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The Perception of Therapists About Compassion Fatigue and Burnout After Working With Victims of Domestic Violence

Bernadine Edwards
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Walden University

College of Psychology and Community Services

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Bernadine K. A. Edwards

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the review committee have been made.

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Walden University
2025

Abstract

The Perception of Therapists About Compassion Fatigue and Burnout After Working

With Victims of Domestic Violence

by

Bernadine K. A. Edwards

MA, Walden University, 2020

BS, Mona Campus Jamaica University, 2015

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

Walden University

February 2026

Abstract

This qualitative study involved gaining a better understanding of the perceptions of therapists who work with domestic violence victims, and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. The goal was to gather firsthand data regarding the lived experiences of therapists. This study involved conducting semi-structured interviews with six counselors, listening to lived experiences, reading transcriptions, taking and reading notes in a journal during and after interviews, and analyzing data. The social ecological theory guided the study. The research identified 11 key themes highlighting the significant stress associated with this job. All participants met the inclusion criteria of the study. They were licensed therapists with experience working with victims of domestic violence and licensed therapists with varying ages and lengths of service. The study found that there is a critical need for mentorship, supervision, and the ability to consult with colleagues and peers about these situations. This underscores the need for institutional knowledge, more robust institutional support, trauma-informed supervision, and social contextual structures that need to be created to protect therapists and victims. The findings of this study have potential implications for positive social change by informing the development of policies and practices that better support therapists and other helping professionals working in high-stress environments.

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Dedication

I would like to dedicate this research study to my amazing mother, Marcia Edwards, whose love, patience, and unwavering belief in me provided the strength to persevere throughout this journey. I am forever thankful for your love, guidance, and sacrifices that kept me moving forward. I would also like to dedicate this to my grandmother, Venus McCree, whose love and prayers carried me through, and to my great Uncle Kelvin Harry, whose words over my life still inspire me; I know you are smiling in heaven. I extend heartfelt gratitude to my family members and friends for their patience, understanding, and encouragement, and above all, I thank God for His wisdom, perseverance, and grace. This achievement reflects divine faithfulness, perseverance, and the love of those who stood beside me. Finally, I can say my life has meaning because I have the Highest God as my Savior, the driving force behind my journey to becoming a future Doctor.

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Chapter 1: Introduction to the Study

Introduction

Over the years, therapists have been assessing, guiding, and working with victims to help them overcome personal issues. Researchers have reported that therapists face difficulties due to their work (McNeillie & Rose, 2021). Hence, there is often a failure to adequately recognize domestic abuse in the victims that they treat (Brandt & Rudden, 2020). Moreover, therapists may become overwhelmed and be unprepared for the complexity of the clinical assessment (Melaki & Stavrou, 2023). Therapists' reactions to the traumatic events of their patients may cause reactions that go unnoticed (McNeillie & Rose, 2021). Helping victims of violence may cause the therapists to be at risk for secondary traumatic stress symptoms and other negative consequences such as burnout and compassion fatigue (Brend et al., 2019). Therapists can become victims of trauma when they try to alleviate the pain and suffering of those who have experienced any trauma (Ogińska-Bulik et al., 2022). Therapists can feel drained and trapped working with their patients (McNeillie & Rose, 2021). This study focused on the perceptions of therapists about compassion fatigue and burnout after working with victims of domestic violence. Specifically, I explored how therapists work impacts them and what coping strategies therapists use to work with this patient population.

It is important to have increased knowledge and awareness of the internal and external factors therapists face in their experiences working with survivors of domestic violence (Melaki & Stavrou, 2023). It is not fully understood how working with survivors of domestic violence affects the psychological functioning of therapists (McNeillie &

Rose, 2021). Hence, the emotional and psychological injuries that therapists may experience are seldom addressed in the research, these effects should be addressed. It is important to have a greater understanding of the problems therapists encounter during sessions, how those problems impact role expectations, and the psychological consequences of working with domestic violence victims (Beckerman & Wozniak, 2018). In general, research about therapists' perceptions of working with survivors of domestic violence is limited. Understanding domestic abuse from the therapist's perspective is vital (Harling et al., 2020).

The purpose of this study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. In this chapter, I will present the background and research problem of the study and provide a brief overview of how the study was conducted to address the gap and address the research questions. The theoretical framework describing social ecological theory will also be described, as well as definitions of terms, assumptions of the study, and limitations/challenges/barriers. This chapter will also include the significance of the study and the anticipated social changes to society resulting from the study. A summary will complete the chapter. This study could aid other therapists, the academic community, trauma victims, counselors, and practitioners in helping them understand the lived experiences of therapists who work with domestic violence trauma victims.

Background of Problem

Some therapists may work with victims of domestic violence. Domestic violence is acknowledged as a severe and violent crime and experiencing it can severely impact therapists who witness the aftermath of domestic violence with their client population (McNeillie & Rose, 2021). It can also seriously affect the therapists, including therapists' physical, psychological, and emotional well-being (Oginska-Bulik et al., 2022). The therapists' focus is often to understand domestic violence, but sometimes, face many stressful situations in the therapist's daily life (Melaki & Stavrou, 2023). Hence, the impact of working with trauma is profound and complex for therapists bearing witness to their client's pain and, concurrently, the therapists' self-development (Beckerman & Wozniak, 2018). In essence, therapists may be plagued with emotional and psychological experiences as a result of repeated exposure to domestic abuse victims (McNeillie & Rose, 2021; Oginska-Bulik et al., 2022). Therapists may be faced with potentially internalizing their victim's stories (Brend et al., 2019). Oginska-Bulik et al. (2022) postulated that therapists who work with trauma victims are themselves affected in an indirect way as a result of listening to and discussing traumatic events from the victim's narrative.

According to Oginska-Bulik et al. (2022), studies have been conducted that focused on the perspective of the victims and perpetrators of domestic violence. The researchers, according to Oginska-Bulik et al. (2022), were attempting to understand the phenomenon better and suggest strategies for victims of domestic violence to successfully address their situation (Dejonghe et al., 2008; Griffing et al., 2006; Ogińska-

Bulik & Michalska, 2020). However, emphasis should be placed on looking at the perspective of therapists who work closely with victims who are associated with trauma (Ben-Porat & Itzhaky, 2009; Bride, 2004; Manning-Jones et al., 2017). Therapists assessing victims of domestic violence have seen therapists neglecting their own needs (Melaki & Stavrou, 2023). Ultimately, therapists can be left feeling drained and like there is no escape from working with victims of domestic violence (Melaki & Stavrou, 2023). As a result, therapists try to understand the effects of trauma as these experiences challenge therapists' existing global beliefs and, as such, change the therapists' cognition (McNeillie & Rose, 2021).

In this research, I sought to gain a better understanding of the perceptions of therapists who work with domestic violence victims, and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Attention to the lived experiences of therapists who work with domestic violence victims is needed to help educate other clinicians, therapists, social service workers, mental health professionals, and researchers in understanding that therapists also experience trauma during therapy after working with victims (Logan et al., 2023). Adequate knowledge of domestic violence is beneficial when working with victims (Dudley, 2008). The information obtained will provide a better understanding of the experiences of therapists working with domestic violence victims. The results of this study should aid other therapists, the academic community, trauma victims, counselors, and practitioners in helping them understand how working with victims of domestic violence may impact therapists.

Problem Statement

Therapists are affected in an indirect way as a result of listening to and discussing traumatic events with victims. Therapists sometimes develop emotional, behavioral, and psychological issues following repeated exposure to trauma (McNeillie & Rose, 2021). However, working with victims of domestic violence can trigger reactions in the therapist that are similar to those experienced by the victims (Melaki & Stavrou, 2023). This trauma effect can involve worrying about the victim who experiences the trauma even after the work is over, feeling irritable, struggling with making decisions and concentrating, changes in the therapist's sleeping patterns, and feelings of detachment (Melaki & Stavrou, 2023; Oginska-Bulik et al., 2021). This trauma may lead to mistakes, including a lack of intervention (Oginska-Bulik et al., 2021). As a result, psychologists and other professionals should be provided with training and be prepared to deal with victims of domestic violence (Sandberg, 2016). Furthermore, research is needed to understand the nuances of how therapists view victims experiencing domestic violence as they experience dissociation, flashbacks, and adverse effects after prolonged periods of working with victims (McNeillie & Rose, 2021).

Most research has focused on women from households of abuse who experience violence in relationships, predisposing psychological factors that can lead to attachment to an abusive partner, and the devastating effects on their psychological, physical, social, and mental health (Andrews et al., 2021; Augustine & Idowu, 2016; Brandt & Rudden, 2020). It is important to understand why therapists who work with domestic violence victims are both positively and negatively affected by their work (Brend et al., 2019). The

negative effects may be a result of being exposed to repeated traumatic patient stories, which could lead to disruptive psychological issues and shock (Beckerman & Wozniak, 2019; Melaki & Stravou, 2023). The focus of this study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Typically, researchers have focused on issues related to violence against women and investigated the effectiveness of therapy from the victim's narratives instead of from the therapists (Karakurt et al., 2013). However, little research has focused on victims attending therapy, the relationship characteristics, and the shared experiences of the victims (Andrews et al., 2021). Nevertheless, they forget that therapists can become victims of trauma themselves as a result of indirect trauma exposure (Oginska-Bulik et al., 2020).

I contributed to this body of literature by conducting research on therapists who work with victims of violence and exploring their lived experiences and perceptions of domestic violence. Literature is lacking that explores the experiences and perceptions of therapists who work with victims of violence. I conducted this study to address this gap in the literature by providing additional research needed to understand therapists' lived experiences with working with victims of domestic violence to gain a better understanding of this phenomenon.

Purpose of the Study

The purpose of this study was to identify and explore the experiences associated with therapists' perception about compassion fatigue and burnout after working with

victims of domestic violence. The study shed light on therapists' thoughts and feelings, the intrapersonal characteristics manifested in their work with trauma victims, and how they maintained their emotional state in their practices. This qualitative approach serves as an opportunity to contribute to the gap in the literature about therapists who work with victims of domestic violence, their perceptions of their stressors, and whether they have experienced any compassion fatigue and burnout.

Research Question

This qualitative study focuses on the perception of therapists who work with women who are victims of domestic violence. It was guided by the following research questions:

- RQ1: What are the lived experiences of therapist relative to domestic violence victims?
- RQ2: To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapist who work with domestic violence victims?

Theoretical Framework

The theoretical framework guiding this study is the social ecological model by psychologist Urie Bronfenbrenner in the late 1970s. According to Bronfenbrenner (1977), individuals affect and are affected by a complex range of social influences. An individual's development can be disturbed by a series of connected environmental systems: individual, community, relationship, and society. The social ecological model demonstrates an understanding of the specific environment in which the individual lives,

which can impact their behavior and development and the situation they are going through (Kilanowski, 2017).

I used social ecological theory to view therapists' perception of domestic violence through their narratives. This theory provides a framework for understanding the interrelations between an individual's personal and environmental factors (Kilanowski, 2017). Furthermore, it considers the complex interplay between individuals, communities, relationships, and society to understand them better to prevent violence of any type (Centers for Disease Control and Prevention, 2022). Understanding therapists' perceptions and cognitive attribution regarding working therapeutically with trauma victims can help develop personal therapy as a coping strategy and bring awareness about the traumatic event that can lead to working with victims of domestic violence (Melaki & Stavrou, 2023). The relevant practices of social ecological theory assisted in gaining a deeper understanding of therapists' perception of domestic violence and the negative consequences of indirect trauma exposure as a result of working with trauma victims (Oginska-Bulik et al., 2022). The social ecological model is tailored to show that the different levels can influence therapists and provides an opportunity to understand violence from the therapist's narrative better (Bronfenbrenner, 1977).

Nature of the Study

Qualitative studies possess deep and rich descriptions of the topic under study (Creswell, 2014). In this qualitative study, I used phenomenology to understand the essence and underlying structure of the phenomenon, situation, or experience. In other words, I investigated the experiences from the therapist's perspective (see Tomaszewski

et al., 2020). Semi-structured interviews were used to help elicit the information needed from the therapists in order to gain an understanding of the therapists about compassion fatigue and burnout after working with victims of domestic violence (McLeod, 2023). Participants were recruited through a purposive sampling method, which ensured that the sample participants meet the inclusion criteria and have their perspective on the topic being studied (McLeod, 2023). These therapists included psychologists, counselors, and social workers. Gender was not a factor in selecting the participants. Moreover, the phenomenological design helps researchers establish the meaning of a specific phenomenon (Wilson et al., 2016).

Before conducting the interviews, I asked the therapist to read and sign the informed consent. I analyzed these interviews to identify the phenomenon's general themes and structural invariant features, as noted in Creswell (2014). The interviews were audiotaped, and overall, the goal of this qualitative analysis was to assist in developing a better understanding of the lived experience of therapists' perception after working with domestic abuse victims. However, I investigated participants' subjective opinions, beliefs, and reflections on their experiences with working with domestic abuse victims, which was necessary to answer the research questions.

Definition of Terms

This section will define definitions of critical key terms used in this study. However, the context of the definition may be specific to this study.

Burnout: Physical, emotional, or mental exhaustion that is accompanied by decreased motivation and negative attitudes toward oneself and others. Therapists can feel overwhelmed by their responsibilities.

Compassion fatigue: The physical, emotional and psychological impact of helping others often through experiences of trauma or stress. Compassion fatigue may affect therapists through their patients' experiences and stress (Paiva-Salisbury & Schwanz, 2022).

Domestic violence: A pattern of abusive behavior (social, emotional, physical, or financial) that one partner may use to gain control of another partner. Also, a phrase that is generally used to include both physical and non-physical violence (U.S. Department of Justice, Office on Violence Against Women, 2022).

Licensed therapist: A person who has the necessary skills, techniques, education, and strategies that meet regulatory requirements in the form of a state licensing examination to provide a patient intervention to minimize or change behavior (Carbajosa et al., 2013).

Phenomenology: seeks to understand the essence and the underlying structure of the phenomenon, experience, or situation. In other words, it investigates the experiences from the individual's (therapist's) perspective (Tomaszewski et al., 2020).

Perception: How an individual understands and explains their surroundings (Epstein et al., 2025).

Qualitative research: A research method that relies on data obtained by observation, interviews, and focus groups to seek an in-depth understanding of a social phenomenon within their natural setting (Creswell, 2014).

Traumatic event: A stressful or disturbing experience in which the level of distress is overwhelming and results in increased feelings of anxiety, intense fear, depression, helplessness, and, at times, posttraumatic stress disorder (PTSD; Kazlauskaitė & Fife, 2021).

Victim: A term used for people experiencing or who have experienced relational abuse, which implies the recipient of abuse was not in any way responsible for the abusive behavior of the perpetrator. Also, any person who has been involved in a criminal act, accident, or act of terror and was injured or killed because of a crime (Ben-David, 2020).

Assumptions

The goal of this study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims, and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating the therapists. I assumed that participants would be willing to share their experiences associated with working with victims of domestic violence. I assumed they would disclose their experiences candidly because of their willingness to volunteer for the study and participation in the interview process. When using a phenomenological research design, I assumed that all participants shared common experiences with the focus of the study. Based on this assumption, it was vital that all included participants would be

willing to discuss and disclose their experiences, feelings, perspectives, thoughts, beliefs, and overall experiences when working with victims of domestic violence and that they would provide details about their encounter that pose a threat to their emotional and psychological affect without violating ethical considerations regarding confidentiality. I also assumed participants would share enough information about their experience to achieve saturation.

Scope and Delimitations

The scope of this qualitative study included licensed therapists of varying ages and length of service and experience who worked with victims of domestic violence. Therapists who have not worked with these victims were not included in the study. The data collection strategy is semi-structured interviews. I delimited the study to the perceptions and experiences of therapists and discussed no other aspect of the topic. This research added to the existing literature on therapists' perception of domestic violence and knowledge regarding the negative consequences of indirect trauma exposure, which can lead to secondary traumatic stress and becoming victims of trauma themselves after exposure.

Findings will benefit other researchers who may want to explore the perceptions and experiences of other licensed professionals as they become traumatized or re-traumatized from exposure to traumatic stories, intrusive images, flashbacks, and burnout after prolonged periods of working with victims (Melaki & Stavrou, 2023). I also considered system theory, founded by Ludwig Von Bertalanffy, which provides a set of principles and concepts that inform our understanding of human behavior and explores

the elements of the family system for this study (Tomisch et al., 2015). It focuses on how an individual's relationships, behavior patterns, and life choices relate to their issues (Tomisch et al., 2015). However, this theory did not fit because the focus of the study was not on the interaction and providing a safe place for victims to talk with the therapist. Instead, it was on the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapist.

Limitations

There will be limitations in conducting a research study regardless of the research design. One limitation of qualitative research is the sample size and participant responses' accuracy. I explored the experiences of a small group of participants to whom I posed the interview questions. In addition, a researcher must consider that the interview questions can impact the participants' thoughts, feelings, and attitudes, leading to biased responses. To control for issues of investigator bias, I examined my personal beliefs, perspectives, and biases. For this study, transparency is essential as it increases its credibility. I avoided allowing biases when formulating the interview questions. I will discuss how the information collected may offer guidance in improving how therapist sessions can be delivered and tailored to meet their needs in the future.

Significance of the Study

The significance of the current study is that the findings will help researchers understand the nuances of how therapists who work with victims experiencing domestic violence describe the experiences they may have encountered as they work with this

issue. Given the impact of this issue, therapists are concerned about fear and anxiety in working with trauma victims to reduce violence. The study findings will fill the gap in understanding the perception of therapists about compassion fatigue and burnout after working with victims of domestic violence. Furthermore, understanding the effects of trauma on therapists will be critical for identifying common patterns of negative behaviors therapists may experience. (Karakurt et al., 2013). Because few studies involve therapist perceptions who work with victims of domestic violence, understanding domestic abuse from the therapist's perspective is vital.

The contribution of this research is that it provides pertinent information for therapists and other scholars so they can understand that patients are not the only ones who experience stressors and trauma but therapists as well. The study also shed light on therapists' thoughts and feelings, the intrapersonal characteristics manifested in their work with trauma victims, and how they maintained their emotional state during their practices. The results of this study should aid other therapists, the academic community, trauma victims, counselors, and practitioners in helping them to understand that therapists are human as well and that they also experience emotional distress after working with trauma victims. Furthermore, the study highlighted that therapist can seek professional briefing with their colleagues and attend to their own professional and psychological health, taking time for themselves, seeking clinical supervision, and staying resilient when working with the stress of domestic violence victims.

Summary

Research is needed to understand how the context of domestic violence affects therapists' psychological functioning. Understanding the experiences of therapists who provide treatment for victims is essential to help other professionals assess for negative issues that result from exposure to violence and reduce the risk of danger among clinical providers. Because of this reality, therapists tend to lack the necessary skills to evaluate and recognize their counterparts who are dealing with issues due to exposure to trauma. Chapter 1 presented a description of this qualitative study, the research question that guided the semi-structured interview, the social problem it addresses, and the theoretical framework that supports the study. Background information was provided regarding therapist's encounters and experiences.

Chapter 1 highlighted a gap in the literature about therapists and their perceptions when working with victims of domestic violence, which supports the significance of the study. Understanding the challenges of working with this population from the therapist's perspective was essential to support and help develop strategies for working with victims and improving the outcome. The information gained expanded on previously published research on therapist perceptions of domestic violence. Results from this qualitative study could provide pertinent information on how therapists' experiences and perceptions influence their personal lives. The findings from this study can be used to inform agencies and organizations of support resources and training programs.

