responses. Three GETs and subsequent subthemes emerged from the data, and these are described below. Then, the researcher explores how the themes and data helped to answer the research questions that guided this study.

Theme Development

During data analysis, the researcher followed the steps suggested for IPA. First, the researcher reviewed the transcripts and then made exploratory notes in order to begin to identify emerging themes (Smith et al., 2009, 2022). Following this, the researcher reviewed initial notes, noted potential meaning behind the statements, developed experiential statements, and searched for patterns across the statements to inform the themes. The researcher used this information to identify PETs for the first participant. Following this, these steps were followed to develop PETs for each participant. The identified PETs for each participant were reviewed and analyzed resulting in the emergence of the GETs (Smith et al., 2009, 2022). Three GETs emerged from the analyzed data: *I'm Overwhelmed on Every Side, I Don't Know What to Do, and I Can Heal.* Table 2 displays the GETs and subthemes, and information about the participants experiencing the phenomenon. The GETs will be described in detail below.

Table 2

GETs Themes and Subthemes

GETs themes	GETs subthemes
I'm Overwhelmed On Every Side	Stress In My Life
	Stress From Business
	Too Tired To Care
	What Happens If I Make Mistakes?
I Don't Know What To Do	Something's Not Right
	I'm Scared
	I've Been Hurt In The Past
I Can Heal	It's Okay To Not Be Okay
	Getting To Know Myself Again
	Taking Care Of Me
	I Grew From It

I'm Overwhelmed on Every Side

Each participant reported that she experienced significant personal and professional stressors over the last few years. They described stressors in multiple aspects of their life (personal life, business, clients, finances, etc.). They also expressed fears they experienced that were brought on by the stress, thus emerging the overall theme **I'm Overwhelmed on Every Side** and four associated subthemes. The subthemes included *Stress in My Life,* such as family stressors, personal losses, and the pandemic. There was also *Stress From Business,* including managing finances, managing staff, wavered competence, and difficulty navigating unexpected changes in business. Furthermore, participants were *Too Tired to Care* for themselves or others, experienced reduced empathy, and had trouble setting boundaries. Participants also reported

worrying about ethical mistakes under the subtheme *What Happens if I Make Mistakes? Stress in My Life* is described below.

Stress in My Life. The importance of the participants' descriptions of their experiences was their identification of the stressors in their personal and professional lives. Six participants reported that they experienced life stressors and personal losses, including stress from the pandemic, loss, societal and political stressors, and financial, and environmental stressors. For example, Margaret stated that stress developed from difficulty with hiring as well as environmental stressors such as seasonal darkness. She described, "We have darkness that starts about this time" and "between that, you know, not having enough people to help, it just kind of like descended down into darkness" (Margaret, p. 4). The two stressors of seasonal darkness and difficulties with work were impactful to her. Another participant, Mary, explained the experience of stress from social injustices and violence stating, "We have had several young Black people killed by police, so that summer of 2020 was terrible" (p. 1). She also experienced an impact to her business during Trump's election stating, "The day after, everybody's mental health tanked, I started to fill up like crazy" (Mary, p. 1). Both Mary and Veronica also described that the pandemic was stressful. Mary reported, "I think if COVID hadn't happened, I would not be burned out right now" (p. 11). Veronica also described the impact of the pandemic:

> And that fall, 2019 is when I started my grad program and then 2020 hit. And so I think it was just kind of like I was prepared to go into private practice and then do the doc[toral] program. But I was obviously nobody was prepared for pandemic so that that was definitely like a huge, huge stressor (p. 2).

The above occurrences of the pandemic, societal and political stressors were unexpected. Seasonal darkness was expected but difficult to manage along with managing a practice. Stress was also evident in participants' businesses.

Stress From Business. All seven participants recounted the impact of *Stress From Business,* such as pressures with building and maintaining the private practice, navigating unexpected changes in business, financial stressors, feeling isolated, and some experienced wavered competence. For instance, JoJo described the stress of figuring out private practice on her own due to lack of preparation and training stating, "There was absolutely no training in how to start a business" (p. 2). There was also a "huge learning curve" with credentialing with "insurance companies" (JoJo, p. 3). She also described stress related to low insurance payments and stated she "would expect that insurance companies would pay more than they did" (JoJo, p. 4). Stress came from the unknowns and teaching herself the logistics of managing a business on her own. Margaret also described the stress from administering a group practice and managing staff and detailed "working with clients at this point in my life is probably a whole lot less stressful than working with staff" (p. 1). The dual stressors of managing a caseload and managing employees was taxing. Further, multiple participants described the stress of managing finances in private practice. Veronica also discussed the impact of the ebb and flow of income in private practice (p. 3). Also, Cheryl, JoJo, and Veronica mentioned that they struggled with accepting money from clients. Navigating the nuances of financial management was stressful for participants.

Participants unexpectedly had to adjust from in-person sessions to virtual therapy. JoJo reported feeling forced to provide virtual therapy during the pandemic "or don't get paid" and stated that there "really was a learning curve trying to do it" (p. 2). Further, two participants

indicated their frustration and worry about the future of the counseling field. Mary was adamant about the impact of venture capitalism and predatory insurance credentialing programs on the future of the counseling field:

> I've always been interested in technology and progress. I feel really concerned about the future of counseling. I just wrote about this on Facebook. It used to be, if you wanted to go into counseling I was like, give them my number. I wanna support you. We need more great people in this field there. And I was a huge cheerleader, like, come and do this work, it really needs to be done. I'm not so much anymore because of I feel like. Now that the world at large has realized there's a tremendous need for mental health services, how great they realize that. What they're doing, though, is funding things like Better Help and Talkspace. They're funding Um, predatory insurance credentialing programs like Alma and Headway (Mary, p. 9).

Mary also reported worrying, "It's gonna eat the field. It's gonna eat the field" and she also predicted reduced pay for counselors (p. 10). There is a fear, lack of trust for those in charge of the profession for Mary and she worries about the impact to the counseling field.

Participants also experienced wavered competence. For instance, two participants questioned their counseling abilities or purpose. JoJo stated, "I feel like that I maybe I'm an impostor, which I don't think that's that unusual" (p. 6). Cheryl communicated, "After doing private practice, I just. I just felt like the imposter syndrome" and she questioned if she was really helping and "is your life changing?" (p. 3). She also described CF felt "defeating, helpless" and "sometimes pointless," and wondering "Why am I doing this?" (Cheryl, p. 14). Cheryl further described feeling confused and disoriented and that "I'm trying to help and nothing seems to be helping" (p. 14). JoJo described client problems as navigating a "tangled

web" (p. 8). Both JoJo and Cheryl experienced feeling like they were imposters. There was also a fear of being unethical. There was also stress from feeling isolated. Veronica noted the difficulties of isolation in private practice and acknowledged, "I think just since like pandemic, that was definitely a lot harder being in private practice and kind of being on your own" (p. 2). She also described the difficulties with being extroverted and having to isolate (Veronica, p. 3). Participants reported stress from teaching themselves how to run a business, financial stressors, fear that the field is dying, the isolation of private practice, and wavered competence. There was stress from feeling pressured to make changes they were not ready for or working with clients who were not used to technology and having to teach them, which was another layer of stress. This lead to feeling too tired to care for self or others.

Too Tired to Care. Participants said that as a result of feeling stressed in many areas of their lives, they were *Too Tired to Care* for self or others. Participants described stress from counseling clients, such as worrying about lack of progress and trouble navigating unexpected changes and managing clients' many needs. Participants also described the weight they felt from CF, such as experiencing brain fog, the heaviness of counseling, and physical fatigue. They reported difficulty sleeping or feeling irritated and on edge. Participants noticed they struggled with reduced empathy, including increased anger, dreading working with clients, and seeing client issues as having little importance. They also struggled with self-care and setting boundaries.

Three participants reported struggling with rest and sleeping. For example, Cheryl recounted she processed her feelings of anxiety, helplessness, and worries about clients in dreams (p. 12). Veronica remembered she experienced "nightmares" and was "restless in my sleep" (p. 5). JoJo also described that her sleep was impacted and recalled, "If I'm stressed. Uh,

maybe in the middle of the night thinking about a particular client, that that raises my anxiety" (p. 6). The participants appeared to be impacted by the work of counseling and were processing the content of sessions during their sleep. Three participants reported feeling irritated, on edge, or anxious. Veronica described that the isolation led to panic (p. 4). She also recalled, "And then, yeah, just kind of that always like about to cry or, like really irritable too, and kind of like I wanted to snap at everybody, you know, like, you feel that like, impulse kind of thing" (Veronica, p. 5). Veronica felt stuck due to isolation and experienced panic, was on edge, and impulsive. Some participants noticed increased irritation to small difficulties.

All seven participants reported they noticed heaviness, fatigue or exhaustion with CF. For instance, Margaret recalled, "Every day I was crying or I would come home exhausted" (p. 3). In response to the question about what CF felt like, she responded, "Like this really heavy weight, like when I mentioned earlier about this carrying the world on my shoulders, and I think specifically the time period was like between the winter and the spring" (Margaret, p. 4). Margaret felt overwhelmed by the stressors, especially during seasonal darkness. Ruby described the heaviness in being a "secret keeper" (p. 10) and recognized that a high caseload was fatiguing and suggested, "And if you can, cutting back on your caseload because that's what just wears you out" (p. 14). The heaviness of holding the secrets that were shared with Ruby weighed her down. For Margaret, it was a mixture of expected and unexpected stressors. For Ruby, it was the content of sessions that were heavy.

Regarding stress from counseling clients, Jody reported the sudden change in client mental health was stressful: "It was also overnight everybody who was in a good place is no longer in a good place" (p. 2). She also discussed the stress of hearing about pandemic-related trauma: "It was also just hearing about people's days all, all day long. You know a lot of clients

lost loved ones" (p. 4). The unexpected changes of the clients coping well and then not coping well was stressful along with hearing about the traumas related to the pandemic. Ruby also identified pressure from clients' many needs and stated, "Stressors have been so many clients in need, so many needy, needy clients" (p. 2). There was also stress from client "terminal illness diagnoses" (Ruby, p. 4) and clients' suicide attempts. She said, "And having someone being intentional about trying to end their own life, that was difficult, that was really difficult" (Ruby, p. 3). Jody struggled with clients suddenly not coping well and the content of sessions. For Ruby, the content of sessions was also stressful in addition to the urgency of sessions with client's urgent needs. Participants also struggled with the overlap of stressors with clients.

Furthermore, four participants reported stress from shared stressors with clients. For example, Veronica reported feeling "overwhelmed with this big issue that like, I as one person can't do anything about" (p. 14). She described the impact to herself if stressors in the world were brought into therapy in stating "clients talk about things in the things, you know, overlap and I get very upset about things in the world and that bothers me" (Veronica, p. 13). There was also stress from suppressing feelings regarding this "shared trauma, global trauma" especially during therapy (Veronica, p. 4). The overlap of her personal stress from the global trauma as well as the feeling that she could not change the stressor was overwhelming. Ruby too identified stress from "COVID and other political issues that were going on because all that was mixed at the same time, you know, the social injustices and now I have work and then people want to bring their political views to therapy" which was "intermingled" and described it as "just a mess" (p. 11). Both counselors and clients going through trauma together was stressful for participants.

Five participants also identified a reduced capacity for empathizing when experiencing CF. For example, Mary noticed increased anger and reduced empathy with clients. She recalled

that clients were doing things that scared her "and instead of going, I totally understand your isolated," instead, "I was like, God dammit, what's wrong with you" (Mary, p. 5). Mary found herself overreacting, and then this led to a reduction in empathic words to clients. Ruby also recounted that "little issues" were frustrating and recalled thinking, "That's all you got because I got a whole lot of my own stuff" (p. 6). She also described feeling drained from loss and grief from losing family members to COVID and recalled, "I had nothing to give" (Ruby, p. 6). She also started ranking client stressors by importance and recalled, "I thought, man, we got bigger fish to fry. People are dying from COVID around here, and you're complaining about your boss's attitude" (Ruby, p. 7). Ruby started comparing types of traumas and erroneously viewing client issues as minor. For both participants, the heaviness of personal stressors and content of sessions combined with client stressors contributed to a lack of empathy for clients.

Three participants identified hindrances to coping with CF in that self-care itself is work, and that it is such a broad term it needs to be defined for each person. In response to the signs of CF, Jody reported that she reevaluated her self-care routine (p. 3). She continued, "Sometimes self-care in and of itself can be overwhelming" and asked herself, "What do I need to do so I can be OK for my sessions tomorrow?" (Jody, p. 5). Jody described the struggle with balancing self-care and other care. Cheryl described her difficulties with finding time to add more self-care and the perceived message:

> Well, you should just do be doing more of the things that make you feel good. And while that's great and easy to say, that's much harder to do, you know, especially you look at, like, I guess on my life is kind of the average American life. Right. Two working parents, two kids at home. You know, all of the intricacies of being in the educational system and the like, the weekly stuff that comes up with that. (Cheryl, p. 15)

Cheryl described it as easy to prescribe more self-care but difficult to implement when already tired and busy. Figuring out the particulars of what self-care means to the person and defining it, balancing other care and self-care and finding time to care for self was a struggle for participants. In addition to struggling with self-care, they struggled with boundary setting.

Further, five participants described their struggle with setting and maintaining boundaries in their practices and with clients. Cheryl explained her frustration with the "pressure to take on clients that that we're not equipped to deal with" where supervisors and directors respond, "Well, you're not gonna always have the experience, but that's part of this learning process" (p. 3). She reported she then wonders when she is supposed to transfer or refer out clients (Cheryl, p. 4). She reported that her supervisors were not gently guiding her but pushing her to accept clients she did not feel prepared to work with, which was confusing to her. Ruby also said that she "used to have them mentality of you can't say no. Umm, that that's rude, that you need to always be available to serve" (p. 14). She was taught to give unconditionally and was uncertain where to set her boundaries. There was pressure to take inappropriate referrals for Cheryl. There was also pressure to always be available for Ruby. These internal struggles between caring for self and others were stressful to participants. Participants also worried about making ethical mistakes.

What Happens if I Make Mistakes? Three participants reported stress from maintaining ethics or managing ethics complaints. JoJo described stress from worrying about ethics complaints (p. 4). She relayed the significant stress when a client did complain,

> And ohh yeah. And I was reprimanded and that was the worst day of my life. Never in my life would I ever have imagined, you know, I did a background check on a client and when I lived in another state, you know, they knew, you know. Umm. And they had disclosed that they and I the only reason I did it was because I wanted to fill in the gaps

> on some of the dates and timelines. Well, as it turned out, obviously the client was upset about that, that I hadn't gotten consent and I totally take responsibility for that (JoJo, p. 3).

