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Original Research

When You Care Enough to Do Your Very Best: Genetic Counselor Experiences of Compassion Fatigue

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Compassion fatigue is a phenomenon that occurs when a caregiver feels overwhelmed by repeated empathic engagement with distressed clients (Figley, 2002). Research demonstrates its existence among nurses, physicians, and mental health professionals, but to date no published study has specifically investigated the nature and prevalence of compassion fatigue among genetic counselors. The present study was an initial attempt to identify and describe the phenomena in genetic counseling by conducting focus group interviews with 12 genetic counselors. Data analysis yielded several themes: a) compassion fatigue occurs and may compromise professional and personal functioning; b) prevalent *triggers* include delivering bad news and difficult patient issues (e.g., terminal illness, anger, psychopathology); c) effective coping strategies include consulting with colleagues, setting boundaries, and humor; and d) risk factors include personality characteristics and traumatic memories. Training, practice, and research recommendations are provided.

KEY WORDS: genetic counselor compassion fatigue; empathy; stress; coping; self-care; countertransference; burnout.

Compassion fatigue is a phenomenon experienced by caregivers who work with traumatized clients (Figley, 2002). Compassion fatigue occurs when a caregiver feels overwhelmed by repeated empathic engagement with clients and client suffering, and it is characterized by symptoms that include reliving aspects of the trauma; avoiding reminders of the trauma; and psychosocial and physiological symptoms such as heightened irritability, sleep disturbances, quick temper, sadness, withdrawal, and task avoidance (Figley, 2002). Joinson (1992) first used the term *compassion fatigue* to describe a prevalent experience among professional caregivers, such as nurses, physicians, ministers, and mental health counselors. According to Joinson, there are four reasons that caregivers ought to be aware of and responsive to compassion fatigue: 1) It can be emotionally devastating; 2) Caregivers' personalities make them prone to experience compassion fatigue; 3) External triggers of compassion fatigue are unavoidable; and 4) Compassion fatigue is almost impossible to recognize without a heightened awareness of the phenomenon.

Baerg (2003) reports signs of compassion fatigue among staff who work in pediatric oncology and speculates that genetic counselors share similar risks. Support for her speculation is provided by Dexter and colleagues (2003) who assessed burnout in 190 genetic counselors and found that they had significantly higher emotional exhaustion scores compared to social services and mental health workers. Although burnout differs from compassion fatigue,

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their data suggest that genetic counselors might be vulnerable to the phenomenon. However, because no published research has investigated genetic counselors' experiences of compassion fatigue, the purpose of the present study was to gather preliminary data about its occurrence.

Figley's Model of Compassion Fatigue

One of the most comprehensive compassion fatigue models was developed by Figley (2002, 2003). According to Figley, compassion fatigue is a natural consequence of working with clients who have experienced distressing events and it develops both because of this exposure and because of the caregiver's *empathy*. Although numerous definitions of empathy exist in the literature, most emphasize two dimensions: emotional empathy (an emotional reaction that mirrors the client's experience) and intellectual empathy (taking the client's perspective to understand her/his frame of reference) (McCarthy Veach *et al*., 2003).

Figley's (2002) model suggests that compassion fatigue is primarily a *by product* of emotional empathic connections with clients, and it consists of 10 components:

Component 1: *Exposure to Suffering/Exposure to Client*—Direct contact with clients exposes caregivers to their suffering and results in the caregiver experiencing client suffering. Figley suggests that one reason people in human service fields become supervisors, administrators, teachers, or even abandon direct practice, is the high cost of this direct exposure.

Component 2: *Empathic Ability*—Empathic ability refers to one's capacity for sensing the pain of others. Empathy is needed in order to help others, but it makes one vulnerable to the costs of caring.

Component 3: *Empathic Concern/Concern*—Empathic concern pertains to a caregiver's motivation to respond to people in need. Empathic concern will motivate a caregiver to use her or his talent, training, and knowledge to deliver the highest quality of services possible.

Component 4: *Empathic Response*—Empathic response refers to the amount of effort a caregiver expends to mitigate client suffering through empathic understanding. Empathic understanding is achieved by putting oneself in the position of the client and gaining cognitive and affective insight into her or his thoughts, feelings, and behaviors. In this process, the caregiver might experience client emotions such as hurt, fear, and anger. One's empathic understanding is affected by the first three components of the model, that is, exposure to suffering, empathic ability, and empathic concern.

Component 5: *Residual Compassion Stress*—Residual compassion stress is the emotional energy left over from empathic responses to clients and from the constant demand to relieve client suffering. When emotional residue from empathic responding is intense enough and is not dealt with, it may compromise the caregiver's health and overall quality of life.

Component 6: *Sense of Achievement/Sense of Satisfaction*—This component refers to the extent to which caregivers feel satisfied about their efforts to help clients. Caregiver satisfaction serves as a coping mechanism that can reduce or prevent residual compassion stress. If efforts to achieve a sense of satisfaction fail to mitigate residual compassion stress, then the caregiver is at increased risk for compassion fatigue.

Component 7: *Disengagement/Detachment*—This component refers to the extent to which caregivers maintain good boundaries and therefore have the ability to distance themselves from client suffering. This component also involves a conscious effort to *let go of* thoughts, feelings, and sensations associated with clients. Disengagement/detachment constitutes a coping mechanism that can relieve residual compassion stress.

Component 8: *Prolonged Exposure/Prolonged Exposure to Suffering*—Prolonged exposure refers to extended periods of feeling responsible to care for suffering individuals, and it comprises a risk factor for compassion fatigue. Periodic breaks from being a service provider, even those as short as one day, may be beneficial.

