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Secondary Traumatic Stress Among Catholic Priests

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Research suggests that the clergy could be at the risk of developing secondary traumatic stress (STS) because of their secondary exposure to trauma within pastoral work; however, there has been no explicit discussion of STS related to Catholic priests who may be more at the risk of developing STS than their counterparts in other churches. The requirement of priestly celibacy often leaves Catholic priests with little to no immediate social and emotional support network of family. Because of their sacred vow to keep the confessional seal unbroken in whatever circumstance, Catholic priests also may not share confessional information, even when the content of such information may be harmful to their mental well-being. Thus, in this qualitative, phenomenological study, the lived experience of STS among Catholic priests was explored. A purposeful sampling method was used to recruit 10 Catholic priests to participate in the study. Data were collected through semistructured interviews. Data analysis followed the transcendental, phenomenological analytic procedures and involved using the MAXQDA 2020 software to aid the coding process. The findings suggested that priests experience STS. Five core themes and 13 subthemes emerged from data analysis, including elements of secondary traumatization and self-care strategies. The findings were validated with rich, thick descriptions and the use of audit trails, reflexive journaling, member checking, and peer review. The findings could lead to positive social change because priests may become better aware of the risk of developing STS and how to prevent or manage the experience. The findings suggest the need for priests to have some training in mental health and that such training could lead to improved pastoral care for traumatized people.

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Dedication

I dedicate this dissertation to Catholic priests and all clergy who tirelessly work to further the healing mission of Jesus Christ among traumatized people, especially those who work in rural areas with little resources to meet their personal and professional needs.

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I acknowledge my indebtedness to the Almighty God for all His benefits, especially for preserving my health throughout the hectic academic schedules leading up to my Ph.D. program and providing the resources to complete them. Also, this research would not have been completed without the expertise of my dissertation committee. I appreciate the painstaking guidance of my committee chair, Dr. Silvia Bigatti, whose prompt feedback and encouragement was very motivational. I also thank the other members of my committee, Dr. Mary Cejka and Dr. Medha Talpade, for their insightful comments during this project's iterative process.

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Chapter 1: Introduction to the Study

Helping people heal from trauma and suffering often involves listening to emotionally distressing stories about the tragic experiences of the victims. While the intent of engaging with traumatized persons is to relieve their posttraumatic stress and suffering, the helper becomes indirectly or secondarily exposed to the sufferer's trauma-related material, including memories, thoughts, and emotions (Evces, 2015). Such indirect exposure to trauma can lead the helper to emotionally engage with the same catastrophic event that so disrupted the traumatized person's life (Coddington, 2017; Figley, 1995). The traumatized person's story, affect, or behavior can so affect the helper that they take on the same trauma. Secondary traumatic stress (STS) is a term used in the mental health literature to describe the experience of psychological distress due to indirect traumatic exposure to the painful experience of others (Butler et al., 2017). According to Figley's (1995) theory of STS, the adverse physical and psychological reactions may naturally occur in helping professionals who provide care for victims of direct trauma. In contrast to primary or direct exposure, in which an individual experiences or observes a threat of or actual harm or loss (Quiros et al., 2020), STS describes the state of being traumatized indirectly by hearing about a traumatic event experienced by another.

The adverse effects of secondary exposure to traumatic events are similar to those of primary exposure. Researchers have noted the common symptoms to include intrusive imagery, avoidance of cues, hyper-arousal, functional impairment, and distressing emotions (Huggard et al., 2017; Ludick & Figley, 2017). Mental health workers can take

on trauma by feeling the painful experience of the traumatized and imagining what it would be like to be in the shoes of the victim (Coddington, 2017). In the most severe instances, STS may warrant a diagnosis of posttraumatic stress disorder (PTSD) when symptoms result in significant distress or impairment in the functioning of a helping professional (Charrois et al., 2020). PTSD is a mental health condition often triggered in individuals directly traumatized by terrifying events (Passmore et al., 2020).

Indirect trauma exposure can occur in several contexts, such as familial, social, professional, or nonprofessional. Scholars have noted that anyone who empathetically engages with suffering and traumatized individuals can be at the risk of developing symptoms of STS resulting from their exposure to the traumatic material of others (Mordeno et al., 2017). In other words, STS is not limited to mental health professionals. The clergy, like mental health professionals, are in contact with suffering victims, often on an ongoing basis, and could be susceptible to STS (Adams et al., 2017; Hotchkiss & Lesher, 2018). Pastoral work often involves traumatic exposure via graphic descriptions and stories of extreme human suffering and by observing the emotions of helplessness, fear, and horror in parishioners.

Whereas there is a growing body of research on STS among several populations of human service workers, I found no study that specifically focused on STS among Catholic priests. Only a few studies have focused on clergy burnout and how they may be at even higher risk for STS because, compared with other occupations, they may have less forewarning about the effects of STS and how to address them (Snelgar et al., 2017). Even so, these studies did not explicitly discuss STS among the clergy, nor were they

specific about Catholic priests. There is a need for more research focused on STS among the clergy who often enter the caregiving roles with a sense of divine calling and faith commitments that motivate them to respond to the suffering in their community.

Clergy motivations to provide care to the suffering are laudable; however, they must equip themselves with the knowledge and support to make their efforts sustainable over time. While mental health professionals might rely on specialized training and experience to manage any unintended or overwhelming negative effects of trauma work, the clergy often lack the training and support for prevention and remediation of any lasting effects of their working with trauma (Snelgar et al., 2017). Thus, like the more studied populations of trauma workers, the clergy need resources and strategies for remaining empathic toward others in their suffering because the clergy's capacity to empathize can be imperiled when secondary trauma renders them unable to be fully present to those they serve.

In the current study, I explored whether Catholic priests experienced STS and, if they did, what the experiences were, and what self-care strategies they employed to either prevent or cope with STS. Catholic priests share in the general vulnerabilities of the clergy described earlier. Through providing counseling, spiritual direction, and helping traumatized people search for meaning anchored in religious and spiritual principles, priests can develop symptoms of STS because of the traumatic exposure that often comes with these roles. As presiders over sacramental celebrations, Catholic priests provide emotionally demanding services, such as reconciliation, anointing of the sick and dying, and funerals. Additionally, priests serve as chaplains to hospitals, prisons, and refugee

camps, where they may encounter increased cases of trauma (Kane, 2017). While all priests may feel obliged by their calling to meet the expectations of their parishioners in these roles, only a few receive specialized training in counseling, social work, and psychology.

Moreover, Catholic priests may be more vulnerable to STS than their counterparts in other denominations. They often live alone with little to no immediate social support network of a family because of the requirement of celibacy. Several studies have found that familial and social support strongly buffers against the development of STS (Diehm et al., 2019; Michalopoulos & Aparicio, 2012). More so, Chan and Wong (2018) and McMinn et al. (2008) have documented the benefits of spousal emotional support for married clergy characterized by not only broad participation in the life of the church but also preventing the experience of emotional isolation in the clergy. Without downplaying the theological value of clerical celibacy, which enables Catholic priests to be fully available for pastoral work (Kane, 2017), the lack of immediate social support network of a family may be a unique factor that can render Catholic priests susceptible to STS.

Another potentially disposing factor to consider is the seal of confession. Although all clergy members supposedly uphold the ethical value of confidentiality, the sacramental seal of confession forbids Catholic priests to share information from the confessional (Daly, 2013). The sacrament of reconciliation (i.e., confession) often involves listening to and counseling the traumatized, including victims who develop trauma-related guilt. Trauma victims may feel extreme guilt for surviving the tragic event when others did not and engage in self-blame arising from the belief that they could or

should have done something different when the traumatic event occurred or prevented the incident from occurring to another (Raz et al., 2018). Given these potential risk factors and the paucity of research focused on STS and Catholic priests, studies on how this clergy group perceive STS and manage their traumatic exposure within pastoral ministry might provide a better understanding of the phenomenon.

The remaining sections of this chapter include the background of the problem of STS, the problem statement, the purpose of this study, the research questions guiding this study, the conceptual framework for the study, and the nature of the study. The chapter also includes the operational definition of the key terms used, the assumptions, the scope and delimitations of the study, the limitations, and the significance of the study.

Background

The science of traumatology is a growing field. Early empirical research on trauma began with a focus on the direct impact of the experience on the victims (Adams, 2009; Agaibi & Wilson, 2005; Wilson, 1989). As the social work field investigated the impact of trauma on clients, researchers initially paid little attention to the adverse psychological impact of trauma on the helping professionals (Sansbury et al., 2015). However, there is now a large body of research that considers the various dimensions of the indirect impact of trauma on both mental health professionals and nonprofessionals who listen to and help suffering people (Hotchkiss & Lesher, 2018; Molnar et al., 2017; Raziani & Ariapooran, 2019). In their systematic review of existing research on STS, Molnar et al. (2017) observed the extensive focus of research on documenting the impact of secondary exposure to trauma upon individuals in first responder agencies, such as law

enforcement, fire response, victim assistance, and emergency medical services as well as other helpers who work with survivors of trauma, including mental health therapists, counselors and volunteers, social workers, and other human service organizations.

As noted earlier, Figley (1999) referred to STS as a set of emotions and behaviors that may naturally follow new knowledge about someone else's experience of a painful event. Thus, STS can occur as a reaction to secondary exposure to trauma material through witnessing or listening to accounts of the traumatic event directly experienced by another (Powell, 2020). Such a reaction may involve symptoms such as invasive flashbacks or memories of the traumatic event, avoidance of reminders associated with the traumatic event, and heightened vigilance or persistent anxiety (Adams et al., 2006). Researchers have recognized these symptoms of STS to be similar to those of PTSD, earlier described as a condition triggered in individuals directly traumatized by terrifying events (Baum et al., 2014; Passmore et al., 2020).

Research findings are mixed regarding the factors contributing to STS. Some studies have suggested that risk factors for STS include a history of personal trauma and the provision of services to highly vulnerable and traumatized individuals (de Figueiredo et al., 2014). Other potential contributing factors include a lack of trauma-specific training, being female, being young, and high levels of occupational or organizational stress (Baum et al., 2014). Studies have also indicated that self-compassion might be protective against STS and burnout (Beaumont et al., 2016; Hotchkiss & Lesher, 2018).

Researchers have found that resiliency-support programs may also help protect against STS (Pfaff et al., 2017). Research has also suggested that organizational support

could play a role in the development of STS. In a study with Australian counselors, Finklestein et al. (2015) found that the strongest predictor of counselor distress was work-related stressors. Van Breda (2016) emphasized the importance of developing resilient organizations, which would require that organizations address resilience in various ways, including the organizational entity itself, the employees, and the organizational service delivery program. Creating workplace policies that address mental health concerns and providing training and supervision could influence the competence of social workers positively (Finklestein et al. 2015; Whitfield & Kanter, 2014).

STS can affect the quality of services provided. Individuals working in the field of trauma, mental health, police, fire response, and emergency services typically engage with distressing events (Bride, 2007; Day et al., 2017; Molnar et al., 2017). Providers may become detached, avoidant, and struggle to maintain safe boundaries with clients. Performance in job tasks may deteriorate on both quantitative and qualitative levels, as the helper may avoid certain job tasks. Rzeszutek et al. (2015) also observed that increased absenteeism, faulty judgment, irritability, irresponsibility, or overwork may be evident in the behavioral performance of individuals experiencing STS. Demoralization, lack of interest, apathy, and detachment may also occur (Robinson-Keilig, 2014). Robinson-Keilig (2014) found that high levels of STS in mental health professionals was associated with lower relationship satisfaction; lower social intimacy; and greater use of negative communication patterns, such as avoidance and withdrawal patterns. Similarly, Lanier and Carney (2019) found that counselors who experienced STS presented symptoms, such as sleepless nights, hypervigilance, fear, lack of safety, loss of appetite,

intrusive thoughts, and bad dreams. Studies with both professionals and nonprofessionals have indicated similar symptoms (Pihkala, 2020; Raziani & Ariapooran, 2019). With such impacts on helpers, STS may prevent the quality of help that victims of trauma require.

Considering the adverse effects of STS for both clients and counselors and the need to build resilience among service providers, researchers have emphasized the necessity of more research toward a better understanding of STS and identification of the various factors that either increase or reduce vulnerability to this phenomenon (Can & Watson, 2019; Cieslak et al., 2014). Hensel et al. (2015) also observed that the experience of STS might vary substantially across occupations of mental health workers. There is a paucity of research on the experience of STS among the clergy; therefore, exploring the perception or lived experience of STS among Catholic priests in the current study could provide more insight into whether and how the phenomenon manifests among pastoral workers.

Problem Statement

The pressures on human service workers have become more burdensome as the physical, psychosocial, and economic crises faced by many people in modern society continue to increase (Ajayi et al., 2019; Moore, 2019: Weiten et al., 2018). According to research, 15% to 50% of individuals in the human service field who listen to or help traumatized or suffering persons will experience an STS response because of their exposure to harmful material from their clients (Sansbury et al., 2015). Human service workers, as noted by Molnar et al. (2017), could experience STS because of their

empathetic listening to the disturbing stories of their clients, thereby developing traumatic symptoms similar to those of the victim.

Members of the clergy have been identified as frontline mental health workers in many communities because the responsibilities of the clergy spread beyond purely spiritual support for parishioners to providing counseling and mental health services (Hirono & Blake, 2017; Scott & Lovell, 2015). Research has also shown that, like mental health professionals, the clergy, in working with persons exposed to extreme stressors, are susceptible to traumatic reactions and other emotional stressors that impact the quality of their lives (Adams et al., 2017). However, while studies on the impact of STS have focused majorly on the secular populations of human service workers, such as therapists, doctors, nurses, and firefighters (Andahazy, 2019; O'Mahony et al., 2018; Waddill-Goad, 2019), the little research done on clergy has focused on non-Catholics.

Whether the findings from available research are generalizable to Catholic priests seems questionable for the two reasons adduced earlier. First, Catholic priests of the Latin rite are unmarried. They often live alone, with limited access to fellow priests. So, unlike married clergy populations who seem to dominate the focus of research on STS, Catholic priests often suffer from emotional isolation and high rates of depression because they have little to no immediate social support network of family and friends with whom to share the load of ministry (Igor & David, 2016). Second, the Catholic priest is under an oath of secrecy (i.e., the seal of confession), which forbids him to divulge information from the confessional for whatever reason (Daly, 2013; Shibaev & Uibo, 2018), even when the information could be harmful to their mental well-being.

Exploring whether Catholic priests experience STS could contribute to knowledge about the risks of traumatic exposure in their pastoral work, given that studies on STS have not focused on this population. Because Catholic priests seem uniquely vulnerable to STS, collecting information from them about whether and how they use self-care in response to traumatic exposure could also be a valuable contribution to the literature on STS.

Furthermore, information from this study might increase priests' awareness of the risk of secondary traumatization and how to develop strategies for self-care toward preventing it. The findings could also draw the attention of the church hierarchy to the need to provide adequate mental health support for priests and highlight the need for specialized training of priests in working with trauma. Additionally, because the requirement of mandatory celibacy often leaves priests without an immediate social support network of family, findings from this study might raise questions about its role in the vulnerability of priests to STS and its impact on the ability of priests to work with traumatized and suffering people effectively.

Purpose of Study

The purpose of this qualitative study was to explore the lived experience of STS among Catholic priests. I conducted semistructured interviews to gather holistic, in-depth information about whether Catholic priests experienced STS, and if they did, what the experiences were, and what self-care strategies, if any, they employed to either prevent or cope with STS. Using a phenomenological approach, I collected the lived experiences of the participants resulting in emergent themes and constructs that contribute to providing a fuller empirical understanding of the phenomenon of STS among Catholic priests.

Research Questions

The following research questions guided this study:

RQ1: What are the lived experiences of STS among Catholic priests?

RQ2: How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?

Conceptual Framework

A combination of Hatfield et al.'s (1994) theory of emotional contagion and Ludick and Figley's (2017) compassion fatigue resilience model (CFRM) provided the framework for this study.

The Theory of Emotional Contagion

Hatfield et al. (1994) presented the emotional contagion theory to explain the transmission of emotions through the facial cues from one person to another in a conversation. The researchers hypothesized that the emotional exchange between two people in a conversation affected the outcome of their interaction. Thus, emotional contagion is a theory of social interactions that focuses on the interpersonal emotional change and the response and emotional state of individuals as they experience emotional contagion (Xiao et al., 2010). In explaining emotional contagion, Hoffman (2002) suggested two cognitive mechanisms. First is the language-mediated association mechanism, which explained how verbal or written descriptions of an individual's situation could make an observer think of a similar situation in which the observer had similar reactions. The imagination of the situation could induce a similar emotional experience in the observer. The second is the active perspective-taking mechanism. In

this mechanism, the observer imagines themselves in the situation of another person and experiences an emotional reaction similar to the reaction of the other person (Hoffman, 2002). The theory of emotional contagion conceptually fits with STS because, as with STS, emotional contagion implies the affective process in which an individual who cares for traumatized and suffering persons feels emotional responses that are similar to those of the suffering person's actual or anticipated emotions (Hatfield et al., 1994).

The CFRM

The CFRM is a theoretical tool developed for predicting who will become vulnerable to STS among human service workers who provide services in direct contact with clients to help improve their lives (Ludick & Figley, 2017). Using the model, Ludick and Figley (2017) represented the current understanding of the primary risk factors for developing STS, including empathic response-related stress, trauma memory-related stress, overexposure to trauma-related stress, and stressful life events-related stress. These variables were potentially counterbalanced by high resilience factors, such as optimization and self-nurturance through self-care, detachment, sense of satisfaction, and social support. CFRM provide me with a lens for addressing the second research question regarding the self-care and resilience among Catholic priests. Although CFRM focuses on the individual human service worker, it also takes into account the systemic and community implications of the professional's vulnerability to distress that may lead to poor performance and adversely impact the overall resilience of the community the professionals serve (Ludick & Figley, 2017). To provide a fuller understanding of whether and how STS is experienced and managed or prevented among Catholic priests,

both emotional contagion and CFRM conceptually offered a useful guide for investigating emerging themes about STS and the strategies for self-care among this population.

Nature of the Study

The nature of the study was qualitative, with the transcendental phenomenological approach. Qualitative research is a scientific method of gathering non-numeric data for inductive meaning making (Merriam & Tisdell, 2016). The key concern of this study, which was to understand STS from the participants' lived experiences, was consistent with the phenomenological approach. As Cilesiz (2010) noted, the interest of a phenomenological study is in the essence or underlying structure of a phenomenon and how people construct meaning and make sense of their experiences and their worlds. I conducted this qualitative study to understand the phenomenon of STS from the perspective of Catholic priests. The phenomenological approach provided a lens for interpreting the collected data. Using the MAXQDA 2020 software to aid the coding process, the descriptions of the participants regarding STS and the role of self-care informed emerging themes that contribute to providing a fuller empirical understanding of the phenomenon of STS among Catholic priests.

Definition of Terms

The following definition of terms aided the understanding of how the terms applied in this study.

Catholic priests: Ordained ministers in the Catholic church authorized to perform the sacred rites of the church's sacraments (Kane, 2017). In this study, I used the terms

Catholic priests and priests interchangeably for ministers of the Latin rite who are unmarried because of the requirement of celibacy.

Seal of confession: The obligation on the part of Catholic priests to maintain absolute confidentiality regarding information disclosed at the confessional by a parishioner in the context of the sacrament of penance in the Catholic church (Daly, 2013).

STS: The behaviors and emotions that naturally result from knowing about a traumatizing event experienced by another and caring for or wanting to help the victim (Caringi et al., 2017; Figley, 1995). In this study, I considered the potential adverse effects of working with trauma among Catholic priests under the construct of STS.

Self-care: A process of implementing strategies consciously directed at the overall physical, emotional, social, and spiritual wellbeing of an individual through activities, such as seeking therapy, practicing mindfulness, making time for personal relationships, striving for personal and professional balance, getting enough sleep, healthy eating, and participating in non-work-related activities (Dorociak et al., 2017; Ludick & Figley, 2017).

Trauma: The experience of emotional shock or distress following direct exposure to a terrible, life-threatening event that might lead to long-term neurosis (Weiten et al., 2018).

Assumptions, Scope, and Delimitations

An assumption in research refers to a statement considered true, though not yet proven (Monette et al., 2014). According to Kirkwood and Price (2013), the researcher's

views and assumptions outline the research they undertake. I made six assumptions in the development of this study. The first assumption was that the participants would be honest in providing the information necessary to address the research questions. My second was that confidentiality would be in place to protect the identity of the participants. Another assumption was that the subjects would participate willingly. I also assumed that uncovering the unique experiences of the participants with the phenomenological approach would yield some commonalities with which to generate themes.

The fifth assumption was that collecting data from 10 participants would be sufficient to reach data saturation. For the qualitative interviews, Creswell (2013) suggested a sample size of five to 25. However, according to Burmeister and Aitken (2012), data saturation is not about the numbers per se, but about the depth of the data. So, I assumed that 10 participants would provide exhaustive data. However, I proposed to recruit more participants if 10 failed to provide sufficient information. At the end of the interviews, the 10 participants in this study did provide information that suggested data saturation as I had assumed. So, I did not recruit more participants. The last assumption in this study was that using semistructured interviews as a data collection method would yield in-depth and contextual information from each participant because the method would allow respondents to answer topic-based, open-ended questions in their own words (see Merriam & Tisdell, 2016).

As indicated above, the scope of this study was confined to Catholic priests. While there is a need for more research focused on STS among the clergy, I considered Catholic priests might be more vulnerable for the reasons of celibacy and confessional

seal. However, this delimitation, which excluded clergy members of other denominations, could also be a barrier to the applicability of the findings to other clergy populations. Because this study was qualitative in nature, I used only semi-structured interview and observation notes for data collection.

Limitations

A potential threat to this qualitative study was the observer effect where the presence of the interviewer influences the responses of the participants. According to Patton (2015), research participants will often say or not say something because of the characteristics of the interviewer. However, Rubin and Rubin (2012) had suggested that for interviews that require the disclosure of sensitive personal information, people who have been through similar experiences could be used as interviewers so they can relate to the participants and obtain valid, trustworthy information. The Catholic priests who were the subjects in this study could have held back information if they felt the interviewer would not understand or might disregard the information. Such situations could pose threats to the trustworthiness of this research (see Merriam & Tisdell, 2016). Given the stated potential threat of observer effect, I personally conducted the interviews to elicit useful data from the participants. Being a priest with similar experience as the participants, I related to them in a manner that could generate in-depth and contextual information. Because the participants could have self-censured and refrained from sharing information about STS they perceived as demeaning to clerical culture, interviewing the participants personally reduced this challenge and encouraged them to

share their experiences more freely. I maintained an audit trail by documenting the flow and processing of the data to enhance trustworthiness (see Patton, 2015).

Additionally, I kept a reflexive journal and clarified the biases that could influence the components of the research process. The phenomenological analytic strategy envisages the bracketing of the researcher's subjectivity (i.e., clarifying preconceptions) throughout the study (Moustakas, 1994). Thus, throughout the processes of data collection and analysis, I was conscious of and set aside personal biases or assumptions about STS that could influence the study. I employed the member-checking technique to ensure that the major findings and themes have resonance with the experience of the respondents (see Monette et al., 2014). Because of my involvement in priestly ministry, I also used a peer reviewer to provide additional oversight of the manuscripts and increase the credibility of the findings (see Dirette, 2020).

Significance

This study addressed a gap in research and contributed to the conversation around the phenomenon of STS among human service workers. With a specific focus on Catholic priests, this study contributed to knowledge by exploring their lived experiences of STS. By collecting information from the priests about whether and how they used self-care in response to traumatic exposure, this study also made an original contribution to the literature on STS. The current study has potential benefits for Catholic priests by helping them become more aware of the risk of secondary traumatization and how to develop strategies for self-care toward either preventing the experience or managing it.

This study could also improve the quality of service received by individuals who rely on priests for pastoral care. Research has indicated that, apart from increasing levels of distress for caring professionals, STS may also lead to a decrease in empathy, which is a necessary quality for any professional in a therapeutic alliance (Teel et al., 2019). Any condition that decreases empathy in those tasked with helping traumatized or suffering people could have far-reaching, adverse effects (Roney & Acri, 2018). If Catholic priests can no longer display compassion and empathy, their counseling interactions with suffering parishioners may become nontherapeutic and potentially harmful, and the pastoral ministry of the Catholic church as a whole may become less fruitful. Information from this study could, therefore, benefit not only the Catholic priests but also the members of the community impacted by the ministry of the priests.

Furthermore, Oliver et al. (2018) identified social and organizational support for professionals working with trauma as necessary for preventing or coping with STS. Findings from this study could draw the attention of the church hierarchy to the need to provide adequate mental health support for priests and highlight the need for specialized training of priests in working with trauma. As an organization, the Catholic church could benefit from this research directly because improving the mental well-being of the individual priests and parishioners would mean well for the entire church. Recent reports indicated there are about 1.3 billion Catholics worldwide, comprising about 16% of the world's population (Vatican Secretariat of State, 2020). With such a vast number of Catholics in the world directly impacted by the pastoral ministry of Catholic priests, the findings of study might provide information for improving the quality of their ministry

with suffering and traumatized people across the globe. Taken collectively, their improved ministry could have a ripple effect on the world, even beyond those practicing the faith.

Summary

Mental health workers are susceptible to STS resulting from their engagement with the traumatized (Caringi et al., 2017; Figley, 1995). The clergy may be more at the risk of developing STS not only because of their exposure to traumatic material as listeners and voices of hope to the traumatized but also because they often have no formal training in mental health and how to handle the unintended, adverse effects of working with trauma. In this chapter, I presented an introduction to the study, including the problem to be addressed, the purpose of the study, the guiding research questions, and the conceptual framework as a map for exploring the topic under study. I also discussed the nature of the study, the operational definition of key terms, the assumptions in the research design, the scope, limitations, and the significance of the study.

In Chapter 2, I will provide a review of the relevant literature, beginning with the theoretical foundation and the various conceptualizations of secondary traumatization. The chapter will include a review of the prevalence of STS, the common risk factors, the traumatization of the clergy, and the role of self-care in mitigating the experience of STS. I will also discuss the propositions of the CFRM (Ludick & Figley, 2017) as a potential resilience-enhancing tool for Catholic priests as they work with trauma in pastoral ministry.

Chapter 2: Literature Review

Pastoral work often involves providing care and support to vulnerable and suffering persons traumatized and distressed by life-altering events, including natural and human-made disasters, violent and sudden death of loved ones, sexual violence, and other physical and emotional abuses (Hirono & Blake, 2017; Scott & Lovell, 2015). In many such instances, the clergy are often the initial contact, and through their essential roles of listeners and voices of hope, they become the first resource for healing their parishioners (Hirono & Blake, 2017). Thus, Flannelly et al. (2005) described the clergy as frontline mental health workers in many communities. Research has been consistent in affirming that individuals engaged in helping and caring for vulnerable populations can experience STS. Several studies have indicated the prevalence of STS among human service workers, such as child protection workers, therapists, doctors, nurses, ambulance personnel, firefighters, shelter workers, and police (Baciu & Virga, 2018; Conrad & Keller-Guenther, 2006; Kim, 2017). A few studies have also suggested that members of the clergy might be vulnerable to developing STS because of their exposure to traumatic material within their pastoral work (Hendron et al., 2012). According to Hotchkiss and Lesher (2018), the clergy may be susceptible to traumatic reactions and other stressors that impact the quality of their lives because they often work with persons exposed to extreme stressors.

The little research done on clergy traumatization due to indirect exposure has focused on non-Catholics, and that was the gap in the literature the current study was conducted to fill. Catholic priests seem uniquely vulnerable to the development of STS

because, unlike the married clergy, they often live alone without the immediate social support network of a family (Igor & David, 2016). Additionally, the seal of confession binds Catholic priests and forbids them to share confessional information, even when such information could have adverse effects on their mental wellbeing (Daly, 2013; Shibaev & Uibo, 2018). Therefore, in the current study, I explored whether Catholic priests experience STS and, if they did, what the experiences were, and how they employed self-care in response to traumatic exposure in their pastoral work. This study contributes to knowledge about the risks of traumatic exposure among Catholic priests, given that previous studies on STS did not focus on this population.

In this chapter, I present the theoretical foundation of STS. I also discuss the perspectives of the theory of emotional contagion and the CFRM, which combined to provide a framework for understanding STS in this study. The literature on the prevalence of STS among various human service workers, the risk factors contributing to the developing STS, the traumatization of the clergy, and the role of self-care in mitigating the effects of secondary exposure to trauma are also reviewed. I organized, integrated, and critically evaluated the existing literature as I deemed applicable to the discussion of the topic under study; consequently, this review of the literature provided the foundation for exploring the phenomenon of STS among Catholic priests.

Literature Search Strategy

The keyword search for literautre involved the use of various combinations of words relating to the research. The keyword combinations included *secondary traumatic stress, secondary trauma, vicarious trauma, compassion fatigue, burnout and the clergy,*

clergy burnout, clergy stress, priests and secondary trauma, compassion fatigue in pastors, Catholic priests and secondary stress, and chaplains and vicarious trauma. Other keywords were *indirect trauma, clergy mental health, trauma-counseling, emotional intelligence and the clergy, clergy stress and self-care, social support and secondary traumatic stress, secondary traumatic stress and life satisfaction,* and *compassion fatigue and compassion satisfaction.* The databases searched were PsycINFO, PsycARTICLES, PsycCRITIQUES, PsycEXTRA, ProQuest, Google Scholar, PubMed, and EBSCO Host. Most of the articles reviewed were from academic journals, including the *International Journal of Traumatology, Journal of Traumatic Stress, Journal of Psychotraumatology, Journal of Pastoral Psychology, Journal of Pastoral Care and Counseling, Journal of Spirituality in Clinical Practice, and the Journal of Spirituality in Mental Health*. Others were the *Journal of Social Work in Mental Health, Journal of Psychiatry, Journal of Psychology, Frontiers in Psychology, Journal of Depression and Anxiety, Journal of Nursing Studies, and the Journal of Americal Art Therapy.* I also gleaned additional literature by tracking citations in related articles as well as consulting my personal library of books and articles, and my 14 years of experience as a Catholic priest.

Theoretical Foundation

STS

As studies on the effects of direct exposure to trauma increased in the 1980s, Figley (1983, 1985, 1988) and Sparks (1982) began to recognize the unique effects of working with trauma on therapists' wellbeing. Figley (1983) suggested that therapists

who provided direct services to distressed families of traumatized persons could experience symptoms of traumatic stress like those of the trauma victims. Having recognized this problem, researchers began to examine how the phenomenon impacted the personal and professional lives of therapists working with traumatized persons (Courtois, 1988, 1993; Figley, 1988). After McCann and Pearlman (1990) used the term *vicarious trauma* to describe the phenomenon, Figley (1995) introduced the term, STS, in the book, *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder in Those who Treat The Traumatized*. According to Figley, STS refers to the behaviors and emotions that naturally result from knowing about a traumatizing event experienced by another and caring for or wanting to help the suffering individual. STS appears as a complex state of dysfunction and exhaustion in which the helpers take on the emotional distress and suffering experienced by trauma victims. In other words, by listening to or helping a traumatized or suffering individual, the helper could experience a depletion of psychological resources for both their self and those in need because of the indirect exposure to traumatic events or disturbing experiences narrated by the beneficiary (Teel et al., 2019).

