THE RELATIONSHIP BETWEEN TRAUMA EXPERIENCES AND COMPASSION FATIGUE IN MENTAL HEALTH PROFESSIONALS: MODERATING ROLES OF EMOTION REGULATION DIFFICULTIES AND DIFFERENTIATION OF SELF

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ABSTRACT

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The current study investigated the moderating roles of difficulties in emotion regulation and differentiation of self in the relationship between trauma experiences and compassion fatigue in mental health professionals. As being related constructs, those variables were also investigated in terms of burnout and compassion satisfaction. The sample consists of 143 mental health professionals, including psychologists, psychological counselors, psychiatrists, and psychiatric nurses. The Demographic Form, Professional Quality of Life Scale - IV, Childhood Trauma Questionnaire, Difficulties in Emotion Regulation Brief Form, and Differentiation of Self Inventory Revised Form were administered to collect data. Moderation analysis revealed that differentiation of self moderated the relationship between childhood trauma history and compassion fatigue. Even though the main moderation effect of emotion regulation difficulties was not observed, the effect was significant together with differentiation of self. On the other hand, difficulties in emotion regulation,

differentiation of self, and the moderation effect of two variables together were significant in the relationship between the level of trauma exposure and compassion fatigue. The findings indicated that when mental health professionals experience emotional distress in empathic interaction with their clients' emotion regulation and self-differentiation could prevent the adverse impacts of the traumatic narratives. The findings of the study were discussed in terms of relevant literature. Limitations of the study and suggestions were presented for future research.

Keywords: Compassion Fatigue, Childhood Trauma History, Level of Trauma Exposure, Difficulties in Emotion Regulation, Differentiation of Self

ÖZET

RUH SAĞLIĞI UZMANLARININ TRAVMA DENEYİMLERİ VE ŞEFKAT YORGUNLUĞU ARASINDAKİ İLİŞKİ: DUYGU DÜZENLEME GÜÇLÜĞÜ VE BENLİĞİN AYRIMLAŞMASININ MODETÖR ROLLERİ

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Bu çalışma, ruh sağlığı uzmanlarının travma deneyimleri ve şefkat yorgunluğu arasındaki ilişkide duygu düzenleme güçlüğü ve benliğin ayrımlaşmasının düzenleyici rollerini araştırmıştır. Şefkat yorgunluğu ile ilişkili olmaları nedeniyle bu değişkenler tükenmişlik ve merhamet tatmini açısından da incelenmiştir. Örneklem, psikologlar, psikolojik danışmanlar, psikiyatristler ve psikiyatri hemşireleri dahil 143 ruh sağlığı uzmanından oluşmaktadır. Veri toplamak için Katılımcı Demografik Formu, Çalışanlar için Yaşam Kalitesi Ölçeği - IV, Çocukluk Çağı Ruhsal Travma Ölçeği, Duygu Düzenlemede Güçlükler Kısa Formu ve Benliğin Ayrımlaşması Ölçeği Gözden Geçirilmiş Formu uygulanmıştır. Moderasyon analizi, benliğin ayrımlaşmasının, çocukluk çağı travma öyküsü ile şefkat yorgunluğu arasındaki ilişkiyi anlamlı ölçüde düzenlediğini ortaya koymuştur. Duygu düzenleme güçlüklerinin temel düzenleyici etkisi gözlemlenmemesine rağmen bu etki benliğin

ayrımlaşması ile birlikte anlamlıdır. Öte yandan, travmaya maruz kalma düzeyi ile şefkat yorgunluğu arasındaki ilişkide duygu düzenleme güçlükleri, benliğin ayrımlaşması ve iki değişkenin birlikte düzenleyici etkisi anlamlı düzeydedir. Bulgular, ruh sağlığı profesyonellerinin danışanlarıyla empatik etkileşimde duygusal sıkıntı yaşadıklarında, duygu düzenleme ve benliğin ayrımlaşmasıını travmatik anlatıların olumsuz etkilerini önleyebileceğini göstermiştir. Araştırmanın bulguları ilgili literatür açısından tartışılmıştır. Araştırmanın sınırlılıkları belirtilmiş ve gelecek araştırmalar için öneriler sunulmuştur.

Anahtar Kelimeler: Merhamet Yorgunluğu, Çocukluk Çağı Travma Öyküsü, Travmaya Maruz Kalma Düzeyi, Duygu Düzenleme Güçlüğü, Benliğin Ayrımlaşması

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CHAPTER 1: INTRODUCTION

The word trauma was derived from the word ‘wound, injury’ in ancient Greek. This analogy both refers to receiving damage to the physical body and being hurt psychologically. As any physical damage to the body makes a wound on the shield of the human body, psychological traumas have the strength to tear apart and leave mark oa mark on humans’ mental integrityois and Ford, 2009). Definition of trauma captures those traumatic experiences that are unbearable, resulting in shattering humans' psychic integrity and emotions (Athanasiadou-Lewis, 2019). More generally, psychological trauma is sudden, unexpected, or non-normative; exceeding the individual's perceived ability to meet demands; and distrupting the individual's core psychological needs and associated schemas. (McCann and Pearlman, 2015). Van der Kolk (2007) asserts that traumatic experiences are the essential ingredients of human nature, emphasizing that the evolution of human beings includes being exposed to terrible events and learning from those experiences. Even though traumatic experiences are considered a natural consequence of being a human, they are unpredictable and leave a break on individuals continuing lives (Van Der Kolk, 1991). Thus, traumatic events are experienced as threats to an individual’s integrity and leave marks on the psychologisurvivors’ psychological well-beingrwhelming experiences might result in loss of power, helplessness, dissociation, confusion, and disruptive feelings (Gold, 2017).

Traumatic events are divided as being naturally caused, such as earthquakes, floodings, or fires, and being human made including rape, war, or accidents. Regardless of its cause, traumatic events threaten individuals’ sense of the world as being predictable and safe place. Such experiences could change the ongoing balance of an individual’s psychological, emotional, and biological capacity and avert the recognition of the present by fixating the memory on the particular event (Van Der Kolk, 2007). The consequences of traumatic experiences depend on the subjective experiences of individuals regarding their preexisting psychic integrity. Historically psychological trauma has been defined as caused by childhood adversities, developmental progress, and other life difficulties including both interpersonal and natural causes. According to Kessler et al. (2017) almost 70% of individuals experience at least one traumatic event over the life course. These striking results

show that the possibility of experiencing and encountering traumatic incidents is quite high in the general population and leaves individuals vulnerable to undesirable consequences.