Component 9: *Traumatic Recollections/Traumatic Memories*—Caregiver memories of past experiences with clients or personal traumatic events can trigger symptoms such as depression and anxiety. Traumatic memories pose risks for compassion fatigue.

Component 10: *Degree of Life Disruption/Other Life Demands*—Every caregiver encounters unexpected events in her or his life that require attention (e.g., changes in personal health, schedule, life style, social status, professional or personal responsibilities). Under normal circumstances, such unexpected events cause some level of distress, but when added to the other components in the model, they increase the chance of compassion fatigue.

Is Compassion Fatigue a Conceptually Distinct Phenomenon?

There is some confusion in the literature regarding distinctions between compassion fatigue and other phenomena such as *burnout* and *vicarious traumatization* (Sabin-Farrell and Turpin, 2003). While some authors use these terms synonymously, others distinguish between them (Baird and Jenkins, 2003). Compassion fatigue, burnout, and vicarious traumatization do share certain similarities. For instance, they can be caused by emotional engagement with clients in the context of a demanding job, they can negatively affect the professional's service provision (Jenkins and Baird, 2002), they share risk factors of empathic ability and interpersonal demands, and they result in psychological distress (Jenkins and Baird, 2002). However, there are important differences. Burnout is often associated with the daily stressors and hassles present in the workplace (Schwam, 1998), whereas compassion fatigue is a result of exposure to patient trauma (Jenkins and Baird, 2002). Burnout gradually *wears down* helpers, making them feel overworked and incapable of facilitating a positive change, while compassion fatigue occurs suddenly, is acute, and occurs when caregivers feel overwhelmed by client suffering (Figley, 1995). Compassion fatigue is highly manageable once it is recognized and appropriately acted upon, whereas burnout may require changing jobs or careers (Figley, 2002).

Pearlman and Mac Ian (1995) define *vicarious traumatization* as a transformation that occurs in helping professionals (specifically therapists or other trauma workers) due to empathic engagement with clients' trauma experiences and their sequelae. Vicarious traumatization is a cumulative process that results in changes in therapists' experiences of self, others, and the world. Both vicarious traumatization and compassion fatigue have been related to trauma exposure, but compassion fatigue is unique because exposure to even one client's suffering can be severe enough to trigger symptoms, whereas vicarious traumatization develops over time and leads to potentially permanent changes in the professional's worldview (e.g., therapists who work with abuse survivors may gradually come to view the world as unsafe). Some authors have suggested that vicarious traumatization involves *emotional contagion* (experiencing another's distress at an unconscious level) (Sabin-Farrell and Turpin, 2003), whereas compassion fatigue involves greater conscious awareness of symptoms (Figley, 1995).

Thus, compassion fatigue appears to be conceptually distinct, particularly with respect to its acute onset, overt symptoms evoked by exposure to traumatized clients, and the degree of caregiver conscious awareness of its symptoms. Caregivers who experience compassion fatigue describe residual suffering that is triggered by their empathy for clients, and they are aware of their distress and how it manifests in their feelings, thoughts, and behaviors. Their symptoms *come on* rapidly and can be alleviated by temporarily *getting away* from compassion fatigue triggers.

Purpose of the Present Research

Compassion fatigue that is unrecognized and untreated may have serious deleterious effects on professional and personal functioning. However, no research has investigated its occurrence among genetic counselors. Accordingly, we conducted focus group interviews with 12 genetic counselors in order to investigate five major research questions: 1) Do genetic counselors experience compassion fatigue? 2) Is Figley's definition of compassion fatigue applicable to genetic counseling professionals? 3) How does compassion fatigue affect genetic counselors? 4) How aware were genetic counselors of the risks of compassion fatigue prior to practicing? and 5) What types of training regarding compassion fatigue do they recommend?

METHODS

Participants

In order to interview individuals with a rich experiential base and enough common experiences to facilitate discussion (Krueger and Casey, 2000), we targeted practicing genetic counselors for participation in this study. Upon receipt of approval from a University of Minnesota institutional review board, we recruited current practitioners from one Midwestern state through an email invitation to participate in a focus-group study of compassion fatigue in genetic counselors.

Twenty-eight genetic counselors received email invitations, and of these, 14 agreed to participate.

Due to last minute scheduling conflicts, two could not attend. Thus, the final sample consisted of 12 genetic counselors (11 female, 1 male) who ranged in age from 29–52 years ($M = 38$ years; Mdn = 37.5). Eleven were graduates from one of six genetic counseling programs located either in the Midwest or the east, and one participant did not have formal genetic counseling graduate training. Five counselors listed one area of practice, three listed two areas of practice, and four listed three or more areas of practice, including: prenatal ($n = 8$), cancer ($n = 3$), pediatrics ($n = 2$), general ($n = 2$), hematology/hemophilia ($n = 2$), laboratory/molecular diagnostics ($n = 2$), neurology ($n = 1$), assisted reproduction technology ($n = 1$), pediatric cardiology ($n = 1$), Down syndrome ($n = 1$), and metabolic ($n = 1$). Their years of genetic counseling experience ranged from 2.5–26 ($M = 11$ years; Mdn = 10.5 years). The average number of patients seen per day ranged from 0–6 ($M = 3$; Mode = 4), and the average number of patients seen per week ranged from 0–24 ($M = 11.9$, Mode = 15). The percentage of time spent in direct service with patients ranged from 0–100% ($M = 68\%$; Mdn = 82.5%). Eight of the 12 participants were currently supervising a genetic counseling student.