Furthermore, Figley (1995) observed that those exposed to STS suffer from intrusive thinking, periods of avoidance or numbing, and persistent arousal just as those diagnosed with PTSD. Thus, therapists with STS may avoid hearing the traumatic narratives; experience imagery related to the traumatic materials; and suffer from physical symptoms in the form of sleep disturbance, headaches, gastrointestinal problems, or heart palpitations (Clark & Gioro, 1998; Figley, 1995; Kanno & Giddings,

2017). These symptoms represent the three clusters of intrusion, avoidance, and arousal, which correspond with Criteria B, C, and D, respectively, of the diagnostic criteria of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association [APA], 2013). Many researchers have used this manual to compare the clinical diagnosis of PTSD to the theoretical concept of STS. These three cluster symptoms of PTSD appear to gain greater recognition as symptoms of STS in the diagnostic classification with the inclusion of a fourth type of exposure as a qualifying event, Criteria (A4). The APA (2013) defined PTSD to including specific mention of experiencing first-hand or repeated exposure to disturbing details of a traumatic event (excluding exposure via print or mass media). This definition seems to weaken the critique of the STS concept as problematic in the context of exposure to traumatic material by mass media (McNally, 2009). Thus, STS, as a construct, is directly related to, or potentially closely parallels, the structure of the symptoms of PTSD. The main difference between them, however, is that STS is a less severe condition and has a faster recovery rate (Caringi et al., 2017; Figley, 1995; Kanno & Giddings, 2017).

Research on the secondary traumatization of mental health workers and caregivers has yielded similar results, indicating there are highly emotional and psychological risks associated with helping and caring for vulnerable populations (Kelly, 2020; Turgoose & Maddox, 2017). However, the process of incorporating these results, in theory, resulted in a variety of overlapping constructs often used interchangeably for describing the adverse effects emotionally demanding jobs. In the following subsections, I describe the

constructs of vicarious trauma, compassion fatigue, and burnout; as well as how these constructs seem to differ from STS, conceptually.

Vicarious Trauma. Vicarious trauma is a term often used to describe the adverse psychological effect of working with traumatized and suffering people. McCann and Pearlman (1990) derived the term from the constructivist self-development theory to describe the changes in a therapist's inner world resulting from repeated empathetic engagement with clients' trauma-related thoughts, memories, and emotions. Vicarious trauma refers specifically to negative changes in the mental health provider's beliefs about the world, self, and others (Long, 2020). The cumulative effects of empathetically engaging with survivors while they narrate their most troubling experiences can profoundly affect and even impair the helping professionals' cognitions about themselves and others in five areas: safety, trust, esteem, intimacy, and control (Bride et al., 2007; Cieslak et al., 2014). A popular instrument used in assessing the vicarious traumatization of workers in helping professions is the Traumatic Stress Institute Belief Scale (Pearlman et al., 1995).

Although vicarious trauma and STS are similar in resulting from exposure to emotionally engaging clients via interpersonally demanding jobs and represent some debilitation that can obstruct a help providers' services, STS differs conceptually from vicarious trauma in several ways. First, while the focus of STS is on observable PTSD symptomatology (Caringi et al., 2017), the theoretical underpinnings of vicarious trauma emphasize the process of self-perceived change using the constructivist self-development theory (McCann & Pearlman, 1990). Second, although trauma-related cognitive shifts

could be symptomatic of STS, the rapid onset of PTSD symptoms are central, with less attention to the context and etiology of symptoms. Vicarious trauma, on the other hand, emphasizes the content of PTSD symptoms in the context of profound changes in belief systems (Evces, 2015). Third, whereas the concept of STS applies to an expanded group of helping professionals and nonprofessionals who provide direct services to traumatized and suffering individuals, vicarious trauma has been chiefly focused on mental health professionals. Finally, whereas STS symptoms can happen quickly with one severe exposure to an individual's traumatic material, vicarious trauma occurs due to a cumulative exposure of the mental health professional to traumatizing experiences narrated by clients over time (Caringi et al., 2017; McCann & Pearlman, 1990).

Compassion Fatigue. After investigating the experience of STS in families of trauma survivors, Figley (1995) introduced the term compassion fatigue, using it to describe the empathic strain and general exhaustion resulting from caring for people in distress. Compassion fatigue, which Figley considered to be a less stigmatizing term than STS disorder, was associated with individuals in the helping professions, including first responders, physicians, and disaster recovery workers (Sacco et al., 2015). Over time, the concept of compassion fatigue began to incorporate notions and processes from secondary trauma, vicarious trauma, and burnout, referring to a broad range of emotional or cognitive consequences of secondary exposure to traumatic material (Evces, 2015).

Recent literature has, however, focused on emotional and physical exhaustion as the primary effects of compassion fatigue rather than PTSD-like symptoms that are more characteristic of STS (Robino, 2019). Specifically, researchers have considered

compassion fatigue in relation to a loss of empathy resulting from chronic exposure to others' suffering (Evces, 2015; Powell, 2020). Unlike vicarious trauma, compassion fatigue does not focus on changes in trauma-related schemas due to exposure to traumatic memories of survivors. Rather, Figley (1995) conceptualized compassion fatigue as a gradual erosion of physical and emotional resources leading to indifference and antipathy towards those in need of help. Compassion fatigue is often measured using the Professional Quality of Life Scale (Stamm, 2010).

Burnout. Introduced as a construct to describe the gradual breakdown of healthy defenses caused by excessive and prolonged exposure to work-related stress (Freudenberger, 1974; Maslach, 1978), burnout has received increasing attention from scholars in the field of psychology. As researchers continue to develop different models for explaining the burnout phenomenon, Maslach's (1998) multidimensional theory of burnout has remained prominent in burnout research. Maslach's theory conceptualized burnout in three key components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to a depletion of an individual's emotional resources resulting from work overload and personal conflict at work. Depersonalization is the interpersonal component that refers to a negative or cynical response to other people, including erosion of idealism. According to the theory, individuals could develop depersonalization as self-protective against emotional exhaustion overload, which could lead to detachment, negative work behavior, and dehumanization. Reduced personal accomplishment refers to a person's negative feelings about themself, such as incompetence, which could lead to depression and an inability to

cope with job demands. For measuring the symptoms associated with these three dimensions of burnout in individuals, Maslach (2008) developed the Maslach Burnout Inventory (as cited in Simancas-Pallares et al., 2017).

Over the years, however, research has shown the conceptualization and measurement of burnout to be largely inconsistent and methodologically problematic (Bianchi et al., 2014; Pacewicz et al., 2019). In a recent article reviewing the concept of burnout, Bianchi and Brisson (2017) questioned the understanding of burnout as a work-related condition. The researchers argued that, because enduring chronic stress is not limited to work, the burnout phenomenon cannot be confined to work. Thus, for Bianchi and Brisson, any activity that can elicit frequent and intense stress response could contribute to the development of burnout. This position seems to echo the earlier claim by Pines and Aronson (1988) that burnout could occur in all spheres where people give a sense of meaning to others (as cited in Chirico & Magnavita, 2020).

Expanding on the previous analyses of the construct of burnout, Bianchi et al. (2019) summarized the problems associated with the construct. First, the authors noted it was unclear what constitutes a case of burnout. Second, they argued that the basic conceptualization and operationalization of burnout were inconsistent. Third, burnout, for the researchers, was unlikely to be the specifically job-induced syndrome as originally conceptualized. Finally, the authors considered the discriminant validity of the construct of burnout as unsatisfactory. These fundamental problems, according to Bianchi et al., seemed to render burnout research inconclusive. Although studies on burnout have

continued to be conducted, there seems to be no resolution of these fundamental problems with the concept (Tavella et al., 2020).

Nonetheless, burnout conceptually differs from STS in that burnout is not primarily interpersonal; does not include active engagement with clients' traumatic material; and does not result in behavioral, cognitive, or emotional shifts outside of the workplace (Evces, 2015). The fact that burnout results from work-related stress and includes physical and emotional exhaustion, interpersonal cynicism and detachment, and a lack of self-efficacy suggests a relationship and some overlap of effects between burnout and STS (Tavella et al., 2020). However, the much wider scope of STS's effects and its relationship to indirect exposure to traumatizing events shows the conceptual difference between the two constructs (Evces, 2015; Mordeno et al., 2017).

In the current study, I considered the potential, adverse effects of working with trauma among Catholic priests under the construct of STS. Because of its heavy reliance on the model and concepts of PTSD, STS appears more organized and more accessible to conceptualize, compared to the other available models (Kanno & Giddings, 2017). Moreover, the much more extensive scope of STS makes it most suitable for exploring and documenting the risks associated with trauma work among a wide range of both professional and nonprofessional mental health workers (Mordeno et al., 2017), including Catholic priests who are the target population of this study.

CFRM

Ludick and Figley (2017) developed the CFRM as a theoretical tool developed for predicting who will become vulnerable to STS among a wide range of human service

workers who provide services in direct contact with suffering clients to help improve their lives. In addition to self-care as the model's first component, which the authors described as the learned behavior of practices and activities aimed at the overall wellbeing of an individual, the CFRM offers three other self-nurturance strategies to counterbalance empathic response-related stress, trauma memory-related stress, overexposure to trauma-related stress, and stressful life events-related stress as primary risk factors of STS. The three components of the model are detachment, a sense of satisfaction, and social support. These resilience propositions of the CFRM might enhance resistance to STS among Catholic priests and ensure positive outcomes for the communities they serve because of the overlap of characteristics associated with resilience and self-care.

Detachment

This component of the CFRM refers to the ability to let go of the client's suffering (Figley, 2002). According to Ludick and Figley (2017), psychological detachment is the off-job action of switching off mentally and not being occupied, physically or mentally, by work-related matters. Research has indicated a positive correlation between psychological detachment and wellbeing, positive mood, and low fatigue. Halevi and Idisis (2017) found that differentiating the self from client experiences and stories of trauma highly predicted resistance to STS. Other researchers have found that workers who could effectively detach and leave client traumas behind had higher quality and longer duration of sleep (Hulsheger et al., 2015) and exhibited high levels of resilience and the least adverse effects (MacKay, 2017). Conversely,

several empirical studies have found that insufficient respite and recovery from work-related stress impair physical and psychological health, with psychosomatic complaints and burnout as the most salient outcomes (Gluschkoff et al., 2017; Kilroy et al., 2020).

Researchers have, however, noted the difficulty involved in detaching or disengaging from thoughts and feelings about stressors. Held et al. (2011) found that, in victims of direct trauma among U.S. military veterans, disengagement partially mediated trauma-related guilt and the severity of perceived PTSD. They claimed that detaching offers only short-term relief but not in the long run because disengagement can also act as denial or temporary self-distraction. Similarly, Aupperle et al. (2012) noted that, with PTSD, there is often a difficulty to disengage from the core of trauma stimulus that drives and maintains the disorder. Such inability to disengage, according to Ludick and Figley (2017), could hinder attentiveness to family, friends, positive emotions, and pleasurable activities, which, in turn, maintain the emotional numbness and depression often associated with trauma exposure. These findings show the need for trauma-exposed workers to process traumatic materials consciously and continuously to assimilate the events in guilt-free, adaptive ways. The ability to effectively detach or disengage from traumatic materials could come with training, experience, and ongoing self-care (Ludick & Figley, 2017).

Sense of Satisfaction

The sense of satisfaction derivable from caring for suffering persons can further negate STS (Figley, 2002; Ludick & Figley, 2017). The sense of satisfaction is also referred to as compassion satisfaction, which Stamm (2010) defined as the positive

feeling of being able to relieve the suffering of others. For Babaei and Haratian (2020), compassion satisfaction is the sense of fulfillment that comes from watching a client transform from victim to survivor and includes a sense of increased personal achievement, confidence, and goodwill. As a component of the CFRM, the sense of satisfaction encompasses the rewards that human service workers receive from observing improvements in client functioning and growth (Ludick & Figley, 2017). According to Wang et al. (2020), deriving a sense of satisfaction from trauma work can ensure that the compassion expressed toward trauma victims does not become exhausted. Thus, trauma workers can regulate the risk of STS by producing positive cognitions about their trauma work and finding a sense of joy and satisfaction in helping their traumatized clients (Wang et al., 2020). Indeed, researchers have found a negative correlation between compassion satisfaction and STS. Ray et al. (2013) and SlocumGori et al. (2013) found a significant inverse relationship between compassion satisfaction and STS among frontline mental health care professionals and hospice palliative care workers, respectively.

Recent research has affirmed these earlier findings that human service workers who possessed the most compassion satisfaction exhibited significantly fewer negative outcomes. In a cross-sectional, descriptive study among 181 cardiovascular nurses, Babael and Haratian (2020) collected data using the Professional Quality of Life Scale (Version 5) with the three subscales of compassion satisfaction, burnout, and STS. The researchers found that higher scores on compassion satisfaction correlated with lower scores on STS. Staudt and Williams-Hayes (2019) examined the relationship between

compassion satisfaction and STS in a sample of 36 interdisciplinary team members of a Child Advocacy Center in the southern United States and found similar results. Participants with lower scores on STS had higher scores on compassion satisfaction.

The above findings are consistent with those of Syed et al. (2017) who also found a significant negative relationship between compassion satisfaction and STS in a sample of 100 paramedics and 85 firefighters and O'Callaghan et al. (2020) who found a positive correlation between compassion satisfaction and resiliency among trauma workers. Overall, these studies seem to suggest that the reciprocal and intense helper-client relationship that can result in the helper's experience of STS can also result in the helper's compassion satisfaction as the victim becomes a survivor. More so, these convergent results seem to highlight the power of compassion satisfaction in negating STS and indicate that emphasizing only the helper's negative experiences from indirect traumatic exposure could undermine the positive quality of life that could come from the good feeling derivable from doing good (Hotchkiss & Lesher, 2018; Ludick & Figley, 2017).

Additionally, researchers have suggested some factors that may promote the development of compassion satisfaction as a buffer against STS among trauma workers. For instance, de Frigueiredo et al. (2014) suggested that believing in one's capacity to succeed, having positive social support, and years of relevant education and experience can promote compassion satisfaction and protect against STS. More recent findings have also indicated that, among trauma workers, better sleep quality, higher job satisfaction, an increase in years of experience, and sufficient social support are predictors of higher

compassion satisfaction (Bellicoso et al., 2017). For Gribben et al. (2019), subjective feelings of competence and fulfillment upon reflection on one's career can positively impact the development of compassion satisfaction among trauma workers. Similarly, in a sample of 105 trauma workers in South Africa, Teffo et al. (2018) found that finding work stimulating, believing in making a difference, enjoying relationships with colleagues, and years of working were predictors of compassion satisfaction. These findings provide insight into how trauma workers may develop a sense of satisfaction that could help them to effectively prepare for the challenges of trauma work and potentially increase positive client outcomes.

Social Support

CFRM's social support component wields preventative, ameliorative, and resilience-building power in trauma work (Figley, 2002; Ludick & Figley, 2017). Having and utilizing a robust social support network is an essential mechanism in minimizing the negative impact of secondary trauma exposure. A review of research indicates that mental health professionals with stronger social supports generally experience fewer symptoms of STS (Diehm et al., 2019; Michalopoulos & Aparicio, 2012). In a sample of 160 licensed social workers, Michalopoulos and Aparicio (2012) examined the role of personal history, social support, and level of experience in the development of secondary trauma. The researchers found that an increase in social support and the experience levels of the social workers were associated with less severe vicarious trauma. Additionally, the interaction effect of social support and trauma history significantly indicated that higher

levels of social support could prevent the experience of vicarious trauma in individuals who had no trauma history.

Similarly, in a more recent study, Diehm et al. (2019) found that psychologists who engage in supervision and who have strong social support from family, friends, and colleagues are less likely to develop STS symptoms. Social support significantly moderated the relationship between hours of clinical contact with trauma survivors and secondary trauma. The findings also indicated that a strong relationship exists between increased levels of secondary trauma and the amount of clinical contact with trauma patients for participants with low levels of social support (Diehm et al., 2019). Thus, insufficient social support for mental health workers could lead to poor psychological health and STS.

The above studies affirm that an individual's connection to family and friends can protect against or reduce the risk of developing the symptoms of STS. Perhaps, by helping individuals working with trauma to maintain appropriate boundaries, social support could highlight the divide between personal and professional life. Sustainable social support is an aspect of resilience that might be challenging for Catholic priests both because they often live alone and are frequently moving to different communities (Rossetti & Rhoades, 2013). Not engaging with caring people might leave trauma-exposed workers with the many testimonies from clients about the callousness and cruelty of humankind, and without nurturing relationships to prove the contrary, the negative experiences will influence cognition (Ludick & Figley, 2017). Thus,

maintaining social support could help in negating the adverse effects of working with trauma.

The CFRM does offer some educational and ameliorative solutions for a diversity of trauma-exposed workers that experience negative outcomes. Increasing a sense of satisfaction, self-care, effective detachment from work-stress, and maintaining social support with caring people are helpful steps towards a healthy life (Ludick & Figley, 2017). The model may satisfy the growing need to address the unintended negative impact of trauma work on mental health providers, first, for their overall wellness and safety and, second, for them to perform their roles effectively.

Conceptual Framework

Two theoretical models combined to provide the framework for this study: The theory of emotional contagion (Hatfield et al., 1994) and the CFRM (Ludick & Figley, 2017). Figley and Kleber (1995) employed the theory of emotional contagion to explain the central role of empathy in the development of STS. Emotional contagion is a theory of social interactions that explains the transmission of emotions through language and facial cues from one person to another. Hatfield et al. (1994) described how the mechanisms of language-mediated association (i.e., the verbal or written descriptions of an individual's situation) and perspective-taking (i.e., imagining oneself in the situation of another) could generate in the empathic observer emotional reactions that are similar to those of the subject. The empathic engagement with the victim suggests that the observer or helper, to understand the victim, requires identification with the victim and their suffering (Figley & Kleber, 1995). The theory of emotional contagion conceptually

fits with STS because, as with STS, emotional contagion implies the affective process in which an individual who cares for traumatized and suffering persons feels emotional responses that are similar to those of the suffering person's actual or anticipated emotions (Hatfield et al., 1994).

The central purpose of this study was to explore the phenomenon of STS among Catholic priests. Therefore, because the theoretical formulations of emotional contagion involve the two mechanisms of language-mediated association and perspective-taking, which could render a helper susceptible to the development STS via empathic engagement with suffering individuals, I employed the framework of emotional contagion as a lens for exploring the phenomenon of STS among Catholic priests who encounter many emotionally challenging situations in pastoral work. Indeed, the harmful physical, emotional, and spiritual effects of chronic self-sacrifice and repeated exposure to such difficult pastoral situations fall within the purview of emotional contagion as a theoretical model (Hatfield et al., 1994).

The scope of this study also extended to exploring how Catholic priests use self-care strategies in response to traumatic exposure in pastoral ministry. Previous research found that more time invested in self-care was unequivocally associated with lower levels of stress and that commitment to self-care held much protective potential against STS (Kulkarni et al., 2013). Thus, to explore this aspect of the study, I used the CFRM, which was described earlier as a theoretical tool developed for predicting who will become vulnerable to STS (Ludick & Figley, 2017).

In building the CFRM, Ludick and Figley (2017) represented the current understanding of the primary risk factors for developing STS, including empathic response-related stress, trauma memory-related stress, overexposure to trauma-related stress, and stressful life events-related stress. These variables were potentially counterbalanced by high resilience factors such as optimization and self-nurturance through self-care, detachment, sense of satisfaction, and social support. Moreover, the CFRM focuses not only on the individual human service worker but also on the systemic and community implications of the professional's vulnerability to distress that may lead to poor performance and adversely impact the overall resilience of the community the professional serves (Ludick & Figley, 2017). With the numerous cited studies supporting the potential efficacy of its propositions, the CFRM may well be an educational tool to encourage and guide Catholic priests to self-care and overall well-being as they encounter trauma in pastoral work. The combination of both emotional contagion and CFRM as a framework for this study, therefore, offered a useful guide for exploring whether Catholic priests experience STS and how they manage their vulnerability to STS in their pastoral ministry.

Literature Review

The Experience of STS

STS can have a widespread impact on the personal and professional lives of the subjects as observed in various human service workers (Cieslak et al., 2014; Manning-Jones et al., 2017). Researchers have noted that, because empathy is central to the development of STS (Figley, 1995), the experience of secondary traumatic exposure is

not limited to mental health professionals. According to Mordeno et al. (2017), anyone who empathetically engages with traumatized and suffering individuals can be at risk of psychological distress due to exposure to others' traumatic material. Indirect trauma exposure could occur in several contexts such as familial, social, or professional, and STS could develop in response to a single occurrence of such exposure to accounts of traumatizing events (Figley, 1995). Sabo (2011) attested that the adverse effects of psychologically traumatic events extend beyond individuals directly impacted by such events because those who provide help to trauma victims become indirectly affected in the process. Thus, human service workers in various specializations, including Catholic priests, can experience secondary traumatic stress due to direct interactions with clients in highly stressful and emotional conditions that create an environment for increased susceptibility.

For many human service workers impacted by STS, intrusion symptoms could consist of recurrent and invasive recollections of the traumatic event; behaving or feeling as if the events were replaying in the form of flashbacks, illusions, or a sense of reliving the experience; and intense psychological distress or emotional reactivity when exposed to internal or external reminders of the event (Bride, 2007; Colombo et al., 2019). Avoidance symptoms may include the helper's efforts to avoid things or events that are associated with the trauma and may evoke traumatic reactions. These symptoms could take the form of conscious efforts to avoid thoughts, feelings, and conversations associated with the trauma, or avoid activities, places, and persons that are reminders of the event. Avoidance may also involve the loss of interest or participation in significant

activities, and withdrawal or estrangement from others (Colombo et al., 2019). Arousal symptoms involve persistent symptoms of anxiety or increased arousal, not experienced before the traumatic exposure, consisting of sleeping difficulties, irritability, difficulty concentrating, hypervigilance, or exaggerated startle response (APA, 2013; Bride, 2007; Colombo et al., 2019).

In a recent review of STS as a construct, however, Sprang et al. (2019) observed that helpers could respond to their exposure to secondary traumatic stressors in ways that are not captured in the PTSD symptom clusters. For instance, the authors noted that symptoms such as a reduction in the professional's empathy and self-efficacy, feelings of stigmatization, and moral distress extend beyond the PTSD symptom clusters. Diehm et al. (2019) made a similar observation, noting that the concept of STS also relates to other difficulties experienced that may not meet severity for PTSD criteria per se. Thus, Sprang et al. described STS as a parallel process of experiencing an empathic reaction to the psychological impact of both the traumatic events and the subsequent PTSD symptoms on the clients. Likewise, Butler et al. (2017) observed that a helping professional's indirect experience of the impact of trauma on their clients is comparable to the traumatic effects of witnessing another person's direct exposure to traumatization. Such experience could come with an added intensity because of the emotional connectedness and responsibility inherent in providing support and guidance to traumatized and vulnerable help-seekers (Sprang et al., 2019).

Researchers have used various assessment instruments to measure the phenomenon of STS among human service providers. One of the assessment tools is

Figley's (1995) Compassion Fatigue Self-Test for Psychotherapists with two subscales to explain the dimensions of STS and burnout. Other tools include the Traumatic Stress Institute Belief Scale, Revision L (Pearlman, 1996), the Impact of Events Scale (Horowitz et al., 1979) and the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004). Many recent studies assessing STS among helping professionals have, however, used the STSS because the instrument has proved to be highly reliable and valid over time (Choi, 2017; Dominguez-Gomez & Rutledge, 2009; Matter & Mousa Thabet, 2016).

Prevalence of STS Among Human Service Workers

Research has been consistent in reporting a high rate of STS among human service workers who engage in caring for traumatized and suffering populations. Although I found no study that precisely measured the prevalence of STS among the clergy, the studies reviewed in this section provide evidence of the prevalence of STS among helping professionals in various fields whose work-related contact with distressed people and the associated psychological vulnerabilities appear to be similar to those of Catholic priests. This similarity between the much-studied populations of helping professionals and Catholic priests, in their engagement with vulnerable individuals, strengthens the justification for exploring whether Catholic priests experience STS.

Bride's (2007) research on the prevalence of STS in a sample of 282 social workers was one of the first studies that documented the extent to which STS is a problem faced by helping professionals. Using the STSS (Bride et al., 2004) to examine the frequency of individual symptoms, the frequency with which diagnostic criteria for PTSD were met, and the severity of STS levels, Bride found that social workers were

highly likely to be secondarily exposed to traumatic material through their work with traumatized populations. The results also suggested that many participants (55%) experienced some symptoms of STS, and a significant minority (15.2%) met the diagnostic criteria for PTSD. Based on the above findings and following from Kessler et al.'s (1995) earlier estimation of 7.8% lifetime prevalence of PTSD in the general population due to all traumas, Bride concluded that, apart from any other traumas that social workers may directly experience, the rate of PTSD in social workers due only to indirect exposure is twice that of the general population.

One limitation of Bride's (2007) study was that the sample was confined to licensed, masters-level social workers in a single state in the southern United States, thus reducing the generalizability of the findings to other groups of human service workers, such as bachelors-level social workers, unlicensed social workers, the clergy, and social workers in other parts of the United States or other countries. Another weakness of the study was that Bride based their findings only on a brief screening measure for STS. Perhaps, different results might have emerged if the researcher had used a structured interview as well. These limitations notwithstanding, Bride demonstrated that helping professionals experience a rate of exposure to traumatic material through their contact with traumatized and suffering people.

Recent research has provided evidence of the experience of STS in varying degrees among different groups of human service professionals. In a study that investigated the extents of STS among helping professionals who provide services for North Korean refugees, Kim (2017) used Bride's (2007) STS scale to measure levels STS

in a national sample of service providers comprising of social workers, psychotherapists, job counselors, and paraprofessional counselors. There were 179 participants in the study. The results indicated that 51.3% of the participants reported having symptoms of STS. Of this population, 22.9% reported a moderate level of STS, 8.4% had a high level of STS, and 20.7% of the participants indicated a severe condition of STS.

Kim's (2017) findings seem consistent with the findings from previous studies identifying chronic exposure to traumatic material as a work-related hazard of providing direct services to traumatized populations (Adriaenssens et al., 2012). The findings also echo those reported by Ewer et al. (2015), where full-time staff showed higher levels of STS than part-time staff. However, contrary to the findings of previous studies that the prevalence of STS varied substantially across occupations (Hensel et al., 2015), Kim found no difference in STS levels either by gender or the type of organization in which the service providers worked. Kim's study, like Bride's (2007), provides quantifiable evidence of STS as a prevalent work hazard for helping professionals who work with vulnerable populations.

Similarly, Baciu and Virga (2018) assessed the prevalence of STS among Romanian social workers. Following Bride's protocol, the researchers examined the frequency of individual symptoms, the frequency with which diagnostic criteria for PTSD were met, and the severity of STS levels. The results showed that 88.7% of the respondents worked with mildly traumatized populations, and 88.1% of the respondents confronted issues related to client traumas. Also, 63.8% of the respondents were highly likely to experience some symptoms of STS, and between 23% and 26% of them met the

diagnostic criteria for PTSD due to secondary exposure to trauma. These findings seem to suggest that at least 1 in 5 social workers in the sample experienced trauma symptoms due to their secondary exposure to distressing material.

Being recent, Baciu and Virga's (2018) findings call for increased attention to the emotional and psychological risks faced by helping professionals. Their study highlights the need for the compulsory provision of support services, specialized training, and supervision for trauma and burnout prevention. Indeed, the study could provide an opportunity for opening a much-needed discussion about the necessity of systemic incorporation of risk management programs in the operations of the human service organizations to protect the helping professionals from the emotional and psychological hazards of secondary traumatic exposure (Choi, 2017).

Research also indicates a high prevalence of STS in nurses. Ratrout and Hamdan-Mansour (2020) focused on identifying the prevalence, predictors, and consequences of STS among nurses working in emergency departments in Jordan. The researchers measured the symptoms of STS with an Arabic translation of the secondary traumatic stress scale. Two hundred and two respondents completed the survey. Participants reported they spent more than half of their duty caring for trauma patients. The results indicated that 94% of the participants experienced STS in various degrees, and more than half of them (52.3%) experienced high to severe STS symptoms. Participants scored highest on arousal symptoms and lowest on intrusion symptoms.

Results from Ratrout and Hamdan-Mansour's (2020) study seems consistent with previous findings indicating a high level of STS among emergency nurses. Dominguez-

Gomez and Rutledge (2009) had found that 85% of the nurses in their study sample reported at least one symptom of STS. Similarly, Adriaenssens et al. (2012) found that, among 248 emergency room nurses in their study, 8.5% of the participants reached the clinical level of STS. Additionally, Morrison and Joy (2016) found that 75% of a sample of emergency room nurses had at least a symptom of STS, and 39% of them met all the STS criteria. Thus, like the previous studies, Ratrout and Hamdan-Mansour's findings suggest that emergency nurses are highly susceptible to developing STS. These studies raise implications for the well-being and performance of human service workers, especially in modern society, where resources are increasingly depleting, and trauma rates are rising (Moore, 2019).

Another group of helping professionals found in the literature was victim advocates who provide emotional support, crisis intervention, and counseling and facilitate victims' reporting and engagement with the criminal justice system (Patterson & Tringali, 2015). Benuto et al. (2018) examined the prevalence of STS among 135 victim advocates. Using an online survey, Benuto et al. collected data from the participants. From the participants' endorsement of items on the three subscales of STSS, that is, intrusion, avoidance, and arousal, the researchers found that 66 participants (48.89%) met the criteria for experiencing clinical levels of STS due to their secondary traumatic exposure. The findings also indicated that participants scored highest in the avoidance subscale. This result indicated a much higher rate of prevalence in the victim advocates than the 15.2% prevalence rate in the sample of social workers that Bride (2007) found.

Benuto et al. (2018) also categorized the severity of the STS levels in the sample and found that one third of their sample had high or severe STS. Using a cut-off to classify participants into dichotomous groups of either meeting or not meeting STS criteria, the researchers found that the prevalence of STS in victim advocates (52.95%) far exceeds the rates of STS in nurses reported in previous studies (20.3%: Mordeno et al., 2017; 38%: Quinal et al., 2009) that used the dichotomous cut score. These results indicate that the prevalence of STS is high among victim advocates as helping professionals. Moreover, the disparity in the rates of STS among victim advocates compared to nurses seems to align with Hensel et al.'s (2015) earlier assertion that the prevalence of STS varied substantially across occupations.

