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Caryn Alyce Honig

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# Walden University

College of Education

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Caryn Alyce Honig

has been found to be complete and satisfactory in all respects,
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Walden University
2019

Abstract

# Compassion Fatigue in Registered Dietitians Who Treat Patients With Eating Disorders

by

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MEd, University of St. Thomas, 2006

BS, University of Texas Allied Health Science Center, Houston, 1992

BA, University of Denver, 1988

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

December 2019

Abstract

Registered dietitians who treat patients with eating disorders may be at risk for developing compassion fatigue due to exposure to patients' chronic complications. Dietetic courses and programs do not comprise coping and resilience training, therefore, dietitians who work with these patients may need additional education. The purpose of this basic qualitative research study was to investigate the perceptions of practicing registered dietitians and dietetic educators on the risk of compassion fatigue, investigate ways to manage and prevent the development of compassion fatigue, and explore the possible need for professional education. Knowles's theory of andragogy provided the conceptual framework as perceptions of educational experiences were explored. Face-to-face semistructured interviews were conducted with 4 registered dietitians who treat patients with eating disorders and 4 registered dietitians who are dietetic educators. Data were analyzed using NVivo 12 and a 6-step thematic analysis technique. The 6 themes that emerged from the data included repeated exposure to pain and suffering caused emotional exhaustion and numbness; the risk of compassion fatigue is highest when dietitians are underprepared for the repeated exposure to trauma, pain, and suffering; seeking support is possibly a way to manage and prevent compassion fatigue; setting boundaries, separation of self from work, and self-care are necessary; and education and awareness about compassion fatigue and self-care is needed. An in-person 3-day workshop on preventing and managing compassion fatigue was developed, which can positively impact social change by improving patient care and contributing to the overall wellness in registered dietitians who work with patients with eating disorders.

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# Dedication

This dissertation is dedicated to my beautiful mother, Arleen Honig, who supported me through all of my hopes and dreams. Sadly, she could not see me complete my doctorate. She would have been so proud. This dissertation is also dedicated to my loving husband, Scott, and my beautiful daughters, Samantha, and Natasha. All three loved and supported me through this entire, very lengthy process. Through the ups and downs, I loved you and will love you always and forever. To my dad who has faced his own challenges head on these past few years. He persevered through his pain and never gave up on life. He taught me to never give up, no matter what challenges, changes, and disappointments I might face.

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Section 1: The Problem

## Introduction

Remen (1996) stated, “The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet” (p. 52). Joinson (1992) first described compassion fatigue when she witnessed nurses losing their abilities to nurture or care. Figley (1995) later described this phenomenon as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant another—the stress resulting from helping, or wanting to help, a traumatized or suffering person” (p. 7). Additionally, Stamm (1999) described compassion fatigue as the combined effects of primary and secondary trauma stress (STS) as well as cumulative stress experienced by professionals in helping fields and healthcare providers. The definition of compassion fatigue has evolved to include the emotional, physical, and spiritual fatigue that derives from prolonged exposure to trauma and giving of the self (Coetzee & Klopper, 2010; Gilmore, 2012). Furthermore, researchers have described it as loss of empathy and disengagement from patients, resulting from a cumulative exposure to trauma (Mealer & Jones, 2013).

The demanding work of healthcare providers, including addressing patients’ suffering, can lead to compassion fatigue. Compassion fatigue can cause clinicians to dread work or patients, avoid work or patients, and experience negative physical and emotional symptoms (Matey, 2016). Compassion fatigue affects healthcare providers’

health and wellness, as well as their job performance, job satisfaction, and patient care (Branch & Klinkenberg, 2015).

Individuals with eating disorders commonly have severe health problems, comorbid diagnoses, resistance to treatment and relapse, and higher mortality rates compared to patients with other psychological disorders, as well as the general public. As a result, healthcare providers, including registered dietitians who treat patients with eating disorders, may experience compassion fatigue (Warren, Schafer, Crowley, & Olivardia, 2013). People with eating disorders have mental illnesses with life-threatening physiological and psychological complexities. Therefore, eating disorder experts should treat patients with evidence-based techniques. Additionally, a multidisciplinary team, including a registered dietitian, is required for optimal care (Academy for Eating Disorders, 2019; The Joint Commission, 2016). Because of the complications and complexity presented with eating disorders and the stress involved in treating eating disorder patients, clinicians may experience compassion fatigue (Abbate-Dage, Amianto, Delsedime, De-Baco, & Fassino, 2013).

The focus of this study was on the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and the possible need for professional education for registered dietitians who treat patients with eating disorders. This section includes the local problem, the description of the rationale, a definition of terms, the significance of the study, and the research questions. A review of literature and implications is also included.

## The Local Problem

Due to environmental, psychiatric, and physical factors, patients who have eating disorders are at a moderate to high risk for complications and death, therefore, clinicians who work with these patients are prone to increased worry, stress, and frustration (Eddy, 2013). Because of the characteristics presented by patients with eating disorders, treatment providers are at an elevated risk for compassion fatigue (Warren et al., 2013). Registered dietitians are exposed to the same emotional stressors and frequently work alongside other healthcare professionals, including "nurses, physicians, social workers, mental health workers, paramedic staff, case managers" (Cieslak et al., 2013, p. 20), in addition to pastoral care workers, which researchers have identified as being at risk for compassion fatigue (Osland, 2014; Slatten, Carson, & Carson, 2011).

A registered dietitian can provide nutritional care as a crucial part of treatment of team support to patients who suffer from all types of eating disorders (Mittnacht & Bulik, 2015; Ozier & Henry, 2011; Tholking et al., 2011). When provided by registered dietitians, medical nutrition therapy helps to normalize eating patterns and stabilizes nutritional status in patients who suffer from eating disorders (Arthur, Strauss, & Mehler, 2015). The American Psychological Association, the Academy for Eating Disorders, and the American Academy of Pediatrics have shown support for registered dietitians being part of the treatment team for patients with eating disorders (Klump, Bulik, Kaye, Treasure, & Tyson, 2009).

The local problem is the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders in a city in the southwest United States.

At a two-day Mindful Self-Compassion: Core Skills Training workshop by Kristin Neff, PhD and Chris Germer, PhD, three of the participants were registered dietitians who treat patients with eating disorders. One participant, noted as RJB, stated that she tries to take care of herself because her patients were getting her "down in the dumps." Another dietitian, JS, agreed and stated that she needed to find ways to find a more balanced life.

One registered dietitian, LL, who has treated patients with eating disorders for over 26 years, stated, "I love the walk and the journey of recovery with my clients, so compassion fatigue can sneak up on me. Before I know it, I am feeling tired, resentful, and trapped," (Dietitian, personal communication, April 8, 2017). Another dietitian, AH, explained that eating disorder work can be draining and, at times, redundant—sometimes with little "proof" that her work makes a difference:

> Compassion fatigue for me shows up as disinterest in sessions, mind-reading what the client is thinking, struggling to see the people separate from their disease, internal frustration, dread before sessions, and feeling exhausted, and burned out at the end of the day or week (Dietitian, personal communication, April 7, 2017).

A factor that may prevent or aid in managing compassion fatigue is professional development and education (Eddy, 2013). According to Showalter (2010), evidence has indicated that the greatest influence on compassion fatigue is by increasing education, recognizing signs and symptoms early, and beginning treatment as soon as possible. According to the Accreditation Council for Education in Nutrition and Dietetics (ACEND) (2018) and the Academy of Nutrition and Dietetics (2018), education in both

preventing and managing compassion fatigue is not required in the curriculum to prepare dietetic students for professional practice.

A gap in practice exists between the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders and the possible need for education to prevent or manage it. I investigated the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, ways to manage compassion fatigue, and ways to prevent compassion fatigue. Moreover, I explored the possible need for professional education to manage or prevent compassion fatigue. Understanding the perceptions of dietitian practitioners and educators represents an important factor in determining whether they need education, types of education that may help prevent and manage compassion fatigue in the clinical setting, and ways to increase and improve healthcare standards.

## Rationale

### Evidence of the Problem at the Local Level

I am a registered dietitian and specialize in treating patients with eating disorders and disordered eating. I am also a member of an eating disorders specialists' group in a large city in southwest United States. According to their website the mission of this 501(c)3 group is, "to promote effective treatment of eating disorders, provide community and professional education, and raise awareness and understanding of these illnesses" (Houston Eating Disorders Specialists, 2017, para.1). This group includes multidisciplinary professionals who concentrate on treating patients with eating disorders; they have commitment to quality care of those inflicted with this mental

illness. There are 130 members, 20 whom are dietitians, in addition to eight treatment programs that have dietitians on staff.

Four local registered dietitians who are members of the Houston Eating Disorders Specialists (2017) discussed their experiences with compassion fatigue. One of them, LL, admitted that she experienced compassion fatigue because of working with the eating disorder population: “I had to take a break from working with eating disorder patients.” She said in a recent interview, “I completely left the field of nutrition and worked for 5 years as an administrator in my church before re-entering the field” (Dietitian, personal communication, June 12, 2017). She described that the break was good for her; now, she combines her nutrition practice with her spirituality practice that she gained from working in her church.

Another dietitian, AB, dedicated her career to treating patients with eating disorders. AB commented, “I am really having a hard time right now. I’m tired of hearing about people’s nutrition problems. They need to just eat” (Dietitian, personal communication, June 12, 2017). A third dietitian dedicated her career to treating patients with eating disorders expressed feeling compassion fatigue and having an interest in exploring other professional opportunities (Dietitian, personal communication, June 12, 2107). Additionally, she stated that she did not receive education on compassion fatigue; therefore, she struggled with how to appropriately handle her feelings. A fourth dietitian stated that she would have benefitted greatly from a class on preventing compassion fatigue and burnout. She added that she was currently taking continuing education classes on self-compassion and self-care (Dietitian, personal communication, June 12, 2017).

**Evidence of the Problem From the Professional Literature**

Throughout the past 30 years, researchers have defined compassion fatigue in addition to describing the causes and effects (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). Since the mid-1990s, the majority of research has been on the prevalence and predictors of compassion fatigue in nurses, therapists, community service workers, and healthcare professionals (Cocker & Joss, 2016). Beck (2011) found that compassion fatigue was prevalent in varying nursing practices. Compassionate care refers to a standard of nursing that is in the American Nursing Association (ANA) Code of Ethics (2015). The cumulative effects of compassion as well as stress in the workplace, personal issues, lack of coping mechanisms, and the sense that needs are being ignored or neglected can result in compassion fatigue. Nurses who experience compassion fatigue demonstrate both physical and emotional symptoms (Nolte, Downing, Temande, & Hastings-Tolsma, 2017).

Therapists provide guidance and support to patients who are suffering, wounded, uncertain, or distressed (Simms, 2017). Kottler (2010) reported that therapists and clients influence one another; moreover, the therapist and client can experience a relationship that may be a positive and negative experience for both. According to Kottler, “The risks that come with the territory of being a therapist emanate primarily from getting perilously close to the flame that burns deep within the sorrow of each client we see” (p. 55).

Healthcare providers interact with patients and families who are experiencing suffering and crisis. Community service workers include social workers and disability sector workers. Healthcare providers as well as community service workers can

encounter prolonged exposure to suffering, empathy, and compassion for those in need as well as a desire to help can experience compassion fatigue (Sorenson, Bolick, Wright, & Hamilton, 2017).

Research studies on registered dietitians and compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma are limited. A thorough search for articles on compassion fatigue in registered dietitians, compassion fatigue in registered dietitians who treat patients who suffer from eating disorders, and articles on compassion fatigue and eating disorders was exhausted during the present study. Only two articles on registered dietitians and burnout were found, and 13 articles on eating disorders and burnout were found, but no articles were found on compassion fatigue in registered dietitians who treat patients with eating disorders. Although this area remains relatively unexplored, the implications are that patient mortality may cause increased worry, frustration, and stress, which attributes to burnout in clinicians who work with patients with eating disorders (Eddy, 2013; Warren et al., 2013). Regarding registered dietitians and professional burnout, a moderate to high number (57.5% out of 405 respondents) of dietitians reported experiencing burnout. However, researchers have suggested that dietitians experience less burnout compared to other health professionals (Gingras, DeJonge, & Purdy, 2010).

Patients who suffer from eating disorders can experience severe health complications, medical morbidity, high dropout rates, relapses in treatment, and higher mortality rates compared to patients with other psychological disorders (Satir, 2013). Researchers have considered patients with eating disorders as difficult and frustrating to

work with regarding patient care (Thompson-Brenner, 2012). Mental health clinicians who provide direct care to patients with complicated mental health needs may experience anxiety, depression, sleep disturbances, conflicts in relationships, in addition to physical aches and pains are often referred to as symptoms of compassion fatigue (Ray, Wong, White, & Heaslip, 2013). According to Warren et al. (2013), mental health professionals, including dietitians who treat patients with eating disorders, may be at high risk for compassion fatigue and burnout.

Researchers have suggested that education may play a role in reducing compassion fatigue in healthcare professionals. Education that focuses on improving relationship with clients, and self-compassion as well as well-being in healthcare professionals reduces the chances of compassion fatigue and burnout (Boellinghaus, Jones, & Hutton, 2014). Kemper, Mo, and Lynn (2015) concluded that education and training in resilience, understanding, and self-compassion could help improve patient care, as well as decrease the incidence of compassion fatigue and burnout in health-care specialists. The purpose of this study was to investigate the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, investigate ways to manage and prevent the development of compassion fatigue, and explore the possible need for professional education for registered dietitians who treat patients with eating disorders.

## Definition of Terms

*Burnout:* “Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job and is defined by three dimensions of exhaustion, cynicism, and

inefficacy" (Maslach, Schaufeli, & Leiter, 2001, p. 397). Unlike compassion fatigue, burnout is not directly related to the exposure to trauma and pain; it is a result of chronic immersion in stressful and demanding situations (Cetrano et al., 2017). Burnout is connected to one's work environment while compassion fatigue develops from one being exposed to another's pain and suffering (Flarity, Gentry, & Mesnikoff, 2013; Maslach, Jackson, & Leiter, 1996).

*Compassion:* Compassion derives from two Latin roots: *com*, meaning "together with," and *patior*, meaning "to suffer" (Godlaski, 2015, p. 943). Compassion is explained as one's discrete emotional response to focusing on alleviating others' suffering (Condon & Barnett, 2013). "Compassion is seen as awareness of someone's suffering, being moved by it (emotionally and, according to some definitions, cognitively), and acting or feeling motivated to help" (Strauss et al., 2016, pp. 17-18).

*Compassion fatigue:* A person experiencing compassion fatigue may encounter spiritual, physical, and emotional depletion due to exposure to patients' pain and trauma. The depletion leads to symptoms that influence the caregiver, relationships, and patient care. A person with compassion fatigue might have frustration, depression, anxiety, boredom, and feelings of hopelessness (Anewalt, 2009; Figley, 1995; Lombardo & Eyre, 2011). Compassion fatigue differs from burnout; compassion fatigue is directly related to the exposure of trauma and traumatic material while burnout is caused by prolonged involvement in stressful and demanding situations (Cetrano et al., 2017). Further, compassion fatigue results from one being exposed to another's' pain and suffering,

while burnout is related to an individual's work environment (Flarity et al., 2013; Maslach et al., 1996).

*Dietetic educator:* Dietetic educators are leaders in providing nutrition education for health professionals, including medical, dental, nursing, nutrition and dietetics, as well as many other healthcare professionals and students (ACEND, 2018; Academy of Nutrition and Dietetics, 2018).

*Dietitian:* A dietitian is a health professional who has earned a bachelor's degree in nutrition and dietetics in addition to completing the required practical training in a hospital and a community setting. A registered dietitian refers to an expert of nutrition and food who has met requirements professionally and academically, which leaders of the Accreditation Council for Education in Nutrition and Dietetics have established (Academy of Nutrition and Dietetics, 2018a). The titles "Registered Dietitian" and "Dietitian" are protected by law; therefore, only qualified individuals who have met the education and continuing professional development requirements can use those titles (Academy of Nutrition and Dietetics, 2018a). The titles "Registered Dietitian" and "Dietitian" are used interchangeably throughout this paper.

*Eating disorders:* Eating disorders are mental illnesses that involve continuous eating patterns and behaviors that harmfully influence one's emotions, health, and abilities to function normally. The most common eating disorders, which are listed in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-V*), include "anorexia nervosa, bulimia nervosa, binge eating disorder, pica, rumination disorder,

avoidant/restrictive food intake disorder, other specified feeding or eating disorder, and unspecified feeding or eating disorder" (2013, p. 20).

*Professional education:* For the purpose of this study, professional education refers to current and continuing education programs that reduce or prevent compassion fatigue in students and practicing dietitians who treat patients with eating disorders (Michalec, Diefenbeck, & Mahoney, 2013; Puckett, 1997).

*Self-compassion:* Self-compassion is a state of mind that involves being mindful, kind to oneself, avoiding self-judgment, increased common humanity, and reduced isolation (Neff, 2016).

## Significance of the Study

Healthcare professionals experience compassion fatigue as an occupational hazard, which may influence those who care about their clients and/or patients (Mathieu, 2007). One must understand compassion fatigue and what treatment in addition to what education are best to prevent and manage compassion fatigue in registered dietitians who treat patients with eating disorders. The present study may promote awareness of compassion fatigue, as well as support the need for appropriate treatment about compassion fatigue in the current standard education curriculum for registered dietitians.

As the present study being the first research study on compassion fatigue in registered dietitians who treat patients with eating disorders, the results may maximize prevention and management of compassion fatigue in these clinicians. The results showed the perceptions of both registered dietitians and dietetic educators on the need for professional education on managing and preventing compassion fatigue in dietitians who

treat patients with eating disorders. The results also indicated ways professional educators can assist and what kind of professional education is needed to assist registered dietitians who treat patients with eating disorders. Furthermore, the results showed the factors that influence registered dietitians who work with eating disorder patients to obtain professional education on preventing and managing compassion fatigue.

The findings of the present study may contribute to positive social change by suggesting training and interventions that can assist registered dietitians who are experiencing or may experience compassion fatigue. Furthermore, positive social change may result from better education about compassion fatigue for healthcare providers. This outcome may lead to better services for patients, as well as higher retention rates in health care providers.

## Research Questions

The problem is the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders. The purpose of the study was to investigate the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, investigate ways to manage and prevent the development of compassion fatigue, and explore the possible need for professional education for registered dietitians who treat patients with eating disorders. The following research questions guided this study:

RQ1: How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue?

RQ2: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working patients with eating disorders?

RQ3: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders of ways to prevent and manage compassion fatigue?

RQ4: What are the perceptions of educators and registered dietitians who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue?

## Review of the Literature

To identify the relevant literature, I used the following databases: PsycINFO, PsycARTICLES, ERIC, SAGE, MEDLINE, CINAHL, and PubMed, as well as online search programs for journals about eating disorders, such as the *International Journal of Eating Disorders.* Outside sources, such as Google Scholar, were also used. The following keywords were used in various combinations for the searches: *compassion fatigue, burnout, eating disorders, education, professional education, registered dietitians, secondary traumatic stress, andragogy, adult learners,* and *Malcolm Knowles.*

The organization of the literature review section begins with the conceptual framework, followed by a review and discussion of compassion fatigue as compared to secondary traumatic stress, vicarious trauma, and burnout, as well as a review of the symptoms of compassion fatigue based on the most widely accepted and tested model of compassion fatigue, the Professional Quality of Life Scale (ProQOL; see Stamm, 2010). Next is a review and discussion of research on compassion fatigue in healthcare

professionals other than dietitians. Following is a description of eating disorders and the specific risk factors identified for compassion fatigue in registered dietitians who work with patients with eating disorders. Next is a review of professional education for compassion fatigue. The literature review section concludes with a review of the present education required for registered dietitians.

**Conceptual Framework**

The conceptual framework for this study was based on theory of andragogy developed by Knowles (1970). The theory of andragogy is an approach to the development, education, and potential for growth of adult learners (St. Clair, 2002). In 1883 a German high school gym teacher, Kapp, first termed *andragogy* (Loeng, 2017). In 1926 an American, Lindeman, defined andragogy as a method for educating adults (Henschke, 2011). Later, Henschke (1998) described andragogy as "a scientific discipline that studies everything related to learning and teaching which would bring adults to their full degree of humanness" (p. 8). Knowles (1975) described andragogy as educating adults who were self-directed and autonomous, while the teachers were the facilitators of learning.

Adult learners want to learn and tend to be self-directing, which is one assumption of andragogy (Imel, 1989). According to Knowles (1975), self-directed learning occurs when individuals take the initiative, determine their own goals, accept and apply learning actions, and appraise their learning outcomes. According to Rothes, Lemos, and Goncalves (2017), adult learners are autonomous, engaged, and growth oriented.

Andragogy promotes learner freedom, as opposed to teacher authority, and promotes self-direction and personal autonomy (Pratt, 1993).

A second area of andragogy consist of adults that have a tremendous number of experiences that are abundant and diverse sources for learning. One studying andragogy may assume that students have lifetime experiences that can be applied to the material and information discussed in class. Adults need and want to use their personal experiences in the classroom to assist their learning (McGrath, 2009). According to Knowles, Holton, and Swanson (1998), adult learners resist and resent lecturers forcing their ideas and will on the learning experience. Adult learners want to use their own experiences in the learning process.

Another area of andragogy is that adult learners are motivated both internally and externally. External factors, such as bonuses from employers or continuing education credits, can be highly motivating; however, the internal factors are more important to the adult learner. Knowles et al. (1998) recognized that when adults found solutions in their own lives, they tended to be more motivated to learn.

A final area of discussion is that adults find it necessary to know the reason behind learning new material and information before they are willing to participate. When adults understand the reasoning behind learning new skills or information, they are more ready and willing to participate in the learning experience, especially if they can connect the material they are learning with what is happening in their own lives (McGrath, 2009). According to Knowles et al. (1998), adult learners should have a firm understanding of the benefits of learning.

Because I focused on compassion fatigue in registered dietitians in this study, using the adult learning theory developed by Knowles (1970) was an appropriate framework to explore registered dietitians' perceptions and experiences of their educational experiences on preventing and managing compassion fatigue. Knowles (as cited in Smith, 2002) believed that educational experiences provide adults with the opportunity to gain self-awareness, develop a personal respect for self and others, and acquire the ability to achieve one's potential and growth in awareness of societal issues and directing social change. To manage and prevent compassion fatigue in registered dietitians who work with eating disorder patients, adult learning theory is important in two ways: guiding instruction for registered dietitians and guiding dietetic educators on strategies for teaching adult learners within their classrooms. Using the conceptual framework of adult learning theory will support registered dietitians and dietetic educators in increasing their knowledge and skills to prevent and manage compassion fatigue in registered dietitians who work with patients with eating disorders.

## Review of Compassion Fatigue

Before reviewing compassion fatigue, one should understand the meaning of compassion. Researchers have described compassion as caring for someone who is suffering, the emotional feeling that accompanies the care, and the desire to reduce and alleviate suffering (Greenberg & Turksma, 2015; Ledoux, 2015). Gilbert (2014) described compassion as a feeling, temperament, and state of being inspired, as well as deliberate actions. Authors have also used compassion in several historical and religious areas. For example, in Judaism and Christianity, compassion is seen in the tradition of

“love thy neighbor as thyself” (Mathew 22:39, King James Version). In Buddhist teachings, compassion encompasses both empathy and sympathy and is regarded as a necessary attribute in all helpers (Gilbert & Tirch, 2009; Nilsson, 2016).

Healing professionals must have compassion as central to their ethical practices (Pellegrino & Thomasma, 1993). In healing professionals, compassion entails an aptitude to comprehend the distress of another, the familiarity of the sources and treatments of that distress, and the desire to help lessen that suffering (Godlaski, 2015). Compassion is an outwardly expressive form of sympathy and is a desirable quality in all healing professionals (Nilsson, 2016). Understanding what compassion is helps understand why there is a need to study the phenomenon of compassion fatigue.

Joinson (1992) first described compassion fatigue as the physical conditions, behaviors, and emotions connected with one experiencing prolonged and continuing exposure to overwhelming stressors from one’s work. Mealer and Jones (2013) characterized compassion fatigue as the disengagement and loss of empathy toward patients due to one experiencing continued exposure to trauma. Shephard (2016) defined compassion fatigue as a person losing his or her capacity to nurture as well as becoming dissatisfied and feeling distressed with a job.

Compassion fatigue can manifest through varied forms (McLamb, 2015). The effects of compassion fatigue can show up physically, cognitively, emotionally, behaviorally, spiritually, and/or on a somatic level (Portnoy, 2011). Joinson (1992) described the effects of compassion fatigue as causing “forgetfulness, decreased attention span, exhaustion, physical illness, apathy, and anger” (p. 20). A person experiencing

compassion fatigue may feel tired, depleted, sad, hopeless, helpless, and even skeptical about life, work, the world, and even oneself (Stamm, 2010). Emotional signs include anxiety, oversensitivity, fear, depression, anger, and irritability (Matey, 2016; Wilson & Thomas, 2004). The symptoms of compassion fatigue can also include feeling apathetic, having difficulty concentrating; questioning the meaning of life, isolating oneself, and engaging in destructive behaviors, such as overspending, overeating, and substance abuse (Lanier, 2017; Sinclair & Hamill, 2007). The physical manifestations of compassion fatigue can include sleep-wake disturbances, fatigue, in addition to gastrointestinal and cardiac symptoms (Matey, 2016). Those who experience compassion fatigue characteristically love their work, but they struggle with maintaining an emotional connection and engagement with their patients. The inability to provide appropriate care to patients derives from compassion fatigue (Lanier, 2017).

The attention to compassion fatigue has increased since Joinson (1992) first identified this phenomenon in the early 1990s. Researchers have presented compassion fatigue as burnout, post or secondary traumatic syndrome, and/or vicarious trauma (Craig & Sprang, 2010; Joinson, 1992; Ledoux, 2015; Yoder, 2010). Although these terms are sometimes used interchangeably, compassion fatigue is different and unique from the others.

Compassion fatigue derives from one facing exposure to another's pain and suffering, while burnout is connected to a person's work environment. Those who experienced burnout are not even exposed to the pain and suffering of others (Flarity et al. 2013; Maslach et al. 1996). Any type of worker in any type of field can experience the

influences of burnout, while professionals in the helping field specifically experience compassion fatigue (Duarte & Pinto-Gouveia, 2017). Furthermore, compassion fatigue tends to occur suddenly, while burnout tends to advance over time (Mason et al., 2014). Valent (2002) identified compassion fatigue as on the continuum of either before or after burnout, while burnout generates or intensifies compassion fatigue.

In many studies researchers have defined compassion fatigue as a consequence of secondary traumatic stress (Burtson & Stichler, 2010; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Potter et al., 2013; Robins, Meltzer, & Zelikovsky, 2009). Figley (1995) defined secondary traumatic stress as stress that might be experienced when a person helps or wants to help those who are traumatized or suffering. The symptoms of secondary traumatic stress and posttraumatic stress disorder (PTSD) are similar; however, PTSD involves a person who experiences symptoms from exposure to trauma while secondary traumatic stress involves exposure to a traumatized person (Beck, 2011). The symptoms of secondary traumatic stress emerge as a result of a victim's experience as opposed to ones' own experience (Valent, 2002). Baird and Kracen (2006) defined secondary traumatic stress as the psychological symptoms experienced by healthcare professionals resulting from being exposed to the trauma and suffering of others. According to Valent (2002), compassion fatigue was later coined to describe the symptoms experienced by healthcare providers who were exposed to a traumatized person.

Conversely, burnout results from work stressors and work frustrations as well as the inability to accomplish work goals. The symptoms of burnout include headaches,

irritability, mental and physical exhaustion, decreased work production, sleeplessness, and cynicism. Conversely, compassion fatigue can be identified on the continuum either prior to or after burnout, or burnout creates or intensifies compassion fatigue (Valent, 2002).

Finally, vicarious trauma refers to the effects on the lives of clinicians as a result of hearing and empathizing with the traumatic events of others. Vicarious trauma leads to harmful changes in healthcare professionals due to exposure to their patients' trauma. Vicarious trauma can be caused by hearing detailed accounts of horrific, traumatic events, witnessing people's cruelty, and participating in traumatic reenactments (Pearlman & McCann, 1995). The effects of vicarious trauma can result in changes in clinicians' views about the world and themselves as well as changes in their values and beliefs (Huggard, Law, & Newcombe, 2017). While the term compassion fatigue is sometimes used interchangeably with burnout, vicarious trauma, secondary traumatic stress, and other traumatic stress syndromes, in this study, I focused on compassion fatigue in registered dietitians who treat patients with eating disorders.

**Compassion Fatigue in Health Care Professionals**

The term compassion fatigue was first used to describe some nurses in emergency room departments who had lost their ability to nurture (Joinson, 1992). Since that time, researchers have studied compassion fatigue in nursing practices, emergency departments, and critical care departments (Duffy, Avalos, & Dowling, 2015; Mason et al., 2014). Researchers have explored compassion fatigue in community-based mental health services staff (Rossi et al., 2012), audiologists (Severn, 2012), and nurses (Hegney

et al., 2014). Lombardo and Eyre (2011) indicated compassion fatigue occurred in human service practitioners, including oncology providers, emergency room personnel, chaplains, first responders, and mental health clinicians. Frontline mental health care experts, comprising of mental health workers, social workers, case managers, psychiatrists, psychologists, and nurses, treating patients with complex needs provide highly intensive care over long periods, which can result in the workers experiencing compassion fatigue (Ray et al., 2013). The healthcare field has become more aware of the effects that occur in healthcare providers who witness pain and suffering in their patients, particularly patients who face an incurable disease (Najjar, Davis, Beck-Coon, & Doebbling, 2009). According to Hooper et al. (2010), the nursing profession encompasses care and compassion. Fagin and Diers (1983) described nursing as the following:

> Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of patients' lives and they cannot hide behind technology or a veil or omniscience as other practitioners in hospitals do. Nurses do for others publicly what healthy persons do for themselves behind closed doors. Nurses, as trusted peers, are there to hear secrets, especially the ones born of vulnerability. (p. 116)

Nurses have also been described as wounded healers (Vachon, 2001). Moreover, Stebnicki (2008) specified, "In traditional Native American teaching, it is said that each time you heal someone you give away a piece of yourself until at some point, you will require healing" (p. 3).

Empathy toward others who are experiencing pain and trauma results in both physiological and cognitive responses, can lead to compassion fatigue (Craigie et al., 2016). While empathy is a prominent feature in a healthcare relationship and increases patient satisfaction, the cost can be compassion fatigue (Decety & Fotopoulou, 2014; Duarte & Pinto-Gouveia, 2017; Wagaman, Geiger, Shockley, & Segal, 2015). Research studies have demonstrated that nurses are especially at risk for developing compassion fatigue because nurses must have empathy and compassion, both of which make them vulnerability to compassion fatigue (Bush, 2009; Larson, 1993). In their study of 221 oncology nurses who filled out a battery of self-report measures, Duarte and Pinto-Gouveia (2017) found a positive correlation between empathic capabilities and compassion fatigue.

Nurses face exposure to suffering, trauma, and pain on a routine basis and are particularly vulnerable to compassion fatigue (Boyle, 2011; Bush, 2009; Kelly & Lefton, 2017). One study found that as nurses gained experiences, they were more likely to encounter higher levels of compassion fatigue and lower levels or compassion satisfaction (Kelly, Runge, & Spencer, 2015). Evidence has shown that nearly 1 in 5 “nurses leave their position within their first year of nursing” (Kovner, Brewer, Fatehi, & Jun, 2014, p. 20), and “many young nurses choose to leave the nursing profession altogether very early in their careers” (Flinkman, Isopahkala-Bouret, & Salantera, 2013, p. 20). In a sample of 114 nurses, 84.4% were found to have moderate to high levels of compassion fatigue (Hooper et al., 2010). Hinderer et al. (2014) found that as many as

27.3% of trauma nurses from a large, urban medical center had ProQOL scores, which indicated the presence of compassion fatigue.

Clinicians who work in oncology inpatient facilities experience compassion fatigue more often than clinicians who work in outpatient oncology units (Potter et al., 2013) and one of the most at-risk group for compassion fatigue in the healthcare field is oncology nurses (Perry, Toffner, Merrick, & Dalton, 2011). The prevalence rate of oncology nurses developing compassion fatigue is 16%-39% (Potter et al., 2013). Oncology nurses provide complex care to patients who experience emotional, physical, and/or spiritual suffering. The complexity of care plus the intense nurse-patient relationship in an oncology setting may place oncology nurses at high risk for developing compassion fatigue (Perry et al., 2011). Due to their intense work and relationships with patients and patients' families who are undergoing a life-threatening disease and perhaps end of life situations, these nurses have a heightened risk of developing compassion fatigue (Fetter, 2012).

Pediatric clinicians who report experiencing high levels of compassion fatigue include those working in critical care, traumatic brain injury, burns, and fetal medicine (Branch & Klinkenberg, 2015). Chaplains working in pediatric units also experience high levels of compassion fatigue (Meadors, Lamson, Swanson, White, & Sira, 2009). Certified child life specialists (CCLSs) who offer psychosocial interventions for children and families are another group of pediatric clinicians who are at risk for developing compassion fatigue. CCLSs who work in intensive care and hematology/oncology units were found to have a higher risk of developing compassion fatigue compared to CCLSs

who work in other hospital units. Furthermore, the compassion fatigue risk in CCLSs was found to be similar to the compassion fatigue risk in other helping professionals (Fisackerly, Sira, Desai, & McCammon, 2016). Working with highly traumatized and complicated children contributes to the development of compassion fatigue for caseworkers, psychologists, and social work clinicians in addition to trainees (De Figueiredo, Yetwin, Sherer, Radzik, & Iverson, 2014).

Genetics workers including physicians, nurses and counselors have been found to experience compassion fatigue (Bush, 2009). Midwives had the highest compassion fatigue scores compared to other healthcare providers (Maki, Emiko, Rumiko, & Akiko, 2013). A large number of child protective (CPS) workers also experience compassion fatigue (Conrad & Kellar-Guenther, 2006). Furthermore, female surgeons from all different specialties are at higher risk to experiencing compassion fatigue compared to their male counterpart surgeons (Wu et al., 2017). Finally, social workers that work in diverse fields and with diverse populations have a 8-16% prevalence rate of compassion fatigue (Adams & Riggs, 2008). The prevalence of compassion fatigue in social workers that work with trauma survivors have a prevalence rate of 50% (Bride, Jones, & MacMaster, 2007; Miller & Sprang, 2017).

**Risk Factors for Compassion Fatigue in Dietitians Who Treat Patients With Eating Disorders**

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (2013) is comprised of diagnostic symptoms or criteria that patients with specific mental disorders have experienced. Patients can be diagnosed and treated appropriately based on the *DSM*.

The most current *DSM* is the fifth edition (APA, 2013), which was released in May of 2013, includes eating disorders, as well as disordered eating. According to the *DSM-V* (APA, 2013), eating disorders and disordered eating include "anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorder (OSFED), unspecified feeding or eating disorder (UFED), pica, rumination disorder, and avoidant/restrictive food intake disorder" (p. 20).

Patients who have eating disorders may be difficult to treat which is a risk factor for the development of compassion fatigue in dietitians who treat this population. Barriers to treatment include personality traits, ethnicity, health beliefs, nutrition and diet beliefs, stigma, geographical barriers, financial barriers, and physician beliefs (Thompson & Park, 2016). Clinicians often experience patients who have eating disorder as reluctant to partake in treatment and resistant to change (Macdonald, Hibbs, Corfield, & Treasure, 2012).

Eating disorder patients often have serious complications due to their illness including high levels of mortality, morbidity, as well as social, physical, and psychological complications (Chesney, Goodwin, & Fazel, 2014; Keshaviah et al., 2014; Kessler et al., 2013; Micali et al., 2015). Eating disorders can adversely affect every organ and system in the body (Campbell & Peebles, 2014; LeGrange, Swanson, Crow, & Merikangas, 2012). Research has shown that eating disorders have the highest mortality rate of all psychiatric illnesses; the majority of these deaths result from suicide and medical complications (Arthur et al., 2015; Wagner et al., 2016). Because of the

complications and risk of death, clinicians who work with eating disorder patients are susceptible to increased worry, stress, and frustration (Eddy, 2013).

Registered dietitians have the difficult job of monitoring food intake, incorporating previously restricted foods, developing meal plans for weight restoration and maintenance, in addition to monitoring weight restoration with patients who have eating disorders. Because there is minimal training on eating disorders included in the core curriculum of most dietetic programs, registered dietitians who specialize in eating disorders base their treatment approach on personal experiences, self-study courses, other registered dietitians, and continuing education programs (Mittnacht & Bulik, 2015). Some patients come to treatment highly motivated, while others do not. Treatment does not always result in a positive outcome, which researchers have associated with clinician stress (Slatten, Carson, & Carson, 2011). These factors may contribute to compassion fatigue in registered dietitians who treat patients with eating disorders.

**Professional Education on Compassion Fatigue**

Researchers have studied compassion fatigue in many different medical, nursing, and health care contexts (Bhutani, Bhutani, Balhara, & Kalra, 2012; Hooper et al., 2010; Sabo, 2006). According to Mathieu (2007), clinicians who care about their clients will eventually develop varying degrees of compassion fatigue. The consequences of compassion fatigue include clinicians leaving their fields of expertise, high turnover rates, an inability to help and possibly even harm the patients (Simpson & Starkey, 2006). Health care professionals must receive professional training regarding the dangers of

compassion fatigue, as well as how to balance personal needs, vulnerability, and expectations (Vargas et al., 2016).

Researchers have suggested that one can manage and mitigate compassion fatigue through education about compassion fatigue, as well as activities that involve self-compassion, self-care, self-awareness, and mindfulness (Cole, Craigen, & Cowan, 2014; Knight, 2013; Sanchez-Reilly et al., 2013). Education on compassion fatigue begins with healthcare providers knowing and recognizing the signs and symptoms within themselves (Fearon & Nicol, 2011). Recognition and identification of compassion fatigue is helpful in preventing and managing compassion fatigue, as well as reducing the harmful consequences on job performance, physical and emotional health, and wellbeing (Cross, 2016; Hooper et al., 2010; Maytum, Heiman, & Garwick, 2004). Researchers stated, "The first step in preventing or ameliorating compassion fatigue is to recognize the signs and symptoms of its emergence" (Bride, Radey, & Figley, 2007, p. 155).

Researchers have defined self-compassion as the compassion one directs inward (Germer & Neff, 2013). Learning to self-soothe and developing self-compassion may increase overall wellbeing, while reducing the risk of compassion fatigue (Duarte, Pinto-Gouveia, & Cruz, 2016; Gustin & Wagner, 2013). Researchers have associated self-compassion with lower levels of compassion fatigue (Duarte & Pinto-Gouveia, 2017). To avoid the risks associated with compassion fatigue, clinicians should practice self-care and self-awareness (Harrison & Westwood, 2009). One of the most protective factors in preventing and mitigating compassion fatigue is self-care (Craig & Sprang, 2010). Richards, Sheen, and Mazzer (2014) described self-care as "choosing behaviors that

balance the effects of emotional and physical stressors" (p. 3). Richards et al. (2014) discussed the importance of paying attention to one's body and practicing self-care, despite the fact that one cannot control their own genes.

Taking care of one's physical, social, emotional, and spiritual needs is included in the definition of self-care (Merriman, 2015). Strategies of self-care include a healthy lifestyle, relaxation, and obtaining emotional support, which may allow health care providers to prevent compassion fatigue and perform effectively in their duties (Desbiens & Fillion, 2007; Smit, 2017). Self-care strategies also include having adequate nutrition, hydration, sleep, and exercise (Goodwin & Richards, 2017). Neff (2003) described self-awareness as having three parts: being kind to oneself, understanding that all humans and the human experience are imperfect, and being nonjudgmental of one's own experiences.