Instrumentation

Focus Group Questions

Drawing upon literature from the medical and mental health professions, we developed the following definition of compassion fatigue:

> Compassion fatigue refers to a state of feeling overwhelmed rather than overworked. Compassion fatigue is caused by repeated empathic engagement with traumatized clients. Compassion fatigue differs from burnout in that burnout is a reaction to excessive amounts of work (e.g., demanding administrative tasks, resource shortages, etc). Some of the symptoms thought to be associated with compassion fatigue include: reliving an aspect of the trauma, avoidance of anything potentially related to the trauma, and physical symptoms of heightened irritability, sleep disturbances, quick temper, and angry outbursts.

We developed a series of questions (See Appendix) asking participants to respond to our definition, provide examples of compassion fatigue and their coping strategies, describe their knowledge of compassion fatigue as students and its role, if any, in their choice of specialty, and to offer suggestions for training. In accordance with Hill, Nutt Williams, and Thompson's (1997) recommendations, we articulated our expectations about participant responses prior to developing these questions, specifically: 1) All participants would report experiences that prompted compassion fatigue; 2) Compassion fatigue would be provoked by the *life and death* nature of some genetic counseling decisions and by the uncertainty and complexity of genetic risk; 3) Figley's (2002) compassion fatigue components would be evident in participant descriptions; and 4) Participants would generally report a lack of awareness of the phenomenon prior to entering the field.

Demographic Questionnaire

We developed a questionnaire to elicit information about participants' demographic characteristics.

Procedure

We conducted two, 2-hour focus groups ($n = 6$ per group) between December 2004 and January 2005, using the focus group questions to co-moderate each group. Participants responded to these questions in approximately the same order with occasional prompts by the lead moderator, the second author who is a licensed psychologist with experience conducting focus group research. The co-moderator was the third author, an experienced genetic counselor who has conducted focus group research. For one group the first author served as a process observer, but she did not attend the other group since it contained participants who did/would serve as her clinical supervisors.

Each group began with participants completing the demographic questionnaire. Next they read the definition of compassion fatigue used in this study and responded to the focus group questions. Each session was audio taped and later transcribed verbatim, with all identifying information removed.

Data Analysis

Transcripts were manually analyzed using a modified form of Consensual Qualitative Research (CQR) (Hill *et al.*, 1997), a methodology based upon elements of phenomenological (Giorgi, 1985), grounded theory (Strauss and Corbin, 1998), and comprehensive process analysis (Elliott, 1989). In CQR, consensus among data analysts is used to construct findings from the data (Hill *et al.*, 2005). In the present study, each transcript was read thoroughly and major comments by participants were noted. Next, participant comments were grouped into *domains* (rationally-derived topic areas). These domains were then used to independently code each transcript. On occasion throughout the coding process, decisions were made to add or modify a domain in order to more clearly represent the data. This analysis resulted in 11 domains. After the 11 domains were identified, each transcript was again reviewed to determine that they reflected these domains.

Next *core ideas* (brief summaries of the participants' exact wording) were constructed within each domain for each transcript, followed by aggregation of the core ideas into categories (specific content areas within each domain). Cross-case analysis (Patton, 1990) was used to compare responses across the two focus groups, and domains and categories were further refined. In focus group research, each group constitutes one case, and domains and categories represent group themes rather than the more idiosyncratic responses of one individual participant (Krueger and Casey, 2000). Finally, two of us served as auditors, verifying initial domains and categories. Any disagreements were resolved by discussion to reach consensus. The final coding resulted in 11 domains and 33 categories.

RESULTS

In the following sections domains and categories, and general themes extracted from participant responses are described, and illustrative quotes are provided.

REACTIONS TO THE DEFINITION OF COMPASSION FATIGUE (3 DOMAINS)

Domain 1: Distinctions Between Burnout and Compassion Fatigue

This domain involves participants' attempts to conceptually separate compassion fatigue from burnout. There are 2 categories:

1) *Burnout is a risk factor for compassion fatigue* ($n = 2$). Too much work (too many patients) and too much stress from administrative tasks lead to burnout which then may render practitioners more vulnerable to and/or less able to manage compassion fatigue: "If you only had to deal with two patients a week and they, you know, were really horrible patients, you would still easily be able to do those as opposed to seeing 15 or 20 patients."; and "If you are overwhelmed by the administrative [tasks], you might feel less able to deal with some of the more emotional tasks."

2) *Distinction is not clear* ($n = 2$). Participants were not always sure whether they were experiencing compassion fatigue or burnout. They reported experiencing aspects of both and commented that the phenomena are hard to separate. A question was raised about whether compassion fatigue is an aspect of burnout.

Domain 2: Goodness of Fit

This domain concerns participants' perceptions of how well the definition of compassion fatigue applies to genetic counselors. There are 3 categories:

1) *Acute versus chronic ($n = 2$).* Participants questioned whether compassion fatigue is transient and acute, or whether it is continually present.

2) *Definition is too extreme* ($n = 2$). Some participants considered wording such as *trauma* in the definition of compassion fatigue to be extreme. They maintained that the phenomenon is more subtle.

3) *Stigma* ($n = 1$). There may be a stigma associated with compassion fatigue, such that genetic counselors do not want to discuss their experiences.

Domain 3: Catalysts of Compassion Fatigue

This domain concerns aspects of the genetic counseling profession and genetic counselor characteristics that may make compassion fatigue especially prevalent. There are two categories:

1) *Uniqueness of genetic counseling* ($n = 1$). Certain unique aspects of genetic counseling may place practitioners at greater risk for compassion fatigue relative to other health-care professionals (e.g., short, intense relationships; and most people do not want to see a genetic counselor because it may mean that something bad happened).