In Chapter 2, I will review the existing literature on this topic and present a concise review of literature relevant to therapist experiences and perceptions about

compassion fatigue and burnout after working with victims of domestic violence, which can lead to them experiencing changes in their schemas. I will explain the literature search and the key search terms used. Also, I will discuss the use of social ecological theory as the framework for the study.

Chapter 2: Literature Review

Introduction

The purpose of this phenomenological study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Therapists may start to have compassion fatigue and burnout because they have been working with domestic violence victims and may face difficulties due to their work (McNeillie & Rose, 2021). Therapists are encouraged to respond authentically in a balanced way when victims disclose personal trauma (Roddy, 2020). Therapists who work with victims who have experienced trauma may also experience negative effects (Melaki & Stavrou, 2023). Hence, this trauma can have a negative effect on the therapists' lives, as frequent exposure to their victims' stories can put them at risk of experiencing compassion fatigue and burnout (Harling et al., 2020). Therapists and other practitioners have overlooked the negative effects of working with trauma victims, which can trigger reactions in therapists that are similar to those experienced by the victims (Melaki & Stavrou, 2023). Nevertheless, research in this area is lacking (Porat, 2015). Therapists undergo an internal process as they try to understand some of the stories they hear from victims (Oginska-Bulik et al., 2022). However, after listening to the victims' experiences of domestic violence, the therapists may experience similar symptoms to those of the victims (Brend et al., 2019; Melaki & Stavrou, 2023). This can affect the therapist's emotional balance; as a result, the therapist must attend to the balance in their professional and personal life (Oginska-Bulik et al., 2022).

A comprehensive review of the literatures produced little research on therapists' perceptions about therapist compassion fatigue and burnout after working with victims of domestic abuse. Most research focuses on the victims' experiences, meeting the victims' needs, addressing their safety, and counseling support that is provided through counseling services (Sandberg, 2016). However, few studies focus on studying therapists who work with victims of domestic violence and the traumatic experiences the therapists encounter (Oginska-Bulik et al. 2022; Sandberg, 2016). Further research is needed to understand the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. In this literature review, the research strategy will be outlined. Literatures related to therapist perceptions about therapist compassion fatigue and burnout after working with victims of domestic violence will be discussed. The social ecological theory will be discussed as the theoretical basis for this study.

Literature Search Strategy

Multiple databases were used to access the research literature needed to complete the literature review. Walden University's library provided databases used for this study. Databases accessed to gather information were EBSCO, PsyArticles, ProQuest, Apa PsychInfo, Walden Library, Taylor and Francis, Eric, SAGE Journals, CINAHL Plus, and SocINDEX. Various internet search engines, such as Google, were also exhausted during the literature search, and Google Scholar was also used for this literature review. All the references were drawn from peer-reviewed journal articles.

Some of the keywords used in the literature search included *therapist, violence, domestic violence, trauma, perception, treatment, phenomenological, social-ecological theory, domestic abuse, women, counselor, abuse, counseling, psychologists, IPV, compassion fatigue, burn-out, and burnout*. These terms are used singly and in combination to obtain research that is relevant to the topic. Also, most of the searches involved peer-reviewed articles and a few dissertations.

Theoretical Framework

The theoretical framework used to guide this study is the social ecological model by psychologist Uri Bronfenbrenner in the late 1970s. According to Bronfenbrenner (1977), individuals affect and are affected by a complex range of social influences. However, in support of the notion that multiple factors influence individual behavior, Bronfenbrenner (1977, 1979) proposed an ecological perspective in which behavior is believed to be affected by both individual and environmental influences. Bronfenbrenner believed an individual's development can be disturbed by a series of connected environmental systems: individual, community, relationship, and society (Bronfenbrenner, 1977). Bronfenbrenner (1977) posited that environmental influences were divided into multiple levels, which allows for a comprehensive exploration of therapists' experiences within the broader context of individuals, communities, relationships, and society. The social ecological model provides a holistic lens through which I explored and analyzed the experiences associated with therapists' perceptions about compassion fatigue and burnout after working with victims of domestic violence.

McLeroy et al. (1988) built on Bronfenbrenner's model as the framework for their social ecological model in which individuals are embedded within and interact with larger social systems. In the social ecological model, multiple dimensions determine behavior, including individual, interpersonal, relationships, community factors, and society (Bronfenbrenner, 1977). I used the individual level to explore the therapists' experiences, perceptions, beliefs, skills, values, and behaviors (see Bronfenbrenner, 1977). This involved understanding how the therapist's attitudes towards domestic violence influence their emotional or psychological well-being. Fishbein and Ajzen (1980) proposed that individual attitudes, expectations, intentions, and beliefs are key predictors that lead to some extent individuals' behavior. Furthermore, the relationship level incorporates formal and informal social networks and support systems, which include partners, colleagues, friends, and family (Bronfenbrenner, 1977). Therapists working with victims of domestic violence are frequently exposed to their victims' suffering, which can put therapists at risk of experiencing compassion fatigue and burnout (Al-Abbadey & Stevens, 2023).

Community factors include the ability to explore workplaces, resources, and the social environment to which individuals belong (Bronfenbrenner, 1977). To improve the safety of the work environment for therapists, it is important to understand how the social ecological model can influence therapists' behavior, norms, values, beliefs, and attitudes in a social context (Brend et al., 2019). Also, the societal level involves the impact of trauma on the therapist's overall well-being (Al-Abbadey & Stevens, 2023). Moreover, it

raises awareness of the key issues that affect therapists internally and externally, directly or indirectly, after working with trauma victims (McNeillie & Rose, 2021).

However, according to Bronfenbrenner (1977), these various levels are believed to influence individual behavior and each other. Hence, this model implies a relationship between the individual and the environmental influences. This approach will be used to understand the perceptions of therapists who work with domestic violence victims and how the therapist's work may contribute to the development of compassion fatigue and burnout in the treating therapists. The relevant practices of social ecological theory assisted in gaining a deeper understanding of therapists' perception of domestic violence and the negative consequences of indirect trauma exposure as a result of working with trauma victims (Oginska-Bulik et al., 2022).

Literature Review

A literature synthesis and review of current studies concerning therapist's perception about domestic violence is included in the following sections. Key concepts will be addressed that contribute to a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Compassion fatigue can result in therapists experiencing overwhelming levels of exhaustion and a reduced capacity for or interest in being empathetic (Adams et al., 2006; Stevens & Al-Abbadey, 2023). Therapists who treat victims of domestic violence are exposed to their victims' experiences of trauma (Robino, 2019).

Emotional Impact on Therapists' Personal Life

Vicarious Trauma

Vicarious trauma, as described by McCann and Pearlman (1990, as cited in Baird & Jenkins, 2003), involves the transformation in a therapist or helper's inner experience as a result of empathic engagement with survivors of traumatic events. In developing their construct of vicarious trauma, McCann and Pearlman proposed that the therapist's cognitive world can be altered by verbal exposure to the client's traumatic material, which can lead to changes in their beliefs, worldview, and emotional responses (Baird & Jenkins, 2003). The authors postulated that the main symptoms of vicarious trauma involve cognitive shifts that may be paralleled by intrusive imagery rather than the full spectrum of PTSD symptoms (Baird & Jenkins, 2003).

McNeillie and Rose (2021) purported that therapists may experience intrusive images, flashbacks or dreams, numbing, and dissociation after prolonged periods of working with victims of domestic violence. These cognitive schema changes may have a negative effect on the therapist's feelings, relationships, and personal life (Beckerman & Wozniak, 2018). Painful images and emotions related to the client's traumatic memories may become incorporated into the therapist's imagery system of memory (Beckerman & Wozniak, 2018; McNeillie & Rose, 2021). This re-experiencing or avoidance of specific aspects of their client's traumatic memories becomes tangible through flashbacks, dreams, and painful thoughts (Baird & Jenkins, 2003; McNeillie & Rose, 2021), making therapists feel emotionally exhausted. McCann and Pearlman (1990) emphasized that by taking care of therapists and acknowledging the impact of vicarious trauma, organizations

can improve the quality of care and provide the support therapists need to avoid feeling emotionally exhausted after working with victims of domestic violence.

Patients' trauma can also have an emotional impact on their therapists. The therapists' experiences of working with trauma patients may trigger a cognitive activity that results in changes to the therapist's internal schemas (McNeillie & Rose, 2021). However, therapists may present with emotional, psychological, and behavioral symptoms due to changes in schemata following exposure to repeated traumatic experiences (McNeillie and Rose) 2021). According to McNeillie and Rose (2021) trauma material can infiltrate the therapist's personal life and may reinforce their view of a hostile world. Therapists are at an increased risk of experiencing the effects of vicarious trauma because of the nature of their work (McNeill and Rose, 2021). According to McNeillie and Rose, therapists in nonprofit organizations reported higher levels of vicarious trauma due to higher caseloads, limited resources, and increased exposure to severe trauma cases. McNeillie and Rose highlighted the profound emotional toll that vicarious trauma can have on therapists, including symptoms such as burnout. Robin (2019) found that therapists reported high levels of avoidance and intrusive thoughts when working with domestic violence victims. According to Beckerman and Wozniak (2018), therapists who provide trauma counseling to domestic violence survivors are exposed to catastrophic stories of danger, physical, and emotional vulnerability. It was noted that therapists who lack clinical experience are more than likely to experience vicarious trauma (Madrid & Drakulich, 2021). Padmanabhanunni (2020) posited that exposure to victim's personal trauma can have an impact on therapists' professional and personal life.

According to Shatto et al. (2023), the lack of experience and techniques in newer therapists who work with domestic violence victims can result in the therapists not realizing how their work is impacting their own mental health. This will cause therapists to feel as if they lack confidence while feeling a sense of fear and a sense of worry about the outcomes when working with victims of domestic violence (Madrid & Drakulich, 2021). In another study, researchers found that therapists who were experiencing higher levels of vicarious trauma were at risk for experiencing low self-efficacy and intrusive images (Melaki & Stavrou, 2023). It was noted (Beckerman & Wozniak, 2018) that a high-stress environment with limited access to health resources and high caseloads contributes significantly to the development of vicarious trauma in therapists' lives. Therapists who work with victims of domestic violence, must create a culture that acknowledges and addresses the emotional impact the therapists experience when working with trauma victims (Beckerman & Wozniak, 2018; Malekai & Stavrou, 2023).

Cummings et al. (2021) discussed risk factors that make therapists more susceptible to vicarious trauma. These include high caseloads of trauma clients, lack of support and supervision, personal history of trauma, and inadequate self-care practices. The authors postulated that therapists should be aware of the signs of various trauma and reduce the risk of it. Finally, vicarious trauma should be addressed by professionals who are exposed to stories of violence and suffering while working with domestic violence victims (Brend et al., 2020). Vicarious trauma can significantly affect both the professional and personal lives of therapists when working with victims of domestic violence (Cummings et al., 2021; Jimenez et al., 2021). Understanding the impact of

vicarious trauma, and recognizing its symptoms, allows therapists to implement strategies to mitigate its effects. This is crucial for therapists to maintain their own well-being (Cummings et al., 2021). For these reasons, clinicians should seek training, therapy, clinical supervision, and peer support groups (Cummings et al., 2021).

McNeillie and Rose (2021) meta-ethnographic review provides valuable insights into the impact of vicarious trauma on therapists. The authors found therapists who work with victims of trauma are frequently exposed to traumatic stories and experiences. However, McNeillie and Rose further stated that understanding vicarious trauma is crucial for maintaining the well-being of therapists and is a crucial role in assisting victims of domestic violence. It is relevant to my study as it also used qualitative literatures that help to explore the experiences and perceptions of therapists who work with victims of violence, and it provides vital information that is needed to understand therapists' lived experiences with working with victims of domestic violence.

Cohen and Collens (2013) conducted a thorough review of vicarious trauma in providers working with individuals who have experienced traumatic events. The results from the 20 articles reviewed showed that vicarious trauma interventions can be divided into four themes: emotional and somatic reactions, coping with the emotional impact of trauma work, changes to inner schemas and behaviors because of trauma work, and changes to inner schemas and the process of schematic change. Although the Cohen and Collens article is an older article, it provides an excellent comprehensive overview of the impact trauma work has on therapists both while and after hearing victims' traumatic stories of domestic violence. It is a foundational article for this study because it explores

therapists' personal experiences in depth and explains the research on vicarious trauma, and burnout among therapists. Cohen and Collens found that alongside the negative emotional schematic impact of working in trauma, which can be presented in the framework of vicarious trauma, therapists also experience growth because of engaging and participating in trauma work. These themes also highlighted how therapists can get involved (in activities to reduce experiencing vicarious trauma, compassion fatigue, and burnout (Malekai & Stavrou, 2023; Salameh, 2022) This meta-synthesis using a qualitative study sheds light on vicarious trauma having a significant impact on therapists' emotional responses when hearing victims' traumatic stories (Cohen & Collens, 2013).

Emotional Exhaustion

McNeillie and Rose (2021) explained that therapists can be left feeling emotionally drained and like there is no escape from working with victims of domestic violence. Oginska-Bulik et al. (2022) found that therapists can become victims of trauma when they try to alleviate the pain and suffering of victims who have experienced trauma. Therapist's continuous exposure to trauma, when working with victims of domestic violence and bearing witness to horror stories and highly emotionally distressing material may result in compassion fatigue and burnout (Beckerman & Wozniak (2018). Work includes strategies for therapists including setting healthy work-life boundaries and finding ways to replenish their self-outside of work in order to recuperate (Hurley & Kirwan 2020).

Emotional exhaustion can result in therapists experiencing lack of energy, difficulty concentrating and negativity (Salameh, 2022). Working with victims of domestic violence can involve specific challenges for therapists, especially considering their exposure to victims that have experienced trauma (Ben-Porat, 2015). However, emotional and other service demands associated with working with victims of domestic abuse can increase the risk of therapists experiencing burnout and compassion fatigue (Carles et al., 2023). According to Padmanabhanunni (2020), organizations can work to help therapists manage emotional exhaustion that they may experience from working with victims of trauma. Cummings et al. (2021) found that training should be essential for therapists who work with trauma patients. This training should focus on recognizing the effects of trauma and establishing a culture that acknowledges and addresses the emotional impact of working with trauma survivors.

Lueng et al. (2022) discussed chronic exposure to traumatic content and high emotional demands can lead to burnout, characterized by emotional exhaustion, and reduced personal accomplishment in therapists. The authors postulated that the well-being of therapists should be a priority.

Interpersonal Challenges

Vicarious trauma can affect personal relationships, as therapists may become more withdrawn or irritable. Therapists who work with survivors of domestic violence face a myriad of interpersonal challenges due to the nature of their work (Beckerman & Wozniak, 2018; Harling et al., 2020). These challenges can impact their personal lives, professional well-being, and the therapeutic relationship with the victims. According to

Yucel and Akoglu (2023), listening to traumatic events and providing services to the victims who experience this trauma can indirectly affect the therapists. Hurley and Kirwan (2020) postulated that practitioners who work with victims of domestic abuse can experience emotional exhaustion and compassion fatigue. Personal trauma history is considered a risk factor for therapists developing secondary traumatic stress (Logan et al., 2023). Additionally, the experience of indirect trauma can affect both the therapist's professional and private life, as well as the therapist's psychological well-being (Yucel & Akoglu, 2023). Therapists must be aware that compassion fatigue and burnout are detrimental to their well-being and professional practice (Stevens & Al-Abbadey, 2023).

Traumatic experiences do not have to be directly experienced by therapists (Dana et al., 2023). The impact of secondary exposure to trauma is a risk factor for therapists who may experience an array of emotional responses to their patients' trauma (Oginska-Bulik et al., 2022). Moreover, therapists face an additional and unique burden in that they experience an extraordinary amount of emotional exhaustion and compassion fatigue (Logan et al., 2023; Padmanabhanunni, 2020). Research has shown that therapists who work with victims of domestic violence experience personal trauma in their own lives.

In a study by Melaki and Stavrou (2023), 14 therapists, seven private therapists, and seven therapists who worked in nonprofit organizations with trauma survivors participated in qualitative study utilizing semi structured interviews. Participants working in private practices reported negative symptoms of vicarious trauma, whereas therapists working in nonprofit organizations experienced less stress (Melaki & Stavrou, 2023).

According to Cummings et al. (2021), therapists who experience indirect exposure to victim's trauma have an increased likelihood of experiencing negative psychological responses, including vicarious trauma and burnout. Working with victims of domestic abuse can have a profound impact on therapists (Cummings et al., 2021).

According to Carles et al. (2023) therapists working with victims of domestic abuse must be aware of their own personal trauma, as they struggle to suppress their own emotional responses because of the challenging experiences of trauma victims.

Beckerman and Wozniak (2018) noted that therapists who are repeatedly exposed to their victims' traumatic stories, abuse, high workload, and emotional fatigue can experience emotional exhaustion.

Yucel and Akoglu (2023) found that therapists who have established a strong bond with their clients, may deal with a wide range of emotions such as anger, helplessness, despair, anxiety and sadness. The study focused on examining the relationship between secondary traumatization, professional burnout and compassion fatigue in mental health professionals. Mental health professionals aged 24–65 years old participated in the study. A quantitative study utilizing semi structured interview, descriptive and cross-sectional design. The findings are important to my study as it revealed working and interacting with traumatized victims pose a mental health risk for therapists in helping professions. It highlighted a connection between burnout and compassion fatigue after prolonged exposure of working with victims of domestic violence.

In another study done by Singer (2018), it was found that therapists who have frequent interactions with trauma victims may be more susceptible to burnout, compassion fatigue and vicarious trauma.

Carles et al. (2023) focused on therapists' personal history of trauma. Carles et al. found that therapists' personal history of trauma can leave them more susceptible to vicarious trauma when working with victims who are survivors of trauma. Trauma counselors who had a personal history of trauma showed more negative effects compared to those trauma counselors without a personal history of trauma (Brend et al., 2019). Melaki and Stavrou (2023) found that newer therapists with a history of trauma and less than two years of therapy experience tended to show more disrupted schemas doing trauma therapy. The authors purported that therapists who work with victims and survivors of domestic violence sometimes experience vicarious trauma due to their own past experiences of trauma.

Understanding Therapist's Perception About Compassion Fatigue and Burnout

Therapists who work with survivors of domestic violence often face unique challenges and stressors that can impact their well-being (Stevens & Al-Abbadey, 2023). Understanding therapists' perceptions of compassion fatigue and burnout can lead to the development of effective coping strategies and interventions (Pirelli et al., 2020). It is essential to investigate the beliefs, attitudes, and viewpoints of therapists who work extensively with individuals impacted by domestic violence. According to Harling et al. (2020), therapists strive to help others with an expectation that they will do so from a stance of unwavering empathy. However, therapists are frequently exposed to their

victims' suffering, which mainly puts them at significant risk of experiencing compassion fatigue and burnout (Pirelli et al., 2020).

Rodriguez and Lown (2019) highlighted that compassionate care is well-researched across other disciplines, but it is not something that is routinely assessed in a psychologist's role. Therapists and other professionals need to be alert and well-informed and take time out for themselves because they can be negatively affected by the disturbances of compassion fatigue and burnout (Harling et al., 2020). According to Harling et al. (2020), the ideal psychologist is most often the person with unwavering empathy, and their goal in life is to help and provide support for others. However, therapists' desires to contribute positively to people and their communities may often include risks that they may face that they are not aware of (Salameh, 2022). Therapists working with victims of domestic violence are less aware of the effects of stories, and the emotional demand that are the result of working with victims who have experienced emotional pain and suffering (Radley & Figley, 2007; Stevens & Al-Abbadey, 2023). Therapists who are frequently exposed to their victims' suffering are at significant risk of experiencing compassion fatigue and burnout (Pirelli et al., 2020). Therefore, therapists' experiences are different with victims of violence due to the nature of their role specifically, as opposed to other disciplines (e.g., social workers, human service providers, legal professionals, and case managers) who provide counseling and advocate for individuals with ongoing mental illness (Salameh, 2022). Therapists are provided with detailed and specific knowledge across a broad range of psychological, emotional, ethical, and practical areas to address the complex needs of their victims and strive to

help others from a stance of unwavering empathy (Stevens & Al-Abbadey, 2023). Thus, there is a vital need to focus on the risks for therapists experiencing compassion fatigue and burnout (Stevens & Al-Abbadey, 2023).