Kabat-Zinn (1994) described mindfulness as one being nonjudgmental and living in the moment. Researchers have also described mindfulness as a psychological process that includes being open, curious, and accepting to a present experience (Bishop et al., 2004). Furthermore, it is described as being in the moment, present, and nonjudgmental about what is happening. Mindfulness involves restraining personal values and accepting that which is unfamiliar as well as achieving a sense of peace and belonging (Gustin, 2017). Tirch (2010) indicated mindfulness can be used to increase compassion in oneself, as well as others. Moreover, practicing mindfulness can reduce stress and increase self-compassion (Gustin, 2017).

The American Counseling Association (ACA) (2014) developed a *Code of Ethics* that includes a section on self-care, titled *Professional Responsibility*, which described

self-care as "counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (p. 8). Unlike the counseling field, the Academy of Nutrition and Dietetics Code (2018) does not have a section dedicated to self-care. Education on compassion fatigue, self-awareness, and self-care may be beneficial in preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders.

**Present Education for Registered Dietitians**

According to the Academy of Nutrition and Dietetics, registered dietitians (RDs) or registered dietitian nutritionists (RDNs) refer to nutrition and food professionals who meet the subsequent standards to receive their RD or RDN credentialing:

1. Earn a minimum of a bachelor's degree at a U.S. regionally accredited university, college, or foreign equivalent, and coursework through an ACEND accredited Didactic Program in Dietetics (DPD) or Coordinated Program in Dietetics (CP).
2. Finalize 1,200 hours of supervised practice through an ACEND accredited Dietetic Internship, Coordinated Program in Dietetics, or an Individualized Supervised Practice Pathway (ISPP) through an ACEND accredited program.
3. Pass a national examination administered by the Commission on Dietetic Registration (CDR).
4. To uphold the qualification, an RD or RDN must complete continuing professional educational requirements ("Academy," 2018b, para. 1).

The coursework for nutrition and dietetic students includes, but is not limited to: "Health promotion and disease prevention, nutrition therapy, health and wellness, public health nutrition, urban health and nutrition, foodservice management, school nutrition, community nutrition, organic chemistry, biochemistry, anatomy, physiology, genetics, microbiology, pharmacology, statistics, metabolism, psychology, sociology, and anthropology" (Academy of Nutrition and Dietetics, 2018b, p. 20). The ASCEND (2018b) does not require nutrition and dietetics programs to address compassion fatigue in the required courses.

In summary, the literature review began with a description of the theory of andragogy established by Malcolm Knowles (1970), which involved an approach to the development, education, and potential growth of adult learners (St. Clair, 2002). Compassion and compassion fatigue were then described, compared, and contrasted with burnout, STS, and vicarious trauma. Compassion fatigue in healthcare providers was explained and was shown to be found particularly in those who have experienced high levels of empathy and compassion. Because patients with eating disorders tend to be difficult to take care of, treatment is complex and does not always result in positive outcomes. Therefore, clinicians, including registered dietitians, who treat patients with eating disorders, may be at risk for compassion fatigue. Researchers have suggested that compassion fatigue can be lessened through education, as well as specific healing activities (Cole et al., 2014; Knight, 2013; Sanchez-Reilly et al., 2013). The literature review concluded with an explanation of the present education requirements for registered dietitians.

## Implications

The ASCEND (Academy of Nutrition and Dietetics, 2018a) does not require nutrition and dietetics programs to address compassion fatigue in registered dietitians who work with patients with eating disorders. Findings from the present study may address the importance and needs of education on preventing and managing compassion fatigue in registered dietitians who work with eating disorder patients. Leaders of hospitals and other health care facilities may also receive direction on training to prevent and manage compassion fatigue in specialized clinicians.

Houck (2014) showed education on compassion fatigue, self-awareness, and self-care has promise for prevention or management of compassion fatigue in healthcare providers. Registered dietitians who work with eating disorder patients may benefit from receiving education on compassion fatigue, self-awareness, and self-care. Other eating disorder healthcare providers may also benefit from the findings of this study.

Based on the findings from the data collection and analysis, one possible project is an onsite professional development workshop on compassion fatigue geared toward registered dietitians who treat patients with eating disorders. Another possible project is creating an online course for students and professionals. The course will help participants recognize signs and symptoms of compassion fatigue, learn to manage stress levels, and increase self-care practices. The course can provide strategies to help participants manage and prevent compassion fatigue, as well as how to engage in self-care and mindfulness.

## Summary

As Figley (1995) described, “there is a cost to caring” (p.1). Experts who heed to others’ accounts of agony, pain, and anguish may suffer themselves because they feel compassion and they care. “Compassion fatigue is an occupational hazard in healthcare,” meaning, clinicians who care about their patients will develop some degree of it (Cole et al., 2014; Mathieu, 2007). Health professionals, including registered dietitians, who work with patients with eating disorders, may be at high risk for developing compassion fatigue and/or burnout (Eddy, 2013).

Education on preventing and managing compassion fatigue is not currently required as part of the curriculum for nutrition and dietetics programs. Therefore, registered dietitians, particularly those who work with patients with eating disorders, may not have the skills necessary to prevent or manage compassion fatigue. There may be merit in encouraging education on compassion fatigue in nutrition and dietetics programs. Researching the need for education on compassion fatigue, self-awareness, and self-care may highlight the importance of training registered dietitians who work with patients with eating disorders to manage and prevent compassion fatigue. Presently, there is a gap in practice between the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders and the need for education to prevent or manage compassion fatigue.

In Section 1, I documented a local problem, defined the problem, proved evidence at the local level, and provided definitions, the significance of the present study, research questions, and review of the literature. Knowles’s (1970) theory of andragogy was

described and provided the conceptual framework for this study. Finally, risk factors and professional education needed were explained. In Section 2, I provide a description of the research methodology, including the research design and approach, criteria for selection, number, and access to participants and the setting. Included in Section 2 is an analysis of the data, a description of the evidence of quality and procedures to assure accuracy of the findings, an explanation of the procedures for dealing with discrepant cases, and the limitations of the project study.

# Section 2: Methodology

## Introduction

This qualitative study was an investigation of the perceptions of registered dietitians and dietetic educators of the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and the possible need for professional education on preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders. Qualitative researchers seek to comprehend the experiences of their participants and how and why those experiences are significant to them (Merriam, 2009). Four semistructured face-to-face interviews with four registered dietitians who treat patients who suffer from eating disorders and are members of an eating disorders specialists' group were completed. Using the same format, four interviews of registered dietitians who are dietetic educators were conducted. The goal was to understand their perceptions of the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and the possible need for professional education on preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders. The following research questions were addressed in this study:

RQ1: How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue?

RQ2: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working with patients with eating disorders?

RQ3: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders of ways to prevent and manage compassion fatigue?

RQ4: What are the perceptions of educators and registered dietitians who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue?

I begin this section with a description of the research design and approach followed by an explanation of the data collection, data analysis, and the results. Next is a summary of the outcomes related to the review of literature and conceptual framework, reliability and validity, discrepant data, and limitations. This section concludes with a summary.

## Qualitative Research Design and Approach

A basic qualitative research design was appropriately used for this study because the objective was to examine the perceptions of registered dietitians and dietetic educators. Creswell (2009) described qualitative research as the methodical exploratory process used for comprehending what significance is attributed to social or human difficulties using the context of inquiry strategies, worldviews, and schemes. Qualitative researchers attempt to interpret the meaning people bring to life events (Denzin & Lincoln, 2011). A quantitative approach would not have been appropriate as "quantitative research is confirmatory and deductive in nature, while qualitative research is exploratory and inductive in nature" (Trochim & Donnelly, 2008, p. 146).

A basic qualitative research design was used to explore the perceptions of registered dietitians and dietetic educators of the risk of compassion fatigue, ways to

manage and prevent the development of compassion fatigue, and the possible need for professional education on preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders. This basic qualitative research design included using open-ended and probing questions as well as an inductive interpretation for profound examination of real-world happenings and experiences (see Bogdan & Biklen, 2007). Other types of qualitative research studies including narrative, phenomenology, grounded theory, ethnography, and case studies were considered, however, they were deemed inappropriate for this study.

Narrative research is written or spoken text, which one can use to give an explanation of an event or sequence of events or an action or sequence of actions that are chronologically connected (Czarniawska, 2004). Moreover, it has a particular attention to the stories individuals tell (Polkinghorne, 1995). Narrative research was not appropriate for this study because the aim of this study involved the perceptions of clinicians, not their stories. Furthermore, narrative researchers focus on the individuals and their stories, as opposed to case study researchers who focus on an issue or issues.

While narrative research encompasses individuals, phenomenological research involves, "the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell & Poth, 2018, p. 75). The focus of phenomenological research is the commonality of the participants while experiencing an event or phenomenon (Creswell & Poth, 2018). Phenomenology also has a philosophical aspect to it (Van Manen, 2014). Phenomenology as a philosophy is described as active engagement in understanding and meaning making that is used to comprehend the lived

world of humankind at a conscious level (Qutoshi, 2018). This type of approach was not appropriate for this particular study. I was not attempting to understand the experiences of people regarding a particular phenomenon. Furthermore, a philosophical approach was not appropriate for this study.

Researchers can use a grounded theory research study when no theory exists or a theory needs to be modified. Grounded theory is defined as a research method that generates a theory (Noble & Mitchell, 2016). The purpose of this study was to explore perceptions of people, not to explore a theory.

Ethnographic researchers emphasize studying a culture (Creswell, 2012). There is a culture to dietetics, however, the culture was not the intention of this study. Finally, case studies are used to gain insight or understanding of individuals, situations, or groups (Lodico, Voegtle, & Spaulding, 2010). Descriptive case studies are utilized to examine a person or a group's perceptions and thoughts (Creswell, 2012).

While a descriptive case study was considered, it was deemed inappropriate because there were not multiple sources of information used, including audiovisual materials, documents, reports, interviews, or observations. Although there are two different groups, dietitians and dietetic educators, the same questions were not asked of each group. In addition, the study was not bounded. For these reasons, a basic qualitative research design was chosen for this research study.

A basic qualitative research design allows participants (dietitians and dietetic educators) to discover how they interpret their experiences, how they conceptualize their world, and the meaning they ascribe to their experiences (Da Costa, Hall, & Spears,

2016). According to Merriam (2002), a basic qualitative study attempts to identify and describe the perceptions of people involved in the study. In this study, I explored the perceptions of both dietitians and dietetic educators.

**Access to Participants**

I obtained formal approval for this project from the Walden University Institutional Review Board (IRB) before I collected any data. The approval number for this study is 02-20-19-0364758 with an expiration date of February 19, 2020. The leadership committee for the eating disorders specialists' group of practitioners was contacted to ensure that I followed correct protocol. Two of the board members of the specialists' group determined that Walden IRB approval was needed, followed by approval from the committee members of the recruitment method, informed consent, and the root interview questions. I contacted the chair of the Health and Human Performance Department at the university where I interviewed dietetic educators to ensure that I followed correct protocol for my research. The chair of the department and the IRB of the university determined that Walden IRB approval would be needed, however, approval from the IRB of the university where I would be conducting interviews would not be needed.

**Participants**

According to Bernard (2002), purposeful sampling involves one deliberately choosing participants because of the qualities they possess. The participants can provide the knowledge or experiences needed by the researcher. Purposeful sampling involves choosing specific participants who are experienced or knowledgeable about a particular

topic of interest (Creswell & Clark, 2011). Bernard noted that in addition to experience and knowledge about a phenomenon of interest, participants must be available, willing to participate, and relate opinions and experiences in a reflective and articulate manner.

In basic qualitative research, there are no specific rules for sample size (Patton, 2015). Therefore, this purposeful sample of eight consisted of two different groups of four registered dietitians. The first group of four dietitians was selected from an eating disorders specialists' group in a city in the southwest United States. According to the website of this group (http://www.houstoneds.org), the mission of this 501(c)3 group is to promote "effective treatment of eating disorders, provide community and professional education, and to raise awareness and understanding of these illnesses" (Houston Eating Disorders Specialists, 2017, para.1). This group includes multidisciplinary professionals who specialize in treating patients with eating disorders and are committed to providing quality care to those inflicted by this mental illness. According to the website, this group currently has 130 active members, as well as eight treatment programs. The members of this group include associates, registered dietitians, physicians, psychiatrists, and therapists. Twenty registered dietitians who specialize in eating disorders are members of this group. These dietitians treat patients in treatment centers, private practices, and hospitals in a city in southwest United States. I am one of the registered dietitians of this specialty group, but I was not a participant in the study.

The specialty group's website lists the members' names, office locations, phone numbers, and email addresses. I have no supervisory responsibility over any of the registered dietitians in this specialty group, and I have minimal contact with the entire

group. I emailed letters to the 19 registered dietitians asking for their voluntary participation. The first four dietitians who had at least 1 year of experience working with patients who have eating disorders and responded to my email request were chosen to participate (see Appendix B for the email to the dietitians).

I selected the second group of four registered dietitians from a group of dietetic educators in the nutrition and dietetics program at a university in a city in southwest United States. Leaders of this large university offer a Bachelor of Science in Human Nutrition and Foods program, which is accredited by the ASCEND of the Academy of Nutrition and Dietetics (2018a, 2018b). At the undergraduate level, the skills obtained by earning this degree are essential for competent entry-level dietitians. Nine educators teach the nutrition classes in this program. Seven of the educators are full time faculty and two are adjunct faculty. Of the nine educators, six are registered dietitians. I am one of the six registered dietitians on the faculty; however, I was not a participant in the study.

The remaining five educators were asked to voluntarily participate in the study. I emailed letters to the five registered dietitian faculty members asking for their voluntary participation, and the first four dietetic educators who responded were chosen to participate (see Appendix C for the email to the dietetic educators). I have no supervisory responsibility over any of the faculty members and being adjunct faculty, I have minimal contact with the faculty.

## Role of the Researcher

I am a registered and licensed dietitian, and I own and operate a nutritional counseling private practice in the city where my research study occurred. I specialize in

treating patients who suffer from eating disorders and have been in practice for more than 25 years. There are times where other registered and licensed dietitians and I are at professional meetings and seminars together. There are also times when we refer patients to one another. While I know all the registered dietitians who were asked to participate in this study, I do not have any supervisory role or authority over any of them and I have limited contact with them.

I am also an adjunct faculty member at the university where my research study occurred. I have been an adjunct faculty member at this university for 14 years. I currently teach two classes per semester. While I know all of the faculty members who were asked to participate in this study, I do not have any supervisory role or authority over any of them. Furthermore, because I am part-time adjunct faculty, I have limited contact and interaction with them. As a registered dietitian working in the field of eating disorders and an adjunct faculty member, I had to remain diligent about remaining free of bias during the development of the questions, as well as during the interview process (Lewis, 2015).

**Researcher Participant Working Relationship**

I have no authority over any of the participants. Participants were informed of the study procedures, as well as their rights. The nature of the relationship between the researcher and the participants was taken seriously and sensitively. According to Creswell and Poth (2018), the potential for a power imbalance may arise between the researcher and participant. I avoided this imbalance by building trust, not sharing

personal impressions, not disclosing sensitive information, and avoiding leading questions.

## Ethical Considerations and Protection of Participants

Before the study began, the participants who were identified and confirmed received a consent form, and informed consent was obtained both verbally and on paper. According to Creswell and Poth (2018), the consent form includes the purpose, procedures, and benefits of the study, participants' rights to withdraw from the study at any time, confidentiality of the participants, any known risks, and my signature and the participants' signature. Important information about the study was fully disclosed to the participants to ensure that there was no deception.

To ensure confidentiality and privacy of the participants, identities were protected by using random letters assigned to each participant (A-H). I kept the list of the names with corresponding letters, as well as all confidential data, in a locked file cabinet in my home office. I am the only one who has access to the file cabinet. I developed back-up copies on my computer and transferred them to flash drives, which I also locked in the file cabinet. I keep one back-up copy in a locked safe of which, only I can access. As required by Walden University, I will store documents for five years. After the required time, I will properly shred and dispose of the documents. In addition, I used the data from this study for this particular study only.

## Data Collection

### Semistructured Interviews

After obtaining permission from Walden University IRB, I collected qualitative data through one-on-one, face-to-face interviews using two high quality audio data-recording devices (Lodico et al., 2010). The interviews occurred in private locations convenient to the participants. I allowed each participant to choose a location that was comfortable and convenient for him/her. The meetings with the practitioners took 45 to 60 minutes, and the meetings with the educators took 30 to 45 minutes.

I started each interview with an explanation of the privacy and confidentiality specifics. I assured each registered dietitian and dietetic educator that I will keep all data confidential and secure. I reminded each participant that they can withdraw from the study at any time. Before the beginning of each interview, I asked all participants to confirm their consent on the audio recording device. I also had them sign a consent form.

Before IRB review as well as before the actual interviews occurred, an expert panel of one registered dietitian who treats patients with eating disorders and one registered dietitian faculty member from a different university than where I am conducting my interviews reviewed the questions. They assessed whether the questions were appropriate and assisted in areas that were in need of development. The criteria to be an expert reviewer for the specialty group was a registered and licensed dietitian who has five or more years of experience working with patients with eating disorders. The expert educator has five or more years of teaching experience in a nutrition program at a university. I reflected on and was mindful of my viewpoints and my biases, as well as

how I managed my perspective throughout the research project (Chenail, 2011). The experts screened the questions for bias issues as well.

Each interview question was established to capture the perceptions of the participants. These interview questions were written based on the four research questions, which in turn related to the overall focus of the study. Because the focus was to establish and recognize the perceptions of RDs and DEs on the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and to explore the need for professional education with dietitians who treat patients with eating disorders, each interview question was aligned for association of the research questions. Table 1 exhibits the research questions followed by the associated interview questions.

Table 1

*Interview Questions Associated With Research Questions*

| Research question | Associated interview questions |
| --- | --- |
| RQ1. How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue? | RD4<br>DE5 |
| RQ2. What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working with patients with eating disorders? | RD5a, RD5b, RD, RD6a, RD6b, RD14, RD15<br>DE6, DE11, DE12 |
| RQ3. What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders of ways to prevent and manage compassion fatigue? | RD7, RD8, RD9, RD14, RD15<br>DE10, DE11, DE12 |
| RQ4. What are the perceptions of educators and registered dietitians who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue? | RD10, RD11, RD12, RD13, RD14, RD15<br>DE7, DE8, DE9 |

*Note*. Abbreviations are as follows: RD = registered dietitian; DE = dietetic educator

I used interview protocols to guide the one-on-one interviews, which was appropriate for this qualitative study to address the research questions. To gain the participants' perspective, I used both open-ended and probing questions that I created, and experts reviewed. The probing questions assisted in obtaining sufficient information used to answer the research questions. The registered dietitians who work with patients with eating disorders and the dietetic educators were asked similar but slightly different

questions (see Appendices B and C for the interview protocols for practitioners and educators). Field notes were taken during the interviews including the study title, the principle researcher, the date, time, and location of the interview, and a critical reflection of my role as the interviewer. According to Berger (2015) and Thoresen and Ohlen (2015), in qualitative research, the researcher's role can shape the results. Critical reflection allows the researcher to assess their performance, biases, and feelings.

## Data Analysis

Phase 1 of the data collection involved identifying who, when, where, and what data were collected. According to Clarke and Braun (2014), the researcher should transcribe the data to facilitate simultaneous familiarization with the data during Step 1. After the recorded interviews were completed, I transcribed two of the interviews and I hired a transcriber to transcribe the other six interviews. The transcriber signed a confidentiality form before I gave her any information regarding the participants as well as the tape-recorded interviews with the participants. Transcribed data were assigned a letter corresponding with either a registered dietitian who treats patients with eating disorders (C, D, E, and G) or a registered dietitian who is a faculty member at the designated university (A, B, F, and H). Corresponding field notes were assigned the same letters.

The transcripts were then delivered to each participant for member checking to confirm that the data were accurate (Creswell, 2012). All participants received their transcriptions and seven of the eight participants reported that no changes were needed. One participant made necessary changes and edits, gave approval, and then returned the

data to me. I then read and reread the transcriptions to become familiar with the contents. Then, I highlighted and recorded relevant items that could ultimately be coded.

Phase 2 involved coding and identifying themes using NVivo software. Phrases and groups of phrases that identified similar themes or ideas were grouped into codes, by placing them together in child nodes in NVivo. The phrases and groups of phrases are identified in Table 2. Throughout the process, a list of verbatim data supporting the codes and themes were entered into a thematic list to facilitate the report writing process (Clarke & Braun, 2014).

Table 2

*Coding Terms and Phrases*

| Terms or phrases | Terms or phrases |
|---|---|
| ability to cope | managing compassion fatigue |
| ability to cope with self-issues | manage compassion fatigue |
| ability to self-treat | management of compassion fatigue |
| anxious or depressed | mindfulness mediation |
| barrier | negative feedback from others |
| bombarded | numbness |
| boundaries | numbness resulting |
| boundary setting | on edge |
| burnout | overworked |
| capping | pain |
| capping caseload | personal issues |
| caseload | personal problems |
| caseload exhaustion | personal support |
| caseload overwhelming | physically fatigued |
| compassion fatigue | population common with compassion fatigue |
| compassion fatigue definition | prevent compassion fatigue |
| compassion fatigue meaning | preventative measure |
| complex psychological disease or illness | preventative methods |
| deal with compassion fatigue | prevention measures |
| deal with eating disorder patients | professional support |
| defense mechanisms | promotion |
| define compassion fatigue | raised awareness |
| dietitian educators | reasons for compassion fatigue |
| dietitians | registered dietitians |
| dietitians who treat patients with eating | repeated exposure |
| disorders | repeated exposure to patient's trauma, pain, and suffering |
| discussion | risk |

| Terms or phrases | Terms or phrases |
|---|---|
| doing too much | risk for combat fatigue |
| eating disorder patients | risk for developing compassion fatigue |
| eating disorders | risk of developing |
| education | risk of developing compassion fatigue |
| education for compassion fatigue | seeking support from colleagues |
| effectiveness in managing compassion fatigue | seeking support from friends |
| elements of compassion fatigue | seeking support from therapists |
| emotional | self needs |
| emotional exhaustion | self-care |
| empathy | self-care strategies |
| experiences of compassion | self-care therapy |
| experienced compassion fatigue | self-care to prevent compassion fatigue |
| experiences of fatigue | self-care would be helpful for preventing and managing |
| exposure to pain | compassion fatigue |
| exposure to suffering | self-issues |
| exposure to trauma | self-supportive environment |
| exposure to trauma with no education | suffering |
| exposure to traumatic patients | support for colleagues |
| factors of compassion fatigue | support from colleagues, friends, peers |
| family support | support from friends |
| fatigue | support seeking |
| fatigue experiences | symptoms |
| fatigued | symptoms of combat fatigue |
| fight compassion fatigue | team support |
| formal education to manage compassion | therapist support |
| fatigue | therapy as self-care |
| friend support | too many patients |
| heavy caseload | training |
| heavy caseload that was very traumatic | trauma |
| help dealing with compassion fatigue | trauma exposure |
| high risk | trauma with no training |

| Terms or phrases | Terms or phrases |
| --- | --- |
| high stress levels | traumatic patients |
| intensity | treat patients with eating disorders |
| intensity of exposure to trauma | treating eating disorder population |
| intensity of work | treatment |
| irritable | treatment for combat fatigue |
| issues | underprepared |
| knowledge | vacations |
| lack of empathy | validation of normal feelings |
| lack of knowledge | validation of norms |
| large caseload | |

Researchers can use descriptive terms to identify emerging themes (Creswell, 2012). I used the qualitative data analysis software NVivo 12 to identify themes. I used NVivo 12, together with the thematic analysis technique of Clarke and Braun (2014), to add to the validity of the results by ensuring that the data were fully organized during the process of analysis. I created a NVivo 12 compatible folder to ensure that data could be easily located, as suggested by Bazeley and Jackson (2013). I developed codes and categories to build descriptions, themes, and perspectives, as suggested by researchers (Creswell & Poth, 2018). I used the six-step thematic analysis process to guide the analysis of the transcribed data, as described by Braun and Clarke (2014).

In Step 2, I completed the initial coding, which entailed assigning succinct labels to identify interesting or pertinent items in the data. For Step 3, I began the search for themes. Clarke and Braun (2014) warned against the assumption that themes would be obvious and emerge easily without concerted effort. Searching for themes is an active

process of rereading and controlling for meaningful patterns within the entire data set. Themes should be meaningful units that could function alone but also connect with other themes to create a narrative or story regarding the data as a whole (Clarke and Braun, 2014).

There were 141 phrases or groups of phrases that were grouped into 24 codes, as indicated in Table 3. During the third through fifth steps of the analysis, the codes were grouped into themes by placing similar child nodes together under parent nodes in NVivo, with the parent nodes representing the themes. The grouping of codes into themes is also indicated in Table 3.

Table 3

*Data Analysis Themes and Codes*

| Theme | Codes grouped to form theme | *N* of phrases or groups of phrases from the data grouped to form code |
|---|---|---|
| Theme 1: Emotional exhaustion and numbness resulting from repeated exposure to clients' trauma, pain, and suffering | Treating eating disorder population | 15 |
| | Doing too much for too long | 10 |
| | Experiences of fatigue | 6 |
| | Intensity of exposure to trauma | 5 |
| | Building defense mechanisms | 5 |
| Theme 2: Risk is highest when dietitians are underprepared for repeated exposure to patients' trauma, pain, and suffering | Exposure to trauma without training | 10 |
| | Issues of empathy | 3 |
| | Lack of training in boundary-setting | 1 |
| | Ability to cope with own issues | 1 |
| Theme 3: Seeking support from therapists, colleagues, friends, family | Team and peer support | 8 |
| | Role of support from friends | 8 |
| | Use of therapy as self-care | 8 |
| | Seeking support | 5 |
| | Validating normal feelings | 3 |

| Theme | Codes grouped to form theme | *N* of phrases or groups of phrases from the data grouped to form code |
|---|---|---|
| Theme 4: Setting boundaries, taking breaks, prioritizing self-care | Capping caseload | 7 |
| | Taking breaks and vacations | 5 |
| | Prioritizing self-care | 4 |
| | Maintaining boundaries | 3 |
| Theme 5: Promoting self-care | Training delivery options` | 9 |
| | Knowing own needs | 6 |
| | Boundary-setting | 3 |
| | Mindfulness meditation | 2 |
| Theme 6: Raising awareness about compassion fatigue | Lack of knowledge as a barrier | 7 |
| | Discussions of compassion fatigue needed | 7 |

Step 4, a review of potential themes, involved revising the themes to determine if they captured the essence of each unit of meaning in isolation but also across the data set. After I reviewed all the themes, I defined and named each one succinctly. Step 5 of thematic analysis contains the most analytical and interpretative processes of all the steps (Clarke & Braun, 2014). To tell the story of the participants in its most rich and nuanced manner, I explored and interpreted the surface and deep structure of the data regarding the full data set (Clarke & Braun, 2014). Step 6 involved capturing all the information by

carefully documenting the codes and themes with regards to how they relate to the research questions. Throughout the six steps, I kept the documentation of this coding and analysis process in folders and labeled for easy identification within the NVivo 12 system. The themes that were found through the interview questions that are associated with the research questions are listed in Table 4.

Table 4

*Association of Themes With Research Questions*

| Research question | Associated themes |
|---|---|
| RQ1. How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue? | Theme 1 |
| RQ2. What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working patients with eating disorders? | Theme 2 |
| RQ3. What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders of ways to prevent and manage compassion fatigue? | Themes 3, 4, 5, & 6 |
| RQ4. What are the perceptions of educators and registered dietitians who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue? | Themes 2, 3, 4, 5 & 6 |

At some point, the researcher asks the question, "did I get the story right?" (Stake, 2005). To make sure that I had an accurate account of what the participants said, I used validation and credibility strategies, including triangulation of data from several sources. The data were triangulated by testing one source of data against another, looking for patterns of behaviors and thoughts, and looking for key events to be analyzed (Creswell & Poth, 2018). I triangulated the responses from the two different groups of dietitians and field notes to shed light on the topic of compassion fatigue in dietitians who work with patients with eating disorders. This provided validity to the research.

## Data Analysis Results

The purpose of this research was to investigate the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, investigate ways to manage and prevent the development of compassion fatigue, and explore the possible need for professional education on preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders. A total of eight dietitians agreed to be interviewed and share their experiences with compassion fatigue. The purpose of the analysis phase of my research was to produce rich descriptions as described and suggested by Hancock and Algozzine (2011). Six themes developed during the analysis of the data. I developed chronicles of the participants' viewpoints and used accompanying quotations from the interviews to support these themes. I was then able to organize the data to provide specific examples to answer each of the four research questions. Following includes the demographics of the participants as well as a presentation of results organized by research question.

**Demographics**

The participants for this study included four female practicing registered dietitians (RDs) as well as one male and three female dietetic educators (DEs), for a total of eight participants. As described in the participants section above, the practicing dietitians were selected from an eating disorders specialists' group in an urban area in the U.S. Southwest. The dietetic educators were selected from a group of educators in the nutrition and dietetics program in an urban university in the U.S. Southwest. Table 5 indicates the relevant demographic characteristics of the participants in this study.

Table 5

*Participant Demographics*

| Partici-pant | Credentials | Practice settings | Years as an RD | Years as an educator |
|---|---|---|---|---|
| RD 1 | MS RD LD | ED residential; private practice; university counseling center | 17 | N/A |
| RD 2 | RD LD | Hospital in-patient; private practice | 13 | N/A |
| RD 3 | MPH RD LD | ED treatment center/IOP/PHP; private practice | 4 | N/A |
| RD 4 | MEd RDN LD | Pediatric hospital in-patient; private practice; ED and SA treatment centers/IOP/PHP | 29 | N/A |
| DE 1 | MS RD | Hospital/outpatient | 18 | 6 |
| DE 2 | MS RD LD CDE | Hospital/in-patient/outpatient | 15 | 13 |
| DE 3 | MS PhD RD LD | Hospital/in-patient/outpatient | 19 | 9 |
| DE 4 | MS PhD RD LD | Hospital/in-patient | 22 | 11 |

*Note.* Abbreviations are as follows: RD = registered dietitian; DE = dietetic educator; LD = licensed dietitian; MS = Master of Science; CDE = certified diabetic educator; PhD = Doctor of Philosophy; RDN = registered dietitian nutritionist; MPH = Master of Public Health; MEd = Master of Education

**Research Question 1**

RQ 1: How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue?

DE 1, DE 2, and DE 4 defined compassion fatigue as toughening or hardening to patients' situations:

> After treating or working with a certain type of patient, you kind of harden or toughen to their situation. At some point, you really have to push your biases aside so that you can effectively understand where that patient is coming from. After working with them for so long, you kind of build up a tough exterior, maybe even a defensive mechanism to some of the things that they may be describing or going through. (DE 1).

DE 2 agreed with DE 1 and stated that after treating patients for a lengthy amount of time, the exposure to [their stories] over and over can weigh on how compassionate and empathetic they are towards the individual. DE 4 added that clinicians want to be compassionate, however, they have just run out of the energy to be compassionate. "Either because you've been over exposed to it or over-sensitized or you've been so sensitized to it, that it's like, 'oh, okay, I can see it- this person is dead - okay, they are dead' and then you move on with it." (DE 4).

DE 3 defined compassion fatigue as losing the ability to feel compassion and empathy as a result of working with a demanding population and not taking care of yourself:

> When you are in a position of constantly accessing the compassion that you have…when you work with a population that requires a lot of your compassion, and you are not nourishing yourself, and taking care of yourself…then you get kind of burned out, and you begin to shut down your access to your compassion and empathy.

RD 1, RD 2, and RD 4 all stated that they had heard of compassion fatigue through me (the researcher), however, could not provide a definition for it. RD 1 added, "I feel like I think of compassion fatigue as burnout or counter-transference… All of that goes into the same little cell in my brain." RD 3 described compassion fatigue as resulting from the clinician's failure to take care of self by taking breaks and detaching from the clients and their suffering:

> I think [compassion fatigue is] not giving yourself the space to remove yourself from your clients. And, tying it in too much with them and feeling their emotions with them and not being able to separate that. . . . You can't hold everybody else's emotions and sooner or later that is going to wear on your "self", and you are not going to be a good clinician because you are not going to be able to take care of yourself.

Participants associated compassion fatigue with burnout and sometimes used the terms interchangeably. RD 4 noted that it was sometimes difficult to distinguish between compassion fatigue and burnout because the symptoms are similar and the self-care techniques for alleviating the two conditions are the same:

> If I am starting to feel anxious or depressed, I know what's happened is that I've gone too long without taking a break. And it may be because of burnout or compassion fatigue, but the solution is the same. I know I have to pull back and take care of myself.

DE 4 likened compassion fatigue to burnout in the sense that both involve a depletion of emotional resources, but noted that compassion fatigue differs from burnout because it results specifically from excessive demands on the clinician's compassion:

> You want to give [patients] the compassion, but you just don't have any energy left or any juice left in you to feel the compassion anymore . . . because you've been over-sensitized or you've been so sensitized to it . . . you've been exposed to it so often, you just kind of continue on.

Participants stated that they used the terms compassion fatigue and burnout interchangeably because the symptoms of both conditions including fatigue, depression, and anxiety, are similar.

One theme emerged during data analysis to answer research question one. Evidence in the form of quotations from the data is provided to support the theme.

**Theme 1: Emotional exhaustion and numbness resulting from repeated exposure to clients' trauma, pain, and suffering.** Compassion fatigue was described as emotional exhaustion and numbness resulting from the repeated exposure to clients' trauma, pain and suffering, particularly when the dietitian has insufficient breaks and rest and fails to set appropriate boundaries. DE 3 remarked that the cause of compassion

fatigue was inadequate boundary-setting, or the clinician's neglecting to place distance between herself and her patients at appropriate times:

> When you work with a population that requires a lot of your compassion, and you're not nourishing yourself, and taking care of yourself, and getting some down-time and getting away from that, then you get kind of burned out, and you begin to shut down your access to your compassion and empathy.

RD 2 described her experiences of emotional exhaustion and the need to numb herself as a result of prolonged and repeated exposure to severe trauma in clients:

> [My patients] would have flashbacks during sessions or they would have just come from being sexually abused and beaten. The intensity of what I was experiencing was really high, and so I think over repeated exposure to that, I somehow got numb to it. I think that was my survival response. Like, how do you deal with something so intense, so much? I think, to be honest, I had two others [severely traumatized patients] at the same time. I had two like that, and I had two whose eating disorders were so severe that likely death was on the horizon and so that felt very traumatic to me as well. I think the way I could cope with four [severe cases] on my caseload at the same time was to numb myself.

RD 2 further reported that while she experienced compassion fatigue she also felt frustration and impatience about the clients situations: "Numbness was a big one and sometimes, I think even impatience, a little bit. . . . [Or] I think frustration might be a better word . . . and it wasn't frustration at them, just at the entire situation." RD 2 expressed that she felt frustration that the patients weren't getting the appropriate level of

care that they needed, no progress was being made and that they were just in a place of pain.

RD 3 described irritability resulting from exhaustion as a symptom of compassion fatigue:

> I think I was irritable and kind of short with people. I was more likely to become tearful or emotional because I was so on edge. It was like, if anything went wrong or someone pushed me too hard, it was like, "I cannot take this anymore."

RD 1 described her symptoms of compassion fatigue as a twitch in her eardrum, fatigue, upset stomach, as well as anxiety, sleep disturbance, and apathy.

**Research Question 2**

RQ2: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working with patients with eating disorders?

All of the participants agreed that registered dietitians who work with patients with eating disorders are at risk for developing compassion fatigue as a result of working with this population. Seven out of the eight participants said that yes, registered dietitians who treat patients with eating disorders *are* at risk for developing compassion fatigue due to working with this population. The eighth participant said, "yes, *certainly,* dietitians who treat patients with eating disorders are at risk for developing compassion fatigue due to working with this population." (DE 3)

Interview Question #5A: Why are registered dietitians who treat patients with eating disorders at risk for developing compassion fatigue due to working with this

population? Six of the participants agreed that repeatedly hearing the patients' stories, struggles, and traumas is a risk factor for developing compassion fatigue. DE 2 explained that dietitians who work with patients with eating disorders are exposed to similar traumas repeatedly, which can make a clinician less compassionate or empathetic:

> It's the same story, just a different individual, or even if some of the details are a little different, it's something they are exposed to over and over and over again. It's feeling like, 'okay, I've heard this multiple times for many, many years.'

RD 4 also described repeated exposure to trauma, pain, and suffering:

> … when you are working with this population you are dealing with people who have suffered trauma or other kinds of stressful situations. People with depression and anxiety. You have to listen to stories over and over and over again. It often takes clients several sessions to become aware of their behaviors and the reasons for their behaviors, so our work requires patience.

DE1 added,

> I still vividly remember some of the stories that I heard [during my dietetic internship], and, they became a part of me. Even when I think about this, I begin to feel what the patient felt as they were telling me. I still remember their stories or their struggles. If you do this day in and day out, you will begin to experience the trauma with the patient as well."

RD 2 recalled one particular patient's story that contributed to her being at risk for developing compassion fatigue:

> One client was actively being stalked, and sexually assaulted by a man. And, she had gone to the police four years ago and the police coerced her into lying that it did not happen. And, because she said that it did not happen, they took her child into CPS custody for a year, and she had to go to a psychiatric hospital… She did not end up getting her child back, but the abuse was still ongoing. And she would move. She was continually moving to different locations and he kept finding her everywhere she went. So, it was an awful, awful, awful situation. She would come into my office and she'd be trying to cover bruises. The other contributing factor with her was my lack of boundary setting in the beginning. So, she would text me a lot. And that was a boundary that I needed to have set with her, but I didn't in the beginning, so I think that lack of boundaries also contributed to compassion fatigue.

RD 1 also shared a patient's story:

> There was one client who had a brain injury from a car accident and literally could not stop vomiting. She vomited on me and just vomited everywhere. Just to know that a car accident could have that kind of effect…

DE 2 commented on the repeated exposure to trauma, which can possibly numb an individual and make them less compassionate. "Simply because it's the same story, just a different individual, or even if some of the details are a little different, it's something they are exposed to over and over and over again." (DE 2). RD 3 described the repeated exposure to patients' trauma as a factor that increases the risk of compassion fatigue and burnout in dietitians:

> We hear stuff all day long that is traumatic. And I think that I for sure clump the two [burnout and compassion fatigue] together. I think a lot of people do, especially in our field because we don't learn these terms. . . We get clients who have had their eating disorders for decades. And sometimes some of the stories, you're like, "did you just make that up or is it real?" And as compassionate clinicians you want to feel for them and be there for them and it's hard to hear over and over again.

RD 1 had an interesting response regarding hearing the trauma of clients who are considered overweight or larger-bodied:

> …I think that you are often trying to present something that is countercultural. And, you are trying to combat what society is telling them about food… Especially as a 'Health at Every Size' dietitian who is working with [larger-bodied] clients, and just day in and day out, hearing about the trauma that a person of size, or a larger-bodied person is experiencing, and trying to keep your wits about you, and not get caught up in that… Especially when we, as healthcare professionals are kind of bombarded with messages about health and weight, and weight loss, etc.

Later during the interview, RD 1 explained that she felt more compassion and empathy towards clients who are larger-bodied or obese:

> I think maintaining compassion and empathy for what feels like more real struggles, which is the overweight or the obese person who is trying to maneuver

> life in a larger body and lives in a weight-biased world – that was easier to maintain compassion.

Another risk factor of developing compassion fatigue is actually working with the eating disorder patients, a population who is known to be difficult and challenging. DE 2 mentioned that the patients can sometimes be manipulative and may not always be as forthcoming as they should be with their treatment. DE 3 remarked that working with eating disorder patients can be hard. She recalled treating patients with eating disorders during her dietetic internship:

> It's hard! It was hard because they were really firm in their beliefs. They would find excuses or different reasons why things didn't apply to them. It was very frustrating for me, working with patients where it was like, 'I'm telling you what you should do. I'm telling you what's good for you, and you're not doing it.'

One theme emerged during data analysis to answer the research question. Evidence in the form of quotations from the data is provided to support the theme.