2*) Genetic counselor personality ($n = 2$)*. Participants speculated that genetic counselors may possess certain traits that increase compassion fatigue risk (e.g., desire to be liked, wanting to control patient reactions, and perfectionism). They described a desire to *control everything* despite knowing that this is not possible. They speculated that their desire may stem from a personality trait and/or from a prior negative clinical outcome that occurred because they were not in control of the situation.

FIGLEY's (2002) MODEL OF COMPASSION FATIGUE

The following domains and categories correspond to the components of Figley's (2002) model of compassion fatigue.

EXPOSURE TO PATIENT SUFFERING (2 DOMAINS)

Domain 1: Delivering Bad News

Participants used the terms *bad news* and *bad outcomes* to refer to information that leads to patient suffering. Examples of bad news include abnormal prenatal results, diagnosis of a devastating condition, and identifying individuals who have a high risk of developing cancer. This was the most prevalent domain and it contains 8 categories:

1) *Difficulty giving bad news* ($n = 2$). It is hard to know what to say or do when giving bad news. Although genetic counseling experience increases one's skills at delivering such information, it is still difficult: "You think it would get easier or, you know, you think you have done this so many times, and it is still hard."

This difficulty often extends to family members who must be told that they are at risk. Family members may feel responsible for passing on a mutation, and/or may express intense emotions. One counselor described a patient who brought her mother to the results session: "Her mother *lost it,* and I did not expect that. It was hard for me and the patient to watch, watch the pain of this lady. It was horrid." Another participant provided a specific example of testing children for Familial Adenomatous Polyposis: "Seeing the kids fall apart in front of their families is just really horrendous."

2) *Volume of bad news* ($n = 2$). Having to disclose numerous abnormal results within a short time span can intensify one's overwhelmed feelings.

3) *Giving bad news by phone* ($n = 2$). In prenatal settings, results often are given by phone, a difficult modality for many participants: "I've had patients drop the phone … I didn't know if she was passed out, I didn't know, and I'm shouting 'What is going on there? Are you still there?' She finally picked up, but it was hard, it was terrible."

4) *Timing of bad news delivery* ($n = 2$). Phoning patients with abnormal results often means calling them after work hours, in the evenings or on weekends; and thus, clinical work is brought into the counselor's home life.

5) *Personal ambivalence re: positive prenatal test result*s ($n = 2$). Some participants mentioned that they were unsure about what they would do if they were to receive a positive prenatal test result – Would they terminate?

6) *Feel responsible for suffering ($n = 1$)*. Being the messenger of an abnormal test result makes some participants feel responsible for the pain it causes patients: "I'm going to destroy somebody's life today. I'm going to ruin their life. After they talk to me, they will never be the same."

7) *Consequences of information* ($n = 1$). Decisions with enormous consequences are made on the basis of test results, for example, to continue or terminate a pregnancy.

8) *Getting "rid of" results* ($n = 1$). It is difficult when patients cannot be reached. Participants described wanting patients to know as soon as possible, and that they wanted to *get it over with* in order to move on to next steps: "I want to give those results as fast as possible, because I know that I would feel better once that result is given to that patient. Then I can let go, I can get rid of it – It is out there, it is done, then the process of at least me feeling more helpful to that patient can begin."

Domain 2: Difficult Patient Issues

This domain concerns the types of patients and/or genetic counseling situations that are particularly challenging. There are 5 categories:

1) *Terminal illness* ($n = 2$). Many patients die or are terminally ill, their family members have died or are terminal, and their babies die. Genetic counselors may or may not see the person who is dying, but they must deal with individuals who are affected by this experience. Some participants attend patient funerals, while others either do not attend or stated that they would avoid attending.

2) *Mental health disorders* ($n = 1$). Patients who have mental health issues can be challenging to counsel because of the difficulty understanding them and their reactions, they have issues that cannot feasibly be addressed in genetic counseling, and/or their needs are beyond the scope of genetic counseling.

3) *Undiagnosed syndromes* ($n = 1$). Often a diagnosis cannot be made since current technology is not advanced enough, and/or there may never be a diagnosis: "Half the patients didn't have a diagnosis, and they would look at you like, 'Why did I come here? . . . We just did all this work, but for them the bottom line is they didn't perceive it like that, [they thought] we didn't do anything ... [they believed that] we wasted their time ... Certainly not giving them what they thought they needed is very difficult."

4) *Infertility* ($n = 1$). Some infertility patients expect to be treated *with privilege* compared to other patients presenting with a similar issue (e.g., advanced maternal age): "This is an IVF pregnancy, so I [the patient] should get in front of the other person."

5) *Responsibility to patients' family members* ($n = 1$). Situations in which they identify high risk for both the individual patient and the family are stressful for participants. They feel responsible for insuring that the patient understands the importance of telling other family members, and they are anxious about legal ramifications when there is no documentation that patients were informed of risks to themselves and/or family members: "I don't know if that information has been shared. It bothers me from an emotional standpoint, but then the legal liability, and have I done enough to make sure I've explained the importance of sharing it with their relatives."

EMPATHY AND RESIDUAL COMPASSION STRESS (1 DOMAIN)

Domain 1: Caring for Patients

The participants spent a fair amount of time discussing their ability to care, times when they were unable to care or help as much as they wanted, instances when they did not care, and negative effects of caring. Seven categories describe residual compassion stress that results from empathic ability, empathic concern, and empathic response.