JoJo described her feelings about the incident in that "I was reprimanded. It's on. I'm on a blacklist" and she reported, "I feel like I've been shamed in a way" (p. 4). Stress came from the fear of making mistakes, the fear of being unethical, and the trauma of being reported and shamed. Also, Mary as a sole practitioner, was considering reducing her caseload due to stress but she worried the board might accuse her of client abandonment. She stated, "Our board is coming after us for abandonment. Everybody is full. How do I cut my caseload without abandoning clients?" (p. 4). She also stated she was uncertain how to later increase her caseload again without risking burnout (Mary, p. 5). Fear came from the unknowns such as how to manage CF through reducing her caseload and trying not to abandon her clients. Both participants described stressors relating to maintaining ethics and fear of being unethical. With these struggles, participants were not sure how to help themselves.

I Don't Know What to Do

Participants experienced uncertainty with whether they should reach out for help. Three participants reported that they had trouble with reaching out for help due to difficulty recognizing CF under subtheme *Something's Not Right* such as having confusing definitions of what CF was, missing signs of CF, and not noticing it until it was experienced. When considering reaching out for help, the participants reported *I'm Scared* such as worrying they would bring the counselor down. They also considered their helper's stress levels, or worried about bothering them. Other worries included a struggle with external and internal stigma.

Further, five participants experienced unhelpful support in the past with the subtheme *I've Been Hurt in the Past. Something's Not Right* is described first.

Something's Not Right. Three participants reported difficulty recognizing CF, which may have hindered them from requesting help with CF. Margaret recalled, "I don't think I really recognized at that moment that it was compassion fatigue" (p. 3) and later attributed this to a possible lack of knowledge as to what it was (p. 4). She also stated that she believes that CF intensifies through missing the signs of CF, stating,

> I think for some of them, they may not even know that it's happening. And just like me, it just kind of creeps up on you and I think that's why in the counseling field, there's such a high turnover rate because they will go years. Kind of like in that little box not realizing that the reason they can't get out is because they have allowed the, the stressors of counseling, just weigh them down and becomes their norm. And when that happens, it's your norm and you're not looking for anything outside of that (Margaret, p. 8).

Conversely, Veronica had heard about CF but was confused that the definitions did not match her experience. She experienced stress from life, such as "other things in my life and in the world that were going on" (p. 13). She further relayed, "Everyone tells you you're, like almost supposed to get fatigued from hearing trauma stories all the time. And I'm not. That's not what bothers me" (Veronica, p. 13). There was confusion for both participants regarding a lack of knowledge for Margaret. For Veronica, it was because she was provided with confusing definitions that contradicted her experience of CF. Participants also worried they might be a burden to their counselor and worried about other perceptions of their need for help.

I'm Scared. Participants also said that they either worried about other counselor stress levels or feared being labeled if they did reach out. Jody described her process of considering

asking for help; “I mean, thankfully I didn’t experience job loss” or “a death in my immediate family, so it seemed hard to turn to other people that maybe were dealing with more severe things than I was” (p. 10). When reaching out, she considered “who is the right person to lean on if I need to and in terms of my own support system” (Jody, p. 10). Jody compared her own stressors with those of others and worried about being a burden to her counselor. Mary’s own experience of being overwhelmed helped her understand that other counselors were probably overwhelmed, but it prevented her from seeking counseling. She recounted, “If somebody had come to me to ask for help, I’d be like, are you freaking kidding me right now? Like, I don’t have capacity, so I was aware that people didn’t have capacity” (Mary, p. 10). She also reported worry for the personal counselor: “I don’t really want to add to it, and also I’m so down on counseling” and worries she might “bring the counselor down” (Mary, p. 10). Mary worried that the content of her own sessions could bring down her personal counselor, and she did not want to add to their stress. Also, Veronica recalled when she considered talking to her supervisor and stated, “I’m like, well, I know they have a lot going on too right now. You know, like, I don’t want to bother them. And so it was really hard to, like, bring it up” (p. 10). Veronica did not want to bother her supervisor and also thought about their own stressors. All three participants struggled with minimizing their needs and possibly overempathizing with their helpers, which hindered them from asking for help. Participants also worried about being labeled.

Five participants described their perception of the stigma around counselors seeking help. Some described the stigma they perceived from others, and some experienced their own internal stigma. For example, Cheryl described her perception of stigma and its effects on herself and other counselors:

> I think the,I wanna say shame, that doesn't feel right. The stigma around compassion fatigue again. If everything is kind of competitive in this field and compassion fatigue is kind of there's a stigma around it of maybe feeling wrong or being wrong or again the answer being well you're just not doing enough self-care. So there's something wrong with you 'cause you're feeling this way. Almost. It's very. Which is hilarious. It's very stigmatizing as a mental health condition, given that we're in the mental health field. Not stigmatizing people for their mental health conditions (Cheryl, p. 21).

Cheryl described this dichotomy: counselors are not supposed to stigmatize others, but counselors feel stigmatized when they struggle. Veronica thought that at first experiencing CF "meant like ohh no I'm not a good counselor" (p. 6). There was also a perception or message that "a counselor can't breakdown like that's not an option" and "that thought really kept me from even accepting that it was happening" (p. 13). Veronica also stated that she wanted to help others with CF, but for herself, she thought, "I shouldn't have that" (p. 11). Cheryl and Veronica both struggled with feeling like they needed to be strong based on their own internal struggles and worried about how others might perceive their need for help. Participants struggled with overempathizing with other counselors in their search for help and also worried about what it might mean that they needed help. Participants also reported inadequate or harmful past support.

I've Been Hurt in the Past. Five participants experienced insufficient support in the past, which may have prevented them from asking for help. Cheryl reported, "At my previous practice, the supervisor was the most neurotic person I've ever met" and "very sick and abusive actually" (p. 8). She also reported that she knows of "narcissists" in the field and stated, "This field can draw the people who are power hungry" (Cheryl, p. 20). This might have brought some

fear of asking for help and worrying about being harmed somehow by the person. In addition, Margaret described stress when her personal counselor shared their own stressors with her:

> It's almost like he thought that because I was also a counselor, that he needed to share with me what was going on in his life. And so I, you know, he, he helped me to, to talk some stuff out, but I didn't go back to him or maybe after a few sessions because I was like, I need somebody that I could talk to, like someone talks to me, that allows me to just, just to share and not have to worry about his stuff too (Margaret, p. 3).

Margaret may have felt the weight of her own stressors and the added weight of her personal counselors' stressors. Veronica also reported that when she worked in community mental health, she developed CF "but not because of my clients. It was more like the administration and like there was a lot of workplace harassment going on" (p. 5). For Veronica, in the past she experienced CF from workplace harassment. Experiences of insufficient and harmful past support may have prevented these participants from asking for further help. However, all participants eventually realized that there was hope for healing through help-seeking and coping.

I Can Heal

All seven participants realized they needed a form of help from others and needed to apply coping strategies to manage CF. Participants realized *It's Okay to Not Be Okay,* which described the realization that CF is part of the job, and it is okay for counselors to struggle, and highlighted the importance of reaching out and requesting help. Participants also benefited from *Getting to Know Myself Again* through journaling, reflecting on their strengths and struggles, insights and self-awareness, and focusing on their faith. The participants also recognized the importance of *Taking Care of Me,* including realizing life involves finding balance with acceptance and change, self-care, rest and exercise, and protecting boundaries. Participants also

realized *I Grew from It*, which involved realizing they were called to be helpers, there is hope with CF, and they could grow through learning and teaching others. *It's Okay to Not Be Okay* is described first.

It's Okay to Not Be Okay. All seven participants recognized it was okay to struggle with CF and that CF is likely part of the job. They also realized it was okay to ask for help and reached out to their therapists, supervisors, sought consultation and support from family and friends. In recognizing it was okay to experience CF, Ruby realized it is normal to "get burnt like that and tired and lack empathy at times" and experiencing this does not mean they are "bad therapists" (p. 12). Ruby also said she cannot expect herself to be perfect or superhuman, stating, "We're not superheroes" (p. 12). Ruby found the benefit in normalizing CF and that she does not need to be perfect. JoJo also echoed that to experience CF was normal, stating, "Again, they're human," and she believes that Jesus may have experienced CF "when he went up to the mountains to pray and he said he had to get away from the people" (p. 9). She commented that CF meant "that I'm human" and it was ok "to love myself as much as I love other people that I sit with" (JoJo, p. 7). JoJo also learned from the ethics complaint and other stressors, stating, "If you get through up till retirement, it's not unusual that you get a complaint" (p. 4). She normalized that counselors are okay if they struggle and pointed to the example from her faith. Both Ruby and JoJo acknowledged that experiencing CF was normal.

Participants also described the realization that CF may be part of the job. For example, in response to inquiring whether CF could be prevented, Margaret answered, "I think it's a part of our, our growth as a counselor" (p. 8). She also stated, "I feel like if we don't go through it, we really don't understand what it is that we are preventing in the 1st place" (Margaret, p. 9). Margaret believed that experiencing CF at some point is part of the job, and experiencing it helps

with recognizing it. Jody stated regarding her beliefs about counselors experiencing CF: “It’s an occupational hazard,” and “I think it comes with the territory,” and “it’s something that if you’re in this field long enough, you’re going to experience some version of it” (p. 9). These participants said that their experiences helped them realize that CF is part of the job of counseling.

All seven participants realized they needed to reach out for help in some manner. For example, Margaret stated that reaching out for help is essential in order to continue the work of counseling and stated if counselors do not reach out, “I think that’s why the turnover rate is so high in many organizations” (Margaret, p. 8). Margaret also stated that new counselors may start out wanting to “help the world,” but they must realize they “can’t do it alone or the weight of the clientele is gonna weigh you down” (p. 8). She believed that asking for help can prevent the work of counseling from being too heavy and can help reduce turnover. Further, Ruby highlighted the importance of being “honest about what you’re feeling” and stated counselors “need the opportunity to feel safe” (p. 12). Ruby highlighted the importance of counselors expressing feelings and having a safe person to talk to. Also, JoJo described that talking something out with a loved one was very beneficial to her and reminding her that she does “have the resources and sometimes I don’t feel like I don’t see myself as positively as other people see me” (p. 8). JoJo said that loved ones highlight the good in herself, which helps her continue the work. Reaching out for help can reduce the weight of counseling, give the counselor space to express feelings, and help the counselor see themself more positively.

Concerning types of support, five participants reached out for help through personal therapy. For example, Margaret attributed her recognition of experiencing CF to her participation in counseling (p. 4) and noted that brainspotting helped her process her initial CF experiences (p.

5). She also valued participating in dialectical behavior therapy with her second therapist and recalled, “So that made such a huge difference for me,” describing the benefit of “being able to dump and not have to worry about being dumped on” (Margaret, pp. 4–5). Margaret found that her therapists helped her recognize CF, helped her process her experiences of CF, and she valued that with her second therapist, she could express her feelings without worrying about their stressors.

Three participants noted the value of supervision or consultation. Mary advocated the importance of receiving consultation for CPPs stating, “I do think consultation is a big part of it if you’re working on your own” (Mary, p. 11). Additional benefits include it is “really, really important, having colleagues and people you can trust who will call you out, but also with love and affection and understanding” (Mary, p. 9). Mary stated consultation helped her identify and process anger as a part of CF, so she would “not bring that anger in the session” (p. 5). Her colleagues also helped her identify that she was “dissociating during sessions” (Mary, p. 9). She also said some of her worst fears with her colleagues about “the venture funding” stating, “I think it’s going to get difficult to be in a sole proprietor private practice person and I’ve been talking to colleagues about that a little bit” (Mary, p. 3). Mary found safety in expressing her feelings to her consultation group, which helped her identify she was experiencing CF and helped her process and cope with her struggles. Professional support from colleagues and supervisors was helpful to these participants in helping them to identify and normalize CF, process feelings and cope with the experience.

Two participants highlighted the value of peer support, such as connecting with therapist friends. For example, When Jody realized she was experiencing CF, feeling validated through connecting with others was important; “So in a lot of ways there was relief and knowing there’s

a community out there like this wasn't something I was going through on my own (p. 5). Jody also acknowledged the importance of consultation or connecting with therapist friends to help buffer the isolation of private practice, "but then you have somebody else that could also say hey, you seem like you're getting a little burned out. What are you doing about it?" (p. 10). Jody also expressed her gratefulness for increasing social connections to help with isolation. She said, "I almost think in some ways I had more social connections virtually during that time, because everybody seemed to need that." Jody found it validating to turn to peers who could help her identify CF in herself, which helped her socialize and helped her manage isolation.

Five participants described the importance of turning to family and friends to help them through their stressors. Ruby reported she vents feelings to her "therapist or even my husband without disclosing, of course, or violating confidentiality" (p. 9). She described the refreshing aspect of surrounding herself with joyful friends who do not rely on her as a counselor:

> And I like to treat myself to a nice dinner and a nice restaurant. I like to laugh a lot, so I'll surround myself with people that make me laugh and not say, well, what do you think? You know, you're a therapist. So what do you think? You know, I want someone I surround myself with my friends who just wanna laugh and have a good time (Ruby, p. 10).

Ruby mentioned the benefits of having friends and family that she could share feelings without pressure to counsel them. Ruby found benefits in expressing her feelings to family and friends and the freedom of friendships without pressure. In the subtheme *It's Okay to Not Be Okay*, participants realized that it was okay to experience CF, recognized CF as part of the job, and acknowledged it was ok to seek help. All participants also sought help through counseling, consultation or supervision, peer support, or family and friends.

Getting to Know Myself Again. Six participants described the benefits of learning about themselves through self-reflection, journaling, or spirituality. Regarding self-reflection, JoJo described that part of her process of coping with CF as first recognizing it, then examining the effects, such as asking herself, "Why am I so irritable?" and "What's this, you know, impatience about?" (p. 8). JoJo also reported, "Sometimes I'll write. I don't keep a daily journal, but I do have an ongoing journal that when I feel like I need to process through something, I'll just start typing" and "so I'll just do that and that gets it off my brain" (JoJo, p. 8). JoJo also worked to separate her identity from being a counselor. She described the value of "having other activities in my life other than just being a professional counselor" and also stated, "I don't wanna be one of those people that needs to be the giver" (JoJo, p. 9). She contemplated, "I also I think about, you know, someday when I retire, what's that gonna be like?" and "who will I be then? Who will I be then? What is my identity then?" (JoJo, p. 10). JoJo found it helpful to journal to help her express and understand her thoughts and feelings and worked to find her identity outside of being a counselor.