**Theme 2: The risk of developing compassion fatigue is highest when dietitians are underprepared for repeated exposure to patients' trauma, pain, and suffering.** DEs and RDs associated the highest risk of compassion fatigue when the dietitians are underprepared for repeated exposure to patients' trauma, pain, and suffering. The participants believe that they need to be trained on how to cope when confronted with patients' trauma, pain and suffering. Participants stated that when confronted with these conditions for which they were underprepared, they were more

likely to experience feelings of helplessness, frustration, and futility, which increased the risk of developing compassion fatigue.

DE 3 alluded to feelings of helplessness when confronted with conditions for which dietitians are underprepared:

> [Dietitians are] working with this population, and eating disorders, like I said, there tends to be lots of comorbidities, where it's not just an eating disorder, there might be depression, anxiety, substance dependence, all these other things, a history of trauma. And dietitians are not trained in working with those things. And, so, you have a caring clinician who wants to help, but doesn't have the skills to help to the fullest extent that they might be able to.

RD 2 mentioned patients' trauma specifically when describing dietitians' lack of preparation:

> There's a lot of emotional heaviness to the information that we are receiving, and we are not ever given any training on how to work with that information. I never received any sort of trauma training in my years. I don't even know if I remember talking about trauma at all in my years of nutrition school. So, I think we don't have the training to match the level of intensity of information we are sometimes provided.

RD 1 also associated an increased risk of compassion fatigue with dietitians' inadequate preparation for repeated exposure to trauma:

> It's not our duty or responsibility, per se, to ask about the trauma, and follow-up on those questions… In fact, we're probably not really equipped to do that as

> dietitians, unless it's something [that] specifically relates to the food. But, trauma can also be just the distressing experience of recovery from an eating disorder, and that can be very draining [to the dietitian] in general.

DE 3 summarized the perceptions of other participants in describing the relationship between dietitians' lack of training and the risk of compassion fatigue:

> We're [as dietitians] not taught - where is our boundary? How much can we be expected to help, right? And, I think, psychologists, and counselors and social workers, first of all, they're trained much more extensively in those skills, and how to work with depression and other mental illnesses. But, I think, also, there is more of an acknowledgement of this is as far as I can go. . . . We're never taught that, we're not aware of that. We're very hard-working, and I think that combination of "They're not getting better, it's my fault," and "I don't know how to make them better because I was not trained to do that. And I care a lot, because that's why I got into this." And so, it's just this terrible combination, the perfect storm.

**Research Question 3**

RQ3: What are the perceptions of DEs and RDs who treat patients with eating disorders of ways to prevent and manage compassion fatigue?

All four of the dietetic educators and all four of the registered dietitians discussed the importance of taking care of the self as a way to prevent and manage compassion fatigue. RD 3 explained that dietitians can be "Type A people" and will push themselves to the extremes:

> It's important especially in this field to realize that you don't have to have it all together, you can be behind, you can see that person tomorrow. So, I think that just hearing that and reinforcing it was just like, okay, here is your permission to take care of yourself.

DE 3 agreed and explained,

> The profession of dietetics is predominantly female…I think with women- we put ourselves last and we work, work, work, we take care of everybody else and we are in a helping profession and there's that personality to just help everyone else. So, you're really fight a lot of cultural barriers there. You're fighting gender laws, like about what women do; you're fighting the biases that surround the helping professions – like you should be helping and not getting help yourself. You're fighting this workaholic type of culture that we have, like do more, do more, do more. So, you really need to sell the importance of it to get women – to get dietitians – to buy into how important it is to take care of themselves.

RD 2 said that taking time for herself is effective in managing compassion fatigue. "…Making sure I have time for me," she said. RD 4 agreed with RD 2 and emphasized the importance of having balance in her life:

> I take care of myself first. My schedule is – my exercise and my prayer time are always first. I don't see clients until 11:00 a.m. All of that is ME first. And then, I have the peace for my clients… I learned that the solution to restoring peace was making time for myself a daily priority.

DE 4 said that clinicians need to do the self-care that works best for them:

> I think it depends on the person. It's going back to the person and saying, 'what works for you?' You know, what self-care works for you? It might be 'maybe I need to go bake a cake.' What works for you to de-stress to bring the center back to yourself and then to come back out again?

DE 2 agreed with DE 4 and said,

> I think you have to look intrinsically at yourself to see what self-care is necessary for you. What brings you happiness, what brings you joy – and filling your life with those kinds of things – so it's not always the work and the trauma. So, that would be different for every individual person. Maybe it's some sort of exercise regimen or some sort of creative activity that you can do outside of this- that brings you joy.

RD 4 further said that she has experienced burnout before, but has not experienced compassion fatigue:

> I think it's because I do so much of my own work… I look into myself if it [client's trauma] is poking different places and seeing if there are places that I need to grow a little bit more. I look deeper into my own wounds… I know that I need to pull back and take care of myself.

RD 1 explained that during the time that she worked in an eating disorder residential treatment center, she learned how to separate work and her professional life:

> When I would leave there, a big group of us would go hiking. And the weekends were our weekends. We didn't, we shouldn't check emails, we shouldn't check

> voicemails, we shouldn't do any of that. It was important to have a life that was totally separate from that, where no one even knows what an eating disorder is.

Two themes emerged during data analysis to answer the third research question. The following discussion includes evidence for the themes in the form of direct quotations from the data.

**Theme 3: Seeking support from therapists, colleagues, family and friends.** DEs and RDs reported that they perceived seeking support from therapists, colleagues, family, and friends as an effective means of preventing and managing compassion fatigue while treating patients with eating disorders.

DE 1 expressed that support for dietitians who treat patients with eating disorders could involve seeing a therapist: "I think that self-care may involve even seeing an individual therapist sometimes. In my experience with therapy, it's just kind of a way to get things off their chest, and just to kind of discuss [compassion fatigue]."
RD 3 reported a similar perception, stating,

> One piece of advice that I do love to give is for [dietitians] to get their own therapist. You never know what [working with patients with eating disorders] is going to bring up for people. . . . Having some sort of clinical support is always really good.

RD 1 stated that she has benefited from the support of peers:

> My peers listen to my experiences of being triggered by a client's story. Through focusing on my feelings, emotions and wounds that surface from an encounter, my peers help me to grow, heal, and understand in a deeper way. . . . having other

> dietitians to talk with, who have been there, I think that's been huge for me. . . . There aren't many people that understand what happens in dietitian's session other than other dietitians. And therapists get the trauma part, but I think, in terms of the ugly eating disorder monster that can come out, that's unique to dietitians.

RD 4 spoke of seeking support from colleagues:

> We have supervision groups whereby we meet with a group of peers. My peers listen to my experience of being triggered by a client's story. Through focusing on my feelings, emotions and wounds that surface from an encounter, my peers help me to grow, heal and understand in a deeper way.

RD 3 stated that peer support is always available in her practice setting: "Our staff at the center is really good about checking in with each other and advocating for what we need."

A specific way in which peers can provide support to help dietitians prevent or manage compassion fatigue is through raising awareness of compassion fatigue, DE 3 said that peers could help dietitians by

> . . . making them aware of what [compassion fatigue] looks like, and what the symptoms are, to be aware for themselves when they see this start to come up, and to validate their experience when that comes up, and to know that they're not alone . . . , making it normal, normalizing it, making it known that this is something that everybody goes through. You know, talking to them about what they can do about it. Depending on who it is, if it's a colleague, let's go to lunch,

> or let's go for a happy hour, have a glass of wine, . . . [or] accompanying them to some of the resources they may have.

RD 1 agreed with DE 3, stating that dietitians could provide valuable peer support to prevent and manage compassion fatigue by raising awareness of the condition and validating one another's feelings:

> The first thing I would tell [a dietitian experiencing compassion fatigue from treating patients with eating disorders] is that it's okay. It's a normal feeling and they shouldn't feel guilty about feeling that way. . . . It's a normal feeling, and it's probably part of our defense mechanism and the way that we treat patients with trauma.

When seeking support, RD 1 has benefited from the circumstance that many of her friends happen to be therapists: "I always felt like I got free therapy, because my friends are therapists, and we would talk about stuff. So, I guess I saw therapists without paying." RD 4 said that seeking support from friends gave her someone to "vent" to, as well as a distraction:

> …It's someone to talk to and to visit with and vent away. When you are working with populations like [patients with eating disorders], especially being a very empathetic person, you have to keep yourself from taking on their pain. We need to be in there with them - walking beside them as they go through their pain. I have to be very careful about that. Just being able to talk about my day. Going out with girlfriends, I do that regularly. Just having fun going out with people and being able to talk about what is going on in my life.

RD 3 seeks support from a roommate and from other friends: "I have a roommate I come home to and if I have a long day, I can vent to her about that. And just like family and friends in general."

**Theme 4: Setting boundaries and separating self from work.** The dietitians and dietetic educators reported that dietitians could prevent and manage compassion fatigue while treating patients by setting boundaries and separating self from work. Setting boundaries was perceived as involving limiting one's patient load and establishing and maintaining appropriate boundaries between the dietitian and the patients. Separating self from work was perceived as taking days off, taking vacations and scheduling breaks into the workday.

RD 4 noted that capping caseloads might not be an option for dietitians who work in hospitals or treatment centers, but she stated that her freedom to do so in private practice has benefited her:

> Being in private practice, I can determine how many come in and how many don't. Versus if I was working for an institution where I was forced to see all of the patients. I can control it a little bit.

RD 2 tries to limit the number of patients with severe trauma, but she noted that it could be difficult to adequately pre-screen for trauma:

> I started sort of decreasing my caseload of that intensity, and now I have one [severely traumatized eating-disorder patient], but only one, and I'm able to more easily manage. So, I think having a more manageable caseload with extreme trauma. The difficult thing is that you can't always pre-screen the level of trauma.

> [Laughs] That feels awful to me, right, like, I've maxed out of my trauma clients and I'm a dietitian. . . . And, I guess it's not that I don't have any other clients with trauma histories, because it's so prevalent, but I don't have it so outwardly talked about in session.

RD 3 has attempted to cap caseloads by advocating for her institution to hire additional dietitians:

> I've been able to go to my boss and say, 'look, we need more dietitians. We need to cap our caseload. We need to do this, and we need to do that.' And, really advocate for spreading it out so that people can get work done and do good work.

Boundaries also needed to be established and maintained with individual patients to prevent and manage compassion fatigue. DE 4 stated:

> You definitely need to have the compassion, definitely need to set the boundaries, definitely need to disconnect [from the patient], because you're not the one living it. There has to be that sort of check-up where, I'm helping you [the patient] through this process, but I'm not the one living it. I'm helping you create goals; get through whatever you need to get through to move past this.'

RD 1 stated that dietitians occasionally need to set boundaries with individual patients by terminating the relationship and referring them to a higher level of care, but warned that this could result in negative feedback:

> If you have a client that's, you know, they're not ready, you, God forbid, in their words, 'fire them,'—I would say 'Refer them to a higher level of care'—as a form

> of self-care, but also in doing what's best for the client. You're also going to get feedback that you've abandoned the client, or you're giving up on the client.

Dietitians can also prevent and manage compassion fatigue when treating patients with eating disorders by separating self from work. RD 2 perceived this form of self-care as a necessity:

> I need to take breaks. Some space from the work. Vacations, space, those kinds of things. Making sure I have time for me, which is slowly starting to happen. So, I think that's another piece. I just need time to process; if I don't give myself time to process it all, it just builds.

DE 4 also perceived separating self from work as a necessity for preventing and managing dietitians' compassion fatigue:

> However, you decide, is that a retreat, or is that a weekend away, or is that something you just need the rejuvenation, or maybe you need a sabbatical for a time period. But somehow, you can limit yourself from that for a time period and come back to it.

RD 3 separates self from work by not working at home:

> I'm going to make sure that I don't do work when I'm at home. And really create that separation. I think it's so easy for me to be like this really needs to be done by Friday and I'm going to take this home and make sure I get it done by Friday, when really as long as I get it done by the following week or before I see the client again- it will be okay. So just not holding myself on too tight of a schedule.

DE 1 learned of the necessity of separating self from work from her mother, who was a nurse:

> My mom was a nurse, so I just recall that in order to not be overwhelmed by the amount of things that she saw, that you almost had to kind of, sometimes, separate yourself, because if not, it would tear you down.

**Research Question 4**

RQ4: What are the perceptions of DEs and RDs who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue?

Before asking the dietetic educators and registered dietitians their perceptions of how education and training can assist with preventing and managing compassion fatigue, I asked the participants if they had ever received or if they were aware of education and training on preventing and managing compassion fatigue. Of the eight participants only one, RD 3, has received education and training on compassion fatigue. She works at an eating disorders treatment center where the staff has weekly check ins with other sister centers around the country. She stated, “We do Zoom calls and there was a power point presentation about compassion fatigue. That was the only formal presentation I can really remember having about it.” The other seven participants had not received nor were they aware of any education or training on compassion fatigue. One dietetic education, DE 4 said, “It’s not any of the knowledge requirements for us to cover this in our program. And, I can tell you that the courses that we offer, we don’t cover this here.” DE 2 stated, “No, I’m not aware of any training or education. I would suspect that some exist, but [I]

have never actually researched that myself." RD 4 added, "No [I have not received education or training on compassion fatigue], but it sounds like a good idea though."

I next asked the four dietetic educators if they were aware of any education and/or training offered through supervision to manage and prevent compassion fatigue for dietitians who treat patients with eating disorders. All four said that they were not aware of any education or training offered through supervision to manage and prevent compassion fatigue for dietitians who treat patients with eating disorders. DE 4 thinks that it would be helpful to have education and training through supervision:

> I'm not aware of any, however, I would think this would be particularly helpful if you're working in an eating disorders clinic and that your supervisor is acutely aware that this can potentially happen. And to be aware of cues. I'm sure they develop cues or whatever, so that if this person is demonstrating that [compassion fatigue] then oh, wait, we need to take self-check time. Maybe we need to go do something – or whatever.

Interestingly, although the registered dietitians were not asked about supervision and self-care, RD 1 mentioned that the supervisors she has worked with included self-care into the curriculum. "I would say most supervisors I've worked with have made it [self-care] into a big deal. Counter-transference, processing counter-transference, dealing with counter-transference has always been knit deeply into my supervision," she said.

The next question I asked to both the dietetic educators and the registered dietitians was: Are you aware of any education and/or training about self-care offered to dietitians who treat patients with eating disorders? One dietetic educator, DE 4, feels that

it is sad that education on self-care is not offered to dietitians who treat patients with eating disorders. He stated, “I would say no, we don’t cover self-care. Isn’t that kind of sad?” One dietetic educator mentioned that she does not know of education specifically for that population, however, believes she has seen continuing education on self-care for clinicians and for the industry, that provides help to others. DE 2 stated, “I would suspect that there are those available, but I can’t speak specifically about what kind of training options there are.” DE 3 said that she actually attended a luncheon during the FNCE conference, which was all about self-care:

> They had a little yoga/meditation/mindfulness session and they were talking about book recommendations. I got the impression from this group that this was an ongoing conversation they had, and this was their DPG to address that issue… and a lot of them are working with eating disorder patients.

Of the registered dietitians who treat patients with eating disorders, three of the four have received education and/or training about self-care. RD 1 explained that education and/or training about self-care is at every conference:

> …not in my formal education, like in college. But, I think every conference you go to, there’s yoga in the morning, and I feel like it’s a theme throughout the conference, and every presentation… Ultimately there is something about taking care of yourself and putting yourself first. Putting yourself first certainly has been beat into my head… I feel like anytime you do continuing education, it comes up. Especially if you are doing mental health continuing education, I feel like there’s at least a slide or two about self-care.

Although RD 2 received education and training about self-care through her wellness coach training when she worked in the employee health and wellness center at a local hospital, she does not feel as though it was helpful. She stated, “They had us do wellness training to become certified wellness coaches. The difficulty on training is that it doesn’t necessarily result in integration. So, I cannot say that the training helped directly.”

RD 3 receives training and education about self-care at the eating disorders treatment center where she works. She described how self-care is talked about daily at the center:

> I feel like we talk about self-care daily at the center. It’s like a constant conversation about taking care of yourself. If you are sick, they want you to stay home. If you are feeling overwhelmed, okay, we can move hours around. They are really, really good about making sure that we have the self-care piece.

RD 4 has not had any formal education and/or training about self-care, however, has figured it out on her own and is now teaching others:

> I read about spiritual and psychological patterns and growth. Marion Woodman’s work- written and audio- has helped me sort out some of my own pain and has equipped me to work with clients through my personal experience. Woodman is a proponent of soul time and recommends an hour daily… And I’m teaching others. I teach self-care a lot. I have taught it to teachers, administrators, spiritual groups. I teach it regularly at the addiction center… to try to teach them about life balance… Through the practice of life balance, we can become our best self.

Two themes emerged to answer research question #4. The following discussion includes evidence from the data to support the themes.

**Theme 5: Promoting self-care.** Both the dietetic educators and the registered dietitians perceive that training and education about self-care can assist with the prevention and management of compassion fatigue in dietitians who treat patients with eating disorders. Participants recommended that training be focused on facilitating the development of self-awareness in dietitians, so they could determine when self-care is needed and what self-care options work best for them. Forms of self-care included taking breaks, setting boundaries, capping caseloads, and seeking support.

DE 2 indicated that self-care is very individual and that dietitians have to find what works best for themselves:

> I think you have to look intrinsically at yourself, to see what self-care is necessary for you. What brings you happiness, what brings you joy, and filling your life with those kinds of things, so it's not always the work and the trauma, and this. So, that would be different for every individual person.

DE 4 also recommended that dietitians be educated to identify the forms of self-care that works best for them:

> I think it depends on the person. It's going back to the person and saying, what works for you. You know, . . . what works for you? It might be, maybe I need to go bake a cake, I don't know, right? What works for you to de-stress to bring the center back to yourself and then to come back out again.

DE 4 added that education can help dietitians become aware of when they need to implement self-care techniques to prevent or manage compassion fatigue:

> The training piece of it is the supervisor is watching—you know, it kind of goes hand in hand. The supervisor has to sort of alert you, but, at that point you need to become aware that, “Oh, these things that are going on, and maybe we need to be, I need to watch it. How can I get that compassion back to take care of the patients?”

RD 3 suggested that education be used to make dietitians aware of what self-care is and of options for implementing it, so dietitians could then use their self-awareness to identify the most effective techniques for managing their own compassion fatigue:

> [Effective self-care] really depends on the person. I think even [training] that simply explains, “these things are self-care.” Like going to bed on time or taking a shower. Or some of the things that people already do that they don’t realize this is self-care. Just further emphasizing that this is you taking care of yourself, I think would be good for dietitians.

RD 2 agreed with other participants that dietitians would benefit from greater awareness of self-care as a way of managing compassion fatigue, and added that self-care training should include material on how the dietitian can cope with her own reactions to patients’ distress:

> I just think the biggest thing is just having more discussions about the concept [of self-care] even. I think, in schooling, being realistic. Even for dietitians not in eating disorders, but having discussions about how do you hold space for any

> emotional distress? Because most people don't come to us because they're happy and excited and loving life. It's because they're struggling in some way. So, just some education in our training on how do you, like, work with emotional distress, and how do you take care of yourself.

RD 4 recommended training retreats for dietitians to practice and learn about self-care for managing compassion fatigue:

> I think what would be helpful would be a weekend conference where you are talking about all of the different aspects of self-care that are important and often forgotten. We get so focused on our clients that we forget our own needs… Kind of a retreat if you will. A getaway where we come back to knowing, understanding, evaluating, and modifying what we are doing.

DE 3 stated that to train dietitians to manage compassion fatigue through self-care, it would be advisable to implement:

> . . . continuing education, there could be workshops . . . I mean, you could have a one-hour symposium session, on just raising awareness for clinicians, and providing some resources, so there would be a need for that. But then, you could also do pre-conference workshops, where there's more skills training happening; practicing some counseling techniques or self-care things. And then, you could also build it into the education, like, you know, internships, and ACEND programming, and you know, all that stuff. So that dietitians coming in would be aware of it, and then clinicians that are already in the field would have access to some knowledge about it.

DE 3 cited the unconscious conformity to gender norms as a trigger for compassion fatigue. She continued by explaining techniques that could possibly alleviate compassion fatigue:

> The profession of dietetics is predominantly female, which is also an issue. I think with women, we put ourselves last, and we work, work, work, we take care of everybody else, and we're in a helping profession, and there's that personality to just help everybody else. So, . . . you're fighting the biases that surround the helping professions, like you should be helping, not getting help yourself. You're fighting this workaholic type of culture that we have, like, do more, do more, do more. So, you really need to sell the importance of it to get women—women—to get dietitians to buy into how important it is to take care of themselves, and then also give them information on what that looks like. I'm real big on experiential learning, and I think actual workshops, where you practice mindfulness meditation or yoga.

RD 2 recommended training dietitians specifically in the self-care technique of boundary-setting, citing her own challenges in setting boundaries with patients who had borderline personality disorder:

> The one I struggle with the most is boundary setting. So, any sort of training on that, especially as it applies to borderline personality disorder individuals would be super helpful for me. Maybe just general education on BPD.

**Theme 6: Raising awareness and validating experiences.** DEs and RDs perceived that education and training can assist with the prevention and management of

compassion fatigue by raising awareness of the condition and validating the experiences of dietitians who are suffering from it. DE 1 spoke of the guilt that dietitians might feel when experiencing compassion fatigue:

> Professionals might feel guilty for feeling that way. They may feel guilty for having compassion fatigue, so I certainly think that some sort of support groups or seminars that really focus on the fact that this is a normal feeling, and that they shouldn't feel guilty about having those feelings. . . . [But] you're not alone, that it doesn't make you a bad person. . . . this is a real kind of feeling that dietitians may experience. They may not even know that they're experiencing compassion fatigue.

DE 2 recommended different methods of raising awareness of compassion fatigue among new practitioners and more experienced dietitians, respectively:

> Maybe for dietitians that are early in their careers, working with eating disorder patients, it may be helpful for them, to just give them identifiers, and say you know, these are signs that [compassion fatigue] may be happening, or this is what may lead to this. And then for the folks that may be a little more seasoned, support groups or some sort of a network where people that have been in the field as long as they have, can relate to one another and dialogue about the kinds of things that have, perhaps, gotten them to the place where they feel like compassion fatigue is setting in.

DE 2 added that raising awareness about compassion fatigue among dietitians who treat patients with eating disorders is important because awareness is a necessary condition of proper self-care:

> If you maybe don't necessarily identify with [compassion fatigue] currently, that's something that you can be aware of and try to find coping mechanisms to maybe not get to the place where you're finally burnt out and, uh-oh, I have compassion fatigue, and I didn't realize that this was happening, and it's been sort of a progressive thing.

RD 1 agreed with other participants in recommending education to raise awareness of compassion fatigue:

> I think just education of what [compassion fatigue] is, and that it exists would be a great place to start. . . . we have to put a name to it first, and identify what it is first. . . . and how it differs from burnout, how it differs from counter-transference.

RD 2 also noted the important of awareness of the signs of compassion fatigue as well as the risk factors of the condition:

> Part of the way to prevent it is to be aware that [compassion fatigue is] possible. If you have no awareness that it's possible, then how do you prevent it? So, the first piece is education on compassion fatigue, then trauma education, and self-care tools.

DE 3 discussed the danger that dietitians who are unaware of compassion fatigue might interpret its symptoms as indications that they are unfit for the profession, instead of as a sign to implement better self-care:

> If clinicians are feeling the way that I did, back then [when I had compassion fatigue], almost 20 years ago, that "Oh, I just need to get out of this profession because it's not for me, because I'm just not feeling anything by these cases that I'm seeing." It could be very helpful to know that this is a normal part of this profession, and these are things to look for, and here are the things you can do about it.

RD 3 described an example of an educational call, which the purpose was to raise awareness of compassion fatigue among dietitians:

> I can remember having one talk on our dietitians call solely devoted to compassion fatigue because the therapists are trained on this starting from day one. Dietitians are taught biochemical structures, but we are not taught how to take care of ourselves. So, we had a whole talk on that. And one of the therapists from the main office was on the call too. They talked to it and such. I thought that was really cool. And, I think it needs to be done more often because it's not talked about. And, new people come on board and maybe they have not had that conversation.

## Outcomes Related to the Literature and Conceptual Framework

In multiple areas, the outcomes of this research study are in accordance with the literature. McLamb (2015) and Portnoy (2011) found that compassion fatigue can show

up physically, cognitively, emotionally, spiritually, behaviorally, and/or on a somatic level. The participants in the present study described their symptoms of compassion fatigue including anxiety, depression, depletion of emotional resources, emotional exhaustion, numbness, frustration, impatience, and irritability. Furthermore, physical symptoms experienced by participants included examples such as an eardrum twitch, fatigue, upset stomach, sleep disturbance, and apathy.

According to research, patients who suffer from eating disorders can be difficult to treat (Thompson-Brenner, 2012) and can experience severe health complications high treatment drop-out rates, and higher mortality rates compared to patients with other psychiatric illnesses (Satir, 2013). These factors can contribute to the development of compassion fatigue in health care providers. Corresponding with the literature, being exposed to the comorbidities, complications, and complexities encompassing the patients, the participants in this study described their frustrations working with this population. The participants, furthermore, described patients with eating disorders as being difficult and challenging.

Researchers have suggested that health care professionals can manage compassion fatigue through education about compassion fatigue as well as participation in activities that involve self-care, self-compassion, and mindfulness (Cole, Craigen, & Cowan, 2014). The dietitians who were interviewed suggested that education and training can assist with managing and preventing compassion fatigue by raising awareness about compassion fatigue as well as validating the experiences of dietitians who suffer from it.

Finally, all eight of the participants in the present study discussed the importance of taking care of the self as a way to prevent and manage compassion fatigue.

The theory of andragogy, developed by Knowles (1970), is aligned with the findings of this study, which encourage dietitians to pursue knowledge and education to reach their “full degree of humanness” (Henschke, 1998, p. 8). The participants in this study described seeking the support and guidance of therapists, colleagues, family, and friends as an effective way to prevent and manage compassion fatigue while treating patients with eating disorders. Adult learners seek to learn and tend to be self-directing, which is part of the theory of andragogy (Imel, 1989). The participants in this study also described the importance of educating dietitians about compassion fatigue, setting boundaries, taking breaks, and prioritizing self-care when working with patients who suffer from eating disorders. Knowles (1975) described andragogy as educating adults who were self-directed and autonomous. Andragogy promotes growth, self-direction, and autonomy (Pratt, 2993). Finally, according to the principles of andragogy, adults have quite a bit of experiences that are sources for learning. According to the participants in the study, their exposure to and experiences with patients with eating disorders were a contributing factor to the development of compassion fatigue. The participants then discussed the need for education regarding how to handle these experiences.

## Reliability and Validity

Different sources of data including one-on-one interviews and field notes were utilized to assist in triangulation and to ensure internal validity of the study. To avoid researcher bias, Lodico et al. (2010) recommended doing member checks by asking some

of the study participants to review their transcribed interviews and ask if the interviews were captured correctly. Merriam (2009) relies on member checking to ensure internal validity or credibility. The transcribed interviews were emailed to the participants so they could confirm or counter the researcher's interpretation of the interviews. Seven out of eight or 87.5% of the participants responded to the email confirming the accuracy of the transcriptions. One of the participants edited the transcribed interview because she felt as though her points were not represented accurately.

In qualitative research, triangulation refers to the use of multiple sources or methods to check and establish validity in studies by analyzing a research question from various perspectives (Creswell & Poth, 2018). The four research questions were asked to two different groups of dietitians to get different perspectives. The two groups of dietitians included dietitians who work with eating disorder patients and dietitians who are educators in a nutrition and dietetics program at a university.

Research Question 1 was as follows: How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue? One theme emerged from that question: emotional exhaustion and numbness resulting from repeated exposure to clients' trauma, pain, and suffering. Three of the participants were not able to define compassion fatigue and the remaining five participants, which included both dietetic educators and dietitians who treat patients with eating disorders, answers lined up with that theme.

Research Question 2 was as follows: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the

risk of developing compassion fatigue due to working with patients with eating disorders? All of the participants agreed that registered dietitians who work with patients with eating disorders are at risk for developing compassion fatigue as a result of working with this population. Seven out of the eight participants said that yes, registered dietitians who treat patients with eating disorders *are* at risk for developing compassion fatigue due to working with this population. The eighth participant said, "yes, *certainly,* dietitians who treat patients with eating disorders are at risk for developing compassion fatigue due to working with this population." Interview Question #5A was: Why are registered dietitians who treat patients with eating disorders at risk for developing compassion fatigue due to working with this population? Six of the participants agreed that repeatedly hearing the patients' stories, struggles, and traumas is a risk factor for developing compassion fatigue. Two dietetic educators said that aside from hearing about trauma over and over, which is another risk factor of developing compassion fatigue is actually working with the eating disorder patients, a population who is known to be difficult and challenging.

One theme emerged during data analysis to answer research question 2: The risk of developing compassion fatigue is highest when dietitians are underprepared for repeated exposure to patients' trauma, pain, and suffering. Two dietetic educators and two practicing dietitians associated the highest risk of compassion fatigue when the dietitians are underprepared for repeated exposure to patients' trauma, pain and suffering.

Research Question 3 was as follows: What are the perceptions of DEs and RDs who treat patients with eating disorders of ways to prevent and manage compassion fatigue?

All four of the dietetic educators and all four of the registered dietitians discussed the importance of taking care of the self as a way to prevent and manage compassion fatigue. Two themes emerged during data analysis to answer the research question. The first theme was how important it is to seek support from therapists, colleagues, family, and friends. Two of the dietetic educators and three of the dietitians who treat patients with eating disorders stressed the importance of seeking both professional and personal support from therapists, colleagues, family, and friends. The second theme that emerged was how important it is to set boundaries and to separate self from work to assist with managing and preventing compassion fatigue. Three of the dietetic educators and all four of the registered dietitians who treat patients with eating disorders discussed the importance of setting boundaries and separating self from work as part of the way to manage and prevent compassion fatigue.

Research question 4 was as follows: What are the perceptions of DEs and RDs who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue? Two themes emerged from the research. The first theme was the importance of promoting education regarding self-care to assist with managing and preventing compassion fatigue. All four of the dietetic educators and all four of the registered dietitians perceive that training and education about self-care can assist with the management and prevention of compassion fatigue in dietitians who treat

patients with eating disorders. The second theme involved the need for education and training to raise awareness about compassion fatigue as well as validating experiences of compassion fatigue. All four of the dietetic educators and all four of the registered dietitians discussed the importance of including education about what compassion fatigue is, how to identify it, and how to manage and prevent it. Furthermore, all of the participants discussed the importance of validating the experiences of the dietitians; reassuring the dietitians that it is completely normal to experience compassion fatigue.

## Discrepant Data

As part of the analysis process, I also considered the role of any discrepant data observed. Discrepant data refer to data that are an exception to patterns or that conflict with the overall findings in a study (Creswell, 2012). There was discrepant data throughout this research study, which I made sure to identify so that bias was avoided.

Conflicting data occurs when one or two of the participants answers questions differently or have different views than other participants (Creswell, 2012). In the present study, of the four practicing dietitians, three have experienced compassion fatigue while treating patients with eating disorders. One practicing dietitian has not experienced compassion fatigue even though she has been working with patients with eating disorders for over 28 years. Furthermore, although all eight of the participants said that dietitians who work with patients with eating disorders are at risk for developing compassion fatigue, that same dietitians mentioned above stated that she does not feel as if she is at risk for developing it.

Because all the participants agreed that dietitians who treat patients with eating disorders are at risk for developing compassion fatigue, the next question was, "why do you perceive that registered dietitians who treat patients with eating disorders are at risk for developing compassion fatigue?" Six of the participants felt as though being exposed to patients' trauma and not being equipped to handle that trauma is a risk factor to the development of compassion fatigue. One dietitian stated that many dietitians who specialize in treating patients with eating disorders have their own history and their own struggles with eating disorder behaviors, which can contribute to the development of compassion fatigue. One dietetic educator said that being exposed to the comorbidities that often accompany eating disorders, including depression, bipolar disorder, anxiety, and borderline personality disorder can increase the risk of developing compassion fatigue.

Of the practicing dietitians, one of the four does not receive professional support, one of the four does not receive personal support, and one of the four has participated in education/training about how to manage and prevent compassion fatigue. Of the four practicing dietitians, one of the four has not participated in education/training about self-care while the other three have. One of the closing questions was, "What advice would you give registered dietitians who work with patients with eating disorders regarding compassion fatigue and self-care?" The dietitians and dietetic educators offered similar advice including the importance of seeking support and collaboration, managing caseload, and taking care of self. One dietitian, however, spoke of the importance of being in a good place with food before working with eating disorder patients. On a

similar note, a dietetic educator advised not working with eating disorder patients if one has a history of their own eating disorder. “I think they get too wrapped up into it. I mean, then it’s really harder to disconnect because they’re bringing back everything they’ve gone through,” he said.

**Limitations**

One limitation of this study involved me as the researcher. I am a registered dietitian and specialize in eating disorders. I am also adjunct faculty at the local university. My role in both settings may have influenced this research project, therefore, I attempted credibility in this study by understanding and describing the experience from the participants’ eyes. I used this method to lower any bias on my part as the researcher. I also employed member checking during my research. Member checking is a technique that can be used to investigate the credibility of the research results. I returned the data to the participants to be checked for accuracy and validity (Birt, Walter, Scott, Cavers, & Campbell, 2016). I also used probing and clarifying questions to gain accurate representation of the participants’ experiences. Throughout the interviews, I allowed the participants to correct errors, clarify their information, and correct misinterpretations. I also used member checking to provide additional information to the participants.

Another limitation for this study was the potential influence of my experiences as someone who has both experienced and witnessed compassion fatigue. As a result, I was in frequent contact with my first chair, and I also kept field notes to avoid research bias during the study. Part of writing field notes involves encouraging reflexivity or the self-exploration of the researchers underlying assumptions concerning various elements of the

research (Barusch, Gringeri, & George, 2011). I did my best to remain open minded and without bias during the research. I also kept an open dialogue with my chair about potential biases. Further limitations involved the issues of validity, reliability, and generalizability. To ensure that I had analyzed the data appropriately and correctly, I hired a research analyst to review my results. He ran my data through NVivo 12 and reviewed my results for accuracy. No changes were made by the research analyst.

## Summary

In Section 2, the methodology of the study was discussed. After careful and thorough consideration, the basic qualitative research design study was chosen. The researcher obtained IRB approval from Walden University (IRB #02-20-19-0364758). Purposeful sampling was utilized to gather the participants, which included four registered dietitians who treat patients with eating disorders and four dietetic educators. Ethical considerations including confidentiality, privacy, protection of the participants, and anonymity were ensured.

Data collection was accomplished through one-on-one face-to-face audiotaped interviews. Descriptive and reflective field notes were taken during the interviews. The interviews were transcribed manually and were checked for accuracy by the participants. Recurrent terms and phrases were coded and themes were identified.

Four research questions were used to guide this qualitative study of the perceptions of registered dietitians and dietetic educators of the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and the possible need for professional education on preventing and managing compassion fatigue

in registered dietitians who treat patients with eating disorders. The first research question was: How do dietetic educators and registered dietitians who treat patients with eating disorders define compassion fatigue? Findings indicated that participants defined compassion fatigue as emotional exhaustion and numbness resulting from sustained empathy for clients. The second research question was: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders regarding the risk of developing compassion fatigue due to working with patients with eating disorders? Findings indicated that there is a risk for developing compassion fatigue and the risk is highest when dietitians are underprepared for repeated exposure patient's trauma as well as to their comorbid conditions.

The third research question was: What are the perceptions of dietetic educators and registered dietitians who treat patients with eating disorders of ways to prevent and manage compassion fatigue? Findings indicated that participants perceived seeking support from therapists, colleagues, family, and friends, as well as setting boundaries, and separating self from work as effective ways to prevent and manage compassion fatigue. Research question four was: What are the perceptions of educators and registered dietitians who treat patients with eating disorders on how education and training can assist with preventing and managing compassion fatigue? Findings indicated that training and education could assist by promoting self-care in dietitians and by raising awareness and validating experiences of compassion fatigue.

Six themes emerged from the research. The first theme that emerged was that repeated exposure to clients' trauma, pain, and suffering caused emotional exhaustion

and numbness in dietitians who treat patients with eating disorders. The second theme was that the risk of compassion fatigue is highest when dietitians are underprepared for the repeated exposure to patients' trauma, pain, and suffering. The third theme that emerged was that ways to possibly manage and prevent compassion fatigue are to seek professional support from therapists as well as support from colleagues, friends, and family. The fourth theme was the importance of setting boundaries, separating self from work, and prioritizing self-care when working with patients who suffer from eating disorders. The fifth theme that emerged was how necessary it is to educate dietitians who treat patients with eating disorders about self-care and how to take care of the self while working with this difficult population. The final theme was that there is a lack of knowledge about compassion fatigue, therefore, there is a need for education to raise awareness about this condition. Findings were related to the problem, research questions, conceptual framework and larger body of literature. Section 2 concluded with a description of reliability, validity, discrepant data and limitations.

Based on the findings of the study, a 3-day professional development program was designed. The professional development program, which is presented in Section 3, is designed to educate dietitians who treat patients with eating disorders to manage and prevent the development of compassion fatigue. Included in Section 3 is the rationale for the project, a review of literature, the project description, implementation and timetable, project evaluation plan, and project implications including social change.

# Section 3: The Project

## Introduction

The primary goal of this basic qualitative research design study was to investigate the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, investigate ways to manage and prevent compassion fatigue, and explore the possible need for professional education for registered dietitians who treat patients with eating disorders. For this study, four dietetic educators and four registered dietitians who treat patients with eating disorders were interviewed. Semistructured interviews were conducted in order to gain an understanding of the two groups of dietitians' perceptions of the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and the possible need for professional education on preventing and managing compassion fatigue in registered dietitians who treat patients with eating disorders. The interview process permitted the participants to explain their perspectives, express their concerns, and provide suggestions about ways to manage and prevent the development of compassion fatigue in dietitians who treat patients with eating disorders.

Six themes evolved from the data analysis, which ultimately guided the formation of the project. The themes included (a) repeated exposure to clients' trauma, pain, and suffering caused emotional exhaustion and numbness in dietitians who treat patients with eating disorders, (b) the risk of compassion fatigue is highest when dietitians are underprepared for the repeated exposure to patients' trauma, pain and suffering, (c) a way to possibly manage and prevent compassion fatigue is to seek professional support from therapists as well as support from colleagues, friends, and family, (d) the importance of

setting boundaries, separating self from work and prioritizing self-care when working with patients who suffer from eating disorders, (e) the necessity to educate dietitians who treat patients with eating disorders about self-care, and (f) the lack of knowledge about compassion fatigue. As a result of these themes, a 3-day professional development program (Appendix A) was established to educate dietitians who treat patients with eating disorders about how to manage and prevent compassion fatigue while treating this complicated and difficult patient population. Based on the themes, the following topics were chosen to guide the professional development program:

- Definition, explanation, and information about compassion fatigue;
- Training on how to handle clients' pain, suffering, and trauma;
- Benefits of seeking support from therapists, colleagues, friends, and family;
- The importance of and implementing setting boundaries and separating self from work, and;
- The importance of and implementing self-care.

## Description and Goals

Through this project study, I concentrated on the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, ways to manage and prevent compassion fatigue, and the possible need for education for registered dietitians who treat patients with eating disorders. Participant dietetic educators and dietitians who treat patients with eating disorders acknowledged that a gap in practice exists between the risk of developing compassion in registered dietitians who treat patients with eating disorders and the possible need for education to prevent or manage it. Participants

expressed interest in exploring ways in the learning environment to manage and prevent compassion fatigue in dietitians who treat patients with eating disorders. Both the dietetic educators and dietitians who treat patients with eating disorders expressed interest in participating in a training program designed to assist in understanding compassion fatigue, ways to manage and prevent compassion fatigue, and ways to take care of the self.

The project is based on the results of the data analysis. The 3-day professional development program includes education on defining and identifying compassion fatigue, ways to handle clients' pain and suffering, and the importance of and methods of setting boundaries and taking care of the self. This training will better prepare dietitians to manage and prevent compassion fatigue while working with patients who suffer from eating disorders.