1.1 The impact of Secondary Exposure to Traumatic Events

Herman (2015) states that psychological trauma leaves the survivor disempowered and disconnected from others. Therefore, recovery from trauma requires empowering the survivor by building new connections. According to Herman (2015), the recovery occurs not in isolation, but within the context of relationships. Concordantly, Stolorow (2015) suggests that emotional traumas, need to find a relational home to find meaning. Painful feelings which are held or attuned are thought to be more bearable since they can find meaning in the presence of the other (Stolorow, 2015). The psychotherapy process is among the contexts in which the presence of others enables the emotional pain to be transferred into a more bearable state in an individual's life. Individuals disclose their emotionally painful experiences to the therapeutic process and therapists facilitate exploring those narratives by reflecting on them in a tolerable manner. The interaction between the psychotherapist and client forms the therapeutic relationship in which the process of change occurs. Empathy is seen to be the key to the therapeutic relationship and is considered an essential part of the change in the therapeutic process (Figley and Nelson, 1989; Greenberg et al., 2001).

Empathic attunement of the mental health professional has been well documented in client outcomes. However, a therapeutic relationship has a reciprocal nature and influences both the client and the therapist (Rasmussen, 2005). Thus, the empathic relationship also influences some aspects of the mental health professionals' well-being (Thomas, 2013; Wagaman et al., 2015). Empathy is described as a 'double-edged sword', reflecting the positive and negative contributions to the impact of traumatic narratives on the therapeutic process (Russell and Brickell, 2015). Thus, being empathic can also leave clinicians to the contagious impact of traumatic narratives (Herman, 2015). Mental health professionals, including psychologists, psychological counselors, and psychiatrists, encounter the survivors of traumatic life events as a part of their profession. They mostly witness the most detailed information of the traumatic narratives of their clients. Being empathically engaged

with clients within the therapeutic relationship leaves mental health professionals emotionally triggered by such narratives and they experience various reactions that can coincide with their clients' reactions to traumatic experiences (Altekin, 2014). Traumatic events constantly challenge the therapist's inner balance, and like the patient, the therapist may withdraw or engage in impulsive, invasive behavior to cope with overwhelming feelings (Herman, 1992).

Empathic engagement with emotionally triggering context challenges the mental health professionals' inner regulating systems. Empathy has been described as "the capacity to share and understand emotional states of others in reference to oneself" (Lamm, Batson, and Decety, 2007). Thus for clinicians to effectively understand and reflect on the inner states of their clients is the central part of their relationship. Rogers (1957) puts empathy at the center of an effective therapeutic relationship and emphasizes the importance of being able to sense the client's inner world as if it is the clinician's own, but without losing the sense of 'as if' quality (Corcoran, 1983). The empathic ability of the clinician enhances the client to regulate and tolerate the strong affect, however, those emotional materials also influence the clinician's inner states (Applegate and Shapiro, 2005; Thomas and Otis, 2010). For this reason, the internal regulatory mechanisms of the clinicians might play an important role when undesirable emotional tension arises in their relationship with the clients. Research provides important support for mental health professionals for regulating the empathic ability in an 'as if' manner as suggested by Rogers (1957). Self-differentiation and emotion regulation were found to be effective protective factors for the inhibition of personal distress and avoidance of aversive arousal when connecting emphatically with others (Lamm, Batson, and Decety, 2007; Thomas and Otis, 2010). Self-differentiation provides mental health professionals to be detached from the emotional overarousal and prevent overidentification with the client (Decety and Lamm, 2006). On the other hand, by regulating the emotional arousal triggered by the client's inner states, mental health professionals could decrease the personal distress and provide effective empathic responses (Decety and Lamm, 2006).

The focus of this study is to identify how mental health professionals in a highly emotionally challenging context experience the vicarious impact of traumatic

narratives as they listen to their clients. Literature focusing on identifying risk and protective factors mostly emphasize the workplace or demographic factors contributing to the impact of secondary traumatization. Personal trauma history and exposure to clients' trauma are announced to be the prerequisite factors in the development of secondary trauma effects (Figley, 2002). Those factors might influence the clinician's empathic ability and increase personal distress. When the personal distress increases clinician's inner regulating systems are activated so that they could effectively respond to the client's emotional states. As suggested by Decety and Lamm (2006) self-differentiation and emotion regulation has a role to decrease the overarousal that is triggered by the empathic connection. Research conducted to better explain and identify possible risk factors for secondary traumatization revealed that empathy, emotional separation, emotion regulation, and detachment as inner psychological constructs of professionals predict the development of secondary trauma symptoms (Sabin-Farrell and Turpin, 2003; MacRitchie and Leibowitz, 2010; Thomas and Otis, 2010). Thus, another focus of this study is to expand the earlier research and investigate whether self-differentiation and difficulties in emotion regulation would predict the mental health professionals' experiences of compassion fatigue in the presence of personal trauma history and levels of exposure to clients' traumatic experiences.

1.2 Compassion Fatigue and Related Constructs

Most of the research focuses on the impact of the direct impact of trauma on individuals. However, recent investigations revealed that professionals who are indirectly exposed to traumatic experiences could also experience some adverse effects (Sabin-Farrell, and Turpin, 2003; Buchanan et al., 2006). Not only mental health professionals, but individuals who are in close contact within a helping and caring relationship with the traumatized individuals are at great risk of experiencing the adverse impact of trauma work. Social workers (Naturale, 2007; Bride, 2007), medical staff including physicians and nurses (Nimmo and Huggard, 2013; Beck, 2011), first responders (Greincacher et al., 2019), and forensic professionals (Bonach and Heckert, 2012; Levin et al., 2021) are among the ones who are at risk for indirect effects of traumatic experiences.

Research including those professionals revealed that there are several terms describing the consequences of being witness to the painful stories of individuals (Bride, 2004). These terms, including countertransference, burnout, secondary traumatic stress, vicarious traumatization, and compassion fatigue, are used reciprocally throughout the literature due to their resembling factors, instead, there are some distinctions reflecting the unique characteristics of those constructs. This current study will focus on identifying specifically the term compassion fatigue of mental health professionals. Before identifying the compassion fatigue model in more detail, related constructs will be presented to investigate the similar and distinctive features within the literature.