All these studies indicate that human service workers who help the traumatized are at risk of experiencing symptoms of traumatic stress and general psychological distress due to their work (MacEachern et al., 2018). The same might be true for Catholic priests whose pastoral work involves dealing with parishioners' tragedy, grief, or emotional and spiritual pain. More so, the risk of experiencing STS might be high for Catholic priests because, as Snelgar et al. (2017) observed, the clergy, unlike the mental health professionals, often lack the specialized training and support for the prevention and remediation of any lasting effects of their working with trauma.

Common Risk Factors of STS

In addition to documenting the prevalence of STS, researchers have sought to understand the risk factors that potentially contribute to the development of STS. Most of the identified factors refer to either internal or external characteristics, or both, relating to

an individual's personality traits, prior experiences of trauma, level of exposure, the general influence of workplace factors, and social support (Bride & Kintzle, 2011; Ewer et al., 2015). The following are common risk factors in the literature that are arguably applicable to Catholic priests whose pastoral work often involves engagement with victims of trauma (Noullet et al., 2018).

Empathy

Empathy is central to the development of STS (Figley, 1995). Using the framework of Hatfield et al.'s (1994) emotional contagion theory, Figley (1995) explained that the helper's empathic engagement with the traumatized, which requires identification with the victim and their suffering, is the primary mechanism by which STS occurs. By psychologically taking the perspective of the victim, the helper indirectly experiences the trauma such that the more empathic the helper is, the more closely they will identify with the negative emotional states of the victim and the more likely they will be at the risk of being secondarily traumatized (Sinclair et al., 2017). For Thomas (2013), people who perceive the suffering of others and empathically engage in prosocial behaviors, wanting to help others and alleviate pain, might conversely feel distressed or overwhelmed as a result. Researchers seem to agree that affective sharing and perspective-taking are components of empathy that could result in vulnerability to STS (Duarte & Pinto-Gouveia, 2017; Thomas, 2013).

In a descriptive-correlation study, Mottaghi et al. (2020) investigated the relationship between empathy and secondary traumatic stress. A sample of 300 participants randomly selected from both public and private hospitals in Kerman

provided the data. In their path analysis, the researchers found that empathy could explain 77% of the participant's susceptibility to STS. Similarly, Yi et al. (2019) found that empathic engagement led to the development of STS in a sample of social workers in Korea. These results show that, because of their empathic presence to patients with trauma and thus their traumatic exposure, helping professionals are very likely to experience psychological distress and become secondarily traumatized (Duarte & Pinto-Gouveia, 2017). Although Mottaghi et al. used a correlation research method that made it more difficult to extract the causal results, their study remains significant because it shows the great extent to which empathy could play a role in the development of STS. These results support the findings of previous research identifying empathy as a risk factor for STS (Ewer et al., 2015; Sinclair et al., 2017).

Remarkably, some researchers have noted that empathy could help to maintain the wellbeing and longevity of social workers. For Yu et al. (2016), empathy may well be a double-edged sword that can both enhance and hurt the professional's quality of life. Also, Gleichgerrcht and Decety (2013) reported that empathic concern was positively associated with life satisfaction. Although most of the studies found empathy to exact a potentially harmful influence on the wellbeing of the helper, none of the researchers recommended that professionals be less empathic in their engagement with their clients because empathic engagement is a necessary component of effective helping (Hansen et al., 2018). Rather, what seems acceptable is that mental health workers seek to bolster self-care and resilience factors.

As empathy is central to the development of STS (Figley, 1995), so is it to effective pastoral care (Kim, 2017). Catholic priests, like other pastors, willingly display empathic perspective-taking. Parishioners see the priests as representing the compassionate God in some overt way because of their apparent faith commitments. With issues of religion, spirituality, and a compassionate God expectedly present in the priests' engagement with the traumatized, they are willing to identify with traumatized parishioners and their suffering (Kim, 2017). However, while feeling close concern for suffering victims of trauma might make pastoral contact effective, an inability to practice detachment may lead to being overwhelmed by the victims' problems and STS (Duarte & Pinto-Gouveia, 2017). Moreover, because for Catholic priests and pastors, empathy is often perceived to be other-centered, in which case pastoral contact begins and ends with only the client's good as the aim (Zondag, 2007), empathy may well lead to the development of STS. Critical self-awareness, as Adams et al. (2017) noted, could be the one significant difference between the mental health professional and the clergy offering empathy. Thus, it might be necessary to emphasize the importance of some training in mental health standards for Catholic priests providing pastoral care.

Level of Exposure

Resolving traumatic stress typically requires that victims of direct trauma engage in the process of reliving the experience by slowly, vividly, and repeatedly telling the story (Weiten et al., 2018). This process indirectly exposes the helper to disturbing trauma imagery such that the more the helper engages in such activities with suffering persons, the greater the risk of developing STS. Indeed, Ludick and Figley (2017)

considered exposure to suffering as the first pathway to STS by which helpers assume the suffering of the client and internalize the expressed emotional energy in every encounter. In their pastoral ministry, Catholic priests are in contact with suffering, often on an ongoing basis, and because there is usually no regard for the dosage of traumatic material (Hotchkiss & Lesher, 2018), the possibility of experiencing adverse effects increases. Measures of exposure have, however, varied across studies and included hours of contact with suffering persons, caseload numbers, and ratios.

Diehm et al. (2019) explored the strength of the relationship between secondary exposure to trauma and the development of STS and examined whether the relationships between individual factors and STS were significant. Seventy-seven Australian psychologists participated in the study by completing an online survey anonymously. The results indicated positive relationships between the hours of clinical contact with trauma clients and the frequency of exposure to graphic detail of trauma. This result suggested that professionals who spend more time with trauma clients and who have been exposed more frequently to graphic details of trauma were more likely to develop STS. Similarly, Benuto et al. (2018) investigated exposure to traumatic material among victim advocates and found that direct service hours spent with victims acted as a contributing factor to the development of STS among victim advocates. These results suggest that cumulative trauma exposure can lead to developing STS among human service workers. While these findings are consistent with previous findings (Galek et al., 2011; MacRitchie & Leibowitz, 2010), they are, however, contrary to those of Furlonger and Taylor (2013)

and Ivicic and Motta (2017) who found no positive correlation between hours of clinical contact and the development of STS in their measurement of exposure to trauma.

Findings on exposure as a risk factor have been consistent when measured in relation to the caseload or the number of clients with whom the professional works. Several studies have found the relationship between the number of clients with a trauma history and levels of STS in professionals to be statistically significant (Makadia et al., 2017). In an earlier meta-analysis of 38 published studies, Hensel et al. (2015) had examined caseload frequency, ratio, and the number of clients, and observed that all the variables indicated significant effect sizes. They found that the caseload ratio was the strongest predictor of exposure, indicating that the number of traumatized clients or the amount of time spent engaging these clients was more strongly related to the development of STS. In other words, the level of exposure to traumatized clients is more important than the length of exposure in that higher proportions of traumatized clients on caseloads and higher proportions of time spent in trauma-related engagement with clients are more predictive of STS (Hensel et al., 2015).

The Helper's Personal History of Trauma

Prior experience of trauma is a common variable in the study of vulnerability to developing STS (Diehm et al., 2019; Hensel et al., 2015). However, a reasonable level of evidence suggests that having a personal trauma history is both linked (Cosden et al., 2016; Sodeke-Gregson et al., 2013) and not linked (Benuto et al., 2018; Makadia et al., 2017; Roden-Foreman et al., 2017) to the development of STS. Commenting on the conflicting findings on the relationship between personal history of trauma and STS,

Masson and Moodley (2020) observed that the discrepant findings across studies might be due to the variation in the definition of trauma.

Although there seems to be no consensus among researchers regarding the role of trauma history in the development of STS, two studies appear to have assessed the extent to which the individual has processed their experiences of trauma as a predicting factor (Hargrave et al., 2006; Makadia et al., 2017). Hargrave et al. (2006) examined whether the extent of personal trauma resolution among 64 volunteer crisis workers in New Zealand associated with STS. The researchers initially found no significant relationship between STS and each level of trauma experience resolution: unresolved, partially resolved, or resolved. However, when the researchers merged the unresolved and partially resolved groups to create two groups (unresolved and resolved), participants with unresolved trauma reported levels of STS that were significantly higher than those with resolved trauma. Remarkably, the volunteer workers with unresolved trauma experiences had higher STS scores than those with partially resolved trauma, whereas those with resolved trauma experiences reported the lowest STS scores in the study. Similarly, Michalopoulos and Aparicio (2012) observed that unresolved trauma negatively impacted licensed social workers' work efficiency and their ability to help their clients.

Contrary to the above, Makadia et al. (2017) explored the relationship between the development of STS symptoms and individual factors such as age, gender, personal history of trauma, resolution of personal trauma, and quality of supervision received with trauma work. In a sample of 564 trainee psychologists, Makadia et al. found no

correlation between STS symptoms and the individual factors, including trauma history resolution. The researchers, however, did not consider the severity of the trauma experienced by participants and their level of exposure in trauma work. Perhaps, this would have yielded different results. These contrary results notwithstanding, Hargrave et al.'s (2006) findings, though not recent, seems to highlight the potential role of resolution in the relationship between trauma history and STS. In other words, the extent to which a helping professional has processed their trauma might impact the levels of STS symptoms experienced (Hargrave et al., 2006). Although measuring these variables is beyond the scope of the current study, it will be a significant contribution to the literature if future research on the role of personal history in the development of STS includes measures of resolution.

Age of the Helper

Research has also associated the age of the helper with the development of STS. However, the findings have been inconsistent regarding this association. Whereas some studies have found no meaningful correlation between age and the development of STS symptoms (Diehm et al., 2019; Rzeszutek et al., 2015), some others have found some small but significant negative correlation between age and STS. For instance, Sacco et al. (2015) examined the relationship between age and the development of STS in a sample of 221 critical care nurses and found that the participants who were aged 50 and above had levels of STS that were significantly lower than the STS levels of the younger participants. In a related study, Rupert et al. (2015) found that younger psychologists reported higher levels of burnout in the emotional exhaustion component of the Maslach

Burnout Inventory than older psychologists. The suggestion of a negative correlation between age and STS could be due to the greater professional and life experience of the older participants, and their greater use of coping strategies over the years.

Years of Professional Experience

Research has also associated fewer years of experience in the human service field with the development of STS. However, as with the age of the professional, some researchers have found some significant relationship between years of experience and the development STS (Avieli et al., 2016; Benuto et al., 2018), while others have found no meaningful relationship between both variables (Cosden et al., 2016; Furlonger & Taylor, 2013; Rzeszutek et al., 2015). In a sample of professional and volunteer caregivers in Israel, Avieli et al. (2016) examined the predictors of professional quality of life and found that participants with less than five years' experience had higher rates of STS. Avieli et al.'s findings support the earlier findings by Rossi et al. (2012), who identified in a sample of 260 community-based mental health staff a significant increase in STS for each extra year spent working in the participants' respective mental health departments. Yi et al. (2019) reported similar results in their study, where they found a positive correlation between years of experience and STS levels.

In contrast, Burr et al. (2020) examined the incidence of STS and PTSD at a diagnostic level due to STS among 201 respiratory therapists and found no difference in STS between participants based on years of work experience. The results indicated that STS and PTSD at a diagnostic level due to STS were common in the participants. Although the findings seem contradictory, the studies seem to reflect the findings of

Branson et al., (2014) that experienced therapists were more likely to carry more challenging caseloads because of their increased responsibilities and expertise. In other words, experience and inexperience could both correlate with the risk of STS. The evidence suggests that the length of experience in providing general psychosocial services seems to have less influence on the development of STS than does the length of experience in specifically providing trauma services. Additionally, the conflicting findings could also be due to variations in work setting across studies and, perhaps, indicate the need for further investigation in less-studied populations like Catholic priests.

Organizational Culture

Several studies have found some aspects of workplace cultural factors playing a role in the development of STS (Begic et al., 2019; Caringi et al., 2017; Lee et al., 2013). Caringi et al. (2017) defined workplace culture as the norms, values, meaning systems, and traditions relevant to an organization, which often outlives individuals who come and go and is difficult to change. Organizational culture could be unhealthy, inhibit self-care, and increase the risk of STS for employees who work with trauma. According to Begic et al. (2019), cultures that discourage emotional expression, autonomy, and self-care increase the likelihood of developing STS among human service workers, especially where support systems are lacking. Employees tend to internalize their organizational norms, and if the norms are unhealthy, they may downplay the need for self-protection or invalidate the efforts to maintain wellness among human service workers exposed to other's traumas (Caringi et al., 2017).

Begic et al.'s (2019) argument seems relatable to the Catholic church as an organization with norms and value systems that could tacitly increase the risk of developing STS among Catholic priests. Church or clerical culture seemingly reinforces perfectionism. Parishioners see their priests as God's representatives who should always be available to all and be exceptionally compassionate toward the suffering and traumatized members of the community they serve (Proeschold-Bell et al., 2016). Likewise, the priests see their ministry as a divine calling to serve. This call may motivate priests to keep working even in the presence of negative emotions such that the desire to care for others may inhibit their taking time for self-care activities (Case et al., 2019).

By their calling, priests are expected to teach others how to experience a positive quality of life and find meaning in times of suffering and distressing circumstances (Kim, 2017). The "wounded healer" image, which suggests that healing capabilities can emerge from the experience of being wounded (Roots & Roses, 2020; Wohlever, 2020), gets used for priests often, sometimes dangerously suggesting that the wounds of caregiving should be accepted or endured without question. Such internalized expectations of perfection could prevent priests from sharing their psychological struggles and seeking help. Thus, cases of depression and emotional isolation could arise among priests, especially in rural areas where they have no access to supportive resources (Case et al., 2019; Scott & Lovell, 2015; Tarrence, 2019). Moreover, sustainable social support is often hampered not only because of the requirement of celibacy but also because of the frequent reassignment of priests to different communities (Rossetti & Rhoades, 2013).

These aspects of the church's culture might increase the risk of developing STS among Catholic priests in their work with trauma.

Secondary Traumatization of the Clergy

Few studies have discussed secondary traumatization among the clergy. Although these studies were not specific on STS as a construct and did not focus on Catholic priests, they provided valuable information to the current research. The earliest study I found in the literature was Holaday et al.'s (2001) research amongst 30 male and female pastors in the United States who specifically provided counseling as part of their ministry. Using the Traumatic Stress Institute Belief Scale (Traumatic Stress Institute, 1997), the researchers compared clergy scores to those of mental health professionals and students and found that clergy totals (181.60) were higher than the totals for mental health professionals (166.83) but lower than the totals for the student sample (192.41). Thus, Holaday et al. suggested there was evidence that these clergy experienced disruption in their lives due to their pastoral counseling practice. Similarly, after the 9/11 terrorist attacks, Roberts et al. (2003) examined compassion fatigue among 317 participants of which 79% were clergy. The remaining participants were disaster relief workers, including mental health practitioners, mental health executives, and others from disaster relief agencies. Using the Compassion Satisfaction and Fatigue Test (Stamm, 2002), the researchers found that most of the respondents were at high risk of compassion fatigue.

In their discussion of the hidden cost of trauma work, Hendron et al. (2012) considered the potential physical and emotional impact trauma work could have on the

clergy. Hendron et al. reviewed several studies on the supportive function of the clergy during distressing, traumatic, and life-altering events. The authors argued that the clergy who play the roles of the counselor and the mental health worker could be vulnerable to similar effects of working with suffering people because exposure to harmful material increases the experience of compassion fatigue or vicarious trauma among mental health professionals. Likewise, in their work with chaplains who provide support to patients and family members experiencing the emotional distress of loss and grief, Hotchkiss and Lesher (2018) acknowledged clergy exposure to secondary traumatization. Although Hendron et al. based their argument on the review of articles that rarely addressed questions regarding the actual experiences of secondary trauma among the clergy, their article provided insight into how the members of the clergy might be susceptible to secondary traumatization.

Additionally, Jacobson et al. (2014) explored the risk of burnout and compassion fatigue among 95 members of the clergy from a cluster of Lutheran churches. The authors also examined the potential for compassion satisfaction in the same sample. The predictive model for burnout, compassion fatigue, and compassion satisfaction included gender, number of years rostered, satisfaction with salary, size of the congregation, and depression. The participants completed the surveys anonymously. The findings suggested that the clergy were at low risk for burnout and moderate risk for compassion fatigue. The results also indicated that the participants' potential for compassion satisfaction was moderate, and the variables of reported depression and the number of years working predicted burnout significantly. The model did not predict the risk of compassion fatigue.

Jacobson et al.'s (2014) research seems to be one of the first empirical studies that examined the risk for burnout and compassion fatigue among the clergy, including the potential for compassion satisfaction. The findings provide insight into secondary traumatization in pastoral ministry. However, the generalizability of the findings seems limited because the participants were from a single cluster of churches. Also, some of the findings contradicted those from previous research. The researchers reported that more years in ministry predicted increased the risk for compassion fatigue and reduced the potential for compassion satisfaction than fewer years. This result seems inconsistent with several previous studies that suggested an increase in years of experience associated with low risk for secondary traumatization (Doolittle, 2010; Francis et al., 2009; Taylor et al., 2006).

Like the previous studies, recent research on clergy traumatization has been mostly quantitative, measuring the predictors of clergy burnout and compassion fatigue (Hotchkiss & Lesher, 2018), the impact of clergy resilience on compassion fatigue (Noullet et al., 2018), and the influence of spiritual intelligence and intrinsic motivation on compassion fatigue (Snelgar et al., 2017). A notable limitation cutting across these studies is the lack of personal interviews. The clergy's desire to present their vocation in the best light possible as a calling from God (Kim, 2017; Patton, 2015) might have impacted the responses to surveys. There could be some disproportionate level of shame or the fear of being taken as faithless that could prevent the clergy from admitting the experience of burnout or STS. Thus, utilizing an in-depth interview to explore how the clergy perceive their exposure to STS may not only corroborate the findings of current

research but provide a fuller understanding of the phenomenon. Moreover, the inconsistency of the existing findings regarding the risk of secondary traumatization among clergy indicates the need for further exploration of the topic.

The Role of Self-Care in Mitigating the Experience of STS

Research has associated self-care with positive physical health, emotional wellbeing, and mental health (Cook-Cottone & Guyker, 2018). According to Dorociak et al. (2017), self-care is a complex process of engaging strategies consciously directed at the overall physical, emotional, social, and spiritual well-being of an individual. In other words, self-care is the learned behavior of practices and activities performed by individuals to maintain health, life, and well-being (Cook et al., 2017; Ludick & Figley, 2017). Kulkarni et al. (2013) observed that more time invested in self-care was unequivocally associated with lower levels of stress and that commitment to self-care held much protective potential against STS. Figley (2002) extolled self-care to hold tremendous benefits and the ability to neutralize harmful energy from working with trauma. Similarly, Glennon et al. (2019) noted that self-care practices are valuable to mental health workers' sustainability and effectiveness in providing care to their clients, especially those who have experienced trauma. Although not focused explicitly on STS, a few studies have also indicated the importance of self-care for Catholic priests as a way to manage the adverse effects of stress and burnout (Case et al., 2019; Tan & Castillo, 2014), spiritual dryness (Bussing, Gunther, et al., 2013; Bussing, Sautermeister, et al., 2017), and aging (Kane, 2017). For Tan and Castillo (2014), incorporating the traditional spiritual disciplines of prayer and meditation, silence and solitude, fasting and simplicity,

and fellowship and service into self-care can help prevent burnout and compassion fatigue among the clergy.

Integrating self-care into trauma work could enable mental health workers to adopt healthy ways of living, including seeking private therapy, practicing mindfulness, making time for personal relationships, striving for personal and professional balance, getting enough sleep, healthy eating, and participating in non-work-related activities (Beaumont et al., 2016; Dorociak et al., 2017; Santana & Fouad, 2017). In their study, Dorociak et al. (2017) examined the relationship between personal and professional wellness, work-related stress and resources, and the use of self-care strategies. Using archived data from previous surveys, the researchers investigated these variables across three career phases of psychologists: early-career, mid-career, and later-career. The findings indicated that the later-career phase had lower work-related stress, more resources, and used more self-care practices than the earlier career phases (Dorociak et al., 2017). This study indicates the importance of self-care in reducing work-related stress and the need to encourage it throughout the professional lifespan.

Beaumont et al. (2016) investigated the relationship between self-empathy, fatigue, wellbeing, and exhaustion in students of cognitive behavior therapy. The researchers used the Professional Quality of the Life Scale, the Self-Compassion Scale, Short Warwick, and the Edinburg Mental Well-being Scale to measure the variables. The results indicated the presence of fatigue and exhaustion among the students, and the ability of self-empathy to manage symptoms and improve the quality of life. Self-care practices also decreased symptoms of fatigue, self-criticism, and exhaustion, and

increased an overall sense of wellness (Beaumont et al., 2016). In a related study, Hotchkiss and Lesher (2018) examined the relationship between the practices of self-care and the quality of life among chaplains who provide support to patients and family members experiencing the emotional distress of loss and grief. Using a hierarchical model, the authors found that self-care practices, compassion satisfaction, and organizational factors among chaplains predicted burnout. Specifically, the authors found that chaplains engaged in regular self-care exercises and coping strategies had a higher quality of life and low risk of burnout risk.

Furthermore, Lewis and King (2019) highlighted the implementation of self-care strategies to enhance the experience of undergraduate students in direct social work practice and practicum as they work with suffering people. The patterns of concerns from the students' practicum experience centered around their perceptions of a lack of balance between home, school, and the field of practice, decreased sleep and time, anxious feelings, undefined emotions, and increasing financial stress. The suggested self-care strategies included the maintenance of physical health through diet and exercises, maintaining spiritual and emotional wellbeing through religious and social activities, keeping friendship, solitude and having time for personal reflection, and attending programs and workshops (Lewis & King, 2019). These strategies are like those that Charrois et al. (2020) identified. In their systematic review of the effectiveness of psychotherapeutic interventions for women who experienced perinatal loss, Charrois et al. described burnout as a mediator between resilience and STS. They argued that both professional and nonprofessional interventions for individuals experiencing work-related

traumatic stress should focus on building personal resources and on decreasing job burnout to prevent a future experience of STS. The results of these studies emphasize the importance of integrating self-care techniques into personal and professional life to prevent compassion fatigue, burnout, and secondary trauma among human service workers.

While observing that those working with traumatized individuals often had more compassion for others than for themselves, Newsome et al. (2012) suggested a higher degree of self-compassion, kindness, and understanding toward oneself instead of being harsh and self-critical. Indeed, Akinsulure-Smith et al. (2018) found that strategies like self-blame, venting, self-distraction, substance abuse, and behavioral disengagement strongly associated with STS and burnout. Like Newsome et al., Glennon et al. (2019) argued it was imperative to develop some self-care techniques that mental health workers may apply as they engage with victims of trauma in real-time. Thus Glennon et al. suggested the following skills: Dual awareness (being conscious of the emotional needs of both the professional and the client), processing countertransference (understanding the emotional reactions), conscious use of self (integration and use of both the professional and personal selves), and containment (bearing witness to and serving as the container of the client's suffering). While other self-care strategies refer to activities outside of the therapeutic sessions, Glennon et al.'s strategies suggest a roadmap for engaging clients during sessions.

Additionally, research has indicated that enhancing resilience as a self-care strategy can buffer against the adverse effects of trauma work. In a sample of 128 social

workers with the South African Police Service, Masson (2019) explored the levels of resilience in the social workers and examined the characteristics that enhanced resilience. The researcher obtained data from the participants using the Resilience Scale and interviews. The results showed a significant relationship between vicarious trauma and resilience, as the researcher had hypothesized. Also, the participants identified the factors that enhanced movement from vulnerability to resilience, such as a nurturing family, education, social involvement, personal relationships, empowerment, religious community, finding meaning, and personality attributes. Other factors identified were supervision, individual counseling, and educational workshops (Masson, 2019).

The above findings show that the participants could identify the factors that boosted their resilience. Identifying such resilience factors and mindfully incorporating them into self-care could be beneficial to trauma workers as measures against developing STS (Noullet et al., 2018). Interestingly, one of the resilience factors identified was finding meaning in helping (Masson, 2019). Pack (2014) had earlier found that experiencing secondary traumatization and the resultant search for meaning fostered the personal and professional resilience strategies of counselors, which, in turn, enhanced their ability to heal. Thus, trauma work could offer practitioners the opportunity to develop resilience as they learn to overcome adversity and experience positive transformation through witnessing the healing processes of their clients (Hernandez-Wolfe et al., 2015).

As part of the self-care programs to enhance the overall resilience of the clergy, Noullet et al. (2018) emphasized the importance of crisis intervention training. Using a

longitudinal design, Noullet et al. assessed the impact of having formal training in pastoral crisis intervention on the resilience levels of the clergy. Thirty-nine clergy members who completed a 3-day training course participated in the study. The researchers used the Connor-Davidson Resilience Scale-2 item and the Professional Quality of Life Scale Version 5 to measure clergy resilience 1 year after the formal training. The findings indicated that the clergy who went through the training had significantly higher scores on resilience and significantly lower scores on both burnout and compassion fatigue (Noullet et al., 2018). These results show that the training of the clergy in pastoral crisis intervention could provide some knowledge for safely engaging in working with trauma.

Noullet et al.'s (2018) research had some limitations, however. First, the small sample size might negatively impact the generalizability of the findings. Second, the self-reported number of incidents by the participants both before and after the training could negatively impact reliability. However, one significant contribution of their findings to the broader conversation around secondary traumatization and self-care among the clergy is the emphasis on having some training in crisis intervention. Given the significant association found between higher levels of resilience and formal training in pastoral crisis intervention (Noullet et al., 2018), more studies may be necessary to examine the relationship between the training of pastoral agents on resilience and their experience of STS. More so, the findings could be a relevant resource in advocating for such self-care and resilience training to be part of the curriculum in theological institutions such as seminaries and divinity schools.

Interestingly, researchers have emphasized self-care as an ethical responsibility for workers in the human service field (Wise et al., 2012). According to Costa et al. (2020), the need for mental health workers to incorporate self-care practices into the overall categories of everyday living is an ethical one. The professional ethics of care requires honesty with self about negative emotional reactions that could have harmful effects on clients and engaging in activities to prevent such harmful reactions (Hotchkiss & Lesher, 2018). Cox and Steiner (2013) considered the ability to engage in self-reflection, including self-care, as a critical characteristic of a competent mental health worker. Indeed, the degree of the aliveness and psychological health of the mental health worker are crucial variables that determine the counseling outcome for trauma victims (Glennon et al., 2019). These researchers suggest that self-care is not just encouraged for the wellbeing of mental health workers but required for the healing of their clients as well.

Summary, Conclusion, and Transition

Researchers have described STS as the behaviors and emotions that naturally result from knowing about a traumatizing event experienced by another and caring for or wanting to help the suffering individual (Andahazy, 2019; Figley, 1995). The symptoms of STS are like those of PTSD, including intrusive thoughts, avoidance, and arousal. The main difference between STS and PTSD is that STS is a less severe condition and has a faster recovery rate (Caringi et al., 2017; Figley, 1995). Researchers also observed that professionals and helpers could develop other STS symptoms that do not fall within the PTSD cluster of symptoms (Diehm et al., 2019; Sprang et al., 2019).

Some researchers used other terms such as vicarious trauma (Caringi et al., 2017; Cieslak et al., 2014), compassion fatigue (Ribono, 2019), and burnout (Simancas-Pallares et al., 2017) to describe similar conditions like STS. However, the heavy reliance of STS on the model and concepts of PTSD differentiates STS as it appears more organized and more accessible to conceptualize compared to the other available models (Kanno & Giddings, 2017). Also, Mordeno et al. (2017) noted that, because of its broader scope, STS is most suitable for exploring and documenting the risks associated with trauma work among a wide range of both professional and nonprofessional mental health workers. I will, therefore, consider the potential adverse effects of working with trauma among Catholic priests under the construct of STS.

The reviewed studies on the prevalence of STS consistently reported a high rate of STS among human service workers who engage in caring for traumatized and suffering populations (Baciu & Virga, 2018; Benuto et al., 2018; Kim, 2017; Ratrout & Hamdan-Mansour, 2020). Researchers are more in agreement than disagreement regarding the factors that contribute to the development of STS. Some of the common factors identified in recent studies are empathic engagement (Mottaghi et al., 2020), level of exposure to secondary traumatic stressors (Diehm et al., 2019), personal trauma history (Cosden et al., 2016), age of the professional (Sacco et al., 2015), years of experience (Benuto et al., 2018), and organizational culture and climate (Begic et al., 2019).

Few studies have discussed secondary traumatization among the clergy (Hendron et al., 2012; Holaday et al., 2001). The more recent studies have been mostly quantitative,

measuring the predictors of clergy burnout, compassion fatigue, and resilience (Hotchkiss & Lesher, 2018; Noullet et al., 2018; Snelgar et al., 2017). A notable limitation cutting across these studies is the lack of personal interviews. Responses to surveys could have been impacted by the desire of the clergy to present their vocation in the best light possible as a calling from God (Kim, 2017; Patton, 2015). In the current study, the use of an in-depth interview to explore how Catholic priests perceive their exposure to STS helped provide a fuller understanding of the phenomenon.

Also reviewed were articles on self-care. Researchers have found that engaging self-care strategies consciously directed at the overall physical, emotional, social, and spiritual wellbeing is valuable to mental health workers' sustainability and effectiveness in providing care to their clients, especially those who have experienced trauma (Dorociak et al., 2017; Hotchkiss & Lesher, 2018). Among the strategies identified as necessary for preventing or managing the experience of STS are seeking private therapy, practicing mindfulness, making time for personal relationships, striving for personal and professional balance, getting enough sleep, healthy eating, and participating in non-work-related activities (Dorociak et al., 2017; Lewis & King, 2019; Santana & Fouad, 2017). In addition to these strategies, Tan and Castillo (2014) emphasized incorporating the traditional spiritual disciplines of prayer and meditation, silence and solitude, fasting and simplicity, and fellowship and service into clergy self-care practices, and Noullet et al. (2018) emphasized the importance of pastoral crisis intervention training to prevent the experience of secondary trauma among they clergy. Finally, Ludick and Figley's (2017)

CFRM appears to be an encouraging educational tool for ensuring self-care and overall wellbeing for trauma workers.

Given that research on STS has not focused on the Catholic priests who also encounter trauma in pastoral work, the current qualitative study explored whether Catholic priests experienced STS and, if they did, how they engaged self-care strategies to prevent or manage the experience. In the next chapter, I will provide a detailed description of the methodology of this study, including the research design, sample, instrumentation, and data analysis plan.