Cheryl described that she recognized her "own internal pressure of helping and fixing, which I really have gotten better at some over the years" (p. 5). Cheryl reported she has considered teaching but is aware of her strengths and limitations in that "I think my ADHD and I'm like I'm not gonna know how to organize information" and she understands she can verbally communicate it "but that's what just makes me so much more personable" (p. 10). Cheryl said that self-awareness was helpful in managing her internal pressures to fix clients and understanding the strengths and limitations of managing ADHD. Self-reflection helped participants understand their strengths, manage their weaknesses, express feelings, and cope with their past. This leads to a discussion about acceptance that CPPs are human.

Four participants also turned to their faith to help them cope. Cheryl described her experience when she learned she was an intercessor:

> Umm, when I first started this in my internship, someone told me I was what was called an intercessor. So I was what my calling was is to not burden myself with whatever was being told to me and shared with me and so honorably disclosed. But to give that over to God and so that that was formative. And this is not supposed to be mine, it never is supposed to be mine. They shared it with me and I'm honored and I will respect and honor that. But I will like immediately give that over to God. So sometimes I feel like this. Like I'm like I'm translucent and it comes through me, but it goes somewhere else (p. 11).

Cheryl said that her faith helped her to manage the content she hears in sessions in that she does not take the traumas but the pass through her to the Lord. Participants worked on *Getting to Know Myself Again* by practicing self-reflection and spirituality. Participants also realized the importance of self-care.

Taking Care of Me. Participants realized the importance of taking care of themselves. This included working on acceptance and a plan for change, increasing self-care, exercise, setting boundaries with workload, and setting emotional boundaries. Participants realized the benefits of balancing acceptance and making changes. Margaret realized she needed to follow her own advice that "nothing changes, if nothing changes" (p. 5). She discussed her process of accepting the seasonal darkness but then focusing on what she could change; "Because, I mean, you can't change the dark, but you can change what you're doing" (Margaret, p. 9). She also described her coping process when clients were not growing or changing and resisted the view that "there must be something wrong with me" (Margaret, p. 2). Instead, she accepted "they're just not at that place yet to be able to make that progress" and that if she is patient and keeps working

with them, “it’s like all of a sudden they the light came on and they were able to make the progress that helps them to move forward” (Margaret, p. 2). Margaret balanced what she could change with what she could not by accepting the seasonal darkness but working on managing her thoughts and feelings. She also worked on accepting that maybe clients were not ready to work on something, but they often grew and changed when she applied patience.

JoJo also described some self-care practices she tried to incorporate; “Well, I think about the five senses and that helps me. What can I go out and see so? When I enjoy flowers, I enjoy. What can I smell?” She stated, “I’ll go and anything that’s sensory really brings me out of myself and refills my tank” (JoJo, p. 7). JoJo learned that self-care was important to implement in order to continue working in the field and found that sensory-based coping was most helpful. For the participants, self-care was unique for each of them but had a common theme of caring for themselves through focusing on their personal needs and interests.

Participants also took care of their bodies through exercise. Margaret conveyed that exercise also helped her with building stress tolerance, stating, “I felt like I could take on more or deal with more stressors by being consistently active” (Margaret, p. 6). For instance, she stated, “I started biking and I saw a huge difference in just having something to look forward to was really helpful because it seemed to help to level me out” (Margaret, p. 6). Margaret found that exercising helped her release her feelings and stressors so she could cope better. Veronica also described her process of adapting and attempting to connect and exercise during the pandemic:

> And so we got a couple of us together and so we just we started doing tennis, that summer and I haven’t played tennis since I was a kid, but they were saying, you know, like this is the safest pandemic sport. And I was like, let’s do that and so. Umm might have I might actually started that at the end of 2020 because I was like, I’ve got to do something (Veronica, p. 8).

In addition, she participated in "a yoga membership for a while, just to like be near people" (Veronica, p. 8). Both Margaret and Veronica highly valued the benefits of exercising. Margaret found biking to be helpful with building stress tolerance. Veronica recognized her need for connection and movement and adapted to playing tennis, which she found safer than other sports.

Participants also set aside time for rest, reduced their workload, or set a more reasonable schedule. They set limits with clientele and rates and set emotional boundaries, which helped protect their peace. For example, Mary described her wishes to be able to take a long break or a vacation to help her manage her feelings:

> I'm reading a book now from the early 1900s where a woman takes 6 months off to, you know, like she's to lay around and steady her nerves. And I'm like, that's what I need to do. I need 6 months off to lay in the sun, setting my nerves. Yeah (Mary, p. 5).

Mary's idea of resting involved a long break from counseling to allow herself to recharge. Mary reported she reestablished boundaries around her availability. She "realized I have let my boundaries go and I need to pull those back, which means training for lack of a better word, my clients to expect less of me" (Mary, p. 6). Mary described her process of responding to the realization that she was experiencing CF and separating her experiences from the client. She stated, "I made my zoom screen smaller, and I made the background of my computer pretty pictures and so when I would feel myself kind of getting lost in that way, I would. I would look at the pictures a little bit" (Mary, p. 6). She also described an additional coping strategy of being mindful of what she is viewing before sessions such as "not getting on Twitter before sessions cause Twitter is always like, Oh my God, the world's coming to an end!" (Mary, p. 6). Mary also restricted her caseload to mainly working with adults (p. 1). For Mary several areas were helpful in protecting her peace, such as pulling back her boundaries and reducing her availability,

working with only adults, monitoring what she meditates on before sessions, and adding pleasant pictures to the background.

Regarding setting emotional boundaries, Cheryl reported that the "therapist shield" takes the trauma for her (p. 11). She described her meaning as "sometimes I dissociate a little bit where it's almost like I disconnect" and stated, "I have like a like the therapist shield takes on the trauma and then that way it doesn't have to land in me" (Cheryl, p. 11). Cheryl also discussed how ethics training helped her realize she needed better boundaries to protect herself and her clients (p. 5). She described that she learned "sometimes the things that therapist did out of a place of helping was the probably the most hurtful thing they could have done or about them in a whole world of trouble" (p. 5). Cheryl found that adding a barrier to protect her emotional health was helpful in sessions where she disconnected from the content of sessions. She also found setting additional boundaries to protect herself and her practice helpful. Participants worked to protect their peace. Mary reduced her availability, and Mary and Cheryl both worked on disconnecting from the content of sessions as a boundary. *Taking Care of Me* involved realizing the need to care for self to continue the work of counseling. In the next section is a discussion of the participants growth through the experience of CF.

I Grew From It. All seven participants also reported growing through their CF experiences. Four participants described the meaning they found in helping others. Three participants described the realization that the experience of CF meant there was hope for healing. Five participants recognized the benefits of growth through learning and teaching, such as expanding their work and learning additional counseling techniques or theories.

Six participants described the meaning they found in helping clients and helping other counselors. For instance, Mary supported other counselors by providing free training about the

science of working in person during COVID because the associations were not providing this (Mary, p. 3). She reported she "pulled together all of the science I could find, all the research, what the CDC was saying, what WHO was saying" and she asked the local counseling association to sponsor it (Mary, p. 3). She also developed a training about the scope of practice "because we're often expected to work outside of scope" to help with "recognizing scope, recognizing competency" (Mary, p. 11). She also reported recognizing that part of preventing CF involves counselors managing their finances "without working ourselves to death" and stated, "I am interested on an individual basis helping people figure out how to do that because I think it's gonna be about specialization and diversification" (Mary, p. 10).

Both JoJo and Margaret stated that the receipt of counseling inspired them to be counselors. JoJo stated, "It propelled me to help other people because it helped me so much, and that's primarily probably why I'm in counseling now because I am one of those wounded people that made it" (p. 9). Margaret also stated prior counseling is "what fueled me to become a counselor in the first place" (p. 10). JoJo said that counseling was her calling and found meaning in that this work matters: "I can't imagine doing anything else at this time in my life. It truly, truly is a calling" (p. 11). Mary turned her struggles into something where she could help other counselors by training them. Both Margaret and JoJo were inspired to help through the receipt of counseling, and JoJo reported she feels she highly values the opportunity to help others. This leads to a discussion about hope.

Additionally, three participants described that when they learned they were experiencing CF, they saw it as a hopeful message. Ruby took CF to mean that there was hope for rest and healing. She stated that it meant "I still do care about people and their well-being and their happiness and their mental health" and "that I do have some feelings that I'm not ready to just go

get a job at McDonald's or, you know, totally leave the field" (Ruby, p. 7). Ruby realized that CF is normal, which means she is human and needs help. Also, through the receipt of support, Veronica also realized that CF meant she was empathic and caring. Jody noticed a "silver lining" regarding the pandemic that sparked awareness of CF (p. 11). She also recognized more effective self-care strategies, which she shared with clients; "I also think it's in a lot of ways made me a more effective clinician too" through "expanding my own self-care horizons" (p. 12). Jody admitted that going through the pandemic helped the counseling community to recognize CF as a problem, and she also found more effective self-care strategies she could use. Ruby recognized that experiencing CF meant she was human and needed help. The participants said that they found hope even when going through difficulties. Participants also noted the opportunity for growth through learning.

Furthermore, five participants found value in professional growth or training. Cheryl noted several times throughout the interview the value of ART in that it protected her from trauma stories. She described sessions as "just the relief and then not having to kind of like keep having to deal with those sensations that come up around random things that are still all related to some kind of trauma" (Cheryl, p. 2). She stated it "is driving a lot more passion in me and I bet if we had had this interview before I started ART, would have been a very, very different interview" and commented it is "giving me life" (Cheryl, p. 2). For Cheryl, ART shielded her from the content of sessions, such as trauma stories, and helped her increase her passion for counseling. Margaret also described that the receipt of brainspotting "prompted me to go do my own training in brainspotting" which "was helpful" (p. 5). Margaret valued the receipt of brainspotting, which inspired her to provide brainspotting to her clients. These participants described the benefits of growing and learning, which protected and inspired growth in the

provision of counseling. Participants grew through their experience of CF through the realization that counseling was a calling; they fine tuned their coping and gave back to other counselors. In the next section, the research question responses and the related themes and subthemes are discussed.

Research Question Responses

In this section, the researcher uses the identified themes and subthemes to answer the identified research questions. There was one OARQ and two SQs. The OARQ that this researcher sought to answer in this study was: What are counselors in private practice's experiences of compassion fatigue? This question addressed the study's overall purpose and met Smith et al.'s (2009) requirements for IPA in attempting to understand CPPs experiences of CF. In this question, the researcher applied both Schlossberg's (1981) transition model and Lazarus and Folkman's (1984) transactional theory of stress and coping in considering CPPs experiences of CF transitions and stress and the meaning of those experiences. The answer to this question emerged in the theme **I'm Overwhelmed on Every Side.** Through this theme, the participants described the stressors experienced, their experiences with CF, and their struggles with coping and setting boundaries. Six participants described stress from environmental, societal, or personal stressors. For example, both Mary and Veronica emphasized they experienced stress from the pandemic and Ruby described stress from personal loss. Mary voiced, "If COVID hadn't happened, I would not be burned out right now" (p. 11). Veronica also stated, "Obviously nobody was prepared for pandemic so that that was definitely like a huge, huge stressor" (p. 2). Ruby described stress from personal losses (pp. 5–6) and being a caregiver (pp. 1–2).

Participants also identified stress from business, such as having to teach themselves how to run a private practice, financial stress, isolation of private practice, unexpected stressors in

private practice, and wavered competence. In terms of stress with building a private practice, JoJo said, “There was absolutely no training in how to start a business” (p. 2). JoJo (p. 3), Cheryl (p. 6), and Veronica (p. 2) also described stress with accepting money from clients. Veronica said that “the ebb and flow of income” in private practice was “challenging” and unexpected (p. 3). Two participants expressed worry about the future of the counseling field. Mary explained that venture capitalism and predatory insurance credentialing programs threaten the counseling profession (p. 3; p. 9). She said, “It’s gonna eat the field. It’s gonna eat the field” (Mary, p. 10). Jody described the unexpected stress from the pandemic and switching to virtual. She recalled that “personal and professional stress was overnight not only trying to learn how to transition everybody myself, but Umm, walking people through it, who weren’t necessarily tech savvy, or even wanting to use the technology “ (p. 1). Three participants described that they experienced stress from isolation. For example, Veronica said that she “was so stuck like I couldn’t do the things that like fill me back up” (p. 3). Two participants reported they questioned their counseling competence. For example, both JoJo and Cheryl recalled feeling like they were imposters and JoJo stated, “I feel like that I maybe I’m an impostor, which I don’t think that’s that unusual” (p. 6).

Participants also felt too tired to care for themselves and others. Participants reported they experienced difficulty with resting. Cheryl recalled occasionally having “dreams about clients,” and she believed this occurred “when there’s something subconscious my brain wants to work out” (p. 12). Three participants reported they felt irritated or on edge. For example, JoJo noticed she might become “triggered in a session related to some piece of content that somebody brings up” (p. 6). All seven participants reported they felt weighed down or fatigued. Such as Ruby described the heaviness of being a “secret keeper” (p. 10). Six participants reported they

experienced stress from working with clients. Margaret described how she experienced stress when clients were "not making any progress" (p. 2). Mary reported working with children was "really stressful" (p. 3). It was also stressful if participants experienced similar stressors to clients. For instance, Jody described the challenge "because typically when a client's not in a good place, you're not also going through the same thing with them at the same time" (p. 2). Also, five participants indicated they experienced a reduced capacity for empathizing. For example, Ruby said that clients' "little issues" were frustrating and remembered thinking, "That's all you got because I got a whole lot of my own stuff" (p. 6). Three participants described fears about being unethical. JoJo reported that when she "was reprimanded and that was the worst day of my life."

SQ1 under the OARQ was, What are counselors in private practice's experiences of their help-seeking behaviors? This question explored the meaning of CPPs lived experiences in terms of help-seeking and acknowledged that the participants are the experts on the phenomenon (Smith & Nizza, 2022). This relates to meaning-focused coping involved with stress (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). This question also explored any stigma attached to help-seeking for CPPs (Carney & Jefferson, 2014; Malikiosi-Loizos, 2013; Neukrug et al., 2017).