1.2.1 Secondary Traumatic Stress and Compassion Fatigue

Compassion fatigue was firstly described by Joinson (1992) reflecting the term as a form of burnout experienced within caregiving professions. Joinson (1992) used the term to apprehend the burnout feelings and a loss in the ability to nurture with the emergency room nurses who are indirectly impacted by their clients However, compassion fatigue has gained importance in the trauma field with the studies of Figley (1995a). Expanding the research on secondary victimization, Figley (1995b) concluded that secondary exposure to trauma has some consequences for a broad range of professions, including mental health professionals. Figley (1995a), first described secondary traumatic stress as a natural outcome of having an urge to help by being a witness to the suffering of other individuals who experiences traumatic events.

In the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) one of the diagnostic criteria for post-traumatic stress disorder is repeated or extreme exposure to the graphic details of the traumatic events (American Psychiatric Association, 2013). Professionals who work with trauma survivors or encounter traumatic events as a part of their work also are indirectly exposed to the details of the events and might mimic the symptoms related to post-traumatic stress disorder. Secondary traumatic stress and post-traumatic reactions are usual and crisis-related responses to being secondarily exposed to traumatic experiences. Secondary traumatic stress reactions are considered as having acute onset and last for a month. However, when the symptoms last for six months or more are described as

Secondary Traumatic Stress Disorder (Figley, 1999; Canfield, 2008). The symptoms mimic the symptoms of post-traumatic stress disorder, which include intrusions, reexperiencing, numbness, avoidance, hyperarousal, and hypervigilance (Figley, 2002; Collins and Long, 2003; Sabin-Farrell and Turpin, 2003).

Later, Figley (1995a) and Figley (2002) used the term compassion fatigue to reflect the symptoms of secondary traumatic stress because compassion fatigue has a more accessible frame and less pathologizing connotation (Baranowsky, 2002; Figley, 2002). Thus, throughout the literature, the terms secondary traumatic stress and compassion fatigue are used interchangeably (Figley, 2001; Stamm, 2010; Cieslak et al., 2014). Moreover, Ludick and Figley (2017) suggest that secondary traumatic stress is a general term for all sectors that work with trauma survivors, but compassion fatigue is more preferred term for helping professions. Figley (1995b) defines compassion fatigue as "a state of tension and preoccupation with clients' individual or cumulative trauma as manifested in one or more ways: re-experiencing the traumatic events, avoidance or numbing of reminders of the traumatic event, and persistent arousal". According to various perspectives, the term compassion fatigue has been defined as a cluster of emotional, and behavioral changes, including a lessened capacity for empathy, resulting from secondary traumatic stress and occurring as a concern for providing help to the traumatized or suffering individuals (Figley, 1995a; Adams, Boscarino, and Figley, 2006; Coetzee and Klopper, 2010).

Empathy and compassion reside at the core of an effective therapeutic alliance when working with individuals who are suffering from adversities in life (Figley, 2002). However, Figley (1995b) posits that as a "cost of caring", compassion fatigue is the result of providing an empathic relationship to the individuals suffering. Compassion fatigue covers the behavioral, emotional, and physiological changes because of exposure to traumatic experiences of clients (Bride, Radey, and Figley, 2007). As being used in relation with secondary traumatic stress, the symptoms of compassion fatigue include similar symptoms with post-traumatic stress disorder. The fatigued mental health professional would experience avoidance, numbing, arousal, or anxiety about the clients' experiences (Figley, 2002). These symptoms also disrupt clinicians' way of being emotionally present for the client and diminish their empathic abilities (Figley, 1995b; Ray et al., 2013).

The scope of this study will be an investigation of compassion fatigue, and the theoretical model and factors associated will be discussed in the following sections. However, there are other constructs concerning the impact of indirect exposure to trauma that will be presented briefly. Even though conceptual distinctions are still in debate through the literature, the main differences will be addressed in short.

1.2.2 Vicarious Trauma

Vicarious trauma is a term defined by Pearlman and Saaktvine (1995) and refers to the changes in the clinician's inner experiences through the empathic engagement with the traumatic narratives of others. This term incorporates both internal and external influences taking into consideration the individual's self.

Vicarious trauma is theoretically based on Constructivist Self Development Theory, which reflects the construction of the world around an individuals' experiences (McCann and Pearlman, 1990). According to the theory, any traumatic event should be investigated within the individual's personality, experiences, and the characteristics of the event in which sociocultural context it occurred. Thus, vicarious traumatization changes the way of individuals' overall experiences and their beliefs about the world. Vicarious traumatization would change individuals' frame of reference, self-capacities, ego resources, cognitive schemas around basic psychological needs including trust, safety, esteem, intimacy, and control, and memory systems.

Vicarious traumatization emphasizes individuals' internal experiences working with trauma victims and encompasses the cumulative responses to traumatic narratives. However, compassion fatigue is described as the behavioral, physiological, and emotional reactions to traumatic material. They both occur because of empathic engagement with the client (Figley, 1995). However, compassion fatigue has been considered as having a more rapid onset, and vicarious trauma is the cumulative changes as a response to the client's trauma experience (Kanno and Giddings, 2017).

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1.2.3 Countertransference

Among other constructs related to the impact of traumatic material on mental health professionals, countertransference has a long history and a broader definition within the psychotherapy practice. The contribution of early psychoanalytic theory sheds light on our understanding of what happens between the therapist and the client. Simply, the term describes both conscious and unconscious reactions of psychotherapists towards clients within a therapeutic process (Berzoff and Kita, 2010; Fatter and Hayes, 2013). Contemporary views define countertransference as a tool that enables therapists to gain access to the client's inner life through their own emotions evoked by the clients' narratives (Racker, 1988).

Even though countertransference reactions of therapists are not specific to therapeutic work with trauma survivors, such reactions could be more difficult for therapists to manage in the presence of client's trauma (Berzoff and Kita, 2010). Working with trauma survivors, clinicians might experience grief processes, including denial, anger, sadness, and depression when witnessing the suffering of individuals (Cunningham, 1999). In an emotionally challenging relationship with the clients, therapists might experience overidentification with the client, leading to blurred boundaries or avoiding reactions that detach the therapists to avoid the anxiety of the situation (Taylor, 2021). Besides having overlapping characteristics with compassion fatigue, countertransference is a reaction to the client's transference and is managed within the therapeutic process (Figley, 1995a). Kanter (2007) argues that compassion fatigue and countertransference explain the same phenomena. On the other hand, Figley (2002) differentiates those concepts by offering different remedies for each experience. Countertransference could be understood within the therapeutic context and could be resolved under supervision or personal psychotherapy. On the other hand, Figley (2002) suggests self-care techniques for the

resolution of compassion fatigue. Compassion fatigue is an accumulated experience of providing care for the individuals who suffer, which results in distortion in the therapist's meaning of life and emotional exhaustion from the work. However, countertransference reactions are immediate and unique for the client and are based on the intersubjective and unconscious world between the client and the therapist (Berzoff and Kita, 2010). These concepts might co-exist in clinicians who confront the traumatic narratives within the therapeutic context (Herman, 2015).