Chapter 3: Research Method

The purpose of this qualitative study was to explore the lived experience of STS among Catholic priests. The study involved collecting holistic, in-depth information about whether Catholic priests experienced STS and, if they did, what their experiences were; and what self-care strategies they employed to either prevent or cope with STS. Although some studies have suggested that the clergy could be at the risk of developing STS because of their secondary exposure to trauma within pastoral work (Hendron et al., 2012; Hotchkiss & Lesher, 2018), there is little explicit discussion of STS related to the clergy in the literature. More so, I found no study that specifically focused on STS among Catholic priests who may be more at the risk of developing STS than their counterparts in other churches. Apart from sharing in the general vulnerability of the clergy, the requirement of priestly celibacy often leaves Catholic priests with little to no immediate social and emotional support network of family, a helpful resource that researchers have extolled as wielding a resilience-building power against STS (Ludick & Figley, 2017). Additionally, because of their sacred vow to keep the confessional seal unbroken in whatever circumstance (see Daly, 2013), Catholic priests may not share confessional information, even when the content of such information may be harmful to their mental well-being.

The current qualitative study, therefore, provided an opportunity for Catholic priests to describe, in their own words, their perceptions of STS and the use of self-care within pastoral work and, thereby, contributed to providing a fuller empirical understanding of the phenomenon of STS among priests. In this chapter, I describe the

components of the methodological plan for the study, which include the following: (a) the research design and rationale, (b) the role of the researcher, (c) the methodology, (d) issues of trustworthiness, and (e) ethical procedures.

Research Design and Rationale

The research questions that guided this study were as follows:

RQ1: What are the lived experiences of STS among Catholic priests?

RQ2: How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?

These questions were consistent with a qualitative research design because they were exploratory and aimed to elicit answers toward understanding the lived experiences of STS among Catholic priests. Merriam and Tisdell (2016) defined qualitative research as a scientific inquiry that focuses on understanding how individuals interpret their experiences, put the experiences into words, and the meaning they give to their experiences. Similarly, Creswell and Creswell (2018) considered qualitative research as a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem that involves a process in which the researcher typically collects data in the participant's setting, inductively build from particulars to general themes, and interpret the meaning of the data. Thus, a qualitative research design was consistent with the purpose of this study, which was to explore and understand how Catholic priests perceived, interpreted, and described the phenomenon of STS and their use of self-care in response to secondary traumatic exposure.

Additionally, in this qualitative study, I followed the phenomenological design. Patton (2020) noted that, because qualitative research is an umbrella term that encompasses various approaches to inquiry, choosing a specific approach with distinct philosophical underpinnings, purpose, technique, method, and presentation of findings allows for a more rigorous inquiry. The qualitative research approach that aligned most closely with the current study's stated purpose was phenomenology, which seeks to understand human experience (see Ellis, 2016). According to Patton (2020), the primary purpose of phenomenological research is to seek reality from individuals' narratives of their experiences, perceptions, and feelings and produce in-depth descriptions of the phenomenon. In other words, phenomenology, as a qualitative research design, aims at gathering the essence of a people's lived experience of the phenomenon under investigation while ascertaining and defining the same (Cilesiz, 2010). Phenomenology was, therefore, an appropriate choice of approach for this qualitative study that sought to provide more understanding of the problem of STS from the lived experiences, perceptions, and narratives of Catholic priests.

Furthermore, this qualitative, phenomenological study was transcendental. Transcendental phenomenology developed from the philosophical writings of Husserl (1858—1938) as a descriptive research approach for exploring and describing human experience (Christensen et al., 2017). Moustakas (1994) described the transcendental phenomenological approach as requiring the researcher to transcend everyday life's perspective, or what Husserl terms the natural attitude, and engage in the phenomenological attitude (i.e., the setting aside of any prior knowledge of the

phenomenon being studied). As Moustakas explained, this transition takes phenomenological researchers from the realm of everyday experience to a state where they perceive the phenomenon of interest anew, as if for the first time. Husserl referred to this process in various ways: bracketing of presuppositions; putting judgments into abeyance; suspension of judgments; and *epoché,* a Greek term meaning "abstention" (Patton, 2020). In other words, the researcher abstains from judgment, bias, and presuppositions such that nothing is determined in advance. Husserl believed that *epoché* or abstaining from prior knowledge would ensure that the researcher does not influence the participants' reality, thus retaining the rigor expected in scientific research (Patton, 2020). For transcendental phenomenologists, understanding the essence of a phenomenon can occur by thoroughly describing it in detail, with no need for interpretation (Creswell & Poth, 2018).

My choice of transcendental phenomenology as the approach for this study was to enable me to keep the participants' voice while analyzing their thoughts, impressions, feelings, interpretations, and understandings of STS. Unlike interpretive phenomenology, which favors the researcher's objective interpretation of participants' behaviors and narratives (Smith et al., 2013), the interest of transcendental phenomenology is in the participants' subjective meanings of the phenomenon (Patton, 2020). Being a priest myself, with experiences that might be similar to those of the would-be participants, my interest in this study was not to bring in interpretations that were not derived directly from the participants but to describe their subjective perspectives. Moreover, Morrow et al. (2015) noted that, because transcendental phenomenology is essentially descriptive,

the approach could be valuable for exploring topics where little research exists, as was the case with STS among the clergy.

However, some researchers have argued that it was impossible to avoid interpretation completely, and that description also involved interpretation (Davidsen, 2013; Rennie, 2012). According to Smith et al. (2013), while the transcendental phenomenological approach requires the researcher to allow the interview to be about the participants and their own experiences, some interpretations may come into play afterward as the researcher describes the phenomenon from the narratives of the participants. Even so, the process of bracketing throughout the research process can encourage self-reflection and increase the researcher's self-awareness. Such increased self-awareness can, in turn, prevent or moderate the application of presuppositions and biases to the research process. In this study, the process of bracketing was plausible and appropriate because the goal was for the participants' narratives of experiences to provide the meaning of the phenomenon of STS. As the researcher, my role was to create the textural and structural narratives without including my subjectivity. I provide more detail on this phenomenological approach and its data analysis steps in the Data Analysis section of this Chapter.

Role of the Researcher

In qualitative studies, the researcher's most significant role is in the collection and analysis of data (Walker et al., 2013). According to Patton (2015), the first role of the researcher is to make the participants aware of their status and role. Therefore, I was responsible for contacting potential participants in this study and informing them how

they fit into the research purpose and questions. In addition to developing the interview questions, I was also responsible for planning and conducting the individual semistructured interviews and writing the observation notes and reflective memos throughout the research process. I was responsible for transcribing the interviews and ensuring the safety of participants' information as well. In phenomenological research, Moustakas (1994) considered participants as coresearchers because the essence of the phenomenon of interest comes from participants' perceptions and experiences, regardless of the researcher's interpretation. So, my role as the primary researcher was not to judge but to observe, record, and learn from the participants. I maintained an attitude of openness to the behavior of each participant and respect their dignity. More so, my relationship with the participants was a relationship between equals without power differentials that could influence the participants' freedom to participate or decline participation in the study.

As a Catholic priest and the researcher in this study, I articulated the following personal presuppositions and views about STS to account for trustworthiness and credibility throughout the study: (a) exposure to STS can occur within pastoral work; (b) priests are mostly unaware of STS and the risks of developing it; (c) developing self-care strategies, including sustainable social support, might help to prevent priests from experiencing STS or reduce its impact; and (d) organizing training in mental health for priests might increase their awareness about psychological well-being and the personal and clerical or ecclesial factors that could negatively impact it. Through the process of bracketing (Moustakas, 1994), I kept these preconceptions aside to ensure faithfulness to

the data throughout the study. In addition to using audit trails, reflexive journaling, and member checking to enhance the credibility of the study, I employed the help of a peer reviewer to validate the findings because of my involvement in pastoral ministry.

Methodology

Participant Selection Logic

The participants in this study were Catholic priests working within the United states. All the participants were diocesan priests actively involved in parish ministry. In addition to their parish work, two participants served in hospitals and one was a university professor. Upon getting the approval of this study by the Walden University Institutional Review Board (IRB), I used a purposeful sampling method to recruit the participants. Patton (2015) described purposeful sampling as a technique that researchers employ to identify and select information-rich cases for qualitative studies. Thus, by consulting public documents, such as a Diocesan Directory, annually published by Catholic Dioceses with information about church organizations, parishes, and priests, I personally identified and sent an email to contact and invite Catholic priests to participate in the study. After contacting the priests, I conducted informal preinterviews to select the study participants. The informal preinterview was brief with questions assessing whether the potential participants had experienced STS and were willing and open to share their experiences in this study (see Merriam & Tisdell, 2016). Information from the informal preinterviews was not part of the main study. The following is a sample question for the informal preinterviews with potential participants:

> My study focuses on learning about priests' experience of working with victims of trauma, as this might increase awareness regarding the challenges involved and prepare other pastoral agents for such challenges. Have you had such experiences and are you willing to share your experience with me for research purposes?

Regarding the number of participants in phenomenological research, suggestions vary in the literature. Creswell (2013) suggested a sample size of five to 25, and Morse (2000) suggested at least six participants. Although the authors suggested these numbers as guidance, they did not present empirical arguments as to why these numbers are sufficient. However, according to Burmeister and Aitken (2012), data saturation is not dependent on the number of participants but on the depth of the data collected. In other words, data saturation is reached when there is enough information to replicate the study (O'Reilly & Parker, 2012; Walker, 2012), when the ability to obtain additional new information has been attained (Guest et al., 2006), and when further coding is no longer feasible (Guest et al., 2006). Thus, what counts is the quality of data and not the quantity (Patton, 2020). For the current study, I recruited 10 participants with the assumption that this number of priests would provide exhaustive information to address the research questions. At the end of the interviews, the 10 participants in this study did provide information that suggested data saturation as I had assumed. So, more participants were not recruited. Interviews with the 10 Catholic priests yielded thick, rich data that provided a clear understanding and description of the phenomenon of STS in the population.

Instrumentation: Semistructured, Open-Ended Interview

The data collection method for this study was interviewing. The choice of interviewing for data collection aligned with the phenomenological approach to the study. Creswell (2013) and Patton (2020) considered in-depth interviews with participants as the primary form of phenomenological data collection because it is an exploratory tool that requires only a few restrictions on the respondents' answers and allows for more in-depth information gathering. For Merriam and Tisdell (2016), a phenomenological interview aims to describe or explain the meaning of a phenomenon that different people share. Accordingly, the nature of the present study required that Catholic priests freely describe their experiences and perceptions of STS and their use of self-care in response to secondary traumatic exposure. Thus, I used the semistructured interviewing method, which allows respondents to answer topic-based open-ended questions in their own words, to collect in-depth and contextual data from each participant (see Merriam & Tisdell, 2016).

I proposed two types of interviews for this study: in-person or face-to-face interviews and synchronous online video interviews on Zoom, Skype, or WhatsApp. The in-person interview was the preferred type for this study because of its advantages over telephone interviews. First, the presence of the interviewer in a face-to-face interview allows for more effective use of probes or follow-up questions to motivate respondents to give more accurate information (Monette et al., 2014). Second, during face-to-face interviews, the interviewer can collect observational information from the attitude and nonverbal reactions of the respondents, which can help to evaluate the responses better,

especially when the questions are personal or controversial (Patton, 2015). However, because of the current public health challenge from coronavirus and the chance that some participants would be unwilling to have a face-to-face interview, I proposed the synchronous online video interviewing on Zoom, Skype, or WhatsApp, depending on what would be available to the participants. Though less preferred for this study, the online video interview also has some advantages, including speed and being less expensive. Moreover, the video component of the online interview option could provide visual contact and a chance to supplement the participants' responses with observational information (Monette et al., 2014). In either case, however, I planned to use a digital voice recorder, with the permission of the participants, to capture the interview contents and transcribe them into text as raw data for analysis.

In addition to the contents of the interview, McNiff (2017) suggested that qualitative researchers could generate documentary data through logs, diaries, and journals to aid data analysis. Thus, I generated research memos and reflexive journals, maintained an audit trail, and took notes throughout the research process as additional sources of information for data analysis. The journaling included all the phases of the planning, implementation, and organization of the research project, the issues that arose during the interviews, and my personal reflection on the entire research process.

In the drafting of interview questions, Rubin and Rubin (2012) suggested three strategies for determining the questions to ask. The first strategy is to allow interview questions to flow from the main research questions. The second is to reason out what to ask based on the general knowledge of the researcher. The third strategy is to consult

previous studies and allow the literature to suggest interview questions. Additionally, Doody and Noonan (2013) recommended that the study's theoretical framework should influence the drafting of interview questions. The two theories of emotional contagion (Hatfield et al., 1994) and CFRM (Ludick & Figley, 2017) form the conceptual framework for this study. While emotional contagion implies the affective process in which an individual who cares for traumatized and suffering persons feels emotional responses that are similar to those of the suffering person's actual or anticipated emotions, the CFRM proposes strategies for self-care and building resilience against STS. Following the suggested strategies by Rubin and Rubin and Doody and Noonan, I drafted the interview questions (see Appendix A) to guide the interview with the study participants.

Information from the participants in response to the interview questions constituted the raw data for analysis. I used Rev transcription to transcribe the interviews and signed a non-disclosure agreement to ensure that interview data remain confidential. I downloaded the interview transcript and deleted the file from Rev's servers permanently. The transcription was verbatim, resulting in a word-for-word reproduction of the verbal data. Verbatim transcription can offer insights into the respondents' life and meaning making and present potential themes and patterns because it provides an accurate account of the interview exactly as the spoken words and gives the transcript a realistic dialogue feel (Powick & Tilley, 2002).

Data Analysis

The data analysis followed Moustakas' (1994) transcendental phenomenological data analytic procedures, which generally include preparing data for the analyses, reducing the data phenomenologically, engaging in imaginative variation, and uncovering the essence of the experience. As earlier explained, bracketing my subjectivity, that is, assuming the phenomenological attitude and clarifying my preconceptions and setting my biases aside was necessary to prevent them from influencing the analysis (Patton, 2015). After assuming the phenomenological attitude, I began with the analysis of data. The following were the eight steps in the data analytic procedures, as Cilesiz (2010) outlined them:

1. Horizontalizing. This step requires the researcher to remain in the phenomenological attitude that sets aside all commonsense presuppositions and read through the participants' verbatim descriptions of the phenomenon, ascribing equal value to every statement. This step also involves listing statements and expressions that provide relevant information about the phenomenon of study and deleting statements that are irrelevant, repetitive, or fall outside the scope of the study (Cilesiz, 2010). According to Moustakas (1994), what remains, after this data cleaning, are the horizons, that is, the textural meanings of the phenomenon.
2. Reducing the experiences to the invariant constituents. This step is the clustering or grouping of the document into meaning units or themes so that each group has only one meaning (Cilesiz, 2010).

3. Thematic grouping. In this step, the researcher clusters and thematizes the core themes of the respondents' experiences, which are invariant constituents of the data (Cilesiz, 2010).
4. Validating the invariant constituents. This step requires the researcher to validate the themes from the interview document by comparing them to field notes (Cilesiz, 2010).
5. Creating individual textural description. This step involves constructing a narrative that describes how each participant perceived the phenomenon under study using the participants' words from the interview (Cilesiz, 2010). This fifth step is the last in the data cleaning or phenomenological reduction process, that is, the reduction of the data of experiences to the textual language by deleting vague, overlapping, and repetitive expressions (Yuksel & Yildirim, 2015).
6. Individual structural description. This step involves using the researcher's imagination to create structures from my understanding of how the phenomenon occurred based on the textural description (Cilesiz, 2010). This step is the first part of the researcher's imaginative variation.
7. Composite structural descriptions. This step is the second part of the imaginative variation and involves the process of adding the appropriate structures for each of the textural descriptions to aid the researcher's understanding of the participants' experience of the phenomenon (Cilesiz, 2010).

8. Synthesizing the texture descriptions and the structure descriptions into one expression regarding the phenomenon. This step involves listing meaning units for each respondent and then creating meaning units that are common to the experience of all the participants and a composite description based on the participants' shared meanings of the phenomenon (Cilesiz, 2010). After creating a composite description of the participants' shared meanings and, thus, the essence of their STS experience, the researcher then reports the composite narratives representing the whole group of participants from a third-person perspective (Cilesiz, 2010; Yuksel & Yildirim, 2015).

To aid the process of data analysis above, I used the MAXQDA 2020 software. MAXQDA is a tool for organizing and coding information. It allows the researcher to store all of the collected data and the codes in one place and code multiple transcripts (Schonfelder, 2011). The MAXQDA software helped in the analytic process, which could be, otherwise, tedious with handcoding, including copying, highlighting, cutting and pasting transcripts, field notes and journals, making multiple copies, sorting and resorting information (Creswell & Creswell, 2018). The organizing capacity of the MAXQDA software permitted me to code more efficiently and in more detail.

Issues of Trustworthiness

A critical question regarding the validity of qualitative research is establishing how inductive researchers can apply the systematic conceptual and analytical discipline that leads to credible interpretations of data while simultaneously convincing readers that the conclusions are plausible, unbiased, defensible, and trustworthy (Bryman, 2016). In

answer to the question of validity in qualitative studies, Shufutinsky and Long (2017) suggested that the researcher must provide evidence that there has been some rigor in the effective use of self as a research instrument and the developed structural method. This research provided some evidence of trustworthiness based on the following criteria: credibility, transferability, dependability, and confirmability.

Credibility

According to Polit and Beck (2014), the credibility criterion is the most important because it refers to the degree of confidence readers can have in the truth of a study's reported findings. To enhance credibility in qualitative studies, Connelly (2016) suggested that the researcher provides evidence of following the standard procedures that are consistent with the specified research approach, and the descriptions of particular human experiences must be true to those same experiences. In the current study, I employed member checking to determine the accuracy of the findings by taking the final descriptions or themes back to the participants to determine whether their descriptions were accurately reproduced. I also used the triangulation technique by examining evidence from different data sources, such as the interviews, reflexive journaling, field notes, and memos to build a coherent justification for the emergent themes. I established the themes based on converging these sources of data and the different perspectives of the participants.

Transferability

This criterion refers to the extent that the findings are useful or applicable to persons or groups of persons in settings different from the research (Creswell & Creswell,

2018). To achieve transferability, I used a rich, thick description to convey the findings of this research. While the participants' stories in this study may not be everyone else's story, providing a detailed description may transport readers to the setting of the study and give the discussion an element of shared experiences. With detailed descriptions of the study setting, the results could become more realistic and richer and enhance transferability.

Dependability

This criterion relates to the extent to which the findings of a qualitative study are stable over time and in similar conditions (Creswell & Creswell, 2018). The challenge for the qualitative researcher is to ensure consistency among the components of the study such that the findings will be similar when conducted by another researcher under similar conditions (Cope, 2014). To enhance dependability in the current study, I proposed the use of reflexive journaling and audit trails to document all the phases of the planning, implementation, and organization of the research project, the issues that could arise during the interviews, and my personal reflection on the entire research process. The documented processes and descriptions could help another researcher to replicate the study with similar participants and in similar situations (Creswell & Creswell, 2018).

Confirmability

Confirmability refers to the extent to which the study is objective (Monette et al., 2014). The nature of the current phenomenological study envisages the bracketing of my subjectivity, that is, clarifying my preconceptions throughout the study. Thus, throughout the data collection and analysis processes, the epoche protocol helped enhance

confirmability because I was conscious of and set aside my personal biases and assumptions about STS that could influence the study. This self-reflection enhanced the creation of an open and honest narrative that could resonate well with the readers. Additionally, employing the member-checking technique mentioned earlier helped ensure that the major findings and themes had resonance with the experience of the respondents (Monette et al., 2014). Also, because of my involvement in priestly ministry, I relied on a peer reviewer to provide additional oversight of the manuscripts toward ensuring the study's objectivity (Dirette, 2020).

Ethical Procedures

After selecting the participants for the study through the informal preinterviews earlier explained, and upon getting the approval of the IRB to conduct this research, I reached reach the participants individually via phone call and emails to determine the type of interviewing they preferred and planned the time for the interview sessions based on each participant's convenience. I also addressed the potential ethical issue of confidentiality that could arise in this study. According to Sanjari et al. (2014), participants in research have a reasonable expectation that their privacy will be guaranteed. Therefore, I assured the participants that all identifying information would be removed from the record, and verbatim quotes from interviews would be presented cautiously to ensure that such quotes do not reveal their identity. Also, no subject's data were revealed to another subject. I kept all collected data securely locked in a satchel and stored in private security safe and store all electronic files in a password-protected computer accessible only to me. Thus, I treated the data confidentially. I debriefed the

participants by asking whether the questions were understandable and comfortable to answer and secured their approval to get back to them if further questions arise.

Another ethical step was providing the participants with the IRB informed consent form to fulfill the ethical requirement for the project before data collection. Informed consent describes the elements of the research that might influence a person's decision to participate in the study (Groves et al., 2009). As I invited Catholic priests to participate in this study, I provided them with details of the purpose, nature, and potential implications of the study. I also emphasized their freedom to decline participation at any stage in the study. While I sought the most honest and detailed descriptions from the participants, I did not take any measures to manipulate them into unwillingly providing any information. For participating in this study, respondents received a verbal appreciation only. The informed consent agreements helped secure the understanding of the participants' relationship with me as the researcher.

I sought some benefits from conducting this study, including academic and personal benefits. Primarily, I conducted this study in partial fulfillment of the requirements for my doctoral degree in psychology. Also, I felt a personal desire to learn more about STS from the participants' perspective. In my 14 years of experience in the Catholic priesthood, I have encountered people with varying degrees of trauma and suffering, and such encounters influenced my assumptions in this study. However, because priests generally lack adequate skills for dealing with mental health issues, I was curious to know the experiences of other priests regarding trauma work and how they employed self-care strategies against the adverse effects of encountering trauma and

suffering. I believe the transcendental phenomenological approach enabled more understanding of STS from the participants' description.

Summary

The purpose of this study was to explore the lived experience of STS among Catholic priests. A qualitative phenomenological design was appropriate for this study because it was exploratory and involved the use of interviews to access the participants' experiences and perceptions (Patton, 2015). The use of an in-depth interview to explore how Catholic priests perceive their exposure to STS provided a fuller understanding of the phenomenon. Also, the transcendental approach helped keep the voice of the participants and their subjective meanings of the phenomenon while analyzing their thoughts, impressions, feelings, interpretations, and understandings of STS (Cilesiz, 2010). This approach aligned with my intention to describe the participants' subjective perspectives and avoid bringing in interpretations that were not derived directly from them.

The next chapter is the result section of the study. The chapter includes a detailed description of the study's setting, the characteristics of the participants, and the procedures for data collection and data analysis. The chapter also includes evidence of trustworthiness and the presentation of the results. I developed the emerging themes into groups using phenomenological reduction and composite structural descriptions and synthesis to represent all or most of the participants.

Chapter 4: Results

The purpose of this qualitative, transcendental phenomenological study was to explore the lived experiences of STS among Catholic priests and how they described their use of self-care strategies to either prevent or cope with STS. The following two research questions guided this study:

RQ1: What are the lived experiences of STS among Catholic priests?

RQ2: How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?

I created these questions after a thorough review of the existing literature from which I identified knowledge gaps related to the impact of trauma work upon those engaged in pastoral caregiving. A knowledge gap held particularly true for research on STS among Catholic priests. To address this literature gap in the literature, I conducted this study to collect information from 10 Catholic priests as they described their lived experiences of working with trauma. I developed interview questions and employed the semistructured interview method to elicit holistic, in-depth information from the participants.

By sharing their lived experiences regarding trauma work, the participants allowed me to gain valuable insight into their STS experience due to pastoral work with traumatized and distressed individuals and families as well as the impact of such exposure upon their well-being. Themes emerged from the analysis of data describing the participants' subjective experiences. In this chapter, I present the findings of the study. The subsections of this chapter include a description of the study setting, the participants'

demographics, the data collection procedures, the data analysis process, the evidence of trustworthiness, the study results, and a summary of the chapter.

Setting

The Walden University IRB emailed me granting approval to proceed with my data collection on December 9, 2020. The official IRB Approval Number, 12-14-20-1004433, came 3 days after. Upon receiving this approval, I used a purposeful sampling method to recruit participants for the study. I consulted the Catholic Directory, a public document, and identified 20 Catholic priests as potential participants. I sent each of these priests an invitation letter to participate in the study using the email addresses I obtained from the Catholic Directory. This initial contact was made to determine whether the priests had the relevant experiences of working with trauma and were willing to share their experiences for this research.

Out of the 20 priests I initially contacted through emails, only 9 responded. Seven of the priests noted that they had some trauma work experiences and were willing to share their experiences for the study. The other 2 priests who responded to the email declined participation in the study for undisclosed reasons. I did not receive any response from 11 of the priests I contacted via email. However, because the IRB had approved my proposal to recruit participants by publicly accessible methods, I reached out to other potential participants directly through phone calls. I obtained the phone numbers from friends and my fellow priests. After making a few calls, I succeeded in recruiting 3 additional priests for the study, which brought the total number of willing participants to 10 and met the number of participants I proposed in Chapter 3. Throughout this

recruitment process, I ensured that each participant knew they were free to accept or decline participation in the research. I sent the informed consent form to all 10 willing priests via email, and each of the 10 priests provided their consent in their reply to the invitation. All 10 priests provided the data for this study and validated the findings through the member checking technique.

Demographics

The participants in this study were Catholic priests. All the participants were actively engaged in pastoral work and had trauma work experience, as reflected in their descriptions of their encounters with victims of trauma. I recruited the priests from across dioceses to enhance the study's reliability. The participants' years of experience in the priesthood ranged from 1 to 19; they had various levels of education and engaged in different aspects of pastoral work. Table 1 shows the demographics of the participants. I used numbers to represent the participants to protect their identity. Each participant's number followed the chronological order of their interviews.

Table 1

Demographics of Participants

P#	Years in Priesthood	Bachelor's Degree	Master's Degree	Other	Current Assignment
P001	12	Philosophy *Theology			Parish administrator/ Hospital ministry.
P002	7	Civil Engineering. *Theology	Peace Studies.		Associate Pastor and youth chaplain.
P003	13	Philosophy *Theology		CPE	Hospital chaplain and parish ministry.
P004	5	Philosophy *Theology			Parish pastor
P005	19	Philosophy	Theology		Parish pastor

		*Theology			
P006	14	Philosophy *Theology	Theology	Ph.D.	Associate pastor and university professor
P007	9	Christian Education	Liturgy		Parish pastor
P008	4	Anthropology	Divinity		Associate pastor
P009	2	Sociology *Theology			Associate pastor
P010	1	Philosophy *Theology			Associate pastor

Note. P# = Participant Number. * = Second bachelor's degree. CPE = Clinical pastoral education.

Data Collection

Semistructured Interview

Ten Catholic priests provided the data for this study. After recruiting the participants and obtaining their consent, the data collection process began. Following my proposal in Chapter 3, I made available to the participants the options of a face-to-face interview or online video communication platforms, such as Zoom, Skype, or WhatsApp. All the participants opted for the synchronous video interviews on Zoom because of the health risks that the COVID-19 pandemic could pose to having a face-to-face interview. According to each participant's preferred date and time, I scheduled, conducted, and audio-recorded all 10 interviews on Zoom. All the participants appeared to be comfortable using the Zoom software.

I followed the interview protocol (Appendix A) and managed the conversation using probes to encourage the respondents to either continue with their answers or confirm, elaborate, or clarify their responses. I listened to each participant attentively and without interruption as they responded to the questions. The participants showed no sign of distress; instead, they freely and openly responded to the open-ended questions and

probes regarding their trauma work experience, the physical and emotional impacts of the traumatic exposure, their engagement in self-care activities, the support systems and resources available to them, and their suggestions for preventing or managing STS. Throughout the interviewing process, I kept a reflexive journal and assumed the phenomenological attitude by setting aside my personal experience and preconceptions about the STS. Being a transcendental phenomenological study, the bracketing protocol required setting aside my preconceptions to be receptive to the participants' new meanings of STS and prevent my own biases from influencing the data collection and analysis (see Patton, 2015).

Each interview took between 45 to 70 minutes. The participants were courteous and appeared to be honest in their responses. Each participant responded from a quiet and conducive virtual environment, which prevented distractions and enhanced the audio-recording quality. Six participants joined Zoon for the interviews from their parish offices and 4 from their homes. I completed the 10 interviews within a relatively short time, from December 15, 2020, to December 24, 2020, because the participants, being priests, preferred to have the interviews before they got busier with their pastoral engagements at Christmas. There were no unusual circumstances throughout the process of data collection.

The interview transcripts and my interview notes and memos suggested data saturation. There were some similarities in the participants' experiences and the categories that arose from their descriptions. More so, the last two participants I interviewed provided information that was not radically new or different from the rich,

thick descriptions of the participants I interviewed earlier in the process. Thus, because the data collected indicated enough information to replicate the study (see Guest et al., 2006; O'Reilly & Parker, 2012), I did not recruit more participants for the study. At the end of each interview, I provided the participant with time for debriefing. I used the Rev transcription service to transcribe the interviews, and the transcriber signed a non-disclosure agreement (Appendix B) to ensure that the interview data remained confidential. The transcription was verbatim, and the thick, rich descriptions of the participants' experiences provided the raw data for analysis.

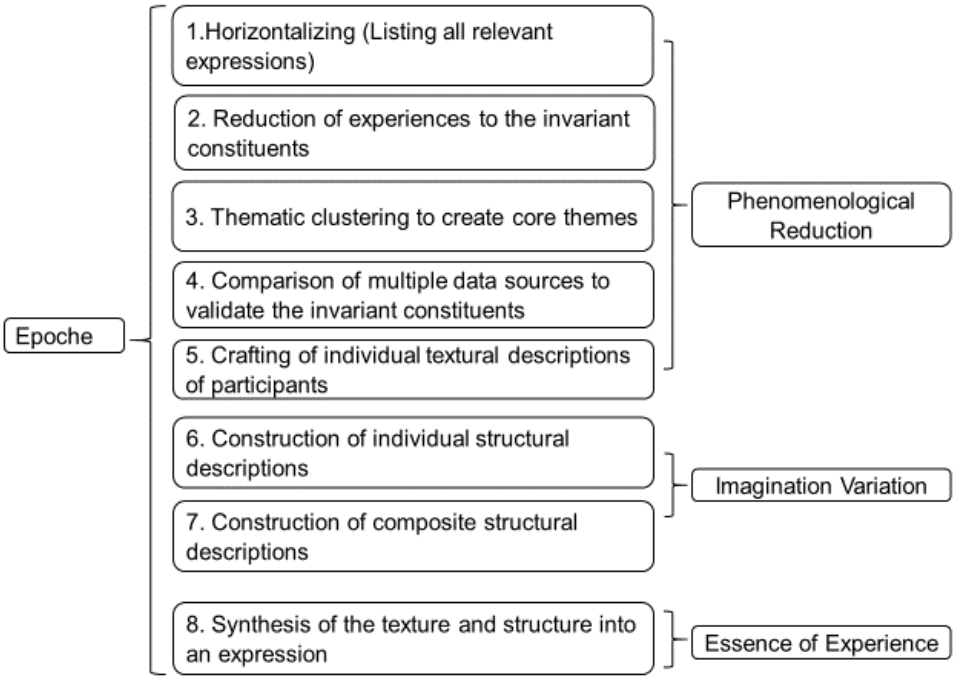
For member checking, I sent a copy of the typed interview transcript to each participant via email. Creswell and Creswell (2018) described member checking as a technique used by researchers to ensure the truth value of the data collected. In other words, with the participants serving as checks throughout the analysis process, the member-checking technique improves the accuracy, credibility, and transferability of the study. In this study, each participant received their interview transcript divided into portions of their descriptions under themes that emerged from my understanding of their reality and meanings of STS. Three participants requested minor edits to their transcripts. I made the edits as requested and confirmed the edits with the participants. However, each participant approved the final themes that arose from their descriptions. Thus, the member checking process helped improve this study's descriptive validity. I stored all the data collected for this study in a password-protected computer, and I removed all identifying information to protect the participants' privacy and ensure the confidentiality of the data, as I outlined in Chapter 3.