1) *Emotionally investing in patients* ($n = 2$). Genetic counselor emotional investment, while beneficial to patients, may make the counselor more vulnerable to patient reactions. For example, it is difficult not to personalize patient anger: [Re: patient who received positive test results]: "I had one guy who threw me zingers all the way out ... right out to the waiting room he is throwing these words at me– like'Well of course it had to be me, and of course you have to tell me this right now, and it's ruining my life' ... and it is all the way down the hall, and I had already spent an hour with him going through processing this, but he was– and I knew he was scared to death. I just knew that's why he was saying it. [But it was hard] anyway ..."

2) *Profound impact of genetic counselor on patients and families* ($n = 2$). Genetic counselors may profoundly impact patients and their families through the counselor/patient relationship and the information presented: "If they [patients] count those five moments in their life that they think back on – it is like you're one of those [5 moments] for so many people."

3) *Genetic counselor efforts are not recognized* *($n = 2$)*. Most patients do not realize the work that is done *behind the scenes* to help them (e.g., locating and organizing relevant information; and coordinating with the patient, laboratories and other health professionals). Genetic counselors make these efforts because they care about patients and want to provide optimal services: "Even before the appointment, I invested a lot of effort, and I did a lot of work."

4) *Genetic counselor crying* *($n = 2$)*. Many participants reported that they have cried in front of a patient or about a patient after the appointment. Most considered their display of emotions in front of a patient to be okay, although they did not consider excessive crying to be helpful either to the patient or to themselves.

5) *Failure to attend* ($n = 2$). Listening fully to patients, while important and desirable, is emotionally demanding. Participants expressed a fair amount of distress about their lack of attention and/or failure to listen at times when they felt overwhelmed by stressful patient situations: "They are talking right now, and I'm thinking they should shut up. Like, 'Oh, my gosh! This is a bad sign!'." Participants expressed regret and guilt about times when they felt they did not care for patients: "I came home totally bummed out, and I thought, 'What the hell is the matter with me! I don't care!'." Another aspect of failure to attend involved lack of tolerance for patients, particularly those whom they regarded as making *foolish* choices.

Participants also mentioned forming pre-judgments: "I've become more cynical as time goes by. I used to have a lot more compassion right away for people in various scenarios, and now I think, 'You know what? Why are you in this situation? You're an adult, live your life, make your choices ..."

6) *Unable to help* ($n = 2$). Participants described their frustration when a patient wants something they cannot provide, or when they *know* what is best and the patient wants something else. Inability to help is very distressing: "I really wish I could have helped you, and I am devastated personally because I couldn't."

7) *Countertransference* ($n = 2$). Broadly defined, genetic counselor countertransference involves conscious and unconscious counselor emotions, fantasies, behaviors, and perceptions that are triggered by the client, client circumstances, or aspects of the counseling situation (McCarthy *et al.*, 2003; Weil, 2000). Countertransference also is defined to include the genetic counselor's unconscious ways of relating to clients that develop from her/his history of relating to others (Djurdjinovic, 1998). Kessler (1998) identifies two forms of genetic counselor countertransference – associative reactions and projective identification. Associative reactions refer to situations in which the client's experiences provoke the counselor's own associations, thoughts and images. When counselors have these associations, they may no longer attend to what the client is saying and feeling, instead focusing on their own internal experience. Projective identification occurs when the counselor identifies with the client, which, while leading to some understanding, also causes counselors to project their own thoughts and feelings, expecting clients to feel as they did.

The participants described countertransference that involved patients who triggered extreme personal emotions, reminded them of someone else, and/or prompted them to think of themselves in the same situation. They concluded that at times their countertransference had both positive effects (such as providing more insight about the patient), and negative effects (evoking painful counselor emotional reactions). For instance, participants who had children discussed how being a parent changed their perspective, helping them better understand patients and increasing their appreciation for their own family, but they now experience greater personal distress about bad patient outcomes because they understand from a parent's perspective.

COPING: DETACHMENT/DISENGAGEMENT AND ACHIEVEMENT/SATISFACTION (2 DOMAINS)

Domain 1: Detachment

This domain concerns the participants' ability to detach from patients and to separate work life from home life. There are 2 categories. The first involves strategies for appropriately detaching, and the other may indicate failure to appropriately detach:

1) *Helpful strategies* ($n = 2$). Participants reportedly use several behavioral strategies to manage emotional aspects of their work. For instance, they *set boundaries* in order to contain their work life, especially boundaries regarding their time–not being available *24/7*. Others mentioned the importance of taking the time to *decompress*, being quiet when first arriving home after work.

2) *Problematic strategies* ($n = 2$). Problematic detachment included cognitive and affective coping strategies which were troublesome to participants. Five types of cognitive strategies included: a) *dreaming about patients*, including their situations and/or what they were going to say/do to help them; b) *intrusive thoughts* about patients, particularly in non-work situations (e.g., "It popped up the entire weekend. It just kept coming up ... it didn't ruin the weekend, but ... I was angry . . . all it did was suck out the freedom of the weekend" and, "If you have to take it home everyday and every night, and it gets into the whole rest of your life, you can't function"); c) *compartmentalizing*, separating situations at work (e.g., "I had this mental list in my head of ... the babies that had died, which ones hadn't died, which ones that are moving on to the list. It almost became more routine, like, 'There are the oranges in the grocery store,' because in order to prevent [myself] from being overwhelmed, I think that it was probably my reaction"); d) *selective forgetting* to the point that they forgot to complete requisite duties (e.g., "I now am to the point where if I have an abnormal result, I have to call myself at home to remind myself to call the person, because by the time I get in my car and get home, I will have forgotten that I have an abnormal result. Now, I think that is not okay. I think that has gone too far the other direction where (and it's not that I don't care), it's that I don't remember. I don't want to remember, maybe that is what it is, that I don't want to remember this is my job, this is my life ..."); and e) *rationalizing* situations involving bad outcomes,

for example, thinking that a potentially devastating situation for a patient isn't really that bad in terms of what the outcome could be.