One goal for this project is to create an environment where learning and training can occur in a supportive and collaborative atmosphere. Data analysis from the interviews revealed that dietitians might feel guilty about developing compassion fatigue, therefore, the environment of the 3-day program will be supportive, nonjudgmental, and shame-free. This type of environment will offer dietitians the opportunity to learn that they are not alone, and what they are experiencing is normal based on the population they are treating. Data analysis from the interviews also revealed that there is confusion about the definition of compassion fatigue as well as ways to manage and prevent it. Therefore, other goals for the project include providing participants information and education about compassion fatigue and ways to manage and prevent it. The professional development

program will consist of three consecutive face-to-face daylong workshops including power point presentations, hands-on activities, worksheets, and personal reflections.

## Rationale

The continuous empathy and compassion that is shown by healthcare providers can prove to be physically, emotionally, mentally, and economically costly (Cocker & Joss, 2016). Clinicians who are repeatedly exposed to patients who are suffering, ill, or dying can experience compassion fatigue and an overall decreased quality of life (Potter et al., 2013). Compassion fatigue can result in clinicians dreading work or patients, avoiding work or patients, and/or experiencing negative emotional and physical symptoms, all of which can affect patient care (Matey, 2016). Successful healthcare providers and organizations wish to decrease the incidence of compassion fatigue, which will benefit both the patients and the employees (Hunt, Denieffe, & Gooney, 2017).

Using a qualitative research approach, I focused on the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue and ways to manage and prevent compassion fatigue. Moreover, I explored the possible need for professional education to manage or prevent compassion fatigue. As the data analysis from this study has shown, there is a lack of knowledge about the definition of compassion fatigue and the importance of self-care in dietitians who treat patients with eating disorders; therefore, education is needed. The data analysis also showed that the risk of compassion fatigue is highest when dietitians are underprepared for the repeated exposure to patients' trauma, pain, and suffering. Managing and preventing compassion fatigue can possibly improve patient outcomes through better care and can furthermore improve occupational

and personal satisfaction for those dietitians who treat patients with eating disorders. Education and interventions to prevent and manage compassion fatigue are essential to improve dietitians' quality of life as well as patient care.

To meet the learning needs of the target population, the most appropriate project is a 3-day professional development program. I will apply for continuing education units (CEU's) from the Academy of Nutrition and Dietetics so that the participants can earn educational credit while learning and improving their skills. Through this program, dietitians will learn the definition of, as well as other information about compassion fatigue. They will be trained on how to handle clients' pain, suffering, and trauma, they will explore the benefits of seeking support from therapists, colleagues, friends, and family, they will learn the importance of setting boundaries and taking breaks, and they will be provided with information about the importance of self-care and how to implement it. As a result of this program, the dietitians will be better prepared to manage and prevent compassion fatigue while treating patients with eating disorders. This program will ultimately impact both the clinicians and the patients they serve.

## Review of the Literature

To identify the relevant literature, searches were conducted using the following databases: PsycINFO, PsycARTICLES, ERIC, SAGE, MEDLINE, CINAHL, ProQuest Central, PubMed, and outside sources including Google Scholar. The following keywords were used in various combinations and using Boolean operations: *professional development*, *Kolb's experiential learning theory*, *workshops*, *registered dietitians' professional development, registered dietitians' workshops, faculty development*

*workshops*, *compassion fatigue, burnout, eating disorders, education, professional education, STS, mindfulness, self-care,* and *support.*

I begin this literature review with an explanation of the project genre followed by Kolb's experiential learning theory, which was the conceptual basis for the project. The next section of the literature review includes the risk factors that were identified through the literature, interviews, and the data analysis. These risk factors include emotional exhaustion and feeling unprepared and inexperienced. The next section includes factors that help prevent and manage compassion fatigue including support systems, separating self from work, and raising awareness about compassion fatigue and compassion satisfaction.

**Project Genre**

Professional development is a crucial issue in a complicated and rapidly evolving and changing field such as nutrition and dietetics (Vogt et al., 2015). Professional development is also important in increasing success and vitality (Torbeck & Dunnington, 2019). Based on the findings of the basic qualitative research design study, a 3-day professional development program was created to educate dietitians who treat patients with eating disorders to manage and prevent the development of compassion fatigue. The 3-day workshop is interactive and involves lectures, activities, instructional strategies, and small group breakout sessions. Participants in the workshop will receive education on risk factors, causes, and management/preventative strategies of compassion fatigue, the administration of the Professional Quality of Life Scale, and recommendations, interactive activities, and suggestions of self-care and self-compassion activities that may

be helpful in managing and preventing compassion fatigue. Interventions that promote self-care and reduced emotional exhaustion and burnout can have an important role in supporting healthcare providers who work with difficult patients and stressful environments (Edmonds, Lockwood, Bezjak, & Nyhof-Young, 2012). Several studies bring to light professional development programs that include education and stress reducing activities as having positive effects on preventing and alleviating compassion fatigue (Kravits, McAllister-Black, Grant, & Kirk, 2010; Rollins et al., 2016; Radey & Figley, 2007). In one study, it was discovered that being able to share experiences of burnout and distress in a supported environment allowed participants to acquire healthy coping skills and stress management strategies. Furthermore, face-to-face workshops promoted support and validation (Axisa, Nash, Kelly, & Wilcock, 2019). In their study of burnout in healthcare providers, Rollins et al. (2016) described the effectiveness of implementing interventions such as education and workshops. Finally, Iskarous and Clarke (2018) suggested that wellness workshops are beneficial in assisting with skills to handle stress, increase resilience, and promote overall wellness in healthcare providers.

**Conceptual Basis**

The experiential learning theory, developed by Kolb (1984), along with the analysis of the research data summarized in Section 2, influenced the 3-day professional development program titled The Cost of Caring: Managing and Preventing Compassion Fatigue in Dietitians who Treat Patients with Eating Disorders. Kolb suggested that learning involves generating knowledge through the process of experience. Experiential

learning includes a range of techniques including private reflection as well as structured activities, role-play, and inquiry-based activities (Tomkins & Ulus, 2016).

According to Kolb (1983), there are two types of experiences, concrete and abstract. Furthermore, there are two methods to convert experiences into knowledge, active experimentation, and reflective observation (Tomkins & Ulus, 2016). Kolb's experiential learning theory is based on four cycle phases including 1) concrete experience, 2) reflective observation, 3) abstract conceptualization and 4) active experimentation (Sudria, Redhana, Kirna, & Aini, 2018). These four cycles phases can be repeated over and over during the learning process with the learner experiencing each stage (Wallace, 2019). Kolb explained it did not matter where the learner started in the cycle, but it was important that the learner experience each stage in a cyclical manner. The four learning cycles have specific learning style described as diverging, assimilating, converging, and accommodating. Each of the four descriptors are associated with the related cycles (Klob, 1984).

Kolb's Experiential Learning Theory can be used for adult education (Kolb & Kolb, 2005) and addresses how experiences can make the learning process more meaningful. The theory, furthermore, emphasizes a need for learners to be involved in educational activities (Akella, 2010). Kolb (1984) defines experiential learning as "a holistic integrative perspective on learning that combines experience, cognition, and behavior." He continued by explaining that learning is a continuous and ongoing process which is based in experience.

**Emotional Exhaustion**

While various definitions of compassion fatigue can be found in the literature, almost all of them concur that it is a loss of compassion experienced by healthcare providers and those who expend a tremendous amount of empathy. In simple terms, compassion fatigue can be defined as a "cost of caring" (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017). Healthcare professionals face demands including heavy caseloads, long hours, organizational systems that are in transition, and stressful work environments. These conditions are associated with increased stress and signs of burnout in the clinicians, which ultimately negatively affect the quality of patient care (Irving, Dobkin, & Park, 2009). Healthcare providers are expected to deliver patient-centered care to each and every patient they treat. For healthcare providers, trust and rapport are established through empathic engagement or a deep connection between the provider and the patient. This allows the patients to explore their thoughts and feelings while the clinician provides empathy (Lee, Veach, MacFarlane, & LeRoy, 2015). Dietitians are expected to adhere to the Nutrition Care Process, which places tremendous importance on patient-centered care (Yang, Low, Ng, Ong, & Jamil, 2019). As a result of ensuring high quality patient care, it comes as no surprise that there is a cost for caring for dietitians.

According to Sinclair et al. (2017), healthcare providers who expend vast amounts of compassion in their work are susceptible to compassion fatigue. Berger, Polivka, Smoot, & Owens (2015) stated that workload and the continuous caring for critical patients were factors that contributed to compassion fatigue. In the meta-narrative of

healthcare literature, Sinclair et al. (2017) speculated that compassion fatigue may be the result of repeated emotional exposure with patients. They noted several studies that described compassion as an energy resource, hence, an overspending of it on emotionally draining patients may surpass the restorative effects of compassion satisfaction and ultimately lead to compassion fatigue (Sinclair et al., 2017). Dietitians invest large amounts of empathy into emotionally draining patients, which may deplete the resource of compassion (Yang et al., 2019).

In a cross-sectional study on dietetic interns in Malaysia, Yang et al. (2019) measured the interns' empathy levels compared to dental and medical students. The results revealed that dietetic students actually had higher empathy scores than dental and medical students. The authors theorized that this may be due to the emphasis of empathy in the nutrition and dietetics education and in the emphasis on the Nutrition Care Process (Yang et al., 2019).

**Feeling Underprepared and Inexperienced**

Sinclair et al. (2017) defined compassion fatigue as a sense of helplessness and guilt that individuals feel when they are incapable of relieving someone of their pain or rescue them from harm. This was echoed by the participants in my study, as they identified being unprepared as well as feelings of helplessness and guilt as risk factors for compassion fatigue. Patients who suffer from eating disorders likely experience interpersonal conflicts, diminished social skills, sensitivities, and low social support as a result of abuse, neglect, bullying, and/or parents/caregivers inability to meet children's needs. (Tasca & Balfour, 2014). There is also evidence that patients with eating disorders

exhibit dysregulation or negative affect (Ivanova, Tasca, Proulx, & Bissada, 2015). When exposed to situations such as these, healthcare providers may experience increased anxiety, which may then increase their vulnerability to compassion fatigue (Lee et al., 2015).

Wald, Haramati, Bachner, and Urkin (2016) evaluated professional burnout and resiliency, two constructs related to compassion fatigue, of medical and nursing faculty, along with senior medical students. Included in the themes were feelings of helplessness and vulnerability as healthcare providers. One participant described the heaviness of being unable to offer tangible help and likened the experience to having an incurable disease and being trapped (Wald et al., 2016). As discussed by the participants in the present study, patients with eating disorders also often have comorbidities which the dietitians are not prepared for, thereby increasing the feelings of helplessness.

Coetzee and Laschinger (2017) explained this type of situation as an effort-reward imbalance, wherein an individual expends great effort in caring for another individual who is ill and receives negative outcomes instead of rewards. These outcomes may elicit negative feedback from the patient, the patient’s family, their supervisors, or most importantly, from themselves (Coetzee & Laschinger, 2017). The participants in the present study stated that patients with eating disorder can sometimes be manipulative and stubborn. The patients insist on their own beliefs and practices, which can be highly frustrating for the dietitians who are trying their best to help this difficult population.

Feelings of being underprepared for the work can also appear as low self-efficacy, or not believing that one can succeed in certain tasks. Tada, Moritoshi, Sato, Kawakami,

& Kawakami (2018) executed a simulated patient intervention targeting self-efficacy for dietetic undergraduate students. An issue that arose in this intervention was the disappointment and regret that the students felt regarding their performances. These findings revealed that self-efficacy may indeed be a problem for dietitians. The findings also showed that the simulated patient intervention increased the dietetic students' self-efficacy (Tada et al., 2018). As such, these findings show promise that self-efficacy can be improved through intervention, and that dietitians' feelings of under preparedness may be addressed in the proposed program.

Researchers of compassion fatigue are in disagreement regarding the role of experience in the development of compassion fatigue. Some researchers believe that less experienced healthcare providers are more vulnerable to compassion fatigue, while other researchers believe that more experienced providers are more vulnerable. In Kolthoff and Hickman's (2017) exploratory descriptive study, nurses caring for the elderly were surveyed regarding compassion fatigue, burnout, and compassion satisfaction. The nurses' years of experience were also taken into consideration. The results revealed that relatively inexperienced nurses were more vulnerable to both compassion fatigue and burnout. The authors then suggested that their inexperience meant a lack of an established peer support group, a lack of knowledge on how to re-energize, or an inability to set realistic boundaries with their work. As nurses grew more experienced and gained these resources, they would be more prepared to tackle compassion fatigue (Kolthoff & Hickman, 2017). On the contrary, Shahar, Asher, and Ben Natan (2019) found age rather than experience was a greater factor in nurses developing compassion fatigue. While

literature is still conflicted regarding the role of experience in the development of compassion fatigue, Shahar et al.'s (2019) theory provides hope that it is not really the amount of experience that matters, rather, the type of experience, training, and education that prepares healthcare providers to prevent and manage compassion fatigue.

The preceding sub-sections examined the specific risk factors for compassion fatigue that were identified by both the participants in the present research study and existing literature. Repeated exposure to difficult patients and trauma, as described by the participants, may indeed deplete dietitians' empathic energy, cause tremendous emotional exhaustion, and lead to compassion fatigue. Dietitians are also prone to feeling underprepared and inexperienced, causing anxiety and frustration, and in turn, compassion fatigue as well. In the following sub-sections, specific tools or protective factors identified by the participants and corroborated by literature are presented.

**Support Systems**

Existing literature on compassion fatigue, burnout, and secondary traumatic stress shows that having a strong support system is a valuable tool in battling the stress experienced by healthcare providers. A support system may involve friends, family, therapists and even colleagues, as described by the participants from this research study as well as several past studies (Berger et al., 2015; Giarelli, Denigris, Fisher, Maley, & Nolan, 2016; Seemann et al., 2019). Support may also come from chaplains (Berger et al., 2015). Sinclair et al. (2017) suggested discussing stressful situations and problematic patients with trained professionals as a self-care strategy for healthcare professionals. The act of discussing and debriefing stressful situations and problematic patients was further

described as a way to increase autonomy, gain social support, and connect with others as described by Poulsen, Sharpley, Baumann, Henderson, and Poulsen (2015).

Support systems are needed when individual coping skills are not enough to manage and prevent compassion fatigue. Cummings, Singer, Moody, and Benuto (2019) investigated the relationship between the coping mechanisms that protective services workers' use and the development of burnout, STS, and vicarious trauma. While protective services workers are not healthcare providers, their work involves helping individuals who may be traumatized or have psychological disorders (Cummings et al., 2019). As such, they are at risk for compassion fatigue. In a study by Cummings et al. (2019), 228 protective services workers completed online surveys which measured work-related coping skills and reactions to stress. The results showed that maladaptive or avoidant coping strategies such as substance use and self-blame were positively related to burnout, secondary traumatic stress, and vicarious trauma, while the only coping strategy that predicted less burnout in protective service workers was social support (Cummings et al., 2019). Another study found that social support along with a decreased workload helped to improve psychological resilience while decreasing vulnerability to stress among trauma workers (Newmeyer et al., 2016). These findings give emphasis to the importance of encouraging social support or support systems for healthcare workers and those in helping or care-giving occupations.

Support systems are supposed to offer "safe havens" where individuals who are experiencing stress or compassion fatigue may express themselves without fear of judgment (Fallek, Tattelman, Browne, Kaplan, & Selwyn, 2019). Vincett (2018)

recommended that individuals create a list of people or groups that qualify as their safe havens. This list should include compassionate and non-judgmental people who have a gift for active listening. Individuals undergoing stress or compassion fatigue should also avoid negative friends or acquaintances who may deplete their energy (Vincett, 2018). Healthcare providers who are at risk for compassion fatigue should surround themselves with positive people and a positive environment where they are "acknowledged, rewarded, and appreciated" (Coetzee & Laschinger, 2017, p.11).

As healthcare providers often spend much of their time at work, it is vital to maintain a positive environment in the workplace. In existing literature, healthcare providers have identified their co-workers, colleagues, and even supervisors, as people they can talk to when experiencing stress or compassion fatigue (Berger et al., 2015; Giarelli et al., 2016). Pfaff, Freeman-Gibb, Patrick, DiBiase, and Moretti (2017) evaluated a pilot compassion fatigue resiliency program in healthcare providers in Canada. One of the main themes that emerged from the data was the importance of collaborative practice and a caring environment for the team. The participants stated that more opportunities for sharing information and discussing concerns would assist in relieving stress. The program helped the participants become more vigilant in identifying when their colleagues were stressed. The program also trained them to be more considerate of one another and allowed participants to employ supportive practices including delegation of tasks when team members needed a break (Pfaff et al., 2017). Practices such as these reflect a positive support system in the workplace that can assist healthcare providers in decreasing the risk for compassion fatigue.

Giarelli et al. (2016) provided recommendations for social support in the workplace including peer-to-peer support networks, buddy systems, interprofessional debrief meetings, supervisor advocates, and one-to-one counseling. Williams, Ross, Mitchell, and Markwell (2019) recommended reflective debriefing sessions especially after emotional cases for dietitians as they contemplate their emotional experiences. Wahl, Hultquist, Struwe, and Moore (2018) conducted a study of nurses who underwent a Peer Support Network training, which showed a significant increase in compassion satisfaction and a nonsignificant decrease in compassion fatigue. Although this decrease was not significant, these results are promising in that it showed how peer support may assist in balancing healthcare providers' compassion energy (Wahl et al., 2018). As the participants in the present study highlighted the importance of support systems in managing and preventing compassion fatigue, the literature presented in this sub-section revealed that positive, nonjudgmental support systems are indeed helpful in decreasing one's vulnerability to stress or compassion fatigue, and that peer support trainings may be beneficial for healthcare providers.

**Setting Boundaries**

According to the participants in the present study, setting personal boundaries is critical to managing and preventing compassion fatigue in dietitians who work with patients with eating disorders. While forming empathic relationships with patients is important for clinicians in therapeutic relationships, it is crucial that these clinicians are wary of over-identification with the patients (McTighe, A.J., DiTomasso, R.A., Felgoise, S., & Hojat, M., 2017). As explained by a participant in the present study, dietitians need

to disconnect and re-orient themselves into thinking that they are helping the patients and not living the patients' lives. McTighe et al. (2017) likewise stated that after the identification step in which a clinician thinks "with" the patient, they must undergo a separation step where the clinician thinks "about" the patient. Salter and Rhodes (2018) noted that this was an essential step in personal-professional development, as maintaining these types of boundaries allowed therapists to handle emotional situations.

Taylor (1998), an experienced nurse, wrote a personal story about becoming overly involved with an elderly patient and his wife, thus crossing boundaries. After discovering that they had similar historical and religious backgrounds, the nurse developed a close kinship with this patient and his wife. After the patient was discharged from the hospital, the nurse called often, spent time at their house, thereby taking on the role of surrogate family member in addition to their nurse. Although she did not realize it at the time, her involvement was inappropriate and unhealthy for both herself and her patient. She later understood that to be an effective and compassionate nurse, she needed to maintain appropriate boundaries. According to Taylor, in order to maintain appropriate boundaries, the following behaviors are considered inappropriate: giving out your personal phone number, lengthy calls to patients after hours, participating in after work activities with your patients, buying or accepting large gifts, and lending money or personal items.

The Academy of Nutrition and Dietetics as well as the Commission on Dietetics Registration (CDR) maintains a Code of Ethics which declares that nutrition and dietetics practitioners are required to maintain appropriate professional boundaries. This code of

ethics helps empower practitioners to behave in a way that supports the standards of the association and is meant to safeguard both the practitioner, and the client/patient (Peregrin, 2018a). Dietitians' self-awareness as well as education about boundaries are essential tools for determining a professional relationship from an unprofessional relationship between the client/patient and the clinician. According to the code of ethics, it is prohibited to have amorous interactions with patients, clients, and students. Furthermore, verbal, physical, emotional and sexual harassment is also prohibited (Peregrin, 2018b).

Professional and ethical boundaries are comprised of "expected and accepted psychological and social distance between practitioners and patients" (Aravind, Krishnaram, & Thasneem, 2012). Appropriate boundaries for dietitians include avoiding any behavior that is sexual in nature, treating the needs of all patients/clients/students the same, avoiding the disclosure of personal details, not spending free time with patients/clients/students, seeking support when needed and balancing work and life to ensure personal satisfaction (College of Dietitians of Alberta, 2017).

Dietitians are part of the caring professions, and as such, must develop a caring relationship with their clients. However, an over-stepping of this caring relationship may cause the relationship to go from professional to platonic, or worse, romantic (Valente, 2017). Valente (2017) listed ways in which boundaries could be violated including over-involvement or special privileges, gifts, excessive self-disclosure, intimate sexual behaviors, dual relationships or role reversal, and in social media "friending" among others.

In the present study, one participant shared how patients would contact her outside the office and beyond office hours, thereby over-stepping that professional boundary. Muse, Love, and Christensen (2015) studied clergy members and noted that unclear professional boundaries were related to burnout, which in turn, related to compassion fatigue. Peregrin (2018a) cited that these boundaries are actually part of the Nutrition and Dietetics Professional Code of Ethics, showing how it applies to dietitians and nutritionists as well. Maintaining professional boundaries and acting in a way that is part of the Academy and CDR Code of Ethics makes certain that the patient/client is obtaining the most favorable treatment from the dietitian and that the dietitian is taking care of him/herself.

**Separating Self From Work**

Because repeated exposure to emotionally exhausting patients and their problems is considered a risk factor to the development of compassion fatigue, separating self from work is necessary for self-care. Several past studies have alluded to this recommendation as well (Berger et al., 2015; Vincett, 2018; Wald et al., 2016). Participants in Berger et al.'s (2015) study recounted how a couple of days off from work or a change of assignment helped relieve some of the stress that they felt at work. Healthcare providers who are more in-demand and are not able to take days off are advised to at least take short breaks while at work to simply breathe, relax, and monitor the state of their body, even for just a few seconds (Pfaff et al., 2017; Wald et al., 2016). Vincett (2018) likewise stated that mental time-outs or short meditations were effective self-care strategies.

Regardless of the length, separating self from work appeared to be something that is fundamentally recommended in the literature.

The influence of culture was also cited by the present study's participants, as workers today are expected to devote most of their time and efforts into their work. Indeed, Kolthoff and Hickman (2017) posited that nurses who were new to their field were more likely to work overtime and take on too much workload. Being in this type of culture, healthcare providers may not even realize that they were overworking and that their minds and bodies are in need of a break. To address this, Wood et al. (2017) presented the National Center for Telehealth and Technology's Provider Resilience (PR) mobile application, which was designed specifically for mental health professionals to combat compassion fatigue and burnout. This application contains versions of the Professional Quality of Life Scale (ProQOL) and the Burnout Visual Analog Scale to help raise the users' awareness of their compassion fatigue and burnout. A vacation countdown clock in the application also reminds the users of the time since their last break (Wood et al., 2017). As healthcare providers nowadays are immersed in their work, applications such as these may assist in raising their awareness regarding compassion fatigue and the need to separate self from work.

In order to be effective, breaks must involve holistic recovery for the clinician, including not just their bodies, but also their minds. A participant in the present study stated that sometimes dietitians may get overwhelmed by the severity of some cases that they have to "separate" themselves from work. As a participant in Vincett's (2018) study put it, breaks must involve just "being" and not "doing." One strategy presented by

Berger et al.'s (2015) participants was to try to leave burdens at work and keep reminding oneself that tomorrow is a new day. These optimistic mantras helped these healthcare providers relax and restore their compassion and energy (Berger et al., 2015). As such, healthcare providers such as dietitians should be trained to separating self from work and ensure that the separation incurs relaxation and restoration upon them.

**Promoting Self-Care**

Contrary to the philosophy of self-sacrifice of Florence Nightingales discussed in Ledoux (2015), researchers have maintained that healthcare providers must care for themselves before being able to care for others (Lee et al., 2015; Sinclair et al., 2017). Not taking care of himself or herself may cause the healthcare provider to be vulnerable to developing compassion fatigue (Beaumont, Durkin, Hollins Martin, & Carson, 2015). Self-care strategies include incorporating a healthy work-life balance, setting boundaries in both work and personal life, participating in activities including arts, journaling, exercise practicing spirituality, and meditation (Melvin, 2015), in addition to developing a supportive social network (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013).

Past studies implementing self-care programs have proven to be effective against compassion fatigue and burnout. Klein, Riggenbach-Hays, Sollenberger, Harney, and McGarvey (2017) utilized a resiliency program promoting self-awareness and self-care on palliative care and neonatal advanced practice professionals. The program lasted six months and proved to be effective in raising compassion satisfaction and decreasing

burnout. Participants mostly provided positive feedback and considered it beneficial to their personal and professional lives (Klein et al., 2017).

Other self-care interventions utilized specific strategies and practices to help reduce compassion fatigue. In a study conducted by Giarelli et al. (2016), the self-care practice of holding positive internal dialogue or self-talk was found to clear minds, relieve tension, and maintain perspective during stressful situations. Self-care practices including breathing exercises, meditation, taking breaks outside of the unit, using essential oils and smelling salts, ingesting certain teas or herbs, and meditating by listening to one's own heartbeat through a stethoscope, were also found to be valuable means for preventing and managing the effects of compassion fatigue in high-risk nurses (Adimando, 2017). Vincett (2018) studied volunteers to women detained indefinitely in an immigrant removal center suggested the following self-care strategies to manage compassion fatigue: self-assessment with a historical time-line, journaling, setting personal boundaries, regular sleep, taking breaks outside for fresh air, good hygiene, exercise, balanced diet, drinking water, limiting alcohol, mental time out, and social support.

As mentioned above, meditation has been identified in the literature as an effective technique to reduce compassion fatigue (Adimando, 2017; Heeter, Lehto, Allbritton, Day, and Wiseman, 2017; Hevezi, 2016). Hevezi (2016) implemented a short, structured meditation program for oncology nurses for five days a week for a four-week period. Included in the program was an educational session involving compassion fatigue, compassion satisfaction, burnout, self-care, and mindfulness. At the outset of the

study, the nurses showed decreased stress and better self-compassion. The researcher highlighted the importance of utilizing short meditation breaks during healthcare providers' tight schedules in order to restore compassion and to avoid compassion fatigue (Hevezi, 2016).

The importance of mindfulness was also emphasized in several studies on self-care (Brown, Ong, Mathers, & Decker, 2017; Harker, Pidgeon, Klaassen, & King, 2016; Hevezi, 2016; Pfaff et al., 2017). Brown et al. (2017) examined compassion fatigue and mindfulness in mental health professionals and Master of Social Work (MSW) students and found a negative relationship between compassion fatigue and mindfulness for both groups of participants. The authors then purported that mindfulness was an effective tool for any profession to combat compassion fatigue (Brown et al., 2017). Furthermore, higher levels of mindfulness appeared to reduce psychological distress in human service professionals working with vulnerable groups (Harker et al., 2016).Pfaff et al. (2017) found that the technique of being and living in the present was presented as an effective self-care strategy. For example, one participant relayed how the simple act of walking the dog and appreciating the sky made them feel relaxed and eased the burden of compassion fatigue (Pfaff et al., 2017).

Because of technological advancements, there are now a plethora of mobile applications geared towards managing compassion fatigue and burnout. The National Center for Telehealth and Technology's Provider Resilience mobile application was specifically designed for the self-care of healthcare providers experiencing compassion fatigue and burnout. This application contains versions of the Professional Quality of Life

Scale (ProQOL) and the Burnout Visual Analog Scale to help raise the user's awareness of compassion fatigue and burnout. Furthermore, a vacation countdown clock in the application also reminds the user of the time since their last break (Wood et al., 2017). Other applications were utilized by Heeter et al. (2017) in their technology-assisted meditation program. Participants in their study received weekly e-mails explaining daily short meditation session applications to be practiced daily. Post-test results revealed increased attention regulation, emotional awareness, self-regulation, body listening, and body trusting measures in healthcare providers (Heeter et al., 2017). Another study explored a 6-week meditation and yoga therapy program for hospice and palliative care workers. Bi-weekly emails reminded participants the importance of practicing meditation and introduced new meditation skills. The results showed significant improvement in managing and preventing compassion fatigue and burnout as well as interoceptive awareness.

Many professional governing bodies add into their code of ethics the importance of self-care as well as managing potential impairment. The code of ethics by the American Counseling (2014) maintained:

> Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own

> professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

The ethical principles and code of conduct for psychologists (APA, 2016) includes:

> Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner. When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

The ethical code of the National Association of Social Workers (NASW, 2017) stated:

> Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action. Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

The Code of Ethics for Nutrition and Dietetics Professionals (AND, 2018a) does not directly include self-care. “Recognize and exercise professional judgment within the limits of individual qualifications and collaborate with others, seek counsel, and make referrals as appropriate,” is the only thing written that is close to the topic of self-care.

**Raising Awareness About Compassion Fatigue**

While compassion fatigue is being addressed in the literature, lack of exposure is still an issue. Studies have shown that raising awareness is an important strategy in managing and preventing compassion fatigue (Mattiolo, 2018). Anderson and Gustavon (2016) examined compassion fatigue in oncology nurses and recommended that new nurses, as well as healthcare providers in general, be educated regarding compassion fatigue and ways to prevent it. Dempsey and Reilly (2016) showed that when nurses are educated and taught about compassion fatigue, they are less susceptible to developing it. “Awareness will help to reduce susceptibility to this condition, possibly reducing staff turnover rates, increasing attendance, and improving satisfaction in nurses.” Furthermore, education and knowledge about compassion fatigue may inspire nurses to practice self-care and be more mindful and ultimately remind them why they chose nursing as a profession (Mattioli, 2018).

Being unaware of compassion fatigue may discourage dietitians who are experiencing it, as they may believe that they are incompetent or not meant for the job. The participants in the present study expressed guilt over experiencing compassion fatigue and some even reported that they thought about quitting at one point in their careers. Lee et al. (2015) shared similar findings, as their participants had doubts about

their career choices due to compassion fatigue. A participant from a study by Seemann et al. (2019) reported the negative thoughts that lingered after particularly emotional work encounters, such as thinking that they were “turning into a bad person” when experiencing compassion fatigue. Healthcare providers dealing with heavy emotional burdens brought about by their patients need to realize that they are not alone in their compassion fatigue and emotional exhaustion (Fallek et al., 2019). Awareness of the incidence rates of compassion fatigue in addition that it does not reflect worker’s competence indicates that dietitians should be targeted and corresponds to the current project.

**Raising Awareness About Compassion Satisfaction**

Existing literature on compassion fatigue have also presented the term “compassion satisfaction” as a positive feeling gained from caring (Berger et al., 2015). Compassion satisfaction is one of the ‘positive aspects of caring’ and one of the positive qualities that helps people to choose to work in healthcare. Compassion satisfaction can be described as relieving suffering that results in a sense of fulfillment and satisfaction (Jakimowicz, Perry, & Lewis, 2107). It is also portrayed as a sense of gratitude or achievement from the act of caregiving as well as being able to meet job requirements (Hooper, Craig, Janvrin, Wetsel & Reimels, 2010). While compassion fatigue and compassion satisfaction may appear to be oppositional, one does not necessarily exist in the absence of the other. Studies have posited that certain factors may influence compassion in an individual, thereby leading to either compassion fatigue or compassion satisfaction.

Compassion satisfaction can be prompted by an individuals' feeling of achievement in aiding traumatized clients, which in turn, increases motivation and the desire to engage in further positive experiences with clients (Wagaman et al., 2015). Unfortunately, research rarely addresses compassion satisfaction in relation to compassion fatigue, STS and vicarious trauma. Compassion satisfaction for caregivers might improve with proper training on work-life balance, setting appropriate boundaries, taking care of oneself and personal welfare (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). Furthermore, providing and supporting continuing education may contribute to greater compassion satisfaction in healthcare professionals.

In sum, this literature review corroborated the findings of the present study regarding the specific risk factors of compassion fatigue and the tools that may be used to reduce its risk. Emotional exhaustion from work and feeling underprepared and inexperienced were discussed as critical factors in increasing compassion fatigue. Having encouraging and nonjudgmental support systems, as well as setting boundaries and taking breaks, were identified as useful tools to counteract these factors. Promoting self-care and raising awareness about compassion fatigue were also identified as vital points that may be used for compassion fatigue interventions, trainings, workshops, and programs. Programs utilized in previous studies have demonstrated the effectiveness of these tools in addition to self-care being taught to help prevent compassion fatigue. The current project will then incorporate these issues and strategies into a 3-day professional development program for dietitians to raise awareness regarding compassion fatigue.

# Project Description

## Potential Resources and Existing Support

There are many reasons to include stakeholders in program/policy development. The stakeholders can contribute helpful information and input during planning (Woodford & Preston, 2011). Participation may also increase the stakeholders' commitment to the agency (Amed et al., 2015). Finally, stakeholder participation can promote successful program/policy implementation, as potential complications and difficulties become known and can therefore be dealt with prior to actual implementation (Bishop & Davis, 2002).

The stakeholders in this project include the faculty members from local universities that have nutrition and dietetics programs, nutrition and dietetic students and interns, and future employers such as local hospitals and eating disorder treatment centers. Registered dietitians who are in private practice and registered dietitians who are members of the local eating disorder specialists' group are also stakeholders.

In the past, I solely created and directed four eating disorders conferences, so I understand and appreciate the planning and resources needed to undertake a professional development program such as the one I am proposing. The training program will mostly be led by me. Other presenters will include dietitians who are experts in the field of eating disorders as well as experts in the field of compassion fatigue, mindfulness, self-care, and trauma. The keynote speaker will be an expert in the field of compassion fatigue. Speakers in the workshop will not receive financial compensation and

involvement is voluntary. The participants, however, can earn CEU's for their attendance and contribution.

The 3-day professional program will be hosted by the university where I am an adjunct faculty member, which has a large student center that is available for conferences, such as the one I am proposing. The center also has a large array of rooms of all sizes including meeting rooms, conference rooms, and ballrooms that can be set up as banquet, classroom, conference or in theater style. All needed audio/visual equipment is available as is parking, special events planning, and dining services. This center hosts conferences and meetings on a daily basis and is quite appropriate for this 3-day professional program.

**Potential Barriers and Possible Solutions**

One potential barrier is that people in the caregiving field are often those who care for the needs of others before caring for their own needs. Self-care practices are often absent from their own lives. The prospective participants, registered dietitians who treat patients with eating disorders, might be resistant to attending a program where the focus is on taking care of themselves rather than the focus on the clinical and professional aspects of dietetics.

Another obstacle might be that dietitians have not been taught about compassion fatigue in the past and, therefore, might be unaware that it could be an issue that needs to be addressed. They might not have eve heard about compassion fatigue before, and therefore might not give any thought to attending the program. Furthermore, there may be

lack of interest from faculty members as they feel as their time is better spent on improving and furthering dietitians' clinical skills.

A potential solution to the barriers described is to demonstrate to dietitians and faculty members the importance of understanding compassion fatigue and how attendance will be beneficial to them. This can be accomplished by posting on the eating disorders specialists' member forum a description of the 3-day workshop and the benefits of attending. The posts will be emailed to all members of the specialists' group, including representatives from hospitals and treatment centers. I will send out monthly posts leading up to the workshop. I will also announce the program at faculty meetings in the months preceding the event. At these meetings, I will provide real-life examples of how the education and hands-on and self-reflection activities will help dietitians understand, manage, and prevent compassion fatigue. Hopefully, the faculty members will want to participate and encourage their students to participate as well.

A final obstacle could be the cost of attending a 3-day program. Again, because compassion fatigue is not addressed in dietetics, employers might feel as though the cost is unjustified and therefore, not be willing to pay for dietitians to attend. Dietitians also might not want to pay the cost for a 3-day program about compassion fatigue, particularly if it is an area of study that they are unfamiliar with. They might prefer to go to a conference where they feel they will learn more valuable clinical skills. A possible solution is to solicit sponsorship money from treatment centers, organizations, and businesses that will benefit from having their names advertised. One organization that might help fund this program is the eating disorders specialists' group that I am a

member of. The website states that the organization, "… works to advocate for better understanding of eating disorders by medical and mental health providers. We are available to local media and community organizations to provide education and guidance about eating disorders. We also sponsor public conferences to educate clinicians and consumers" (Houston Eating Disorders Specialists, 2017, Advocacy, para. 1). Through sponsorship, the fee to attend will be lowered, student rates can be offered, and the fee can be waived for those who cannot afford to attend. One final solution is to offer volunteer positions for those who wish to attend but cannot afford to, who also will be encouraged to attend the program.

## Implementation and Timetable

Before scheduling and implementing the 3-day workshop, I will first meet with the stakeholders to present my research findings. After receiving support from the shareholders, I will then implement a realistic and achievable timeline for the program to occur. Collaboration between the educators, dietitians in practice, treatment centers, local hospitals with eating disorder units, dietetic students, and the group of eating disorders specialists is necessary for this program to be well attended and successful.

National Eating Disorders Awareness Week is held annually in February. I will aim for the workshop to be held in early March since eating disorders will be fresh on dietitians' minds. Planning will begin in August, six months prior to the workshop.

Participation, dedication, and cooperation from multiple departments, individuals, and organizations will be necessary to help make this program a

success. As the founder and organizer of this program, my duties include (but are not limited to):

1. Contacting the university student center to get permission to hold the workshop.
2. Securing dates, rooms, and ancillary personal (security, custodial, etc.) from the university student center.
3. Obtaining funding from hospitals, treatment centers, organizations, and companies (Abbott for example).
4. Creating a steering committee of interested dietitians, faculty members, students, members of the eating disorders specialists' group, and experts in the field of compassion fatigue.
5. Delegating tasks and responsibilities to the steering committee to secure presenters, organize volunteers, create handouts, order food and beverages, and accomplish any other assigned jobs.
6. Scheduling monthly meetings for the steering committee for the first three months then twice a month for the next two months leading up to the workshop. Additional meetings will be scheduled as needed.
7. Keeping in contact with and checking the progress of the members of the steering committee.
8. Serving as a speaker and facilitator during the workshop.

## Project Evaluation Plan

There are many different types of evaluation methods that can be used to determine the effectiveness of the program including outcome-based, goal-based, summative, and formative. It is important to choose the evaluation method that will provide the most useful and beneficial information to the stakeholders. The evaluation will also be used to improve and strengthen the professional development program in the future. Furthermore, the evaluation process substantiates that the professional objectives and goals are met.

To establish the effectiveness and success of the professional development program, I chose to use the summative evaluation method. Stiggins (2004) described summative evaluations as assessments of learning. The data collected from summative assessments can provide educators with constructive data that can be used to modify their instructional ways to improve student learning (Black & Wiliam, 2003).

The summative evaluation is a written questionnaire with Likert-style questions with room for written comments (see Appendix A). The questionnaires will be placed in the participants' program folder and will be collected at the end of the program. The participants will be awarded their CEU certificates after turning in their program evaluations.

The data from the questionnaires will provide participants' feedback on the entire workshop as opposed to each individual session. The summative evaluation will allow participants to offer feedback and suggestions for areas of improvement

for workshops in the future. The summative evaluations will also measure whether or not the goals of the workshop were attained.

### Overall Goals and Evaluation of Goals

The first goal of the professional development project is to create an environment where learning and training would occur in a supportive and collaborative atmosphere. Another goal is for the participants to be able to define, explain and identify compassion fatigue. A third goal is for the participants to be able to understand and explain the relationship between treating patients with eating disorders and the risk of developing compassion fatigue. Other goals include being able to identify and incorporate ways to manage and prevent compassion fatigue. A final goal for the summative evaluation is to provide key stakeholders including the nutrition and dietetics faculty members from local universities, nutrition and dietetic students and interns, future employers such as local hospitals and eating disorder treatment centers, and registered dietitians with information on how to manage and prevent compassion fatigue and improve dietitians' quality of life as well as patient care.