Data Analysis

The data analysis followed Moustakas' (1994) transcendental phenomenological data analysis procedures. The analysis process involved the bracketing (epoche) protocol and the different stages of reducing the data phenomenologically, engaging in imaginative variation, and uncovering the essence of the participants' experience. Figure 1 illustrates the eight steps I followed in analyzing the data.

Figure 1

Transcendental Phenomenological Data Analysis Procedures



Note. Created using information obtained from "A Phenomenological Approach to Experiences with Technology: Current State, Promise, and Future Directions for Research," by S. Cilesiz, 2010, *Educational Technology Research and Development, 59*(4), pp. 499–500 (https://doi.org/10.1007/s11423-010-9173-2).

Epoche (Bracketing)

Throughout this study and especially during the data analysis, the epoche protocol enhanced my self-awareness and self-consciousness. Being conscious of my assumptions and biases regarding the phenomenon under study, I put them aside to learn from the participants' subjective experiences. This protocol prepared me to be receptive to the new knowledge and meanings of STS that arose from the participants' descriptions (see Moustakas, 1994). I abstained from judgment and determined nothing in advance; instead, I allowed the participants' descriptions to answer the research questions. Therefore, the epoche protocol helped preserve the participants' voice as they constructed the meanings of their experiences.

Horizontalization

This first step in the phenomenological reduction stage required that I read through the participants' verbatim descriptions of the phenomenon and identify and list the participants' statements and expressions that provide relevant information about the phenomenon under study. Thus, putting aside all commonsense presuppositions and biases, I read through each participant's interview transcript, and using the MAXQDA 2020 software, I identified and coded each participant's statements that were relevant to the research questions. The following is a list of some significant statements and quotes from each participant's responses to the interview questions.

Significant Statements from P001

- "Confronting the reality of human suffering and helplessness can really be overwhelming, and I begin to get in touch with my own sense of vulnerability, finitude, you know, and things like that."
- "…listening to these persons [traumatized persons] narrate their ordeal can also be very overwhelming and very moving, especially when I discover that I am, most times, very helpless in helping these people [trauma victims] go through their pain."
- "I have had moments I felt reluctant. You know, naturally, you don't want to get involved in crisis because you know that you could get caught up emotionally with it."
- "I feel sad about what they [trauma victims] are going through, you know, sad about what has happened to a human being like yourself, and your sense of pity and compassion drags these experiences along with you. It is very difficult to disengage my mind from what I see and hear sometimes.…at what point are you able to disengage and not have your own traumatic experience, you know, after you've left the people who are the primary victims of such trauma? It is difficult and very disturbing."
- "Right now, I'm the only one, staying alone, I don't have an associate, so, I'm alone. So, I have to process all of these alone, you know. And that has its own challenges and burdens."

- "…the same priest who has just finished condoling with a family is getting the news of someone who has just given birth. So, you need to switch moods. So, there is a whole lot, and it's one man doing all these."
- "[For self-care], I seek connection, connecting with people like, you know, friends, family, relatives, other priests." "…getting away on a little weekend getaway, vacations, you know. Things like that help me."

Significant Statements from P002

- "Ministering among suffering individuals is a mixed bag…it always comes with emotional pain on the on hand, and on the other, it is fulfilling that I am living out my calling as a priest, helping to heal others spiritually and emotionally."
- "…there is also the pain I sincerely feel…especially when I can do nothing more to help."
- "Encountering the reality of human suffering breaks me sometimes as a person. It takes a toll on me."
- "Sometimes I feel reluctant, not because I don't want to be available, but because I have no immediate solution to some of the challenges."
- "The helplessness involved in human suffering is, perhaps, the most common experience for me."
- "…As they [victims of spousal abuse] leave my office, I am racked with pain, and I worry about what their next experience would be."

- "I am fulfilled when I am able to console and comfort an individual in such moments."
- "I worry because I keep remembering them."
- "Sometimes I can't sleep because of the suffering I see or because of the stories of pain that I have heard."
- "I was afraid because I couldn't tell whether I was able to convince him [suicidal person] that life is worth living."
- "My heart skips a beat when I recall the details of his [suicidal person] stories."
- "There are times when I really feel lonely, especially with such pastoral burdens on my heart."
- "[For self-care], I try to make a phone call to a close friend, a fellow priest."
- "I take long walks whenever I have a free evening. I've not been faithful to doing my physical exercises, though."

Significant Statements from P003

- "It's mostly an overwhelming experience."
- "Sometimes I come back really drained of strength."
- "I sometimes take on the moral injury from their suffering."
- "Being a human being, the impulse is to fix, the impulse is to provide solution, but when I find myself not doing that, I leave feeling defeated. I leave, sometimes taking upon myself, guilt for what I am not actually responsible for, and that builds up over time."

- "Mentally I find myself questioning God. Some experiences like that shake my faith. I find myself asking God, are you really there? Is this how you really want it to be? Is it really true that you have no power over this? Do you really enjoy it this way? Or is it the case that there is something you are doing behind the scenes that I cannot see? So, I have found myself asking many of those kinds of questions."
- "Sometimes I go, thinking I am going to minister to the patients, and their sufferings end up ministering to me."
- "I connect with my own vulnerability. That's what I have come to learn…that we are all human and weak, and at our weak moments, we need each other's support."
- "[For self-care], music is an outlet for me. Some of my best compositions come from my worst days," "…and…also learning the languages, it's an outlet for me." "Preaching on my YouTube channel, and having a good number of friends that challenge me to achieve a lot of things is a great outlet for me. And, of course, prayer."

Significant Statements from P004

- "Sincerely, …the feeling of helplessness…is always there when you cannot help or do anything humanly possible to solve the emotional pain in another person."
- "People's [trauma victims'] experiences remind me of my own experience."

- “I had suffered parental emotional and physical abuse as a child…the news of my dad’s death brought me serious guilt. I was blaming myself for not doing more than I did to receive him back into my life. So, I was really in a bad place, emotionally. It was during that time, when I needed some help, you know, that a young man approached me with his tales of experiencing similar abuse. I knew I was not in the right frame of mind to help him, ordinarily. I had to struggle to put aside whatever pain I felt to attend to him; you know, that’s our life.”
- “As I help such victims to find strength, I find some strength, too. The solutions I proffer work for me, too. That’s why I said that when I counsel victims, I counsel myself in the process.”
- “I have had such emotional pain, and I know how devastating it could be.”
- “I feel the pain of not only those I am ministering to but my own personal pain.”
- “Sometimes I am baffled by the fact that the emotional wounds I thought had healed are renewed by just listening to those who come to me.”
- “Sometimes I can't sleep. I can't sleep, not because I don't want to sleep but because I think of the painful stories I hear.”
- “This is an area of work where helplessness is a common experience. That, itself, is a source of sorrow.”
- “When I am emotionally down, it can be frustrating when you do not have a person to hear you out, especially those moments when you are alone, and you

need someone to understand you. I must admit it [living single] is also a very stressful life to live."

- "While celibacy ensures that priests are available to be sent anywhere without looking back, it also creates room for some unmet emotional needs and dangers in pastoral work."
- "[For self-care], I feel good whenever I am well dressed. I feel like I'm practicing self-love." "Sometimes, I go shopping for myself no matter how small, just to distract myself from those burdens of the heart." "Also, I have a close female friend I talk to, who is very supportive of priestly life." "And my mother, she is a strong support and confidant."

Significant Statements from P005

- "It [trauma work] is just weighing down on me."
- "…and inside, there is a lot of resistance because it [trauma work] is stressful."
- "I notice that even my words sometimes do not help the situation in these people's [trauma victims'] lives."
- "Sometimes, inside me, there is a little bit of some stress or tiredness I have listening to the same thing."
- "I have had those experiences so many times whereby I feel like I am tired of listening and listening to the same stuff all over again."
- "There is stress. I can't deny it. I can't say no. I have had so many experiences of internal resistance."

- "I do feel inadequate sometimes because I don't have the right answers to their problems."
- "Dealing with issues of this nature…they just weigh down on me mentally."
- "[For self-care], I have a wide range of social support among priests and laity. I am all inclusive. I have a number of parishioners where I can go and have dinner and talk to them, and I come back home, and I am more relaxed."

Significant Statements from P006

- "To be candid, when I face certain conditions, depending on what they may be, sometimes it agitates me, it angers me personally, and I even lose my appetite to eat."
- "I may be lying on my bed but then my body is not sleeping, and my mind is absolutely at work, functioning."
- "Sometimes, some of the things I heard…began to play in my memory because these things can affect the man of God clothed in human skin."
- "I was scared when I heard all he [a repented criminal] told me he had done. For weeks, my mind was just active. I was like, is this how people can do evil to others? Suppose this guy wanted to kill me, he would just have done that, and that would be all…if he could do that to many people. I was really scared. You know, we carry these symptoms because the experiences that we have coming in direct contact with suffering is enormous."

- "There are some situations I just wish to stay away from or simply avoid in order to save myself from the bigger dangers that come from wanting to help some [traumatized] persons."
- "Sometimes, drawing the line between the one who is in need of spiritual assistance and the one who is falling in love gets collapsed in-between."
- "… And if they had told their story in a way that is personal to you, they touch in a more unique way."
- "I would say that the experiences have been quite enriching and challenging as well."
- "These things we engage ourselves in, later on, they engage us psychologically and mentally. Bodily also, we become dull."
- "[For self-care] I try to refuel my spiritual energy through finding time for meditations, recollections, and retreats. They help me find myself when I get lost in the work and take me back to who I really am. These activities work for me and help me stay sane while working in the ministry."

Significant Statements from P007

- "For me, the experience has been overwhelming and stressful."
- "There is always a need to reach out to somebody, to support and comfort somebody who is going through a traumatic experience. I must be ready to be on call all the time. One day ends, another begins, and the stress continues, and in the midst of all of this, I get overwhelmed with the work."

- “The most overwhelming aspect of ministering to trauma victims is that in most cases you are not able to provide the solution that they need.”
- “As a human being, there are times when I feel reluctant, especially when the story of the person is already known to me.”
- “You know, deep within me, is a strong desire to be available and help people to navigate through their pains, but again, how much can I do?”
- “It is actually a tormenting experience to watch a fellow human being suffer when you helplessly watch.”
- “…but that feeling is sometimes there…when I just wish to avoid some of these encounters.”
- “Some of the stories that I hear are so traumatizing that I want to be able to solve the problem and relieve the pain of the person…the feeling of inadequacy comes from the fact that I cannot help.”
- “Some of the [trauma] stories people bring could take your whole day trying to figure out what to say or do, and I struggle with everything that needs my attention.”
- “All these make me anxious. I’m not going to lie. Because it is not just enough to be seen working, the quality of your work matters as well. So, I am, kind of under continuous pressure.”
- “Sometimes I have headaches, and I believe it has to do with my inadequate sleep. Whenever I am deprived of sleep, I have headaches, and I experience weakness and dullness.”

- "[For self-care], I have not been really committed to doing something for myself. Once in a while, I do a few minutes of physical exercise, but not in a steady manner. It's something that I just do when I feel like it, you know, and that's not good enough. I love music. I love playing the guitar. But for months now, the best I have come to music is just listening to it. I really need to work on my self-care routines."

Significant Statements from P008

- "My pastoral experience of working with people who are victims of trauma has been stressful."
- "I have experienced stress and sometimes, depressive experiences just by hearing the struggles that people go through and thinking of my own struggles."
- "The feeling of inadequacy is always there for me. Sometimes I feel like I need some training in mental health, you know, perhaps that would help me better understand and accompany people through the psychological impact of their experiences."
- "My feeling of inadequacy makes me feel downcast. It is as if I have failed to help, you know, and it weighs down on my conscience, knowing that these people's [trauma victims'] experience of the bad situation will likely continue because I cannot help. The helplessness in the face of these encounters can be depressing at times."

- “Frankly speaking, there are sometimes I really feel like avoiding these encounters because they just render me sad and depressed. There is only so much the human person can take, you know. I feel like that sometimes.”
- “I have had nightmares, physical stress and bodily weakness, sleeplessness, and overeating in the process. I know that these symptoms have to do with the stories I hear and the cases I have to handle.”
- “The emotional investment in some of the cases can be really distressing sometimes.”
- “The fact that these experiences they have could take a very long time to heal could be very frustrating. So, it is a very difficult experience for me.”
- “It is a frustrating experience when you try your best, and your best is not enough because of the enormity of the problems you are dealing with.”
- “Celibacy removes an important aspect of the support that could have been helpful. You know, everybody needs somebody. So, no matter how tired I get, I still have to personally attend to the smallest of my needs, no one close by to help. No emotional support when you are down, or someone to ask, how was your day? Or why is your face like that? You know that emotional support helps when there’s someone who cares and looks out for you and is able to read your moods when it looks like you are getting overstretched emotionally.”
- “[For self-care], for me, it is finding time to connect with nature. I feel refreshed when I can meditate and quietly observe nature and wildlife. I also

like photography, taking shots of beautiful sunsets and beautiful landscapes. These are some of the fun things I like to do, but I do not always have the time to enjoy doing them."

Significant Statements from P009

- "It is a difficult and challenging experience. Difficult and challenging in the sense that some of the experiences you hear about are beyond you, they are just what they are."
- "The question of where God is when bad things happen has remained the most difficult question to confront. Questions like this can be very disabling, and they attempt render God indefensible."
- "The difficulty comes with the fact that you appear as a priest to the people as the presence or symbol of God's love in the world, and yet the reality of that love is being called to questioned by the current harrowing experience of the people who believe God exists."
- "Somehow, the pain of the victims follows me as I leave."
- "Sometimes I remember someone I have encountered or something I have failed to do, and my heart skips the beat. Then I become anxious until I convince myself that things will be okay or that God will somehow take control and save the situation."
- "For me, there are sometimes the feeling of, 'Oh my God; so, I have to face this again.' I don't like to confront those moments when fellow human beings

are traumatized or in pain. If I have my way, I mean…unfortunately, it's not possible, but if it were, I would stay away sometimes."

- "I feel very inadequate…of course, for me, it is when I cannot get help for them [the victims]. You know that feeling of defeat, you know, when you are staring at evil right before you, and all that you can do is to be present, just be present and watch them going through the pain."
- "I once encountered a penitent who was suicidal. I felt very unprepared to help him. Now I feel guilty that I could not handle the case better than I did. Looking back now, I feel like I over-spiritualized that encounter."
- "I always struggle with migraine, I guess due to my worry and sometimes the lack of sleep."
- "[For self-care] …now, that is where the problem is. You know, we can all talk about how good self-care is, how good to do physical exercises, eat well, and so on. But doing these very things, for me, has been a problem. I have not found the motivation and time to help myself."

Significant Statements from P010

- "It [trauma work] is a very difficult experience."
- "…seeing people in such situation can sometimes be like swallowing very bitter pills."
- "I am lost, trying to understand why some of these evils happen to people."

- “Working among the people and seeing their suffering, especially such tragic events [mass shooting] can be a very difficult and stressful experience. I still remember that day with shock.”
- “I do not know how to stop thinking about these experiences. The stress is much for me.”
- “Ministering to the victims of the mass shooting left me frightened and distressed for many weeks, such that even now, I experience anxiety, sometimes, when I go into the church, I begin to imagine things.”
- “Going to listen to confessions and counseling people who are hurting has become something that causes me anxiety. I am always suspicious of my environment and everyone that comes close to me.”
- “Sometimes, I feel so overwhelmed that I feel like…I pray I don’t have to face any of these again today, you know. It’s a negative feeling to want to stay away from the people, but it is a real feeling for me sometimes.”
- “I often have anxiety, and the fear of violence to me at the confessional is very real.”
- “Sometimes, what I hear makes me drift away to remembering my inner struggles, you know, and I am not fully present to the person before me at that moment.”
- “Sometimes, I cannot sleep. I cannot concentrate, you know.”
- “[For self-care], I am trying to replace them [negative coping] now with more positive ones like doing physical exercises, even if it is for a few minutes

before going to bed at night. I kind of discover that it helps my body to relax. Whenever I have the time, I also watch movies. I have a circle of friends I call occasionally. These are things I sometimes do to distract myself."

After identifying significant statements from each participant's description of the phenomenon, I used the Word Cloud function of the MAXDQA 2020 software to search the entire interview transcripts for the words or adjectives most used by the participants to describe their experience of trauma work within the pastoral ministry. The search results indicated that most of the participants described trauma work as making great demands on their emotions, skills, time, and attention. Table 2 shows the participants' most used descriptive words, the number of participants that used each word, and the frequency of the word in the participants' descriptions of their experiences.

Table 2

Words Most Used by Participants to Describe Their Experiences in Doing Trauma Work

Descriptive words	Number of Participants	Frequency
Helpless/helplessness	10	52
Stressful/stress	10	46
Challenging	9	37
Overwhelming	7	37
Fulfilling/fulfilment	10	21
Learning curve	10	21
Difficult	8	17
Worrying/worry	10	17
Tiring/draining	5	12
Burdensome/burden	6	10
Revealing	3	10
A struggle/struggling	5	8
Enriching	2	4

Reduction of the Experiences to the Invariant Constituents

This second step in the analysis process is the grouping of the document into meaning units so that each group has only one meaning. This step also involves deleting elements that are irrelevant, do not help in the understanding of the phenomenon, or fall outside the scope of the study (Cilesiz, 2010). Thus, having done the preliminary horizontalization and identified the participants' significant statements, I indicated on the comments pane of the coding software portions of the documents that had similar meanings to create the meaning units. Next, I reviewed and deleted the elements that were not specific to the participants' experiences, such that what remained were the horizons, that is, the textural meanings of the phenomenon (Moustakas, 1994).

The participants' expressions I deleted during this second step of the phenomenological reduction stage included the following: "But how we respond to such temptation depends on our individual ability to handle the challenges and situations we face," "And many more that I might not be able to remember now, but basically, it is something that brings one to a situation where you know that you can be in danger," "You know, the midwife does not give a child to the woman who is pregnant. The pregnant woman comes with the child and then…err…the midwife helps the pregnant woman to give birth the child the woman has," "that something has not happened to me, I can take certain things for granted," "That something has not happened to me doesn't mean that I can't feel for someone who is going through certain experience or that I'm aware that something like this can happen to someone because I have seen it happen," "Why would a young man, full of life want to kill himself just because his girlfriend left

him, and then you bring your entire family to grief? Or why would someone drink himself to stupor and goes right before a train in motion?" "Sometimes, I read stories in a book or I see in the movies, I see a series of tragedy, you would think, oh, it's just something in a book, a fictional story or a movie." "Sometimes, encounters with these people makes it real. So, it gets away from fiction, imagination to reality," "I hear some dioceses are beginning to provide some basic psychological resources to help their priests' mental health." "But how we respond to such temptation depends on our individual ability to handle the challenges and situations we face." "Everyone has his own experience, different ways of reacting, you know, but the experience is real." "The world would be better, and life would be less stressful if they let go."

Thematic Grouping

In this third step of the analysis, I formed the invariant themes that emerged from the respondents' descriptions of their lived experiences regarding STS and their use of self-care. According to Cilesiz (2010), forming themes from the invariant constituents of data in phenomenological research best reflects reality when the researcher allows the themes to emerge directly from the data. I reviewed the transcript again and developed themes from the participants' responses to each interview question. The responses were mostly specific to the interview questions. Thus, I formed the themes guided by the participants' statements and phrases and the questions they answered. This process yielded 5 core themes and 13 subthemes. The core themes I formed were pastoral motivation, encountering people with trauma, caregiver stressors, understanding of self-care, and suggestions for priests' well-being. I discussed these core themes with the

subthemes in the result section of this chapter. Table 3 shows the emergent themes relative to the participants' responses to the interview questions.

Table 3

Themes Formed Relative to Participants' Responses to Interview Questions

Interview Question	Themes and Subthemes Formed
1. Tell me about your pastoral experience of ministering to persons who were traumatized.	Pastoral motivation, encountering people with trauma, feelings of inadequacy, emotional dissonance, feeling reluctant to encounter people in distress, learning curve, the impact of sexual abuse crises
2. Describe how your experience of helping traumatized people affected your subsequent pastoral disposition to similar situations.	Feeling reluctant to encounter people in distress, feelings of inadequacy, pastoral motivation, the impact of sexual abuse crises
3. In what ways did you feel inadequate to help such persons regain their emotional wellbeing?	Encountering people with trauma, feelings of inadequacy, pastoral motivation, learning curve, the impact of sexual abuse crises
4. Describe ways in which ministering to the suffering and traumatized causes you stress and anxiety and how you handle it.	Stress factors, coping with stress and anxiety, prolonged experiences related to trauma work
5. What specific physical symptoms do you experience due to your pastoral availability to the suffering members of your congregation? How do you cope with the symptoms?	Prolonged experiences related to trauma work, physical symptoms
6. As a Catholic priest, you are not married and do not have a family. How does your single status impact your experience of stress due to pastoral work?	The impact of celibacy, coping with stress and anxiety, prolonged experiences related to trauma work, the impact of sexual abuse crises
7. Tell me about any support systems that you may have in the church if you experience stress or anxiety.	Church resources for priests' mental health, coping with stress and anxiety, suggestions for priests' well-being
8. In what ways might the church prepare future priests for working with traumatized people?	Suggestions for priests' well-being, preparing future priests for trauma work
9. Describe what self-care means to you.	Understanding of self-care, self-care activities
10. Tell me about the activities you engage in that lead to self-care.	Understanding of self-care, self-care activities
11. In what ways does the church promote self-care among priests?	Understanding of self-care, self-care activities, church support for priests' self-care

12. What suggestions do you have for improving self-care practices among priests?	Suggestions for priests' wellbeing, self-care activities
13. What other relevant information would you like to share from your experience?	Suggestions for priests' wellbeing, preparing future priests for trauma work, the impact of sexual abuse crises

Validating the Themes

This fourth step required that I validate the themes from the interview document by comparing them to the other data sources (Cilesiz, 2010). From the start of the research project to the data collection, I kept a reflexive journal. I made notes and entries after each interview and documented reflections, observations, thoughts, and hunches. While being mindful of preventing my preconceptions from influencing the presentation of the participants' experiences, the content analysis of my journal entries and interview notes indicated elements that, when compared to the interview transcripts, were mostly synonymous with the themes I developed. The elements of data from my journal entries and notes that corroborated the emergent themes were elements I had noted under subheadings that included the following: priests' experience, priests' motivation, faith or spiritual questions, the stress in pastoral work, feeling helpless and inadequate, emotional burden, and the fulfillment from helping. Thus, this validation process resulted in a convergence of information from different data sources and strengthened the themes' validity.

Individual Textural Description

This fifth step in the analytic process involves constructing a narrative that describes how, from their own words, each participant perceived the phenomenon under

study (Cilesiz, 2010). Thus, using verbatim excerpts from each participant's interview, I described their experiences of working with trauma. According to Moustakas (1994), this process uncovers the "what" of the phenomenon. The following is the textural description of each participant's experience based on their responses.

Textural Description of P001

The feelings helplessness and being overwhelmed are recurring experiences for P001, "…ministering to people in crisis…has been overwhelming." "…listening to these persons [trauma victims] narrate their ordeal can be very overwhelming and very moving, especially when you discover that you are very helpless in helping these people go through whatever they are going through." Sometimes, P001 cannot find the right words to counsel his suffering parishioners, "I just didn't know what to tell him." "I have come to discover that it is not in every circumstance that one has the right words to console people." "Sometimes, they [words] can be inadequate, and some people can take it as if you are not feeling with them exactly as they feel." Also, P001 experiences sadness and grief over trauma victims' situations, "…you see yourself unconsciously grieving, unconsciously being in the moment with traumatized people, because you're sad about what has happened to a human being like yourself, and your sense of pity and compassion drags these experiences along with you." Sometimes P001 feels reluctant to get involved in trauma cases: "I have had such moments when I felt like avoiding these experiences. Naturally, you don't want to get involved in crisis because you know that you could get caught up emotionally with it."

Additionally, P001 experiences growth by learning to build resilience from the traumatic exposures: “Such experiences become opportunities to learn, to build resilience for myself.” “There might be challenges in life, but I try to see these things and learn that it is helpful to build resilience for oneself, to have good human connections to process certain situations.” Further, the adverse impact of trauma work on P001 is increased by the requirement of celibacy: “Right now, I’m the only one, staying alone, I don’t have an associate, so, I’m alone. So, I have to process all of these alone, you know. And that has its own challenges and burdens.” P001 seeks distractions from distressing thoughts about the traumatic cases, “I try to deescalate it for myself as soon as possible, you know, that’s what I try to do.” “Sometimes I try to use other things in the setting where I find myself, to like, you know, distract me from my emotional situation,” “sometimes I can get engaged in conversations with people where I get some lighter moments of laughter and jokes, you know, so, that kind of helps me.” Finally, P001 is conscious of the need for self-care and engages in some activities for self-care: “I seek connection, connecting with people, like friends, family, relatives, other priests.” Sometimes, getting away on a little weekend getaway [and] vacations. Things like that help me.” “Sometimes I sit down to watch movies, listen to music, you know. These are ways that I deescalate the day’s stress.”

Textural Description of P002

P002 finds fulfillment in trauma work, “I am fulfilled when I am able to console and comfort an individual at such moments,” but also feels helpless in the face of human suffering: “…but there is also the pain I sincerely feel when I realize that some cases are

just what they are, our helplessness as mortals often comes to play… especially when I can do nothing more to help." "…encountering the reality of human suffering breaks me sometimes as a person. It takes a toll on me." P002 experiences emotional dissonance in trauma work, "I have to always project strength and not weakness, even if I am emotionally weak, so that those who look up to me can also find strength and not weakness." P002 sees trauma work as part of the priestly calling, "I am living out my calling as a priest helping to heal others spiritually and emotionally."

However, P002 hesitates to get involved in crisis sometimes: "Sometimes I feel reluctant, not because I don't want to be available, but because I have no immediate solution to some of the challenges." "…because I cannot solve every problem, I sometimes feel reluctant, and I just want to stay away, and my inability to help sometimes makes me lose interest, sometimes, you know, I just feel like avoiding such hopeless stories." Moreover, P002 experiences the classic symptoms of STS, "I worry because I keep remembering them," "sometimes I can't sleep because of the suffering I see or because of the stories of pain that I have heard," "sometimes my heart skips a beat when I recall the details of his [Suicidal person] stories." To help with sleeplessness, P002 takes alcohol, "I drink only occasionally now, especially when I can't find sleep." P002 acknowledges being vulnerable and feels the need for social and emotional support, "I am human, with my own weaknesses, and some of the distressing stories I hear remind me of my own need for support. Their stories remind me of my own internal struggles." More so, P002 faced the temptation to engage in maladaptive behavior: "Many [priests] have fallen into alcoholism, some kind of addiction, erm, and other behaviors that are not

helpful. And when I say this, I must admit I have been tempted as too." Due to celibacy, P002 feels "those emotional gaps, especially at those lonely moments. There's no one to go home to, no one to talk to." "… yes, living a single life has its advantage of ensuring that the priest is available, but it also leaves emotional gaps that make us vulnerable."

Textural Description of P003

P003 approaches trauma cases believing in the internal strength of the victims, "they have their problems, they also have their solutions. But all I need to do is to help them bring the two together." However, P003 also feels helpless and defeated at the suffering of the people, "Being a human being, the impulse is to fix, the impulse is to provide a solution, but when I find myself not doing that, I leave feeling defeated." "I leave, sometimes taking upon myself, guilt for what I am not actually responsible for, and that builds up over time." More so, P003 sometimes experience crises of faith, "Mentally I find myself questioning God. Some experiences like that shake my faith," and asks questions, "I find myself asking God, are you really there? Is this how you really want it to be? Or is it the case that there is something you are doing behind the scenes that I cannot see?" "So, I have found myself asking many of those kinds of questions."

Additionally, P003 is overwhelmed by trauma work, "It's mostly an overwhelming experience." "Sometimes I come back really drained of strength." P003 feels exposed to trauma in ministry, "I am open to a lot of trauma that the people are going through" and P003 carries moral injuries, "I sometimes take on the moral injury from their suffering," including guilt, "I leave, sometimes taken upon myself, guilt for

what I am not actually responsible for, and that builds up over time." P003 also learns from the encounter with trauma victims, "Sometimes I go, thinking I am going to minister to the patients, and their sufferings end up ministering to me." P003 engages in activities that contribute to self-care, "Music is an outlet for me. Some of my best compositions come from my worst days," "…and learning the languages, too. It's an outlet for me," "Preaching on my YouTube channel, and having a good number of friends that challenge me to achieve a lot of things is a great outlet for me," "…and, of course, prayer."

Textural Description of P004

In trauma work, helplessness in the face of human suffering and trauma is a source of sorrow for P004, "This is an area of work where helplessness is a common experience. That, itself, is a source of sorrow." "Sincerely, the feeling of helplessness is always there when you cannot help or do anything humanly possible to solve the emotional pain in another person." P004 experiences emotional dissonance by hiding personal pains to attend to others, "I was really in a bad place, emotionally…I needed help…I knew I was not in the right frame of mind to help, ordinarily. I had to struggle to put aside whatever pain I felt to attend to him." "I have had such emotional pain, and I know how devastating it could be."

Further, P004 remembers and suffers from personal and unresolved childhood trauma experience upon hearing victims' stories, "People's experiences remind me of my own experience," "sometimes I am baffled by the fact that the emotional wounds that I thought had healed are renewed by just listening to those who come to me." "I feel the

pain of not only those I am ministering to but my own personal pain," and suffers from intrusive thoughts, "sometimes I can't sleep. I can't sleep, not because I don't want to sleep but because I think of the painful stories I hear." Also, P004 feels the adverse impact of loneliness as a Catholic priest, "When I am emotionally down, it can be frustrating when you do not have a person to hear you out, especially those moments when you are alone, and you need someone to understand you." "I must admit that it [living single] is…a very stressful life to live." "While celibacy ensures that priests are available to be sent anywhere without looking back, it [living single] also creates room for some unmet emotional needs and dangers in pastoral work."