Affective strategies included *disconnecting emotionally* in genetic counseling sessions when they felt overwhelmed (e.g., "I am full. I can't invest anymore in that. 'Here's a chromosome. Hi and bye.").

Domain 2: Sense of Achievement/Satisfaction

This domain refers to performing well, times when one's ability to perform is compromised, counselor responsibility, and self-reflection about one's performance. There are 2 categories, 1 involving satisfaction and 1 involving dissatisfaction:

1) *Satisfaction* ($n = 2$). A thank you from a patient can help participants feel as if they have made a difference. Participants also stated that feeling good about their performance helps prevent stress (e.g., "I feel like I'm on a high when we pick up a family, tell which people need colonoscopies. When we detect a really advanced polyp, and we prevent colon cancer, that is great. That still leaves me on a high and, to a certain extent, it offsets some of the other stuff").

2) *Dissatisfaction* ($n = 2$). Many participants at times *second guessed* themselves, questioning whether they functioned adequately and/or did all that they could: "I'm trying to figure out what happened, and I think about it, and I rehash it – 'What did I do? What could I do differently?'" Sometimes they *felt so overwhelmed* that they worried about their skills being diminished (e.g., " ... descent to the lowest common skill level"). They also described a type of *vicarious liability* when coordinating care with other professionals and laboratories. Specifically, participants reported not wanting to relinquish tasks to others because they feel responsible and ultimately they deal directly with patients (e.g., "I tend to feel responsible for how the whole thing works ... When the lab's going to be another three weeks, you feel like you failed the patient").

Participants also described how it is easy to *misperceive their impact*, downplaying the importance of their role in situations with good outcomes and dwelling upon their role in situations with bad outcomes (e.g., One participant described her surprise when a patient recalled verbatim how on a previous occasion she had delivered a good test result. "I think I underestimate my role in the situation where things are normal ... like I maybe thought, 'This is no big deal ... ,' but obviously that minute [that I spent thinking] about what I was going to say before I called her, it was enough to make a difference to her."). Finally, some participants expressed their dissatisfaction about difficulties remembering *who* they said *what* to, or their inability to connect faces with a name even after they saw a patient that day. Forgetting was more likely when participants felt overwhelmed by sheer patient volume and/or the number of prenatal patients with abnormalities (e.g., "I couldn't actually keep track of who I said what to ... or, I even said to a patient, 'We got your FISH results.' She said, 'Oh, I didn't think we did FISH. [I said,] 'Oh, yeah, wait. No, we didn't'.").

PROLONGED EXPOSURE TO SUFFERING (1 DOMAIN)

Domain 1: Periodic Breaks

According to Figley (2002), prolonged exposure to patient suffering requires periodic breaks, even short ones. This domain refers to attempts by participants to provide themselves with *time outs* from exposure to suffering, and includes various cognitive, affective, and behavioral activities. There are two categories:

1) *Helpful strategies* ($n = 2$). Talking to colleagues about patient issues provides a type of *productive venting* because colleagues understand patient issues (e.g., "You can just throw out the lingo, and you don't have to describe everything. You can just do a quick data dump."). Participants also reported using *humor* to discuss difficult situations. *Leisure pursuits and family activities* can help to get one's mind off work. One participant mentioned that a *peer support group* helped her deal with stressful situations. Finally, some participants *fantasized* about having a job without an intense emotional component.

2) *Unhelpful strategies* ($n = 2$). Behavioral strategies include: discussing patients with spouses/partners can be *unproductive venting* since they lack understanding about genetic issues and genetic counseling. Spouses/partners tend to draw comparisons to issues in their own lives that are not relevant, especially with respect to severity (e.g., "I always win on the *bad day* factor"). Another unhelpful strategy involves *isolating one's self* physically or emotionally from peers.

TRAUMATIC RECOLLECTIONS AND MEMORIES (1 DOMAIN, NO SEPARATE CATEGORIES)

Domain 1: Traumatic Memories ($n = 2$)

Some participants described how memories about certain patients or situations still provoke an emotional response, and how similar patients can activate these memories. Some participants, such as the following person, cried as they related their personal examples: "I thought of one really bad situation, in which I think I suffer from the symptoms [of compassion fatigue] every single day– I realize now as we talk. I know I take a deep breath every time I check my voicemail –'How many angry voicemails did I get today?' And I can't leave until I call back all the angry people – just as long as I get the angry ones covered, I can go home."

OTHER LIFE DEMANDS (1 DOMAIN, NO SEPARATE CATEGORIES)

Domain 1: Other Life Demands ($n = 2$)

Being overwhelmed by work can affect the ways that participants manage situations at home and vice versa. Some participants mentioned times when they were unable to deal with emotional demands at home and at work and therefore avoided situations that required emotional energy. For example: "I'm so stressed out with patients, I can't call my sister who is freaking out . . . I just can't do it . . . "I can't call her."