Stevens and Al-Abbadey (2023) conducted a study that explored the impact of compassion fatigue and global compassion fatigue on psychologists' practices. A total of 10 registered psychologists, aged 41–63 years, were invited to participate in (Stevens & Al-Abbadey, 2023). This study focused on psychologists within a private practice (Stevens & Al-Abbadey, 2023). In the current study, practicing psychologists highlighted the impact personal circumstances can have on their ability to provide compassionate care, especially if exposed to the victim's personal experiences and suffering (Stevens & Al-Abbadey, 2023). With the notable rise in workloads, therapists may struggle to maintain balance because of the increase in work demands from their job. This increase in workload far outstrips their sense of balance and overall well-being. These therapists are found to be at risk for burnout and compassion fatigue (Salameh, 2022). Moreover, as compassion fatigue and burnout become a problem for the therapists, it begins to influence both their professional and personal lives. They are less able to recognize the adverse effects on the various aspects of their lives (Salameh, 2022). Some therapists may find that they are not fully engaged in sessions, unable to complete their usual tasks, physically exhausted. They may even suffer from symptoms such as intrusive thoughts and nightmares (Oginska-Bulik et al., 2022).

As a result, therapists may attribute these symptoms to additional work demands when working with victims of domestic violence. Wilson and Lindy (1994) postulated

some ways in which trauma work can change the encounter and performance of a therapist. According to (Carlise et al., 2021; Wilson & Lindy, 1994) therapists might experience intrusive thoughts, nightmares, and a heightened sense of vulnerability as a result of working with victims of trauma. The authors coined the term empathic disequilibrium, describing therapists who are touched by their victims' stories after frequent exposure to traumatic stories. This empathic disequilibrium can lead to burnout and emotional strain (Wilson & Lindy, 1994). While Wilson and Lindy's (1994) research are older, it provides an excellent comprehensive overview of the impact trauma work has on therapists. It also documents the therapists' emotional responses to their victims' traumatic experiences and how that can have an effect on therapists' work experience. The results of the therapists' role in treating victims of violence have often been overlooked. These results may include compassion fatigue, feeling overwhelmed by the victim's trauma, experiencing intrusive thoughts, and having difficulty maintaining emotional boundaries (Cummings et al., 2021; Oginska-Bulik et al., 2022). The negative effects may be as a result of being exposed to repeated traumatic patient stories, which could lead to disruptive psychological issues and shock (Beckerman & Wozniak, 2019; Melaki & Stravou, 2023).

Harling et al. (2020) conducted a study to investigate participating psychologists' experiences with compassion fatigue. Their goal was to identify individual, interpersonal, and organizational factors and strategies perceived as contributing to compassion fatigue or protecting therapists from compassion fatigue. Eight psychologists (three men and five women with more than 5 years of clinical practice) participated. In the study, the

researchers found that all of the participants had experienced the negative impact of compassion fatigue on their personal lives (Harling et al., 2020). A phenomenological qualitative design was used to gain insight into the participants' personal experiences of compassion fatigue in their work as clinical psychologists (Harling et al., 2020). The participants reported initial unawareness of their symptoms and often misattributed them to general stress or workload (Harling et al., 2020).

Further research is needed on the effects of compassion fatigue in order to better understand therapists' perspectives. There is significant information indicating that work environment contributes heavily on compassion fatigue (Harling et al., 2020). According to Harling et al. (2020), the participants wished for more professional development, which included supervision at work, and the opportunity for further education. The participants reported feeling that an increase in education would help the participants to hone their skills and protect themselves against compassion fatigue. The authors concluded that professional development, such as supervision and education, were protective factors against compassion fatigue (Harling et al., 2020). The researchers also found that going to therapy and maintaining a healthy lifestyle were also important self-care practices, that psychologists used to maintain their physical wellbeing (Harling et al., 2020).

Emotional and Psychological Impact Therapist Experience

Burnout

Burnout may arise from workplace stress other than that which is the result of exposure to others' distress. Burnout is a result of chronic exposure to victims' emotional

distress when therapists work with victims of domestic violence who are in emotionally demanding situations (Pirelli et al., 2020). Moreover, it is a gradual process of emotional exhaustion. Fatigue, poor sleep, headaches, anxiety, irritability, depression, and hopelessness characterize burnout. Therapists working with victims who have experienced domestic violence reported that violence has an impact on their emotional, psychological, and physical well-being (Brend et al., 2019). Therapists are left feeling disturbed, powerless, emotionally drained, and angry after traumatic experiences with victims (Brend et al., 2019; Iliffe & Steed, 2000). The impact of the trauma has left therapists feeling isolated and like there is no escape while working with domestic violence victims (McNeillie & Rose, 2021). However, therapists posited that some of the stress they feel is related to hearing the descriptions of the violence against victims (Steven & Al-Abbadey, 2023). Many times, therapists who have been exposed to these traumatic events have a tough time addressing their secondary trauma and processing the experiences after prolonged periods of working with victims (Hurley & Kirwan, 2020).

According to Brend et al. (2019), therapists seldom speak about their suffering and experiences of trauma. Hence, the support and treatment to address their trauma can be challenging. As a result, therapists will continue to work with victims while suffering from traumatic experiences (Brend et al., 2019). Pirelli et al. (2020) postulated that therapists are directly exposed to victims who are negatively impacted by violence. Burnout and compassion fatigue are similar and can be experienced by therapists and other professionals in job-related work environments as a result of direct and indirect trauma exposure (Harling et al., 2020).

Despite burnout being a known problem in many practices (Johnson et al.,2018), there is a lack of guidance for managing increased workloads and weakness in effective interventions to support therapists experiencing burnout. According to Cummings et al. (2021), therapists' indirect exposure to victim's trauma increases the likelihood of therapists' experiencing negative psychological responses, including vicarious trauma and burnout. Burnout refers to work-related outcomes commonly ascribed to practicing therapists, given their exposure to victims' traumatic experience (Leung, 2023). These symptoms result in physical, emotional, and psychological exhaustion, which can be attributed to the therapist helping victims of domestic violence (Leung, 2023; Newell & MacNeil, 2010). However, according to (Carles et al., 2023), burnout can occur with any therapists that works with victims who have experienced trauma.

In a study by Carles et al. (2023), social workers experienced stories of burnout when working in the mental health sector. The study was qualitative; the method used was in-depth interviews to narratively understand and organize the experiences of 10 Australian mental health social workers who had a self-identified as experiencing burnout. The findings highlighted that therapists need more support and burnout preventative practices in their organizations (Carles et al., 2023).

In another research study, Leung et al. (2023) found that therapists working with victims of trauma were more likely to experience vicarious trauma and burnout. Leung conducted a systematic review to examine the association of personal trauma with mental health workers. The researchers postulated that burnout is an adverse effect that can occur in therapists after being exposed to their victims' traumatic stories.

Cummings et al. (2021) found that helping professionals' indirect exposure to victims' trauma increased the chances of therapists experiencing vicarious trauma and burnout. Experiencing vicarious trauma and burnout can also impact therapists' work performance with victims who are trauma survivors (Cummings et al., 2021; Stevens & Al-Abbadey, 2023). Therapists do not receive the support and assistance in preventing and mitigating the adverse effects of burnout and compassion fatigue (Steven & Al-Abbadey, 2023). The presence of such trauma history leads to therapists indirectly experiencing the trauma (Yucel & Akogul, 2023).

Compassion Fatigue

Harling et al. (2020) posited that compassion fatigue is a work-related state. It develops when therapists empathize with the victims' emotional pain and suffering (Pirelli, 2020). Moreover, compassion fatigue is described as an acute, affective phenomenon that engenders high levels of stress for the therapists, where the therapists' symptoms parallel those experienced by the victims as a result of exposure (Robino, 2019; Stevens & Al-Abbadey, 2023). In other words, it is the adverse effects of being exposed to domestic violence victims suffering (Harling et al., 2020). Nevertheless, individual strategies to protect against compassion fatigue include monitoring therapists' well-being to identify compassion fatigue and other related symptoms and make necessary changes in the therapist's professional and personal lives (Harling et al., 2020).

According to Oginska-Bulik et al. (2022), one of the negative consequences of indirect trauma exposure is secondary traumatic stress. Beckerman et al. (2018) found that when therapists bear witness to these frightening narratives, it results in a

sympathetic form of trauma known as secondary traumatic stress. Stevens and Al-Abbadey (2023) explained that therapists must remain impartial and empathetic throughout their clinical practice so that the therapists can protect themselves from the adverse effects of domestic violence.

A meta-analysis by Cavanagh et al. (2019) recognized that the consequences of compassion fatigue on healthcare professionals are detrimental to their well-being, professional practice, and the workforce. Clinicians in trauma practice find themselves exposed to risk factors that may contribute to the development of burnout and compassion fatigue. According to Steven and Al-Abbadey (2023), psychologists are at risk of compassion fatigue due to the emotional demands of helping individuals who have experienced pain and suffering. Stevens and Al-Abbadey explored the impact of compassion fatigue and global compassion fatigue on practitioner psychologists' practice. The researchers used a purposive sample of 103 registered psychologists, and 10 participants were selected from the sample. Stevens and Al-Abbadey claimed the literature expanded on the limited study of compassion fatigue.

According to Steven and Al-Abbadey (2023), this study highlighted insights into strategies used to mitigate the effects of compassion fatigue on clinical practice and on psychologists being aware when they are affected by this adverse effect. Harling et al. (2020) found that there may be a taboo surrounding therapists expressing feelings about compassion fatigue. As a result, therapists sometimes may find themselves hurting because of the psychological disturbance of compassion fatigue and burnout, as they need

to be alert and care for their physical well-being (Melaki & Stavrou, 2023; Brend et al., 2019).

Newell and Mac Neil (2010) emphasize the importance of self-care and organizational support to prevent compassion fatigue. The authors posited that professionals who treat victims of trauma, exposure to secondary traumatic stress might contribute to them experiencing compassion fatigue. The authors reported that therapists who treat individuals other than trauma victims might also experience compassion fatigue without experiencing secondary traumatic stress. Therapists who work with trauma victims can find themselves being exposed to risk factors that can contribute to the development of vicarious trauma, burnout and compassion fatigue (Guitar & Molinaro, 2017; Stevens & Al-Abbadey, 2023).

According to Logan (2023) therapists are at risk for developing compassion fatigue which can come on quickly without notice. Frontline health professionals often provide treatment to victims which can result in physical and psychological disturbances in therapists, referred to as compassion fatigue. Therapists face an additional and unique burden in that they experience compassion fatigue while working with trauma victims.

Ray et al. (2013) studied the relationships between compassion satisfaction, compassion fatigue and burnout among frontline health professionals. Moreover, the researchers used a convenience sample of 430 participants in the mental health institution. The authors noted that literature is limited on the subjects of compassion fatigue. Ray et al. found that therapists who reported a trauma history had a higher level of compassion fatigue than participants who did not have a trauma history. According to

the writers, this study provided some valuable insight into how there may be an emotional toll for therapists working with victims of domestic violence. This work can contribute to therapists being susceptible to compassion fatigue and burnout (Ray et al., 2013). While Ray et al is an older article it provides an excellent comprehensive overview of the impact trauma work has on therapists, and the effect that it causes. The cause of compassion fatigue often goes unnoticed and may influence therapists' emotional responses to their victims traumatic experiences. This may also have an effect on therapists' personal life and work experiences.

Trauma Training and Education for Therapists

Training on self-care, trauma-informed care, and coping strategies can equip therapists with the tools to manage compassion fatigue and burnout (Stevens & Al-Abbadey, 2023). Insights into therapists' views on compassion fatigue and burnout can inform the development of these training programs (Harling et al., 2020). These programs can focus on coping strategies, setting boundaries, and recognizing signs of emotional exhaustion (Harling et al., 2020). It may be that expressing symptoms of compassion fatigue may be taboo in psychology, given that many psychologists expect to sustain consistent levels of empathy over time despite being repeatedly exposed to clients' suffering (Harling et al., 2020). Some studies have addressed the field professionals' disciplines and the specific trauma training that the therapists may receive (Hurley & Kirwan, 2020). Most research has included professionals from diverse disciplines (Cavanagh et al., 2019; Hurley & Kirwan, 2020; Robino, 2019; Pirelli et al., 2020). However, in some cases, the differences in the professions were examined to determine

whether they influence the risk of therapists developing compassion fatigue and burnout (Salameh, 2022).

According to Rodriguez and Lown (2019), most research addresses the importance of compassionate care across various disciplines. However, it is not assessed routinely in a psychologist's role. In their study, Loncar and Scott (2022) found that therapists were at greater risk for compassion fatigue than other clinicians. Social workers, criminologists, counselors, domestic violence advocates, and others are also exposed to stories of violence and suffering in the course of their work (Brend et al., 2019). This exposure can impact them and may indicate that the type of professional background or the specific job role requires trauma-informed training because of the risk of harm from working with domestic abuse victims (Coulling et al., 2024; Salameh, 2022).

By understanding therapists' perceptions of compassion fatigue and burnout, organizations and stakeholders can create a more supportive and sustainable work environment (Salameh, 2022). This does not only benefit the therapists themselves but also improves the quality of care provided to survivors of domestic violence. Brand et al. (2019) specified that due to the complex trauma and related psychological disorders patients suffer, much more training in conducting carefully paced, staged treatment needs to be made available to professionals. According to Salemeh (2022), training, education, and clinical programs are required early in a therapist's career to prevent and mitigate burnout and compassion fatigue.

Brand et al. (2019) state that the failure of most training programs and their inability to provide systematic education and support for psychologists working with victims of trauma results in many therapists neglecting their well-being. They found that peer support was a critical, essential, and a viable strategy for preventing and mitigating burnout and compassion fatigue in therapists. According to Paiva-Salisbury and Schwanz (2022), integrating knowledge about compassion fatigue into the therapist training can help them develop resilience and effective coping strategies. Bekerman and Wozniak (2018) claim that ongoing training programs for therapists should focus on recognizing and managing the personal well-being of therapists. Training should include self-care techniques, trauma-informed services, and coping skills to help mitigate stress related to compassion fatigue (Beckerman & Wozniak, 2018).

Barre et al. (2023) noted that professionals who work with victims of trauma are exposed to traumatic stories, negative experiences, which increases their vulnerability to compassion fatigue and burnout. Due to these specific and ongoing stressors, implementing training programs is vital to prevent compassion fatigue and burnout in therapists, and for therapists to gain the skills needed to better work with victims of trauma.

Stressors

Emotional Stressors

Compassion fatigue refers to emotional or physical stress from a gradual depletion of empathy (Stevens & Al-Abbadey 2021). Therapists work towards providing care for their victims from a stance of unwavering empathy. They are exposed to the

constant fear of further violence for the victims, hypervigilance, and anxiety about safety concerns for themselves and the victims. Victims of domestic violence may experience panic attacks and generalized anxiety disorders (Yucel & Akoglu, 2023). The impact of working with domestic violence victims on therapists can be profound, affecting their emotional well-being, professional performance, and personal lives (Harling et al., 2020). By recognizing the signs of vicarious trauma and implementing supportive strategies, both organizations and therapists can work together to mitigate these effects (Beckerman & Wozniak, 2018). Ensuring regular supervision, peer support, continuous training, and a supportive work environment are critical steps in maintaining the mental health and effectiveness of therapists working with domestic violence victims (Beckerman & Wozniak, 2018). This, in turn, ensures that victims receive the best possible care and support from therapists. Cummings et al. (2021) found that therapists' indirect exposure to victims' trauma increases the chances of therapists experiencing compassion fatigue and burnout.

Psychological Stressors

Leung et al. (2022) conducted a systematic literature review that provides valuable insights into the impact of a personal history of trauma on the experience of secondary traumatic stress, vicarious trauma, and burnout among mental health workers. According to Cummings et al. (2021), therapists can face vicarious trauma, emotional exhaustion, and intrusive thoughts. These symptoms can closely resemble those of PTSD, indicating the profound impact that vicarious exposure to trauma can have on therapists (Cummings et al., 2021). The authors postulated that therapists who are frequently

exposed to their victims' suffering could be at risk for experiencing PTSD symptoms such as flashbacks, intrusive thoughts, and emotional numbness due to traumatic experiences (Cummings et al., 2021; Stevens & Al-Abbadey, 2023).

Exposure to Trauma

In the study by Levin et al. (2021), therapists who repeatedly heard and processed victims' traumatic experiences led to therapists experiencing vicarious trauma, loss of sleep, anxiety, and intrusive thoughts. These therapists internalized their patient's trauma and were affected by the trauma. According to Taylor et al. (2019), helpline staff should receive more education about trauma triggers, and ongoing support should be provided to reduce the impact on the therapists' home and social life, thus improving therapists' mental well-being and job satisfaction. This qualitative study was conducted to explore the well-being and needs of domestic violence helpline workers (Taylor et al., 2019). Ten helpline staff members, ranging in age from 22 to 54 years old, participated in the study. Semi-structured interviews were used to collect the data (Taylor et al., 2019). The findings suggest that helpline staff should receive more education about trauma triggers and ongoing support to reduce the impact on their home and social lives, thus improving mental well-being and job satisfaction (Taylor et al., 2019). This is a duplicate sentence. The authors also noted that working with victims of trauma can result in challenges that can affect therapists' personal lives and pose a risk to the therapist who may begin experiencing burnout and compassion fatigue (Leung et al., 2023; Taylor et al., 2019).

Emotional Overload

Therapists working with victims of domestic violence are frequently exposed to their victims' suffering, which can put therapists at risk of experiencing compassion fatigue and burnout (Al-Abbadey & Stevens, 2023). According to Yucel and Akoglu (2023), the intensity and frequency of traumatic stories can overwhelm therapists emotionally, leading to symptoms similar to those experienced by their clients, such as flashbacks, intrusive thoughts, and anxiety. Furthermore, emotional and other service demands associated with work can also position mental health social workers at risk of burnout (Carles et al., 2023). Despite burnout being a known problem in mental health practice (Johnson et al., 2018), there is a lack of guidance for manageable mental health workloads and weakness in effective interventions to support therapists experiencing burnout. Makadia et al. (2017) discussed the relationship between exposure to trauma work and well-being (general psychological distress, trauma symptoms, and disrupted beliefs) in trainee clinical psychologists. The authors stated that therapists who are exposed to trauma work need to develop coping strategies to reduce stress, and the level of stress of clinical work may contribute to trauma symptoms (Makadia et al., 2017).

Also, according to (Cummings et al., 2021; Makadia et al., 2017; Rollins et al., 2021), Secondary traumatic stress, vicarious trauma, and burnout are a result of work-related outcomes commonly ascribed to mental health workers because of their exposure to victims' traumatic experiences. Carles et al. (2023) noted that therapists' work environment should foster support from organizations within to have measures in place to help prevent burnout, as therapists are unaware of this emotional toll on themselves.