P004 draws strength from trauma work for coping with personal distress, "As I help such victims to find strength, I find some strength, too. The solutions I proffer work for me, too. That's why I said that when I counsel victims, I counsel myself in the process." P004 also engages in some behaviors and activities for self-care, "I feel good whenever I am well dressed. I feel like I'm practicing self-love," "sometimes, I go shopping for myself no matter how small, just to distract myself from those burdens of the heart," and P004 has some minimal social support, "I have a close female friend I talk to, who is very supportive of priestly life," "…and my mother is a strong support and confidant."

Textural Description of P005

Avoidance of trauma reminders is one of the classic symptoms of STS that P005 sometimes presents, "There is stress. I can't deny it. I can't say no. I have had so many experiences of internal resistance," "…and inside, there is a lot of resistance because it

[trauma work] is stressful." P005 feels tired listening to the sad stories of the victims, "Sometimes, inside me, there is a little bit of some stress or tiredness I have listening to the same thing," "…yes, I have had those experiences so many times whereby I feel like I am tired of listening and listening to the same stuff all over again. It's really tiring." Also, P005 feels overwhelmed by trauma work, "It [trauma work] is just weighing down on me," experiences the inadequacy of words, "I notice that even my words sometimes do not help the situation in these people's lives," and struggles with feelings of inadequacy, "I do feel inadequate sometimes because I don't have the right answers to their problems."

Besides, P005 experiences sadness and struggles internally doing trauma work, "I try to accommodate them [trauma cases] and try to handle it, but inwardly, that is stress. I feel sad that they are going through this [trauma]." P005 experiences recollections of their situation, "I think about it, and it is mental stress because I can't do more than just listen to their pain sometimes." "Dealing with issues of this nature…they just weigh on me mentally." Finally, P005 builds and uses robust social support to cope with the adverse effects of trauma work: "I have a wide range of social support among priests and laity. I am all-inclusive. I have a number of parishioners where I can go and have dinner and talk to them, and I come back home, and I am more relaxed."

Textural Description of P006

P006 experiences a series of symptoms of STS due to trauma work within pastoral ministry, such as excitement and irritability, "To be candid, when I face certain conditions, depending on what they may be, sometimes it agitates me, it angers me

personally, and I even lose my appetite to eat," sleeplessness, "I may be lying on my bed but then my body is not sleeping, and my mind is absolutely at work, functioning," and intrusive thoughts and recollections, "sometimes, some of the things I heard…began to play in my memory, because these things can affect the man of God in human skin." In some cases, P006 experiences prolonged intrusive thoughts and fear, "For weeks, my mind was just active." "…I was like, is this how people can do evil to others? Suppose this guy wanted to kill me, he would just have done that and that would be all, if he could do that to many people. I was really scared." Trauma work is overwhelming for P006, "You know, we carry these symptoms because the experiences that we have coming in direct contact with suffering is enormous."

Additionally, the challenge of managing caregiver-client boundaries is real for P006, "Sometimes, drawing the line between the one who is in need of spiritual assistance and the one who is falling in love gets collapsed in-between." This participant also presents the avoidance symptom, "There are some situations I just wish to stay away from… or simply avoid these encounters in order to save myself from the bigger dangers that come from wanting to help some persons." While realizing that some of the stories of trauma get personal, "… And if they had told their story in a way that is personal to you, they touch in a more unique way," and acknowledging the psychological impact of working with trauma, "These things we engage ourselves in, later on, they engage us psychologically and mentally, [and] bodily also, we become dull," P006 finds trauma work enriching as well, "I would say that the experiences have been quite enriching and challenging as well." For self-care, P006 relies on spiritual resources, "I try to refuel my

spiritual energy through finding time for meditations, recollections, and retreats. They help me find myself when I get lost in the work and take me back to who I really am." P006 added, "These activities work for me and help me stay sane while working in the ministry."

Textural Description of P007

Trauma work experience is hectic for P007, "For me, the experience has been overwhelming and stressful," and this participant has little time off work, "There is always a need to reach out to somebody, to support and comfort somebody who is going through a traumatic experience." "I must be ready to be on call all the time. One day ends, another begins, and the stress continues…I get overwhelmed with the work." More so, for P007, "Some of the [trauma] stories people bring could take your whole day trying to figure out what to say or do, and I struggle with everything that needs my attention." Although P007 is always on call, there are moments when P007 feels reluctant, "As a human being there are times when I feel reluctant, especially when the story of the person is already known to me," and "…that feeling is sometimes there to just avoid some of these encounters." The hesitation that P007 feels comes from a sense of helplessness, "You know, deep within me, is a strong desire to be available and help people to navigate through their trials, but again, how much can I do?" The helplessness involved in trauma work is a challenge for P007, "The most overwhelming aspect of ministering to the suffering people is that in most cases you are not able to provide the solution that they need," "It is actually a tormenting experience to watch a fellow human being suffer when you helplessly watch."

Feeling inadequate is another experience of P007, “Some of the stories that I hear are so traumatizing that I want to be able to solve the problem and relieve the pain of the person…the feeling of inadequacy comes from the fact that I cannot help.” P007 also experiences anxiety, “All these make me anxious; am not going to lie. It is not just enough to be seen working; the quality of your work matters as well. So, I am, kind of under continuous pressure,” and some physical symptoms associated with STS, “…sometimes I have headaches, and I believe it has to do with my inadequate sleep. Whenever I am deprived of sleep, I have headaches and I experience dullness.” Finally, for self-care, P007 is not doing enough, “I have not been really committed to doing something for myself.” “Once in a while, I do a few minutes of physical exercise, but not in a steady manner. It’s something that I just do when I feel like it, you know, and that’s not good enough.” P007 does not have enough time even for the once-loved hobbies, “I love music, I love playing the guitar. But for months now, the best I have come to music is just listening to it. I really need to work on self-care.”

Textural Description of P008

Encountering victims of trauma and providing them with spiritual and emotional care is stressful and sometimes, depressing for P008, “My pastoral experience of working with people who are victims of trauma has been stressful,” “I have experienced stress and sometimes depressive experiences just by hearing the struggles that people go through.” This participant also feels incompetent to provide care in some cases, “sometimes I feel like, I need some training mental health, you know. Perhaps that would help me better understand and accompany people through the psychological impact of

their experiences," "…the feeling of inadequacy is always there for me." P008 feels they are not doing enough to solve the problems of trauma suffers, "My feeling of inadequacy makes me feel downcast. It is as if I have failed to help, you know." "It weighs down on me, knowing that these people's experience of the bad situation will likely continue because I cannot help." Because of the helplessness P008 feels and the seriousness of some trauma work cases, P008 feels the need to avoid such encounters, "The helplessness in the face of these encounters can be depressing at times…[and] frankly speaking, there are sometimes I really feel like avoiding these encounters because they just render me sad and depressed."

Furthermore, P008 experiences frustrated because of their inability to change the situation of suffering victims, "The fact that these experiences that they have could take a very long time to heal could be very frustrating. So, it is a very difficult experience for me." "It is a frustrating experience when you try your best, and your best is not enough because of the enormity of the problems you are dealing with." The impact of trauma work also comes with some physical symptoms for P008, "I have had nightmares, physical stress and bodily weakness, sleeplessness, and overeating in the process." "I know that these symptoms have to do with the stories I hear and the cases I have to handle." P008 does not have time for some fun things to de-stress, "I like to connect with nature. I feel refreshed when I can meditate and quietly observe nature and wildlife." "I like photography, taking shots of beautiful sunsets and beautiful landscapes, but I do not have the time to enjoy doing them to relieve stress."

Textural Description of P009

Trauma work in pastoral ministry for P009 is a difficult and challenging experience, "Difficult and challenging in the sense that some of the experiences I hear about are beyond me." This participant finds God sometimes indefensible in the face of human tragedy, "The question of where God is when bad things happen has remained the most difficult question to confront." "Questions like this can be very disabling and they render God indefensible." For P009, representing the God of love among the people who suffer is even more frustrating,

> The difficulty comes with the fact that you appear as priest to the people as the presence or symbol of God's love in the world, and yet the reality of that love is being called to questioned by the current harrowing experience of the people.

Further, P009 finds disengaging from victims' trauma experiences difficult, "Somehow, the pain of the victims follows me as I leave." P009 develops physical symptoms, especially when the victims' experiences and needs are not fully addressed, "Sometimes I remember someone I have encountered or a something I have failed to do, and my heart skips the beat." "I become anxious until I convince myself that things will be okay or that God will somehow take control of the situation." "…I always struggle with migraine, I guess due to my worry and sometimes the lack of sleep."

P009 also feels inadequate or incompetent to provide specialized mental health care, "I feel very inadequate…of course, for me, it is when I cannot get help…help for them [the victims]." "You know that feeling of defeat, you know, I feel it." P009 feels a sense of guilt for the inability to help trauma victims, "I once encountered a penitent who

was suicidal. I felt very unprepared to help him." "I feel guilty that I could not handle the case better than I did. I feel like, I over-spiritualized that encounter instead of being more realistic." More so, the demanding nature of trauma work sometimes makes P009 inwardly unwilling to hear cases, "For me, there are sometimes I have the feeling of, 'Oh my God; so, I have to face this again.'" "I don't like to confront those moments when fellow human beings are sorrowing or in pain." "If I have my way, I mean, unfortunately it's not possible, but if it were, I would stay away sometimes to stay sane." P009 does not engage in self-care activities, "Self-care? [laughs]…now, that is where the problem is." "You know, we can all talk about how good self-care is, how good to do physical exercises, eat well, and so on. Doing these very things, I have not found time for them. It has been a problem."

Textural Description of P010

P010 is just a year in the priesthood and finds trauma work challenging, "It [trauma work] is a very difficult experience." "…seeing people in such situation can sometimes be like swallowing very bitter pills." P010's earlier experience of a mass shooting incident affects their pastoral work among people who suffer, "Working among the people and seeing their suffering, especially such tragic events [mass shooting] can be a very difficult and stressful experience. I still remember that day with shock." P010 keeps having recollections of the incident, "I do not know how to stop thinking about these experiences. The stress is much for me." "Ministering to the victims of the mass shooting left me frightened and distressed for many weeks." P010 experiences anxieties, "I experience anxiety sometimes when I go into the church and I begin to imagine

things." P010 also experiences a lack of concentration, "Sometimes, what I hear makes me drift away to remembering my inner struggles, you know, and I am not fully present to the person before me at that moment."

Because P010 witnessed a traumatic incident [mass shooting], P010 is frightened by cues of the incident and becomes anxious, "I am always suspicious of my environment and everyone that comes close to me because of the victims' story about the shooting experience." P010 earlier trauma experience impacts their pastoral duties, "Going to listen to confessions and counseling people who are hurting has become something that causes me anxiety." P010 also feels like avoiding the tragic stories of suffering, "Sometimes, I feel so overwhelmed that I feel like…I pray I don't have to face any of these again today, you know." "It's a negative feeling to want to stay away from the people, but it is a real feeling for me sometimes."

P010 experiences both psychological and physical symptoms, such as, "I often have anxiety or fear of violence to me at the confessional." "I have recollections of the tragic stories I hear." "Sometimes, I cannot sleep. I cannot concentrate." "Sometimes, I get angry unnecessarily, especially when I am stressed, and I take it out on others." P010 is trying to develop positive coping strategies, "I am trying to replace them [negative coping; alcohol] now with more positive ones like doing physical exercises, even if it is for a few minutes before going to bed at night." "…I kind of discovered that it [alcohol] helps my body to relax." "Whenever I have the time, I also watch movies." P010 also relies on friends for support, "I have a circle of friends I call occasionally. These are things I sometimes do to distract myself."

Individual Structural Description

This sixth step in the data analysis process is based on the textural descriptions and imaginative variation. According to Cilesiz (2010), this step uncovers the hidden dynamics of a participant's experience and shows the "how" of the phenomenon under study. Thus, after reflecting on my presuppositions and bracketing them, I used my imagination to create the structural description of each priest's lived experience of providing care to trauma sufferers based on their textural descriptions.

Structural Description of P001

The lived experience of P001 is that of a Catholic priest who is overwhelmed by stories of distressed parishioners. When confronted with the traumatic experiences of parishioners, P001 often feels helpless, especially when such experiences are beyond immediate solutions and, as a result, this priest experiences sadness and grief over trauma victims' situations. Also, because of the feeling of helplessness or the inability to relieve the pain of parishioners, P001 occasionally feels reluctant and tries to avoid getting involved in trauma cases. In moments of crisis, P001 often cannot find the right words to counsel his suffering parishioners. More so, P001 has discovered that words can be inadequate and that providing a silent presence among the sufferers can do better than words in some cases. Although P001 appreciates the grace of celibacy and the freedom from marital obligations to immediate family, this priest also experiences loneliness in the parish and experiences the emotional stress of bearing the burden of pastoral work among the distressed people alone.

However, the experiences from traumatic exposures are not all negative for P001 because the priest also sees the encounters with trauma victims as opportunities to learn from other people's stories, appreciate human finitude, and build resilience. P001 is also conscious of the need for self-care, seeks connections with people, builds social support. As much as time allows, P001 tries to go on short vacations and uses their annual leave to visit with families and friends. With these practices, P001 hopes to assuage the stress that comes from pastoral work and the negative impact of providing care to traumatized parishioners.

Structural Description of P002

P002 finds fulfillment in consoling and comforting people experiencing pain but also feels helpless in the face of human suffering. The enormity of the work takes a toll on this priest. When listening to traumatic narratives and providing care to victims of trauma, P002 often tries to project strength, even when emotionally weak, so that those who rely on the priest can find strength. Although P002 sees trauma work as part of their priestly calling, their disposition to help people in distress is sometimes laced with feelings of reluctance because of the emotional stress that comes with the work. Moreover, P002 experiences STS related symptoms, including intrusive thoughts, sleeplessness, and anxiety, and to cope with these symptoms, P002 engages in negative behavior occasionally, such as drinking alcohol to find sleep. P002 described being emotionally vulnerable due to celibacy and feels the need for social and emotional support. Finally, P002 has minimal commitment to self-care.

Structural Description of P003

The lived experiences of P003 include feeling helpless and defeated at the suffering of the people. Despite being overwhelmed by trauma work, P003 experiences satisfaction by being available to suffering parishioners and providing them with listening ears and a compassionate, nonjudgmental presence. P003 learned to approach trauma cases believing in the internal strength of the victims. However, P003 sometimes experience crises of faith and questions God about the troubling conditions of their people. Additionally, P003 experiences guilt and carries moral injuries from the pain that parishioners and trauma victims go through. P003 engages in activities that could contribute to self-care, including making music, learning languages, connecting with friends, and prayers. Finally, for P003, living the single life as a priest has been advantageous because of the time and freedom it affords this priest to focus on either pastoral work or doing other things that are personally desired for self-care without being pressured by the unignorable commitments to marriage.

Structural Description of P004

Helplessness in the face of human suffering and trauma is a source of sadness and pain for P004. This sorrow is partly because of P004's personal unresolved trauma experience, having been abused as a child. Thus, P004 occasionally remembers the personal trauma experience while listening to related narratives from other people's experiences. This experience also helps P004 to process personal internal struggles and counsel others who have similar experiences because by helping others find hope and strength through their struggles, P004 finds strength in the process. While being a

shoulder for others to lean on in their time of emotional needs, P004 experiences emotional dissonance by hiding personal pains to attend to others and projecting pastorally acceptable emotions. Apart from having recollections of trauma sufferers' narratives, P004 experiences other symptoms, including occasional sleeplessness and headaches. P004 also appreciates the value of priestly celibacy and sees it as a means of grace. However, this priest who lives alone also experiences celibacy as failing to meet certain needs for emotional support. P004 does find some minimal social support in the mother as a confidant and a female friend who is supportive of the priestly life.

Structural Description of P005

The lived experience of P005 has been mostly with people who are grieving the loss of loved ones and those who are divorced or distressed due to broken relationships. Realizing that grieving is a time for being sensitive to people's pains, P005 sees the need to be consistently trustworthy among the people. However, this priest experiences trauma work as stressful and overwhelming. Although P005 does not experience physical symptoms associated with trauma work, avoidance of trauma reminders is one of the classic symptoms of STS that P005 sometimes presents, and the priest feels tired of listening to the sad stories of the victims. P005 occasionally experiences a bit of internal resistance to getting involved because of the distressing nature of some cases and the inadequacy of words to console. Besides, P005 experiences sadness and struggles internally doing trauma work and has recollections of their pains, which weighs down on the priest. P005 is effective in trauma work and ministry because of the freedom and availability ensured by celibacy. Also, convinced that God principally does the work of

helping people struggle through their trials, P005 is motivated to just be available, not to defend the God of love but to show the love of God to people who are hurting. Finally, P005 relies on their nearly 2 decades of experience and builds and uses robust and inclusive social support to counteract the adverse effects of trauma work.

Structural Description of P006

This participant, P006, experiences trauma care as difficult and distressing but also satisfying because of the opportunity it gives to be part of people's healing process. Due to working with trauma, and depending on the severity of the cases, P006 occasionally experiences a series of symptoms related to STS, such as excitement, anxiety, and irritability. The helplessness in the face of certain human conditions and the lack of the needed resources makes P006 feel inadequate. Further, P006 often have prolonged intrusive thoughts and fears, and recollects narratives from encounters with suffering people, some of which are difficult to disengage from. However, P006 pulls through the experience, having realized that the priest is the man of God that is clothed in human skin. Still regarding recollections of narratives, this priest especially experienced prolonged disturbances and the fear of violence because of narratives from individuals at the confessional. Additionally, P006 also encounters cases where managing boundaries with trauma sufferers is a challenge. Thus, because of the challenges in trauma work and the helplessness involved, P006 also presents the avoidance symptom in feeling reluctant to hear trauma stories. Despite the challenges involved, P006 also finds trauma work enriching because of the experience they gain. To maintain personal focus and wellbeing,

P006 relies on spiritual resources, such as meditations, monthly spiritual recollections, and annual retreats.

Structural Description of P007

The lived experience for P007 is that trauma work is distressing. P007 has a loaded pastoral work schedule and has little time off work. More so, for P007, some trauma cases take whole days and weeks of attention such that this priest struggles with every other thing needing attention. Although P007 is always on call and believes in remaining available to all, there are moments when P007 feels reluctant or hesitant, and this hesitation comes from a sense of helplessness. P007 experiences helplessness and a sense of inadequacy as the most overwhelming aspect of ministering to the suffering people. P007 feels tormented to helplessly watch trauma victims suffer. Anxiety, inadequate sleep, headaches, and physical weakness and dullness are the symptoms that P007 experiences. P007 is not doing enough for self-care and lacks enough time for hobbies formerly enjoyed.

Structural Description of P008

Encountering victims of trauma and providing them with spiritual and emotional care is a fulfilling experience for P008's priestly calling. However, being stressed and depressed are also part of P008's lived experience of providing care to trauma victims. An encounter with a suicidal trauma sufferer made P008 experience feelings of incompetence in providing care and the need to get some training in mental health. Also, P008 feels weighed down when victims' situations turn ugly, and they cannot get help. Because of the helplessness P008 feels and the depressive mood that some trauma work

cases bring to P008, sometimes, there is the feeling of hesitation toward having some trauma work encounters. The lived experience is also that of frustration for P008 when giving the best of care the priest can provide is not enough to end the suffering. The physical symptoms associated with trauma caregiving for P008 include nightmares, bodily weakness, sleeplessness, and overeating. P008 loves the fun of admiring nature and photography to de-stress but lack time for these fun things.

Structural Description of P009

For P009, the lived experience of trauma work within the pastoral ministry is that of a never-ending challenge. The most difficult aspect of ministering to trauma sufferers, for P009, is that God's love is indefensible in the face of human tragedy. Thus, for P009, representing the God of love among the people who suffer is frustrating. Further, P009 finds disengaging from victims' trauma experiences difficult, experiences anxiety, and develops physical symptoms, such as migraine and inability to sleep, especially when the victims' experiences and needs are not fully addressed. P009 also feels inadequate or incompetent to provide specialized mental health care, over-spiritualizes some encounters, and feels a sense of guilt for the inability to help trauma victims. More so, the demanding nature of trauma work sometimes makes P009 inwardly unwilling to take up or continue cases to stay sane. P009 knows the value of self-care and engages in some physical exercises.

Structural Description of P010

P010 is just a year in the priesthood and finds trauma work challenging. P010's earlier experience of a mass shooting incident affects their pastoral work among people

who suffer from violent abuses because P010 keeps having recollections of the incident. The incident left P010 frightened and distressed such that they drift away to their inner struggles upon hearing narratives of violence from other victims, and sometimes, P010 lacks the presence of mind to counsel help-seeking victims. P010 is frightened by cues of the incident and becomes anxious and excited when alone with a stranger. Thus, being alone with a help seeker at the confessional is a source of recurring anxiety for P010 because of the suspicion that the other person could be violent. This participant is always conscious and suspicious of their environment and strangers. P010 also presents the avoidance symptoms as they try to avoid the anxiety-provoking situations and the tragic stories of suffering. This priest realizes that avoiding trauma sufferers is a negative strategy, but P010 experiences hesitation toward hearing tragic stories. Other symptoms experienced include sleeplessness, wondering thoughts, and lack of concentration. For coping, P010 has not approached any facility for mental health care. However, this participant has used spiritual direction and struggles to replace reliance on alcohol with physical exercise, watching movies, and reaching out to friends for support.

Composite Structural Descriptions

This is the seventh step in the analysis process, and this step required me to incorporate the textural description for each participant into a structure to understand how the phenomenon occurred (Moustakas, 1994). Thus, I read through the textural description for each participant and used imaginative variation to unearth the meanings that are representative of all the participants' lived experiences. This process revealed that Catholic priests' experience of providing care to trauma sufferers is both fulfilling

and distressing. Fulfilling because, as 8 of the 10 participants described, helping people heal from trauma and accompanying them spiritually, emotionally, and physically through their journey of healing is part of the priestly calling. Thus, the participants feel satisfied and fulfilled when they can live up to this aspect of their calling as priests.

However, the experience is also distressing for Catholic priests because, as all the participants described, they are always on call to encounter human suffering and helplessness, and their textural descriptions indicate a personal, social, emotional, and spiritual cost associated with this aspect of their ministry. More so, their feelings of helplessness, fear, anxiety, inadequacy or incompetence, hesitation, and depression due to trauma work, and the accompanying physical symptoms of sleeplessness, headaches, chest pains, and bodily weakness for some, are all indications of secondary traumatic experience (Evces, 2015; Powell, 2020). The next step, the final step in the analysis process, is the synthesizing of the participants' textural and structural descriptions into one expression to represent the essence of the entire group of participants' experiences and shared meanings of the phenomenon.

Synthesis of the Textural and Structural Descriptions

Catholic priests encounter trauma survivors in their pastoral work. Their lived experience is that providing spiritual and emotional care and support to people who have experienced trauma is a basic part of pastoral ministry. Seeing their priesthood as a calling from God, priests often find satisfaction and fulfillment in their pastoral caregiving to trauma survivors. The priestly satisfaction in trauma work comes from being available to suffering parishioners, providing them with listening ears and a

compassionate, non-judgmental presence, and being part of people's healing process. In this caregiving vocation, priests' prevailing attitude is sacrifice, without asking for anything in return, because a priest's caregiving vocation is considered a divine calling. In addition to the often-high and continuous pressure of their work, priests are typically on call to minister to those in need, and they provide emotionally demanding services to people suffering from various sources of trauma, including loss of loved ones, domestic violence, terminal illness, divorce and broken relationships, and other life-altering events.

Although priests find fulfillment in consoling and comforting people experiencing pain, their lived experience descriptions of this aspect of their ministry also reveals that their trauma work is distressing, stressful, difficult, and overwhelming. The enormity of trauma work takes a toll on priests. When confronted with the traumatic experiences of suffering individuals, priests often feel helpless, especially when such experiences are tragic and beyond immediate solutions. Priests also experience frustration when their best caregiving skills and resources are not enough in the face of human suffering. As men of God in human skin, priests feel tormented to helplessly watch trauma victims suffer. The God of love is difficult to defend in times of pain and anguish. Thus, representing the God of love among the people who suffer can be frustrating for priests. While priests experience a crisis of faith and question God about the tragic experiences of their parishioners, priests also believe that God principally does the work of helping people process their trauma and pains. Thus, relying on faith and believing in the inner strength of the victims to pull through their experiences, Catholic priests are motivated to be

available, not to defend the God of love but to show the love of God to people who are hurting.

In addition to the feelings of helplessness, Catholic priests feel a sense of inadequacy in providing the needed mental health support to trauma survivors. In some cases, priests feel a sense of guilt for their inability to provide adequate help and over-spiritualizing encounters that required a more skilled approach to serve victims of trauma. In other words, due to their sense of inadequacy, priests experience guilt and carry moral injuries from the pains that parishioners and survivors of trauma go through. The lived experience of Catholic priests also involves a sense of reluctance or hesitation toward encountering people in distress. Although priests realize that avoiding traumatized people and their suffering is antithetical to their calling, they experience a sense of reluctance or internal resistance, occasionally, to avoid the distressing narratives and reminders of the trauma that provoke emotional stress, anxiety, and sadness. Catholic priests also experience emotional dissonance by projecting acceptable emotions that are discrepant with their felt emotions. For instance, when listening to traumatic narratives or providing care to victims of trauma, priests try to project strength, regardless of their emotional state. Thus, in trauma work, priests experience emotional dissonance by hiding their personal emotional pains and reactions and projecting pastorally acceptable emotions.

Regarding the impact of celibacy on trauma work experience, Catholic priests consider living the single life as advantageous because of the time and freedom it affords them to focus on either pastoral work or doing other things for self-care without being pressured by the unignorable commitments to marriage. Celibacy is a grace that allows

for priestly availability. Nonetheless, due to celibacy, priests also experience emotional vulnerability, loneliness, and depression as they process alone whatever traumatic material they encounter in their ministry.

The lived experience of priests also involves the presentation of several symptoms associated with secondary traumatic stress, including intrusive thoughts, irritability, sleeplessness, excitement, nightmares, and anxiety. Other symptoms are overeating, headaches, physical weakness, dullness, and lack of concentration. However, priests' lived experiences from traumatic exposures are not all negative because they also use the encounters with trauma victims to learn from other people's stories, appreciate human finitude, and build resilience. Priests gain experience to process personal internal struggles and counsel others who have similar experiences. Thus, despite the challenges involved in providing care to trauma survivors, trauma work is enriching for priests because of the experience they gain.

Not all Catholic priests engage in self-care activities. Some priests realize the need for self-care in the face of their traumatic exposure but have no commitment to self-care. However, some others are conscious of the need to de-stress, and they make efforts to engage in self-care activities as much as their schedules allow. Some seek connections with people to build social support. Some go on short vacations to visit with families and friends. Some maximize the use of spiritual resources, such as meditations, monthly spiritual recollections, and annual retreats. Priests also engage in other self-care activities and hobbies, such as physical exercises, watching movies, making music, learning languages, admiring nature, photography, reading, and writing. These efforts,

notwithstanding, the lived experience of priests is that they hardly have enough time off work to engage in self-care activities regularly.

Evidence of Trustworthiness

The critical question of validity in qualitative studies requires researchers to provide evidence that there has been some rigor in the effective use of self as a research instrument and the developed structural method (Shufutinsky & Long, 2017). In this study, I carefully applied the systematic, conceptual, and analytical frameworks proposed in Chapter 3 to ensure the credibility of the findings and allay any concerns from the readers about the plausibility and defensibility of the study's conclusions. I present some evidence of trustworthiness based on the following: credibility, dependability, confirmability, and transferability.

Credibility.

Credibility in qualitative research requires the researcher to provide assurances of the fit between respondents' lived experience and the researcher's representation of the same (Patton, 2015). I followed Moustakas' (1994) transcendental phenomenological data analysis process, a proven standard and rigorous process for analyzing qualitative data and ensuring that the phenomenological researcher's descriptions of human experiences remain true to those same experiences. To enhance credibility and bolster confidence in the truth of this study's findings, I used a peer reviewer who provided additional oversight of the manuscripts. I also used the member-checking technique. During the recruitment process and prior to the interviews, I notified each participant about the member-checking process via email. Each participant received a copy of their

interview transcript divided into portions of their descriptions according to the themes that emerged from my understanding of their reality and meanings of STS. As I earlier noted, three participants requested minor edits to their transcripts. One participant wanted the statement, "I felt incompetent," replaced with, "I was unable." The other participants indicated only a few typographical errors. I made the edits as requested and confirmed the edits with the participants.

However, all the participants approved the final themes I formed as consistent with their experience. Thus, the member-checking process helped improve this study's descriptive validity. I also used the triangulation technique by comparing evidence from the interview transcript to my reflexive journal and interview notes and memos to build a coherent justification for the emergent themes. Thus, I formed and validated the themes based on the converging evidence from the different sources of data.

Transferability

This criterion refers to the extent that the findings are useful or applicable to persons or groups of persons in settings different from the research (Creswell & Creswell, 2018). I used rich, thick descriptions to convey the findings of this study. I provided a detailed description of the study setting, the participants' demographics, and their shared experiences of STS. Thus, I enhanced transferability by providing enough information such that readers could establish the degree of similarity between the population I studied and the population to which a reader might transfer the findings.

Dependability

This criterion relates to the extent to which the findings of a qualitative study are stable over time and in similar conditions (Creswell & Creswell, 2018). I ensured consistency among the components of this study design and followed the processes outlined in Chapter 3. I used reflexive journaling and audit trails to document all the phases of the planning, implementation, and organization of this research project, including my personal reflection on the entire research process. I documented all the steps I took during the participant recruitment stage and my observations from the interviews to ensure that the research process was logical and traceable. The documented processes and descriptions can help a future researcher replicate this study with similar participants and situations (Creswell & Creswell, 2018).

Confirmability

Confirmability refers to the extent to which the study is objective (Monette et al., 2014). The measures of confirmability in this study remained as proposed in chapter three. Following the epoche protocol in transcendental phenomenological research design, I bracketed my preconceptions about STS throughout this study. Thus, I enhanced confirmability by being conscious of and setting aside my personal biases and assumptions about STS that could influence the study. This process created an open and honest narrative that can resonate well with the readers. Additionally, employing the member-checking technique mentioned earlier ensured that the significant findings and themes resonated with the respondents' experiences (Monette et al., 2014).

Study Results

The purpose of this qualitative transcendental phenomenological study was to explore the lived experience of STS among Catholic priests and how they described their use of self-care strategies to either prevent or cope with STS. Data collected from the participants addressed both research questions sufficiently. The data analysis process yielded five core themes and 13 subthemes from the Catholic priests' rich descriptions of their lived experiences of trauma work. Table 4 shows the emergent themes organized into core themes and subthemes.