1.2.4 Burnout

Burnout has a long history among other terms that have been described for professionals working in the helping contexts. Burnout is conceptualized as a more general term that is associated mostly with eternal factors, such as caseloads, work environments, and bureaucratic factors (Canfield, 2008). Maslach (1976) identified burnout as a result of the cumulative responses to emotionally demanding situations and stressful work and life conditions. Burnout was conceptualized as work-related emotional distress that is comprised of emotional exhaustion, depersonalization, and a reduced capacity for personal accomplishments (Maslach, Schaufeli, and Leiter, 2001). Highly demanding workloads, lack of control over the work conditions, inadequate support including being rewarded and recognized, disruption of fairness in the workplace, disruption in the sense of community, and value conflicts are identified as the major environmental roots of professional burnout (Masclach and Leiter, 1997).

Burnout refers to the professional's feelings of emotional and physical tiredness which are followed by feeling negative emotions towards work and other areas of life, including the coworkers and clients. Moreover, burnout also results in a diminished sense of achievement of the individual, resulting in less involvement in the work (Schaufeli and Peeters, 2000). The overwhelming psychological and physical exhaustion that is the result of burnout might be experienced with somatic problems, emotional symptoms, such as being irritable, feeling anxious, behavioral symptoms that include absenteeism at work, substance abuse, and interpersonal symptoms, such as being less empathic to the client's suffering (Figley, 1995b). According to Figley (1995b), burnout diminishes the professionals' sense of their

capacities, abilities, and resources, so that professionals feel insufficient effectiveness when working with their clients.

Professional burnout has been linked to a perceived lack of professional support, work pressure, role conflict, and role ambiguity (Devilly, Wright, and Varker, 2009). Even though burnout is mostly associated with work-related factors and not directly linked with working in the trauma field, recent studies have found that burnout symptoms share similar symptoms with the secondary impact of trauma (Adams, Boscarino, and Figley, 2006). Thus, exposure to the traumatic narratives as a part of work increases the possibility of burnout.

On the other hand, individual factors, such as personal trauma history of the professionals also increases the risk for burnout. research indicates that especially having adverse experiences in childhood increases the risk for burnout in professionals working in helping services (Bride and Figley, 2007). In a recent study conducted with trainee counselors indicated that having a history of childhood adversities increased the likelihood of experiencing higher levels of burnout (Parker et al., 2022).

1.2.5 Compassion Satisfaction

Much of the research with regards to the impact of traumatic events and secondary exposure to traumatic experiences focus on the negative impacts of such experiences. However, not every individual who experiences traumatic events develop post-traumatic symptoms but might overcome adversity owing to some protective factors (Bonanno, 2008; Hambrick, 2018). Correspondingly, even though the research mostly targets identifying the negative consequences of trauma work (Figley, 2002; Killian, 2008; Hensel, et al., 2015), there are some shreds of evidence that highlight the importance of positive outcomes of working with trauma. Unlike other constructs addressing the detrimental impact of doing trauma work, compassion satisfaction reflects the beneficial facet of working with trauma survivors (Radey and Figley, 2007).

Research on compassion fatigue lead Figley and colleagues to investigate the affirmative aspects of working with individuals who are suffering, and they

concluded that positive aspects of trauma work might compensate for the negative components (Radey and Figley, 2007). Compassion satisfaction is described as the fulfillment and the sense of accomplishment the mental health professional experiences as a result of doing the work effectively (Stamm, 2005). Compassion satisfaction is influenced by the amount of control the mental health professional perceives over exposure to the traumatic material and the amount of support a mental health professional receives related to the trauma work (Stamm, 2002). How the professional perceives the work as satisfying, feelings of competency towards the exposure to traumatic narratives and the level of support that the professional obtains from the environment are the determinants of feeling compassion satisfaction (Stamm, 2002; Sodeke-Gregson, Holttum, and Billings, 2013).

Compassion satisfaction literature implies that the construct has an inverse relationship with compassion fatigue. The inverse relationship indicates that as compassion satisfaction increases, a decrease in compassion fatigue is expected (Rossi et al., 2012; Samios, Abel, and Rodzik., 2013). Moreover, compassion satisfaction protects the professional from the impact of compassion fatigue and burnout that the professional could experience (Radey and Figley, 2007). As compassion satisfaction performs as a balancing and protective factor for the adverse impacts of trauma work, the factors that contribute to compassion fatigue also influence the development of compassion satisfaction. Social support, having work-related support, years of education and experience, receiving trauma-specific training, and adaptive coping skills are among the vastly investigated factors that contribute to compassion satisfaction (Figley, 2002; Killian, 2008; Craig and Sprang, 2010; Rossi et al., 2012; Dehlin and Lundh, 2018). On the other hand, personal trauma history defined as a vulnerability factor for the adverse impact of working with trauma survivors, could also impact the professional's satisfaction with their work. having a personal trauma history might hinder the desirable parts of the work to rise on the surface. Studies investigating whether childhood traumatic experiences have relationship with compassion satisfaction indicate that when the professionals have lower levels of childhood traumatic experiences, they are more likely to exhibit compassion satisfaction (La Mott and Martin, 2017; Brown et al., 2022).

1.3 Research on Compassion Fatigue

Research revealed that compassion fatigue is a highly prevalent condition among the professionals who provide helping services to individuals in need (Turgoose and Maddox, 2017). Empathy is vital for mental health professionals when they provide effective therapeutic services for their clients, however suffering from compassion fatigue might result in a reduction in their capacity to be empathic and bear the suffering of clients (Figley, 2002). The reduction in empathic capacity would inevitably endanger the relationship between mental health professionals and their clients. thus, investigating the risk and protective factors is important to understand how compassion fatigue develops and could be reduced.