Therapists Who Treat Domestic Violence

The history of domestic violence spans centuries and reflects deep-rooted societal norms and structures. Understanding this history is crucial to grasp the evolution of societal attitudes and legal responses to domestic violence and for understanding the complex interplay of factors that lead to domestic violence (McNeillie & Rose, 2021). Domestic violence is a complex issue influenced by a myriad of stressors that can trigger or exacerbate abusive behaviors (Hegar, 2023). These stressors do not justify the abuse but help us in understanding its dynamics and creating effective prevention and intervention strategies that therapists can share with their patients (Madrid & Drakulich, 2021).

Therapists who work with survivors of domestic violence face unique challenges that can impact their professional performance and personal well-being (Cummings et al., 2021). The trauma and intense emotional experiences associated with domestic violence cases can lead to significant stress, vicarious trauma, compassion fatigue, and burnout, all of which can affect the quality of care provided to victims (Makadia et al., 2017).

According to Guitar and Molinaro (2017) health care professionals who have been trained to provide treatment for individuals who suffer from trauma are at risk of developing vicarious trauma and secondary traumatic stress. Vicarious trauma and secondary traumatic stress may result in adverse symptoms for the healthcare provider that often mimic PTSD. The authors postulated that vicarious trauma develops over time as the clinician is continually exposed to their clients' traumatic experiences. Clinicians experiencing secondary traumatic stress may begin to experience the symptoms of PTSD

due to secondary exposure to the traumatic event (Coulling et al., 2024; Hurley & Kirwan, 2020; Levin et al., 2021; Makadia et al., 2017).

Coulling et al. (2024) in their study noted that cumulative exposure to distressing stories can result in significant emotional and psychological challenges, such as vicarious trauma, compassion fatigue, and burnout. Their research emphasized the importance of trauma-informed training, regular supervision, and access to mental health resources to support professionals in maintaining their well-being while working in high-stress environments. Accessing trauma-informed supervision can help therapists process their emotional reactions to clients' trauma. Barre et al. (2023) noted that professionals who work with victims of trauma are exposed to traumatic stories, negative experiences, and a continuous emotional toll, which increases their vulnerability to secondary traumatic stress, vicarious trauma, and burnout. This constant exposure can lead to emotional exhaustion, difficulty maintaining empathy, and personal distress, impacting their professional effectiveness and personal well-being (Barre et al., 2023). The study emphasizes the importance of providing mental health professionals and practitioners with resources for self-care, peer support, and supervision to mitigate the effects of working in such emotionally intense environments (Barre et al., 2023)

Summary

The next chapter will describe the methods and procedures for the research. This study was needed to address the gap in the literature and to provide a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue

and burnout in the treating therapists. Much of the research on domestic violence has been conducted on vicarious trauma and secondary traumatic stress, with little or no research on therapists who experience burnout and compassion fatigue. Research on interventions to improve burnout and work engagement is limited (Rollins et al., 2021).

This literature review synthesized information from current studies that were used to inform and develop the present study. The theoretical framework that is the foundation for this study is social ecological theory. This theory was discussed both in terms of the theoretical construct and how it will be applied to this study. Current studies regarding vicarious trauma, compassion fatigue, burnout, and its effects on therapists were addressed. Therefore, the purpose of this study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists.

This study will add valuable new information for therapists and other practitioners who work with domestic violence victims. Chapter 3 will include the introduction, research plan and design, the participant selection process, the role of the researcher, methodology, data collection, and data analysis plan.

Chapter 3: Research Method

Introduction

The purpose of this study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. In Chapter 3, I will describe the methods used to collect and analyze the data required to address the research questions developed for this study. The topics included are the research design and rationale, research tradition, role of the researcher, research questions, methodology site selection, participant selection, instrumentation, choice of qualitative data collection methods, data collection, data analysis, trustworthiness, and ethical considerations. The findings of this study will provide an understanding of the lived experiences of therapists who work with domestic abuse victims.

Research Design and Rationale

The selected qualitative approach, phenomenology, allowed me to describe, understand, and interpret the perspectives of therapists who work with victims of domestic violence. It is focused on the lived experiences of people who have experienced shared encounters in their practices. Phenomenology is used to understand the essence and underlying structure of a phenomenon, situation, or experience. In other words, it allowed me to investigate the experiences from the therapist's perspective (Tomaszewski et al., 2020). In this study, the focus was on the therapists' perception about compassion fatigue and burnout after working with victims of domestic violence. Phenomenology is geared towards understanding, capturing, exploring, describing, and interpreting a

phenomenon and how the therapists make meaning of it, describe it, perceive it, sense it, and speak about it with others (Wilson et al., 2016)

Moreover, a phenomenological approach was used to explore the meaning, essence and structure of the lived experiences of compassion fatigue and burnout among therapists after working with domestic violence victims. Phenomenological research is used when the research assumes that the participants have experienced the same phenomenon. The data that resulted from the interviews were used to address the two research questions that guided this research study:

RQ1: What are the lived experiences of therapist relative to domestic violence victims?

RQ2: To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapist who work with domestic violence victims?

Research Tradition

In this study, a phenomenological research design was used. The focus was to explore the lived experiences of therapists who work with victims of domestic violence. This type of research is appropriate when participants who are included in the study have experienced the phenomenon (Meriam, 2009). According to Alhazmi and Kaufmann (2022), phenomenological research is used to understand the essence and the underlying structure of the phenomenon, situation, or experiences. It is also used with participants to describe their experiences with the phenomenon under study.

Phenomenological research is used when the researcher assumes the participants have experiences shared encounters in their practice (Meriam 2009). Meriam (2009) found that the participants experience regarding the phenomenon of interest are condensed, compared and grouped in order to determine the likes and dislikes among the participants. Phenomenological research also describes the underlying structure of the phenomenon, putting aside any beliefs or biases regarding the personal experiences that can interfere with the study. Phenomenology is used to provide a description of the lived experiences of a group of people who shared a common phenomenon (Alhazmi & Kaufmann, 2022), using data from in-depth semi-structured interviews. In this study, the phenomenon being studied was the lived experiences of therapists about compassion fatigue and burnout after working with victims of domestic abuse. Therefore, with this research design, data were collected from a small group of participants for analysis (see Alhazmi & Kaufmann, 2022).

Role of the Researcher

The role of the researcher is to interact with the participants to collect the data. However, regarding data collection, in this study, the role of the researcher was that of a participant-observer. I asked participants open-ended questions that produced answers to the research questions. The researcher's credibility is extremely important in qualitative studies, and the researcher is the critical instrument to collect, observe, and analyze the data (Geraldi-Gauci, 2019). The researcher brings many meanings to a research project. As the interviewer, I needed to be aware that personal beliefs, assumptions, and values can play a part in data collection and research analyses. I had to acknowledge how the

role of a researcher and my relationship with the participants would help generate rapport and trust. Researchers must engage in reflexivity and become mindful of their role in creating knowledge. This is done by researchers looking at the impact of their personal biases, beliefs, and personal experiences related to the research project (Rodham et al., 2015)

The data collection process involved conducting semi-structured interviews with the participants as they shared their personal experiences working with victims of domestic violence. I had no professional or personal relationships with the participants. Also, I was careful not to interject any personal biases during data collection. Throughout the research, I put aside beliefs and understanding of the phenomenon being studied. Awareness of personal biases helped me analyze the interviews without prejudice. I worked to remain impartial, even if the participants shared adverse opinions about their beliefs, experiences, and challenges after working with victims of domestic violence. The interviews were conducted once the Walden University Institutional Review Board (IRB) approved the study.

Methodology

This section will provide information regarding participant selection, instrumentation, procedures for recruitment participants, data collection, and data analysis. The participation selection includes identifying the population, sampling strategies, techniques to contact and recruit participants, and sample size estimation. The interview transcript was sent back to each participant to check whether they had any

changes that they wanted to make. The data analysis section includes data connections to the research question, type, and techniques for coding, and software used for analysis.

A phenomenological design was used to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. The phenomenological approach was used to explore the phenomenon's effect on the lives of the therapist. Data were collected and analyzed on the therapists' perceptions of a specific, definable phenomenon including the human factors involved in their experiences.

Participants

The participants for this study six licensed therapists. Anonymity was ensured by assigning participants a number during the analysis process. I used a purposive sampling method to recruit participants. According to Merriam (2009), purposive sampling ensures that the participants meet the inclusion criteria. This type of sampling method is used when conducting qualitative studies, especially phenomenological research. It requires the researcher to have sufficient knowledge of the phenomenon so that the appropriate individuals can participate in the study. In addition, purposive sampling aids in recruiting the right participants for the sample. In addition, I emailed each participant a copy of the informed consent form, a description of what the study entails, and an invitation with a convenient date and time for them to participate in the study, and I asked them to reply to the email with the words, "I consent to participate in this study."

Recruitment, Participation and Data Collection

After selecting the six respondents for the research, I conducted semi-structured audio interviews with licensed therapists. Open-ended questions were developed for the interview. Permission was obtained from the participants in writing before conducting the interviews while respecting their privacy (Crewell & Poth, 2018). Follow-up questions may be used to clarify the participant's answers to the interview questions. The interviews lasted between 45 minutes and 1 hour. Sample questions were included in the informed consent. Interviews were recorded and transcribed. Transcribed interviews were kept electronically in a password-protected file on a password-protected computer. I used NVivo software to perform thematic analysis and organize and interpret findings. The identified themes were then organized, and findings were interpreted.

The data collection method most appropriate for this research study was Zoom videoconferencing (<https://www.zoom.com>). Individual videoconference interviews were conducted with the participants and recorded using Zoom recording.

Data Analysis Plan

The data analysis procedures employed in this study included methods for data collection, transcription review, and the development of thematic matrices based on the perspectives of information-rich participants who shared their lived experiences as therapists working with victims of domestic violence. I analyzed data using Braun and Clarke's (2023) six-phase thematic analysis framework to explore the lived experiences of six licensed therapists working with victims of domestic violence. The thematic analysis process involved transcribing the data, thoroughly reviewing the transcripts

multiple times, listening to the audio recordings, documenting initial impressions, developing a coding framework, and identifying descriptive data to capture the essence of participants' perceptions. During the data analysis stage, each audio recording was listened to multiple times to ensure accurate interpretation and to deepen understanding of the participants' narratives. Interview transcripts were generated using the Rev transcription service (<https://www.rev.com>), after which each transcript was meticulously verified through comparison with the corresponding audio recordings. The necessary corrections were made to ensure the accuracy and integrity of the data. After verification, the transcripts were imported into NVivo qualitative analysis software.

NVivo facilitated the organization and systematic coding of the data by identifying keywords, recurring phrases, and salient terms that were used across the interviews. The software helped to group related code into broader categories and themes. Common phrases emerged consistently across participants, and unique responses were noted from individual participants. This variability was anticipated, given the semi-structured nature of the interviews, which allowed participants to describe their experiences in their own words. Data saturation was achieved after six interviews, as recurrent patterns and themes were evident across the participants' responses. In the subsequent phase of analysis, I developed codes by carefully reviewing each transcript and identifying recurring concepts and patterns related to participants' experiences. These codes were then organized into categories, which were further refined into overarching themes that captured the central aspects of the lived experiences of therapists working with victims of domestic violence.

Instrumentation

Semi-structured interviews were used to collect the data. Interviews were conducted virtually (via Zoom) to facilitate face-to-face communication. Interview questions may be followed up with probing questions to allow the participants to elaborate on a response as the interview progresses. Open-ended questions were used so the participants could provide their most genuine responses and answer the research questions.

Issues of Trustworthiness

The trustworthiness measures used in this study include credibility, transferability, dependability, and confirmability. Creswell and Poth (2018) highlighted the importance of trustworthiness in qualitative research methods. However, according to Lincoln and Guba (1985), the goal of trustworthiness in a phenomenological study is to convince the readers that the study results are relevant and have truth value or credibility. As the researcher, I had to maintain neutrality or conformability to build on the findings in participants' experiences and not on my biases (Lincoln & Guba, 1985). The use of bracketing ensured that there would be no preconceptions about the research question and that I would set aside any beliefs about the situation or phenomenon researched.

Credibility

Guba and Lincoln (1992) asserted that credibility is significant in verifying trustworthiness. Credibility is staying consistent and providing evidence that the study will be done (Merriam, 2009). Credibility for this study was established by giving participant member checks, where the participants checked the transcript for accuracy

and validity. I sent a copy of the transcript to the participants who will then had the opportunity to provide feedback on the transcript. Guba and Lincoln (1992) described member checking as vital to building credibility.

Transferability

Transferability means that the study can be replicated, and the same results and outcomes can be extracted. Ravitch and Carl (2021) explained transferability as a point where a qualitative researcher provides concentrated, descriptive accounts that maintain distinct, characteristic robustness while applying it to other contexts. Transferability with qualitative methods consists of identifying patterns and in-depth descriptions as well as formulating ideas or themes. Transferability is about understanding whether the study's findings, interpretations, and conclusions can be relevant, applied, and meaningful in other similar situations or contexts. According to Ravitch and Carl (2021), transferability in qualitative research focuses on the applicability of findings to different settings or groups. Transferability is successful when the goal of the study is accomplished.

Dependability

Ravitch and Carl (2021) stated that dependability means administering specific formats to achieve alignment with collected data and an evidence-based assertion. Dependability refers to the stability or consistency of findings in qualitative research. Inquiry audits and triangulation are the most common methods to establish dependability (Johnson et al., 2020). According to Polit and Beck (2016), dependability indicates that the findings represent the participants' lived experiences with the phenomenon being studied, and it should not reflect any researcher bias. A detailed account of the entire

research process will be documented in Chapter 4 to ensure dependability. After each interview, reflective journaling will be used to achieve triangulation. Dependability also means there is publicly accessible documentation and explanation of any adjustments or shifts in the methodology used in the study.

Confirmability

The study also shows objectivity through confirmability. Ravitch and Carl (2021) denoted confirmability as neutrality, where the researcher explains ways in which biases or preferences could taint interpretations of data but puts reflective, systematic activities in place to guard against misinterpretation of data collection and analysis. However, the findings should reflect the situation being researched without any form of bias or beliefs. Confirmability audits were conducted as the study progresses to check for any errors and remove any biases in order to facilitate confirmability.

Ethical Procedures

Compliance with all ethical requirements is integral in any research process. In a phenomenological study, written permission must be obtained from the participants who have experienced the phenomenon to be studied (Creswell & Poth, 2018). IRB approval was sought and obtained for this study to ensure that all ethical procedures were followed (IRB Approval No. 03-27-25-0978203). Throughout the study, the principle of beneficence was followed, which includes protecting the research respondents from harm and exploitation (Varkey, 2021). I conducted the study in a manner that respects the principles of human dignity, which includes the right to full disclosure and self-determination. This was done by allowing the participants to voluntarily inquire about the

study and informing them that they had the right to refuse to participate entirely or in part if they felt uncomfortable at any time. I refrained from causing any harm to the participants, so they were informed that the interview would be recorded.

Participants were informed in writing during the consent process and before the interview that they may withdraw from the study at any time without fear of negatively affecting the study. Identifying information was removed, and numbers were assigned to protect participant privacy and confidentiality. Confidentiality was ensured by any physical data for the study being stored in a password-protected folder on a password-protected computer. Also, Word documents, recordings, and transcriptions were locked in a filing cabinet. In addition, although the participants signed the consent forms prior to participation, they were informed that they could revoke their consent at any time.

Summary

A phenomenological design was used to identify and explore the experiences associated with therapists' perception about compassion fatigue and burnout after working with victims of domestic violence. The participants for the study were recruited through a purposive sampling method and included psychologists, counselors, and social workers who are licensed in their fields. Moreover, each participant was given a description of the study, a consent form, and an emailed invitation. Data collection consisted of semi-structured, face-to-face individual interviews using a virtual-enabled device (Zoom) and were audiotaped. Semi-structured interview questions that focus on the participants' experiences working with domestic violence victims were used to guide the interviews.

This chapter included a detailed description of the research methodology. It included the research design and rationale, my role as the researcher, the instrumentation, recruitment, participation, data collection and data analysis plan, trustworthiness, and ethical procedures. In Chapter 4, the results of the study will be presented. The data analysis, emerging common themes, and the summary of the results, findings, and recommendations will be addressed in Chapter 4.

Chapter 4: Results

The purpose of this phenomenological study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Data were collected through semi-structured interviews with licensed therapists. The study was guided by the following two research questions:

RQ1: What are the lived experiences of therapists relative to domestic violence victims?

RQ2: To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapists who work with domestic violence victims?

This chapter provides an overview of the study setting, demographics, data collection procedures, data analysis, and evidence of trustworthiness, as well as a presentation of the results. A summary of the interpretation of the themes that emerged from the analysis of the interviews will be discussed.

Settings

As explained in Chapter 3, I used a purposive sampling strategy to recruit participants for this study. The social media platforms Facebook and LinkedIn were used to post a general invitation to the study outlining the eligibility requirements. Interested individuals, if they met the criteria, were asked to email me using the email address and contact number to gain further information. The response allowed me to acquire emails

from potential volunteers and send them emails with the formal invitation and description of the study, with the consent form. Interviews were conducted in a private room within my home, ensuring a quiet and interruption-free environment that promotes open and uninfluenced responses from participants

Demographics

The goal was to recruit six to eight participants who would meet the study's inclusion criteria to complete the interview. Six participants who met the inclusion criteria completed an interview. All participants' demographics and characteristics relevant to the study included five licensed therapists who resided in the United States and one in South Africa. A phenomenological design was used to explore the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. Interviews lasted 45–60 minutes. Participants for the study were (a) licensed therapists with experience working with victims of domestic violence and (b) licensed therapists with varying ages and lengths of service. Before participating in the study, participants had to read and complete an informed consent form. Participants were instructed to reply to the email with the attached consent form with the words "I consent" to ensure privacy. The participants' identities were kept confidential, and each was assigned a number as a pseudonym for protection.

Data Collection

Participation in the study was entirely voluntary. No incentives or gifts were offered to those who chose to participate, including those who inquired about the study

through social media. Contact information, such as participants' names, emails, and phone numbers, was collected solely for study-related purposes (e.g., sending consent forms, scheduling interviews). Participants were informed that interviews would be conducted via Zoom at a time convenient for them, ensuring privacy and confidentiality.

Identifying information was kept separated from the collected data. All interviews were conducted in private and audio-recorded for transcription purposes. This measure was intended to protect participants' identities during the study and data collection process. Participants were also assured that all information obtained was confidential and that they would not be identified in the final report. In addition to audio recordings, notes were taken on the tone, statements, and follow-up questions that were asked for clarification. Each interview included a summary of the participants' responses to ensure that the researcher captured the participants' responses. All therapists were asked the same questions during the interview. Probing questions were asked to obtain additional information.

Evidence of Trustworthiness

My goal as the researcher was to maintain quality and integrity throughout the data collection and analysis processes. A fundamental aspect of qualitative research is the exploration of complex human behaviors and experiences to establish credibility and reliability while safeguarding trustworthiness. This section outlines the elements of credibility, transferability, dependability, and confirmability (see Ahmed, 2024). To ensure the quality of my study, I adhered to the guidelines proposed by Guba and Lincoln (1992).

Credibility

Guba and Lincoln (1992) asserted that credibility is significant in verifying trustworthiness. Credibility is staying consistent and providing evidence that the study will be done by clearly outlining the research design, participant selection, data collection, and analysis procedures. Ensuring transparency, minimizing bias, and validating findings through methods like member checking or triangulation strengthen the study's trustworthiness (Merriam, 2009).

Credibility for this study was established by giving participant member checks, where the participants checked the transcript for accuracy and validity. I sent participants a copy of the transcript, and participants had the opportunity to provide feedback on the transcript. Guba and Lincoln (1992) described member checking as vital to building credibility. To protect my research study from any personal bias, I also kept a journal where I wrote down every process.