Table 4

Core Themes and Subthemes Formed From Participants' Descriptions

Core Themes (5) and Subthemes (13)	P	*N*
1. Core Theme: Pastoral Motivation	8	32
1a. Learning curve	10	21
2. Core Theme: Encountering people with trauma	10	88
2a. Feelings of inadequacy	8	71
2b. Emotional dissonance	6	26
2c. Feeling reluctant to encounter people in distress	9	55
3. Core Theme: Caregiver stressors	10	69
3a. Prolonged experiences related to trauma work	7	49
3b. Physical symptoms	6	23
3c. The impact of celibacy	10	44
3d. The impact of sexual abuse crises	5	19
4. Core Theme: Understanding of self-care	10	26
4a. Self-care activities	10	37
4b. Coping with stress and anxiety	9	47
4c. Church support of priests' self-care	8	17
4d. Church resources for priests' mental health	6	29
5. Core Theme: Suggestions for priests' well-being	10	66
5a. Preparing future priests for trauma work	10	32

Note. P = # of participants. *n* = # of occurrences.

Tables 5, 6, 7, 8, and 9 show the formation of the 5 core themes and 13 subthemes based on quotes from the participants' descriptions of their trauma work experiences. I

presented each core theme and their subthemes separately for clarity. I used Table 5 for Core Theme 1 and Subtheme 1, Table 6 for Core Theme 2 and Subthemes 2, Table 7 for Core Theme 3 and Subthemes 3, Table 8 for Core Theme 4 and Subthemes 4, and Table 9 for Core Theme 5 and Subtheme 5.

Table 5

Core Theme 1 and Subtheme Based on Participants' Descriptions

Theme (Participant Influence)	Quotes from Participants' Descriptions
Core Theme 1: Pastoral motivation (8)	"I am living out my calling as a priest helping to heal others spiritually and emotionally." "I am fulfilled when I am able to console and comfort an individual at such moments." "I realize that they are also…children of Abraham, children of God, needing attention." "God has appointed me to help people, to discover their own channels of how they can reach God." "It's a rewarding and enriching experience to be able to help people navigate through their traumas."
Subtheme 1: Learning curve (10)	"Such experiences become opportunities to learn, to build resilience for myself." "It [trauma work] brings one to a level of discovery, and I learn to not take certain things for granted." "Sometimes I go, thinking I am going to minister to the patients, and their sufferings end up ministering to me." "As I help such victims to find strength, I find some strength, too." "People have a lot of trust in us, and it has helped me to trust them, too, to try to stay with them where they are." "The revelation, the discovery, the lessons learned from some of these experiences help me to counsel myself and others."

Table 6

Core Theme 2 and Subthemes Based on Participants' Descriptions

Theme (Participant Influence)	Quotes from Participants' Descriptions
Core Theme 2: Encountering people with trauma (10)	"It's a situation that makes me feel vulnerable and helpless, sometimes, because of life's circumstances and what life throws at people, and that can really be overwhelming." "…encountering the reality of human suffering breaks me sometimes as a person. It takes a toll on me." "…ministering to people in crisis…has been overwhelming." "…seeing people in such situation can sometimes be like swallowing very bitter pills." "It's mostly an overwhelming experience for me." "It's difficult and challenging because some of the experiences you hear about are beyond you." "For me, the experience has been overwhelming and stressful." "My pastoral experience of working with people who are victims of trauma has been stressful."
Subtheme 2a: Feelings of inadequacy (8)	"The feeling of inadequacy is always there for me. People bring all kinds of problems. How many can you effectively address?" "I do feel inadequate sometimes because I don't have the right answers to their problems." "I recently counseled a suicidal person…I was afraid because I couldn't tell whether I was able to convince him that life is worth living." "It is as if I have failed to help, you know, and it weighs down on me, knowing that these people's experience of the bad situation will likely continue because you cannot help." "Sometimes, trying to use words can really offend these people person because words can be inadequate, and some people can take it as if you are not feeling with them exactly as they feel." "I feel very inadequate…of course, for me, it is when I cannot help them."
Subtheme 2b: Emotional dissonance (6)	"…I have to always project strength and not weakness, so that those who look up to me can also find strength too." "I was really in a bad place, emotionally. I knew I was not in the right frame of mind to help him, ordinarily. But I couldn't let him see that. I struggled to put aside whatever pain I felt to console him." "I have, sometimes, the feeling of, 'Oh my God. So, I have to face this again.' But I still have to show empathy"
Subtheme 2c: Feeling reluctant to encounter people in distress (9)	"I just feel like avoiding such hopeless stories." "The stress makes me lose interest sometimes, you know." "I sometimes feel reluctant and I just want to stay away." "And inside me, there is a lot of resistance because it [trauma work] is stressful." "Of course, there are times I just wish to stay away." "I feel like avoiding these encounters because they leave their scars on you." "Yes. It's a natural feeling for me, you know. You don't want to get involved in crisis…and get caught up emotionally with it."

Table 7

Core Theme 3 and Subthemes Based on Participants' Descriptions

Theme (Participant Influence)	Quotes from Participants' Descriptions
Core Theme 3: Caregiver Stressors (10)	"Some cases could take your whole day trying to figure out what to say or do." "The parish workload is a silent killer." "It [trauma work] is just weighing down on me." "I take the moral injury." "I have had depressive moments because of some trauma stories" "The helplessness is, itself, a source of stress and anxiety." "The administrative work is just one hell of work on its own." "I feel guilty and anxious about what I am not actually responsible for, and that builds up over time." "Mentally I find myself questioning God."
Subtheme 3b: Prolonged experiences related to trauma work (6)	"For weeks, my mind was just active, thinking about their experience." "My sense of pity and compassion drags these experiences along with me." "You see yourself unconsciously grieving over their situation." "I worry because I keep remembering them." "I leave, sometimes taking upon myself the guilt for what I am not actually responsible for, and that builds up over time." "I feel the pain of not only those I am ministering to but my own personal pain." "I may be lying on my bed but then my body is not sleeping, and my mind is absolutely at work, functioning." My heart skips a beat whenever I remember some things I've heard."
Subtheme 3c: Physical symptoms (7)	"I can't sleep because of the painful stories I hear." "I have nightmares, occasionally." "…I always struggle with migraine." "Sometimes my heart skips a beat when I recall of his [Suicidal person] stories." "Sometimes it agitates me, it angers me personally." "I even lose my appetite to eat." "I can't concentrate." "I have headaches and I experience dullness. "I experience physical stress and bodily weakness."
Subtheme 3d: The impact of celibacy (10)	"I must admit that it [living single] is a very stressful life to live, sometimes." Celibacy is a grace…it's a sacrifice I am happily making, though I feel the social and emotional challenges too." "Right now, I'm the only one. I have to process all these alone. And that has its own challenges and burdens." "I feel those emotional gaps, especially at those lonely moments." "It [celibacy] creates room for some unmet emotional needs in pastoral work."
Subtheme 3e: The impact of sexual abuse crises (5)	"…the bishops have generalized their zero tolerance policies, as if they expect priests to be 100% perfect." "Perfect priests don't exist on earth." "So, you are working but you are not happy." "…dealing with the fact that you might be betrayed by the very people you are called to serve." "This has created much fear and unnecessary anxiety in priests, and there is a disconnect between the priests and their parishioners for fear of being wrongly accused."

Table 8

Core Theme 4 and Subthemes Based on Participants' Descriptions

Theme (Participant Influence)	Quotes from Participants' Descriptions
Core Theme 4: Understanding of self-care (10)	"…doing the things that keep me healthy." "…being aware of myself, my health, my environment, and avoiding the things that threaten my wellbeing." "knowing yourself enough and using your experience to help." "…all about taking care of myself." "…caring for myself so that I can care for others." "…engaging in activities, choices, or behaving in ways that promote my personal wellbeing." "…being conscious of my wellbeing and health and letting that consciousness guide my choices in what and how I do things."
Subtheme 4a: Self-care activities (10)	"I do a few minutes of physical exercise, but not steadily." "Sometimes I watch movies." "Music is an outlet for me." "I love playing the guitar. But for months now, no time to touch it." "I set goals to learn languages." "I feel good whenever I am well dressed. I feel like I'm practicing self-love." "I take my off day every week." "I feel refreshed when I can meditate and quietly observe nature and wildlife." "I do not handle it well. I do not. I just try to cope with the work, each day as it comes."
Subtheme 4b: Coping with stress and anxiety (9)	"I have learned with time to try to put a boundary between what I am doing so that I can have my own life." "…my mother is a strong support and confidant." "I used to drink a lot…yea, not that I was addicted. It provided a temporary break from mental stress. I drink only occasionally now, especially when I can't find sleep." "I…overeat." "I was on antidepressants at some point…" "I seek connection, connecting with people, like you know, friends, family, relatives, other priests." "I engage in conversations with people where I get some lighter moments of laughter and jokes."
Subtheme 4c: Church support of priests' self-care (8)	"Occasionally, during retreats and gatherings, issues about selfcare and health are discussed. That's all about it." "Each person is expected to make efforts to stay healthy." "…every priest is to look after himself as best as he knows how." "Our diocese encourages a lot of peer groups like classmates." "There is no organized support for self-care [in my diocese]."
Subtheme 4d: Church resources for priests' mental health (6)	"…spiritual directors…and confessors are highly recommended for priests." "There are a few mental health facilities across the country that priests are sent to for their mental health needs." "There is a priest [in my diocese] in charge of our personal, internal affairs that I can talk to, and we call him 'the servant of servants.'" "We have no support system in this diocese. Priests' mental health as a topic sometimes draws a short-lived attention only when there is a failure or abuse on the part of an individual priest, and that's when the harm has been done."

Table 9

Core Theme 5 and Subthemes Based on Participants' Descriptions

Theme (Participant Influence)	Quotes from Participants' Descriptions
Core Theme 5: Suggestions for priests' well-being (10)	"Priests should be trained as mental health experts and let them help their fellow priests manage their stress and mental health issues." "…all dioceses [should] have a counseling unit where priests can visit the professionals in their diocese on their own when they have some troubles." "…having access to both spiritual and mental health resources will contribute to the overall wellbeing of priests." "Every seven years, priests should be allowed to go on a sabbatical year and get back to ministry refreshed, reinvigorated." "Before a priest is assigned somewhere, I think there is need for much more of consultation between the priest on the authority." "Let there be more motivational incentives for priests stressing with heavier pastoral workloads." "[There should be] sponsored ongoing refresher courses for all priests every year." "…design one to three months programs around the anniversaries of priests after 10 years and after 20 years of ministry where they come together to re-evaluate and rediscover themselves and take up new challenges going forward."
Subtheme 5: Preparing future priests for trauma work (10)	"Introduce mental health courses in seminary curriculum and workshops." "[Assign] seminarians to various care facilities as interns under supervision." "Expose seminarians to the reality of crisis and how to manage it." "…train seminarians on self-care… because if dealing with this emotional stress is real, then self-care is on the flip side of the conversation." "…connect seminarians with psychologists, psychiatrists, therapists and life coaches, both for personal wellbeing and for possible collaborative ministry."

Thematic Outcomes Addressing Research Question 1

The first set of core themes and subthemes, that is, Core Themes 1, 2, and 3 and the subthemes, addressed the first research question: *What are the lived experiences of secondary traumatic stress among Catholic priests?*

Core Theme 1: Pastoral Motivation.

This theme emerged from the participants' responses to Interview Questions 1, 2, and 3 (see Appendix A). The participants spontaneously described their ministry to the

traumatized and suffering people in their communities as part of their priestly calling. The theme of "pastoral motivation" was coded 32 times in 8 of the 10 participants. The priests described their pastoral caregiving as satisfying and fulfilling. P006 stated, "I am living out my calling as a priest by helping to heal others spiritually and emotionally." P003 similarly shared, "God has chosen me and appointed me to help people to discover their own channels of how they can reach God." The priests' consciousness of their divine calling and the strong sense of spirituality connected to their sacred duties influenced their lived experience and pastoral disposition toward the suffering members of their parish communities.

Closely related to pastoral motivation was the subtheme coded as "learning curve." This subtheme highlighted what Catholic priests shared about personal growth, improvement, or changes due to their trauma work and experiences. "Learning curve" was coded 21 times across all participants. The priests shared they had increased empathy and a greater appreciation for their own life experiences. P001 shared, "It [trauma work] brings me to a level of discovery about what people are going through, and I learn to not take certain things for granted." P005 mentioned, "…because I have seen and lived through many pastoral situations, I have grown over the years regarding the management of my emotions." Likewise, P003 shared, "The revelation, the discovery, and the lessons learned from some of these experiences help me to counsel myself and others." P008 added, "Such experiences become opportunities to learn, to build resilience for myself." Priests also found meaning in being needed and useful. P005 described this experience,

"People have a lot of trust in us, and they depend on us. This has helped me to trust them, too, and try to stay with them where they are."

Core Theme 2: Encountering People With Trauma

In pastoral caregiving to people who have experienced trauma, the amount of stress and trauma experienced, and the victims' distressing accounts may take a toll on the caregivers and lead to STS. As a theme, "encountering people with trauma" highlighted the participants' descriptions of their encounters with traumatized persons as stressful, challenging, overwhelming, difficult, frustrating, and emotionally draining. This theme emerged in response to Interview Questions 1, 2, and 3 (see Appendix A) and was coded 88 times across all participants. P010 described encounters with traumatized people thus: "It is a very difficult experience. The kind of suffering that people go through, seeing people in such situation can sometimes be like swallowing very bitter pills." For P002, "encountering the reality of human suffering breaks me sometimes as a person. It takes a toll on me because I come face to face with the reality of human suffering." Similarly, P009 described the experience as "…a difficult and challenging experience. Difficult and challenging in the sense that some of the experiences you hear about are beyond you." Participants also described their prolonged periods of empathic listening to trauma narratives as having shaken their faith. For instance, P003 shared, "Mentally, I find myself questioning God." Similarly, P009 described the experience with a string of questions addressed to God, "I sometimes ask God, 'Are you watching this person suffer helplessly? Is this your will for them, or are you doing something behind the scenes that I cannot see?' You know, the helplessness can be demoralizing."

Subtheme 2a: Feelings of Inadequacy. Interview Question 3 (see Appendix A) created an opportunity for the participants to share their experiences of inadequacy in providing care to traumatized persons. This theme was coded 71 times in 8 of the 10 participants. The priests shared their feelings of inadequacy and helplessness in the face of human suffering and trauma. For instance, P008 described, "The feeling of inadequacy is always there for me. People bring all kinds of problems. How many can you effectively address? I carry the moral injuries from all these, and the helplessness can be depressing at times." In addition to the lack of resources, which limits priests' ability to help traumatized people, participants also described feelings of inadequacy due to the lack of skills. For instance, P002 stated, "I recently counseled a suicidal person. I could not sleep afterward. I was worried. I was afraid because I couldn't tell whether I was able to convince him that life is worth living." P002 continued, "I think I over spiritualized that encounter." Participants also described feeling inadequate due to lacking the right words. P005 shared, "I do feel inadequate sometimes because I don't have the right answers to their problems." P001 added, "Sometimes, trying to use words can really offend them because words can be inadequate, and some people can take it as if you are not feeling with them exactly as they feel."

Subtheme 2b: Emotional Dissonance. I formed this subtheme from the participants' responses to Interview Questions 1, 2, and 4 (see Appendix A). Emotional dissonance highlighted the participants' lived experiences of the tension that occurred when they perceived their internal role conflict and displayed feelings that were discrepant from their actual emotions. "Emotional dissonance" was coded 26 times in 6

of the 10 participants. The priests described their experience of showing pastorally expected emotions regardless of their felt emotions. P002 described the experience, "…as a priest and…sign of comfort, I have to always project strength and not weakness, so that those who look up to me can also find strength also." P004 described the experience of emotional dissonance after listening to a parishioner's trauma stories and remembering personal trauma experience: "I was really in a bad place, emotionally. I knew I was not in the right frame of mind to help him, ordinarily. But I couldn't let him see that." "I struggled to put aside whatever pain I felt to console him." Participants also described this experience based on how their parishioners' diverse emotional needs contribute to the mental stress in the priest. P001 offered a description that summarizes the experience:

> The same priest who has just finished condoling with a grieving family is getting the good news of someone who has just given birth, while planning the wedding of a new couple. And I must give my full mental attention to everyone because the people will know if I am not fully present for them. So, I must switch moods and be perceived as authentic in each mood. So, there is a whole lot, and it is one man doing all these.

Subtheme 2c: Feeling Reluctant to Encounter People in Distress. This theme included the participants' descriptions of their experiences in response to Interview Question 3 (see Appendix A). The theme was coded 55 times in 9 of the 10 participants who described their experiences of hesitation and internal resistance to getting involved with crises or hearting distressing stories. P010 described their experience: "I feel like avoiding these encounters because they leave their scars on you." The participant added,

"I just feel like avoiding such hopeless stories." P005 likewise stated, "I have had so many experiences of internal resistance. There is a lot of resistance because it [trauma work] is stressful." For P001, "…it's a natural feeling, you know. I don't wish to get involved in crisis and get emotionally caught up with it. Yea, because the stories are often distressing." P006 also shared, "Occasionally, I have that feeling, like, 'Oh my God. Not again.' I cannot solve every problem…and I just want to stay away." Describing the internal conflict of feelings experienced, P003 added, "It is not a good feeling to want to stay away from the people's tales of trauma, but the feeling is real."

Core Theme 3: Caregiver Stressors

As a theme, "caregiver stressors" captured any participant's descriptions about what caused them stress in pastoral caregiving. This theme was coded 69 times across all participants, and the theme emerged in response to Interview Questions 1 to 6 (see Appendix A). Caregiver stressors included the adverse psychological effect of trauma work and the participants' administrative engagements and overall workload. P007 captured their lived experience in the parish as follows:

> The experience has been overwhelming and stressful. There is always a need to reach out to somebody, to support and comfort somebody who is going through a distressing experience. I am always on call, ready to answer the call all the time. You know, one day ends, another begins, the stress continues, and I get overwhelmed trying to find a balance between the administrative work and attending to those who are experiencing painful events in their lives and families.

> The dreadful days of COVID 19 were very traumatizing for my community here. The experience was really stressful and overwhelming.

Several statements from all the participants corroborated the above quotation. P002 stated, “Some cases could take your whole day trying to figure out what to say or do.” For P004, “Cases with domestic violence are always very stressful.” P009 described, “The parish workload is a silent killer.” P001 similarly stated, “The administrative work is just one hell of work on its own.” Describing trauma counseling, P008 mentioned, “All these encounters leave you wondering…, I am lost trying to figure out what to do, and the helplessness is, itself, a source of stress and anxiety.” P005 shared, “People's experiences remind me of my own experience, my own internal struggles.” P006 described their experience of stress trying to maintain professional boundaries, “Sometimes, drawing the line between the one who is in need of spiritual assistance and the one who is falling in love gets collapsed in-between.”

Subtheme 3a: Prolonged Experiences Related to Trauma Work. The theme of prolonged experiences due to trauma work included the participants’ experiences of intrusive thoughts and unexplained reactions occurring in their everyday lives outside the trauma caregiving arena. “Prolonged experiences” was coded 49 times in 7 of the 10 priests. Participants’ descriptions included feelings of guilt, not having done enough for a suffering individual, and the fear that a sufferer’s situation might worsen. P006 described having helped a victim of sexual abuse and, “For weeks, my mind was just active, thinking about their experience.” P001 described this experience and shared, “My sense

of pity and compassion drags these experiences along with me, and I see myself unconsciously grieving over their situation."

Additionally, participants experienced on guilt from trauma work. P003 had the experience over patients' conditions in the hospital, "I leave, sometimes taken upon myself guilt for what I am not actually responsible for, and that builds up over time." P010 witnessed a mass shooting incident that impacted their trauma work. Narratives about violence "…reminds me of that experience…and I am often suspicious of people close to me and…suspicious of my environment." Also, "…Being in the church to listen to confessions and counseling people who are hurting causes me a bit of anxiety because I am always suspicious of my environment and everyone that comes close to me." Participants described these experiences as distressing.

Subtheme 3b: Physical Symptoms. The physical symptoms domain included descriptions of the participants' experiences of physical symptoms associated with trauma work stress. Interview Question 5 (see Appendix A) specifically asked participants to share any physical symptoms they experienced, and this theme was coded 23 times in 6 of the 10 participants. Catholic priests described their physical symptoms, which included sleeplessness, loss of appetite, headaches, lack of concentration, migraines, bodily weakness, and dullness. P002 experiences palpitations and startle responses after recollections of traumatic narratives, "Sometimes my heart skips a beat when I recall details of his [Suicidal person's] stories." "Sometimes it agitates me; it scares me personally."

Subtheme 3c: The Impact of Celibacy. Interview Question 6 (see Appendix) was specific about determining the impact of celibacy on the participants' stress experience in caregiving. "The impact of celibacy" was coded 44 times across all participants. Catholic priests described celibacy as freedom; freedom from the obligations of marriage, and freedom to serve God and God's people. P005 stated, "I look at celibacy as a blessing in disguise for me. I manage my own time, and I do not have a family stressing me directly. My commitment is complete to God and his people." The priests described their lived experiences of stress as more connected to their workload than being unmarried. For instance, P001 shared, "Right now, I'm the only one, staying alone. I don't have an associate. I'm alone, and I have to process all these alone. And that has its own challenges and burdens." When asked whether being married could have reduced the current stress experienced, P001 added, "Celibacy is a grace, and it is a sacrifice I'm happily making. Stress, for me, is due to the workload, which could reduce if I had associate priests in the parish." Priests also described celibacy as different from loneliness. For P006, "being celibate does not mean loneliness for me. I'm celibate and alone, but I am not abandoned. I always connect with friends and family."

However, Catholic priests also described living a single life as a contributory stress factor. P009 described, "…living a single life has its advantage of ensuring that the priest is available, but it also leaves emotional gaps that make us vulnerable." P002 also described, "I feel the adverse impact of living alone sometimes, especially when I feel lonely with no one around to hear me out." Similarly, P004 described, "It [celibacy]

creates room for some unmet emotional needs and dangers for priests. That is why living in community with brother priests is essential, though many of us live alone."

Subtheme 3d: The Impact of Sexual Abuse Crises. This subtheme included participants' descriptions of how priests' sexual misconduct cases impacted their stress experience in trauma work and caregiving. The theme emerged from participants' responses to Interview Questions 1 to 6, and 13. "The impact of sexual abuse crises" was coded 19 times in 5 of the 10 priests. Catholic priests described the demonization of the clergy and the collective shame they experienced as stressors in caregiving because of the issues of trust involved. Priests also expressed dissatisfaction with their bishops' blanket zero tolerance policies. P005 shared, "Instead of treating each case based on their merit, the bishops have generalized their zero tolerance policies, as if they expect priests to be 100% perfect. They just added fear to the stress. Perfect priests don't exist." The participants described how this fear creates a disconnect between the priest and the help seeker. P008 shared, "These cases have created much fear and unnecessary anxiety in priests, and there is a disconnect between the priests and their parishioners for fear of being wrongly accused." P001 also experienced working with this fear:

> How do you minister in a way that you are not misunderstood? The fear is always there…dealing with the fact that you might be betrayed by the very people you are called to serve, the very people you hold dearly and pour out your life for; they are the very ones who are going to be your problem. So, while I carry the burden of their pains, I also face the challenge of putting my compassion in check

> for fear of being misunderstood. You, know, this is a dilemma that creates emotional conflict inside me.

Referring to the same experience, P002 added, “So, you are working but you are not happy.” These descriptions convey the various stress factors impacting Catholic priests’ trauma work experiences.

Overall, the descriptions of Catholic priests, relative to Research Question 1, suggest they had STS experiences with symptoms mimicking the three components of PTSD symptoms described earlier: arousal, avoidance, and intrusion. For instance, priests’ experiences of prolonged anxiety, frustration, sleeplessness, and anger mimicked the arousal symptoms. Their feeling reluctant to encounter people in distress to avoid reexperiencing accounts of trauma in which they had been involved suggested the avoidance symptoms. Their experiences of anxiety, sleeplessness, and guilt feelings due to recollections and memories of their parishioners’ trauma narratives were relative to the symptoms of intrusion.

Table 10 illustrates each participant’s shared experiences related to STS symptoms. Six participants shared experiences related to all three symptoms categories (arousal, avoidance, and intrusion), three participants shared experiences related to two symptoms categories each, and one participant (P003) reported experiences related to just one symptoms component. However, all 10 participants shared experiences related to intrusive thoughts. For some of the participants, the intrusive thoughts involved the traumatic events related to the parishioners and a reminder of their own feelings of

helplessness to address or avoid the situation. Some recalled extreme behaviors that impacted their personal lives through illness, fatigue, and depression.

Table 10

Participant's Reported Symptoms Related to STS

P#	Arousal (a)	Avoidance (b)	Intrusive thoughts (c)	Quotes from participant's descriptions relative to STS symptoms
P001		X	X	(a) No symptom shared by participant (b) "I felt like avoiding these experiences." (c) "I find myself unconsciously grieving."
P002	X	X	X	(a) "…I can't sleep because of the stories." (b) "I just feel like avoiding such…stories." (c) "I worry because I keep remembering them."
P003			X	(a) No symptom shared by participant (b) No symptom shared by participant (c) "I leave…taking the guilt upon myself."
P004	X		X	(a) "sometimes I can't sleep." (b) No symptom shared by participant (c) "I think of the painful stories I hear."
P005		X	X	(a) No symptom shared by participant (b) "I have…experiences of internal resistance." (c) "I think about it, and it is mental stress."
P006	X	X	X	(a) "Sometimes it agitates me, it angers me…" (b) "…I wished I could avoid these encounters." (c) "For weeks, my mind was just active."
P007	X	X	X	(a) "All these make me anxious." (b) "There are times when I feel reluctant." (c) "Thinking…about them can be tormenting."
P008	X	X	X	(a) "I have had nightmares…sleeplessness." (b) "I feel like avoiding these encounters." (c) "These [stories] render me sad, depressed."
P009	X	X	X	(a) "My heart skips…I become anxious." (b) "I don't like to confront those moments." (c) "I feel guilty." "I feel inadequate."
P010	X	X	X	(a) "I experience anxiety. I imagine things." (b) "I feel like…I pray I don't have to face any of these again today." (c) "I don't know how to stop thinking of them."

Note. X = Presence of symptoms. (a) = Arousal quotes. (b) = Avoidance quotes. (c) = Intrusion quotes.

Thematic Outcomes Addressing Research Question 2

The second set of core themes and subthemes, that is, Core Themes 4 and 5, and the subthemes, addressed the second research question: *How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?*

Core Theme 4: Understanding Self-Care

During the interviews, I asked the priests to define self-care (Question 9, Appendix A). Their definition ranged from being conscious of one's well-being to engaging in behavior that promotes personal wellbeing. The theme was coded 26 times across all participants. Together they described self-care as necessary for ensuring personal health and quality in pastoral care. P004 defined self-care as "…taking care of my physical and emotional health and meeting my own personal needs." "While most of the time I am thinking about others and putting them first, I know that I cannot be a helpful or effective person if I cannot care for myself first." P007 also defined self-care as "…engaging in activities, choices, and behavior that promote my personal wellbeing." Further, for P005, self-care is "…being conscious of my wellbeing and health and letting that consciousness guide my choices in what and how I do things."

Subtheme 4a: Self-Care Activities. The self-care activities domain included participants' descriptions of caring for themselves personally and what they did to maintain their health. This domain emerged in response to Interview Question 10 (see Appendix A) and was coded 37 times in 6 of the 10 participants. Self-care strategies included physical exercises, eating healthy, and taking breaks from work. P005 shared, "Each week, I take my day off. If I skip an off day because of a funeral, I usually create it

somewhere else for self-care so that I don't stay in the parish all week." P001 also shared, "Sometimes, I go on a little weekend getaway or vacations, you know. Things like that help me." For P002, "I watch movies sometimes to relax and distract my mind from thinking about the sad stories." Other self-care strategies described were taking walks, listening to music, and contemplative practices, like meditation, mindfulness, and prayers.

Catholic priests also described their difficulty in remaining committed to self-care activities. When asked about the self-care activities they engaged in, P009 responded:

> [Laughs] now, that is where the problem is. You know, we can all talk about how good self-care is, how good to do physical exercises, eat well, and so on. But doing these very things, for me, has been a problem. For instance, I wish I could eat more healthy foods. I always like to make my meals myself, but I often have no time or am too exhausted. I have not been faithful to my workouts as well. Some time ago, I started working out in the evenings with my dog, and it was quite refreshing. But I couldn't stay committed to doing that. You know, these activities are difficult to keep up with. They get crowded out by other pressing commitments.

Subtheme 4b: Coping with Stress and Anxiety. This subtheme encompassed any strategy or behavior Catholic priests implemented in response to their stress and anxiety. This theme developed in response to Interview Questions 4 and 5 (see Appendix A). Overall, the coping domain was coded 47 times in 9 of the 10 priests. The coping types included creating boundaries, having social support, spirituality, use of

medications, and some maladaptive strategies. P005 described creating boundaries as a mechanism, “I have learned with time to try to put a boundary between what I am doing so that I can have my own life.” P010 disclosed, “…my mother is a strong support and confidant.” P002 similarly shared, “I seek connection, connecting with people like friends, family, relatives, other priests.” “I engaged in conversations with people where I get some lighter moments of laughter and jokes.” For P008, “My secret is maintaining a healthy connection to God because our spiritual wellbeing is connected to our bodily well-being.” P006 also described, “I try to refuel my spiritual energy through finding time for meditations, recollections, and retreats.”

Participants also used medication to cope with anxiety on the job. P007 stated, “I was on antidepressants at some point, but I had to stop them because they came with joint pains and headaches. But I’m good now.” When asked if they had any coping strategies they considered negative, participants shared some maladaptive coping they had used. P010 disclosed, “I used to drink a lot…yea, not that I was addicted, but it provided a temporary break from mental stress. I drink only occasionally now, especially when I can’t find sleep.” For P003, the experience was, “I…overeat.” Participants, however, described their difficulty in coping as well. Unlike the other participants, P002 stated, “I do not handle it [stress] well. I do not. I just try to cope with the work each day as it comes.”

Subtheme 4c: Church Support of Priests’ Self-Care. This subtheme emerged from the participants’ responses to Interview Question 11 (see Appendix A). The theme was coded 17 times in 8 of the 10 participants. Catholic priests described ways the church

encourages self-care among priests. P005 shared, "…our diocese encourages a lot of support groups…like classes of priests, or priests who have something in common. We support and help each other." P002 also shared, "Occasionally, during retreats and gatherings, issues about self-care and health are discussed. That's all about it. Each person is expected to make efforts to stay healthy." Priests described self-care as requiring personal commitment, "…how else will the church promote self-care than to talk about it and encourage everyone? You know, every priest is to look after himself as best as he knows how." For P003, "The church needs to be more conscious of the mental wellbeing of the priests to ensure the mental health of the church itself."

Subtheme 4d: Church Resources for Priests' Mental Health. Interview Questions 7 and 11 provided an opportunity for participants to describe the resources in the church that might relieve their stress and anxiety experiences. This domain was coded 29 times in 6 of the 10 participants. Participants' descriptions included varied lived experiences regarding the availability of mental health resources. For P001, "…spiritual directors and confessors are highly recommended for priests. These can be helpful for counseling and direction." P006 described other spiritual resources:

> Daily meditation, faithfulness to the liturgy of the hours, monthly recollection, and our annual retreats have been great resources for me. Retreats are not only moments of prayers, but they are also opportunities for unwinding and sharing my experiences with fellow priests.