## Implications Including Social Change

Based on my research study, dietitians who treat patients with eating disorders are at risk for developing compassion fatigue, which can have a detrimental effect on the clinicians as well as the patients they treat. Therefore, the 3-day workshop was designed to educate dietitians who treat patients with eating disorders how to manage and prevent the development of compassion fatigue. This workshop addresses the needs of the dietitians in the local community by providing them with both an educational and

experiential experience. On the local level, a positive impact can be made on the dietitians who treat patients with eating disorders as well as the patients they care for. By instilling the importance of managing and preventing compassion fatigue, dietitians who treat patients with eating disorders can potentially be catalysts for change in the health care setting. These dietitians can share what they have learned about compassion fatigue to other dietitians, dietetic interns, and dietetic students. Furthermore, faculty members from the local nutrition and dietetic programs can participate in the workshop and, in turn, educate nutrition and dietetic students about compassion fatigue.

**Far Reaching**

After presenting the workshop in the local area, the next logical step would be to take the program to other large cities that have eating disorder treatment centers, hospitals with eating disorder units, eating disorders specialists, and universities that have nutrition and dietetics programs. Perhaps the program can be adapted for universities with nutrition and dietetics programs also. Faculty members can teach future nutrition and dietetics students about compassion fatigue and how to manage and prevent it, thereby improving dietitians' quality of life as well as patient care. The program can then be expanded to focus on other medical, nursing, and health care communities. On a global level, positive social change may result from better education about compassion fatigue and how to manage and prevent it for all health care providers.

## Conclusion

In Section 3, the professional development program was outlined and described based on the research findings described in Section 2. Included in Section 3 was the description of the program as well as the goals, rationale, review of literature, project design, potential barriers and solutions, implementation, timetable, evaluation plan, and social change. Section 4 includes my reflections and conclusions of this qualitative project study including project strengths, limitations, alternative approaches, scholarship, project development, leadership and change, implications, applications, and directions for future research.

# Section 4: Reflections and Conclusions

## Introduction

It is hard for me to believe that I am at the place in this very long doctorate journey where I am reflecting on this project study and offering conclusions. To me, the word reflection means seriously thinking about and considering. As a junior tennis player on the national circuit and then an All-American collegiate player, I used to reflect after every match: What were my strengths? What were my weaknesses? How could I perform better? As a marathon runner, I reflect after each race: What did I do right, what did I do wrong, and how can I improve? Now as a scholar, I am reflecting on these last few years of research and writing as well as this final project.

There is a need for education and training on compassion fatigue in registered dietitians who treat patients with eating disorders. Preparing dietitians who are entering into the field as well as seasoned dietitians specializing in eating disorders to be better equipped to manage and prevent compassion fatigue is crucial for patient care as well as the health, well-being, and job satisfaction of the clinicians. Educating nutrition and dietetic students, dietetic interns, and practicing dietitians about compassion fatigue was my goal at the beginning of this very long journey. Included in this section are the project strengths and limitations as well as recommendations for alternative approaches to the local program identified in this research study. Additionally, it includes scholarship, project development and evaluation, and leadership and change. This section concludes with my reflection of the importance of the work as well as implications, applications, and directions for future research.

## Project Strengths and Limitations

Education about ways to prevent and manage compassion fatigue is not currently required in nutrition and dietetics programs (Academy of Nutrition and Dietetics, 2018a). One strength of this project, a 3-day professional development program, is that it provides education about ways to prevent and manage compassion fatigue in dietitians who treat patients with eating disorders. The program provides education for dietetic students, dietetic interns, new dietitians, and seasoned dietitians, all levels of dietitians can benefit. Another strength of the program is that dietitians can earn CEU credits by attending. A further strength of the project is the assistance and support from the stakeholders as both the dietitians who treat patients with eating disorders and the dietetic educators are on board to help create the education needed to manage and prevent compassion fatigue in dietitians who treat patients with eating disorders. Stakeholder involvement is ideal in health research because they can assist with research and interventions that are appropriate to stakeholders' needs (Boaz, Hanney, Borst, O'Sheal, & Kok, 2018). Finally, the program is affordable as financial constraints are addressed through sponsorship, lowered fees, student rates, and volunteer positions.

A limitation of this project involves the buy-in from the registered dietitians who treat patients with eating disorders. As explained by DE3, "We work, work, work-we should be helping others – not getting help ourselves." The dietitians will need to be willing and open to spending 3 days not working and instead learning about compassion fatigue and how to prevent and manage it. Another limitation is that the project is geared to a very specific population, that of registered dietitians who treat patients with eating

disorders. This is a limited population, and, as a result, it might be difficult to get enough attendees to make the program worthwhile.

## Recommendations for Alternative Approaches

There are alternative approaches that could have been deemed appropriate for this project. One option is an online program where participants read professional articles and journals and then watch the power point presentation, which is web-enhanced with audio included. The participants can complete the online program at their leisure and then submit a pre- and post-test plus a comprehensive final exam to assess formative learning. Offering the course online is a solution to tackling the time constraints dietitians face while still allowing them to partake in the program. The downside of this format is that the participants would not have the opportunity to ask questions or participate in the group discussions. Furthermore, they would not be able to collaborate with others during the learning process.

Another option is a 16-week class at the university. This class could be a requirement for the Accreditation Council for Education and Dietetics (ACEND) program. The class can be comprised of power point lectures, expert guest speakers, group presentations, and exams. There can be a textbook as well as a workbook on compassion fatigue, self-care, and resilience. Offering the mandatory course would ensure that the nutrition and dietetics students would be exposed to compassion fatigue prior to entering the professional field. The downside would

be that the course is limited to university students; therefore, the dietitians in the community would not have the opportunity to access the information.

## Scholarship

"A journey of a thousand miles begins with a single step" is a Chinese proverb that originated as "A journey of a thousand Chinese miles starts beneath one's feet." This saying teaches that the longest and most difficult undertakings have a starting point, which begins with one step. I feel like my entire EdD program, which began with a dream, was a journey of a million miles. This project study, which began with an idea, was the most tedious endeavor I have ever completed and one that I am incredibly proud of. This project took an incredibly large amount of dedicated time and purposeful planning.

Identifying a local problem, summarizing it in a scholarly way, and finding supporting research was a very long and arduous process that took extensive honing and many rewrites. The literature review that supported the local problem and problem on a larger scale was nothing short of daunting. The actual interviews and analysis of the data was a fascinating process for me. From each interview that I completed, I learned more about how to be an effective interviewer. Using the six-step thematic analysis of Clarke and Braun (2014) I learned how to code data from transcribed interviews. Finally, from the coded data I developed themes that related to the research questions.

At the beginning of this journey, my scholarship skills were quite undeveloped. Throughout this journey, my scholarship skills have been cultivated and are still being refined. While I do not aspire to be a research clinician, I am confident that when I do

need to conduct research, I will be able to do so without hesitation. This project study taught me that scholarship moves through many stages, some easily, some with difficulty, some move quickly, others slowly. Each stage of the process was certainly a learning experience.

## Project Development

Designing and creating the 3-day professional development program was the most exciting and favorable part of this entire journey for me. It was the one part of this project study that I actually felt confident while developing it. As mentioned in a prior subsection, I have designed and put on many eating disorders conferences in the past. I also have been teaching college courses for the past 15 years. As a result, I am comfortable with developing a program as well as delivering the information. I enjoy project development as well as public speaking, so this part of the project was truly a pleasure for me to concur.

This professional development program addresses the identified gap in practice between the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders and the possible need for education to prevent or manage it. This professional development program involves a 3-day workshop where participants will learn the definition, explanation of, and information about compassion fatigue. Participants will receive training on how to handle clients' pain, suffering, and trauma through self-regulation and relaxation; will learn the benefits of seeking support from therapists, friends, and family as well as learning to understand the importance of and

how to implement setting boundaries and taking breaks. Perhaps most crucial participants will learn the importance of and how to implement self-care.

This in-person 3-day workshop offers training from experts in the field of compassion fatigue who are passionate about educating clinicians about the ways to both manage and prevent compassion fatigue while increasing compassion satisfaction. The workshop will include lectures using power point slides, hands-on activities, breakout sessions, and interactive discussions. Guided yoga, mindfulness, relaxation, Pilates, and meditation will also be offered. By working on every phase of the project from the organizational parts to the actual power point slides and activities, I have a true understanding of the topic as the developer and the participants will as well.

## Analysis of Self as a Scholar

The journey to achieve my EdD actually began about nine years ago when I was in Arizona at an on-site visit to an eating disorders residential treatment program. One morning at breakfast, I noticed a dietitian who was also on the on-site visit busy at work on her computer. We began talking and she showed me the Walden online doctorate program she was immersed in. She was so enthusiastic about the program and spoke very highly of the classes and the professors. When I got back to Houston, I went to a recruiting dinner that Walden hosted and before I knew it, I was enrolled in the EdD program.

I've never considered myself particularly intellectual or scholarly and I also have the tendency to procrastinate. As a result, I never thought I could actually complete my doctorate. The further I got, however, and with the support of my first chair, Dr. Borja, I

began to think that maybe I could really finish this. Then, life happened, and my mom tragically suddenly died. She always wanted one of her children to become a "doctor". My two siblings went to law school and work in the legal field, so it was up to me to get a doctorate (medical school seemed out of the question at this stage in my life). And so, I persisted.

This journey has assisted me in so many ways. Each discussion post as well as every paper and project completed throughout the program has helped me to grow as a student, clinician, and educator. It has taught me that the more I learn, the more I realize that there is so much more to learn and to unlearn. I read somewhere that knowledge takes you from darkness to more darkness, meaning the more you learn the more you realize that there is a lot that you still do not know. I have found that to be so true throughout my entire journey. I have also realized that compassion fatigue is prevalent in dietitians who treat patients with eating disorders, and it is so important to provide education to manage and prevent it. After I implement the program to dietitians, I plan to expand the program to other clinicians including therapists, medical doctors, nurses, and other healthcare providers. I think that anyone in the helping field can benefit from learning about compassion fatigue.

## Analysis of Self as a Practitioner

For the past 26 years, I have been a practicing dietitian specializing in treating patients with eating disorders. For the past 15 years, I have been an adjunct faculty member in the nutrition and dietetics department at University of Houston, main campus. In my various roles as an educator, I have combined the science of nutrition, the art of

counseling, and the field of teaching. I feel as though I have made a significant difference in the patients I have treated as well as the students I have taught.

The field of dietetics and the educational field of nutrition and dietetics is constantly changing and evolving. It is my job as a practitioner and an educator to change with the times and continue developing as a professional. Education about compassion fatigue is not currently required in nutrition and dietetics programs, however as an educator, in the near future. I will be teaching about compassion fatigue in the Introduction to Nutritional Counseling course that I teach at University of Houston. I will include symptomatology, risk factors, and protective factors of compassion fatigue with the upper level nutrition and dietetics students that I teach. In my private practice, I will teach the dietetic interns about compassion fatigue throughout their rotation with me. It is my hope that after the 3-day professional development program, other dietetic educators, supervisors, and practitioners will also incorporate the teaching of compassion fatigue into their classes and practices. According to Alkema, Linton, and Davies (2008), "These discussions will normalize the experience of compassion fatigue and thus encourage early intervention. It is important for both supervisors and interns to understand the symptoms of compassion fatigue because the onset of symptoms may be rapid as a result of exposure to client material" (p. 115).

## Analysis of Self as a Project Developer

In regards to this study and project development, I feel as though I will have contributed significantly at the local level, and I am hoping to take this project to a higher level and to broader audiences. I have participated in many project developments in the

past, however, this one was much more detailed, thorough, and in depth. During the past, the projects I developed and led were less detailed and less structured. For this project, I was forced to be more organized, meticulous, and specific. I was able to use my experiences as a registered dietitian specializing in treating patients with eating disorders, an adjunct faculty member, and a public speaker to make the project interesting, exciting and thought-provoking. The final project was created because of the data analysis and will be used to educate dietitians how to manage and prevent compassion fatigue when treating patients with eating disorders. I am very proud of how well the project turned out and am proud that I will make a difference in the lives of clinicians. I truly believe that this is just the beginning and I will be able to expand this project to other populations, enabling me to touch so many clinicians.

## Leadership and Change

For more than 25 years, I have practiced as a registered dietitian specializing in eating disorders. Additionally, for the past 15 years, I have taught at a large Tier One university. Throughout my career as a dietitian and educator, I have consistently been independent and influential in my area of expertise. I was the second dietitian in Houston to open a private nutritional counseling practice specializing in eating disorders. At one time my practice was one of the largest private nutritional counseling practices specializing in eating disorders in Houston and in the state of Texas. Throughout the years in practice, I have supervised and trained dietitians who went into the field of eating disorders. To this date, seven dietitians who I trained and employed went on to open their own private practices specializing in eating disorders.

At the university, I created two courses, one of which has become a required course for nutrition students who are on the ASCEND track. I have also taught thousands of students, many of whom went on to specialize in the field of eating disorders. I feel as though I have had an influence in the fields of dietetics and eating disorders.

As a result of my experiences, my research focused on compassion fatigue in dietitians who treat patients with eating disorders. I believe that this research and project has allowed me to impact a social change at a local level and in the future will have an impact at the state, national, and perhaps on an international level. The research as well as the creation and development of the project has shown me that I can be more than a dietitian and adjunct faculty, I can be a program leader helping all types of caregivers at local, state, national, and international levels.

**Reflection on Importance of the Work**

I have dedicated my career as a registered dietitian to treating patients who have eating disorders as well as teaching future dietitians how to treat patients with eating disorders. I wholeheartedly believe in the importance and significance of the work that dietitians do in the field of eating disorders and I know the challenges that are faced as a result of working with this challenging population. Those challenges were described in detail in this study.

Some researchers suggest that compassion fatigue is presently more common among caregivers because of increased patient loads, a shortage of healthcare providers, and budget constraints (Lanier & Brunt, 2019). Furthermore, because of the challenges and complications presented with eating disorders and the stress involved in treating

patients who struggle with eating disorders, clinicians who work with this population may experience compassion fatigue (Abbate-Dage et al., 2013). Regardless of the causes of compassion fatigue, the results are costly personally, professionally, and financially.

I have experienced compassion fatigue and I have witnessed other caregivers who have experienced compassion fatigue. I truly understand and appreciate the effects that compassion fatigue has on caregivers, patients, families, friends, and institutions. These experiences have been the impetus and drive for the completion of my doctoral research.

The focus of this study was on the risk of compassion fatigue, ways to manage and prevent it, and the possible need for professional education for registered dietitians who treat patients with eating disorders. I interviewed both registered dietitians who treat patients with eating disorders and faculty members at a university, which has a nutrition and dietetics program. Through the basic qualitative research design, I created a detailed plan on ways to manage and prevent compassion fatigue in dietitians who treat patients with eating disorders. This plan includes a 3-day learning workshop that can easily be adapted to the needs of other healthcare providers.

Personally, this comes at a perfect time in my life as I am at a point where I would like to stop seeing patients at my private practice to move towards offering workshops and classes on compassion fatigue. Instead of taking care of patients, I would like to help caregivers take care of themselves. I will also include compassion fatigue in my curriculum at the university to teach future dietitians about compassion fatigue including ways to identify, manage and prevent it. The research I have conducted, as well as the 3-

day program I developed has been the impetus for me to create positive social change in healthcare providers.

**Implications, Applications, and Directions for Future Research**

Throughout my research, I was unable to find published literature on compassion fatigue in dietitians who treat patients with eating disorders. As far as I know, this is the first research study on the perceptions of dietitians and dietetic educators regarding the risk of developing compassion fatigue in registered dietitians who treat patients with eating disorders as well ways to manage and prevent compassion fatigue and the possible need for education for these clinicians. There are many opportunities for future research based on the findings of this study.

This particular study used a small sample size of 8 total participants, four registered dietitians and four dietetic educators. The dietitians all specialized in treating patients with eating disorders and the dietetic educators were all faculty members at the same university. Additional studies can be conducted using larger diverse groups of dietitians and dietetic educators. For example, dietitians who specialize in oncology, renal disease, diabetes, cardiology, and other areas aside from eating disorders can be studied in relationship to compassion fatigue. Furthermore, the other types of dietetic educators including dietetic preceptors, clinical managers, and clinical supervisors can be targeted for the research.

Even more studies can be conducted using other types of clinicians with different areas of expertise. Physicians, nurses, social workers, therapists, physical therapists, physician assistants and more with all different specialties for instance. Their perceptions

of the risk of developing compassion fatigue, ways to prevent and manage it and the possible need for education can be used for research. On an even larger scale, research can also be done on compassion fatigue in other caregivers including firefighters, chaplains, police officers, and attorneys, just to name a few.

## Conclusion

The purpose of the study was to investigate the perceptions of registered dietitians and dietetic educators on the risk of compassion fatigue, ways to manage and prevent the development of compassion fatigue, and to explore the possible need for professional education for registered dietitians who treat patients with eating disorders. An extensive literature review provided the groundwork to move forward with interviewing both dietitians who treat patients with eating disorders and dietetic educators. The analyzed data provided an in-depth picture of the dietitians' perceptions of the risk of developing compassion fatigue as well as ways to manage and prevent compassion fatigue as well as the education needed thereof. As a result of the study, a 3-day workshop was designed to educate dietitians who treat patients with eating disorders on ways to identify, manage, and prevent the development of compassion fatigue. This workshop addresses the needs of the dietitians in the local community by providing them with both an educational and experiential experience. Although this particular workshop is tailored specifically to registered dietitians who treat patients with eating disorders, the workshop outline, schedule, lectures, and activities can apply to other healthcare providers. The workshop can be customized to fit the educational

needs of other clinicians and healthcare providers as well as other caregivers. By learning practical ways to manage and prevent compassion fatigue, health care providers have the opportunity to improve their own lives as well as having the opportunity to positively affect the lives of the patients for whom they care.

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Appendix A: The Project

# The Cost of Caring: Day One

## Optional Morning Event

| | |
|---|---|
| 7:00 – 7:45 a.m. | Mindful Yoga (Bring your own mat) |

## Program Schedule

| | |
|---|---|
| 7:45 – 8:15 a.m. | Continental Breakfast/Registration |
| 8:15 – 8:45 a.m. | Introduction to Caryn Honig and summary of research on CF |
| 8:45 – 10:15 a.m. | Keynote Speaker #1 (Compassion Fatigue) |
| 10:15 – 10:30 a.m. | Break |
| 10:30 – 11:45 a.m. | Slides 2-16 |
| | Journal |
| 11:45 a.m.– 12:45 p.m. | Lunch |
| 12:45 – 2:00 p.m. | Slides 17-43 |
| 2:00 – 2:15 p.m. | Break |
| 2:15 – 3:45 p.m. | Slides 44-52 |
| 3:45 – 4:00 p.m. | Guided meditation |
| 4:00 p.m. | Closing remarks |

# The Cost of Caring: Day Two

## Optional Morning Event

| | |
|---|---|
| 7:00 – 7:45 a.m. | Mindful Meditation (Bring your own mat) |

## Program Schedule

| | |
|---|---|
| 7:45 – 8:15 a.m. | Continental Breakfast/Registration |
| 8:15 – 8:30 a.m. | Caryn Honig and summary of Day 1 |
| 8:30 – 10:00 a.m. | Keynote Speaker #2 (Trauma, CBT, DBT) |
| 10:00 – 10:15 a.m. | Break |
| 10:15 – 11:45 a.m. | Slides 53-61 |
| | Journal |
| 11:45 a.m.– 12:45 p.m. | Lunch |
| 12:45 – 2:00 p.m. | Slides 62-69 |
| | CBT activities |
| 2:00 – 2:15 p.m. | Break |
| 2:15 – 3:30 p.m. | Slides 70-77 |
| 3:30 – 4:00 p.m. | Guided meditation |
| 4:00 p.m. | Closing remarks |

# The Cost of Caring: Day Three

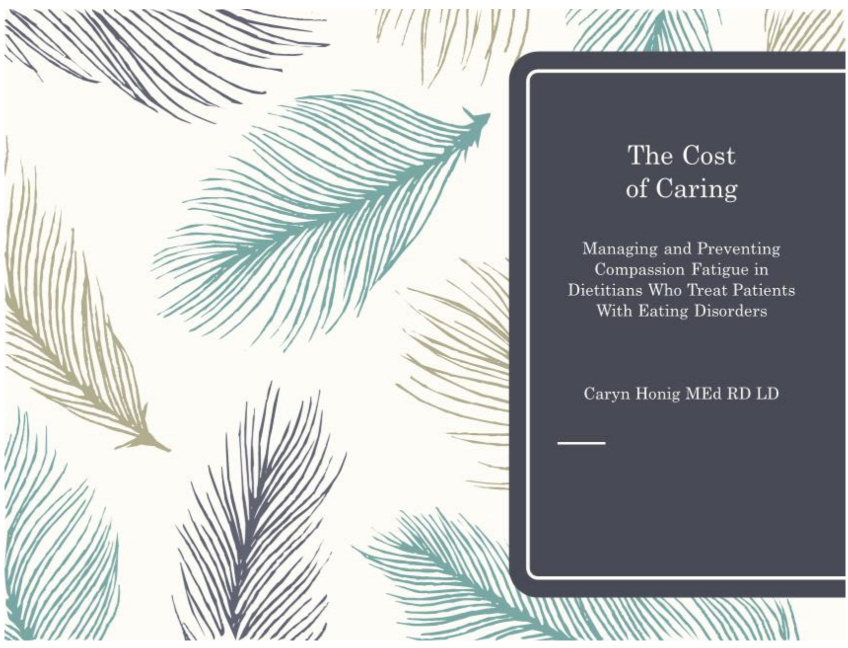
## Optional Morning Event

| | |
|---|---|
| 7:00 – 7:45 a.m. | Mindful Pilates (Bring your own mat) |

## Program Schedule

| | |
|---|---|
| 7:45 – 8:15 a.m. | Continental Breakfast/Registration |
| 8:15 – 8:30 a.m. | Caryn Honig and summary of Day 2 |
| 8:30 – 10:00 a.m. | Keynote Speaker #3 (Self-Compassion) |
| 10:00 – 10:15 a.m. | Break |
| 10:15 – 11:45 a.m. | Slides 78-89 |
| | Journal |
| 11:45 a.m.– 12:45 p.m. | Lunch |
| 12:45 – 2:00 p.m. | Slides 90-99 |
| 2:00 – 2:15 p.m. | Break |
| 2:15 – 3:30 p.m. | Slides 100-103 |
| 3:30 – 4:00 p.m. | Guided meditation |
| | Evaluations/CEU’s |
| 4:00 p.m. | Closing remarks |

Slide 1:




Slide 2:

*"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."*

R.N. Remen

Slide 3:

## Silent Witness
## *The Effects of Our Work*

– On your index card, write down three (3) negative effects from your work as a caregiver.

– For 3-5 minutes, circulate around the room allowing others to see your card.

Source: Saakvitne, Gamble, Pearlman & Lev (2000). Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse. Sidran Press.

Slide 4:

- The prevalence of compassion fatigue is high among helping professionals.
- ~79% of hospice nurses have moderate to high rates of compassion fatigue (Wicks, 2006)
- 50% of child welfare workers are impacted and 54% of medical residents are impacted (Borritz et al, 2006)
- American surgeons indicate that they think about suicide 1.5-3 times more than the general population (Beyond Blue, 2013)
- Mental health specialists are at high risk for compassion fatigue and burnout (Teater & Ludgate, 2014)

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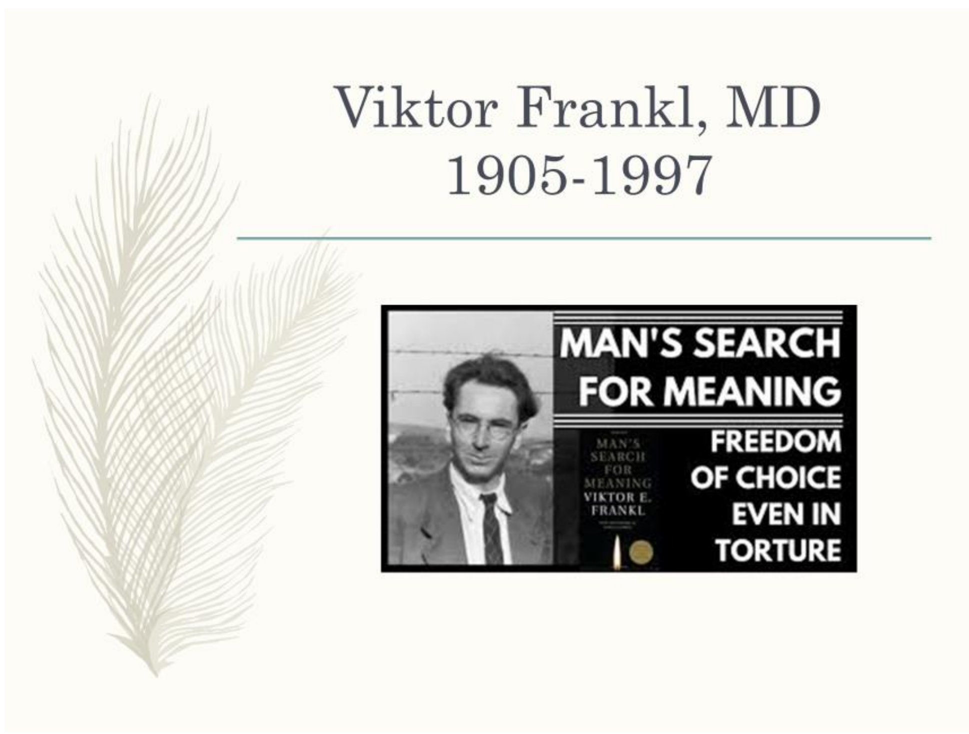
Slide 5:

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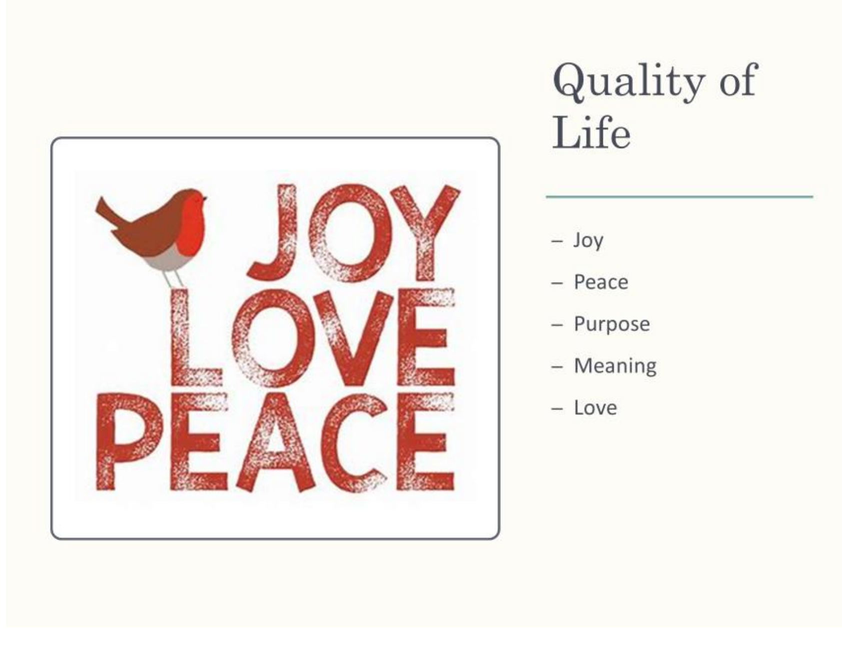

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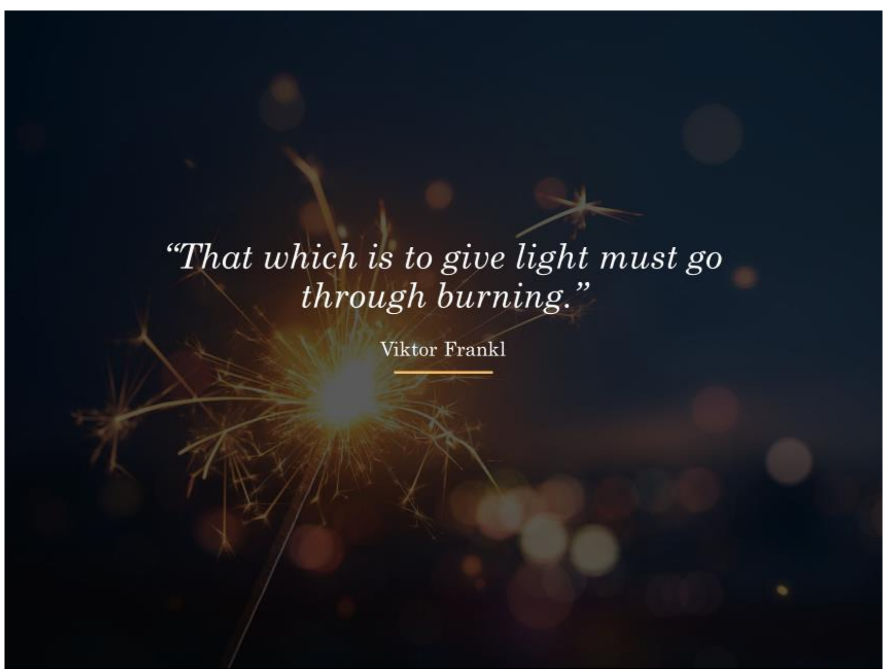


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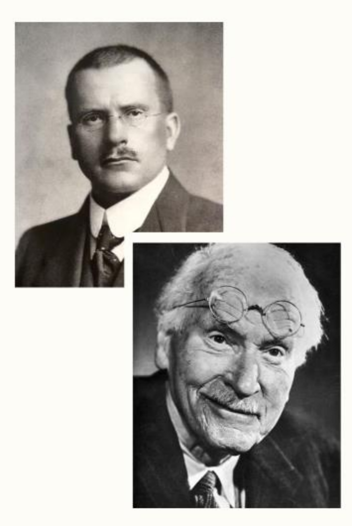


Introduction to Compassion Fatigue

Carl Jung (1889-1961)

- First modern writer about the negative affects of caregiving.
- Going into the patient's life means the doctor loses some of his health while the patient gains health.
- The doctor did not choose this profession by chance.

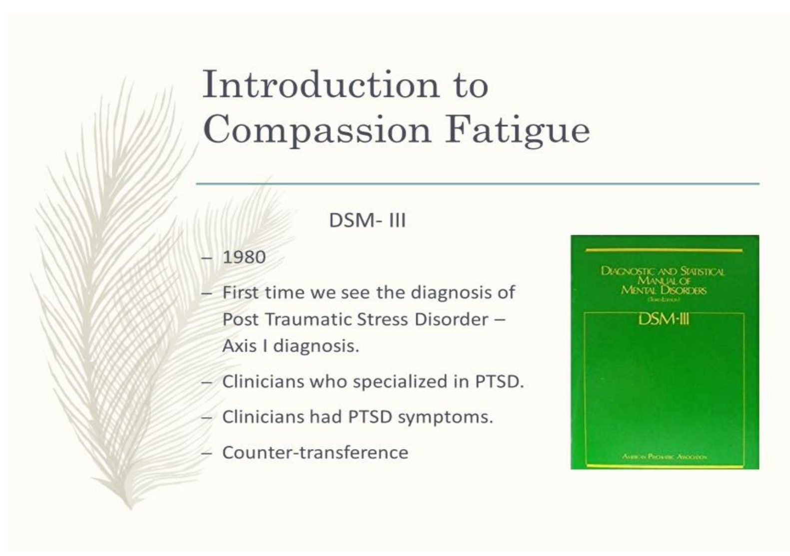
Slide 9:

# Introduction to Compassion Fatigue

Yael Danieli

- Mid 70's worked with survivors of the Holocaust.
- Trained other professionals to work with survivors.
- "Conspiracy of silence"
- Trauma – it's important to own the narrative and share the narrative.
- Caregivers could not tolerate the trauma.

Slide 10:



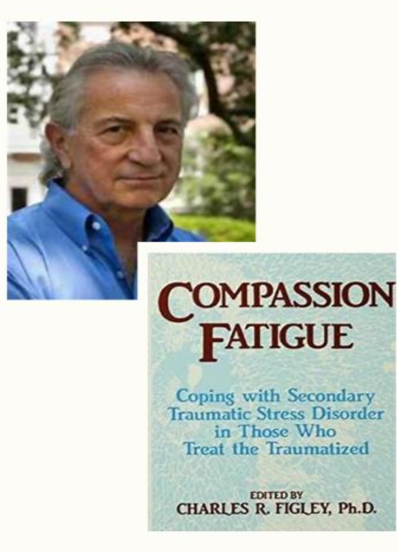
Slide 11:

# Introduction to Compassion Fatigue

Carla Joinson RN (1992) coined the term compassion fatigue.

She described compassion fatigue in nurses as a form of burnout and postulated that the same personality traits that lead a person into nursing put that same person at risk for compassion fatigue.

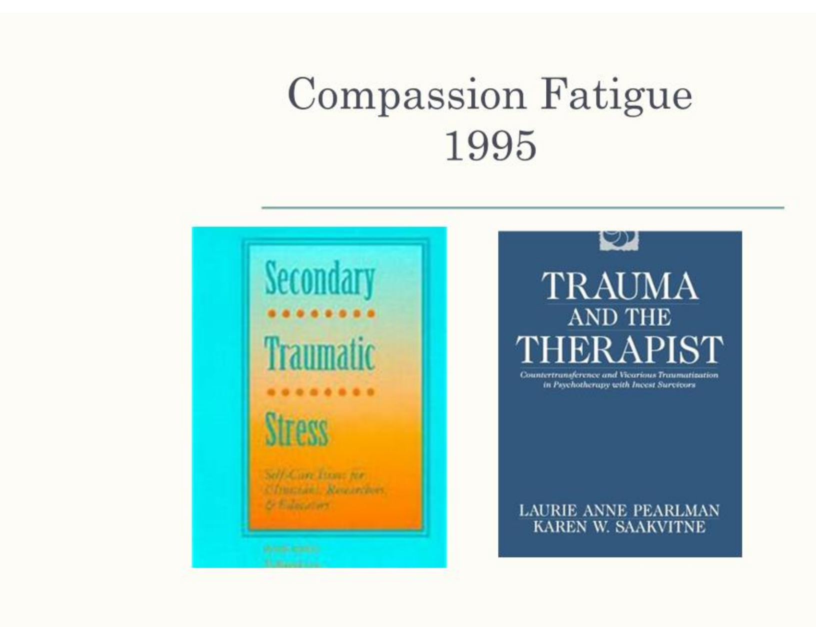
Slide 12:




# Introduction to Compassion Fatigue

- 1995: Big year for compassion fatigue.
- Compassion fatigue becomes part of the fabric of working with traumatic stress.
- Charles Figley writes an important book about compassion fatigue.

Slide 13:



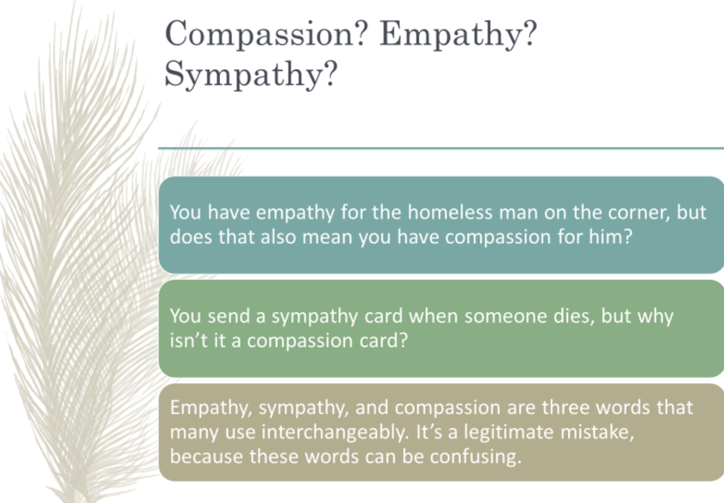

Slide 14:

Slide 15:

## Mother Teresa Understood Compassion Fatigue

– She wrote in her plan to her superiors that it was MANDATORY for her nuns to take an entire year off from their duties every 4-5 years to allow them to heal from the effects of their care-giving work.

Slide 16:



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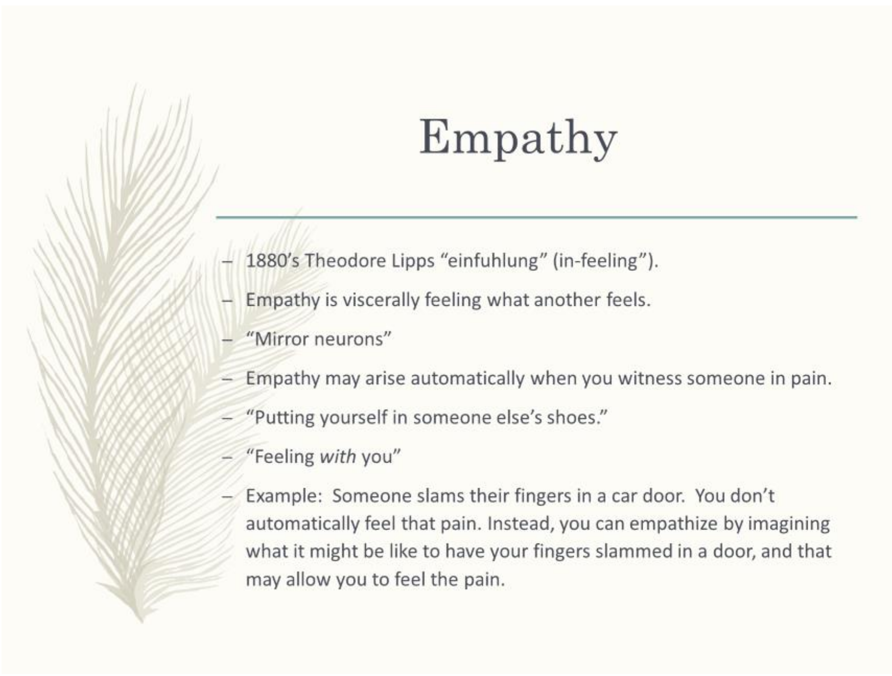

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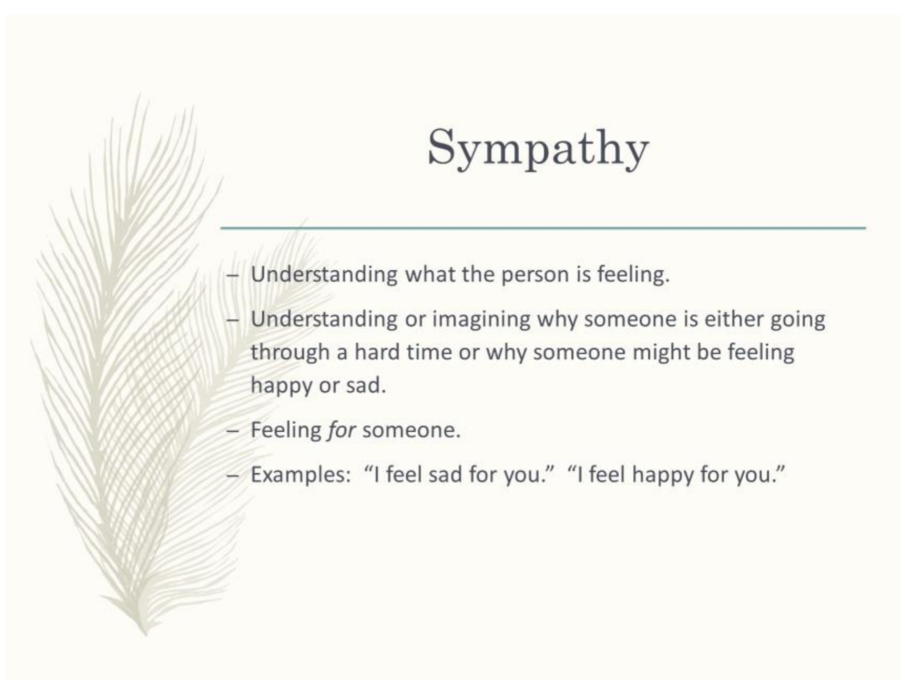


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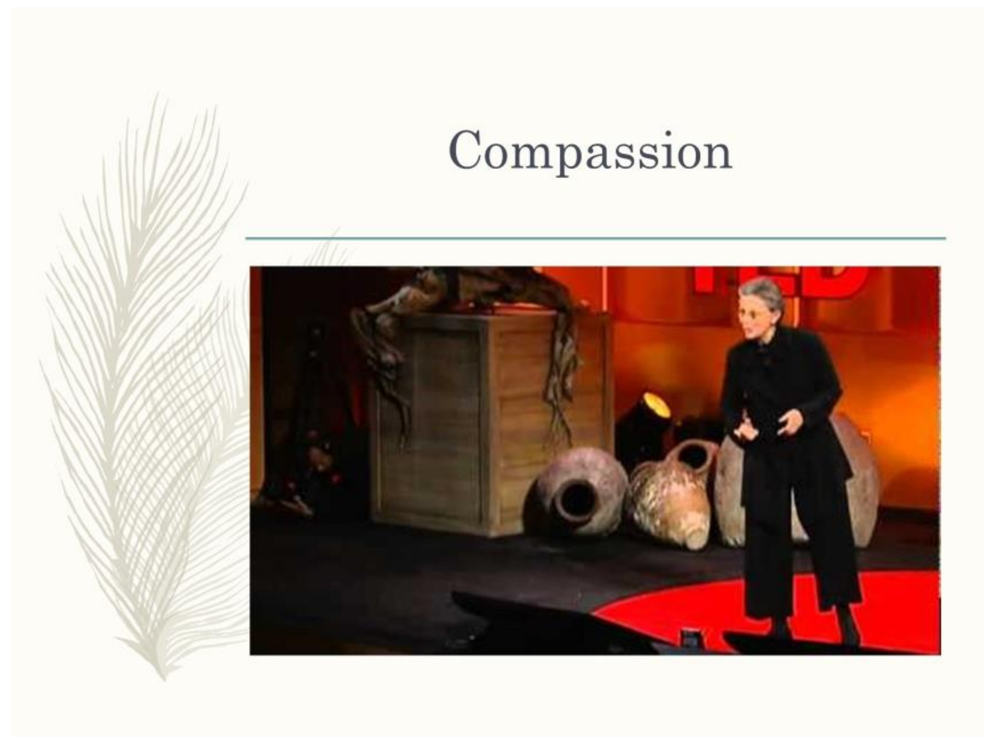
Slide 21:

Slide 22:



Slide 23:

## Compassion Fatigue Definitions

– Figley (1995) described compassion fatigue as a state of tension and preoccupation with traumatized clients in which the counselor reexperiences traumatic events disclosed by the client, avoids reminders of client material, and experiences persistent anxiety associated with the client.