The response to this question includes the themes **I Don't Know What to Do,** and **I Can Heal.** In the theme **I Don't Know What to Do**, participants reported they experienced an inability to recognize CF and struggled with reaching out for help. For example, Veronica identified that the known definitions were confusing and that she experienced CF from "other things in my life and in the world that were going on" (p. 13). However, she reported confusion because "everyone tells you you're, like almost supposed to get fatigued from hearing trauma

stories all the time" and "that's not what bothers me" (Veronica, p. 13). Three participants reported they worried about burdening their personal counselor, which prevented them from asking for help. Mary said that understanding her own overwhelm prevented her from asking for help. She stated, "I don't really want to add to it and also I'm so down on counseling" and said she might "bring the counselor down" (Mary, p. 10). Five participants expressed a fear of being labeled or stigmatized. There was an internal stigma with participants struggling with the meaning behind needing counseling and an external stigma in participants worrying about how other counselors perceived them. Cheryl explained her experience and stated, "So there's something wrong with you 'cause you're feeling this way" (p. 21), and Veronica thought CF "meant like ohh no I'm not a good counselor" (p. 6). Five participants also said that they received unhelpful support in the past. For example, Cheryl described that "the supervisor was the most neurotic person I've ever met" and was "very sick and abusive actually" (p. 8).

I Can Heal also helped answer SQ1. Five participants realized that they needed to ask for help. For example, Ruby emphasized the significance of being "honest about what you're feeling" and said, "We need the opportunity to feel safe" (p. 12). Five participants conveyed the value they found in the receipt of personal therapy. Ruby stated, "Just like our clients, you know, and I just think therapists need therapists" (p. 12). Furthermore, three participants described the value of supervision and consultation. Mary strongly advocated attending consultation groups and stated the value she has derived from this. She described it is "really, really important, having colleagues and people you can trust who will call you out, but also with love and affection and understanding" (Mary, p. 9). Additional support came from therapist friends. Jody said that consultation or therapist friends can help with the isolation of private practice (p. 10). Also, five participants reached out to family or friends for help and described that their spouses

were supportive, and some noted the value of friendships. Ruby stated that having friends who do not ask for advice is helpful and added, “I want someone I surround myself with my friends who just wanna laugh and have a good time” (p. 10).

SQ2 under the OARQ was, How do counselors in private practice make sense of coping with compassion fatigue? This question also met IPA requirements in identifying lived experiences (Smith et al., 2009; Smith & Nizza, 2022). Schlossberg’s transition model and Lazarus and Folkman’s transactional theory of stress and coping address coping strategies and reappraising of coping strategies. This question also explored meaning-focused coping with stress (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004).

The response to this question appears in the themes **I’m Overwhelmed on Every Side,** and **I Can Heal.** Regarding **I’m Overwhelmed on Every Side**, three participants said that they were too tired for self-care, and it needed to be defined further. For example, Veronica described self-care as “such a big word now that people say, but like most people don’t really know what that feels like and looks like for them, right? Like what actually fills you back up and what you need to prioritize” (p. 12). Five participants also reported they were unsure when or how to set boundaries. Some of the boundary difficulty was external from supervisors and directors and added “pressure to take on clients that that we’re not equipped to deal with” (Cheryl, p. 3).

I Can Heal also answered part of SQ2. Participants normalized CF and realized that it was okay to experience CF. Mary said, “I actually felt really relieved that it was a thing and not just umm, I’m a terrible therapist.” (p. 5). Five participants also realized CF was part of the job of counseling. Jody also stated she believed it was “an occupational hazard” and “it’s something that if you’re in this field long enough, you’re going to experience some version of it” (p. 9). Six participants identified the value of self-reflection and understanding their identity apart from

counseling. For example, Ruby reported she "journaled more than I think I've ever journaled" (p. 8). Four participants also reported they used their faith as a coping strategy. Ruby expressed the value of emotionally regulating through faith, stating, "I'm a Christian and I have to stay connected to God, otherwise, I won't make it" (p. 12).

Further, participants found that self-care was helpful. Veronica stated that self-care helps with prevention: "When something big happens, we're better prepared" (p. 12). Jody described the importance of having a plan, stating, "When it happens, it's helpful to have an awareness and seek your own treatment or utilize your own strategies, your own support system" (p. 9). Six participants also described the value of rest. Mary described that she is reading a book "from the early 1900s where a woman takes 6 months off to, you know, like she's to lay around and steady her nerves" and continued, "that's what I need to do" (p. 5).

Participants also adjusted their workload or schedule and set emotional boundaries. For example, Mary "realized I have let my boundaries go and I need to pull those back, which means training for lack of a better word, my clients to expect less of me" (p. 6). Furthermore, five participants described the importance of taking care of their bodies as a coping strategy. Margaret recalled she "felt like I could take on more or deal with more stressors by being consistently active" (p. 6). Participants also used meaning-focused coping and grew from their experiences. For example, four participants reported they felt called to help others. JoJo stated, "You know, it goes very deep into what it means to help people it it's what really matters" (p. 11). Three participants also realized that experiencing CF meant there's hope for healing. For example, Veronica took CF as a "sign of like you're human" and "you're an empathetic, compassionate person or this would not affect you at all" (Veronica, p. 7). Additionally, five participants noticed they could grow or help others grow through learning. For example, Cheryl

adamantly expressed the value of training in ART, relaying, “A meeting is and just the relief and then not having to kind of like keep having to deal with those sensations that come up around random things that are still all related to some kind of trauma” (p. 2).

Summary

The purpose of the study was to build further understanding concerning CPPs experiences of CF and the meaning found in help-seeking and coping behaviors. Seven participants met the study criteria, completed the Qualtrics survey and completed the interview. The interview was transcribed through Microsoft Teams and then checked by the researcher. This was then sent to the participants who all approved the transcripts accuracy. The researcher then identified the experiential statements for each participant and comprised these into PETs. Following this, the researcher identified connections and divergences between the themes for the participants and added these to the GETs. A total of three GETs identified including *I’m Overwhelmed on Every Side, I Don’t Know What to Do,* and *I Can Heal.*

Chapter Five: Conclusions

The purpose of this phenomenological study was to understand the meaning CPPs found in experiences of CF, and their help-seeking and coping behaviors. This chapter summarizes the research findings in conjunction with the study's purpose and research question conclusions and discuss the findings in connection with theoretical and empirical research. Then it provides the study's theoretical, empirical, and practical implications and delimitations, limitations, and recommendations for future research. The chapter concludes with a summary of the entire study.

Summary of Findings

This study explored the participants' experiences of CF and their help-seeking and coping behaviors. The themes **I'm Overwhelmed on Every Side**, **I Don't Know What to Do,** and **I Can Heal** emerged from the analysis of the data. The **OARQ** of this study was, What are counselors in private practice's experiences of compassion fatigue? The answer emerged in the theme **I'm Overwhelmed on Every Side** as all seven participants described their experiences of multiple stressors, including stress in their lives, the stress in business, feeling too tired to care for themselves or others, and worrying about making mistakes.

The first SQ was, What are counselors in private practice's experiences of their help-seeking behaviors? The answer emerged in themes **I Don't Know What to Do** and **I Can Heal**. The participants reported experiencing hindrances to requesting help, such as difficulty recognizing CF, feeling unsure and fearful about requesting help, and remembering past experiences of insufficient or insufficient or harmful support. Regarding help-seeking behaviors, participants recognized **I Can Heal** through normalizing CF, acknowledging the need for help, and seeking personal therapy, supervision or consultation, peer support, or support from family or friends.

The second SQ was, How do counselors in private practice make sense of coping with compassion fatigue? The answer to this question emerged in **I'm Overwhelmed on Every Side** as all seven participants experienced hindrances to coping with CF, such as feeling too tired to care for themselves and difficulty setting boundaries. Participants also recognized that **I Can Heal** and used multiple coping strategies such as normalizing CF, self-reflection, self-care, and setting boundaries. Participants also grew through their experiences with CF.

Discussion

Three themes were identified: **I'm Overwhelmed on Every Side**, **I Don't Know What to Do,** and **I Can Heal**. This section discusses the relationship between the findings of this IPA study and the theoretical literature presented in Chapter 2. The theories that grounded this study are Schlossberg's (1981) transition model and Lazarus and Folkman's (1984) transactional theory of stress and coping. Additionally, the relationships between the findings of the study and the empirical literature regarding counselor stress, help-seeking, and coping behaviors are discussed.

Theoretical Literature

In Schlossberg's (1981) transition model, expected transitions could be prepared for, but unexpected transitions could not be prepared for (Anderson et al., 2011). Further, Lazarus and Folkman's (1984) transactional theory of stress and coping provided insights into stress and coping processes. The primary appraisal was based on the individual's perception of the event, including their surroundings as well as their interpretation as inconsequential, neutral leaning positive, or as stressful (Biggs et al., 2017; Lazarus & Folkman, 1984). The theme **I'm Overwhelmed on Every Side** shows how unexpected changes and stressors were experienced by all participants, such as the pandemic, sudden political or societal pressures, grief from

unexpected loss, and sudden unexpected changes impacting private practice. For example, Ruby experienced unexpected stressors of the pandemic and personal losses and recalled supporting her son, who had experienced loss and grief recalling, “That drained me because I felt so helpless.” This finding helped to answer the OARQ, which inquired into the CF experiences of CPPs.

Part of the transition model is taking charge, which consists of strengthening resources and adding tools and strategies to manage the transition (Anderson et al., 2011, 2021). Similarly, the secondary appraisal with the transactional theory of stress and coping involves taking steps to cope (Lazarus & Folkman, 1984). As described in the theme **I Can Heal,** participants managed the transitions and stressors they were experiencing by reaching out for help and coping. They sought help from counselors, peers, supervisors or consultants, and family or friends. For example, Jody expressed the value of talking to her “very supportive spouse, so connecting on a regular basis” and “turning to other therapists.” The participants also used multiple coping and self-care strategies. For instance, Margaret recognized the importance of self-care, stating, “How can I tell my clients ‘well you should really take care of yourself’ if I’m not able to do the same thing.” These findings helped to answer both SQs inquiring into the help-seeking and coping strategies of CPPs.

The transactional theory of stress and coping included using emotion-focused coping resulting from the reappraisal of ineffective coping after experiencing difficulty (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). Participants struggled with coping and encountered barriers such as avoidance of help and sometimes an inability to cope. In terms of avoiding requesting help, there was a fear of being labeled in theme **I Don’t Know What to Do**. This theme helped to answer the second SQ, which inquired into coping strategies with CF.

Ruby stated that what prevented her from asking for help was the perceived message that "I have to be strong. That I can do anything." In contrast, participants' reappraisal of coping and subsequent growth exemplified meaning-focused coping in the theme **I Can Heal**. For example, Jody realized that "there's a purpose for this fatigue." This theme also helped to answer the second SQ. The stressors encountered, barriers to coping and help-seeking, coping strategies used, and the related literature are discussed further in the empirical literature section.

Empirical Literature

Three main themes were identified by reviewing the participant data and exploring the similarities and differences between participants. Three themes were identified, including **I'm Overwhelmed on Every Side**, **I Don't Know What to Do,** and **I Can Heal**. In this section, the identified themes and their connections or divergences from the empirical literature are described.

I'm Overwhelmed on Every Side. Participants identified multiple stress areas such as the pandemic, unexpected political and societal stressors, losses, business stressors, isolation, worrying about the profession, difficulty with client stressors, ethics concerns, and wavered competence. For example, Jody noted the unexpected, sudden changes that occurred during the pandemic that impacted her business and personal decisions regarding safety. She stated, "So I am a solo provider, but I was also trying to keep not only my own safety and my family safety, but the safety of all my clients in mind too." In the literature is found the potential impact of unexpected stressors such as natural disasters (Anderson et al., 2011; Stebnicki, 2021). Litam et al. (2021) described the impact of the pandemic on counselors and CPPs in terms of stress and trauma symptoms. They found that professional quality of life was significantly predicted by posttraumatic stress, coping responses, resilience, and perceived stress (Litam et al., 2021).

In addition to the pandemic and other stressors, participants experienced stress from the complicated aspects of running a private practice. For instance, JoJo said that "there was absolutely no training in how to start a business" and she had to teach herself. This lack of business instructions was confirmed as a problem in the field (Bradley et al., 2013; Brauner, 2015; Reese et al., 2013). Administrators of education programs may consider adding further training on running a business to aid CPPs. Also, four participants (Jody, JoJo, Mary, and Ruby) mentioned stress from suddenly adapting to virtual counseling to maintain clients' mental health. The potential for stress from unexpected change was supported in the literature. The transition model describes that unexpected transitions could not be prepared for (Anderson et al., 2011). A qualitative study looked into transitions with career change and found that most career-defining moments were unexpected (Ensher et al., 2017). This literature does not describe CPPs, and this study expanded the knowledge base in applying the transition model and the impact of unexpected changes with CPPs.

Participants also mentioned stress in managing finances. Margaret mentioned that financial stress was her "biggest stressor" such as worrying if she could cover payroll. Cheryl also described the limited options for health insurance for an independent contractor. Similarly, Veronica was unprepared for "the ebb and flow of income." Four participants (Cheryl, JoJo, Margaret, and Mary) described stressors regarding working with accepting insurance. Furthermore, according to Cheryl, existing support for counselors was viewed as inadequate and costly, and specialized training was also expensive, according to Margaret. The research supported the impact of financial stressors on the private practice professional. Malikiosi-Loizos (2013) described that a barrier to receiving help was the sensitive content of sessions and the cost of receiving help. Brauner (2015) and Harrington (2013) pointed out that financial stressors in

private practice involved inconsistencies with salary, limitations with payments from insurance companies, and the weight of managing the finances and administration. In their sample, CPPs described disparate payments based on their license as well as inconsistent payments (Darcy & Abed-Faghri, 2013). Schonfeld and Mazzola (2015) found that ambiguity in finances, working many hours, and the pressures of finding health insurance were factors impacting stress. Researchers also suggested that CT may be related to the development of CF (McCann & Pearlman, 1990; Stebnicki, 2000). Cheryl, JoJo, and Veronica also reported difficulty accepting money from clients, which is recognized in the literature (Lu et al., 2017; McCann & Pearlman, 1990; Stebnicki, 2000; Yalom & Leszcz, 2005). CT was also related to fee setting in private practice (Apostolopoulou, 2013; Moore et al., 2020).

Participants also expressed fears about the future of the counseling field. An illustration of this occurred when Mary adamantly stated that she believes that venture capitalism and predatory insurance credentialing programs are "gonna eat the field." Therefore, Mary reported she stopped supporting new counselors in entering the field. Mary also predicts reduced pay for counselors. Cheryl also reported uncertainty in advising the next generation of counselors and then feeling disheartened that there are limited career options with a counseling degree. No studies in the literature review discussed venture capitalism and predatory insurance credentialing programs. This is another area expanded in this study and is worth further inquiry.