Further, P005 shared, "[My] diocese has so many programs that could be helpful. There is a priest in charge of our personal, internal affairs that I can talk to, and we call him the

servant of servants." P005 added, "[My] diocese is very supportive in terms of sending [priests] to treatment centers sometimes, if they know somebody has a problem."

Other participants like P002 had a different lived experience in their diocese regarding mental health resources:

> As far as I know, we have no support system in this diocese. Every priest is left to figure it out and manage their stress and mental health as they deem fit. Priests' mental health as a topic sometimes draws short-lived attention only when there is a failure or abuse on the part of a priest, and that's when the harm has been done. In most cases, the immediate response is to send the priest on a compulsory spiritual retreat or recommend some psychotherapy. But that has not led to a systemic or proactive measure by my diocese as an organization.

Similarly, P004 shared, "…in the area of mental health support or psychological resources; I cannot identify any resources in my diocese." In this sub-theme of church resources, participants shared differing lived experiences regarding the availability of mental health resources.

Core Theme 5: Suggestions for Priests' Well-being

This theme developed from the participants' responses to Interview Questions 12 and 13 (see Appendix A). "Suggestions for priests' wellbeing" was coded 66 times across all participants. Catholic priests' suggestions for improving their well-being included training fellow priests as experts in psychotherapy, organizing refresher courses for priests, and providing motivational incentives. P007 suggested, "I would recommend that

fellow priests be trained as mental health experts and let their role be to help their fellow priests manage their stress and mental health issues." P004 similarly suggested,

> Every diocese needs to invest in this [mental health] because, as we are encouraged to go on this journey with spiritual directors, priests in distress also need advice from psychologists. All dioceses [should] have a counseling unit where priests can visit the professionals in their diocese on their own when they have some problems.

Participants also suggested that the assignment of priests be done after consultations with priests. P005 stated, "We are all priests but gifted differently. I recommend there should be more consultations between priests and their bishops before a priest is assigned." The participant added, "I am given an assignment, and I am told to do certain things. I am not happy about it, but I go anyway because I have to obey. Now, that is the beginning of stress." Additionally, P001 recommended,

> Every 7 years, priests should be allowed to go on a full sabbatical year so they can get back to the ministry refreshed, reinvigorated. You know, the vigor of a priest after 10 years is not the same as 2 years. The vigor of a priest 15 years into the ministry is no longer the same. The vigor is no longer the same after 20 years. So, at some point, authorities should allow priests to determine what ministry areas would be best for them. Priests should be allowed to experience different aspects of ministry, not just parish ministry but also campus ministry, or school ministry, or youth ministry, or music ministry. These can break the monotony in the experience and prevent burnout.

Participants also suggested refresher courses for priests. For P006, "[There should be] sponsored ongoing refresher courses for all priests every year." The church should "…design 1 to 3 months programs around the anniversaries of priests after 10 years and after 20 years of ministry where they come together to reevaluate and rediscover themselves and take up new challenges going forward." P003 added, "Our experience as a church shows that it is not enough just to ordain priests and say: 'you are ordained, and therefore you are now responsible for yourself and your upkeep.' The carer needs care, too."

Core Theme 5 had a subtheme that was coded "Preparing Future Priests for Trauma Work." This subtheme encompassed any suggestions priests provided for preparing seminarians for trauma work in response to Interview Questions 8, 12, and 13 (see Appendix A). Overall, this domain was coded 32 times across all participants. Suggestions included introducing mental health courses in the seminary curriculum, exposing seminarians to the reality of trauma work and how to manage it, and training seminarians on self-care. P006 suggested, "[Assign] seminarians to various care facilities as interns under supervision." P004 commented, "Most priests are doing badly on self-care…training seminarians on self-care…is necessary. If dealing with this emotional stress is real, then self-care is on the flip side of the conversation." Similarly, P001 suggested, "…connect seminarians with psychologists, psychiatrists, therapists, and life coaches, both for personal wellbeing and for possible collaborative ministry."

Summary

The purpose of this qualitative, transcendental phenomenological study was to explore the lived experience of STS among Catholic priests and how they described their use of self-care strategies to either prevent or cope with STS. Using the semistructured interview method, I collected rich data from 10 Catholic priests to answer the research questions: (a) What are the lived experiences of secondary traumatic stress among Catholic priests? (b) How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry? I followed Cilesiz's (2010) outline of Moustakas' (1994) transcendental phenomenological data analysis process. I used the MAXQDA 2020 software to organize, code, and group the data.

The data analysis process yielded 5 core themes and 13 subthemes that sufficiently addressed both research questions. The first core theme was pastoral motivation, with learning curve as a subtheme. The second core theme was encountering people with trauma, and the subthemes were feelings of inadequacy, emotional dissonance, and feeling reluctant to encounter people in distress. The third core theme was caregiver stressors, and the subthemes were coping with stress and anxiety, prolonged experiences related to trauma work, physical symptoms, the impact of celibacy, and the impact of sexual abuse crises. The fourth core theme was understanding self-care, with self-care activities, coping with stress and anxiety, church support of priests' self-care, and church resources for priests' mental health as the subthemes. The fifth core theme was suggestions for priests' well-being, and the subtheme was preparing future priests for trauma work. I defined each theme, used tables to illustrate each group

of themes, and described the participants' lived experiences with excerpts from their interview transcript. Chapter 5 will include the interpretation of the findings, the limitations of this study, recommendations, and the study's implications.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand how Catholic priests described their lived experiences of STS due to pastoral caregiving and their use of self-care to prevent or cope with the experience. Previous empirical research suggests high rates of STS in individuals who care for traumatized people (Kim, 2017; Ratrout & Hamdan-Mansour, 2020). However, I found no explicit discussion of STS among Catholic priests in the extant literature. Thus, by exploring Catholic priests' lived experiences working with trauma, this study expands the literature on STS among human service workers to include Catholic priests. I used the transcendental phenomenological approach for this study because the methodology allowed for collecting rich contextual data from the participants and keeping their voice and subjective meanings of STS. According to Morrow et al. (2015), the transcendental phenomenological approach is essentially descriptive and, therefore, valuable for exploring topics where little research exists. I found this approach very beneficial to this study.

I used the semistructured interview method to collect data from 10 Catholic priests. I followed the epoche protocol as recommended for a transcendental phenomenological inquiry (see Moustakas, 1994) and bracketed my assumptions and biases about STS. The priests described their lived experiences relating to encountering people with trauma, pastoral motivation, caregiver stressors, understanding and use of self-care, and the support systems and resources available to them. The findings revealed that Catholic priests find trauma work fulfilling as well as distressing, stressful, difficult, overwhelming, and frustrating.

In this chapter, I interpret this study's findings and compared them to findings from previous research. I also present the limitations of the study, my recommendations for future studies, the implications of the current study for positive social change, and a conclusion.

Interpretation of Findings

I divided the interpretation of findings into two parts as they related to the two research questions that guided this study. The first research question was: What are the lived experiences of STS among Catholic priests?

The findings indicate that priests experience symptoms mostly consistent with Bride et al.'s (2004) description of the classic symptoms of STS mimicking PTSD, namely arousal, avoidance, and intrusive thoughts. Besides these symptoms directly associated with STS, the findings also confirmed those of previous studies that discussed other related indicators of secondary traumatization. For instance, Sprang et al. (2019) observed that helping professionals could respond to their exposure to secondary traumatic stressors with symptoms such as a reduction in the professional's self-efficacy. Similarly, Foreman et al. (2020) reported that counselor trainees described experiencing doubts about their competence and having emotional and cognitive reactions to trauma cases. The current study results showed that priests questioned their aptitude (i.e., feelings of inadequacy) as they expressed challenges to their competency and felt inadequate and helpless. Despite differences in experience, priests' lived experiences in the current study confirmed the earlier findings and pointed to the need for some basic

training in mental health for priests and collaboration with professionals in the mental health field.

Findings from this research are also consistent with past studies indicating that trauma victims had trouble disengaging from traumatic material. Aupperle et al. (2012) observed that people living with PTSD often had difficulty disengaging from the core of trauma stimulus that drives and maintains the disorder. According to Ludick and Figley (2017), this inability to disengage from the traumatic content could hinder attentiveness to family, friends, positive emotions, and pleasurable activities, which, in turn, maintain the emotional numbness and depression associated with trauma exposure. Catholic priests in the current study described that they had prolonged experiences related to trauma work, including flashbacks, loss of appetite, anxiety, and fear. The current findings confirm those of the previous studies and show the need for Catholic priests to process traumatic materials consciously and continuously to assimilate the events in guilt-free, adaptive ways.

Additionally, priests reported experiencing tensions when they perceived their internal role conflict and displayed feelings that were discrepant from their actual emotions. This finding relates to the literature on emotional dissonance. Fiabane et al. (2019) described emotional dissonance as the conflict between the emotions that employees are required to show at work and the emotions they genuinely feel. Earlier studies found that emotional dissonance had detrimental consequences for workers' mental health and organizational performance (Mroz & Kaleta, 2016). Fiabane et al. found that emotional dissonance was significantly related to emotional exhaustion in

health care professionals. In the current study, the lived experiences of priests included showing pastorally expected emotions regardless of their felt emotions during encounters with traumatized parishioners. This dissonance in emotions could have contributed to priests' reluctant feelings (i.e., avoidant symptoms) and might lead to cynicism or disdain toward the people they care for, an attitude not normally expected among members of clergy.

Furthermore, participants in this study reported personal growth and improvement because of their experiences in trauma work. Posttraumatic growth encompasses the positive changes in self-perception, interpersonal relationships, and philosophy of life (Foreman et al., 2020; Yu et al., 2016). Catholic priests described how they had grown, improved, or expanded their perspectives about life from ministering to trauma victims. They also discussed having an increased appreciation for life. These findings are similar to those of Brockhouse et al. (2011), who evaluated posttraumatic growth in professional counselors, and Lu et al. (2017), who reported improved self-efficacy, the importance of self-care, and increased motivations for learning among counseling students exposed to trauma cases. The findings of the current study extend the literature on posttraumatic growth to include Catholic priests.

Despite the evidence from previous studies associating religion or spirituality and spiritual resources with enhanced physical and mental well-being (Lewis & King, 2019; Tan & Castillo, 2014), findings from the current study suggest that, given the adverse effects of trauma work, the practice of religion or spirituality alone, even by priests, does not guarantee the absence of STS experience. Instead, this study confirms that anyone

who empathically engages in helping traumatized individuals could experience STS (Figley, 1995, Mordeno et al., 2017), including those who consider trauma work as part of their divine assignment. The findings provide additional evidence that a person does not need to be responding to major trauma events or providing counseling per se as part of the work for STS experience to be considerable. Instead, the secondary exposure to trauma, which comes as part of the ministry of caring for others, may be sufficient to evoke a traumatic reaction. Thus, the priests' descriptions of the cost demanded from them due to trauma work may not be surprising.

However, what was surprising was that some of the priests did not mention the subjects of God and faith in their interviews. This observation suggests various interpretations. One interpretation could be that, given their priestly role, these participants assumed I would accept the influence of their faith as a given assumption and, therefore, there was no need to mention it. Another interpretation could be that these priests, whose personal and professional essence is tied to their faith and spirituality, felt pressured not to admit a cost that involved their spirituality and faith. While this second interpretation may have some validity, participants in this study did not appear to intentionally hold back on this subject, given their honesty in the other aspects of the interviews.

The other participants who did mention the subject of God, as expected, described their faith-related motivation for trauma work and their dependence on God when they faced helplessness in trauma work. Contrary to Saakvitne and Pearlman's (1996) observation that trauma-related experiences could lead to a loss of faith in God, these

participants did not describe losing their trust in God due to trauma work. Instead, their faith and dependence on God appeared to have been strengthened through the helplessness they experienced in trauma work.

New findings in this study suggest that the veil of absolute secrecy under which priests provide counseling could sometimes be an added source of emotional disruptions in priests. Participants described their prolonged experiences of fear because they encountered individuals with confessional stories about doing violence to others. A participant also mentioned, "Sometimes, drawing the line between the one who is in need of spiritual assistance and the one who is falling in love gets collapsed in-between" (P006). Unlike professional therapists who may be ethically and sometimes legally required to breach confidentiality if help seekers pose imminent dangers either to themselves, the therapists, or others (Welfel, 2016), the legalities of a duty to warn do not extend to priests, except in cases involving the abuse or neglect of children where, in some states, priests have a mandate to report (Child Welfare Information Gateway, 2019). While this veil of confidentiality may have a spiritual and ethical value for their ministry, the current findings indicate that this secrecy could be an added stress factor for priests as they take on trauma and cannot share the experience.

Priests reported additional caregiver stressors not found in the previous literature. The cases of sexual misconduct by some clergy in recent years and the consequent generalized outcry against the clergy created much fear and anxiety in the participants. Their lived experiences included feelings of disconnection from their help seekers for fear of being wrongly accused. On the organizational level, the blanket zero tolerance

reactionary policies across dioceses further increased priests' mental stress. These secondary battles with collective guilt and shame possibly exacerbated the participants' experiences of STS symptoms and adversely impacted their pastoral caregiving to their parishioners.

Overall, trauma work, for the participants, appeared to be a sacred burden, which they bore as part of their call to undertake Christ's ministry on earth. Despite their symptoms of STS, they found ways to steady themselves and carried on with their work. Although individual differences might have influenced each priest's experience, the interviews revealed that their involvement in trauma work was a major source of the painful experiences they described.

The second research question that guided this qualitative research was: How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?

Priests in the current study accessed personal resources of self-care strategies, such as physical exercises; healthy eating; taking breaks; music; contemplative practices, like meditation, mindfulness, and prayers; and connecting with others as ways to mitigate the impact of their trauma work experiences. These strategies are similar to the self-care activities described in previous studies (Dorociak et al., 2017; Lewis & King, 2019; Tan & Castillo, 2014). The priests in this study agreed with Pakenham (2015) that self-care is principally a personal responsibility. However, the findings in the current study indicate that priests often ignored their own physical and mental health needs, thereby possibly affecting the help they provide for their parishioners.

What was apparent from the interviews was that strategies to ameliorate the effects of trauma work were left mainly to each priest and not multilayered. Priests portrayed the church as not proactive in raising and promoting awareness regarding priests' self-care and well-being. While an organizational approach may not minimize the responsibility of priests to ensure that their mental health and development are intact as they navigate the impact trauma work, the church needs to provide tailored support to priests to increase their resilience levels and equip them to have a balanced approach to life and work. Such organizational commitments to priests' well-being should be reflected in the church's governing policies.

Organizational support could include a formal training of priests in crisis intervention. Like the previous research, which associated higher levels of resilience to formal training in pastoral crisis intervention (Noullet et al., 2018), the findings of the current study indicate that training in crisis intervention could help increase resilience levels in priests. For instance, P003, being the only participant with clinical pastoral education (see Table 1), experienced the least symptoms (see Table 10). Perhaps, this participant was more resilient because of their training in crisis intervention. For Catholic priests, exposure to secondary trauma is inevitable; therefore, the church's attention needs a deliberate shift to providing support and resources to enhance coping strategies and increase priests' resilience levels.

Comparison of the Findings to Emotional Contagion Theory

With emotional contagion theory, Hatfield et al. (1994) explained how the transmission of emotions from the observed to the observer occurs through language

mediation or perspective taking. Regarding STS, the emotional contagion theory was conceptually consistent because the theory implied the affective process in which trauma caregivers feel emotional responses like the trauma victims' actual or anticipated emotions. Thus, as a component of the conceptual framework for this study, the emotional contagion theory provided a pathway for approaching the first research question regarding the lived experiences of STS among Catholic priests and offered a lens for understanding the participants' descriptions in answer to the question. Table 11 shows the alignment of the emotional contagion theory with themes from the participants' descriptions.

Table 11

Comparison of Themes to the Theory of Emotional Contagion

Conceptual Framework/Theories	Themes	Alignment with Conceptual Framework/Theories
Hatfield, Cacioppo, and Rapson's theory of emotional contagion (Hatfield et al., 1994). Transmission of emotions: Implying the affective process in which trauma caregivers feel emotional responses that are like those of trauma victims' actual or anticipated emotions.	Encountering people with trauma, feelings of inadequacy, emotional dissonance, feeling reluctant to encounter people in distress, learning curve, prolonged experiences related to trauma work, caregiver stressors, physical symptoms	Catholic priests described having repeated encounters with trauma in pastoral work. They empathically identify with the negative emotional states of the traumatized, psychologically take the perspective of the traumatized, and are at the risk of being secondarily traumatized. Priests described having the various emotional and physical symptoms associated with STS: arousal, intrusive thoughts, and avoidance.

Comparison of the Findings to CFRM

Ludick and Figley (2017) developed the CFRM with four components: self-care, detachment, sense of satisfaction, and social support. These components counterbalanced empathic response-related stress, trauma memory-related stress, overexposure to trauma-related stress, and stressful life events-related stress. As a part of the conceptual framework for this study, the CFRM was consistent with the second research question inquiring how Catholic priests used self-care to respond to secondary traumatic exposure in pastoral work. The priests' various descriptions of self-care and suggestions for well-being were akin to the components of CFRM. Thus, the CFRM provided the lens for understanding priest's perceptions and use of self-care and the basis for making suggestions to improve their overall well-being. Table 12 shows the alignment of CFRM with themes from the participants' descriptions.

Table 12

Comparison of Themes to Compassion Fatigue Resilience Model

Conceptual Framework/Theories	Themes	Alignment with Conceptual Framework/Theories
Ludick and Figley's compassion fatigue resilience model (Ludick & Figley, 2017). The model offers four nurturance strategies for self-care: Self-care, detachment, sense of satisfaction, and social support.	Understanding of self-care, self-care activities, coping with stress and anxiety, church support of priests' self-care, church resources for priests' mental health	Catholic priests were aware of the importance of self-care to buffer against the impact of traumatic exposure in trauma work. They engaged in some activities like physical exercises, creating boundaries, contemplative practices, and hobbies. They acknowledged the need for each priest to pay a closer attention to their self-care and wellbeing and for the church organization to provide mental health support and resources.

Limitations of the Study

The current study provides in-depth information on the impact of trauma work on Catholic priests and contributes to the literature on STS. However, identifying the limitations of a qualitative study enhances the trustworthiness of the findings (Creswell & Creswell, 2018). There are four limitations to consider in this study. First, I am a Catholic priest and the researcher in this study. While being a Catholic priest possibly enhanced my access to the participants and encouraged them to share their personal experiences more freely and honestly with me for this study, concerns about my objectivity, as the researcher, may arise. Monette et al. (2014) observed that sharing similar characteristics with the research participants could lead to researcher-induced biases in a study. To counter this threat to trustworthiness, I engaged in the phenomenological attitude, set aside my preconceptions throughout this study, and preserved the voice of the participants and their subjective meanings of STS. These bracketing efforts notwithstanding, some researchers have argued that establishing and maintaining pure bracketing was impossible (Davidsen, 2013; Rennie, 2012). These researchers may interpret the findings of this study differently.

Second, the qualitative, phenomenological research approach to this study did not allow for a larger sample size. For a phenomenological study, Creswell (2013) suggested a sample size of five to 25. Thus, a sample size of 10 participants was appropriate for this study, and the participants did provide rich data that adequately addressed the research questions. However, a different research approach may allow for more research

participants and generate evidence that either strengthen or weaken this study's conclusions.

Third, the information shared in this study is limited to the experiences of Catholic priests, a homogenous group whose experiences may not match the experiences of clergy from other denominations and religions. Last, because the participants in the current study were priests working in the United States, replicating the study among priests outside the United States, especially in collectivist cultures where priests may have a different social support experience, may yield different results. In the next section, I present some recommendations for future research based on these limitations and the findings of the study.

Recommendations

This study is the first to discuss STS among Catholic priests explicitly, and the findings reveal the psychosomatic price that priests pay for providing care to traumatized individuals in their parish communities. Given these findings and the paucity of STS research among the clergy, researchers have an almost ethical and moral obligation to engage in research that provides further understanding of this phenomenon among priests. For instance, this study's findings emerged from data collected from cross-sectional interviews. Future studies with longitudinal perspectives may focus on how STS experiences evolve and impact priests' personal and professional lives and morale over time.

Additionally, participants in the current study reported fulfilment in trauma work despite the hardships they experienced. More research on the positive aspects of this

ministry may provide a better understanding of how to enhance its rewards and decrease or prevent unnecessary stress. Further, future researchers may employ the mixed methods design, which allows for larger sample size and enables researchers to capitalize on the strengths of both qualitative and quantitative methods to produce complementary and corroborative evidence. Such research efforts may determine whether differences exist in STS experiences between priests of rural dioceses where access to helpful resources is often limited compared to priests of urban dioceses who may have fewer challenges accessing help.

Researchers may apply the same approach to determine the extent of differences in STS experiences between priests from religious orders, who often live in a community with other priests, compared to diocesan priests who often live alone in parishes. Such future research may further clarify this study's findings that being alone in the parish impacted priests' STS experiences more than being celibate. Researchers may also examine secondary traumatization in priests serving in places where they could have a higher likelihood of being exposed to STS than in parishes, such as the military, prisons, and hospitals. Furthermore, as I earlier alluded, research on STS experiences among priests outside the United States may provide additional insight into the conversation due to the potential differences in sociocultural factors that may influence priest's experiences in trauma work.

Implications

Positive Social Change

The findings of the present study can create or increase priests' awareness of the risk of secondary traumatization and how to develop strategies for self-care toward either preventing or managing the experience. This awareness creation can enhance priests' overall well-being and lead to improved quality of pastoral care for traumatized individuals who rely on their priests for help. Catholic priests may display more of the compassion and empathy needed in their therapeutic alliance with their parishioners and make counseling interactions more fruitful. Although this is the first study to focus on STS among Catholic priests, the findings can have a global impact as more research continues to pay attention to the issues raised in the current study. As I earlier described in chapter one, there are about 1.3 billion Catholics worldwide, about 16% of the world's population (Vatican Secretariat of State, 2020). With such a vast number of Catholics in the world directly impacted by the pastoral ministry of Catholic priests, the findings of this study can have global implications as the improved ministry of priests to traumatized people can collectively have a ripple effect on the world, even beyond those practicing the Catholic faith.

Institutional Implications

The current study has implications for informing theological institutions of learning. The findings indicated that formal training in crisis intervention helped increase resilience and decrease STS in priests, thus highlighting the need for specialized training of priests in working with trauma. Given this potential benefit associated with training in

crisis intervention, institutions involved in educating priests, such as seminaries and theological colleges and departments, should consider offering formal pastoral crisis intervention training as a part of their curriculum. Priests and seminarians may benefit from receiving such training focused on role definition, increasing competency in assessing and providing mental health services, increasing resilience, and informing priests about community resources that can support their pastoral caregiving to traumatized individuals.

Whereas priests' confidence (or feelings of inadequacy) may improve with years of experience in other areas of ministry, like preaching and administration, the same may not be assumed about priests' confidence in trauma work. Despite the participants' years of experience ranging from 1 to 19 in this study, their reported experiences of trauma work and use of self-care were not different essentially. Thus, without specific training and continuing education in mental health counseling and resources for building support and resilience, priests' confidence as trauma workers may not improve with years of experience alone.

Implications for Church Leadership

This study has several implications for the leadership of the church as an organization. Participants' experiences in the current study confirmed Oliver et al.'s (2018) observation that organizational support for professionals working with trauma was necessary for preventing or coping with STS. Priests' experiences in this study suggest the need for a more deliberate effort on the part of the church leadership to provide adequate mental health support for priests. For instance, bishops or dioceses could

establish and adequately fund mental health support programs that provide confidential professional consultations for priests engaged in pastoral work. There is a need to pay attention to subtle changes and behaviors that indicate a priest experiencing stress and needing tailored support. Such clinical assistance should not be seen as professionally negative or stigmatizing but as a normal part of the ministry of pastoral caregiving. Presenting spirituality as the only protective factor against secondary traumatization in priests may be undercutting the impact of traumatic exposures in pastoral ministry and could result in priests living with STS denying the experience and failing to seek help for fear of being perceived as lacking in faith or unspiritual.

Additionally, the findings point to the need for the church to train experts in psychology and psycho-spirituality to screen for problems in priests in training and provide them with the needed help before ordination. Candidates with psychological issues, such as persons with unresolved trauma histories, those with anxiety disorders (e.g., generalized anxiety, phobias, or panic), those with personality disorders (e.g., narcissistic, dependent, or antisocial), or addictive personalities should be identified early in the process because they may be particularly vulnerable to STS and self-destructive and impulsive behaviors (see Weiten, 2018). In addition to resources like spiritual direction and formation, the church needs to increasingly recognize the role that psychotherapy can play in assessing whether these issues can be resolved sufficiently for seminarians to continue the candidacy process.

Bishops, superiors, and others responsible for the pastoral posting of priests could also find value in the participants' suggested need for consulting with priests on their

individual abilities and psychological readiness before assigning them pastoral responsibilities. Assigning priests duties for which they are not suited could be the beginning of their mental stress experiences. Likewise, incentivizing priests, especially those with heavier pastoral workloads, could demonstrate the church's recognition of the priests' pastoral efforts and commitment to their welfare. Such incentives could boost the priests' self-esteem and motivation, which can get eroded with continuous exposure to traumatic material.

Given the findings in this study regarding priests' experiences and behaviors, the church may need to pay closer attention to psychological research as a tool for identifying, understanding, and findings solutions to problems that could render pastoral work less fruitful. I have recommended some areas for further research based on priests' experiences shared in this study. More research could be a means of unearthing potential damages to the body of Christ. The church could fund and benefit from such research directly as the mental well-being of priests and parishioners would mean well for the entire church.

Implications for Practice

This study also has implications for practice. Consistent with past studies, the findings emphasized the importance of adequate self-care on the part of priests, including prioritizing their mental health. Self-care could include receiving regular spiritual direction from a trusted confessor or mentor, having a disciplined spiritual life, and joining a support group where there is a satisfying depth of bond. A priest's commitment

to personal and professional health could also include the essential tasks of tending to their own self-care and treating themselves to therapy.

Additionally, the findings suggest the need for priests to pay attention to their feelings, know the limits of their expertise, and set boundaries at work. Priests may consider caring for the traumatized as a sacred duty, but interactions with the traumatized could be counterproductive or even harmful when factors related to personal struggles and work demands stress the priests mentally. Reflexive practice and increased self-awareness would not only enhance the quality of pastoral caregiving but could potentially assist priests in regulating the negative effects of trauma work and increase work satisfaction. Priests should make personal and collegial efforts to be familiar with STS and related psychological concepts described in this study, including vicarious trauma, compassion fatigue, and burnout, to increase their awareness of some of the inherent hazards in the counseling process.

Conclusion

The purpose of this study was to explore Catholic priests' lived experiences of STS and how they used of self-care in response to secondary traumatic exposure in pastoral ministry. The findings revealed that Catholic priests experience STS and present various symptoms of the condition due to their indirect exposure to parishioners' traumatic material. The qualitative approach to this study enabled the gleaning of the physical, emotional, behavioral, and cognitive manifestations of STS among priests. These personal, social, and psychological costs associated with priestly ministry to the traumatized may not be surprising because of the role that priests generally play, which

spans from the first point of contact when a parishioner is considering seeking help with some niggling concern of distress to the most intense crisis support when parishioners experience extreme life-altering events. Given this fluidity of priests' role, defining the limits of their work may be difficult to articulate and even more challenging for priests to implement. In the process, priests get exposed to various stressors, sometimes including extreme traumatic material like those described in this study.

Although the participants acknowledged the importance of self-care for personal well-being, the findings revealed that priests could ignore their own well-being while caring for others and meeting the daily pastoral and administrative demands. Therefore, as caregivers who are exposed and vulnerable to STS, priests need to pay closer attention to their self-care. They need to receive adequate training, become aware of the risk of secondary traumatization, and learn to build resilience. Additionally, the church organization needs to be proactive in developing structures and designing and funding programs that provide adequate mental health support resources and training for priests. These efforts are essential and should be continuous if priests are not to become traumatized and less effective in furthering the church's mission of healing. Overall, the current study extends the extant literature on STS to include the lived experiences of Catholic priests and can inform more outcome research that assesses effective strategies to prevent or reduce STS experience among Catholic priests and the clergy in general.

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Appendix A: Interview Protocol

Secondary Traumatic Stress Among Catholic Priests

Date of Interview:

Time of Interview:

Interviewer:

Interviewee #:

Research Question 1. What are the lived experiences of secondary traumatic stress among Catholic priests?
Interview Guide: Tell me about your pastoral experience of ministering to persons who were traumatized. Describe how your experience of helping traumatized people affected your subsequent pastoral disposition to similar situations. In what ways did you feel inadequate to help such persons regain their emotional wellbeing? Describe ways in which ministering to the suffering and traumatized causes you stress and anxiety and how you handle it. What specific physical symptoms do you experience due to your pastoral availability to the suffering members of your congregation? How do you cope with the symptoms? As a Catholic priest, you are not married and do not have a family. How does your single status impact your experience of stress due to pastoral work? Tell me about any support systems that you may have in the church if you experience stress or anxiety. In what ways might the church prepare future priests for working with traumatized people?
Research Question 2. How do Catholic priests use self-care in response to secondary traumatic exposure in pastoral ministry?
Interview Guide: Describe what self-care means to you. Tell me about the activities you engage in that lead to self-care. In what ways does the church promote self-care among priests? What suggestions do you have for improving self-care practices among priests? What other relevant information would you like to share from your experience?

Thank you very much for your time and for sharing experience with me for the purpose of this research. I hope I can get back to you if I have further questions. Thanks a lot.

Appendix B: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

This research is being undertaken by Richard Ehusani, PhD candidate in the Department of Psychology, Walden University. The purpose of the research is to explore secondary traumatic stress among Catholic priests. As a transcriber of this research, I understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentially agreement. I agree not to share any information on these recordings, about any party, with anyone except the researcher of this project. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

I, Gabe Goldman (Rev Transcription) _____ agree to:

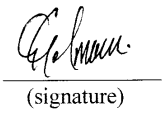
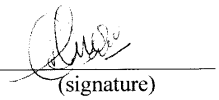
1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format (e.g. WAV files, CDs, transcripts) with anyone other than the Researcher. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.

2. Keep all research information in any form or format (e.g. WAV files, CDs, transcripts) secure while it is in my possession.

3. Return all research information in any form or format (e.g. WAV files, CDs, transcripts) to the Researcher when I have completed the transcription tasks.

4. After consulting with the Researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher (e.g. CDs, information stored on my computer hard drive).

5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.

Transcriber: **Rev Transcription Service**		**Dec/10/2020**
(print name)	(signature)	(date)
Researcher: **Richard Ehusani**		December/10/2020
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