The method used to collect data involved conducting semi-structured interviews with female therapists who have worked with victims of domestic violence. To enhance the credibility of the study, multiple strategies were employed during data collection and analysis. Semi-structured interviews were conducted via Zoom with a licensed therapist who worked with victims of domestic violence. The interviews were audio-recorded, Zoom's transcription feature was used to support accurate documentation. Additionally, handwritten notes were taken during each interview to capture nuanced observations and the participants' lived experiences. After each session, I carefully reviewed the audio recordings, transcriptions, and notes to ensure the accuracy and clarity of participants'

responses. This triangulation of data sources contributed to the trustworthiness of the findings. Furthermore, by comparing responses across participants and organizing the data into tables, it was confirmed that data saturation had been achieved, as themes and experiences reported were consistently echoed among participants.

Transferability

Transferability means that the study can be replicated, and the same results and outcomes can be extracted. Ravitch and Carl (2021) explained transferability as a point where a qualitative researcher provides concentrated, descriptive accounts that maintain distinct, characteristic robustness while applying them to other contexts. Transferability with qualitative methods consists of identifying patterns and in-depth descriptions as well as formulating ideas or themes. Transferability is about understanding whether the study's findings, interpretations, and conclusions can be relevant, applied, and meaningful in other similar situations or contexts. According to Ravitch and Carl (2021), transferability in qualitative research focuses on the applicability of findings to different settings or groups. Transferability is successful when the goal of the study is accomplished. The overall purpose of this qualitative, phenomenological study was to understand the lived experiences of therapists who work with victims of domestic violence. Transferability was achieved through the use of rich, thick descriptive data, which will allow readers to decide if there are resemblances to their own experiences.

Dependability

Ravitch and Carl (2021) stated that dependability means administering specific formats to achieve alignment with collected data and an evidence-based assertion.

Dependability refers to the stability or consistency of findings in qualitative research. Inquiry audits and triangulation are the most common methods to establish dependability (Johnson et al., 2020). According to Polit and Beck (2016), dependability indicates that the findings represent the participants' lived experiences with the phenomenon being studied, and it should not reflect any researcher bias. A detailed account of the entire research process was documented in Chapter 4 to ensure dependability. After each interview, reflective journaling was used to achieve triangulation. Dependability also means there is publicly accessible documentation and explanation of any adjustments or shifts in the methodology used in the study. Other researchers should be able to duplicate this study by promoting dependability throughout this research project.

Confirmability

The study also shows objectivity through confirmability. Ravitch and Carl (2021) denoted confirmability as neutrality, where the researcher explains ways in which biases or preferences could taint interpretations of data but puts reflective, systematic activities in place to guard against misinterpretation of data collection and analysis. However, the findings should reflect the situation being researched without any form of bias or beliefs. Confirmability audits were conducted as the study progressed to check for errors and remove any biases in order to facilitate confirmability. Trustworthiness through confirmability was maintained throughout the study. By listening to the interviews, reviewing the word-by-word transcriptions, and keeping a reflective journal.

Member Checking

Member checking occurred throughout the study. This process was employed to confirm the accuracy of participants' statements, clarify any ambiguous or unclear responses, and ensure that their perspectives were not misrepresented during data interpretation. Verification was done with the participants in relation to what they said in their interviews. Each participant received a summary of their interview transcription and was invited to review it for accuracy. The participants were encouraged to provide feedback, corrections, or clarifications as needed. One participant responded, affirming that the summary accurately reflected their views. In addition, this participant made minor edits to the grammar and speaker line before returning the reviewed summary.

Results

Research Question 1: What are the lived experiences of therapists relative to domestic violence victims? Five themes emerged that were related to the lived experiences of therapists relative to domestic violence victims: background, motivation and personal influence in working with domestic violence victims, navigating stressors in domestic violence therapeutic work, emotional burden of clients' stories, lived experience of violence and its influence on practice, and burnout and emotional exhaustion in the field.

Theme 1: Background, Motivation, and Personal Influence in Working With Domestic Violence Victims

This theme explores the professional trajectories and personal motivations that guide participants toward working with victims of domestic violence. Therapists

described a complex interplay of formal training, personal values, and lived experiences that shaped their clinical engagement with this population. Three subthemes emerged: (a) description of professional background and experience working with domestic violence victims, (b) personal motivation and initial interest, and (c) influence of personal experiences.

All six participants reported a professional foundation rooted in mental health fields such as counseling, psychology, and social work. Many participants began their careers in general therapeutic roles and later gravitated toward domestic violence work through internships, advocacy settings, or specialized clinical practice. Five of the interviewees, Participants 1, 2, 4, 5, and 6, stated that they were licensed professional therapists. Participant 1 noted that her career shifted after decades as a secretary:

My professional background is that for about 30 years, I've been a secretary, and then I went on to college while working full-time to get my counseling degree in school counseling. ... I went on a few years later to get my LCPC. Off and on at different agencies as an LCPC.

Participant 2 shared, "I am an associate clinical mental health counselor in Northwestern State. [I'm also] a therapeutic breathwork practitioner. I primarily worked with somatic trauma and somatic experiencing." Participant 4 said, "Even before becoming a therapist, like I am now." Participant 5 emphasized both training and international context:

I'm a licensed counselor based in South Africa. I completed my six-month internship in order to register as a licensed counselor. ... My internship was spent

at two nonprofit organizations, namely Rise Against Domestic Violence South Africa, and the second one being Silent Rights.

Participant 6 shared, “I’m a licensed professional counselor in West South Central state and Midwestern State.”

Several participants also highlighted diverse clinical environments as crucial to their preparedness, including private practice, nonprofit organizations, shelters, and sexual assault centers. Participant 4 reflected on early experiences: “My first job out of college was working for a sexual assault center... I worked in programs that were centered around domestic violence, people coming out of sex trafficking.” Others underscored extensive direct contact with survivors through counseling, advocacy, and community-based interventions. Participant 3 noted,

I still have a handful of clients on my caseload who either have a history of domestic violence or a family history, or generational trauma related to domestic violence. ... I do forensic crisis counseling. After a sexual assault or a strangulation, when they need medical intervention and evidence collection.

Participant 6 shared, “In my master’s internship... they offered free counseling for survivors of domestic violence, specifically in intimate partner violence. I was on the counseling side.”

All six participants highlighted that they felt equipped to work with victims of domestic violence while maintaining personal and professional boundaries in domestic violence work. Participant 2 stated, “What I would say is I feel equipped to work with survivors of domestic violence clients who are currently engaged in the domestic

violence cycle within their relationships.” A vast majority of the participants acknowledged that they were motivated to work with domestic violence victims since they wanted to make a meaningful impact, and one reason was that they were also victims of domestic violence. Participants expressed a combination of reasons that motivated them to work with domestic violence victims, including personal reasons, passion, and a desire to make a meaningful impact.

Theme 2: Navigating Stressors in Domestic Violence Therapeutic Work

This theme captures the emotional, cognitive, and logistical challenges therapists face in their daily work with victims of domestic violence. Participants described an array of stressors, including emotional labor, safety concerns, workload intensity, and the complexity of client presentations. Despite professional training, therapists often encountered situations that exceeded the boundaries of clinical preparation, leading to feelings of overwhelm, helplessness, and ethical tension. Subthemes that emerged during the data analysis process included (a) stressors experienced in professional and personal life and (b) balancing professional and personal stressors in domestic violence work.

Participants mainly stated that they got stressed as a result of barriers to justice due to distrust in the legal system, internal professional strain, and personal traumas. Two of the six participants, Participants 1 and 2, acknowledged that they were stressed as a result of barriers to justice due to distrust in the legal system. Participant 1 stated, “Family trauma stuff, just dealing with family and what that means, having been divorced and so forth.” Participant 2 stated, “The client, again, with a history of abuse and violence, which was just familiar to it. I have my own histories as well that I’ve brought

into counseling.” Two of the six participants, Participants 2 and 5, stated that their main source of stress was a result of internal professional strain. Participants 1 and 2 highlighted that they got stressed from their personal trauma background resulting from their family stuff, like divorce, poverty as a single mom, and poverty as a woman. Participants 2 and 3 revealed that they got stressed since they had sleep deprivation from neglecting basic physical needs like eating. Participants 2, 3, 4, and 5 also noted that sociocultural and systemic factors in their profession were another source of stress.

Two of the six participants, Participants 2 and 4, mentioned that they were stressed from their profession due to vicarious trauma from client experiences. Participant 2 stated,

I was assigned a client who was in a severe domestic violence relationship at the time that I did their intake and began working with them. She had physical bruises and markings on her body. I think about working with that client, and I learned a lot. I felt like I interacted with someone in that DV cycle, active DV cycle, who had so much suffering, but also a lot of resignation, of this is my life. This is what I deserve. So, it was a very distressing experience for me. Active suicidal ideation, active self-harming behaviors, did have a plan and intent to commit suicide because they were not able to escape the DV cycle. Then she did not show up for her next scheduled session. No one heard from her for a number of days. Oh my goodness. And we ended up having to file a missing person’s report. We did end up hearing from the police that she was hospitalized due to abuse and almost died. Working with a client who almost died because of DV was like that.

Participant 4 explained,

They have broken bones, broken ribs, and things like that—the trauma of listening, of absorbing. People stay in relationships and stuff like that, after they're being abused, they stay in a relationship. ... I'm very much about self-defense and making sure that I can take care of myself.

Experiences regarding balancing professional and personal stressors, and participants managing work-related stress while maintaining personal relationships and mental well-being outside of their professional roles. Participants 5 and 6 stated that they balanced their professional life and personal stressors by practicing emotional resilience despite physical strain. Participants expressed going to counseling and helping other therapists. Participant 6 expressed, “Counseling? I’m going for sure. Yes, I go to counseling. Exercise. Since leaving my last DV job, I have been working out more and have had more time, space, and energy to do that.” All six participants expressed stressors while working with victims of domestic violence. These stressors, often overlooked, contribute directly to burnout and can reflect systemic issues in domestic violence service agencies.

Theme 3: Emotional Burden of Client Stories

This theme captured the emotional intensity of listening to client narratives and the cumulative toll this can have on professionals working in domestic violence settings. It explored how hearing repeated stories of abuse affected the interviewed participants’ emotional well-being, professional identity, and long-term capacity to remain in the field. A vast number of participants 1, 2, 3, 4, and 6, noted that they developed emotional

boundaries and regulations. Participants reported experiencing secondary emotional responses such as sorrow, anger, numbness, and moral injury. The recurring exposure to graphic and emotionally charged stories often left participants emotionally saturated, leading to lingering cognitive and physical effects beyond the therapeutic hour. Two subthemes were identified during the data analysis process that included: (a) emotional and professional impact of domestic violence victims' stories and experiences, and (b) specific moments that deeply affected therapists in their line of work.

Three of the interviewees, Participants 1, 2, and 3, revealed that domestic violence victims' stories and experiences made them develop more emotional boundaries and regulations personally. Participant 1 stated, "I got to take care of myself. I can't hear this much of this story. I can't carry it." Participant 2 stated, "I know how regulation works when I'm listening to stories in the moment, how I take care of myself." Participant 3 said, "I definitely have cried a lot privately over some of this stuff and with supervisors, and just felt a lot of that pain. I have the resources I need to manage that. So I've learned to kind of tap into that."

Two of the six participants, Participants 2 and 4, highlighted that they found their thoughts in existential questioning and worldview sadness because of these stories. Participants 3 and 4 disclosed that they experienced burnout symptoms due to being emotionally overwhelmed. Participant 3 stated, "There are definitely times when some symptoms of burnout show up, feeling really overwhelmed by that, or I don't have good management of that." Participant 4 revealed, "I was only halfway through the day of

sessions, and I was like, I don't think I can keep hearing." Participant 4 shared, "As the client was sharing the stuff with me, I started feeling myself just kind of disassociating."

Two of the six participants, Participants 4 and 6, asserted that they devised defensive psychological responses as a result of clients' domestic violence stories. Participants 1 and 4, articulated that they found it difficult to maintain clinical boundaries as a result of these stories. Participants 3 and 6 acknowledged that they were emotionally exhausted from listening to clients narratives. Participant 3 stated, "It's hard to hear people talk about these really wounding, traumatizing experiences emotionally, yeah, it's taxing for sure." Participant 6 explained, "Emotionally, sometimes it's hard, and then when it's not hard, I'm concerned that it wasn't hard. But for me, that was a notice of like, you can't do this and write a dissertation. You need a break."

Participants 1 and 2, revealed that they experienced trauma-related emotional symptoms as a result of listening to clients' domestic abuse stories. Participant 1 stated, "I would just be triggered constantly." Participant 2 indicated, "I became more hypervigilant, I became very aware, much more aware of my surroundings had nightmares. I definitely was more in a hyper arousal state. I was more dysregulated, more frequently experienced more sadness."

Participants reported that domestic violence work enhanced their use of trauma-informed practices such as emphasizing safety, client autonomy, and emotional pacing. They often adjusted their clinical interventions to reflect the complexity of victims' lived realities. Participant 2 shared,

Working with domestic violence completely shifted how I think about trauma. Safety has to come first—before anything else. That includes emotional safety, not just physical. ... I was first learning to do that work, and I am a pretty social justice-oriented person, so I would get really hung up on the justice aspect of this. So much injustice is involved in terms of the legal aspects and reporting.”

According to Participants 1 and 6, there were specific moments that deeply affected them in their line of work that left a lasting impact, shaping their emotional and professional outlook. They revealed that these moments transform the encounters with victims of domestic violence.

Theme 4: Lived Experience of Violence and Its Influence on Practice

This theme focuses on participants who had firsthand or close experience with violence and how this informed their understanding, empathy, and therapeutic approach when working with victims of domestic violence. The main lived experiences of domestic violence by the interview participants were disrupted emotional and cognitive processing, evolving emotional boundaries between work and personal life, and managing trauma responses through grounding. Participants 1, 2, 3, 4, 5, and 6 expressed how they felt working with victims of d Participant 1 stated,

I might get a foggy brain, too. Suddenly, I’m back in my past, and I’m not really as much as what they’re going through. It usually hits me later. I might have a crying spell, or I might just have memories. ... I manage trauma responses through grounding.

Participant 3 explained, “Less so now that I work less directly with this population or less frequently. Definitely in the past, definitely brought it home. It was very hard to shed that.” However, participants indicated that their own experiences with violence or trauma served as a guiding influence in their decision to work with domestic violence survivors. These personal histories allowed for a heightened sense of connection and purpose in their clinical roles.

Theme 5: Burnout and Emotional Exhaustion in the Field

This theme explores the prevalence and manifestations of burnout among therapists working with victims of domestic violence. All six participants acknowledged experiencing varying degrees of emotional exhaustion and fatigue. The therapists also highlighted how burnout affects clinical presence, motivation, and personal well-being. Two subthemes emerged during data analysis: (a) experiences of compassion fatigue or burnout and approaches to addressing them and (b) recognition of signs of burnout.

Participants consistently described symptoms such as emotional fatigue, irritability, disconnection from clients, and difficulty maintaining therapeutic empathy. These signs often emerged gradually and, in some cases, became normalized over time.

Participant 2 stated, “I didn’t notice it at first. But I started feeling numb during sessions... like I was just going through the motions. That’s when I realized I was burning out. ... I started to notice symptoms of burnout and compassion fatigue.”

Participants 3 and 6 averred that they experienced direct burnout and compassion fatigue as a result of prolonged exposure to trauma. Participant 3 noted, “definitely experienced symptoms of burnout, definitely experienced symptoms of compassion fatigue.”

Participant 6 shared, “I have definitely, again, going to counseling, making sure that I’m eating, making time to eat, that is important. And making time in between things to go to the bathroom at a minimum.” Participants 1, 2, and 5 mentioned that they experienced burnout affecting their emotional regulation and their personal well-being, and during training in their early career stages. Participant 2 shared, “I started to notice how vigilant I was when I would be walking my dog outside of my home.” Participant 5 noted, “It was work, and I had sessions come back socially drained entirely. But then you still need to show up for family, you still need to show up for the partner, you still need to be present.” Participants 4 and 6 asserted that they had emotional processing related to burnout. Participants 1, 2, 3, and 5 highlighted that they were psychologically strained and had self-doubts from emotionally demanding client work. Several participants commented about their own experiences of compassion fatigue or burnout. Participant 1 commented,

Yes. I had severe burnout a couple of times to the point where I was hospitalized. I ended up attempting suicide, actually, and I have major depression from the marriage, the abusive marriage, when I was 19. After 5 months with them, I realized I was hitting burnout again. I had a bit of a breakdown, went and saw my therapist, and went to the hospital.

Participant 5 shared,

You have to be costly, basically one case after the other, with very few breaks in between, still keeping that space for them to actually be okay and to make sure

that they're in a neutral space to actually, for them not to do anything risky. So that went over a lot into personal time.

According to participants, strategies used to manage work-related strains included seeking professional medical and therapeutic interventions, setting boundaries by limiting caseload commitments, and creating intentional grief space by maintaining a non-judgmental stance. Four of the six participants, Participants 1, 2, 4, and 5, disclosed that they sought professional support and therapeutic intervention by accepting human limitations. Participant 1 shared,

I got hospitalized, and I got on medication. I went to the IOP program there and learned some more about how to manage my own issues. I just quit the job quickly and basically stayed home for a couple of weeks trying to get my head back on straight. At another place in Brunswick. They had had a peer come in, and it was a really good talk, and I went home.

Participant 2 stated, "Accountability from colleagues and talking about these things with my colleagues and in consultation is a very protective factor." Participant 4 noted, "To know that I'm human and that we all have our limits." Participant 5 stated, "Yes. So I did see my supervisor basically, who then just gave some guidance on basically how to manage it and how to pace myself and time as well."

Participants 3, 5, and 6, stated that they set boundaries that helped them limit caseload commitments. Participant 3 shared, "burnout, I feel like I have the resources and support that I need to set new boundaries for myself or make my caseload smaller." Participant 5 stated, "I set limits for myself as well in the sense of how much I am

prepared to actually give.” Participant 6 reported, “Additionally, I set some boundaries. Like everybody’s crisis is not my crisis.”

Participants 2 and 6 revealed that they created intentional grief space by maintaining a non-judgmental stance and maintaining accountability and role boundaries. Participant 6 stated that they identified signs of burnout through emotional and motivational warning signs:

I know for sure that I’m experiencing an episode of burnout because it looks a lot like depression for me. I usually have more than one job, and all of a sudden, I want to quit all of those jobs, which is very much not like me, or the idea of going to work is just the worst thing in the world. I don’t even want to go or hope that a scheduled session does not show up because I don’t want to do it. And when they do, I still enjoy it somehow, I get through it, and I love what I do, but it’s that right? The 10 minutes before that, I’m just like, please don’t show up. Please don’t show up.

The participants reflected on how burnout impacted their clinical effectiveness and emotional availability. Some spoke about distancing themselves emotionally to cope, while others acknowledged questioning their ability to continue in the field. Participant 1 shared,

The productivity was really high. You’ve got to see so many people. You’ve got to see 20 clients a week. You only get paid like 20 to \$30 an hour, as a licensed therapist, which is, that’s what no money.

Participant 5 noted,

You have to be costly, basically one case after the other, with very few breaks in between, still keeping that space for them to actually be okay and make sure that they're in a neutral space to actually, for them not to do anything risky. So that went over a lot into personal time.

Research Question 2: To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapists who work with domestic violence victims? To answer Research Question 2, six themes emerged from the interviews. These themes were personal and relational impact of domestic violence work, emotional reactivity and self-awareness during therapeutic encounters, domestic violence knowledge shaping clinical practice, coping strategies and support systems in domestic violence work, guidance for new professionals entering domestic violence work, and broader reflections and insights on the field.