– Rank et al. (2009) expanded this definition, suggesting that compassion fatigue had an interactive—or synergistic—effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted clinician.

Slide 24:

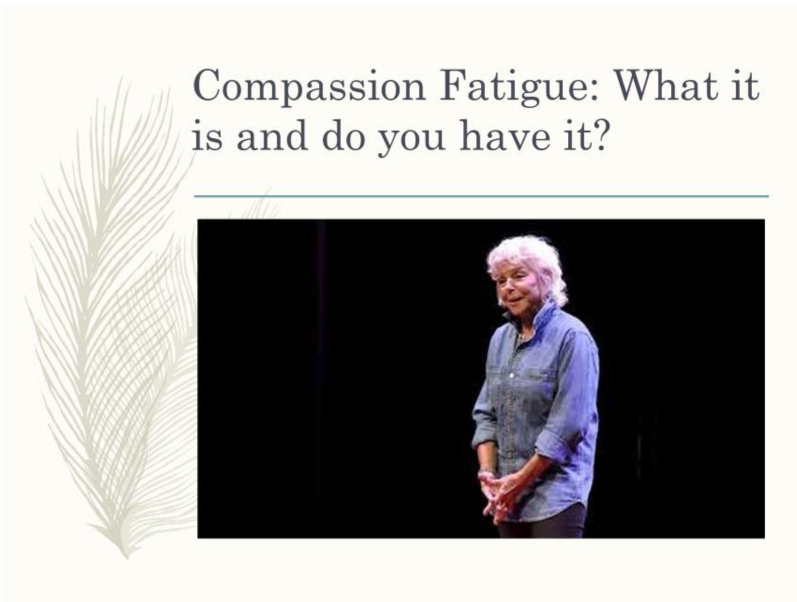
## Compassion Fatigue Definitions

– Alkema et al. (2008) explained compassion fatigue as a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain—a possible consequence of clinicians' awareness of the suffering of clients coupled with the wish to relieve it.

– Similarly, Rank et al. described compassion fatigue as a condition that is a consequence of a depletion of internal emotional resources.

Slide 25:

Slide 26:



Slide 27:

"I don't think this is doing me any good."

# Burnout

- General exhaustion and lack of interest or motivation regarding one's work.
- The chronic condition where the perceived demands outweigh the perceived resources.

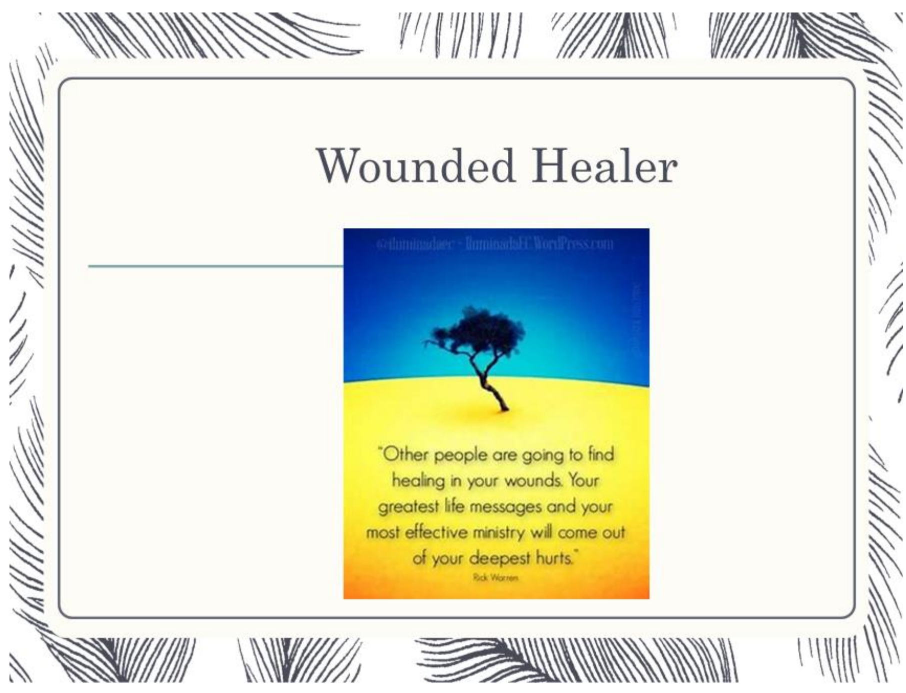
(Gentry, 1988)

Slide 28:

# Counter-transference
# Vicarious Trauma
# Secondary Traumatic Stress

- **Counter-transference:** when a clinician transfers feelings or emotions to a client/patient.
- **Vicarious Trauma:** emotional residue of exposure that clinicians have from hearing patients' trauma, pain, fear and terror. A change in worldview might happen.
- **Secondary Traumatic Stress:** the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Clinicians exhibit symptoms like the sufferers.

Slide 29:

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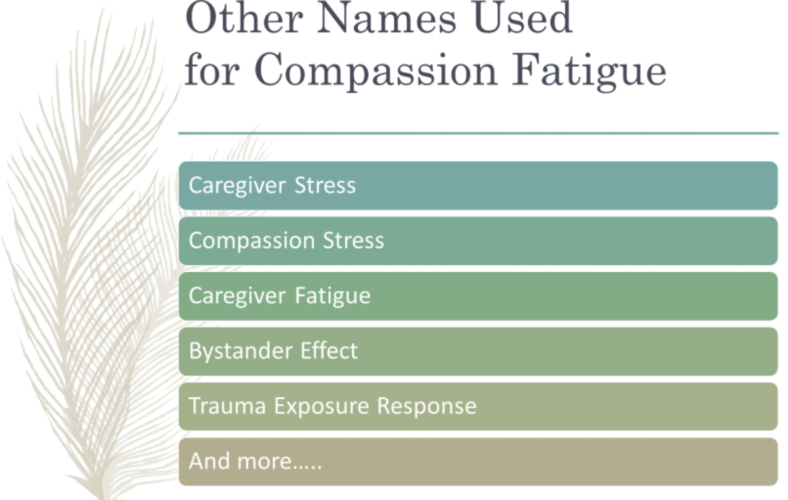

Slide 31:

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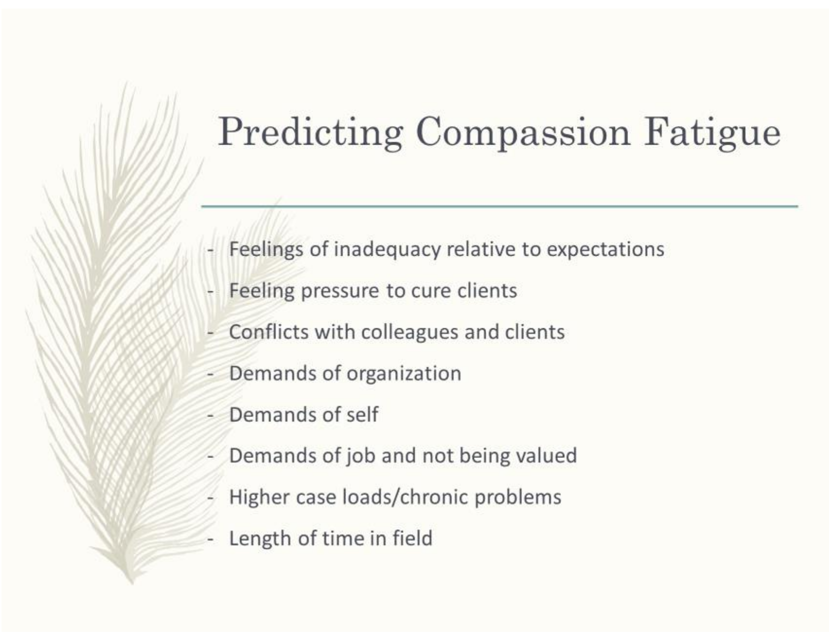


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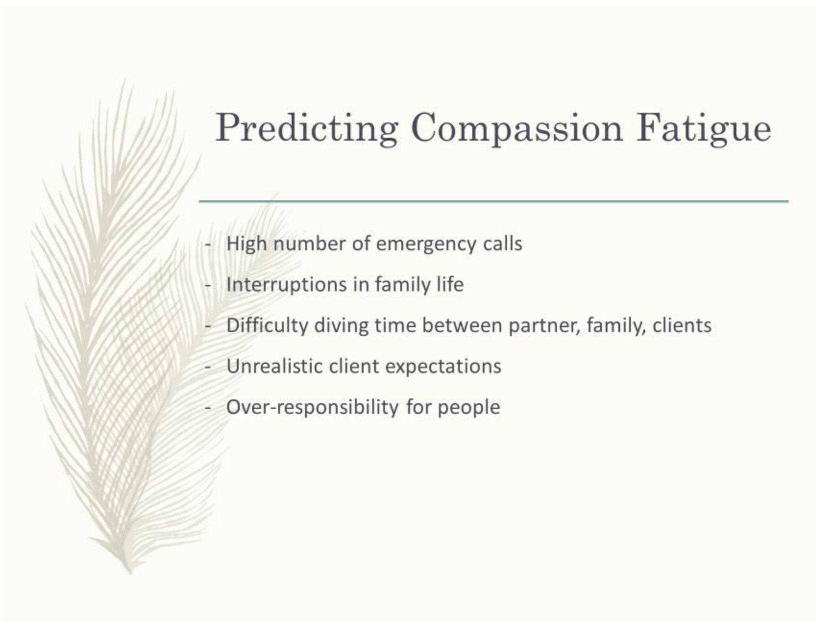

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Slide 36:

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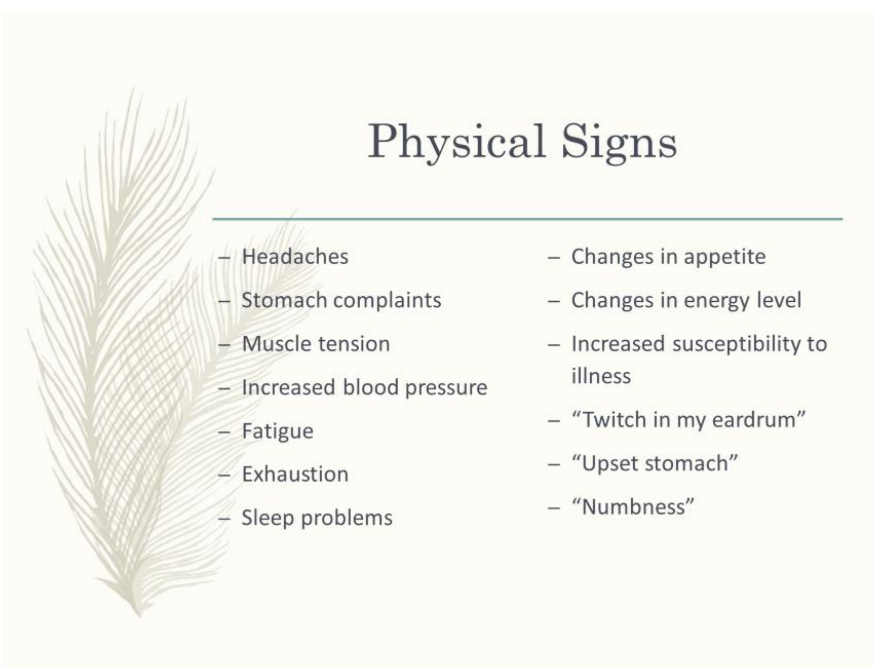


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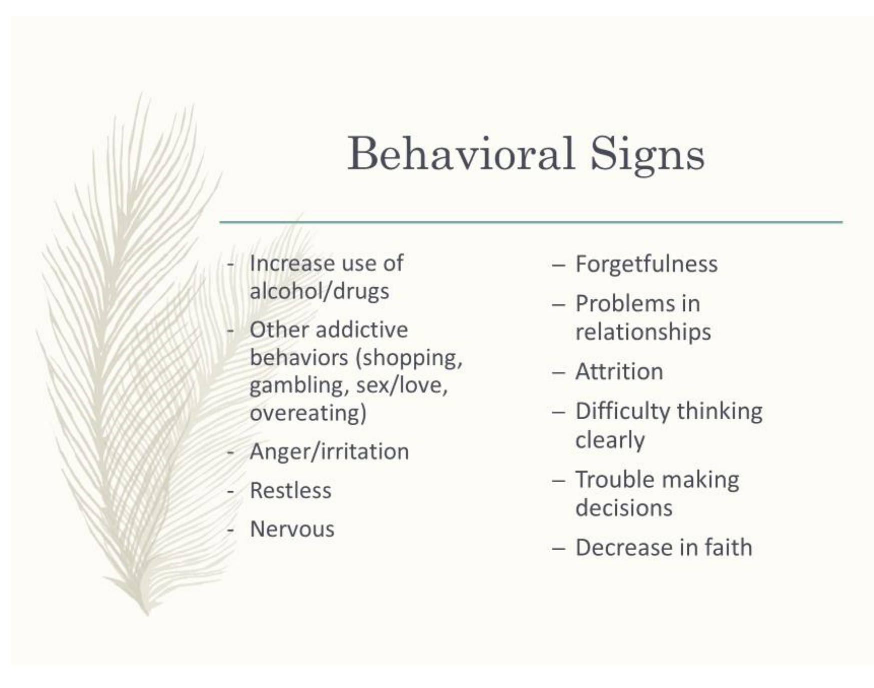

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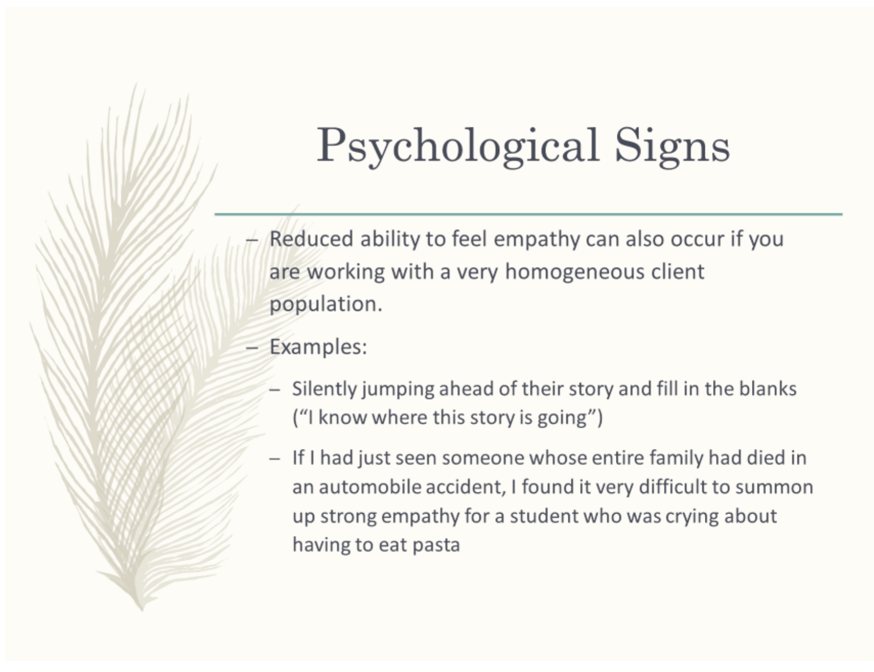

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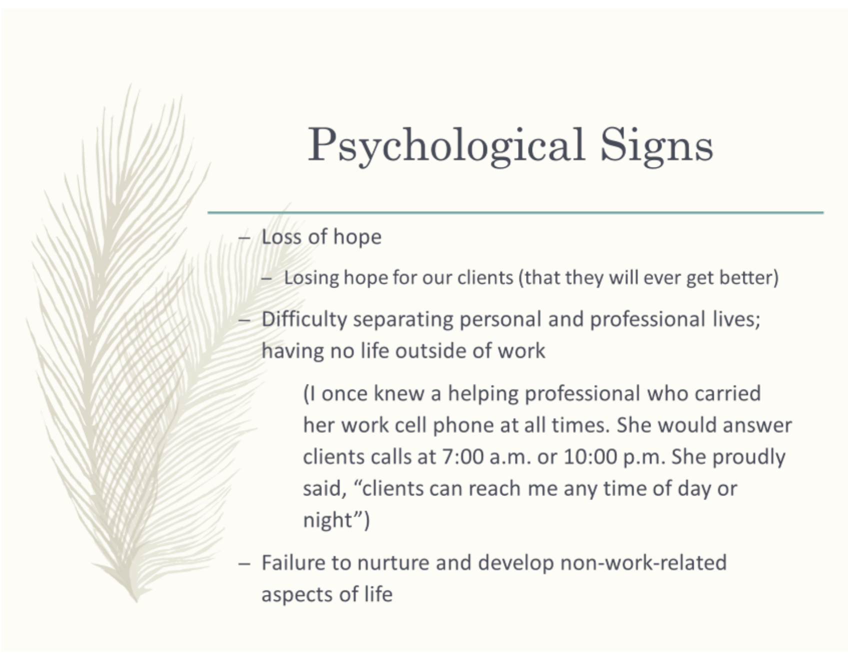

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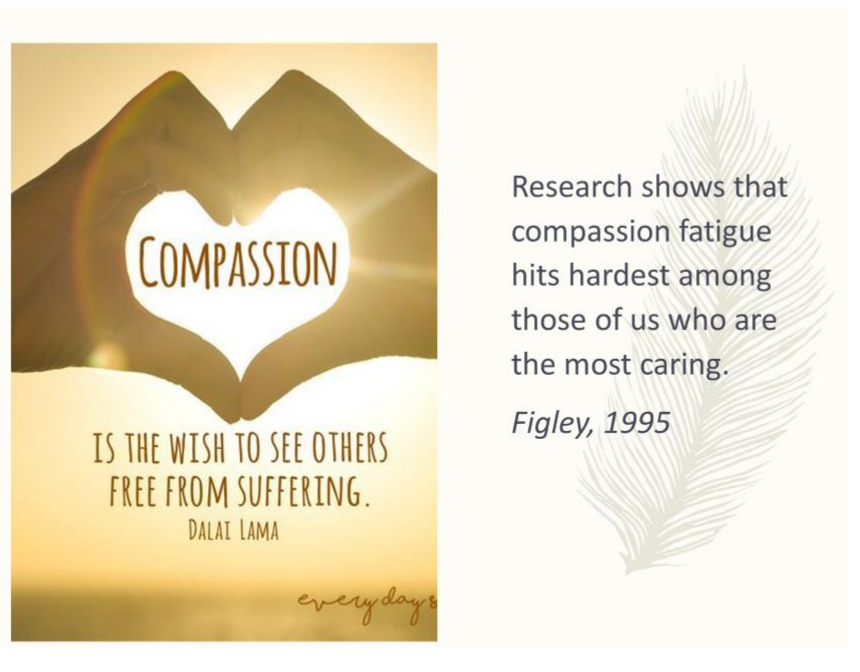

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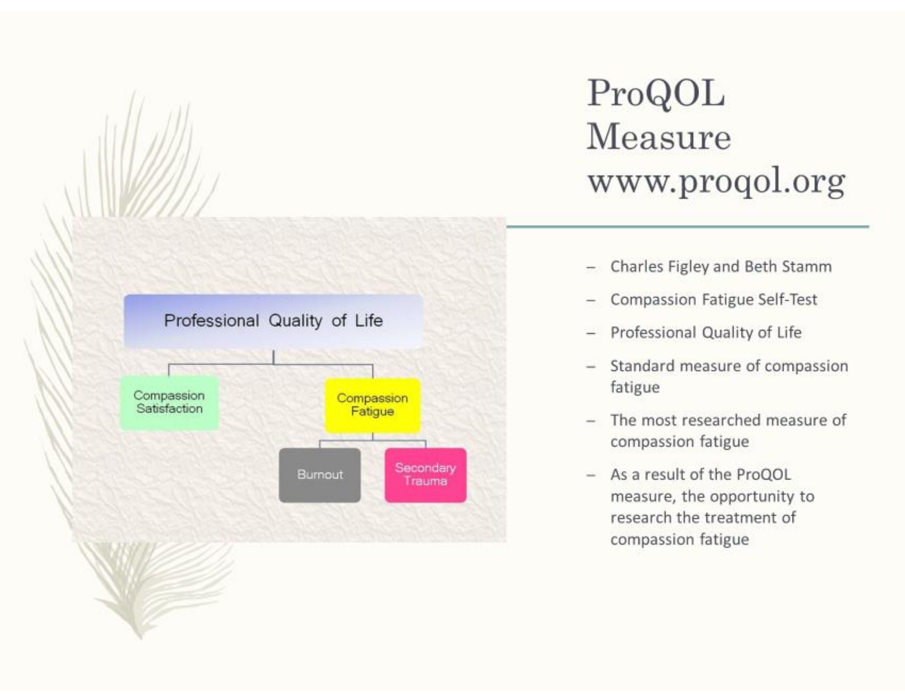


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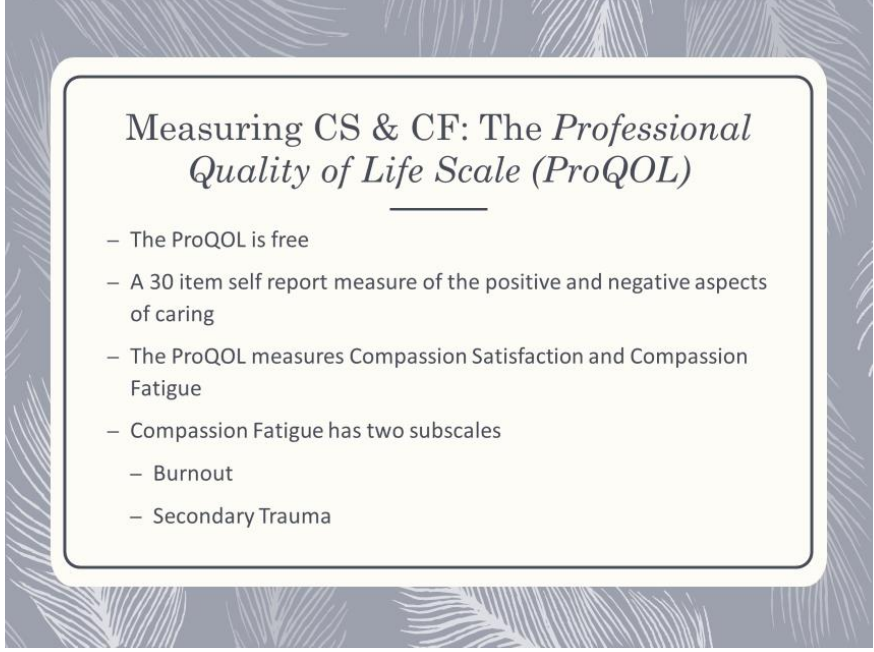


Slide 51:

Well Established

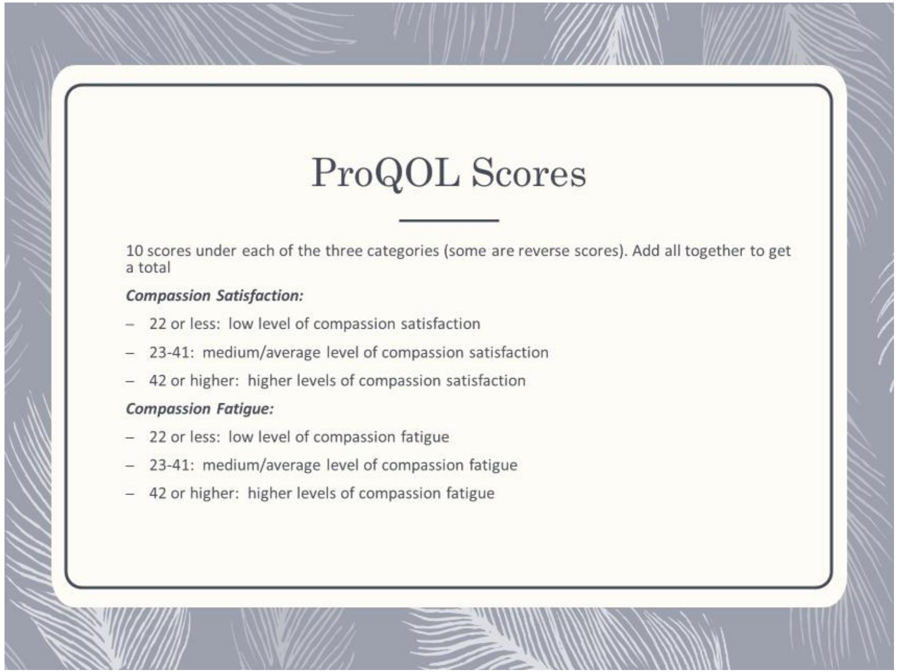
– The ProQOL is the most widely used measure of the positive and negative aspects of helping in the world
– The ProQOL has proven to be a valid measure of compassion satisfaction and fatigue
– It has been used for over 15 years
– The measure was developed with data from over 3000 people

Slide 52:

Interpreting Scores

– Scores on individual scales tell us about a person's responses on each of the constructs
– Viewing the combination of scores helps us "paint a picture" of what the person is telling us
– Can be used to track an individual's CS and CF

Slide 53:

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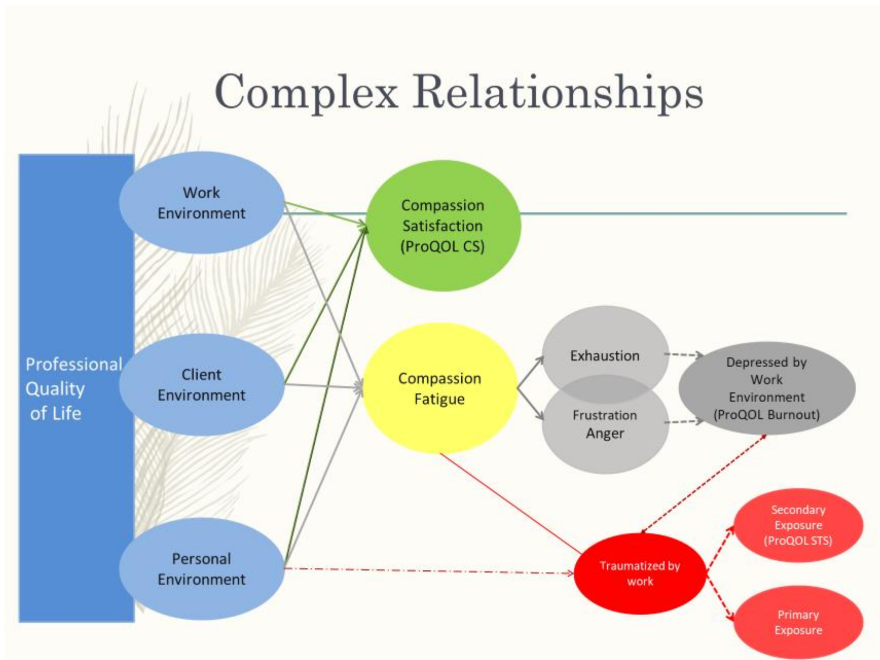

Slide 55:

Slide 56:

Slide 57:

Is Your Job Stressful?

– Come up with a list that causes this stress?
– What are the negative effects of this stress (personal and professional)?
  – Food, alcohol, snarky, loss of joy, loss of sense of humor, headache........

Slide 58:

These "stressors" are not the cause of your stress/negative effects in your life

***- What causes stress?***
- It is the perceived threat from past experiences (examples – traffic, criticism, public speaking)
- Example: fear in a parking garage
- It happens before you are even conscious of it
- What are physical responses when we perceive threat?
- How does this effect you long-term? (Post-traumatic stress)

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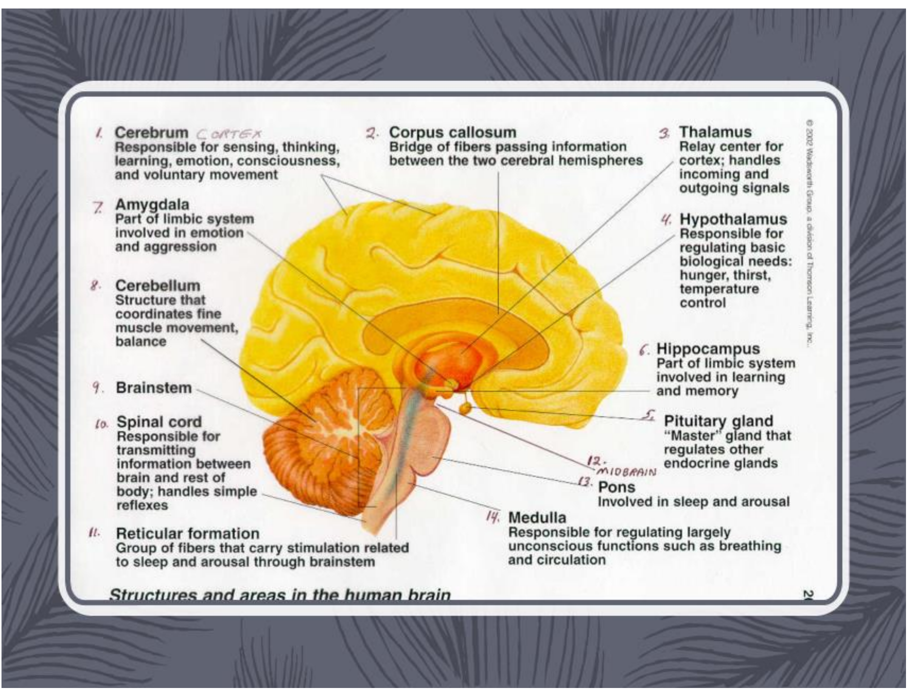


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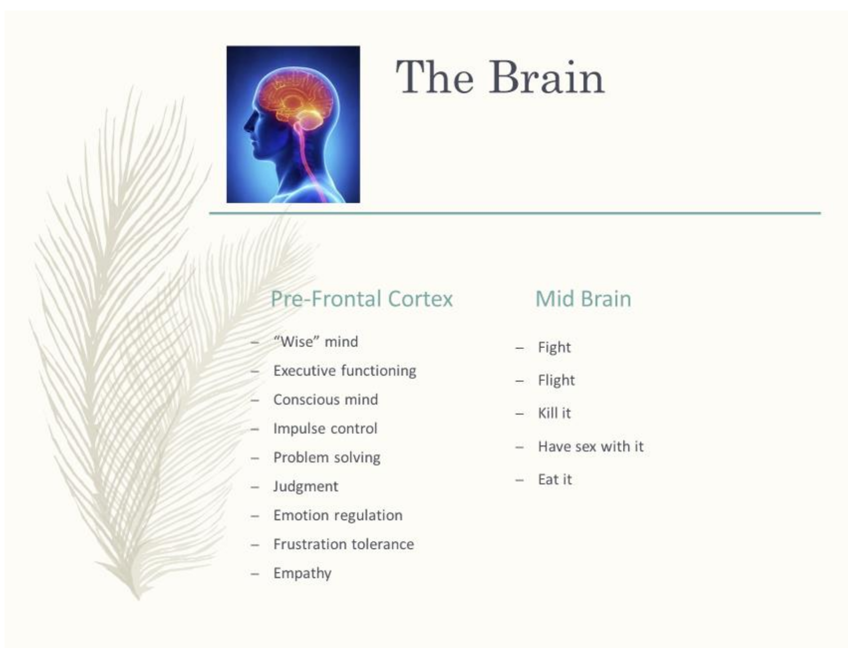

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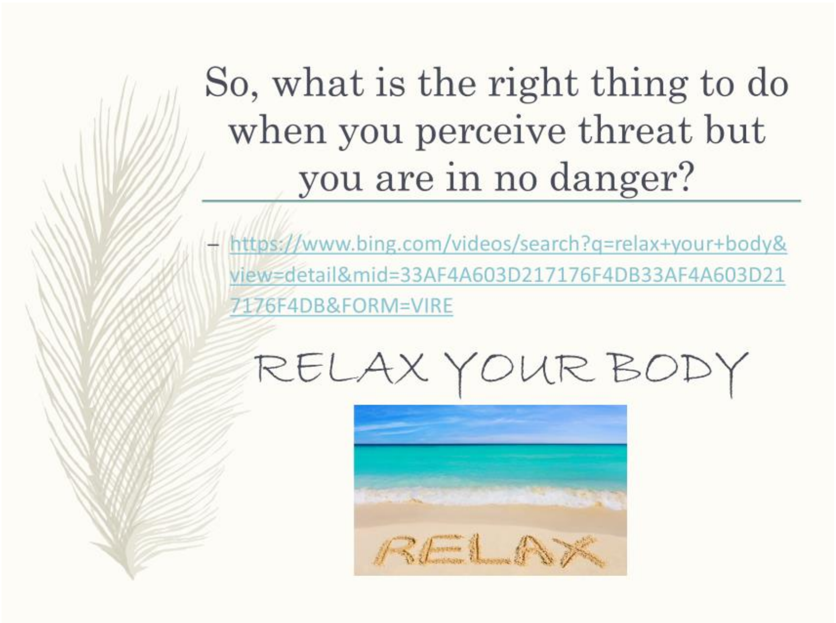


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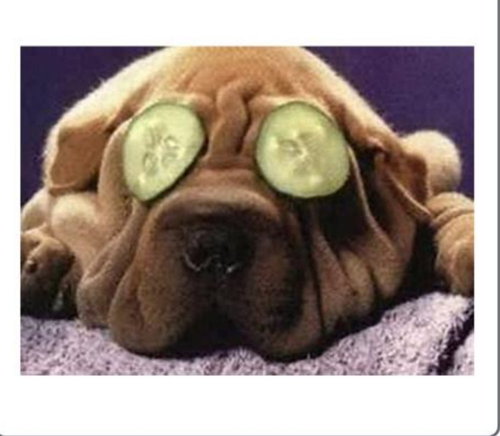

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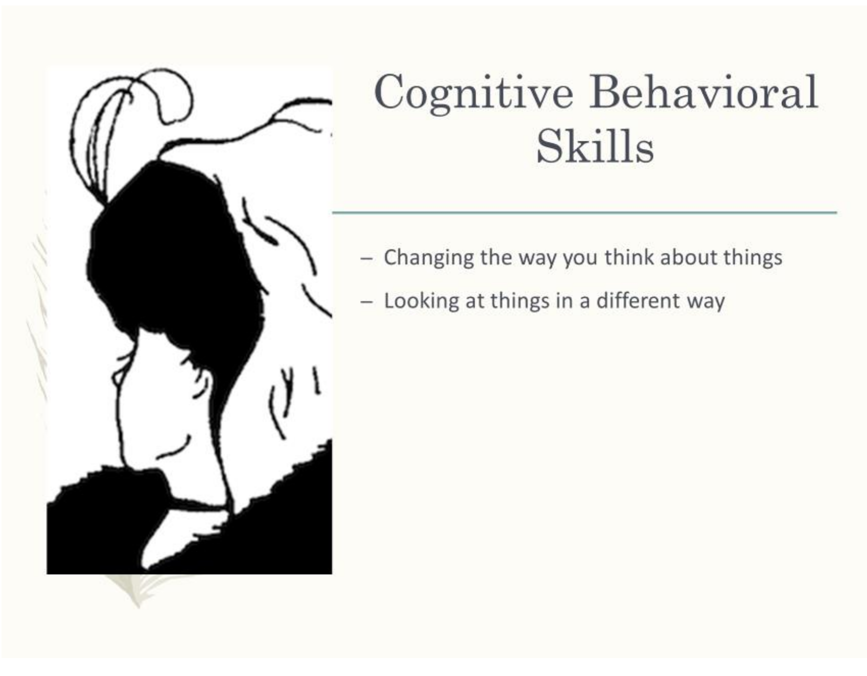

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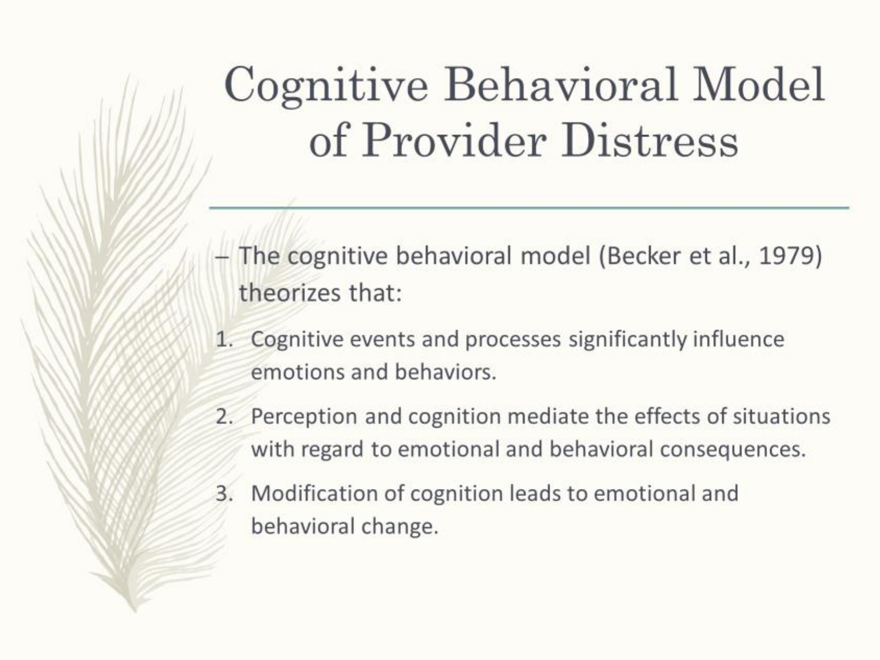