Further, three participants reported they experienced stress from isolation. For example, Veronica mentioned that isolation in private practice was more difficult "since the pandemic." She explained that she was extroverted, had to isolate herself, and could not access recharging coping strategies. She stated, "I couldn't do the things that like fill me back up like I'm a very extroverted person." Further, she could not access venting opportunities such as the "compassion

fatigue parties" where counselors coped together with their stressors. Jody also reported that professional connections were important, "especially in private practice, because it can be isolating." Researchers confirmed that isolation could be problematic in private practice (Brauner, 2015; Carney & Jefferson, 2014; McCann & Pearlman, 1990; Salyers et al., 2015; Savic-Jabrow, 2010).

Also, two participants reported they questioned their competence as counselors. Both Cheryl and JoJo reported feeling like an imposter in terms of helping clients. JoJo relayed client problems felt like navigating a "tangled web." Cheryl reported feeling blocked with helping clients. Stamm (2010) described that part of CF included feeling ineffective in one's work. Also, the research indicated that using ineffective treatments, clinical errors, and poorer client outcomes were potential outcomes (Brennan, 2013; Carney & Jefferson, 2014; Salyers et al., 2015). The imposter feelings are an unexpected finding, which can be explored further.

Another topic with CF was the experience of dissociating. This experience was mentioned by two participants who reported they experienced a form of dissociation. Dissociation was used for coping for one participant, and the other found it was more of a symptom of CF, which is described further in a later section. Regarding dissociation as a potential symptom, Mary reported that a trauma expert colleague helped her realize, "Ohh I'm dissociating during sessions." In the literature, van Dernoot Lipsky and Burk (2009) stated helpers may experience feelings of helplessness, hypervigilance, difficulties with managing complex situations, reduction in creativity, dissociation and avoidance. In managing dissociation, Hardiman and Simmonds (2013) found that existential well-being was related to reduced emotional depletion, reduced dissociation, and increases in self-esteem.

Participants also described feeling too tired to care for others. Five participants reported they experienced a reduced capacity for empathizing. For example, Cheryl questioned when she did not look forward to working with clients if she should be referring them out. The literature indicates that part of CF is difficulty with empathy or empathy fatigue (Stebnicki, 2017; Stebnicki, 2021; van Dernoot Lipsky & Burk, 2009). Moore et al. (2020) described that eight participants experienced similar stressors as worrying if they were the right fit for their clients. In terms of fit, Neukrug et al. (2017), in researching the aspects of fit, stigma, and value, described fit as "one's sense of comfort being in counseling and trust in the process of counseling" (p. 33). Also, Acker (2012) reported that 56% of their sample experienced emotional exhaustion, and 50% considered leaving the job. Acker described attending counseling, but this may be interpreted as internal stigma when looking at the participants and their struggles with self-stigma.

They experienced stress from working with clients. Cheryl reported that she was processing session content during dreams, and JoJo reported personal triggers during a session, which may indicate CT struggles. Moore et al. (2020) described stress from unprocessed past events, the content of sessions, and in-depth work with clients. Margaret also stated she experienced stress when clients were "not making any progress" despite her efforts. Cheryl reported "pressure" from clients to do the work for them. For Ruby, client suicide attempts "almost made me want to not do this anymore." In a qualitative study, Moore et al. (2020) found several aspects of counselor stress, such as *Client Characteristics,* involved unpredictable or aggressive behaviors, manipulation, boundary violations, and resistance to change. Concerning another theme, *Relationship Dynamics,* the intensity of the counseling work was another aspect of stress (Moore et al., 2020).

Veronica reported an impact if stressors from the world overlapped with client stressors and frustration from being unable to change the big issues. There was also stress from having to suppress feelings in these "shared trauma" situations. Mary echoed this stating that abortion legislation impacted she and her clients and asserted that "Roe V Wade" and the "heartbeat bill, that has been a shitshow for me and for all of my clients." Jody described the challenge of experiencing stressors along with clients "because typically when a client's not in a good place, you're not also going through the same thing with them at the same time." Regarding connections to the literature and overlapping world stressors, Finklestein et al. (2015) researched trauma and VT in social workers in a war-exposed area that impacted both helper and client. PTSD symptoms were influenced by professional experience, subjective exposure, and views of the professionals abilities. Litam et al. (2021), in studying the impact of the pandemic, noted that counselors were likely experiencing stress and trauma symptoms. Stebnicki (2021) also described that the overlap of client and counselor stressors could impact the counselor's ability to think positively about the future and the world.

Participants described difficulty with self-care in feeling too tired to care for themself. Participants also struggled with resting and felt weighed down and fatigued. Regarding the experience of having difficulty sleeping, two participants, Cheryl and JoJo, reported they processed session content at night process sessions at night. Veronica reported having "nightmares" and also feeling "restless in my sleep." Figley (1995) and Stamm (2010) that sleep changes as part of STS. Skovholt and Trotter-Matheson (2016) defined sleep as a requirement for good health and described sleep difficulties to be linked with poor performance and mood difficulties. Participants also experienced feeling irritated and on edge, including JoJo's recollection of having "an overreaction to things" and Veronica noticing that she would "snap at

everybody." This sensitivity was also supported by the literature where intrusive effects were described as an aspect of STS (Figley, 1995; Stamm, 2010), and the signs of burnout included isolation, personality changes, on-edge feelings, irritability, and quick-tempered reactions (Freudenberger, 1975). This expanded the literature concerning the experience of CF with CPPs. Furthermore, all seven participants reported they felt weighed down and fatigued when experiencing CF. For example, Margaret mentioned that CF felt "like this really heavy weight, like when I mentioned earlier about this carrying the world on my shoulders." This was supported by research in terms of the description of the weight of the world or the weight of stressors influencing the helper (Freudenberger, 1975; Knight, 2013) and expanded the knowledge base of the impact to CPPs.

Also, it was "overwhelming" caring for self and others according to Jody, and difficult to fit into a busy family schedule for Cheryl. Veronica also mentioned that self-care is unique to each person and commented "self-care, such a big word." Barton (2020) supported this idea with an IPA study with the identified theme *Perceptions of Inadequate Preparation for Self-Care* in which participants reported receiving little guidance on how to implement self-care. Skovholt (2012) also supported the idea of unique self-care, focusing on strategies that recharge the counselor so they can continue to invest energy toward helping. This study helped to expand the definition of self-care based on individual responses. The consensus is that self-care needs to be defined and is likely particular to each person, but that ideas could be generated.

Participants also described difficulty with setting and maintaining boundaries. Mary and Ruby described the pressure they felt to take too many clients, and the pressure to always give. According to Ruby, there was also pressure to work outside of office hours, difficulty balancing work and time off for JoJo, and a fear of loss if not working hard. Mary stated that when

stressors increased in the world, she overbooked herself. In the literature, boundary problems with employment and one's life can be problematic (Freudenberger, 1975; Moore et al., 2020; Tabaj et al., 2015). Other risk factors included increased control, taking on too much and failing to delegate, and not making time for socialization, recreation, and hobbies presents a risk for burnout (Freudenberger, 1975). This expanded the literature concerning CPPs struggles with setting boundaries.

There was also stress with worrying about mistakes and maintaining ethics. Further, as a group practice owner, Margaret had to let staff go because they were "harming the clients," and she remembered this was "very stressful" due to not having other workers to replace them. Ruby also mentioned the stress she experienced when clients attempted suicide, and there were likely associated ethical fears. This type of stress regarding maintaining ethics requirements was an unexpected finding. It expanded the literature in that the guidelines for maintaining ethics that protect counselors and clients appear to be part of the cycle of stress or impairment with CPPs. Apostolopoulou (2013) described the impact of stress from maintaining ethics in terms of fee setting during difficult economic times. Litam et al. (2021) discussed that counselors might experience challenges postpandemic such as confidentiality with virtual counseling and ethical considerations. Barton (2020) also echoed this in that assessing risk and considering breaking confidentiality increased anxiety for a participant. Fear of ethics complaints was an unexpected finding and is supported by Brennan (2013) in a discussion about maintaining ethics. Skovholt and Trotter-Matheson (2016) also described the stress and fears related to ethical and legal counseling requirements in protecting the client and others. The theme **I'm Overwhelmed on Every Side** detailing the experiences of CF, helped to answer the OARQ and part of SQ2, which inquired into coping with CF. The participants described their experiences of multiple stressors,

including stress in their lives, the stress in business, feeling too tired to care for themselves or others, and worrying about making mistakes. In the next section, hindrances to receiving help are discussed.

I Don't Know What to Do. For participants, there were also barriers to identifying CF and fears with requesting help and receiving help. Regarding difficulty recognizing CF, if participants did not know what it was or could not recognize it, they could not seek help. As stated earlier, Veronica was confused by her experiences with CF and the definitions. She experienced stress due to the impact of stressors from the world around her and not from client stories. JoJo did not recognize CF until she "collapsed" and then realized she was "exhausted." Margaret stated that failing to recognize CF may lead to leaving the field; "It just kind of creeps up on you, and I think that's why in the counseling field, there's such a high turnover rate." Regarding confusing definitions of CF, Foreman (2018) found that exposure to trauma stories did not reduce wellness, and the higher the amount of wellness, the lower the VT impact. Foreman pointed out that their findings might contradict those of McCann and Pearlman (1990), who speculated that the more exposure to trauma, the higher the risk to VT. Knight (2013) discussed a gap in the research: STS, CT, and burnout are often described synonymously, and indirect trauma needs a more informed definition. Concerning the risk of turnover, Acker (2012) also reported that 56% of their sample experienced emotional exhaustion, and 50% considered leaving the job. Hopefully, these findings will help current and future counselors identify and manage CF.

Three participants also considered other counselors' stress levels when requesting help. For instance, Veronica did not want to be a "bother," and Jody viewed her own problems as less severe than others'. Mary reported she worried that she "would probably bring the counselor

down." This was an unexpected finding and a potential area to explore with CF research. It sounds like there may be a form of overempathizing for other counselors that may prevent help-seeking. This subsequently opens the discussion of having too much empathy.

Five participants reported experiencing either internal or external stigma when considering help-seeking. An example of the internal stigma came from Margaret, who described "an expectation that you put on yourself, that everything is supposed to be fantastic. And it's not by any means." Margaret also thought, "if I can help all these other people, you know, I should be able to help myself too." An example of external stigma came from Cheryl, who described her perception: "It's very stigmatizing as a mental health condition, given that we're in the mental health field. Not stigmatizing people for their mental health conditions." Mullen and Crowe (2017) called the internal stigma, "self-stigma" in terms of being perceived as having a mental health diagnosis (p. 402). Negash and Sahin (2011) provided information concerning a more external view of stigma in that counselors may not request help because of others' perceptions. Stigma was defined by Neukrug et al. (2017) as the therapist's shame and worry about other's perceptions of their receipt of personal counseling. Additional research exploring internal and external stigma with CPPs could help clarify hindrances to reaching out for help.

Also, five participants revealed they previously received harmful support, which included terrible supervision and administrative support or lack of support from counseling organizations. For example, Mary and Cheryl both reported harmful supervision. Mary recounted the lack of support in her prior agency job and reported, "I had terrible supervision" and "it wasn't a safe place to seek consultation." Cheryl also said a supervisor pushed her to take clients she was unprepared to work with. Ellis et al. (2014) noted that incompetent and harmful supervision can negatively impact both the supervisee and the clients and lead to harm. Mary also described her

frustration with the lack of support from the ACA because they were not addressing venture capital's predatory behaviors toward new counselors. Freudenberger (1975) analyzed employment stress and relayed that risk factors for impairment included varied needs and unreasonable expectations from the supervisors and that the helper may push themself to their limits or may put their needs last, which increases the risk for burnout. The theme **I Don't Know What to Do** helped to answer the first SQ inquiring into CPPs experiences of help-seeking behaviors. Participants struggled with identifying CF, and worried about the consequences of reaching out for help, such as burdening their counselor or worrying about stigma. Also, some participants had been hurt in the past when receiving support.

I Can Heal. It was encouraging to note that all seven participants reached out for help with CF and used coping strategies. For instance, Mary reduced her caseload when she noticed CF, and she sought consultation. JoJo also used self-assessment to check in on her feelings and symptoms. Cheryl recognized the importance of personal therapy to understand self & history, boundary difficulties and coping. The ACA (2014) *Code of Ethics* recommended self-evaluation to determine if the counselors are impaired and to request help from other professionals to prevent client injury (C.2.g). Brennan (2013) echoed this and recommended monitoring through continued self-assessment and self-examination concerning respective strengths and weaknesses, personal experiences, and examining how this impacts counseling performance.

Regarding the transition model, help-seeking is considered seeking support (Barclay, 2015). An important part of seeking support is recognizing CF. According to the ACA (2014) *Code of Ethics*, if counselors notice colleagues or other professionals are impaired, the counselor should offer assistance or consultation to prevent potential harm to clients (C.2.g). It was found that when participants reached out for help, their colleagues, therapists, or others helped them

realize they were experiencing CF and helped them manage it. Every participant reached out for help, whether with a counselor, a colleague, a consultation group, supervision, or family and friends. First, the realization that it is okay to struggle and request help is described. Following this will be a discussion of coping strategies used.

Neff (2003) described SC as being kind to oneself, acknowledging collective experiences or common humanity, and mindfulness. There were aspects of SC in the findings. For example, six participants found it helpful to accept that struggling was okay. In this finding, five participants—Cheryl, Jody, JoJo, Ruby, and Veronica—realized CF meant they were human. Jody also mentioned how they learned it was ok to receive help, and for Mary and Jody, it was valuable to know they were not alone. JoJo later realized ethics complaints were not uncommon. Also, Mary and Ruby recognized that experiencing CF did not mean they were bad therapists, and JoJo realized it was ok to "love myself as much as I love other people that I sit with." Also, Ruby said self-compassionate words, stating counselors need to express feelings without guilt, and said we "cannot judge ourselves for it but we need to talk about it." The use of SC as coping was supported in the literature. Stebnicki (2021) suggested coping with the pandemic by normalizing that it was okay to experience various feelings. In an IPA study, Barton (2020) identified another theme of *Perceptions of Caring for Self*, including participants caring for themselves and one participant reported practicing SC. Aspects of SC were also found in a narrative inquiry under the theme *Counselors' Stances in Session* which included self-kindness with thoughts, mindfulness, taking time for self, and accepting imperfection (Patsiopoulos & Buchanan, 2011). This present research expands the literature concerning the specifics of applying SC as a CPP. Strategies included acknowledging one's humanity and imperfection and accepting that help-seeking is ok.

Five of seven participants also indicated that CF was part of working in the counseling field. For example, two participants, Mary and Ruby, reported they were uncertain if CF could be prevented. Jody also realized that most counselors experience CF at some point and stated it is an "occupational hazard" and "if you're in this field long enough, you're going to experience some version of it" (p. 9). This was supported by the research that CF exists with CPPs (Acker, 2012; Brauner, 2015; Thompson et al., 2014). Litam et al. (2021) also described the occupational hazards of empathy and discussed CF, burnout, VT, and resilience. Further research is needed to help determine how much CPPs know about CF, if they can recognize it, and to help build an understanding of prevalence. If CF is part of the job, master's training program administrators could consider adding CF management psychoeducation to their curriculum. This is discussed further in recommendations for further research.