Theme 6: Personal and Relational Impact of Domestic Violence Work

This theme explores how the interviewed therapists' personal lives and relationships were affected by their engagement in domestic violence work. Three main subthemes emerged: (a) influence of working with domestic violence victims on daily life and personal outlook, (b) impact of domestic violence work on interactions with family and friends, and (c) shifts in views on relationships or safety due to domestic violence work. The majority of the interviewed participants acknowledged that they had a heightened awareness of abuse and relational dynamics, personal transformation with mixed outcomes through survivor work, and a deepened emotional response toward victims as a result of working with domestic violence victims.

Participants 1, 2, and 3 stated that domestic violence work heightened their awareness of abuse and relational dynamics. Participants 2, 5, and 6 asserted that their professional work led to a shift in their personal transformation with mixed outcomes through survivor work. Participant 2 shared, “I think it’s shifted my perspective a lot on what a healthy relationship is -I have a lot of gratitude for my husband”. Participant 5 reported, “Because of my own personal drive to actually help in those cases, being able to rectify that it actually assisted people and led new lives. It’s rewarding.” Participant 6 expressed,

That I used to love certain TV shows. I cannot do that. I have become a very vivid dreamer, especially with melatonin. So, I don’t do that anymore. I can’t watch a lot of violence. Violence that is similar to that area.

Participants 1 and 2 acknowledged that domestic violence work helped deepen their emotional response toward victims. Participants expressed that domestic violence work shaped their daily lives and outlook: increased emotional sensitivity, reduced judgment toward survivors, and strengthened drive for justice.

Participants 2, 4, and 5 reported that the impact of domestic violence work on interactions with family and friends was increased vigilance and analytical interactions. Participants 1 and 6, acknowledged that there was increased vigilance and analytical interactions with their family and friends.

Participant 1 shared,

My family is not very supportive. I’m from a generation, I’m 60, so 61. So, my generation and before that don’t believe so much in mental health.” A couple of

friends kind of lean on me for that more. Well, because a therapist, you could help me with this. I say, well, call Ula, and we will make an appointment or something, because I work through telehealth, and I do not give people a lot of advice.

Participant 6 remarked, "It certainly makes me on edge if I hear something that I know statistically is a problem." Participants 2 and 5, noted that they now focused on client education and maintaining personal safety. Participant 2 shared, "I also provide some psychoeducation to my clients about relationship dynamics in regards to power or equity, and just how to identify those things as well."

Participant 5, expressed,

I have my personal boundaries in place, and I have my protection mechanisms. It wasn't because I felt like he would attack me or the potter with the technique. It was more from the sense of the potter doing anything for the other client.

Four of the six participants acknowledged becoming more cautious and vigilant in their personal lives, especially in how they approached relationships, public spaces, and perceived safety. Participant 2 noted, "Assessing for safety has gotten a lot better." Participant 5 stated, "Intuition plays a big role there. So, I asked the security to actually come sit outside the door, and I kept the door open, and I got the consent for the door to stay open." Participants 4 and 5 revealed that domestic violence work made them more aware of threats without personally feeling unsafe." Participant 4 shared, "I had been hearing stories like that of when I worked with people who were coming out of sex trafficking and stuff." Participant 5 stated, "I'm safe. No. No, not yet." Participant 4 acknowledged that they now had a different way of viewing the world for what it is.

Participant 4 stated, “I feel like I have a different view of what this world is, the stuff with ‘Puff Diddy’ and stuff like that. I know there’s a lot of messed-up stuff that happens.”

Theme 7: Emotional Reactivity and Self-awareness During Therapeutic Encounters

This theme examined participants’ emotional responses while engaging with clients and the strategies they used to manage difficult moments. Two subthemes emerged : (1) managing situations where the victims’ trauma triggers unexpected reactions in the therapist and (2) instances of unexpected emotional responses during domestic violence work. The interviewed licensed therapists described how they handled emotionally charged moments when their own trauma or vulnerabilities were unexpectedly activated during client interactions. The common ways that the interviewed participants employed to manage victims’ traumas triggered due to unexpected reactions in therapy were using personal therapy, deferring from emotional processing until after the therapy sessions, and using self-awareness as a coping strategy.

Participants 2, 4, and 6 shared that they made use of personal therapy to manage situations where clients’ trauma triggered unexpected reactions during therapy sessions.

Participant 2 noted,

I talked to my supervisors about it. I talked to my colleagues about it. I talked to my therapist about it. I’ve engaged in my own trauma work around it, because frankly, yeah, my client’s trauma has impacted me, and it has touched on my own. And so, it’s taken me deeper into my own trauma work. So, I engage in EMDR.

Participant 4 shared,

I'm honest with myself about it. A lot of times, if that really is the case, I will process it after the session. I will make sure that if I need my own sessions to do that. And I remember when I worked in those places where it was that intense, I had a nightly practice where I would just kind of sit with everyone whom I had seen that day. And then I would guess it would be kind of like a prayer. I would send all the stories that I heard to the light, may they all be healed. Definitely doing my own therapy, doing my own or whatever, journaling, whatever practices that I know.

Participant 6 reported, "I will either bring it up in therapy about self-spotting."

Two of the six participants, participants 4 and 5, acknowledged that they deferred from processing their emotions until they were done with the therapy sessions.

Participants 5 and 6 stated that they managed triggers through self-awareness as a result of a coping strategy and prioritized their clients' emotional space over their own.

Participant 5 shared, "We're not there for ourselves. It's not our emotional space. It's not our place to express our thoughts." Participant 6 shared, "I don't want to be in a place where I can't show up for people either."

Participants 2 and 5, averred that they recognized and addressed practitioner burnout to address these unexpected triggers. Participant 2 shared, "I think it's an inevitable part of working with clients who have those experiences that it needs continuous attention."

Participant 5 explained,

I've had two cases, two times that I've hit burnout, actually. Compassion fatigue does come in from time to time. It only happened, I would say, twice. You do not have any more emotional capacity to give or any more social capacity. Your social battery is just completely drained.

Participants 1 and 4, reported that they made use of therapeutic techniques for emotional regulation during sessions.

Participant 1 commented,

Thankfully, I've had the mindfulness practice enough over the years that I can distance myself in the moment when it's really upsetting me, I can pull back and kind of observe and then calm myself down so that I don't just react. I'm able to decide how to respond. Mindfulness, some kind of Buddhist CBT-type stuff. Lots of therapeutic modalities have helped a lot." Participant 4 stated, "I do something called tapping, 'Emotional Freedom Technique. ' That's a technique that I use that sometimes even during sessions and stuff like that, if I'm getting dysregulated by someone's story, I'll do whatever I need to do to keep myself regulated.

Other ways participants managed situations where victims' trauma triggered unexpected reactions during therapy sessions included: being proactive in seeking help, choosing responses deliberately, maintaining objectivity during sessions, and selectively sharing personal feelings with friends to build trust.

Participant 2 shared, “I’m pretty good about reaching out for help and for support and being proactive about that.” Participant 1 commented I’m able to decide how to respond.”

Participant 5 noted,

For the most part, actually, I’ve been able to keep my objectivity.” ‘Sharing a little bit of yourself actually helps the person connect with you, and that builds the therapeutic relationship.” Participants experienced emotional reactions to victims’ stories, such as anger, sadness, or helplessness that surprised them in the course of their work.

Participant 6 reported,

It was vicarious trauma from emotional reactions to client stories. It was bringing up stuff in me that was just making me angry. I’m like, why do you keep giving me all the details? I’m a very visual, vividly visual person, so if you try to explain something to me, I literally have scenery in my head. So literally every week I’m watching her in my head get raped, and this is a bit much, but that was because it was triggering something in me.

Theme 8: Domestic Violence Knowledge Shaping Clinical Practice

This theme focused on how the interviewed participants applied their understanding of domestic violence in therapeutic contexts, including adapting interventions and tailoring support strategies. Three main subthemes emerged: (1) influence of understanding domestic violence on treatment plans and interventions, (2) tailoring treatment plans for individuals with different backgrounds or experiences, (3)

technical interventions considered most effective in working with domestic violence victims. Participants described ways in which they integrated their knowledge about abuse dynamics into their clinical decision-making and therapeutic models.

Three of the interviewed participants, 1, 2, and 4, stated that they mainly set realistic and phased treatment plans for the clients. Participant 1 shared, “You can’t jump right into it. Let’s talk about your trauma. It has to be a buildup.” Participant 2 noted, “being realistic about what is tangible and realistic in terms of the treatment plan right now for the client.”

Participant 4 stated, “I try to keep the goals realistic and reasonable with knowing that if someone’s in a situation like that, a lot of the time it’s pretty complicated.” Two of the six participants, Participants 2 and 6, acknowledged that they ensured that their clients had access to all relevant support resources. Participant 2 noted,

Bring in local resources like the YWCA or these other organizations that are informed about this person’s experience. I like to provide thorough information about housing, food, clothing, and other places where they can receive those resources.” Participant 6 shared, “ Just giving them all the resources that I can.

Participants 1 and 4 noted that they had become less judgmental and offered holistic treatment consideration. Participants 1 and 2 asserted that they prioritized their clients’ safety in initial treatment planning. Participant 1 shared, “With trauma-informed therapy, safety has to come first. That’s where I start with them. What is it? You need to feel safe.” Participant 2 noted, “What I understand of it so far is assessing for safety and then mitigating risk.”

Participants 1 and 5 stated that they tailored individualized treatment options for each client's needs. Participant 1 noted, "You tailor treatment plans for individuals with different backgrounds and experiences." Participant 5 commented,

You need to be able to detect and have enough background information to be able to see which kind of case this is, a case of domestic abuse in the form of sexual abuse in childhood, a very different approach to somebody who, for example, is a child who had an autistic parent and experienced abuse during childhood. So that's also domestic abuse, it's just more psychological. I tailor treatment to every single client that I see. So, I'm very eclectic in my I find cognitive behavioral therapy very effective, but it also depends on the personality of the client. So, for example, if CBT might work for one client, it might not necessarily work for the other client; maybe that client needs acceptance supplement therapy, or maybe they need something more along the lines of solution-focused therapy. For example, I found that with men, solution-focused therapy tends to work a lot better there because they're not very in tune with their emotions.

Participants 6, 2, 3, and 4 integrated their knowledge about domestic violence abuse into the decision-making therapy models. Participant 6 shared, "My understanding of domestic violence makes me come at them with compassion first." Participant 2 reported,

Doing a safety plan or providing a strength-based approach. With a safety plan, I provide a copy to my client, and then I also write it down on my end. If that is not safe for them to have a physical copy. Then I keep the copies, and they have it on

their phone. I create expectations of whether I'm going to check in with them at some point, if there are safety concerns. We'll put it in there, text my therapist tomorrow at this time.

Participants 6 and 1 shared respecting client autonomy and emotional nuance and trauma work with a focus on the victim's readiness.

Participant 3 noted,

Most of my work in private practice is trauma-focused. So, a lot of psychoeducation around trauma comes into my treatment plans a lot. And just using trauma-focused interventions, I guess, like I'm EMDR (Eye Movement Desensitization and Reprocessing) trained and being able to bring that in. And I mentioned trauma because we know that that is the experience that people often have in these situations. So, I think just understanding it as within the context of trauma has really helped me as far as treatment planning." The participants emphasized the need to remain clinically flexible, tailoring approaches to accommodate the specific needs, readiness, and safety concerns of clients impacted by domestic violence.

Participants 4 and 6 adjusted their approach to accommodate clients from diverse cultural, social, or experiential contexts.

Participants 4 and 6 stated that they tailored their treatment plans to suit the needs of individuals from diverse cultural, social, or experiential contexts. Participant 4 shared, "Then I just kind of work around that because people want different things. I like to know why you're here and what your specific and personal goals are. And then

I just kind of work around that because people want different things. People come into the space for different reasons.

Participant 6 noted, “It doesn’t mean that I haven’t switched things up when I saw that somebody might better benefit from a narrative therapy approach. And so I might trade that in for CBT.”

Participant 6 explained,

My treatment plan is flexible, but has enough bones to properly treat trauma. When you strip down the personal things, you’re still going to get regulation skills. Everybody needs those. Still going to think about how you think about yourself and how important that is, and you’re still going to process some trauma via the brain.

Two of the six participants, participants 3 and 6, disclosed that the techniques they found most useful or reliable when supporting domestic violence clients were specialized trauma-focused therapies. Participant 3 shared, EMDR (Eye Movement Desensitization and Reprocessing) therapy has been tremendously helpful as a trauma-focused intervention.” Participant 6 added, “Yes, I do trauma-focused cognitive behavioral therapy. So that’s where brain spotting comes in.”

Participants 3 and 6 found group therapy and regulation skill development intervention effective in working with domestic violence survivors. Participant 3 shared, “A high-quality, safe, well-facilitated group is really, really helpful in my experience.” Participant 6 stated, “I don’t have one client that I haven’t given regulation skills to, ways to put yourself back in control of yourself instead of sitting in trauma responses.”

Theme 9: Coping Strategies and Support Systems in Domestic Violence Work

The interviewed therapists revealed their main sources of support and self-care practices that they relied on to remain resilient and effective in their work. Two main subthemes emerge: (1) support systems or resources found most helpful in coping with challenges of domestic violence work, and (2) seeking professional help or support for compassion fatigue. This subtheme identified the formal and informal resources the interviewed participants leaned on to help them cope with the challenges of domestic violence. Participants 2, 3, and 4 declared that they received support from their colleagues and supervisors, and supportive peer collaboration.

Three of the six participants, specifically participants 2, 3, and 4, reported receiving support from their colleagues and supervisors. Participant 2 shared,

We provided collaborative care for this client, I as a counselor, and then my supervisor as more in a social work capacity, doing case management. It was nice to have additional support from my supervisor and the local police. A supervisor who's available when there's a crisis, A supervisor who is experienced in working with domestic violence. Who is plugged into local resources?

Participant 3 commented, "I have a great supervisor." Participant 4 noted, "The best thing was the other staff being able to come together and commune and process with each other." Participants 2, 3, and 5 reported that they engaged in supportive peer collaborations, which were helpful in addressing domestic violence-related work.

Participant 2 stated,

Definitely having a collaborative team. We have a local YWCA. I have relationships there with people so that we're all staying connected on just certain clients. Yeah, I mean, having organizational infrastructure and then also having my own peer and professional support is vital.

Participant 3 shared, "I have a good network of colleagues." Participant 5 commented,

I'm part of various groups of counselors, psychologists. I do pose the question to the group, basically to get input from other professionals. So that has been a very, very valuable resource, actually. It can be isolating. So, this is where those networks actually come into play, and they're so helpful and so beneficial.

Participant 5 shared,

Especially private practice space. Work on your own. Yes, as a lady, as it is, I find it fairly rewarding because of the fact that you own your own schedule, you have your own clients, you're doing your own thing, but it can be isolating. So, this is where those networks actually come into play.

Two of the interviewed participants, Participants 4 and 5, experienced emotional support through structured communal reflection. Participant 4 noted, "Being able to have that communion in it, I think, was one of the best things." Participant 5 reported,

Every couple of weeks, there'll be a meeting where you're allowed to come and debrief. Basically, it's like a safe space for customers to discuss that debrief, and that's an amazing space, actually.

Participants 2 and 5 asserted that they received external connections that supported private practice. Participants found access to hotline services and maintaining work-life boundaries helpful in their domestic violence work. Participant 2 noted, “We have Montana 9 88, or a hotline that can be accessed 24/7.” Participant 6 mentioned,

Just having people around me that is not talking about it with me all the time. I don’t have to eat, live, and breathe it outside of what I do.” Participants also pursued therapy, consultation, or other professional services to manage the emotional toll of their work. Participant 6 noted,”

You have to put that somewhere, and it can’t be your family and friends, what are you going to do? Traumatize them.” “Yes. Yeah, I’ve been in counseling. I do believe in being in counseling while working with heavy trauma clients. You need to be in somebody’s office, if not weekly, biweekly, if not biweekly, then monthly.

Theme 10: Guidance for New Professionals Entering Domestic Violence Work

This theme delved into the suggestions and recommendations that the interviewed respondents offered to individuals beginning a career in domestic violence counseling.

Three of the six participants, participants 1, 2, and 6, advised new professionals entering the domestic violence work to prioritize emotional self-care and awareness. Participant 1 shared, “Self-care has to be number one.” Participant 2 stated, “If you’re going to do this work, you really have to take care of yourself. Or you’ll burn out.” Participant 6 noted, “If it’s your hope that somebody doesn’t show up. That’s when you address something.”

Participants 1 and 2, proposed that new professionals should accept professional boundaries and realistic expectations.

Participant 1 noted, “Don’t buy into it; you have to be productive according to your boss to be a successful counselor.” Participant 2: “You can do everything, and you can do everything right. People will still, I mean, reenter relationships, people will.”

Participants 1 and 3 advised new professionals in the domestic violence profession to be alert to risks of burnout and vicarious trauma. Participant 1 shared, “They saw during COVID with doctors and nurses. You can’t just pressure people to work 24/7.” Participant 3 reported, “It makes sense that new therapists might not be ready, and that’s going to be overwhelming, and secondary trauma is going to be high.”

Two of the six participants, 1 and 2, recommended that the new professional entering the domestic violence profession establish strong professional and personal support systems. Participant 1 shared, “Setting up resources supports a therapist, good friends, fun times, breaks.” Participant 2 noted, “Really have support professionally and personally.”

Recommendations offered by the participants to individuals starting their career in domestic violence included: Participant 6 stated, “Address things early if something is bothering you. You don’t wait for it to blow up, and now you’re angry with your clients.” Participant 3 shared, “Don’t be alone in it.” Participant 2 commented,

Some of the advice is just so misinformed.” ”Educate yourself on the nuances of Domestic Violence and some of the risks involved.” Understand the psychology

behind it, to be compassionate. Understanding the cycle is very, it's very important.

Participant 5 stated,

It takes a lot of time and a lot of dedication, and you really need to put your heart, blood, soul, and everything into it." Clients come back, and they've actually managed to rethink their lives. They live a completely different life from where they started when they started therapy, and there's a lot of reward in that, and that's actually.

Participant 3 noted,

Process everything. I know I had classmates and colleagues there who did not have that experience and were really caught off guard by symptoms of secondary trauma and burnout, and compassion fatigue, and did not feel prepared for that.

Participant 4 shared, "Having mentorship is the best thing because that was the big one for me. Someone who's been at this way longer than me that I can go to with stories or that I can go to when I'm stuck."

Participants stressed the need for mentorship and supervision from clinicians with experience in trauma and domestic violence work. They identified these supports as crucial for developing ethical, grounded, and sustainable clinical practices. Participant 3 remarked,

I don't think it was really an appropriate placement for students. Treading lightly and really feeling informed and supported before taking on a full caseload like this. Having the supervisor or being well-versed in that field.

Participant 5 shared, “Yes, it doesn’t necessarily make much money in the very beginning, but you see the people actually.”

Theme 11: Broader Reflections and Insights on the Field

This theme captured the interviewed participants’ overarching thoughts on additional insights or reflections about the domestic violence profession, misconceptions around working with domestic violence victims, and helpful insights that the general public should have about the emotional toll of domestic violence work. Three subthemes emerged: (1) additional insights or reflections on domestic violence work, (2) misconceptions about working with domestic violence victims, and (3) insight the general public should have about the emotional toll of domestic violence work. Participants shared final thoughts, personal reflections, and additional insights that they wanted to communicate based on their career experiences, covering aspects that had not been previously discussed. A vast majority of the interviewed participants complained about insufficient field-specific burnout resources and a lack of structured organizational support systems in the domestic violence line of work.