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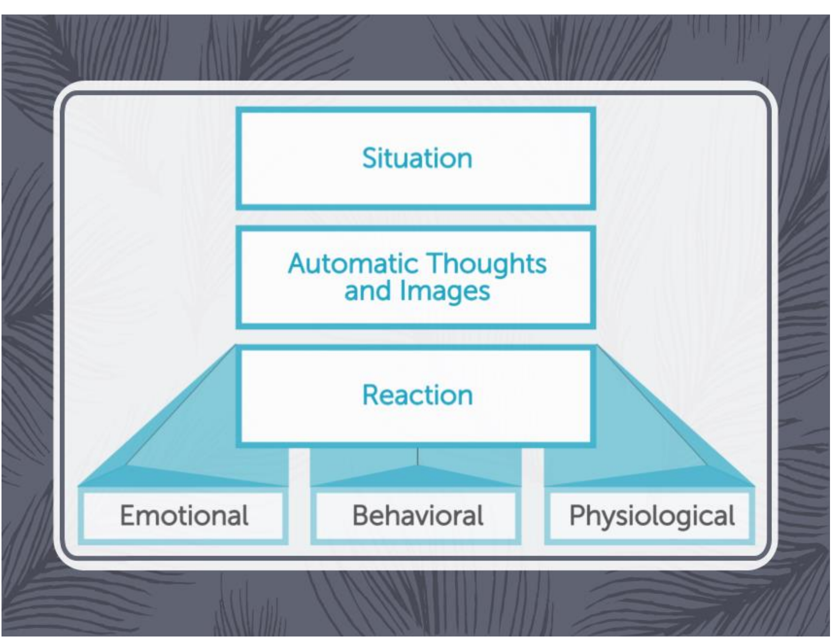


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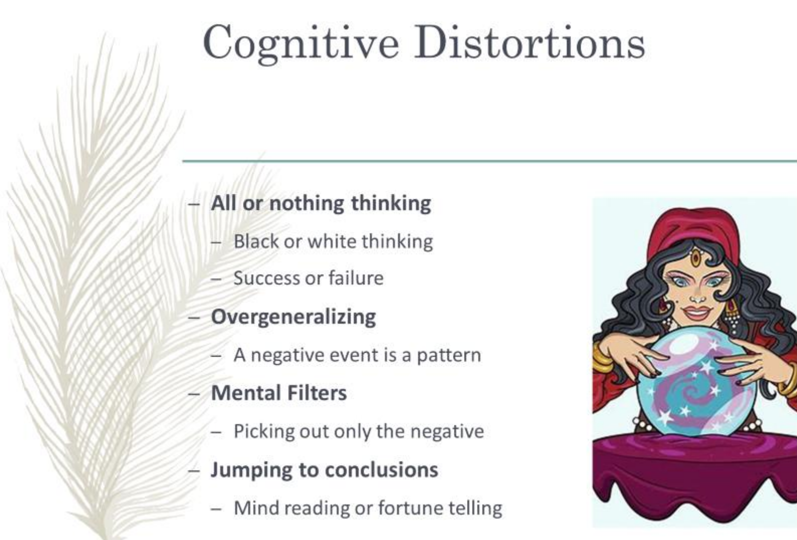



Slide 70:

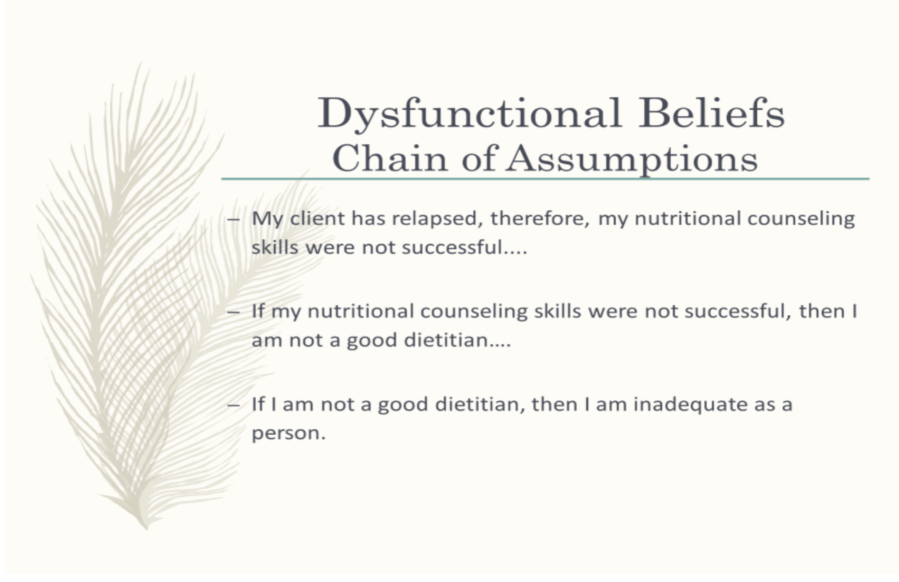
Could have, should have, would have
Oh well... what's done is done

## Cognitive Distortions

- **Disqualifying the positive**
- **Catastrophizing**
- **Emotional Reasoning**
  - I feel it so it must be true
- **Should and shouldn'ts**
- **Labeling**
  - "I'm worthless"
- **Personalization**

Slide 71:

Slide 72:



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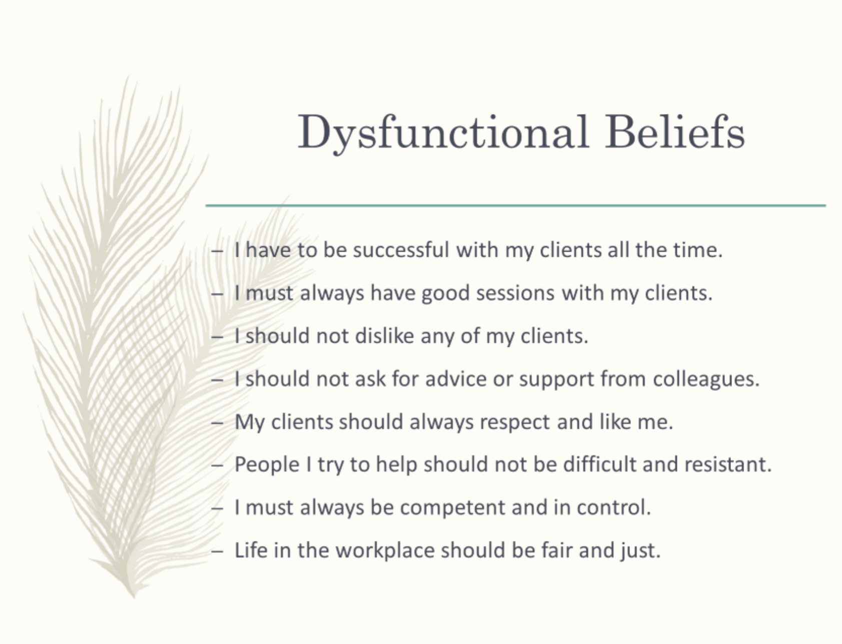


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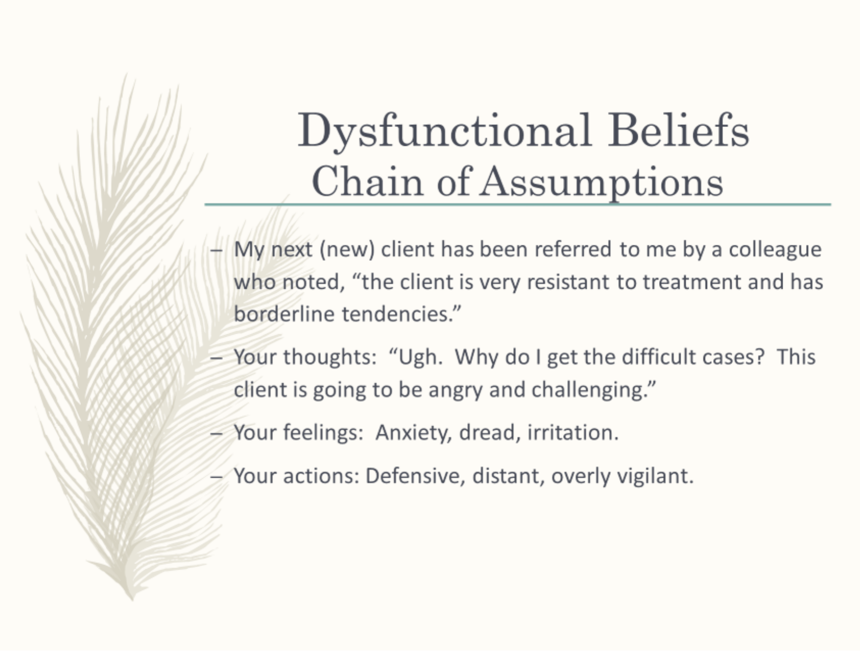

Slide 75:

## Dysfunctional Beliefs Challenging the Thoughts

– Challenging and modifying the thoughts:
– "I will have to wait and see what, if any, borderline traits this client has. Meanwhile, I will concentrate on the two goals for the session:
  – 1. Establish rapport and a relationship
  – 2. Identify problems and targets

  – This reduces the anxiety and irritation and facilitates more effective therapy.

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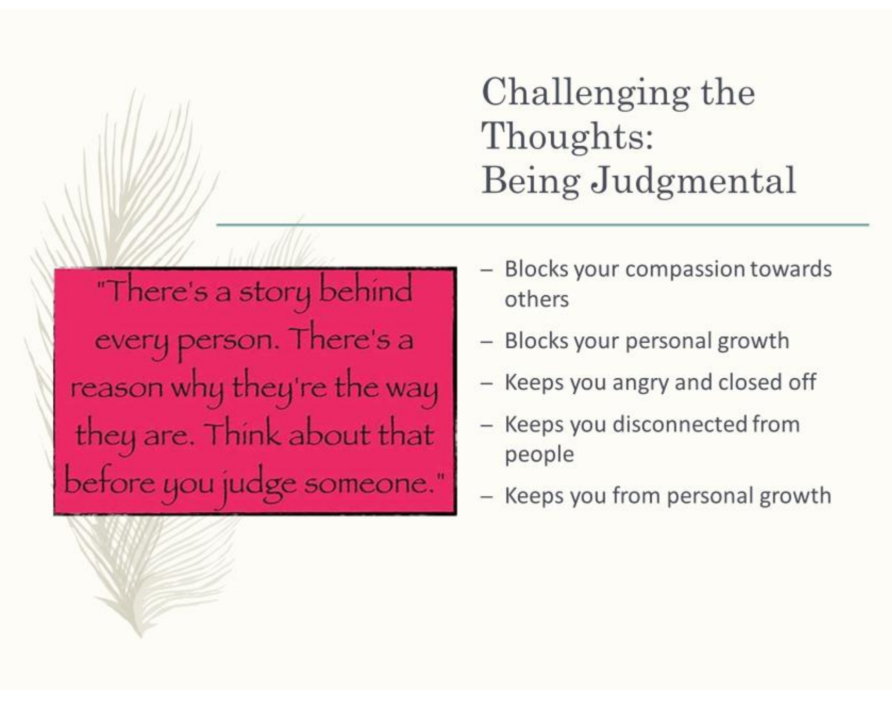

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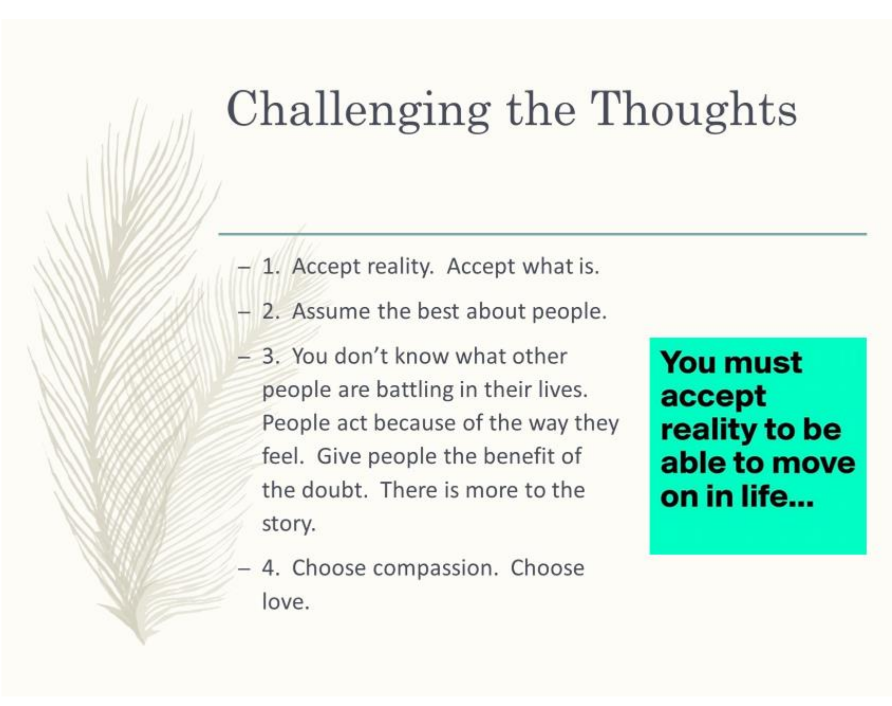


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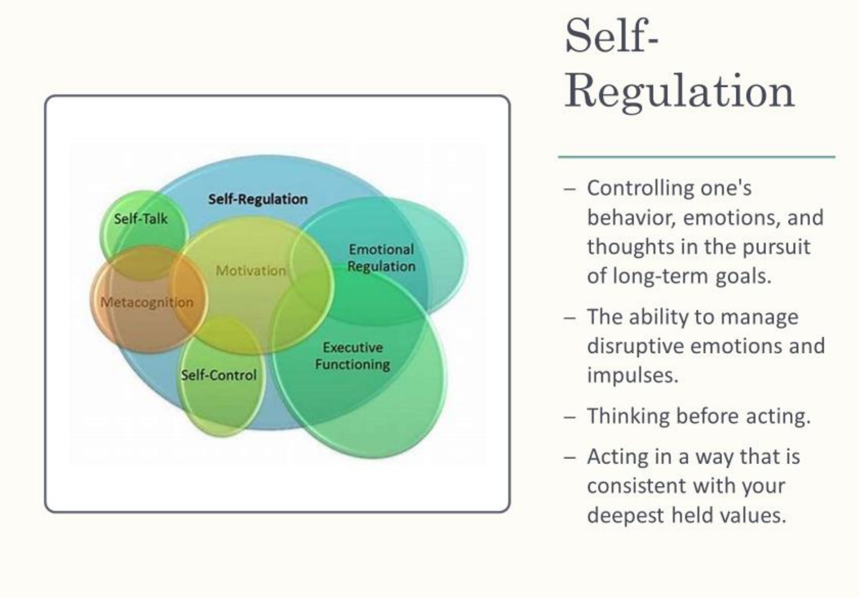

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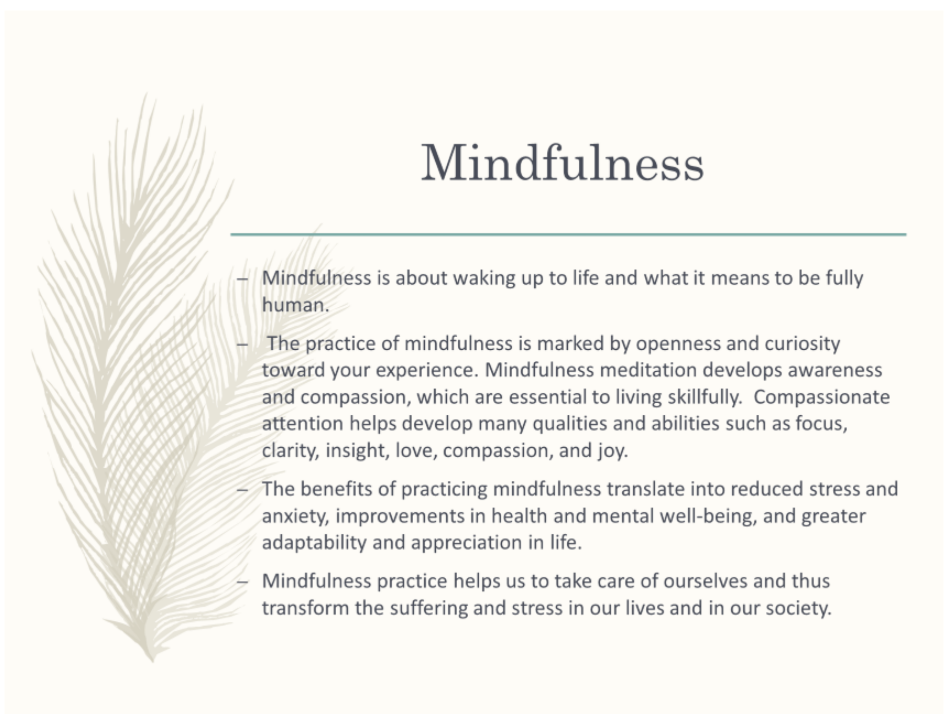


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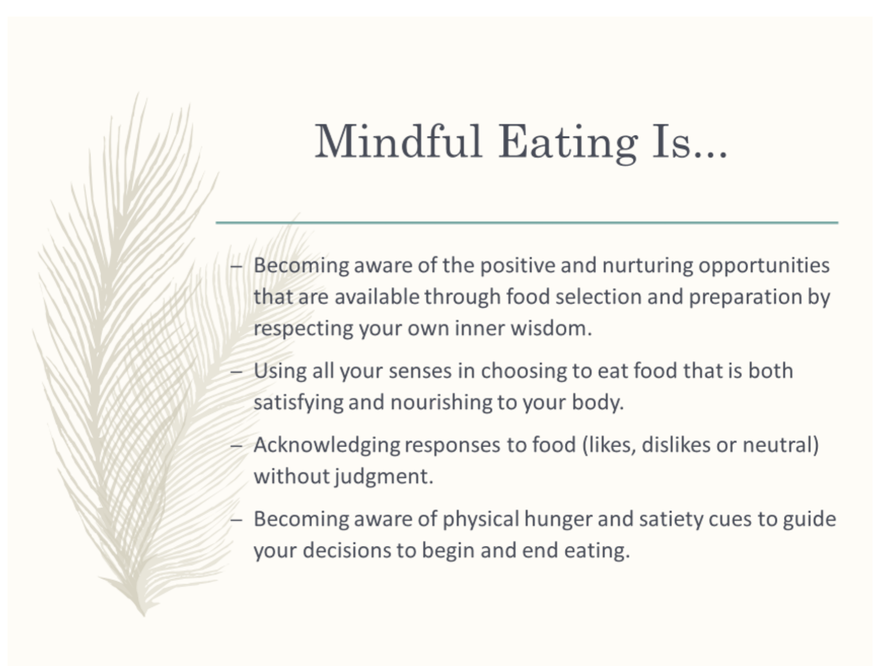


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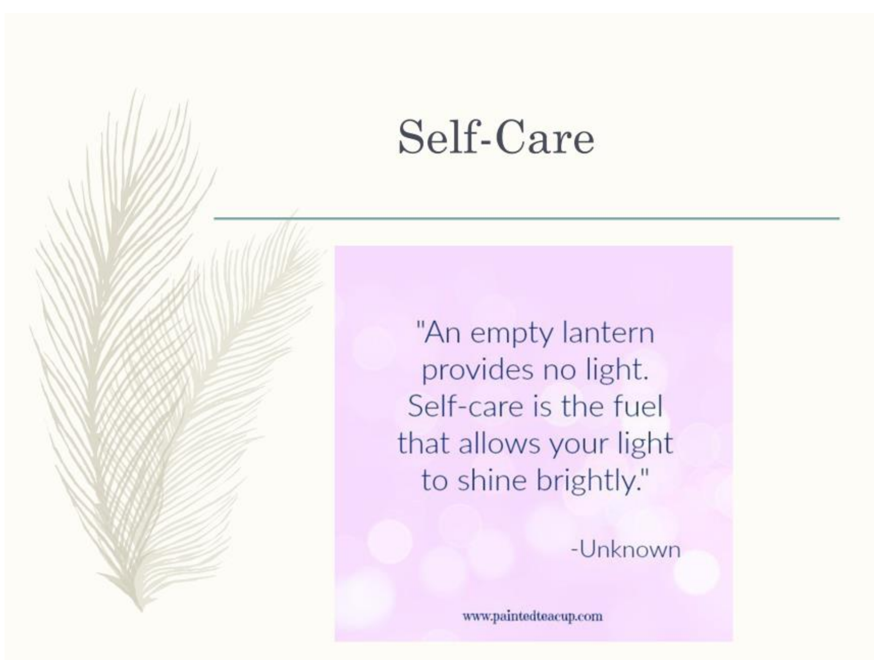

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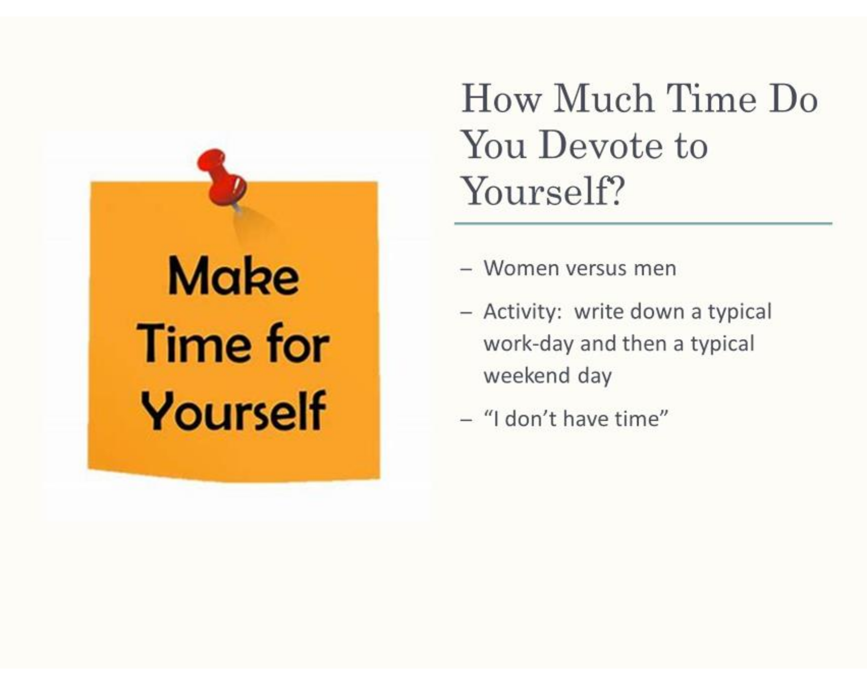


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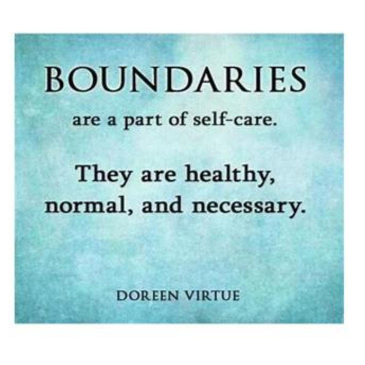
Slide 90:

Slide 91:

# Boundaries




- Boundaries are guidelines, rules or limits that a person creates to identify for themselves what are reasonable, safe and permissible ways for other people to behave around them and how they will respond when someone steps outside those limits.

Slide 92:

# Boundaries: No Trespassing

- Personal boundaries, just like the "No Trespassing" sign, define where you end, and others begin and are determined by the amount of physical and emotional space you allow between yourself and others. Personal boundaries help you decide what types of communication, behavior, and interaction are acceptable.

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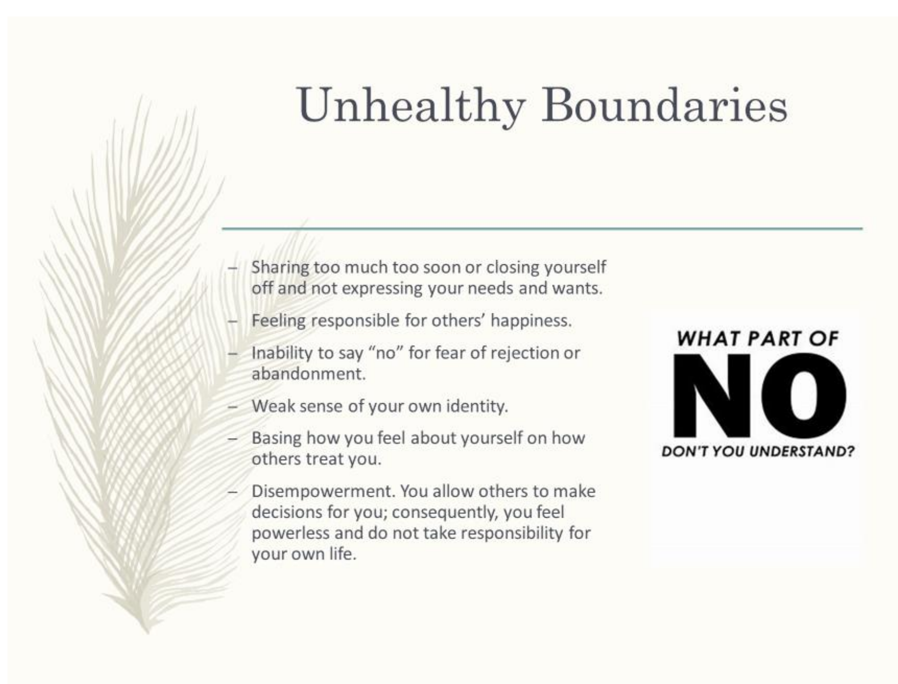


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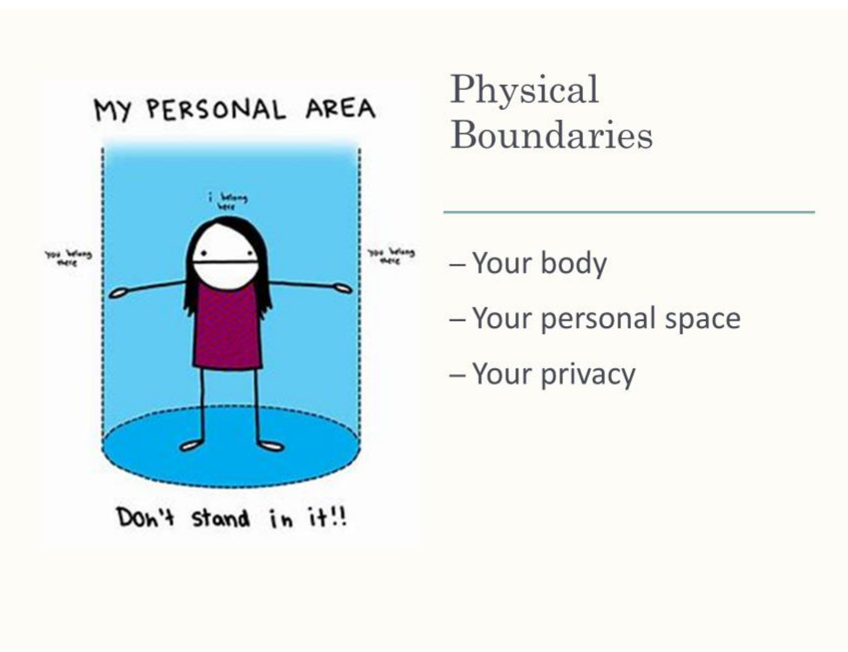


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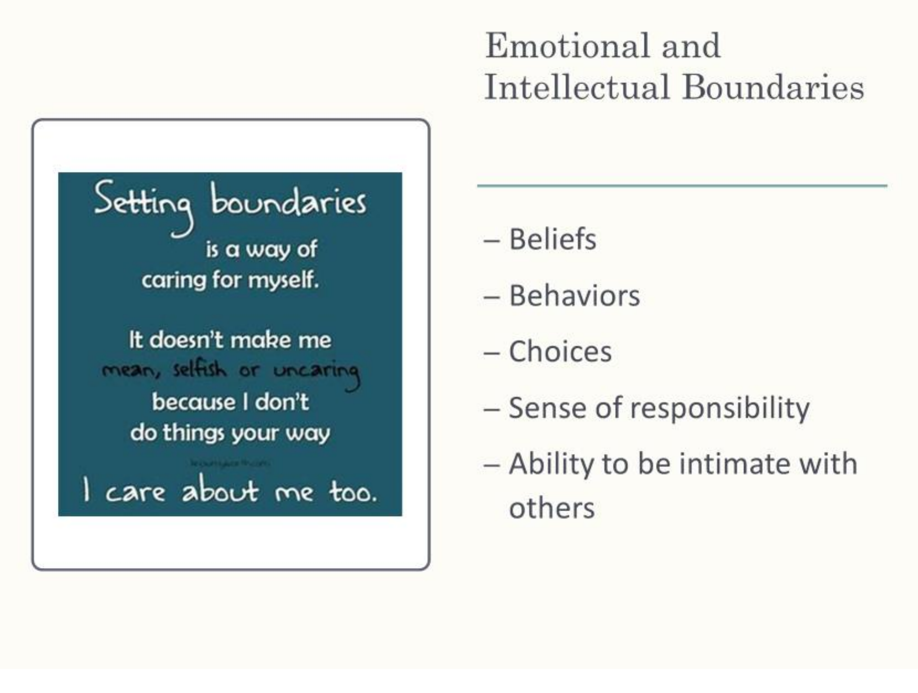


Slide 97:

Barriers to Setting Boundaries

- FEAR of rejection and abandonment.
- FEAR of confrontation.
- FEAR of disappointing/hurting others.
- We were not taught healthy boundaries.

Slide 98:

Slide 99:

Tips for
Setting Boundaries

- Do it clearly, calmly, firmly, respectfully, and in as few words as possible.
- Do not justify, get angry, or apologize for the boundary you are setting.
- You are not responsible for the other person's reaction to the boundary you are setting. You are only responsible for communicating your boundary in a respectful manner.
- Remain firm. Your behavior must match the boundaries you are setting.
- You cannot successfully establish a clear boundary if you send mixed messages by apologizing.

10 STEPS TO SETTING HEALTHY BOUNDARIES

1. Clearly identify your boundary.
2. Understand why you need the boundary.
3. Be straight forward.
4. Don't apologize or give long explanations.
5. Use a calm and polite tone.
6. Start with tighter boundaries (and then loosen up if appropriate).
7. Address boundary violations early.
8. Don't make it personal.
9. Use a support system.
10. Trust your intuition.

Happily Imperfect | PsychCentral

Slide 100:

*Two seeds lay side by side in the fertile soil.*

*The first seed said, "I want to grow! I want to send my roots deep into the soil beneath me, and thrust my sprouts through the earth's crust above me ... I want to unfurl my tender buds like banners to announce the arrival of spring ... I want to feel the warmth of the sun on my face and the blessing of the morning dew on my petals!"*
And so she grew...

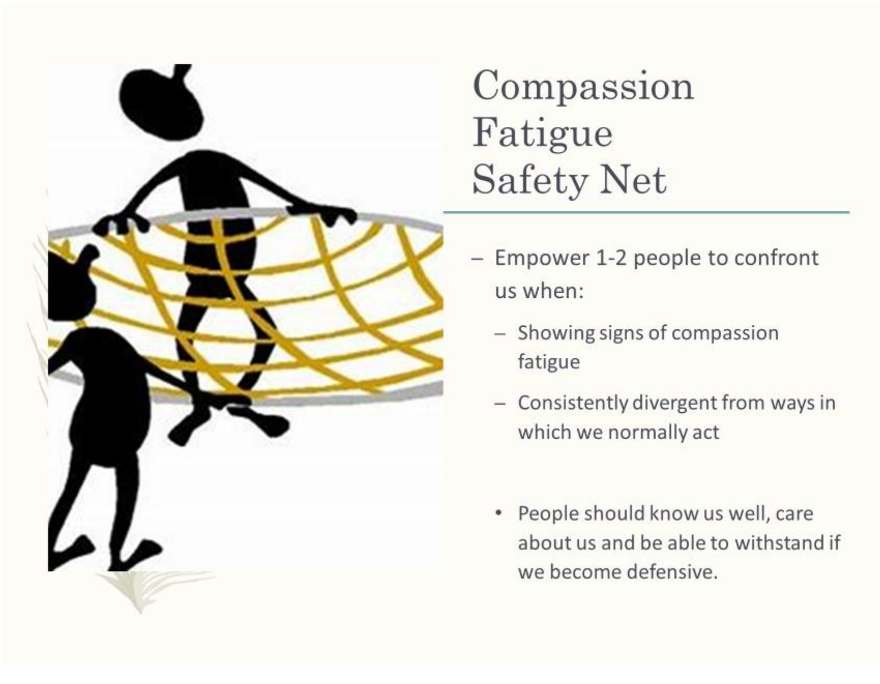
*The second seed said, "I am afraid. If I send my roots into the ground below, I don't know what I will encounter in the dark. If I push my way through the hard soil above me I may damage my delicate sprouts ... what if I let my buds open and a snail tries to eat them? And if I were to open my blossoms, a small child may pull me from the ground. No, it is much better for me to wait until it is safe."*
And so she waited...

*A yard hen scratching around in the early spring ground for food found the waiting seed and promptly ate it.*

Moral of the Story : Those of us who refuse to risk and grow get swallowed up by life.

Slide 101:

Slide 102:



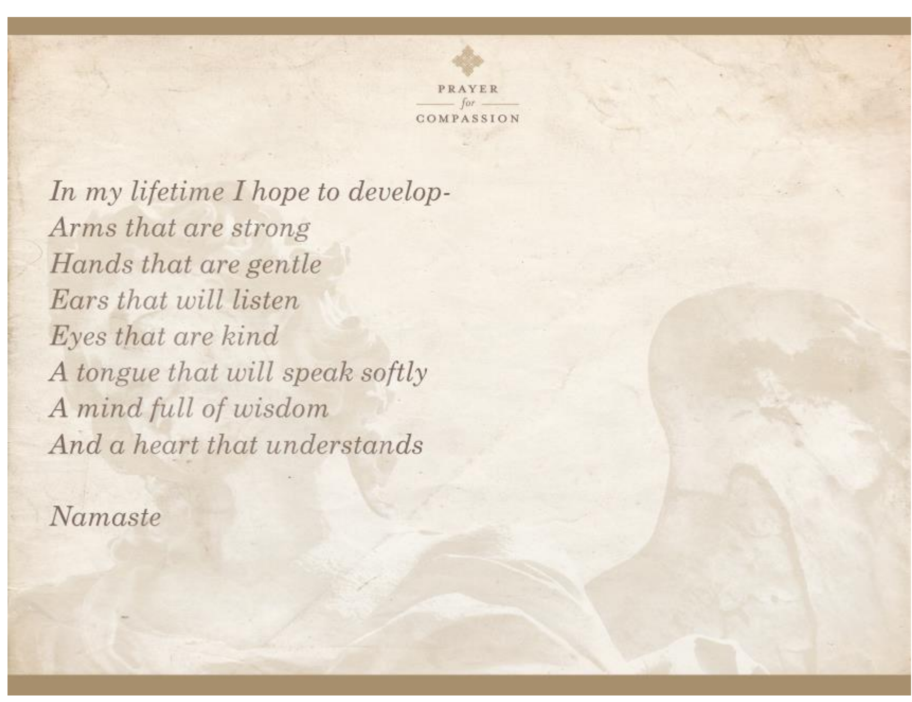
Slide 103:

# Open our hearts....

"It is not possible to open our hearts and minds to our clients without being deeply affected by the stories they tell us. But what is important to notice is how severe these disruptions have become for you.
*Laurie Anne Pearlman, PhD*

Slide 104:

Slide 105:



## DAY ONE

Slide 1 – FACILITATOR

Introduction to Caryn Honig

Caryn Honig is a Registered and Licensed Dietitian and owns *The Healthy Weigh*, a private practice offering nutritional counseling where she counsels patients who struggle with eating disorders and disordered eating. She also works at Texas Children's Hospital with employees who struggle with eating disorders/disordered eating and chronic diseases. Finally, she is an adjunct clinical professor at University of Houston—and teaches Introduction to Nutritional Counseling and Current Issues in Eating Disorders. She chose the field of nutritional counseling because of her past struggles with anorexia and bulimia. She has been in recovery for over 25 years.

Growing up, Caryn was a state and nationally ranked junior tennis player. She was a scholarship player for the University of Denver and became a collegiate All-American tennis player. She was University of Denver Female Athlete of the Year in 1987, chosen to be on the Silver Anniversary Team for Women's Athletics in 2000 and was inducted into the University of Denver Hall of Fame in 2004.

After college, Caryn hung up her rackets and became an avid runner and triathlete. To date she has completed 43 full marathons, numerous triathlons, one full Ironman triathlon and one 50-mile endurance running race.

Caryn has undergraduate degrees from the University of Denver and the University of Texas Health Science Center. She completed a master's degree in counseling from the University of St. Thomas in Houston. She completed her doctorate in Education from Walden University in 2019.

Slide 2: CARYN

As (the facilitator) said, I received my first bachelors from the University of Denver. My first degree was in communications and my first career was in television and radio. To become a dietitian, I had to start all over, from the top – taking science classes – organic chemistry, biochemistry, anatomy and physiology. So, you know I really wanted to be a dietitian to do that much undergraduate work- 9 years total between my two undergraduate degrees.

My first job as a dietitian was at Texas Children's Hospital in 1992. Five years later, I went into private practice as a dietitian specializing in eating disorders. I started my career as a dietitian with enthusiasm, idealism and gusto. I had high hopes that I was going to change the world. I was one of the first dietitians in private practice specializing in eating disorders – so I was swamped with patients….and lectures….and traveling….and conferences. Eating disorders were so new – I was really on the forefront of eating disorder treatment.

Throughout the past 25 plus years – my enthusiasm and gusto has waxed and waned throughout the years. Sometimes I am very passionate about my work and other times, well, let's just say my optimism is lacking.

My interest in compassion fatigue came as a direct result of working with patients with eating disorders and then the sudden and tragic death of my mom. I've seen many patients go through trauma and struggles and then I went through my own, which clearly showed me how important it is to take care of ourselves so we can better help others.

My interest in compassion fatigue grew as I did my doctorate study in compassion fatigue in dietitians who work with patients with eating disorders. I spent years researching compassion fatigue and I'm happy to share all that I have learned.

For my doctoral research study, I interviewed 4 registered dietitians who had experience working with patients with eating disorders and 4 dietetic educators. I asked them questions about compassion fatigue: had they heard of it, were they at risk for developing it, why or why not, did they think dietitians who treat patients with eating disorders are at risk for developing compassion fatigue, and what were ways they thought compassion fatigue could be managed or prevented? And, finally, what education did they think was needed to manage and prevent compassion fatigue? Six themes emerged from the data including: repeated exposure to pain and suffering caused emotional exhaustion and numbness; the risk of compassion fatigue is highest when dietitians are underprepared for the repeated exposure to trauma, pain, and suffering; seeking support is possibly a way to manage and prevent compassion fatigue; setting boundaries, separation self from work, and self-care is necessary; education about compassion fatigue and self-care is needed.

Based on the research, it was decided that an in-person 3-day workshop on preventing and managing compassion fatigue is the most appropriate intervention to help manage and prevent compassion fatigue in dietitians who treat patients with eating disorders.

So, I want you to spend a second thinking about why you are here. You are in the right place if you want to:

Do more than just survive.

If you want more emotional health…more joy….more fire…more peace…more excitement.

If you are a caregiver I am going to guess that you feel emotions deeply. And you feel everyone else's emotions deeply. That's a lot to take on.

Quote: The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.

Compassion fatigue is a normal part of being a caregiver. Compassion fatigue can be managed. It does not mean that you are damaged or that you cannot do this work. It just means you have to do the work to keep yourself healthy and whole.

Slide 3: Silent Witness - 15 minutes

Pass out index cards. Write down 3 ways that you have been negatively affected by work.

Hold your card below your chin and walk around allowing others to see what you have written on your card.

Slide 4: You are not alone

After: Can you identify the purpose of this activity?

This normalizes compassion fatigue. This was a validating exercise – that you are not alone.

How many blank cards were there? Probably none.

There are effects of being a professional caregiver. There is no way to do professional caregiving without having negative effects.