1.3.1 Compassion Fatigue Model

Upon extended research on compassion fatigue, Figley (2002) proposes a theoretical model in which the factors contributing to the development of compassion fatigue are introduced. Figley (2002) describes compassion as bearing the suffering of other individuals and suggests that being empathic and compassionate are the core elements for the development of compassion fatigue. Figley (2002) explains the model based on the psychotherapists' experiences. For psychotherapists to provide effective responses to their clients, empathy and emotional energy are the essential qualities that form the therapeutic relationship (Figley, 1995a; Figley, 2002). However, bearing the clients' suffering with empathy and compassion would cost the psychotherapists, which is called compassion fatigue (Figley, 2002).

In this theoretical model, Figley proposes that both the empathy-related components, and extraneous factors, such as exposure to clients' trauma, personal trauma history, and perceived stress contribute to the development of compassion fatigue (Figley, 2002). The cycle starts with *being exposed to clients*. The psychotherapist experiences the emotional energy by being exposed to the suffering client. This emotional energy triggered by the narratives of the client combines with the empathic ability of the psychotherapist, through which the clinician notices how the client suffers. In this model, Figley (2002) asserts that empathy is the prerequisite for compassion stress and compassion fatigue. *Empathic ability* both provides attunement for the therapist to the client's internal world and at the same time leaves the therapist vulnerable to the following adverse impact of such narratives. The

ability to be empathic alone is not sufficient for providing the required services to the clients. The psychotherapist should also have an *empathic concern*, which initiates the motivation to help others. Enough empathic concern leads psychotherapists to deliver the knowledge and training that are needed when helping others. With the comprehension of the clients' suffering through empathic ability and empathic concern, psychotherapists develop an *empathic response* that includes the efforts of reducing the suffering of clients. psychotherapists project their self into the client's perspective, in this way gain insight into the feelings, thoughts, and behaviors of their clients. Through empathic response psychotherapists, both benefit from a strong therapeutic relationship but are also influenced by the emotions that are elicited by their clients. The emotional energy triggered by the empathic response and continuing need to relieve the suffering of others transforms into *compassion stress* which left unmanaged contributes to the development of compassion fatigue with the pressure of other factors.

Sense of achievement and *disengagement* are proposed as protective factors for psychotherapists to manage compassion stress. Feeling a sense of achievement in the efforts for helping the client, psychotherapists could lower or prevent the compassion stress. If the psychotherapists could protect the distance between their own responsibilities and clients' experiences, the compassion stress is effectively managed. The clinician should be able to recognize the importance of self-care and release the thoughts, feelings and emotional impressions elicited by the client between the sessions. However, these protective factors might not always be sufficient. Figley (2002) claims that prolonged exposure to clients' narratives increases the responsibility to meet the demands, psychotherapists' own traumatic experiences which might be recalled through clients' narratives, and other life disruptions, such as illnesses, changes in lifestyle, and personal responsibilities also contribute to the development of compassion fatigue when combined with other mentioned factors.

1.3.2 Role of the Level of Exposure to Client's Trauma

As Figley (2002) described in the compassion fatigue model, exposure to the client's traumatic experiences is the determinant factor of the stress in mental health professionals. The exposure indicates the direct interaction with the suffering of

clients who apply for mental health services (Figley and Figley, 2017). Exposure to suffering culminates the compassion stress and activates the cognitive and emotional reactions of mental health professionals (Karademas, 2009; Figley and Figley, 2017). Karademas (2009) indicates that minimizing the trauma caseloads could be a protective factor since prolonged and loaded exposure might result in disruption in overall well-being. Prolonged exposure increases mental health professionals' responsibility for providing care to the suffering, and the mental health professionals eventually would be unable to reduce the compassion stress (Figley, 2011). Repeated exposure to the traumatic narratives through empathic engagement leaves mental health professionals cumulatively disrupted emotional energy (Radey and Figley, 2007).

The level of exposure to the client's traumatic narratives has been released as the prerequisite factor for the development of compassion fatigue following the compassion stress and emotional energy provided to the clients. The level of exposure refers to the frequency, severity, and duration of direct interaction with the client's traumatic narratives (Dutton and Rubinstein, 1995). Moreover, the level of development of adverse reaction to the exposure is accepted to be unique for each mental health professional as some traumatic narratives could be harder to manage and the level of exposure could differ among mental health professionals (Cerney, 1995; Dutton and Rubinstein, 1995; MacRitchie and Leibowitz, 2010). The intensity of the traumatic event, the level of unpredictability, and the source of traumatic experiences might explain the unique responses elicited through exposure (Macliam, 2003; MacRitchie and Leibowitz, 2010). Even though the level of exposure has been declared as the subjective experience of mental health professionals, research examining the association between the level of exposure and compassion fatigue reveals that higher trauma caseloads increase the possibility of secondary traumatic stress or compassion fatigue (Steed and Bicknell, 2001). Studies indicate that the average percentage of trauma cases that the mental health professionals have on their caseloads increased the risk for compassion fatigue (Sprang, Clark, and Whitt-Woosley, 2007; Craig and Sprang, 2010), supporting the idea that the level of exposure could be accepted as a vulnerability factor for the adverse impacts.

The level of exposure has been investigated within the literature by assessing either the number of trauma cases in their caseloads or the average of hours that mental health professionals spend with trauma cases. However, how frequently mental health professionals encounter traumatic narratives and the types of traumatic events they listen from their clients were not included in most of the studies. MacRitchie and Leibowitz (2010) proposed a checklist to conceptualize the caseload by asking about the frequency and the type of traumatic events that the professionals encountered within the three months. Even though the findings of the study did not reveal a significant association between the level of trauma exposure and secondary traumatic stress (MacRitchie and Leibowitz, 2010), examining the exposure levels through the frequency and type of traumatic events is important to investigate the subjective perceptions of mental health professionals regarding their trauma exposure. On the other hand, some studies reveal insignificant results in the predictive role of the level of exposure on compassion fatigue (Sodeke-Gregson, Holttum, and Billings, 2013). These inconsistent results might be related to some other factors, such as the personal variables that influence the vulnerability to compassion fatigue.

1.3.3 Role of Personal Trauma History

Figley (2002) identifies the personal trauma history of the clinician as a risk factor for compassion fatigue because traumatic memories could be triggered when encountering the client's trauma. Like the clients, mental health professionals also experience traumatic events throughout their lives and become vulnerable to further disruptions in their overall functioning. When the traumatic memories are reactivated through the empathic connection with the client, mental health professionals become vulnerable to personal distress, increased anxiety, or depressed mood (Figley and Figley, 2017).