Two of the participants, participants 1 and 3, stated that there were insufficient field-specific burnout resources for therapists dealing with domestic violence survivors. Participant 1 shared, “You’d think that in the field of mental health, they would’ve said, Oh, hey, you’re approaching burnout.” Participant 3 stated, “I don’t know that there are systems that I feel like are available to me to help manage compassion fatigue in this specific realm.”

Participants 1 and 3 had concerns over the lack of structured organizational support systems for domestic violence therapists. Participant 1 shared, “Even when I was having trouble at my job, no one said, Let’s get you some EAP (Employee Assistance Program) immediately.” Participant 3 noted, “I don’t know that there really are any systems.”

Participants 2, 1, and 4 also shared their thoughts regarding domestic violence work. Participant 2 noted, “I just appreciate that you’re focusing on this area. I think it’s important.” Participant 1 remarked,

It can be an intersex thing where trans people suffer gay couples, hurting each other. Men are abused by their wives. The impact on the children is so important that they really need to be looked at so much more. “I think I’m still investigating that, Bernadine. I think that in the many years now that I’ve been around this system, just not been participating in it because I was working, but seeing right now Facebook, I have a peer support group on Facebook. So sometimes we talk about issues. Mostly it’s for advertisements. Like, oh, I have an opening for a client. There’s that. I don’t belong to a local therapist group.

Participant 4 noted, “Hopefully, you’re able to take it and highlight the need for support for people working in the field because it’s traumatizing.”

Misconception that the participants thought the general public had about working with domestic violence victims was challenging simplistic views of victim behavior and domestic violence dynamics, as revealed by Participant 1, “What I’ve often heard is Why do they keep going back? And the average is seven times. And the psychology of it is

going back to an abuser and getting away. And the psychology behind that is to start believing in themselves enough to say, I'm worth it. I deserve a better life. Because we all get familiar with what we grew up with. Substance use has a much greater influence on domestic violence than anyone probably wants to admit."

Participants 5, 4, 3, and 6 addressed misconceptions about working with domestic violence victims and shared what they believed the public should better understand about this specialized field of practice. The main views from the participants that the general public needed to have were that cumulative trauma exposure leads to emotional exhaustion, the emotional toll of domestic violence work is heavy and persistent, and misconceptions oversimplify domestic violence work and its challenges.

Participants 4 and 5 stated that accumulated trauma exposure leads to emotional exhaustion. Participant 4 noted, "I just cried. I just cried and cried, and it was all the stories. They all just came in. It hit me like, this is bad. We've got to change some things." Participant 5 shared,

Work with people's emotions at the end of the day, and these are experiences, and yes, you'll hear stories that are going to completely make your jaw drop. Now they're getting a vivid basic image of something that they don't really know could exist, and people can get extremely violent.

Participants 3 and 4 articulated that the emotional toll of the work is heavy and persistent. Participant 3 noted, "It can be overwhelming, and it can be, it's dark. It can be really scary." Participant 4 shared, "That it is labor and that it is work. Because I've noticed that sometimes people think that it's an easy thing to do."

Participants 4 and 6 acknowledged that misconceptions oversimplify domestic violence work and its challenges. Participant 4 shared, “I’ve even heard sometimes people will make statements that make me think that they think that we are just out here.” Participant 6 stated,

There’s a misconception that it only exists in heterosexual relationships towards females, when that is not true at all. That it is strictly a power and control thing that is in there, but it is not something that is at the root all the time of why people are doing what they’re doing to their partners.

Two of the six participants, 4 and 5, asserted that responsibility to clients requires emotional self-awareness. Participant 4 stated,

You are the lifeline because they are coming to you and pour all of their encounters or what they go through, and they trust you so much that they can come to you and hear you and give them the advice that they need, or they point ‘em in the right direction.

Participant 5 shared, “ Knowing what you are capable of handling. Don’t necessarily force yourself into going into that field if you can’t really handle it.”

Participants 3, 4, 5, and 6 shared other insights that the general public should have about the emotional toll of domestic violence work, including: clients’ needs go beyond emotional support. Emotional difficulty is inherent in this work and requires a level of readiness from the therapists. The emotional impact also differs across cultural and individual contexts.

There can be enjoyment despite emotional heaviness. However, therapists also experience grief when outcomes are negative. Importance of patience in trauma work, especially given the ongoing issue of victim blaming.

This population is not light to work with. There are risks of burnout when emotional boundaries are ignored, as well as a sense of danger and risk for the helper. Supporting clients through trauma requires emotional endurance, and the job involves emotional labor and tears. Participants emphasized “ that the needs of clients extend far beyond emotional support, often requiring practical interventions such as relocation and assistance with housing and stuff like that.” Participant 3 noted, “There is an emotional toll, and that’s okay. We can expect that, and that makes sense. It would be kind of weird if there wasn’t. I think being prepared for that.”

Participant 5 stated,

Coming from a country, a culture, or a background where this is not really discussed. That can have very much basically secondary victimization. One therapist is not going to necessarily react or feel any sort of effect of hearing a very traumatic story, whereas the next one will, and that might completely just make them turn around and just say, No, I’m done.

Participant 6 shared, “Despite the heaviness of the work, it doesn’t mean that the people don’t enjoy it. You need patience”. The participants identified key attributes necessary for sustaining this work, particularly patience and emotional endurance. Participant 6 added, “I think even today, there’s a lot of victim-blaming.”

Participant 3 stated, “There is grief when things don’t end well, and that’s hard. This isn’t really a light population to be working with. As someone helping, that can feel like a risky position to occupy,” Participant 5 shared, “You’re going to cause a lot of burnout. Emotional drainage that actually happens internally, with you needing to process all of this.”

Participant 4 commented,

It’s not to hold space for someone in their most raw and vulnerable moments. Watch people fall apart, and then try to help them to come back together so that they’ll be okay or so that they can walk out the door in the hour or whatever. That is not easy. Think if people knew the labor, the labor, and the tears.” Ultimately, therapists characterized their role as deeply emotional labor, with work that demands patience, endurance, and often comes with tears.

Summary

This qualitative research study aimed to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists’ work may contribute to the development of compassion fatigue and burnout in the treating therapists. Two research questions guided the research: What are the lived experiences of therapists relative to domestic violence victims? To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapists who work with domestic violence victims?

In this chapter, I provided a detailed summary of the analysis process. Concluding with the findings of this study from the analysis of the data that was collected from six

participants. The participants had experience working with the population studied.

Responses of the participants were analyzed and 11 themes were as identified as follows:

(a) background, motivation, and personal influence in working with domestic violence victims, (b) navigating stressors in domestic violence therapeutic work, (c) emotional burden of client stories, (d) lived experience of violence and its influence on practice, (e) burnout and emotional exhaustion in the field, (f) personal and relational impact of domestic violence work, (g) emotional reactivity and self-awareness during therapeutic encounters, (h) domestic violence knowledge shaping clinical practice, (i) coping strategies and support systems in domestic violence work, (j) guidance for new professionals entering domestic violence work, (k) broader reflections and insights on the field.

The results indicated that participants enjoyed their work, underscoring the need for institutional knowledge, more robust institutional support, trauma-informed supervision, and social contextual structures that need to be created to provide protection for workers and the victims they help. Participants highlighted the critical need for mentorship, supervision, and the ability to consult with colleagues and peers about these situations. The participants postulated about insufficient field-specific burnout resources and a lack of structured organizational support systems in the domestic violence line of work, for mentorship and supervision from clinicians with experience in trauma and domestic violence work. The participants identified these supports as crucial for developing ethical, grounded, and sustainable clinical practices.

Some participants experienced burnout symptoms from emotional overwhelming. Participants revealed that they experienced trauma-related emotional symptoms as a result of listening to victims' domestic abuse stories. Some participants pursued therapy, consultation, or other professional services to manage the emotional toll of their work. Participants also experienced direct burnout and compassion fatigue as a result of prolonged exposure to trauma. One participant stated they identified signs of burnout through emotional and motivational warning signs. The participants utilize personal therapy, therapeutic techniques for emotional regulation to manage situations where victims' trauma triggers unexpected reactions during therapy sessions. A few participants stated that they received support from their colleagues and supervisors.

During the interviews, participants discussed their concerns about insufficient field-specific burnout resources and a lack of structured organizational support systems in the domestic violence line of work. Chapter 5 will provide a discussion of the interpretation of the findings, limitations of the study, and the implications for positive social change. Additionally, Chapter 5 will conclude with recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the phenomenological study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. A phenomenological research design was used to understand the lived experiences of therapists working with victims of domestic violence. Semi-structured interviews with six participants led to rich data. Purposeful sampling was used to select the participants. The interview was audio-recorded via Zoom. Rev application service was used to transcribe the resulting data, after which each transcript was meticulously verified through comparison with the corresponding audio recordings.

Due to the lack of research and information regarding this phenomenon, it was vital to investigate the lives of these therapists to understand their experiences when working with domestic violence victims. Additionally, the study was conducted to fill a gap in the literature and add to existing knowledge. It was designed to offer therapists an additional tool to help improve their work with domestic violence victims. The study also aimed to increase awareness of the consequences of indirect trauma exposure. Such exposure can lead to secondary traumatic stress, compassion fatigue, and burnout. Over time, therapists may even become victims of trauma themselves as a result of prolonged exposure. For this research, the theoretical framework of the social ecological model, developed by psychologist Urie Bronfenbrenner in the late 1970s was utilized.

Data were analyzed using Braun and Clarke's (2023) six-phase thematic analysis framework to explore the lived experiences of six licensed therapists working with victims of domestic violence to help conceptualize the findings. The following research questions guided the study:

RQ1: What are the lived experiences of therapists relative to domestic violence victims?

RQ2: To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapists who work with domestic violence victims?

Analysis of the participants' responses to the eight interview questions produced 11 themes: (a) background, motivation, and personal influence in working with domestic violence victims, (b) navigating stressors in domestic violence therapeutic work, (c) emotional burden of client stories, (d) lived experience of violence and its influence on practice, (e) burnout and emotional exhaustion in the field, (f) personal and relational impact of domestic violence work, (g) emotional reactivity and self-awareness during therapeutic encounters, (h) domestic violence knowledge shaping clinical practice, (i) coping strategies and support systems in domestic violence work, (j) guidance for new professionals entering domestic violence work, and (k) broader reflections and insights on the field.

Interpretation of the Findings

This study offers new research findings regarding the lived experiences of the phenomenon under study. This research has examined the experiences, stressors, and

related aspects of working with victims of domestic violence from the perspectives of therapists employed in such roles, specifically focusing on their motivations, emotional impacts, system “stressors,” and their attitudes about support and resilience. Ultimately, the data identified close connections between therapists, their personal histories, and the structural environment in which domestic violence services exist.

Participants in the study described varying professional and personal experiences and related their experiences of coming to work with victims of domestic violence. Many reported a sense of strong purpose through the unity of past exposures to violence and personal relationships marred by trauma and violence. Some described an upbringing vacillating between acknowledging violence and neglecting it altogether. For these participants, their understanding and acknowledgment of their experiences directly impacted their decision to grant others the support they were not afforded at some point in their lives. Others had education and early career experiences that illuminated the systematic failures directing their interest, motivation, and ultimate desire to assist others with requests for help while supporting their own intentional and responsible informational intents.

The licensed participants who were interviewed indicated that the emotional weight of their everyday work can be very intense, particularly when clients stay in harmful relationships or refuse intervention due to fear or distrust. Some of the participants learned that their clients had vanished, had to be hospitalized, or died from abuse, which had a stinging emotional impact. Trauma stories, visible injuries, suicidal ideation, or just hearing the strong emotions of survivors emotionally burdened the

participants. The participants reported emotions that included sleep disruption, self-esteem issues, and feelings about boundaries. Furthermore, the participants in the study expressed their frustration over the legal system's ineffectiveness in prosecuting abusers and protecting victims, or witnessing the processes being extended over time.

Stressors in personal lives come into play; the participants described how they dealt with their long-distance relationships, former lives as single parents, a history of poverty, as well as previous trauma in relationships that may have occurred while they were children. Some of the therapists also indicated they managed ongoing mental health stresses such as PTSD due to their profession and/or past lives during times when they worked in under-resourced environments, agency politics, and policing systems, and their own mental health issues usually compounded stress. Systemic problems surrounding stigma of mental health, gendered microaggression, and societal trauma continued to intensify their situations.

Although the emotional impact was significant, participants shared that having supportive networks served to buffer the impact of these realities. Supervisors and colleagues were significant resources in developing emotional support, working through complicated cases, and providing assistance in safety planning. For some participants, collaborating with the police or another professional provided reassurance of some safety and predictability. Almost all participants emphasized the critical need for mentorship, supervision, and the opportunity to consult with colleagues and peers about these situations, particularly when risks were high or they were being threatened in some way.

Taken as a whole, the findings suggest a multifaceted environment where, when faced with both the systemic barriers and emotional drains to professionals in domestic violence (and the inherent uncertain nature of it), the professional dedication was regularly challenged, but often the commitment remained high. There were participants who enjoyed their work very much, underscoring the need for institutional knowledge, more robust institutional support, trauma-informed supervision, and social contextual structures that need to be created to provide protection for workers and the victims they help. Eleven themes emerged from the data, manifesting the research questions, each offering insight into the professional and personal realities of domestic violence therapy. In the following sections, I discuss each of the themes in relation to findings from the literature review.

Theme 1: Background, Motivation, and Personal Influence in Working With Domestic Violence Victims

A vast majority of the participants acknowledged that they were motivated to work with domestic violence victims since they wanted to make a meaningful impact, and one reason was that they were also victims of domestic violence. Participants expressed a combination of reasons that motivated them to work with domestic violence victims, including personal reasons, passion, and a desire to make a meaningful impact. It was noted that therapists who lack clinical experience are more likely to experience vicarious trauma (Madrid & Drakulich, 2021). Padmanabhanunni (2020) posited that exposure to a victim's personal trauma can have an impact on therapists' professional and personal lives. Six participants highlighted that they felt equipped to work with victims of

domestic violence while maintaining personal and professional boundaries in domestic violence work

This theme, as extracted from the data, correlates with findings in the literature that state therapists who work with survivors of domestic violence face unique challenges that can impact their professional performance and personal well-being (Cummings et al., 2021). Study participants shared the importance of maintaining a balanced work-life position, and also a combination of reasons that motivated them to work with domestic violence victims, including personal reasons, passion, and a desire to make a meaningful impact.

Theme 2: Navigating Stressors in Domestic Violence Therapeutic Work

Within this theme, all six participants expressed stressors while working with victims of domestic violence. These stressors, often overlooked, contribute directly to burnout and can reflect systemic issues in domestic violence service agencies. Victims of domestic violence may experience panic attacks and generalized anxiety disorders (Yucel & Akoglu, 2023). The impact of working with domestic violence victims on therapists can be profound, affecting their emotional well-being, professional performance, and personal lives (Harling et al., 2020). According to Cummings et al. (2021), therapists can face vicarious trauma, emotional exhaustion, and intrusive thoughts.

In this study, participants stated they were stressed from their profession due to vicarious trauma from client experiences, expressed going to counseling and helping other therapists, got stressed as a result of barriers to justice due to distrust in the legal system, internal professional strain, and personal traumas. Cummings et al. (2021) found

that therapists' indirect exposure to victims' trauma increases the chances of therapists experiencing compassion fatigue and burnout. Therapists' continuous exposure to trauma, when working with victims of domestic violence and bearing witness to horror stories and highly emotionally distressing material, may result in compassion fatigue and burnout (Beckerman & Wozniak (2018). The findings of this study confirm that therapists experienced compassion fatigue and burnout symptoms due to being emotionally overwhelmed.

Theme 3: Emotional Burden of Client Stories

Many of the subthemes that emerged in the findings correspond to the core factors of the emotional burden of client stories. Participants revealed that domestic violence victims' stories and experiences made them develop more emotional boundaries and regulations personally. One participant expressed experiencing trauma-related emotional symptoms as a result of listening to clients' domestic abuse stories. Participants mentioned that they were stressed from their profession due to vicarious trauma from client experiences. Therapists who work with survivors of domestic violence face unique challenges that can impact their professional performance and personal well-being (Cummings et al., 2021). Coulling et al. (2024) in their study noted that cumulative exposure to distressing stories can result in significant emotional and psychological challenges, such as vicarious trauma, compassion fatigue, and burnout. In this theme, participants affirmed what has been found in the literature as Barre et al. (2023) noted that professionals who work with victims of trauma are exposed to traumatic stories, negative experiences, and a continuous emotional toll, which increases their vulnerability

to secondary traumatic stress, vicarious trauma, and burnout. This constant exposure can lead to emotional exhaustion, difficulty maintaining empathy, and personal distress, impacting their professional effectiveness and personal well-being (Barre et al., 2023).

Theme 4: Lived Experience of Violence and Its Influence on Practice

Study participants reported that their own experiences with violence or trauma served as a guiding influence in their decision to work with domestic violence survivors. These personal histories allowed for a heightened sense of connection and purpose in their clinical roles. According to Guitar and Molinaro (2017) health care professionals who have been trained to provide treatment for individuals who suffer from trauma are at risk of developing vicarious trauma and secondary traumatic stress. In this research, Participants 1, 2, 3, 4, 5, and 6 expressed how they felt working with victims of domestic violence. shared that the main lived experiences were disrupted emotional and cognitive processing, evolving emotional boundaries between work and personal life, and managing trauma responses through grounding.

This dual influence highlights the delicate balance between personal experience as a strength and as a potential vulnerability. Carles et al. (2023) noted that therapists' work environment should foster support from organizations within to have measures in place to help prevent burnout, as therapists are unaware of this emotional toll on themselves. In addition, the literature validated the theme that stated

Participants indicated that their own experiences with violence or trauma served as a guiding influence in their decision to work with domestic violence survivors.

Theme 5: Burnout and Emotional Exhaustion in the Field

This theme emerged as participants acknowledged experiencing varying degrees of emotional exhaustion and fatigue. The therapists also highlighted how burnout affects clinical presence, motivation, and personal well-being. Therapists working with victims of domestic violence are frequently exposed to their victims' suffering, which can put therapists at risk of experiencing compassion fatigue and burnout (Al-Abbadey & Stevens, 2023). Participants consistently described symptoms such as emotional fatigue, irritability, disconnection from clients, and difficulty maintaining therapeutic empathy. Participants 3 and 6 averred that they experienced direct burnout and compassion fatigue as a result of prolonged exposure to trauma, asserted that they had emotional processing related to burnout.

Participants 1, 2, 3, and 5 highlighted that they were psychologically strained and had self-doubts from emotionally demanding client work. According to Harling et al. (2020) therapists strive to help others with an expectation that they will do so from a stance of unwavering empathy. However, therapists are frequently exposed to their victims' suffering, which mainly puts them at significant risk of experiencing compassion fatigue and burnout (Pirelli et al., 2020). The literature also proffered that Coulling et al. (2024) in their study noted that cumulative exposure to distressing stories can result in significant emotional and psychological challenges, such as vicarious trauma, compassion fatigue, and burnout. Participants 1, 2, 3, and 5 highlighted that they were psychologically strained and had self-doubts from emotionally demanding client work. Several participants commented about other experiences of compassion fatigue or

burnout. Newell and MacNeil (2010) emphasized the importance of self-care and organizational support to prevent compassion fatigue. The authors posited that professionals who treat victims of trauma, exposure to secondary traumatic stress, might contribute to them experiencing compassion fatigue.