COMPASSION FATIGUE AND PROFESSIONAL DEVELOPMENT

Awareness of Compassion Fatigue as Students

When asked whether they expected to experience compassion fatigue once they began their careers, some participants reported that they had no idea what they would go through emotionally. Others had vague ideas but lacked full awareness of the extent of their subsequent emotional reactions: "I went in knowing that I needed to compartmentalize . . . there was *job* and there was *not job* . . . I didn't have an appreciation as to how emotionally draining it would be while you were at work . . . It's a whole entire day filled with trauma for people." Some participants were unaware of how difficult it would be to balance administrative demands with patient stressors. One participant said that genetic counseling as a student felt like *practice*, and she had a transitional shock upon realizing that this is *real life*. Finally one participant commented that students perform for their supervisors and therefore are less emotionally involved with patients.

Choice of Specialty

When asked whether compassion fatigue played a role in their choice of specialty, some participants said that they initially thought that they would be unable to handle a certain specialty but now work in that specialty and enjoy it. Some reported never avoiding a job in a particular specialty, while others stated that they would never take a job in a certain area: "You could pay me a million dollars; I would never do peds." Finally, one participant intentionally changed specialties: "I have been for years trying to figure out what it is that made me so happy to get out of it. You can ask all of them [colleagues]; I will do anything to avoid seeing a prenatal patient."

Training Regarding Compassion Fatigue

Participants provided several suggestions for graduate and post-graduate training: 1) Knowledge– make students aware of compassion fatigue and its symptoms; 2) Coping mechanisms—help students develop coping strategies rather than leaving them to *figure it out* for themselves; 3) Supervisor self-disclosure—supervisors should disclose about how they manage difficult emotional issues; 5) Tools—provide concrete examples for recognizing, avoiding, and coping with compassion fatigue; and 6) Workshops—provide continuing education that emphasizes early recognition of compassion fatigue triggers and symptoms and *normalizes* compassion fatigue experiences.

DISCUSSION

In the present study, 12 practicing genetic counselors participated in focus groups designed to gather preliminary data about the nature and prevalence of compassion fatigue. Major themes are discussed in the following sections.

Genetic Counselor Compassion Fatigue Resembles Other Caregivers' Experiences

Every participant described experiences indicative of compassion fatigue. Prevalent themes included feeling overwhelmed because they care about patients, lack of control over patient suffering, and feeling responsible. The vast majority of their examples involved patients and patient suffering, which is consistent with a compassion fatigue explanation. Their descriptions suggest that intense emotions (their own, their patients,' and patient family members') are particularly challenging. Dealing with intense emotions has been identified in prior research as a major professional challenge for genetic counselors (Bower *et al*., 2002; McCarthy *et al*., 2001). Participants also speculated that genetic counselors have *personality characteristics* that may increase their risk for compassion fatigue, for instance, a desire to be in control, wanting to be liked, and perfectionism. Although to date, no published research has been done to assess personality characteristics of genetic counselors, it makes intuitive sense that high levels of such traits would increase their risk.

Conceptual Distinctions

Participants agreed that compassion fatigue exists in the profession, but some were unsure whether their experiences constituted compassion fatigue or burnout. While some of the symptoms may overlap, and certain intrapersonal characteristics may make genetic counselors vulnerable to both phenomena, we believe that compassion fatigue and burnout triggers differ. Specifically, burnout is often associated with workplace structural strain (Schwam, 1998), whereas compassion fatigue is the result of exposure to patient trauma (Jenkins and Baird, 2002). We further contend that any worker from any field is at risk for burnout, whereas compassion fatigue is restricted to human service professionals who directly respond to patient suffering. There may be a reciprocal relationship such that burnout and compassion fatigue exacerbate each other. For instance, when genetic counselors devote time and attention to dealing with burnout, they deplete their resources for managing compassion fatigue.

Genetic Counselor Compassion Fatigue Corresponds to Figley's Model

The participants' responses generally are congruent with components of Figley's (2002) model of compassion fatigue.

Exposure to Patient Suffering

Delivering bad news was the most prevalent trigger and it resembles those identified by Maytum *et al*. (2004) in their study of compassion fatigue in nurses who care for chronically ill children. Both the nature of the news and how it is delivered increase a genetic counselor's exposure to suffering. Delivering bad news never becomes *easy*, despite one's experience/skill level, and the risk for compassion fatigue is even greater when such news is delivered to numerous patients. Some participants reported difficulty distancing themselves from the *message;* they felt responsible for causing patient suffering. This sense of personal responsibility is concerning and likely contributes to compassion fatigue.

Empathy and Residual Compassion Stress

Without empathy, there would be no compassion fatigue Figley (2002, 2003). Genetic counselors repeatedly invest in relationships with patients that often are emotionally intense and intimate. Their depth of caring is evidenced by behaviors such as crying or otherwise showing emotions with patients, and by their distress when they cannot be helpful and/or feel they do not care enough about patients. Compassion fatigue hinders their ability to put forth their best effort towards empathic understanding, and they feel regret and guilt about their diminished performance.

Coping Strategies

Figley (2002, 2003) defines detachment as a professional's ability to distance from the patient's suffering and argues that detachment can reduce the risk of compassion fatigue. Participants described several behaviors that could be viewed as an inability to detach (e.g., sleep disturbances; intrusive thoughts about patients), as well as effective strategies that included setting boundaries and taking time to *decompress*.

Feeling satisfied with one's work may also decrease the risk/experience of compassion fatigue (Figley, 2002, 2003). Participants experienced satisfaction when they recognized their own accomplishments and when their patients expressed appreciation. However, several participant behaviors, ostensibly used to maintain a sense of satisfaction, could be considered *hypervigilance*, which is a symptom of compassion fatigue (e.g., being overly cautious about triaging tasks; feeling responsible for how a patient shares information with family members; trying to maintain control of *everything*; and reacting negatively when not in control). These behaviors appear to perpetuate a vicious cycle of anxiety-relief, rather than promoting a sense of satisfaction.