In line with Figley's model (2002), studies investigating the impact of personal trauma history on compassion fatigue revealed complementary results. Throughout the secondary traumatization literature, investigators suggest that personal history of trauma can be regarded as a risk factor for vicarious trauma and compassion fatigue (Ghahramanlou and Brodbeck, 2000; Deighton, Gurris, and Traue, 2007; Killian, 2008, Hensel et al., 2015). Pearlman and Mac Ian (1995) suggest trauma therapists

with a personal trauma background presented heightened arousal symptoms and higher cognitive disruptions. Research on the impact of personal trauma history of professionals investigated both past traumas covering the childhood experiences, and more recent traumatic experiences that happened in adulthood. To investigate whether there is a difference between the types of trauma history Kassam-Adams (1995) studied with psychotherapists and revealed that childhood traumatic events accounted more for the prediction of secondary trauma symptoms than the recent events (Bride, 2004).

Childhood traumatic experiences have been found to be increasing the risk for compassion fatigue (Newell and MacNeil, 2010). Nelson-Gardell and Harris (2003) investigated the association between childhood trauma history and secondary trauma symptoms with the child welfare workers and found out that childhood trauma history increases the risk for adverse impacts of trauma work. In a similar vein, childhood trauma history increases the risk of disrupted cognitions of clinicians working with trauma cases, and for vicarious trauma symptoms (Dunkley and Whelan, 2006; VanDeusen and Way, 2006).

The impact of trauma on individuals has been studied extensively. One of the prominent research subjects is how childhood adversities change the overall functioning throughout the lifespan of individuals. Bruce Perry (2009) has been investigating the impact of early childhood adversities and revealed that stress in the early years of life would result in increased susceptibility to stress, anxiety, and other disruptions in the functioning of individuals in their following years. Research examining the impact of adverse childhood experiences also reveals the parallel outcomes indicating that childhood trauma increases the vulnerability to psychological and physical difficulties in later life (Drapeau and Perry, 2004; Kim, Talbot, and Ciccihetti, 2009). Clinicians are also vulnerable to the adverse impact of childhood experiences which can be brought to the surface through their interactions with the clients. The clients' traumatic experiences might trigger the mental health professionals' early memories and experiences. They might overidentify with the clients' narratives and their empathic connection could get disrupted. Thus, they become more vulnerable to the adverse impact of the traumatic narratives and might develop compassion fatigue symptoms.

Not every mental health professional with a history of personal trauma experiences adverse outcomes from working in the trauma field. Ray et al. (2013) have found that mental health providers are at risk for compassion fatigue even in the absence of personal trauma history. However, personal history of trauma increases the emotional energy and anxiety of mental health professionals through empathic engagement with the clients. Thus, the inconsistent results could be explained by other factors that are associated with anxiety management skills of mental health professionals when they encounter emotionally triggering clients.

1.3.4 Other Factors Associated with Compassion Fatigue

The extended literature on the issue of compassion fatigue indicates that compassion fatigue is an occupational hazard for mental health professionals who work with traumatic narratives (Killian, 2008; Craig and Sprang, 2010; Sodeke-Gregson, Holttum, and Billings, 2013; Altekin, 2014; Turgoose and Maddox; 2017). However, not every mental health professional who engages in therapeutic work with clients develops adverse symptoms. Like the individuals who vary in responses to adversities in their lives, mental health professionals also differ in their reactions to their clients' traumatic narratives. Differences in the professionals' reactions lead researchers to investigate the factors which might provide risk and protective factors for compassion fatigue (Figley, 2002; Craig and Sprang, 2010; Ray et al., 2013). The research shows that both the personal variables and experiences and the work-related environmental factors contribute to the development of compassion fatigue (Schimpff, 2019).

Personal risk factors contributing to compassion fatigue are mostly investigated under demographic categories. Gender was found to be a risk factor for compassion fatigue (Sprang, Clark, and Whitt-Woosley, 2007; Rossi et al., 2012). Females were found to be more prone to the negative impacts of their profession. However, these findings are inconsistent throughout the literature since some studies suggest that gender is not a significant predictor of compassion fatigue (Thompson, Amatea, and Thompson, 2014). Age and years of experience are the other variables that have been investigated as personal variables. The younger age of mental health professionals was found to be an increasing factor for compassion fatigue (Craig and Sprang, 2010; Sodeke-Gregson, Holttum, and Billings, 2013). However, Craig and Sprang

(2010) suggest that years of experience in the profession account more for predicting compassion fatigue, decreasing the predictive role of age. Other studies examining the role of years of experience reveal contradictory results. Some studies indicate that increase in the years of experience in the field raises the likelihood of compassion fatigue (Birck, 2001; Robins, Meltzer, and Zelikovsky, 2009). On the contrary, some studies suggest that compassion fatigue decreases as the experience year increases (Craig and Sprang, 2010; Thompson, Amatea, and Thompson, 2014). These contrasting results could be related to the other factors that might contribute to compassion fatigue, such as the number of trauma cases in their caseloads or coping and self-care strategies that the mental health professionals implement (Turgoose and Maddox, 2017).

Research indicates that not only demographic variables of mental health professionals contribute as a risk factor for compassion fatigue, but also the work-related variables have been investigated. Mental health professionals who received trauma-specific training were found to experience lower levels of compassion fatigue and higher levels of compassion satisfaction (Sprang, Clark, and Witt-Woosley, 2007). Trauma-specific training might enhance professionals' self-efficacy by providing specific and effective intervention skills when working with trauma (Sprang, Clark, and Witt-Woosley, 2007). Additionally, receiving such training could enhance the awareness of professionals on the adverse impact of working with traumatic materials. For a mental health professional supervision and personal therapy, as can be referred to as work-related support components, are essential factors to effectively conduct the therapeutic services. Supervision provides emotional support and enhances mental health professionals' effectiveness when working with clients who experienced traumatic incidence (Bell, Kulkarni, and Dalton, 2003; Barrett and Barber, 2005). Throughout the research forms of supervision, such as peer or personal supervision, are found to be significant protective factors for secondary traumatic stress (Creamer and Liddle, 2005; Cieslak et al., 2014; Kanno, Kim, and Constance-Huggins, 2016). Moreover, Linley and Joseph (2007) suggest that therapists who received personal therapy and supervision were associated with positive psychological functioning when providing therapeutic work to traumatized clients.