All of us are wounded healers. However, we can lead productive, happy, lives even while we are giving of ourselves.

Slide 5: Viktor Frankl

Viktor Frankl was a neurologist in Vienna. In 1941 he and his wife were captured by the SS and were taken to a holding camp and then separated. After they were separated, he never saw her again. She was killed in 1945 in a concentration camp. Dr. Frankl was taken to Auschewitz where he witnessed and experienced horrific atrocities for 3 ½ years. He clearly had a miserable existence, but he found quality of life even in these horrible conditions. He found joy, peace, purpose, meaning, and love.

Slide 6: Quality of Life

Joy, peace, purpose, meaning, and love. Those are the greatest measures of quality of life. That's a really important message. The quality of our lives is not contingent on external circumstances. Viktor Frankl taught that:

As long as we have a pulse, no matter how bad my situation, if I so choose I can find joy, peace, purpose, meaning and love. That is an internal capacity. Every single person can have that quality of life…not matter how heinous their history of trauma. No matter what their circumstances are. That understanding can help with resilience as you sit across from people who have experienced trauma. We have to be able to hold that transformation and healing and positive expectancy for our clients. Because that state of positive expectancy is contagious.

Slide 7:

Beautiful quote by Victor Frank: “That which is to give light must endure burning.” Any time you are giving of yourself – to shine your light - there is going to be a consequence. We are going to get “burned.” That is the essence of the caregiving profession. But it doesn’t have to mean “burning out.” It can mean burning within.

In the past, we were taught: the way you remain resilient is to remain objective. Keep distance with clients. Do not get drawn into clients. If I don’t get drawn in then I will remain unscathed by this work.

What Dr. Frankl is saying is that objectivity does not produce resiliency. Stocisism does not produce resiliency. It produces hardness and brittleness.

He said that we are all effected by this work. And we have to be able to learn to be resilient. We have to be able to take the hits but not be damaged by them.

Slide 8: Introduction to Compassion Fatigue

Carl Jung – First modern writers about the negative affect of caregiving.

When the doctor goes into patient’s life…in that process of going into the patient’s life – the doctor loses a little bit of his health while the patient gains some health. The relationship between the doctor and the patient is intense – both the patient and the doctor are altered.

The doctor did not choose this profession by chance.

Carl Jung said that we are going to go into a patient’s life and get contaminated by it.

Jung really foreshadowed the work we’ve done on compassion fatigue.

Slide 9: Introduction to Compassion Fatigue

Yael Danieli in the mid-70's – worked with Holocaust survivors and trained other therapists to work with these survivors. She came up with the term, "conspiracy of silence."

It was really difficult for the professionals to hear the stories of horror and atrocity. The professionals would guide the survivors away from that narrative by saying, "We can come back to that. Let's look at your life today. Let's look at your peace and joy today."

As we know, it is very important for people who have experienced trauma to own their stories and talk about the trauma. And have that narrative witnessed. That is part of the healing process. However, the therapists/caregivers could not bear to hear about it. They could not tolerate it.

Slide 10: Introduction to Compassion Fatigue

1980 – big deal. Edition of the DSM-III

First time we see the diagnosis of Post Traumatic Stress Disorder.

Described PTSD – diagnostic criteria so it could become an Axis I diagnosis.

It was certainly around before—even in the 1880's it was described - but now we have a diagnosis for it. Prior we were calling it neurosis or hysteria. Patients treated by generalists.

Now there could be clinicians who specialized in PTSD.

Then the specialists in PTSD – they were starting to have PTSD symptoms. They were starting to look like their patients, which was curious. This was the beginning of

countertransference working with trauma survivors, which was different than

countertransference in other professionals.

Slide 11: Introduction to Compassion Fatigue

Carla Joinson RN (1992) coined the term compassion fatigue.

She described compassion fatigue in nurses as a form of burnout and postulated that the same personality traits that lead a person into nursing put that same person at risk for compassion fatigue.

Slide 12: Charles Figley

1995- Charles Figley Book: Compassion Fatigue

Charles simplified the model for compassion fatigue.

Compassion fatigue = the effects of burnout and the effects of secondary traumatic stress

Slide 13:

Two other books on compassion fatigue published in 1995.

Trauma and the Therapist by Laurie Pearlman and Karen Saakvitne

Secondary Traumatic Stress by Beth Stamm

Slide 14: Compassion Fatigue is REAL

Introduction to Compassion Fatigue.

Compassion fatigue – fact or fiction?

FACT. Compassion fatigue is real.

It's a normal consequence of the work you do. Of course you are going to be affected by the work you do with people….people who are hurting.

Compassion fatigue is:

A combination of emotional, physical, spiritual, psychological exhaustion or depletion that occurs when we are repeatedly exposed to others pain, suffering, and trauma.

There is nothing wrong with you if you are experiencing compassion fatigue – it is not a character flaw. It is indicating an imbalance. You are expending too much of yourself and not taking in enough. Not enough self-care/self-love coming in. Not enough rekindling yourself. That's where the imbalance occurs.

Slide 15: Mother Teresa

Even Mother Teresa understood compassion fatigue. She wrote She wrote in her plan to her superiors that it was MANDATORY for her nuns to take an entire year off from their duties every 4-5 years to allow them to heal from the effects of their care-giving work.

Slide 16: Compassion? Empathy? Sympathy?  15 minutes

Participants get into groups of 2-3. Answer the questions. Group discussion.

Slide 17: Compassion, Empathy, Sympathy

While these words are close cousins, they are not synonymous with one another.

*Empathy* means that you feel what a person is feeling.

*Sympathy* means you can understand what the person is feeling.

*Compassion* is the willingness to relieve the suffering of another.

Slide 18: Empathy

880's Theodore Lipps "einfuhlung" (in-feeling").

Empathy is viscerally feeling what another feels.

"Mirror neurons"

Empathy may arise automatically when you witness someone in pain.

“Putting yourself in someone else’s shoes.”

“Feeling *with* you”

Example: Someone slams their fingers in a car door. You don’t automatically feel that pain. Instead, you can empathize by imagining what it might be like to have your fingers slammed in a door, and that may allow you to feel the pain.

Slide 19: Sympathy

Understanding what the person is feeling.

Understanding or imagining why someone is either going through a hard time or why someone might be feeling happy or sad.

Feeling *for* someone.

Examples: “I feel sad for you.” “I feel happy for you.”

Slide 20: Brene Brown: Empathy Vs Sympathy.  3 minute video

Slide 21: Compassion

Compassion means “*to suffer with”* (Latin).

Compassion takes empathy and sympathy one step further.

When you are compassionate, you feel the pain of another (i.e., empathy) or you recognize that the person is in pain (i.e., sympathy), and then you do your best to alleviate the person’s suffering from that situation.

Putting yourself in someone else’s shoes and trying to alleviate the suffering.

Slide 22: Video about compassion

13 minutes

Slides 23-25: Compassion Fatigue Definitions

Slide 26: Compassion Fatigue Video - 14 minutes

Slide 27: Burnout

Burnout

Early 1970’s – research on burnout started.

People who did not have a passion for their work did not get burnout from their work.

Those who experience burnout the most have true passion for their work.

A state of fatigue or frustration brought on by devotion to a cause, way of life or relationship that failed to produce the expected reward.

The disconnect by the system, the patients, the families…everything in the workplace caused burnout.

Maslach Burnout Inventory – by Christene Maslach in the 70’s.

Maslach defined burnout as: a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment. MBI measures these three on subscales.

Symptoms of burnout include exhaustion and fatigue and depersonalization (being like a robot). Not being present with clients. Not being whole with their clients. Not being able to maintain a quality therapeutic relationship. When a clinician is experiencing burnout – it is harmful for patients.

Research has shown that burnout is from the environment, the work conditions…the demands and the relational environment. The relational environment and the physical environment have a significant impact on the burnout scores.

Dr. Gentry did not like the definition for burnout because he felt like people become victims of their environment.

Dr. Gentry (1998) came up with another definition for burnout: the chronic condition where the perceived demands outweigh the perceived resources.

Slide 28: Counter-transference, Vicarious Trauma, Secondary Traumatic Stress

Counter-transference

Vicarious Trauma

Secondary Traumatic Stress- getting so absorbed into the stories – it's as though we have experienced the trauma ourselves. We are going to be affected in some way. From creating the visualizations – we experience symptoms of STS.

Definitions/explanations

Slide 29: Wounded Healer

Those who have done their own work and worked through their own trauma are more resilient to compassion fatigue. Everyone has wounds. Harville Hendricks says, "We haven't learned to raise our children without hurting them."

Compassion fatigue is the combined effects of burnout and secondary stress…..and primary trauma.

Slide 30:

Other names for compassion fatigue

Slide 31:

Who is Affected?

Slide 32: Risk Factor for Dietitians Who Treat Patients With Eating Disorders

- Patients are difficult to treat
    - Personality traits, health beliefs, diet beliefs, nutrition beliefs
- Serious complications
- Dietitians wear many hats
    - Monitoring food intake, challenging food fears, developing meal plans, monitoring refeeding
- High relapse rate
- High death rate

Slides 33-34:

Predicting compassion fatigue

Slide 35-36:

Warning Signs

Slides 37:

Physical Signs

Slide 38:

Behavioral Signs

Slides 39-44

Psychological Signs

Slide 45: Making It Personal

20 minutes

Slide 46:

Put up quote while participants are working on Making It Personal

Also, put music on.

Slide 47:

Definition of compassion satisfaction: The pleasure you derive from being able to do your work well. Compassion satisfaction is when you feel positively about your colleagues, your ability to contribute to the work setting. You feel as though you are working toward the greater good of society and you are helping others through your work. Compassion satisfaction is the helper's high – those moments when you really feel that you are in the right place at the right time and that you what you are doing is making a difference.

Discussion of compassion satisfaction. When you have compassion satisfaction, you are able to handle new protocols. You feel successful and happy with your work. You have a desire to continue to engage in your work. You feel satisfied and invigorated by the act of helping others. You feel pleasure regarding the progress of your clients. And, you feel optimistic about your ability to make a difference.

Slide 48:

15 minutes

Get with 2 other people and talk about what rewards do you get from doing the work that you do? What are the positives about doing the work that you do?

Audience feedback: what rewards to you get from doing the work that you do?

Some caregivers even state that the work they do feels like a "calling." Many of us feel that we are doing what we were born to do…that our work is a natural extension of ourselves. Caregivers that I have interviewed said:

- They express pleasure at being able to reduce distress in the people they serve
- Many feel honored to be connected with others on an intimate level. They feel as though it's a gift to be trusted to engage with others in a very deep and meaningful way.
- There is an intellectual and emotional challenge to being "in the moment" with people and trying to help them.
- The work can be challenging and spontaneous.
- Working with people provides unlimited variety and stimulation. No two people are the same. The work is rarely boring.

It's important to realize that the same work that can be the most rewarding can also most increase our risk for compassion fatigue.

Slide 49-50

45 minutes

Charles Figley and Beth Stamm developed the Compassion Fatigue Self-Test

Evolved into Professional Quality of Life Measure. It is the standard measure for compassion fatigue in our field. It is the most researched tool for compassion fatigue.

With the ProQOL came the opportunity to research treatment for compassion fatigue.

Discussion of the ProQOL

Participants take the ProQOL

Slides 51-53

Participants score the ProQOL

DAY TWO

Slide 54

Discussion of complex relationships

Slide 55: Your Narrative

20 minutes

Your narrative/your story/your timeline

Write a brief chronological narrative that articles your timeline as a caregiver.

Identify events that have negatively impacted your job as a caregiver and perhaps contributed to CF. Experiences that are painful with patients/clients/training. The longer the line, the more negative it impacted you.

Identity events that have positively impacted your job as a caregiver and perhaps contributed to CS. The higher the line, the more positive.

You can use the timeline for your narrative.

Write out that narrative.

Owning of your own narrative. The better you are at owning your own narrative, the better you are at helping others. You lead by example.

Sharing your own stuff becomes less and less threatening.

Share your timeline with another person.

15 minutes

Slide 56: Funny cartoon

Slide 57: Is your job stressful?

10 minutes

Ask the participants: Is your job stressful?

Make two columns.

If yes, make a list of what causes this stress? Write these in the left column.

Coworkers, commute, criticism, bosses….

List the negative effects that these stresses have caused in your life- in the right column.

Alcohol, food, isolation, headache, snarky at work, sarcastic, dreading work, loss of joy….

We will come back to this list….

Slide 58:

These stressors are not the cause of your stress/negative effects of your life.

What causes stress? It's the perceived threat that you are experiencing.

So, let's talk about perceived threats.

We perceive threat because of a "witnessed" experience. Maybe you have heard it on t.v. or read it in a book or heard about it through someone else.

Example: Going into a parking garage at night. You've seen scary movies, you've heard about muggings on the news.

The next and future times that you are in that context, you are perceiving threat because of a "witnessed" experience. You perceive the treat even before you are even aware of it. Before you are consciously aware of it.

How many times do you perceive threat per day? Maybe thousands.

What are the physiological changes when we perceive threat?

Hear rate increases, HPA gets involved - chemicals get secreted into the bloodstream, less blood carried to the extremities, more blood to center mass, ***muscles tighten***.

How often during the day are your muscles tight? Most of us find throughout the day with tight muscles. The cause of the tension/tightening is due to perceived threat.

The brain changes too. While the brain is relaxed/not perceiving threat- all of the electrical energy is going to the pre-frontal cortex. Parasympathetic nervous system dominance.

With threat – the electrical energy changes – there is a continued shifting away from the pre-frontal cortex – and sending it to the mid-brain – the thalamus/ the fight/flight area.

The prefrontal cortex/frontal lobe: decision making, judgement, reasoning, planning, emotional regulation, impulse control, identity-our principles/our code, fidelity to time and stay on task, goal directed, fine motor control, moving with grace.

With perceived threat – you lose these skills. You are unable to function at a normal level with acuity.

When anxiety is disregulated (perceived threat)– people lose temporal lobe functioning - the ability to generate words and talk/language. We think with words….during perceived threat – we think thoughts we don't want to think. Can't generate words. Thoughts become racing, harsh and critical—language you have learned in your past. Commanding and demanding language. It's all words to try to get you out of the perceived threat. The thoughts become more and more racing and harsh.

When we are not perceiving a threat – the parasympathetic nervous system is in control.

When we do perceive a threat – the Sympathetic Nervous System is in control.

Humans are the only animal in the planet that has the advantage of the prefrontal cortex. The rest of the animals act on the sympathetic nervous system only.

What is the purpose of the sympathetic nervous system? Excitement, juice of life. It was built to fire – to give us a jolt of energy. Eat, reproduce, kill. Activated when perceived threat.

How much disease is caused by staying in that threat mode.

Go back to the two columns and ask yourself what is actual threat versus perceived threat.

Slide 59-60:

Explanation of the brain: the pre-frontal cortex and the mid-brain

Pre-frontal cortex: Executive functioning, wise mind, empathy, frustration tolerance.

Mid-brain: Fight or flight, kill it, have sex with it, eat it. Survival.

Slide 61:

Very important question: what do you do when you perceive threat but are not in danger? What is the right action when you perceived threat but you are not in danger. The answer is always the same: RELAX the body.

What do you have to learn to do when you perceive threat but are not in danger?

You must relax your body. 10-30 seconds.

When you relax your body…you get a relaxed body.

Your prefrontal cortex will then become engaged: get back judgment, wise-mind, organization.

You can't do this when you are in perceived threat. You can only have your frontal lobe functions when you are relaxed.

When your Sympathetic Nervous System is dominant:

Lose 25-30 percent of speed, agility, and strength.

Example of when your sympathetic nervous system is dominant:

This could happen if someone hurts your feelings and you are ruminating over that. The more energy is used to fight or flight. The purpose of fight is to destroy or neutralize the perceived threat. The purpose of flight is to get away from the perceived threat. This is a lot of energy used. Physics: If you continue to dump energy into a closed system – it moves towards chaos until it explodes. If you stay in that perceived threat – you will cross threshold and you will act on fight or flight. Every breach of integrity is a fight or flight behavior.

This is where you have to stop and think about the real danger versus perceived threat. If you relax, you can stay with your integrity. You are able to live principle-based lives. You can live with integrity. You can live an intentional life.

15 minutes: Let's try it. Let's do a relaxation activity. Guided relaxation.

Slide 62:

Relaxation

Slide 63: Cognitive Behavioral Skills

Slide 64: Cognitive Behavioral Skills

Slide 65: Cognitive Behavioral Skills

Video – Discussion – 10 minutes

Slides 66-67 Cognitive Behavioral Model

Slide 68: Trigger Situations

Slide 69-70: Cognitive Distortions

**All or nothing thinking**

**Activity: 15 minutes**

In your packet is a list of several pairs of opposite words.

Some of them are simple; some are a little more complex. However, these are words that you probably use on a daily basis. Here's the challenge: write down each of the below pair of opposites on a piece of paper. Then, write down a word — a SINGLE word — that accurately describes the middle ground between the pair of opposites.

Example: hot and cold. A good answer here would be "warm", "lukewarm", or "temperate".

Got your list? Alright, take a good look at all of the words you've written down. Do they have anything in common? If your list is anything like mine, all of the "middle ground" words are similar in a way: they're all a bit muddy and bland. Let's go over some possible answers: obviously, the color "gray" falls between black and white, and I'll bet you wrote that one down. Where are you if you're not left nor right? Well, you're "moderate" or in the "center". If you're not young or old, perhaps you're "middle-aged". What if you're buying a shirt and it's not small or large? It's probably a medium. Medium, middle-aged, moderate, average, gray. Maybe you even wrote the words "normal", "so-so", or "average" on your paper. Most writers try to avoid using these

words and other gray-colored language altogether. (Unless they're writing a blog entry about those very words.)

Did you have trouble nearing the end of the activity? Don't worry, you're not alone. I couldn't find any way to describe the middle ground between "shy and outgoing" or "calm and anxious" with a single word. Or even with a bunch of words. There's no convenient word or phrase in the English language, it seems, to describe the middle ground between several sets of the polar opposites listed above. How does this deficiency of the English language harm us?

Take a look at the word list again. How often do you use words like "happy and sad"? You've probably uttered most of them today without even realizing it. After all, simplifying our stories for others with polar words like "sad", "bad", and "far" is convenient. It's easier for a student to lament that his or her research paper is "far" from being completed (especially if they're seeking empathy) than to get into the details of exactly how much is done and how much is left to write.

Dichotomous language leads to dichotomous thinking. So, what is the solution? The answer is to catch yourself when you are using black and white thinking….and correct your vocabulary to the gray.

**Overgeneralizing**

A negative event is a pattern.

When overgeneralizing, a person may come to a conclusion based on one or two single events, despite the fact reality is too complex to make such generalizations. If a friend misses a lunch date, this doesn't mean he or she will always fail to keep

commitments. Overgeneralizing statements often include the words “always,” “never,” “every,” or “all.”

**Mental Filters**

This cognitive distortion, similar to discounting the positive, occurs when a person filters out information, negative or positive. For example, a person may look at his or her feedback on an assignment in school or at work and exclude positive notes to focus on one critical comment.

**Jumping to conclusions**

Mind reading or fortune telling

This type of thinker may assume the role of psychic and may think he or she knows what someone else thinks or feels. The person may think he or she knows what another person thinks despite no external confirmation that his or her assumption is true. A fortune-telling-type thinker tends to predict the future, and usually foresees a negative outcome. Such a thinker arbitrarily predicts that things will turn out poorly. Before a concert or movie, you might hear him or her say, “I just know that all the tickets will be sold out when we get there.”

Slide 70:

**Disqualifying the Positives**

This extreme form of all-or-nothing thinking occurs when a person discounts positive information about a performance, event, or experience and sees only negative aspects. A person engaging in this type of distortion might disregard any compliments or positive reinforcement he or she receives.

**Catastrophizing**

This occurs when a person sees any unpleasant occurrence as the worst possible outcome. A person who is catastrophizing might fail an exam and immediately think he or she has likely failed the entire course. A person may not have even taken the exam yet and already believe he or she will fail—assuming the worst, or preemptively catastrophizing.

**Emotional Reasoning**

Mistaking one's feelings for reality is emotional reasoning. If this type of thinker feels scared, there must be real danger. If this type of thinker feels stupid, then to him or her this must be true. This type of thinking can be severe and may manifest as obsessive compulsion.

**Shoulds and Shouldn'ts**

Thoughts that include "should," "ought," or "must" are almost always related to a cognitive distortion. For example: "I should have arrived to the meeting earlier," or, "I must lose weight to be more attractive." This type of thinking may induce feelings of guilt or shame. "Should" statements also are common when referring to others in our lives. These thoughts may go something like, "He should have called me earlier," or, "She ought to thank me for all the help I've given her." Such thoughts can lead a person to feel frustration, anger and bitterness when others fail to meet unrealistic expectations. No matter how hard we wish to sometimes, we cannot control the behavior of another, so thinking about what others should do serves no healthy purpose.

**Labeling**

This distortion, a more severe type of overgeneralization, occurs when a person labels someone or something based on one experience or event. Instead of believing that he or she made a mistake, people engaging in this type of thinking might automatically label themselves as failures.

**Personalization**

When engaging in this type of thinking, an individual tends to take things personally. He or she may attribute things that other people do as the result of his or her own actions or behaviors. This type of thinking also causes a person to blame himself or herself for external circumstances outside the person's control.

Slide 71: Reactions

Slides 72-73: Dysfunctional Beliefs

Slides 74-75: Dysfunctional Beliefs: Challenging the Thoughts

Slides 76: Challenging the Thoughts: Being Judgmental

Slide 77: Challenging the Thoughts

Slide 78: Self-regulation

This is where your life can be different. Often times, health care providers agree to do the self-regulation and relaxation work when what they are doing doesn't work anymore. "When the pain of staying the same is greater than the fear of change, we will change." Self-regulation can be defined in various ways. In the most basic sense, it involves controlling one's behavior, emotions, and thoughts in the pursuit of long-term goals. More specifically, emotional self-regulation refers to the ability to manage disruptive emotions

and impulses. In other words, to think before acting. It also reflects the ability to act in a way consistent with your deepest held values.

Self-regulation involves taking a pause between a feeling and an action—taking the time to think things through, make a plan, wait patiently. Children often struggle with these behaviors, and adults may as well

It's easy to see how a lack of self-regulation will cause problems in life. A child who yells or hits other children out of frustration will not be popular among peers and may face reprimands at school. An adult with poor self-regulation skills may lack self-confidence and self-esteem and have trouble handling stress and frustration. Often, this might be expressed in terms of anger or anxiety, and in more severe cases, may be diagnosed as a mental disorder.

Self-regulation is also important in that it allows you to act in accordance with your deeply held values or social conscience and to express yourself in appropriate ways. If you value academic achievement, it will allow you to study instead of slacking off before a test. If you value helping others, it will allow you to help a coworker with a project, even if you are on a tight deadline yourself.

In its most basic form, self-regulation allows us to stay calm under pressure.

So, how do you self-regulate?

Self-regulation: the ability to soften and relax the muscles in your body while you are in the daily activities of your life. So, the first step in self-regulation is to soften and relax the muscles in your body.

The next step in self-regulation is to recognize that you have a choice in how to react to situations. While you may feel like life has dealt you a bad hand, it's not the hand you are dealt, but how you react to it that matters most.

Recognize that in every situation you have three options: approach, avoid or attack.

While it may feel as though your choice of behavior is out of your control, it's not. Your feelings may sway you more toward one path, but you are more than those feelings.

Do you feel like running away from a difficult situation? Do you feel like lashing out in anger at someone who has hurt you? Monitor your body to get clues about how you are feeling if it is not immediately obvious to you. For example, a rapidly increasing heart may be a sign that you are entering a state of panic.

Start to restore balance by focusing on your deeply held values, rather than those transient emotions. See beyond that discomfort at the moment to the larger picture. If you want to live by your principles then, act in a way that aligns with self-regulation.

Example: Think of one principle that you want to live by. Mine is to be compassionate.

This is who I want to be. This is my code of honor. Now, think about a situation or context that comes up where you breach that code (personally and professionally).

So, I wake up and made the oath to be a compassionate person.

Then I get behind the wheel of a car. Suddenly, I'm not very compassionate anymore. I start acting in a way that I don't want to act.

At work, sometimes I dread seeing clients….teaching at UH – sometimes I dread seeing students walking in the door of my classroom.

There will always be a trigger – anything that happens that makes us act out in a certain way that breaches to our integrity.

Triggers for me: when clients or students are smug, when parents are critical of my work, when students consistently challenge me (and have no experience). These triggers are a perceived threat.

STOP – why would I perceive a threat when a parent is critical of my work or when a student challenges me? Clearly there is no danger. This is all past learning where I have been criticized. It's past learning that associates with danger.

At this point, you have to recognize what is happening and RELAX.

The first thing you get is a relaxed body and you are able to walk through those situations while being able to stay compassionate. You can act with intention. You do the absolute best that you can do. I can use my words that bring about health, healing and solution rather then spread the toxicity because that is not the way I want to live. It gives us the ability to act with integrity.

By relaxing the body – I am desensitizing the trigger.

For caregivers, it allows you to be the best at your job that you can be.

DAY THREE

Slide 79-81: Mindfulness

Slide 82: Mindfulness Video - 10 minutes

Slides 83-84: Mindful Eating

Slide 85: Mindful Eating Activity - 15 minutes

Slide 86: Self-Care

Slide 87: Self-Care -30 minutes

Think about a typical work day. In your packet, I've given you a worksheet labeled "Typical Work Day." Please spend the next 10 minutes filling out your typical work day.

Music: Let it Shine

How did you spend your time? How many hours did you work? Commute?

Is there self-care during that day? Did you take breaks? Did you nurture yourself with good food? Did you replenish yourself physically, emotionally, spiritually?

Often hear: "I don't have time." When you tell yourself you don't have time, you're keeping yourself stuck. You do have time to do self-care. We do find time to do the things we value. And, we need to value ourselves.

Challenge: how much time do you spend scrolling through emails? Keeping up with the Kardashians? Facebook? Online shopping.

That time could be spent on self-care: little chunks of time journaling, meditating, taking a 10-minute walk.

Self-care is essential.

One participant in my doctorate study said, “as women…we go go go and do do do…”

Let’s do a 10-minute self-care break right now.

Journal your thoughts.

After 10 minutes, circle the actual facts. What are true facts are what are your thoughts?

What emotional state is your thinking creating?

Example: I’m not a good enough dietitian.

Thoughts create feelings. Feelings create actions.

So, what feeling comes up with “I’m not a good enough dietitian.” Disappointed, stressed, overwhelmed. Wait, I don’t want to feel this way.

Okay, how can I see this differently? How can I look at this in a different way?

How else can I see this? Your brain wants to answer the questions.

Think about the quote by Dr. Dwyer: When you change the way you look at things, things change. In order to change the way you feel, you have to change the way you think about something.

Slides 88-90: Self-Care - 20 minutes

Do self-care plan

Slide 91: Boundaries. Setting boundaries is essential if we want to be both physically and emotionally healthy and to help manage and prevent compassion fatigue.

Creating healthy boundaries is empowering. By recognizing the need to set and enforce limits, you protect your self-esteem, maintain self-respect, and enjoy healthy relationships.

A lack of boundaries is like leaving the door to your home unlocked: anyone, including unwelcome guests, can enter at will. On the other hand, having too rigid boundaries can lead to isolation, like living in a locked-up castle surrounded by a mote. No one can get in, and you can't get out.

What Are Boundaries? Boundaries are guidelines, rules or limits that a person creates to identify for themselves what are reasonable, safe and permissible ways for other people to behave around them and how they will respond when someone steps outside those limits. (outofthefog.net)

Slide 92: Boundaries

The easiest way to think about a boundary is a property line. We have all seen "No Trespassing" signs, which send a clear message that if you violate that boundary, there will be a consequence. This type of boundary is easy to picture and understand because you can see the sign and the border it protects. Personal boundaries can be harder to define because the lines are invisible, can change, and are unique to each individual. Personal boundaries, just like the "No Trespassing" sign, define where you end and others begin and are determined by the amount of physical and emotional space you allow between yourself and others. Personal boundaries help you decide what types of communication, behavior, and interaction are acceptable.

Slide 93: Unhealthy Boundaries

Sharing too much too soon or, at the other end of the spectrum, closing yourself off and not expressing your need and wants.

Feeling responsible for others' happiness.

Inability to say “no” for fear of rejection or abandonment.

Weak sense of your own identity.

You base how you feel about yourself on how others treat you.

Disempowerment. You allow others to make decisions for you; consequently, you feel powerless and do not take responsibility for your own life.

Slide 94: Why is it important to set boundaries?

- To practice self-care and self-respect
- To communicate your needs in a relationship
- To make time and space for positive interactions
- To set limits in a relationship in a way that is healthy

Slide 95: Physical Boundaries

Physical boundaries include your body, sense of personal space, sexual orientation, and privacy. These boundaries are expressed through clothing, shelter, noise tolerance, verbal instruction, and body language.

An example of physical boundary violation: a close talker. Your immediate and automatic reaction is to step back in order to reset your personal space. By doing this, you send a non-verbal message that when this person stands so close you feel an invasion of your personal space. If the person continues to move closer, you might verbally protect your boundary by telling him/her to stop crowding you.

Other examples of physical boundary invasions are:

Inappropriate touching

Looking through others’ personal files and emails.

Not allowing others their personal space. (e.g., barging into your boss's office without knocking)

Slide 96: Emotional and Intellectual Boundaries

These boundaries protect your sense of self-esteem and ability to separate your feelings from others'. When you have weak emotional boundaries, it's like getting caught in the midst of a hurricane with no protection. You expose yourself to being greatly affected by others' words, thoughts, and actions and end up feeling bruised, wounded, and battered. These include beliefs, behaviors, choices, sense of responsibility, and your ability to be intimate with others.

Examples of emotional and intellectual boundary invasions are:

• Not knowing how to separate your feelings from your partner's and allowing his/her mood to dictate your level of happiness or sadness (a.k.a. codependency). • Sacrificing your plans, dreams, and goals in order to please others. • Not taking responsibility for yourself and blaming others for your problems.

Slide 97: Barriers to Boundary Setting

Why is it hard to set boundaries?

FEAR of rejection and abandonment.

FEAR of confrontation.

GUILT of disappointing/hurting others

We were not taught healthy boundaries.

Slide 98: FEAR

Slide 99: Tips for Setting Healthy Boundaries

Modified from the book, Boundaries: Where You End and I Begin by Anne Katherine)

When you identify the need to set a boundary, do it clearly, calmly, firmly, respectfully, and in as few words as possible. Do not justify, get angry, or apologize for the boundary you are setting.

You are not responsible for the other person's reaction to the boundary you are setting. You are only responsible for communicating your boundary in a respectful manner. If it upset them, know it is their problem. Some people, especially those accustomed to controlling, abusing, or manipulating you, might test you. Plan on it, expect it, but remain firm. Remember, your behavior must match the boundaries you are setting. You cannot successfully establish a clear boundary if you send mixed messages by apologizing.

At first, you will probably feel selfish, guilty, or embarrassed when you set a boundary. Do it anyway and remind yourself you have a right to self-care. Setting boundaries takes practice and determination. Don't let anxiety, fear or guilt prevent you from taking care of yourself.

When you feel anger or resentment or find yourself whining or complaining, you probably need to set a boundary. Listen to yourself, determine what you need to do or say, then communicate assertively.

Learning to set healthy boundaries takes time. It is a process. Set them in your own time frame, not when someone else tells you.

Develop a support system of people who respect your right to set boundaries. Eliminate toxic persons from your life— those who want to manipulate, abuse, and control you.

Slide 100: Risking

Slide 101: Taking Risks

Letting go of what is out of your control.

Activity: two columns of control.

30 minutes

Slide 102: Safety Net

Have 1-2 people in your lives confront you if they see that you are acting differently. If you are exhibiting behaviors that are problematic. Somebody to say, "Are you okay? What's going on?"

And those people should be able to handle if you say, "mind your own business…"

People will automatically push others away if they are struggling.

If you know that people who are concerned about you are watching you – you are much more likely to address compassion fatigue on your own…to get the help you need.

Slide 103: Quote while participants ask questions.

Slide 104:

We started this conference with the quote: "*The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."* It is possible to stay dry while walking through water if we are protected. We can wear a wet suit, we can put on fishing waders or we can pull on rain boots. We can avoid getting we if we have a solid self-care plan in place.

# The Cost of Caring
# Evaluation Form

Your suggestions and comments are important to the organizers of this conference. ***Select 5 if you strongly agree, to 1 if you strongly disagree. Only circle one choice per statement.***

**OVERALL EVALUATION**

1. Overall, this was a worthwhile conference. 5 4 3 2 1

2. The handouts from the conference will be/were useful. 5 4 3 2 1

3. If offered, I'd attend additional conferences on this subject area. 5 4 3 2 1

4. I will try to implement the knowledge and skills learned in this conference into my practice. 5 4 3 2 1

5. The conference topic was of interest to me. 5 4 3 2 1

6. All objectives were met. 5 4 3 2 1

**PRESENTER: Caryn Honig MEd RD LD**

1. The presenter was prepared. 5 4 3 2 1

2. The presenter kept the interesting and lively. 5 4 3 2 1

3. The methodologies employed by the presenter were effective. 5 4 3 2 1

4. The presenter effectively answered questions. 5 4 3 2 1

5. The presenter communicated in a clear, understandable manner. 5 4 3 2 1

**PRESENTER: Keynote Speaker #1**

| | |
|---|---|
| 1. The presenter was prepared. | 5 4 3 2 1 |
| 2. The presenter kept the interesting and lively. | 5 4 3 2 1 |
| 3. The methodologies employed by the presenter were effective. | 5 4 3 2 1 |
| 4. The presenter effectively answered questions. | 5 4 3 2 1 |
| 5. The presenter communicated in a clear, understandable manner. | 5 4 3 2 1 |

**PRESENTER: Keynote Speaker #2**

| | |
|---|---|
| 1. The presenter was prepared. | 5 4 3 2 1 |
| 2. The presenter kept the interesting and lively. | 5 4 3 2 1 |
| 3. The methodologies employed by the presenter were effective. | 5 4 3 2 1 |
| 4. The presenter effectively answered questions. | 5 4 3 2 1 |
| 5. The presenter communicated in a clear, understandable manner. | 5 4 3 2 1 |

**PRESENTER: Keynote Speaker #2**

| | |
|---|---|
| 1. The presenter was prepared. | 5 4 3 2 1 |
| 2. The presenter kept the interesting and lively. | 5 4 3 2 1 |
| 3. The methodologies employed by the presenter were effective. | 5 4 3 2 1 |
| 4. The presenter effectively answered questions. | 5 4 3 2 1 |
| 5. The presenter communicated in a clear, understandable manner. | 5 4 3 2 1 |

**CONFERENCE AMMENITIES**

1. The room was comfortable (chairs, temperature, etc.) 5 4 3 2 1

2. The audio/visual was appropriate and effective. 5 4 3 2 1

3. The food was ideal (choices, taste, amount) 5 4 3 2 1

4. The location was ideal (convenience, parking) 5 4 3 2 1

**EXTRA ACTIVITIES. On a scale of 1-5 (5 being excellent, 1 being poor), please rate the following extra morning activities:**

Day One: Yoga 5 4 3 2 1

Day Two: Meditation 5 4 3 2 1

Day three: Pilates 5 4 3 2 1

**Overall Comments/Suggestions:**

________________________________________

________________________________________

________________________________________

________________________________________

Please leave the completed questionnaire in the box marked “Questionnaires”

Thank you.

# Appendix B: Interview Question Protocol for Registered Dietitians

Demographics:

1. What are your credentials?

2. Number of years that you have been a registered dietitian?

3. Number of years working with patients with eating disorders?

4. What type of setting do you work in (private practice, hospital, treatment center)?

5. Have you heard of compassion fatigue before? If so, how do you define compassion fatigue? (RQ1) (Definition then given)

6. Do you perceive that dietitians who treat patients with eating disorders at risk for developing compassion fatigue due to working with this population? (RQ2)

   a. If yes, why do you perceive that dietitians who treat patients with eating disorders are at risk for developing compassion fatigue? (RQ2)

   b. If no, why do you perceive that dietitians who treat patients with eating disorders are NOT at risk for developing compassion fatigue? (RQ2)

7. Have you experienced compassion fatigue?

   a. If yes, what symptoms did you experience? What were the contributing factors to developing compassion fatigue? Can you recall any one specific situation or patient experience which contributed to you experiencing compassion fatigue? (RQ2)

b. If no, are you at risk for developing compassion fatigue? Why or why not? (RQ2)

8. If you have experienced compassion fatigue, how have you managed compassion fatigue? Of those mentioned, what was most effective in managing compassion fatigue? (RQ3)

9. If you have not experienced compassion fatigue, how have you prevented getting compassion fatigue? (RQ3)

10. Do you have personal support to help you manage and prevent compassion fatigue? If yes, please explain. (RQ3)

11. Do you have professional support to help you manage and prevent compassion fatigue? If yes, please explain. (RQ3)

12. Have you ever received formal education/training about how to manage and prevent compassion fatigue? If yes, can you elaborate on how it has been or how it has not been effective to you in managing/preventing compassion fatigue? (RQ4)

13. Have you ever received formal education/training about self-care? Can you elaborate about how it has been or how it has not been effective to you in managing and preventing compassion fatigue? (RQ4)

14. What type of education/training about compassion fatigue would be helpful in managing and preventing compassion fatigue in dietitians who treat patients with eating disorders? (RQ4)

15. What type of education/training about self-care would be helpful in managing and preventing compassion fatigue in dietitians who treat patients with eating disorders? (RQ4)

Closing questions: As we wrap up, I have a few closing questions.

14. What advice would you give other registered dietitians who work with patients with eating disorders regarding compassion fatigue and self-care? (RQ2, RQ3, and RQ4)

15. Are there any other thoughts you'd like to share about compassion fatigue and self-care when treating patients with eating disorders? (RQ2, RQ3, and RQ4)

Thank you so much for your responses; they are most helpful.

Appendix C: Interview Question Protocol for Dietetic Educators

Demographics:

1. What are your credentials?

2. What year did you obtain your RD?

3. Number of years as a dietetic educator?

4. Have you ever treated patients who suffer from eating disorders? If so, what did you learn about treating patients with eating disorders? If not, what do you know about treating patients with eating disorders?

5. Have you heard about compassion fatigue before? If yes, how would you define compassion fatigue? (RQ1). (Definition is then provided)

6. Do you perceive that dietitians who treat patients with eating disorders are at risk for developing compassion fatigue due to working with this population?

    a. If yes, why do you perceive that dietitians who treat patients with eating disorders are at risk for developing compassion fatigue? (RQ2)

    b. If no, why do you perceive that dietitians who treat patients with eating disorders are NOT at risk for developing compassion fatigue? (RQ2)

7. Are you aware of any formal education/training that is offered about managing and preventing compassion fatigue in dietitians who treat patients with eating

disorders? What about education/training via supervision? What about for all nutrition students? (RQ3 & RQ4)

8. What type of formal education/training would be helpful to manage and prevent compassion fatigue in dietitians who treat patients with eating disorders? (RQ3 & RQ4)

9. Are you aware of any formal education/training offered about self-care to dietitians who treat patients with eating disorders? Is formal education/training about self-care offered to all nutrition students? (RQ3 & RQ4) If yes, what type of formal education/training is offered about self-care to dietitians who treat patients with eating disorders? (RQ3 & RQ4). If no, what type of formal education/training about self-care would be helpful for dietitians who treat patients with eating disorders? (RQ 3 & RQ4)

10. What type of training about compassion fatigue and self-care would be helpful for preventing and managing compassion fatigue in dietitians who work with patients with eating disorders? (RQ3 & RQ4)

11. What advice would you give registered dietitians who work with patients with eating disorders regarding compassion fatigue and self-care? (RQ3 and RQ4)

12. Are there any other thoughts you'd like to share about compassion fatigue and self-care when treating patients with eating disorders? (RQ1,RQ2, RQ3, & RQ4)

Thank you so much for your responses, they are most helpful.