The participants realized they needed help through personal counseling, supervision or consultation, peer support, and contacting friends and family. Regarding the essential need for requesting help, Ruby described the importance of "being honest about my feelings and not feeling guilty for what I was feeling." Cheryl valued "being able to just unload my energy to somebody." Mary stated she learned that "connection mitigates trauma, so relationships mitigate trauma." Regarding supporting research, Finklestein et al. (2015) found that professional support may be helpful and that VT experiences may build strength.

Five participants reached out for help through personal counseling. For example, Cheryl described the numerous benefits of personal therapy, such as understanding self and history, boundary struggles, coping, and knowing "who you are inside and out." In the research, 90.3% had attended counseling and 27% were presently attending (Kalkbrenner et al., 2019), and 35% of the sample attended counseling (Savic-Jabrow, 2010). Malikiosi-Loizos (2013) described the

benefits of counseling, such as personal and professional growth, and progress toward self-actualization. Additional research into the prevalence of receiving personal therapy for CPPs could be helpful. Three participants also sought supervision or consultation to help them with CF and managing stressors. For example, Mary strongly advocated for CPPs to attend consultation, and she benefited from this type of support in identifying CF and processing fears, anger and resentment. Ruby also described the benefits of seeking supervision as well as consultation. Seeking supervision is supported by the literature (Knight, 2013, O'Connor et al., 2018; Savic-Jabrow, 2010). Falender and Shafranske (2012) pointed to the benefits of competent supervision in aiding successful therapy outcomes. In terms of gaps, Carney and Jefferson (2014) reported that little research has been completed concerning the receipt of consultation for CPPs. This study helped to expand the knowledge base concerning the benefits of receiving consultation for CPPs and managing CF. Further research into consultation groups could be helpful.

Two participants reported the benefit of seeking peer support. Jody reported she valued connecting "with other therapists that were feeling the same way and hearing from frontline workers." The literature supports seeking peer support as a solution to having one-way relationships with clients (Skovholt & Trotter-Matheson, 2016). Peer support was portrayed as a common help-seeking behavior (Moore et al., 2020; Savic-Jabrow, 2010). The benefits of peer support included expressing feelings, discussing caseload management, self-care psychoeducation, and the benefits of connecting (Stebnicki, 2000). Peer support was also listed as a strategy for building a successful practice (Darcy & Abed-Faghri, 2013). Five participants reported that they also reached out to family and friends. These participants said they turned to their spouse for help to manage stressors or to express CF and feelings. For example, JoJo described her husband as a great resource stating they "share each other's burdens, and he totally

gets it." The research supports seeking support from family members, friends, and others (Ensher et al., 2017; Mullen & Crowe, 2017). According to Myers and Sweeney (2005), the social self consists of community, family, friendships, and love, which can protect from loneliness and stagnation. Further research into the types of support used could help clarify CPPs help-seeking.

Additionally, participants reported the benefits of self-reflection and getting to know themselves again, an aspect of mindfulness. Self-reflection strategies included expressing thoughts and feelings with journaling for JoJo and Ruby. JoJo described that she needed activities other than counseling and did not want to base her identity solely on being a counselor. Also, Ruby would watch "wholesome TV shows," and Veronica reestablished a habit of "reading for fun." Considering the research, mindfulness is viewed as part of SC and is described as a balanced awareness of feelings (Neff, 2003). Several studies described mindfulness as a positive coping strategy (Barton, 2020; Coaston, 2017; Hayes et al., 2004; Patsiopoulos & Buchanan, 2011; Thompson et al., 2014). Contemplation coping strategies were also supported (Bradley et al., 2013; Savic-Jabrow, 2010). Bennett-Levy and Finlay-Jones (2018) asserted that personal self-reflection and therapist self-reflection could enable personal and professional growth. In terms of identity, Myers and Sweeney (2005) state that the essential self is composed of components of identity such as spiritual, existential, self-care practices, views on gender, and culture.

Five participants also realized that life is a balancing act of managing acceptance and change. Concerning change, Jody and Margaret used strategies of building awareness and having a plan to cope. There was also acceptance of areas that could not change and yet moving into action with what they could change for Margaret and Veronica. For example, Margaret worked on acceptance with clients and staff that they may not be ready to change. The benefit of this

work was that she would sometimes see breakthroughs with clients in later sessions by using acceptance. Skovholt (2012) described the value of working diligently and balancing acceptance in that the majority of the work rests with the client. Stebnicki (2021) also supported the strategy of balancing acceptance and change. Brach (2003) discussed a coping strategy for managing anxiety and stress from perfectionism, which includes acceptance-based thinking. Radical acceptance is not based on avoidance, resignation, or passivity but actively working toward the acceptance of imperfection (Brach, 2003). When looking at Margaret's experiential statements, she reported that she enjoyed seeing both sides of dialectical behavior therapy as both the counselor and the client, which is evident in her coping strategies. Furthermore, mindfulness and prayer were found to be important coping strategies (Patsiopoulos & Buchanan, 2011). The application of mindfulness, acceptance, change, and self-reflection appeared to be unique to each participant.

Four participants described the value of spirituality. Faith was also recharging for JoJo and Margaret, and JoJo trusted the Lord to provide clinical "wisdom" to them for working with clients. Spirituality as a coping strategy was also supported in the literature. Myers and Sweeney (2005) described the essential self*,* which includes spirituality, as an essential aspect of wellness. Lawson and Myers (2011) discovered that participants with elevated wellness also valued spirituality for career sustaining. Barton (2020) also provided an IPA study and stated all five of their participant's valued spirituality. Thompson et al. (2014) found that emotion-focused coping, of which religious support was part, was associated with reduced burnout, and religious beliefs were protective. Skovholt and Trotter-Mathison (2016) pointed out that pursuing religious coping may aid counselors in finding meaning.

Self-care was found to be a broad concept that needs to be defined for each CPP. Each participant identified different types of self-care, and all seven participants realized the importance of taking care of themselves. Jody evaluated the self-care she needed to add in order prevent "that stress to carry over into my home life" and she reported she implemented this by allowing weekends to be unstructured to allow time with family and friends and to complete chores and errands. In the literature, the effects of VT were found to be mitigated by coping and well-being for community mental health counselors (Williams et al., 2012). This research expanded the knowledge base concerning unique self-care strategies used by CPPs.

Participants also worked to protect their peace by setting boundaries with their caseloads and schedules, setting aside time for rest and setting emotional boundaries. Ruby provided an example of setting aside time for rest when she scheduled time off, some "mental health days." She said that if CF can be prevented, then rest, reducing caseload, and increasing self-care may contribute to this prevention. Having a real lunch break was also beneficial to Jody and Ruby. In the literature, recharging strategies included exercising, recuperating through sleep, relaxation techniques (Skovholt, 2012), spending time in nature, and grounding strategies (Coaston, 2017). Freudenberger (1975) described the benefits of rest and vacations, feeling expression, professional development activities, maintaining exercise routines, and building boundaries between life and work.

Mary and Ruby realized they could not always be available to clients. JoJo, Mary, and Ruby worked to reduce their caseload or stopped accepting new clients. Cheryl set a reasonable schedule working four days per week. Stress from a complex or large caseload is confirmed in research (Freudenberger, 1975; O'Sullivan & Bates, 2014). Also, elevated workload was associated with burnout, yet having choice and autonomy with one's work was protective

(O'Connor et al., 2018). Veronica and Cheryl set boundaries with clientele and with their payment rates. JoJo and Mary also set boundaries with the insurance they will work with. In considering the literature, good boundaries have been shown to have protective properties (Brennan, 2013; Lawson & Myers, 2011; Skovholt, 2012; Skovholt & Trotter-Matheson, 2016). Further, counselor wellness was associated with being in private practice and having a reduced caseload of high-risk clients (Lawson & Myers, 2011). CPPs may have a unique benefit of setting boundaries regarding practice management (Brauner, 2015; Harrington, 2013) and their time (Brauner, 2015; Brennan, 2013). These conclusions add to the knowledge base about CPPs struggles with high caseloads and managing it through reducing their cases and workload. The knowledge was also expanded in terms of boundaries with insurance and accepted clientele. These are other areas of further research in understanding CPPs management of CF.

Participants also set emotional boundaries with their clients. For example, Cheryl reported, "Sometimes I dissociate a little bit where it's almost like I disconnect. I have like a like the therapist shield takes on the trauma and then that way it doesn't have to land in me." Dissociation as a form of coping is discussed further in the theme **I Can Heal**. This is listed as a form of emotion-focused coping in that distancing may be a helpful strategy (Folkman & Moskowitz, 2004). Margaret also set boundaries and trusted God to help her to separate from seeing clients in practice and running into them in a small community. Further, Veronica set boundaries in not discussing her personal life with clients. Connery and Murdock (2019) found that when participants built emotional boundaries, they may have protected themselves from overinvolved feelings and the content of sessions. Further research is needed to look into how CPPs set their emotional boundaries or a therapist shield. This may be a form of dissociation but used as a coping strategy and setting professional distance. In connecting with the theory, with

the transactional theory of stress and coping, emotion-focused coping was depicted as strategies used to reduce emotional distress, such as avoiding and blocking, focusing on certain aspects of the situation, reframing, and finding the positives (Lazarus & Folkman, 1984). Emotion-focused coping was also associated with reduced burnout (Thompson et al., 2014). Further research may help determine the healthy aspects of avoidance and the unhealthy elements.

Five participants confirmed the benefits of exercise in aiding stress tolerance. Margaret confirmed, "I felt like I could take on more or deal with more stressors by being consistently active," and noticed a "huge difference" with looking forward to biking. Mary and Ruby also intentionally made time for exercise, and Veronica joined yoga "to be near others." Exercise as a coping strategy is confirmed in the literature (Patsiopoulos & Buchanan, 2011; Savic-Jabrow, 2010; Skovholt, 2012). Coaston (2017) also described the value of maintaining physical health, including yoga. Making time for exercise, although exhausted, was described as a potential struggle with this strategy (Puig et al., 2012).

Participants used one or more meaning-focused coping strategies and grew through their experiences of CF. Participants reported feeling called to help, realizing that there was hope in the experience of CF, and described growth through learning. Regarding feeling called to help, two participants, JoJo and Margaret, reported that undergoing counseling inspired their journey to become counselors. Two participants, JoJo and Veronica, indicated that they believed that counseling was their calling. Jody found hope and meaning through the exhaustion with helping "a purpose for this fatigue." Ruby reported she finds supervision to be a "happy stressor" and reported she was also "excited" about participating in this study. Mary is also sharing her knowledge of building financial stability and not overworking in assisting other counselors build "specialization and diversification." She has refocused her stressors into something to use to

support others. This could be categorized under CS in giving back to other counselors is a benefit of helping but it may be a unique area in CS and could be researched further..

Further, three participants recognized that there was hope and saw CF as a positive message. The message that Ruby received was that there was hope for rest and healing, and she did not need to leave the field. It meant that Veronica was "an empathetic, compassionate person." Jody was grateful for the "small silver lining" that the pandemic sparked awareness and support for CF, and going through it improved her coping recommendations to clients. Viewing CF as a positive message was an unexpected finding. This is supported by the research in terms of the primary appraisal with the transactional theory of stress and coping where the participants perceived the event as either inconsequential, neutral leaning positive, or stressful (Biggs et al., 2017; Lazarus & Folkman, 1984). These participants learned to see it as a positive message in that they were human and there was hope for healing.

Five participants reported they grew through learning or teaching others. Cheryl highly valued her training in ART because it protected her from trauma stories, and reinvigorated her work. Margaret was inspired by receiving brainspotting and pursued training in this technique. Mary reported working in teaching and is building a psychoeducation project, and Ruby started a coaching business. Cheryl and Veronica aimed to start a private practice as a coping strategy. Some gains from working in private practice include CPPs being able to manage their own time boundaries (Brauner, 2015; Brennan, 2013) and having more freedom to choose according to the management of their practice (Harrington, 2013). Skovholt (2012) urged counselors to focus on professional growth, including increasing counseling skills which can be revitalizing. Savic-Jabrow (2010) described the importance of setting aside time for professional development.

Cheryl suggested that preventing CF involves receipt of training during the master's program (p. 20), which could be added to a master's training course. Reese et al. (2013) developed a course that teaches private practice entrepreneurship, which could benefit counselors in private practice. Regarding burnout, Joinson (1992) urged helpers to consider building awareness around CF, and Finklestein et al. (2015) found that further training in understanding trauma and VT could be protective.

The research supports meaning-focused coping, resilience building, and CS as coping. The transactional theory of stress and coping includes assessing positive and negative emotions and acknowledging that meaning-focused coping is an outcome of the reappraisal of ineffective coping in terms of hardship (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004). Skovholt (2012) described CS as the reward of providing therapy, which could be a helpful coping strategy. One of the benefits of working in private practice is a potential increase in CS (Lawson & Myers, 2011). Naghavi and Salimi (2018) found that participants experienced emotional difficulties and posttraumatic growth. Increased resilience was related to increased CS and may be related to a greater sense of purpose in terms of helping people during a pandemic (Litam et al., 2021). Further, resilience and CS were found to be protective against CF and burnout (Gonzalez et al., 2019; Thompson et al., 2014). Stebnicki (2021) confirmed that managing thoughts, taking action, and focusing on the positives can build resilience in counselors. The joys, meaning, and benefits or CS that counselors derive from therapy can help protect them from the stressors and transitions involved and provide valuable information in further supporting CPPs. **I Can Heal** helped answer part of the second SQ inquiring into CPPs experiences of coping with CF. Participants normalized CF, recognized it was part of the job,

and focused on self-reflection, faith activities, self-care, and meaning-focused coping strategies. In the next section, the implications of the study are described.

Implications

The Theoretical Implications section consists of a description of the expansion of the knowledge base regarding the theories in regard to CPPs and understanding their stressors, transitions coping, and meaning-focused coping through the lens of the theories. The Empirical Implications section consists of building further understanding regarding counseling stressors and their help-seeking and coping behaviors. Both theories are interwoven into the discussion of theoretical and empirical implications. Following this, the practical implications are also addressed.