In a study conducted in Turkey, Zara and İçöz (2011) revealed that secondary traumatization of mental health professionals was associated with workplace factors, type of profession, level of education, and receiving supervision. Their results indicated that individuals who received supervision would experience lesser degrees of secondary traumatic stress. They also indicated that type of trauma that mental health professionals encounter was a predictive factor in secondary traumatization. Interpersonal traumas, namely traumatic incidences caused by humans, were found to be more predictive of secondary traumatic stress other than natural causes (Zara and İçöz, 2011).

Most of the research on compassion fatigue or secondary traumatization literature focuses on the demographic or external components as risk factors. However, as individuals differ in terms of their inner experiences in the face of adversities in life, the intrapsychic experiences of mental health professionals could be predictive of how they are influenced by the traumatic experiences of their clients. Empathy is regarded as the prerequisite for the development of compassion fatigue. Empathy as the inner experience of mental health professionals has been documented as a predictive factor in the development of compassion fatigue (MacRitchie and Leibowitz, 2010; Thomas and Otis, 2010). Higher scores on empathy scales were found to be the increasing factor for compassion fatigue. Moreover, Thomas and Otis (2010) indicate that personal distress triggered by empathic engagement increases the possibility of compassion fatigue. Empathy was also reported as a moderating factor in the relationship between the previous trauma history of participants and compassion fatigue (MacRitchie and Leibowitz, 2010). Emotional experiences of professionals were also found to be associated with compassion fatigue. As conceptualized as being differentiated and remaining separate from the clients' experiences, emotional separation was suggested as a protective factor on the adverse impact of trauma work (Badger, Royse, and Craig, 2008; Thomas and Otis, 2010). Emotional separation functions as a protective system when the empathic concern of the mental health professional raises by providing maintenance of the balance of emotional distance and anxiety provoked by empathic engagement (Badger, Royse, and Craig, 2008).

Following these studies reveal that both workplace factors, personal variables, and inner psychological processes of mental health professionals provide information to understand the underlying factors contributing to compassion fatigue. As Figley (2002) stated in the compassion fatigue model, the level of trauma exposure and personal trauma history of clinicians play a crucial role in the development of compassion fatigue by increasing the clinician's empathic stress and responsibility to provide an empathic response for their clients. The literature provides conflicting results in terms of the relationship between the level of trauma exposure, personal trauma history, and compassion fatigue symptoms. Thus, investigating whether those variables are moderated by different components remains important to comprehensively understand how these factors contribute to the development of compassion fatigue. Empathic interaction with the clients' traumatic experiences has the potential to trigger the inner experiences of mental health professionals, especially when they have personal traumatic histories. Without being aware of their own emotions, having difficulties in the emotion regulation, and lack of intact boundaries and overidentification with the clients' trauma could lead mental health professionals vulnerable for the adverse impacts of trauma work. Thus, the ability to regulate emotions and protect boundaries could prevent the adverse impact when encountering traumatic experiences. Moreover, prolonged exposure to the traumatic material leaves mental health professionals deprived of emotional energy by increasing their responsibility to care for their clients. For this purpose, the focus of this study is to investigate the moderating roles of difficulties in emotion regulation and self-differentiation, which are thought to be regulating functions for the emotional energy generated by trauma exposure and personal trauma history.

1.4 Emotion Regulation

1.4.1 Definition of Emotion Regulation

Emotions are defined as the processes that establish, maintain, or disrupt the relationship between the individual and the internal or external environment (Campos, Campos, and Barrett, 1989). Emotions facilitate how individuals adaptively respond to the environment. Living in the social context, one of the most important functions of emotions is that they regulate social interactions so that they are the fundamental aspects of social functioning. They allow individuals to connect with other people, understand other people's reactions, regulate their own, and attend

to prosocial actions (Weilenman et al., 2018). Emotions can be described as processing out of awareness, simultaneous, and promoting changes in response systems (Gross and Munoz, 1995). Thus, they are conceptualized as having irresistible and uncontrollable forces (Koole, 2009). On the other side of the coin, Gross (2002) asserts that emotions do not force individuals to respond in certain circumstances, but they increase individuals' possibility to react to the events. Thus, emotions can be defined as controllable and manageable in some respects. Undesirable consequences might occur when the emotions are evoked, and the intensity cannot be tolerable. From this perspective, regulation of emotions remains essential for individuals to adaptively continue their lives, (Helion, Krueger, and Ochsner, 2019).

In general terms, emotion regulation is an ability that enables individuals to determine when and how to endure their emotions, and how to disclose their reactions (Gross, 1998). According to Eisenberg et al. (2000), emotion regulation is a process that includes the initiation, maintenance, and modulation of emotions which also results in changing the intensity and duration of inner and physiological states evoked by emotions, which serves for individuals to accomplish their goals. Gratz and Roemer (2004) identify emotion regulation as a combination of recognizing and understanding emotions, acceptance of both desirable and undesirable emotions, choosing appropriate emotion regulation skills, and the ability to perform goal-oriented behaviors while experiencing undesirable emotions. Emotion regulation skills develop based on the characteristics of early interactions with caregivers, and they are determined by psycho-biological factors. In the early years of development, by interacting with caregivers, the child learns how to regulate emotions by mirroring the primary caregivers' responses. The responsiveness of the caregiver to the child's distress determines their emotional communication, and with the synchrony provided by the caregiver, the child acquires skills for self-regulation (Sidal, 2018).

Gratz and Roemer (2004) emphasize the difficulties in emotion regulation by referring to the deficiencies in identification, acceptance, and engaging in goal-directed behaviors while experiencing the emotions. Difficulties do not occur due to emotions themselves, but they occur because of the lack of individuals' ability to be aware of emotions, accept their emotions and maintain the functionality while the

undesirable emotions are present (Leahy, Tirch, and Napolitano, 2011). Since emotion regulation enhances individuals' ability to regulate the duration and intensity of their emotions, it promotes individuals' adaptability to the environment. On the other hand, difficulties in emotion regulation refer to la ack of effective regulation of undesirable emotions in terms of reactivity, intensity, endurance and lack of adaptability to situational demands (Gratz and Roemer, 2004). Gratz and Roemer (2004) assert that rather than controlling the emotions, regulation of emotions is the modulation of emotions in the service of reduction of the urgency of the emotions to be in control of behavior. In contrast, emotion regulation difficulties are defined as the frustrations or lack of modulations of arousal with the emotional experiences and expressions towards the events that individuals encounter (Cole, Michel, and Teti, 1994).