Theme 6: Personal and Relational Impact of Domestic Violence Work

This theme captured how the work often extended beyond the professional setting, affecting therapists' personal lives and relationships. Participants acknowledged that they had a heightened awareness of abuse and relational dynamics, personal transformation with mixed outcomes through survivor work, and a deepened emotional response toward victims as a result of working with domestic violence victims. This theme was supported in the literature by Bekerman and Wozniak (2018), who claimed that ongoing training programs for therapists should focus on recognizing and managing the personal well-being of therapists. Training should include self-care techniques, trauma-informed services, and coping skills to help mitigate stress related to compassion fatigue (Beckerman & Wozniak, 2018).

Therapists working with victims of domestic violence are less aware of the effects of stories, and the emotional demands that are the result of working with victims who have experienced emotional pain and suffering (Radley & Figley, 2007; Stevens & Al-Abbadey, 2023). Participants 1 and 2 acknowledged that domestic violence work helped deepen their emotional response toward victims. Participants expressed that domestic violence work shaped their daily lives and outlook: increased emotional sensitivity, reduced judgment toward survivors, and strengthened drive for justice. The study

emphasizes the importance of providing mental health professionals and practitioners with resources for self-care, peer support, and supervision to mitigate the effects of working in such emotionally intense environments (Barre et al., 2023)

Theme 7: Emotional Reactivity and Self-Awareness During Therapeutic Encounters

Study participants spoke of how they handled emotionally charged moments when their own trauma or vulnerabilities were unexpectedly activated during client interactions. Participants 2, 4, and 6 shared that they made use of personal therapy to manage situations where clients' trauma triggered unexpected reactions during therapy sessions. According to Taylor et al. (2018), helpline staff should receive more education about trauma triggers, and ongoing support should be provided to reduce the impact on the therapists' home and social life, thus improving therapists' mental well-being and job satisfaction. Participants 4 and 5 acknowledged that they deferred processing their emotions until they were done with the therapy sessions. Participants 5 and 6, stated that they managed triggers through self-awareness as a result of a coping strategy and prioritized their clients' emotional space over their own.

This theme coincides with research by Cummings et al. (2021), who stated that therapists who work with survivors of domestic violence face unique challenges that can impact their professional performance and personal well-being. In addition, the literature validated this theme by stating that therapists who are exposed to trauma work need to develop coping strategies to reduce stress, and the level of stress of clinical work may contribute to trauma symptoms (Makadia et al., 2017).

Theme 8: Domestic Violence Knowledge Shaping Clinical Practice

The eighth finding highlighted how the interviewed participants applied their understanding of domestic violence in therapeutic contexts, including adapting interventions and tailoring support strategies. Many participants describe ways in which they integrated their knowledge about abuse dynamics into their clinical decision-making and therapeutic models. Participants 6, 2, 3, and 4 integrated their knowledge about domestic violence abuse into the decision-making therapy models. Participants disclosed that they used different techniques that they found most useful or reliable when supporting domestic violence victims. According to Saleme (2022), training, education, and clinical programs are required early in a therapist's career to prevent and mitigate burnout and compassion fatigue.

This theme, as extracted from the data, correlates with findings in the literature by a study that was conducted by Harling et al. (2020). The authors postulated that the participants sought more professional development, which included on-the-job supervision and opportunities for further education. The participants felt that an increase in education would help participants to hone their skills and protect themselves against compassion fatigue. Study participants shared the importance of therapy, which has been tremendously helpful as a trauma-focused intervention.

Theme 9: Coping Strategies and Support Systems in Domestic Violence Work

This theme demonstrated how participants employed coping mechanisms such as personal therapy, mindfulness, and supervision to manage the emotional toll and sustain their work. Three of the six participants, specifically Participants 2, 3, and 4, reported

receiving support from their colleagues, supervisors, and peer collaborations. This study confirmed and expanded on prior research that therapists should be provided with support when working with victims of domestic violence. Participants also pursued therapy, consultation, or other professional services to manage the emotional toll of their work.

These findings support the research of Taylor et al. (2019), who argued that helpline staff should receive more education about trauma triggers, and ongoing support should be provided to reduce the impact on therapists' home and social lives. This, in turn, can improve therapists' mental well-being and job satisfaction. Participants also stressed the importance of support. They noted there are insufficient field-specific burnout resources and a lack of structured organizational support systems in the domestic violence line of work. Participants highlighted the need for mentorship and supervision from clinicians with experience in trauma and domestic violence work.

For these reasons, clinicians should seek training, therapy, clinical supervision, and peer support groups (Cumming et al., 2021). The study emphasizes the importance of providing mental health professionals and practitioners with resources for self-care, peer support, and supervision to mitigate the effects of working in such emotionally intense environments (Barre et al., 2023). The findings of this research provided further insight into providing formal and informal resources that participants can lean on to help them cope with the challenges of domestic violence.

Theme 10: Guidance for New Professionals Entering Domestic Violence Work

This theme delved into the suggestions and recommendations that the interviewed respondents offered to individuals beginning a career in domestic violence counseling.

According to Shatto et al. (2023), the lack of experience and techniques in newer therapists who work with domestic violence victims can result in the therapists not realizing how their work is impacting their own mental health. This will cause therapists to feel as if they lack confidence while feeling a sense of fear and a sense of worry about the outcomes when working with victims of domestic violence (Madrid & Drakulich, 2021). Participant shared, “Some of the advice is just so misinformed.” Educate yourself on the nuances of Domestic Violence and some of the risks involved.” The public should understand the psychology behind it, to be compassionate. Makadia et al. (2017) discussed the relationship between exposure to trauma work and well-being (general psychological distress, trauma symptoms, and disrupted beliefs) in trainee clinical psychologists. The authors stated that therapists who are exposed to trauma work need to develop coping strategies to reduce stress, and the level of stress of clinical work may contribute to trauma symptoms (Makadia et al., 2017).

Theme 11: Broader Reflections and Insights on the Field

Participants shared final thoughts, personal reflections, and additional insights that they wanted to communicate based on their career experiences, covering aspects that had not been previously discussed. Participants 5, 4, 3, and 6 addressed misconceptions about working with domestic violence victims and shared what they believed the public should better understand about this specialized field of practice. The participants shared that the public needed to know that cumulative trauma exposure leads to emotional exhaustion, the emotional toll of domestic violence work is heavy and persistent, and misconceptions oversimplify domestic violence work and its challenges. Brand et al.

(2019) stated that the failure of most training programs and their inability to provide systematic education and support for psychologists working with victims of trauma results in many therapists neglecting their well-being. They found that peer support was a critical, essential, and viable strategy for preventing and mitigating burnout and compassion fatigue in therapists.

In this theme, participants affirmed what has been found in the literature, enunciating that the new professional entering the domestic violence profession should establish strong professional and personal support systems, including mentorship and supervision from clinicians with experience in trauma and domestic violence work. They stressed the need for societal awareness of victim blaming, improved systemic support, and continued advocacy. These reflections underscore that domestic violence therapy is both deeply meaningful and inherently taxing.

Limitations of the Study

Several barriers were encountered during this study, primarily related to recruitment, sensitivity of the topic, and variability in participant experiences. Recruiting therapists with experience working with domestic violence victims proved challenging due to their demanding schedules and the emotionally taxing nature of the work. Discussing secondary trauma, burnout, and compassion fatigue was sometimes difficult for participants, which may have influenced the depth of some responses. Additionally, participants' experiences varied based on professional setting, personal history, and level of exposure to trauma cases, which required careful analysis to identify consistent

patterns while honoring individual narratives. A notable limitation of the study was observed.

Limited access to participants, as discussed in Chapter 1, was a potential limitation that may have impacted the transferability of the research due to the reduced number of willing participants. The study only used a small sample of participants. Originally, 8 participants were sought for this study. However, many of the candidates who expressed interest via email did not respond when contacted, and some of the responses were bots. The participants who work with domestic violence victims who were included in this study cannot be generalized to the larger population. However, the results of qualitative studies are not necessarily intended to be generalizable.

Based on the findings of this study, several recommendations are offered for practice, policy, and future research. The participants in this study reported a need for supportive networks that can serve to buffer the impact of these realities. Supervisors and colleagues, they stressed, are significant resources in developing emotional support, working through complicated cases, and providing assistance in safety planning that is needed for therapists who work with victims of domestic violence. Keeping participants' information confidential allowed for more open dialogue from the participants. Another recommendation is to recruit from the Walden participant pool for a study on this topic and to offer a small gift card in order to recruit participants at a faster rate.

For professionals in the domestic violence profession, they need to be alerted to the risks of burnout and vicarious trauma. Participants also recommended that the new professional entering the domestic violence profession establish strong professional and

personal support systems. Therapists working with domestic violence victims would benefit from structured organizational supports that acknowledge the emotional demands of this work. Institutions should provide consistent trauma-informed supervision, access to mentorship from experienced clinicians, and regular opportunities for peer consultations. In addition, organizations should promote self-care practices and provide access to counseling or wellness services for therapists to mitigate the risk of compassion fatigue and burnout. Training programs for new professionals should emphasize emotional boundaries, coping strategies, and the realities of working with trauma to better prepare clinicians entering this field.

Mental health agencies and professional organizations should establish policies that prioritize therapists' well-being in high-risk fields such as domestic violence work. This includes integrating field-specific burnout prevention strategies, developing clear guidelines for supervision, and ensuring that therapists have access to resources designed to support resilience.

Recommendations

Future research should expand on this study by including a larger and more diverse sample of therapists to capture a broader range of experiences. Comparative studies across different clinical populations could help determine whether compassion fatigue and burnout manifest differently in domestic violence work versus other trauma-focused fields. Longitudinal research would also be valuable in examining how therapists' experiences evolve, and which supports are most effective in promoting long-term sustainability in practice. Finally, exploring organizational interventions aimed at

reducing burnout could provide practical models for agencies seeking to better support their staff.

Implications for Social Change

The findings of this study can have important implications for positive social change by highlighting the need to strengthen support for therapists who work with domestic violence victims. When therapists experience compassion fatigue and burnout, the quality of care they provide may be compromised, which can negatively affect victims seeking safety, healing, and empowerment. By identifying the emotional challenges therapists face and the organizational gaps that contribute to these difficulties, this study underscores the importance of creating systemic changes that protect both practitioners and the victims they serve. This qualitative research study, with a phenomenological approach, contributed to a deeper understanding of the lived experiences of therapists who work with victims of domestic violence. The research findings shed light on therapists' concerns about insufficient field-specific burnout resources and a lack of structured organizational support systems in the domestic violence line of work. However, McNeillie and Rose (2021) further stated that understanding vicarious trauma is crucial for maintaining the well-being of therapists and plays a crucial role in assisting victims of domestic violence.

This study supported the gap in the literature because it provided insight into how those experiences with domestic violence victims on therapists can be profound, affecting their emotional well-being, professional performance, and personal lives (Harling et al., 2020). In this study, the participants shared their experiences and insight into the

emotional stressors they faced while working with victims of domestic violence. They described managing ongoing mental health stresses, such as PTSD due to their profession and past lives during times when they worked in under-resourced environments, or navigated agency politics, and policing systems. Additionally, participants' own mental health issues usually compounded the stress associated with their work. This motivation highlighted the importance of continuing this qualitative study to further explore the stressors therapists experience when working with victims of domestic violence.

The results of this study may provide a deeper understanding of the lives of therapists working with victims of domestic violence. On the organizational level, the results suggested that agencies should implement trauma-informed supervision, structured mentorship, and peer consultation opportunities. These practices can reduce the emotional toll of trauma work, promote therapist resilience, and ultimately improve outcomes for survivors of domestic violence. On a community and societal level, this study highlights the need to address ongoing issues such as victim blaming and stigma, which not only harm victims but also add strain to therapists. By fostering greater awareness and understanding of domestic violence within communities, therapists may experience increased support in their work, leading to stronger systems of care.

Also, on a professional level, findings revealed that training programs can integrate education on compassion fatigue, burnout prevention, and emotional regulation strategies to better prepare clinicians for the realities of trauma-focused practice. This proactive approach can build a more resilient workforce that is equipped to sustain meaningful, ethical, and effective care. In summary, this study contributes to positive

social change by advocating for systemic support that strengthens the well-being of therapists. Healthier, better-supported therapists are more capable of providing consistent, high-quality services to victims, ultimately improving access to healing and safety for those impacted by domestic violence.

Finally, this study contributes to the growing body of literature on therapists who work with victims of domestic violence and underscores the need for systemic improvements in clinical practice and professional support. The insights gained from participants emphasize the importance of developing comprehensive organizational structures, trauma-informed supervision, and targeted training programs. Strengthening these areas will ensure that therapists are better equipped to provide effective, ethical, and sustainable care, ultimately promoting positive social change by improving outcomes for both practitioners and the victims they serve.

For this study, I utilized the social ecological model by psychologist Uri Bronfenbrenner in the late 1970s. This study adds to the theoretical knowledge base of this framework by elucidating a research area unexplored yet underpinned by this theory. According to Bronfenbrenner (1977), these various levels are believed to influence individual behavior and each other. Hence, this model implies a relationship between the individual and the environmental influences. Bronfenbrenner (1977, 1979) proposed an ecological perspective in which behavior is believed to be affected by both individual and environmental influences. Bronfenbrenner believed an individual's development can be disturbed by a series of connected environmental systems: individual, community, relationship, and society (Bronfenbrenner, 1977). Bronfenbrenner (1977) posited that

environmental influences were divided into multiple levels, which allows for a comprehensive exploration of therapists' experiences within the broader context of individuals, communities, relationships, and society.

This theory was used to understand the lived experiences of therapists who work with victims of domestic violence. The social ecological model provides a holistic lens through assisting in gaining a deeper understanding of therapists' perception of domestic violence and the negative consequences of indirect trauma exposure as a result of working with trauma victims (Oginska-Bulik et al., 2022). By situating therapists' experiences within this multi-layered framework, the study provided a comprehensive understanding of how ecological factors collectively contribute to both the risks and supports associated with domestic violence therapeutic work.

In response to research questions, study participants described varying professional and personal experiences and related their experiences of coming to work with victims of domestic violence. Participants shared that having supportive networks served to buffer the impact of these realities. One participant described varying professional and personal experiences and related their experiences of coming to work with victims of domestic violence. The participants expressed the critical importance of maintaining professional boundaries, engaging in regular self-reflection, participating in personal therapy, and seeking collegial support as essential strategies for managing the demands of working with this population.

Researchers of the social ecological model have suggested that victims of domestic violence are frequently exposed to their victims' suffering, which can put

therapists at risk of experiencing compassion fatigue and burnout (Al-Abbadey & Stevens, 2023). Study participants reported that they experienced direct burnout and compassion fatigue as a result of prolonged exposure to trauma. Participants stated that they experienced burnout affecting their emotional regulation and their personal well-being. The participants shared that they had emotional processing-related burnout.

These results aligned with Bronfenbrenner's social ecological model, which asserted that the individual level will be used to explore the (therapist) experiences, perceptions, beliefs, skills, values, and behaviors (Bronfenbrenner, 1977). This framework was appropriate for examining therapists' experiences of compassion fatigue and burnout when working with domestic violence victims, as these challenges extend beyond the individual level.

In the application of this theory to the study population, participants described enjoying their work, underscoring the need for institutional knowledge, more robust institutional support, trauma-informed supervision, and social contextual structures that need to be created to provide protection for workers and the victims they help. Participants described employing personal therapy, postponing emotional processing until after sessions, and utilizing self-awareness as coping strategies to help mitigate compassion fatigue and burnout. Based on these insights, the findings contribute to the existing body of knowledge and align with the guiding theoretical framework. Finally, while prior research has highlighted general stressors in trauma-focused therapy, this study revealed context-specific challenges unique to domestic violence work, such as navigating victim blaming, feelings of danger, and the cultural dimensions of trauma.

These findings expand the current body of knowledge by situating therapist experiences within the broader ecological systems outlined in the Social Ecological Model.

Conclusion

A literature review revealed a lack of scholarly research on therapists' perceptions about compassion fatigue and burnout. In this qualitative phenomenological study, data were collected from six participants. The purpose of this qualitative phenomenological study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists. This study explored the lived experiences of therapists who work with domestic violence victims and examined how such work may contribute to compassion fatigue and burnout. Guided by the social ecological model (Bronfenbrenner, 1977), the findings highlighted the complex interplay of individual, interpersonal, organizational, and societal factors that shape therapists' experiences. Participants described both the rewards and challenges of their work, emphasizing the emotional toll of listening to trauma narratives, the risks of burnout when boundaries are blurred, and the importance of emotional endurance in sustaining their practice.

Despite the emotional weight of this work, therapists expressed a strong commitment to supporting domestic violence victims and found meaning in their professional roles. At the same time, they underscored the need for more robust organizational support, trauma-informed supervision, mentorship, and opportunities for peer consultation. These resources were identified as critical for fostering resilience,

promoting ethical practice, and ensuring sustainable engagement in this challenging field. The purpose of this qualitative phenomenological study was to gain a better understanding of the perceptions of therapists who work with domestic violence victims and how the therapists' work may contribute to the development of compassion fatigue and burnout in the treating therapists.

Overall, the study contributed to a deeper understanding of how domestic violence work affects therapists and calls for systemic changes to better support those who serve this vulnerable population. By acknowledging the emotional demands of this work and prioritizing structural support, the counseling profession can create healthier environments for practitioners while improving services for survivors of domestic violence. This research study found a critical need for mentorship, supervision, and the ability to consult with colleagues and peers regarding these situations. This study also underscored the need for institutional knowledge, more robust institutional support, trauma-informed supervision, and social contextual structures that need to be created to protect therapists and the victims. The results of this study could help counselors, psychologists, social workers, future practitioners, mental health professionals, and researchers to better prepare counselors who provide services to domestic violence victims. Findings will benefit other researchers who may want to explore the perceptions and experiences of other licensed professionals as they become traumatized or re-traumatized from exposure to traumatic stories.

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Appendix: Interview Guide

Thank you for participating in this study and taking the time to speak with me today. I really appreciate it. I'm a postgraduate student studying forensic psychology at Walden University. This interview is part of my dissertation research, which focuses on therapists' perception of compassion fatigue and burnout after working with victims of domestic violence. The goal of this interview is to better understand your personal experiences and perspectives, and there are no right or wrong answers. You're free to skip any question or stop the interview at any point, and your responses will be kept completely confidential and anonymous.

This interview will take approximately 45-60 minutes and will be audio-recorded so that the details of your responses will be accurately captured. The audio recording of the interview will be transcribed and stored securely and only used for research purposes. The interview will begin with a couple of background questions, then move into more focused areas around your experiences with burnout, compassion fatigue, and coping strategies.

The researcher utilized the following questions to guide the interview.

Research Question 1:

What are the lived experiences of therapists relative to domestic violence victims?

Interview Questions

Can you describe your professional background and your experience working with domestic violence victims?

Please describe the stressors experienced in your professional and personal life. How do the stories and experiences of domestic violence victims impact you emotionally and professionally?

Have you experienced symptoms of compassion fatigue or burnout? If so, how have you addressed them?

Research Question 2:

To what extent does domestic violence affect the lived experiences, beliefs, practices, and treatment for therapists who work with domestic violence victims?

Interview Questions

How has your work with domestic violence victims influenced your daily life or personal outlook?

How do you manage situations where victims' trauma triggers unexpected reactions in you?

How does your understanding of domestic violence influence the treatment plans or interventions you create for your victims?

What support systems or resources have been most beneficial in helping you cope with the challenges of this work?

Is there anything else you will like to share about your experiences that I have not addressed?

Thank you for participating today and for taking the time to share your experiences, it really means a lot and will help with my research. If you'd like, I can send you a copy of the transcript when I have transcribed this interview, and you will have the opportunity to make any necessary corrections.