Traumatic Memories and Other Life Demands

Figley (2002, 2003) argues that *traumatic memories* and *other life demands* can increase the risk of compassion fatigue. Some participants expressed a fair amount of emotion when describing their experiences, for instance crying as they spoke in the focus groups. Their *traumatic memories* of past clinical events (some of which occurred quite a while ago) still elicit an emotional response, and sometimes, other patients evoke memories of the traumatic event. Participants also described how being overwhelmed with emotions from work hampered their ability to deal with emotional demands in their home life and vice versa. Some reported feeling distracted during family functions and avoiding certain home situations that required emotional energy.

Study Strengths and Limitations

This exploratory study generated a large amount of data that provide a rich picture of the nature of compassion fatigue in genetic counselors. However, qualitative data are not intended to be generalized to the population of interest. *Prevalence* of a domain or category is not necessarily synonymous with *importance* (Krueger and Casey, 2000), and any effects on the findings due to participant familiarity with each cannot be determined. Although the use of Figley's (2002) model as a framework for data analysis is a legitimate qualitative method (Strauss and Corbin, 1998), it is possible that some data categorization reflects our expectations. Given these limitations, further research should be done with larger, more diverse, and anonymous samples.

Implications for Training and Practice

Compassion fatigue constitutes a promising *conceptual organizer* to help explain, normalize, and guide genetic counselors in achieving a delicate balance between empathic connection and detachment. This balance is essential in order to avoid being overwhelmed by residual compassion stress. Compassion fatigue is an inevitable byproduct of empathic connection. To use an analogy, there is no *lead shield* for the professional to step behind in order to avoid absorbing radiation from the patient's X-rays. Genetic counselors will absorb at least some patient suffering. Therefore, they must develop a repertoire of strategies for managing their compassion fatigue in order to prevent diminished performance (Figley, 2003).

Compassion fatigue was a novel and surprising experience for participants who reported at best only a vague awareness of the emotional demands of their work when they began their careers. They advocated graduate and post-graduate training on compassion fatigue to foster awareness and to normalize the phenomenon. We concur with their suggestions and further recommend participation in peer supervision groups, a strategy that has been found to be helpful for genetic counselors to process their personal reactions to cases (Bosco, 2000; Kennedy, 2000). In addition, students may benefit from an intensive orientation to the gamut of genetic counselor tasks in order to help anticipate their compassion fatigue triggers. Given the *psychic costs* of delivering bad news, we recommend that students receive numerous opportunities to deliver positive test results. If the length of clinical rotations limits such opportunities, then simulated exercises can be used.

The present findings further suggest that genetic counselors need to fully acknowledge the reality of the work. There **are** bad outcomes, genetic counseling **is** fraught with uncertainty and ambiguity, and intense emotions abound. Furthermore, genetic counselors' personal characteristics (ability to connect empathically and to feel responsible) interact with their clinical work to produce compassion fatigue. Students and practitioners may need periodic guidance to *reframe* their view of what it means to be helpful—it is not necessarily taking away patient suffering, they do not bear sole or even primary responsibility for patient outcomes, etc. They may also need encouragement to celebrate their successes, to reflect upon what they enjoy about their work, and to pursue leisure activities and work tasks (e.g., public education, supervision) that provide them with a *break* from clinical work. Finally, the Green Cross Foundation (www.greencross.org) offers training and workshops resources for compassion fatigue.

Research Recommendations

Studies are needed to further assess the validity and importance of the domains and categories identified in this study. While Figley's (2002, 2003) model of compassion fatigue was a useful guide for analyzing the present data, it was difficult to classify some data into discrete domains. We believe that the domains and categories are interrelated because they reciprocally influence one another and also because they overlap conceptually. For instance, some *risk factors* may also be *symptoms* (e.g., wanting to control patient reactions). Longitudinal research of genetic counselors' experiences of compassion fatigue might help to determine the extent to which compassion fatigue develops in a linear or reciprocal fashion, and also help to distinguish between risk factors and symptoms.

The present participants raised questions about possible connections between compassion fatigue and burnout. Research should be done to determine whether there is a significant relationship between these two phenomena. For example, does burnout lead to compassion fatigue, as some authors have suggested (e.g., Collins and Long, 2003), or is the reverse true? Finally, studies of individual difference factors (e.g., personality characteristics, level of genetic counseling skill) and situational factors (e.g., practice specialty, patient caseload) may help to identify individuals who are at increased risk for compassion fatigue.

Appendix : Focus Group Questions

- What is compassion fatigue? As you review the definition (provided) does it fit with what you think compassion fatigue would be, or are there ways you would modify, add to or change the definition? Would you alter it in any way with regard to genetic counseling, or would you leave it the way it is?
- We would be interested in examples of compassion fatigue, including recent examples and/or really significant, intense examples. (Prompts: Is countertransference related? Has compassion fatigue affected your ability to provide genetic counseling service?)
- Is genetic counseling what you thought it was going to be like when you first entered the field? Did you know that you were going to have these kinds of reactions and that this would be your *life* as a genetic counselor?
- How do you cope with compassion fatigue?
- Has compassion fatigue played any kind of role in your choice of specialty?
- If you would recommend any kind of training around this topic, what would that be (Prompt: Whether in school or post-degree)?
- Re-visit definition
- Are there additional comments that anyone would care to make?

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