Theoretical Implications

In terms of applying the transition model, the unexpected aspects of the pandemic, social injustices, violence, political changes, and pressures impacted the participants in various ways. Some changes were expected, such as seasonal darkness or moving; however, many other stressors were unexpected, such as the pandemic, social injustice, violence, and changing to virtual counseling. There were also chronic hassles, employment stressors and transitions. Participants strengthened their tools and resources as they went through difficulties. The researcher was unaware of any prior research applying the transition model to CPPs regarding the experience of CF. This study expanded the knowledge base concerning the impact of transitions to CPPs.

In considering the transactional theory of stress and coping, the participants were aware of their stressors in the primary appraisal and evaluated their responses. They experienced harm or loss in terms of the pandemic, social injustices, violence, political changes, and other

pressures. Counselor stress included the theme **I'm Overwhelmed on Every Side,** which included stress from the pandemic, political stress, societal stressors, and personal losses. The impact of outside stressors was confirmed in the literature (Anderson et al., 2011), including with CPPs (Litam et al., 2021), and this study expanded the knowledge base concerning potential stressors that CPPs may experience. Participants used a form of meaning-focused coping defined as a result of the reappraisal of ineffective coping in terms of hardship (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004).

Empirical Implications

Participants experienced additional stressors relating to their business, struggling with caring for themselves and others and worrying about making ethical mistakes. The theme **I'm Overwhelmed on Every Side** and the subtheme *Stress from Business* reflected the literature. For example, lack of self-employment business instruction or guidance was confirmed as a problem in the field (Bradley et al., 2013; Brauner, 2015; Reese et al., 2013). Administrators of education programs might consider adding further training on running a business to aid CPPs.

Other stressors included the suddenness of changes, having to increase safety management, counseling strategies now ineffective, navigating virtual counseling, staff changes, technology changes, and unknowns. A qualitative study that did not include CPPs looked into transitions with career change and found that the majority of career-defining moments were unexpected (Ensher et al., 2017). This finding supported the application of the transition model in understanding the impact of unexpected occurrences with CPPs as no studies were found that applied this theory. Consultants, supervisors, administrators, and associations may consider guiding CPPs navigating unexpected stressors in private practice through further research, training, and instructional articles. In addition, participants reported experiencing financial stress,

which reflects the research (Brauner, 2015; Darcy & Abed-Faghri, 2013; Harrington, 2013; Malikiosi-Loizos, 2013; Schonfeld & Mazzola, 2015). This study expanded the knowledge base concerning the types of financial stressors CPPs may face: determining taxes, covering payroll, the ebb and flow of income, stress from finding personal health insurance, cost of receiving help, paying for specialized training, and financial aspects of vacations. The experience of the fear of a dying field under *Stress From Business* was an unexpected finding. No studies in the literature review discussed venture capitalism or predatory insurance credentialing programs. This is another area that is expanded in this study and worth further inquiry to determine how the stress from these programs impacts new and experienced CPPs.

Two participants experienced wavering competence, such as feeling ineffective or blocked, which is supported by the research (Brennan, 2013; Carney & Jefferson, 2014; Salyers et al., 2015; Stamm, 2010). The experience of feeling like an imposter was an unexpected finding, which suggests further inquiry is needed. The participants' experience of difficulty accepting payments was also supported in the literature (Apostolopoulou, 2013; Moore et al., 2020). Further, three participants may have experienced CT, a confirmed finding in the literature for counselors (Lu et al., 2017; McCann & Pearlman, 1990; Stebnicki, 2000; Yalom & Leszcz, 2005). This study expanded the knowledge base concerning CPPs possible experiences of CT (Apostolopoulou, 2013; Moore et al., 2020).

The subtheme *Too Tired to Care* included lack of client progress, clients' many needs, unexpected difficulties, and time management, which reflected the research (Acker, 2012; Moore et al., 2020) and expanded the knowledge base concerning types of stressors from working with clients. Furthermore, the experience of relating to clients' stress, such as shared traumas, also reflected the research (Finklestein et al., 2015; Litam et al., 2021). Participants reported they had

trouble sleeping, which was supported by the literature (Figley, 1995; Skovholt and Trotter-Matheson, 2016; Stamm, 2010). They also reported they felt irritated and on edge, a confirmed finding (Figley, 1995; Freudenberger, 1975; Stamm, 2010) that expanded the knowledge base for CPPs. All seven participants reported they felt weighed down, which was supported by the literature (Freudenberger, 1975; Knight, 2013) and also expanded the literature. Participants also reported a reduced capacity for empathizing, which was supported in the literature (Stebnicki, 2017; Stebnicki, 2021; van Dernoot Lipsky & Burk, 2009) and expanded the literature for CPPs. The experience of wondering if the participant was the right fit in counseling a client was also supported (Moore et al., 2020). In terms of fit, Neukrug et al. (2017), in researching the aspects of fit, stigma, and value, described fit as pertaining to attending counseling; however, the finding in this study may be interpreted as an internal stigma. Further research into self-stigma may be beneficial.

Poor boundaries under the theme **I'm Overwhelmed on Every Side** and subtheme *Too Tired to Care* included the pressure to always give, take too many clients, work outside of office hours, difficulty with balancing time off, and fear of loss if not working hard, which were all confirmed by the research (Freudenberger, 1975; Moore et al., 2020; Tabaj et al., 2015) and expanded knowledge concerning CPPs struggles with setting boundaries. Participants struggled with feeling too tired to care for themself. The inadequacy of the definition of self-care was supported (Barton, 2020) as well as the need to define self-care uniquely (Skovholt, 2012). Counselors, consultants, and supervisors working with CPPs with CF may consider working with CPPs on defining a plan for self-care particular to their unique needs. The theme *What Happens if I Make Mistakes?* was also supported by the literature (Apostolopoulou, 2013; Barton, 2020; Litam et al., 2021), and the fear of ethical complaints was an unexpected finding that was

supported by the literature (Brennan, 2013; Skovholt and Trotter-Matheson, 2016) and expanded the research concerning understanding the struggled of CPPs.

Regarding the transition model, help-seeking was considered a kind of seeking support (Barclay, 2015). Regarding counselor help-seeking behaviors, there was a struggle with seeking help under the theme **I Don't Know What to Do** and realizing *Something's Not Right.* Participants realized that something was wrong, but they had difficulty identifying CF. This finding supported that there is a gap in the research and confusing definitions (Foreman, 2018; Knight, 2013). It could be that each CPP experiences CF differently or uniquely, and the definitions may need to be expanded and further training provided. Another area of difficulty included *I'm Scared* or fear of being a burden to other counselors. This was an unexpected finding, and further research is needed to identify what underlies this theme further. There may be a form of overempathizing for other counselors that may prevent some from requesting help. Additionally, there was a fear of being labeled and perceived internal and external stigma. This finding was unexpected in terms of differentiating between types of stigma. This was supported by research defining stigma overall by Neukrug et al. (2017), discerning internal stigma (Mullen & Crowe, 2017) and external stigma (Negash & Sahin, 2011). Further research with CPPs could help explore internal and external stigma and understand hindrances to reaching out for help.

The subtheme *I've Been Hurt in the Past* was partially supported in that harmful supervision exists and can impact counselor and client (Ellis et al., 2014) or that supervisors might push the helper beyond their limits (Freudenberger, 1975). An unexpected finding concerned the lack of support from the ACA and other agencies. The ACA and local associations may consider researching this factor in terms of the impact to private practice. Further research

into supportive versus unsupportive consultation or supervision could be helpful in understanding the struggle of CPPs.

SC was also used as a coping strategy, as exemplified under **I Can Heal,** and subtheme *It's Okay to Not Be Okay* in that participants acknowledged their humanity and normalized CF. Participants also realized the benefits and that it was okay to reach out for help. The use of SC with CPPs is supported in the literature (Barton, 2020; Patsiopoulos & Buchanan, 2011), and this study expanded the literature concerning the specifics of applying SC as a CPP. Participants also realized that CF may be part of the job of counseling, which was partially supported in the literature (Acker, 2012; Brauner, 2015; Litam et al., 2021; Thompson et al., 2014). If CF is part of the job, master's training program administrators could consider adding CF management psychoeducation to their curriculum.

The benefits of reaching out for help were supported in the literature (Finklestein et al., 2015). The literature also supported the benefits of obtaining support in personal therapy (Kalkbrenner et al., 2019; Malikiosi-Loizos, 2013; Savic-Jabrow, 2010). Further research into attendance rates for CPPs could be helpful. Also, counselors seeking support in supervision was confirmed in the research (Falender & Shafranske, 2012; Knight, 2013; O'Connor et al., 2018; Savic-Jabrow, 2010). However, Carney and Jefferson (2014) described the limited research concerning consultation, and this dissertation helped expand the benefits of consultation and group consultation in private practice. Seeking support from peers was also supported by the literature (Darcy & Abed-Faghri, 2013; Moore et al., 2020; Savic-Jabrow, 2010; Skovholt & Trotter-Matheson, 2016; Stebnicki, 2000). The benefits of seeking support from family and friends was also confirmed (Ensher et al., 2017; Mullen & Crowe, 2017; Myers & Sweeney,

2005) and this study expanded the knowledge base to include CPPs. Further research into the types of support used could help clarify CPPs help-seeking.

Further, participants used a form of mindfulness with *Getting to Know Myself Again*. This added to the knowledge base concerning mindfulness and acceptance in that it may be that mindfulness applications are unique to each CPP. Some studies have described mindfulness as a positive coping strategy that may help prevent CF (Barton, 2020; Coaston, 2017; Hayes et al., 2004; Patsiopoulos & Buchanan, 2011; Thompson et al., 2014). Contemplation and self-reflection were also supported (Bennett-Levy & Finlay-Jones, 2018; Bradley et al., 2013; Savic-Jabrow, 2010). Participants also worked to build their identity apart from counseling, focusing on other things besides work, watching shows, and reading. According to the research in terms of identity, this may be representative of the essential self (Myers & Sweeney, 2005) and discerning between the personal self and the therapist self (Bennett-Levy & Finlay-Jones, 2018). In terms of ethical implications, several participants used self-assessment, which is backed by the literature (Brennan, 2013) and the ACA (2014) *Code of Ethics* (C.2.g), and all seven participants used help-seeking and coping strategies. Further research into self-assessment in private practice could also be beneficial. Using spirituality was also a supported finding (Barton, 2020; Lawson & Myers, 2011; Myers & Sweeney, 2005; Skovholt & Trotter-Mathison, 2016; Thompson et al., 2014). This expanded the knowledge base concerning the use of spirituality as coping and self-care with CPPs and is also worth further inquiry.

Under the theme **I Can Heal** and subtheme *Taking Care of Me*, participants described how they understood that life is a combination of acceptance and change, a supported finding (Anderson et al., 2011; Brach, 2003; Skovholt, 2012; Stebnicki, 2021). All seven participants reported realizing the importance of self-care strategies such as time with friends, chores,

errands, doctors' appointments, unstructured weekends, getting a massage, and exercise. Self-care as a protective factor was supported where VT symptoms were mitigated by coping and well-being for community mental health counselors (Williams et al., 2012). Other coping strategies such as setting aside time for rest were also supported in the literature (Coaston, 2017; Freudenberger, 1975; Skovholt, 2012) and expanded the knowledge base concerning the benefits of breaks and rest for CPPs. The research also supported exercise as a coping strategy (Patsiopoulos & Buchanan, 2011; Savic-Jabrow, 2010; Skovholt, 2012), and making time for exercise, although a counselor might be exhausted, was described as a potential struggle with this strategy (Puig et al., 2012).

Regarding boundary setting, participants used several types of boundaries, such as setting emotional boundaries, which was supported in the research in terms of the use of emotion-focused coping (Lazarus & Folkman, 1984; Thompson et al., 2014) and reducing the risk of overinvolved feelings (Connery & Murdock, 2019). Further research into how CPPs can more effectively set these emotional boundaries or apply dissociation as coping, such as Cheryl's "therapist shield," could be helpful. Dissociation as a coping strategy through emotion-focused coping (Folkman & Moskowitz, 2004) was an unexpected finding. Further research is needed to explore emotion-focused coping and blocking as coping and to explore dissociation associated with CF in CPPs.

Participants also protected their peace by adjusting their workload and schedule, which was also supported in the literature (Freudenberger, 1975; O'Connor et al., 2018; O'Sullivan & Bates, 2014), and this study expanded the literature concerning CPPs. Participants also set limits with clientele and rates. The practice of setting boundaries was supported in the literature (Brennan, 2013; Brauner, 2015; Harrington, 2013; Lawson & Myers, 2011; Skovholt, 2012;

Skovholt & Trotter-Matheson, 2016). The knowledge base seems to have expanded regarding boundaries with insurance and accepted clientele. This is another area of further research with managing CF.

Participants discovered meaning-focused coping strategies through **Taking Care of Me,** and *I Grew From It.* Participants found some of the benefits of working in private practice, which was a supported finding (Brauner, 2015; Brennan, 2013; Harrington, 2013). They also realized the benefits of professional growth (Savic-Jabrow, 2010; Skovholt, 2012) and receipt of support through attending training in understanding CF (Finklestein et al., 2015; Joinson, 1992). Further, the realization that there was hope in the experience of CF, which meant they could heal, was an unexpected finding supported by the research in terms of CS and resilience. Some participants gave back by teaching other counselors, mentoring, and supervising. The benefits of giving back to other counselors could be categorized under CS in that giving back to other counselors is a benefit of helping but may be a unique area in CS and could be researched further. Meaning-focused coping (Biggs et al., 2017; Folkman, 1997; Folkman & Moskowitz, 2004), resilience building or posttraumatic growth (Naghavi & Salimi, 2018), and CS (Gonzalez et al., 2019; Lawson & Myers, 2011; Litam et al., 2021; Skovholt, 2012; Thompson et al., 2014) are coping strategies supported by the research. This expanded the knowledge base concerning the use of meaning-focused coping and the value to CPPs, protecting them and helping them cope with CF.

Practical Implications

According to these findings, CPPs are under a lot of stress from their personal, world, and employment stressors. Coping and help-seeking in this sample of counselors helped them manage CF and prevent further CF. CPPs need to be able to access resources to help them

maintain their businesses and continue to counsel clients. Consultants, supervisors, administrators, and associations who support CPPs may consider offering more cost-effective solutions to enable CPPs to access help, or they may consider compiling a list of the affordable or free options as many free Facebook group sites exist for supporting CPPs and they may not know about these supports. Counselors, consultants, and supervisors working with CPPs experiencing CF may consider working with them on tailoring a plan for self-care particular to their unique needs, including exercise, fun activities, breaks, vacations, rest, and spiritual self-care. ACA and other state counseling associations addressing the impact of venture capitalism and large insurance credentialing firms and the effect to the small private practice owner could help alleviate the fears for CPPs. Professors providing support in counselor training programs may consider adding additional information about CF as well as how to effectively run a private practice and training concerning ethics in private practice as well as coping strategies and supports.

Delimitations and Limitations

This study focused on CPPs who were independently licensed and had experienced CF while working in private practice. Delimitations for this study included that participants needed to hold an LPC/LMHC or state-equivalent license. Agency and other work settings were excluded and nonlicensed persons were also excluded. Another delimitation was the participants needed to have worked in private practice and experienced CF in the last 2 years while working in private practice. This delimitation helped focus the interview questions on past experiences of CF to reduce risk to the participant. The delimitations were chosen in order to ensure that the participants experienced the phenomenon to be explored.

There were also limitations in that the results may not be generalizable due to the qualitative design, small sample size, and homogeneity of the sample. All participants were female as well; however, that sample bias reflects the makeup of the profession, which is predominantly female. Also, the study was closed to other disciplines in the helping profession. Another limitation included that I, the researcher, fit the inclusion criteria for the study and could have been a participant. There was also low participant interest, so this issue could be revisited. The researcher overestimated the interview length, which averaged around 30 to 45 minutes. Counselors usually schedule 45-minute to hour-long appointments with clients. It could be that the participants did not have enough time to meet for an hour and a half due to busy schedules, and updating the posted length of the interview might help. Harrington (2013) described that there is not much incentive for CPPs to participate in research. Further, the researcher posted the Qualtrics survey and announced the compensation of a $25 Amazon Gift card around Prime Day, so the survey was overloaded with random responses, as indicated by the numerous fake email addresses and names provided by unqualified respondents. Additional security measures would be needed in future research to prevent random responses.

Recommendations for Future Research

The results indicate multiple suggestions for future research, such as replicating this study on a larger scale and exploring CF with counselors from other professions in private practice could clarify similarities and differences between professions. The impact of the pandemic on the participants' lives and work was evident. Further research with a larger quantitative study evaluating the relationship between the pandemic and CF could help support CPPs. In applying the transition model to understanding stressors that CPPs experience, further research into stressors that are expected versus unexpected could be beneficial in helping CPPs

better manage stress. Researchers could explore the impact of unexpected stressors on CPPs such as the pandemic, political unrest, racial tensions, and having to change to virtual counseling. Researching similarities and differences between those who were experienced in virtual counseling and those not experienced could also provide valuable information.

Further research into how a therapist sets emotional boundaries as a form of healthy disconnecting, dissociating, or a "therapist shield," as Cheryl called it, could be helpful. Related to this, further research is needed into emotion-focused coping and using blocking as coping in looking at the benefits and drawbacks. Also, research into healthy dissociation as coping versus dissociation as a potential symptom of CF may be helpful. Further research into how many universities prepare students for potential CF would likely be valuable in preparing them, as five out of seven participants in this study realized that CF was part of the job. As suggested by a participant, adding CF training or psychoeducation to master's programs could be beneficial. Conducting a larger study with a questionnaire and interview with additional questions about CF and inquiring how many CPPs believe that CF is part of the job could be helpful in considering adding it as part of a training program at universities. Also, all participants were female in this study; exploring CF differences across gender and racial identification is another area to be explored. Additional research exploring CPPs' fears about maintaining ethics and worrying about ethics complaints could also be valuable in understanding how to support them.

Further research looking into venture capitalism and large corporations and their impact on CPPs could assist them with coping with these changes. Also, research into SC, the benefits of normalizing CF, and the similarities and differences between mindfulness, acceptance, and self-reflection, may also be beneficial. Additional research looking into coping with spirituality and how participants used spirituality could support CPPs further. Further exploration

concerning the types of meaning-focused coping strategies that help CPPs in terms of the protective aspects of CS could also be helpful in applying the transactional theory of stress and coping. Research that provides a more precise definition of mindfulness could also be beneficial so that CPPs could use it and explain it better to themselves, their clients, and their supervisees. Further research into the varying stress of expected versus unexpected stressors could be helpful in applying the transition model with CPPs. Further research into self-stigma may be beneficial. Also, research into the potential for overempathizing toward other counselors when CPPs are seeking help could be another area of interest. Another hindrance included the participants worrying about being a burden to their personal counselor, which was an unexpected finding, and further research is needed to develop this theme and research it further. Further research into understanding the benefits of consultation groups and how to form consultation groups could also be helpful. The knowledge base seems to have expanded regarding boundaries with insurance and accepted clientele. This is another area of further research in managing CF. Further research into therapists working with complicated cases and how they adapted and successfully navigated CF could be another area to explore. Exploring the connection of CF and whether CPPs were attending personal counseling or not could also be researched.

Summary

The purpose of this phenomenological study was to understand the experiences of CF, help-seeking, and coping strategies among CPPs. Seven participants met the criteria for the study and completed the questionnaire, and attended the audio and video recorded interview. IPA was used to understand the data from the interviews, and three main themes were identified. Regarding the first theme, **I'm Overwhelmed on Every Side**, all seven participants provided a detailed description of their particular stressors, such as the pandemic and business-related

stressors. Participants reported feeling too tired to care for themselves and others, worrying about ethical mistakes, and struggling with setting boundaries. Participants struggled with uncertainty with the theme **I Don't Know What to Do** in difficulty identifying CF and with worries and fears about the potential consequences of reaching out for help. However, all participants reached out for help to personal counselors, supervisors, attended consultation groups, or reached out to peers or family under the theme **I Can Heal.** They used coping with SC, mindfulness, self-reflection, self-care, and meaning-focused coping strategies, such as realizing the benefits of being a counselor, a form of CS.

Removing barriers to CPPs obtaining help, such as affordability of support, could make a huge difference in managing CF for CPPs. Also, working with CPPs to identify a unique self-care and coping plan instead of a generic plan could also be helpful. It could be beneficial to provide a safe, affordable, and accessible place for CPPs to vent their feelings about clients and the work of private practice. The use of setting emotional boundaries, blocking, and a "therapist shield" was helpful to participants. Further research into how to use a therapist shield and healthy blocking could be helpful to support other counselors in setting emotional boundaries. The advantages of attending consultation groups was highlighted strongly, and further research into this help-seeking behavior could be beneficial. Further research into building meaning-focused coping, CS, and resilience could also be helpful. ACA and state associations looking into the impact of large corporations entering the mental health field, venture funding, and large insurance credentialing groups could also be helpful. The world and the field of counseling appear to be in constant flux. Continued research into the impact of these changes with CPPs could be helpful as they adapt to the stressors and transitions to support other counselors in managing stressors and potential CF.

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Appendix A: Permission Request Letter

Date
Recipient Name

Dear _____:

As a graduate student in the department of Community Care and Counseling/School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The title of my research project *Understanding the Experiences of Compassion Fatigue Among Counselors in Private Practice: A Phenomenological Approach* and the purpose of my research is to understand counselors in private practice who have experienced compassion fatigue and their help seeking and coping behaviors. I am writing to request your permission to contact members of your Facebook group or online forum to recruit participants for my research.

Participants will be asked to complete a questionnaire and if they meet the pre-screening requirements, they will be asked to sign the informed consent form and participate in an online audio and video recorded interview. Following the interview, participants will be asked to review the transcript for accuracy. The data will be used to build understanding of compassion fatigue in counselors in private practice. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please respond by email.

Sincerely,

Brie-Anna M. Willey, LMHC, CRC, QS
Doctoral Candidate

Appendix B: Recruitment Template: Social Media

ATTENTION COUNSELORS IN PRIVATE PRACTICE: I am conducting research as part of the requirements for a Doctor of Education degree at Liberty University. The purpose of my research is to understand counselors in private practices' experiences of compassion fatigue and their help-seeking and coping behaviors. To participate, you must be 18 years of age or older, licensed as an LPC, LMHC, or the state equivalent of the license, work in private practice while actively seeing clients, and identify as having experienced compassion fatigue in the last two years while working in private practice. Participants will be asked to attend an online audio- and video-recorded interview (60-90 minutes) and review their transcripts for accuracy (15 minutes). If you would like to participate and meet the study criteria, please click here to access a screening survey. A consent document is provided as the last page of the screening survey. Participants will receive a $25 Amazon gift card upon completion.

Appendix C: Participant Recruitment Letter

Dear Therapist,

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to better understand counselors in private practice and their experiences of compassion fatigue, and their help seeking, and coping behaviors, and I am writing to invite eligible participants to join my study.

Participants must be 18 years old or older and currently licensed as an LMHC, LPC, or state equivalent of the license. Participants must work in a private practice and have an active client caseload. Participants must have experienced compassion fatigue in the last two years while working in private practice.

Participants, if willing, will be asked to:

- Participate in the audio and video recorded interview (60-90 minutes).
- After the interview, review the transcripts to ensure accuracy (15 minutes).

Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please click here to access a screening survey:

A consent document is provided to you as the last page of the screening survey. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent at the end of the screening survey. Doing so will indicate that you have read the consent information and would like to take part in the interview.

Participants will receive a $25 Amazon gift card upon completion.

Sincerely,

Brie-Anna M. Willey, LMHC, CRC, QS
Doctoral Candidate

Appendix D: Prescreening Questions and Demographic Questionnaire

1. What is your age?
    - 18–21 years old
    - 22–25 years old
    - 26–35 years old
    - 36–45 years old
    - 46–55 years old
    - 56 years old or older
    - Under 18 years old

2. What nonrestrictive counseling license do you hold?
    - LMHC
    - LPC
    - State equivalent (specify)_____
    - Other mental health discipline (LMFT, LCSW, psychologist, etc.)
    - I am not currently licensed

3. Do you currently work in a private practice?
    - Yes
    - No

    a. If yes, do you currently see clients (have an active client caseload)?
        - Yes
        - No”

4. How many years have you worked in private practice?
    - 1 year or less
    - 2–4 years
    - 5–9 years
    - 10 + years

5. Review the following definition of “compassion fatigue” as defined by Stebnicki (2017): “Compassion fatigue is empathy fatigue that negatively impacts the mind, body and spiritual self, broken into two parts: burnout and secondary traumatic stress.

    Burnout—counselors’ feelings of hopelessness, exhaustion and lack of effectiveness in your work.
    Secondary traumatic stress—counselors secondary exposure to trauma experienced by clients.”

    In considering the above definition of compassion fatigue, in the past 2 years have you experienced compassion fatigue (burnout and/or secondary traumatic stress) while working in private practice?
        - Yes
        - No”

6. What is your racial identification? Check all that apply.
    - Black
    - African American
    - Latinx/Latin American
    - Native American
    - Asian American/Pacific Islander
    - Asian
    - White
    - Arab American
    - African
    - Not listed (please specify)_____
    - Prefer not to answer

7. To which gender identity do you most identify?
    - Female
    - Male
    - Gender diverse
    - Nonbinary
    - Nonconforming
    - Not listed
    - Prefer not to answer

8. How many clients are you currently seeing per week?
    - 1–5
    - 6–10
    - 11–15
    - 16–20
    - 21–25
    - 26+

9. Of the clients you are seeing per week, how many have experienced a traumatic event?
    - 1–5
    - 6–10
    - 11–15
    - 16–20
    - 21–25
    - 26+

10. Are you currently seeing a therapist?
    - Yes
    - No

Appendix E: Consent

Title of the Project: Understanding the Experiences of Compassion Fatigue Among Counselors in Private Practice: A Phenomenological Approach.
Principal Investigator: Brie-Anna M. Willey, LMHC, CRC, QS, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate you must be 18 years old or older, be a licensed professional counselor/licensed mental health counselor (or state equivalent), work in private practice while actively seeing clients, and identify as having experienced compassion fatigue in the last two years while working in private practice. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this study is to understand the meaning counselors in private practice attribute to their experiences of compassion fatigue and help seeking and coping behaviors. This information will help the researcher to understand perceived stress from managing a private practice with an active caseload and the counselors' experiences of compassion fatigue in private practice. This will also help the researcher to learn about how participants cope with this perceived stress and any barriers to asking for help.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in a video- and audio-recorded interview (60-90 minutes).
2. After the interview, review your transcripts for accuracy (15 minutes).

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include gaining an understanding of counselors in private practice experiences of compassion fatigue and their help seeking and coping behaviors.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. While distress is unlikely, a list of counseling resources will be provided should you become distressed.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only

the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked folder on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Upon completion of the interview and reviewing transcripts for accuracy, participants will receive a $25 Amazon gift card via email. Monetary benefits will not be pro-rated if the participant does not complete the study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Brie-Anna Willey. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her. You may also contact the researcher's faculty sponsor, Dr. Tanisha Sapp.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

Appendix F: Confirmation Email

Date
Recipient Name

Dear Prospective Participant,

Thank you for completing the demographics questionnaire and signing the consent form. After reviewing your information, you have been selected to participate in this dissertation study.

Please use this link to access my calendar and select the day and time that works best for you to participate in the 60–90-minute audio- and video-recorded online interview:

Upon scheduling the interview, you will receive the link to join the interview in your confirmation email. At the time of our interview, you will click the link to join the interview.

Also attached, you will find a physical copy of the informed consent document to keep for your records. If you have any questions, please contact me.

Thank you for your time and I look forward to meeting with you soon.

Sincerely,

Brie-Anna M. Willey, LMHC, CRC, QS
Doctoral Candidate

Appendix G: Interview Questions

1) Please describe the population of clients you work with in your private practice.
2) Please describe the stressors experienced in your personal and professional life.
3) What stressors have you experienced while working in private practice?
4) What were some of the unexpected stressors you experienced?
5) Can you describe how you came to experience compassion fatigue?
6) What did compassion fatigue feel like?
7) What did it mean to you when you recognized you were experiencing compassion fatigue?
8) What did you do once you noticed your symptoms of compassion fatigue?
9) What strategies did you use to help you cope with compassion fatigue?
10) Please describe your process of coping with compassion fatigue.
11) What coping strategies did you find most beneficial?
12) What are your beliefs about counselors who experience compassion fatigue?
13) How do you believe compassion fatigue could be prevented?
14) What do you believe may have prevented you from asking for help, if anything?
15) Is there anything else you would like to share about your experiences that I have not addressed?

Appendix H: Referral Sources

If you need further support, please contact:

1. Better Help: https://www.betterhelp.com/
2. National Alliance on Mental Illness (NAMI): https://nami.org/Home
3. Open Path Collective: https://openpathcollective.org/
4. Substance Abuse and Mental Health Services Administration (SAMSHA): https://www.samhsa.gov/
    - SAMHSA's National Helpline: 800-662-HELP (4357) TTY: 800-487-4889
5. Talk Space: https://www.talkspace.com/
6. Teladoc: https://www.teladoc.com/
7. Therapy for Black Girls: https://therapyforblackgirls.com/