Difficulties in emotion regulation could be an indicator of psychological adjustment problems and disruption in the functionality and social interactions of individuals since emotion regulation strategies act as a way of coping in times of adversities in life (Cole, Michel, and Teti 1994). Individuals experiencing emotion regulation difficulties might perform ineffectively in emotional and social situations (Roth et al., 2014). Cumulative consequences of difficulties in emotion regulation might reflect the maintenance and increase in undesirable affective experiences (Campbell-Sills and Barlow, 2007). Furthermore, individuals with emotion regulation difficulties have obstacles in interpersonal relationships due to having lack of convenient responses in social situations (Akdur and Aslan, 2017). Overall, difficulties in emotion regulation play an important role in the development of various psychopathologies by covering and organizing each area in individuals' lives and impacting their functionality.

1.4.2 Emotion Regulation and Compassion Fatigue

A therapeutic process is an emotionally charged interpersonal interaction in which both the client and the therapist influence each other's well-being (Soma et al., 2020). Through the empathic connection with the client, the therapist provides a holding environment through which the client could reach previously avoided emotional arousal and acquire abilities to regulate emotions with the emotional responses of the therapist (Soma et al., 2020). Likewise, therapists can also be

impacted by the client's emotional responses through the psychological processes including emotional contagion (Hatfield, Cacioppo, and Rapson, 1994). Trauma is an emotionally overwhelming experience. The emotional load of the traumatic narratives could be overwhelming for both the ones who directly experience and for the ones who secondarily experience (MacRitchie and Leibowitz, 2010). Thus, mental health professionals who are indirectly exposed to trauma through their clients' narratives might be emotionally triggered, and experience vicarious reactions to trauma. Thus, the emotion regulation abilities of the mental health professionals who work in highly emotion-triggering contexts could provide an understanding of the underlying mechanisms of compassion fatigue.

Research on the examination of emotion regulation difficulties and compassion fatigue is very limited. The symptoms of compassion fatigue are defined as sharing similar features with post-traumatic stress disorder symptoms (Figley, 2003). In a study conducted by Ehring and Quack (2010), emotion regulation difficulties were found to be a strong predictor of the development and maintenance of post-traumatic stress disorder. Similar findings were found in terms of the impact of secondary exposure to trauma. The study conducted by Măirean (2016) revealed that cognitive reappraisal, an adaptive emotion regulation strategy, was negatively correlated with secondary traumatic stress, and expressive suppression a maladaptive emotion regulation strategy was positively associated with secondary traumatic stress symptoms. Moreover, compassion satisfaction was found to be positively related to cognitive reappraisal. These results seem empirically parallel to the results of the research investigating emotion regulation and primary exposure to trauma. Expressive suppression was also found to be positively correlated with secondary traumatic stress, and compassion satisfaction was found to be the mediator between cognitive reappraisal and psychological well-being of mental health professionals (Amjad, Abbasi, and Ijaz, 2020). These findings suggest that maladaptive emotion regulation strategies could be a risk factor for secondary traumatic stress. On the other hand, professionals who can reinterpret the anxiety-provoking situations and regulate their emotions will find the situation less threatening, which will increase compassion satisfaction and psychological well-being eventually. With the findings from the study with protection officers, Benuto et al. (2020) claim that emotion regulation mediates the relationship between secondary traumatic stress and

maladaptive coping, which is found as a risk factor for secondary traumatic stress. These findings reflect the importance of emotion regulation as a buffer for the maintenance of both maladaptive coping styles and secondary traumatic stress symptoms for the professionals.

Empathic ability both provides mental health professionals be attuned and responsive to the narratives of their clients, and also increases their vulnerability to the secondary effects of working with trauma survivors (Figley, 1995; Ludick and Figley, 2016). When working with trauma narratives, empathic listening arouses the emotions vicariously, so that the regulation of vicarious emotions would prevent the aversive consequences that mental health professionals would experience. Decety and Jackson (2004) assert that an empathic response would occur in a beneficial direction when the emotions are regulated. In a dissertation study, conducted with mental health professionals in Turkey, Cemgil (2019) investigated whether difficulties in emotion regulation moderates the relationship between empathy and secondary traumatic stress. Results of the study conducted with mental health professionals in Turkey showed that difficulties in emotion regulation significantly and positively correlated with secondary traumatic stress and burnout, whereas negatively related to compassion satisfaction. Mental health professionals with higher levels of emotion regulation difficulties exhibited increased levels of secondary traumatic stress and burnout symptoms, but decreased their compassion satisfaction levels (Cemgil, 2019). As supported by the earlier studies, adaptive emotion regulation strategies of mental health professionals could act as a protective factor when working in emotion-triggering conditions, especially when working with the clients' traumatic experiences.

1.5 Differentiation of Self

1.5.1 Definition of Differentiation of Self

Bowen (1978) first described differentiation of self as a construct in family systems theory. According to this theory, both the demand for individuality and closeness are fundamental needs that balance individuals within their family of origin (Kerr and Bowen, 1988). In more general terms, differentiation of self refers to an individual's ability to sustain strong emotional and cognitive functioning while balancing intimacy and autonomy in interpersonal interactions (Bowen, 1978; Kerr

and Bowen, 1988). Hence, differentiation of self is comprised of two parts. The first one is the intrapersonal aspect that reflects differentiating thinking from feeling by regulating the emotional responses. Higher levels of self-differentiation in this domain reflect that an individual would experience less emotional reactivity, the ability to manage stress, and a stronger sense of autonomy when encountering stressful situations (Kerr and Bowen, 1988). The second one is the interpersonal component that enables the preservation of an autonomous sense of self through the emotional interaction with others (Kerr and Bowen, 1988; Titelman, 2015). This component determines that individuals with higher levels of self-differentiation could preserve healthy boundaries with others when pressured by keeping the distance balanced and without enmeshment with others (Kerr and Bowen, 1988; Skowron and Schmitt, 2003; Stapley and Murdock, 2020).

Differentiation of self has been investigated under four factors that reflect the interpersonal and intrapersonal dimensions. *Emotional reactivity* reflects the individual's ability to remain calm in emotionally triggering settings with other people and the tendency to giving impulsive decisions in stressful situations (Bowen, 1978; Kerr and Bowen, 1988). *I position* demonstrates the individual's ability to maintain individuality in relationships and the ability to protect own beliefs and opinions when encountering emotional distress in interpersonal settings (Bowen, 1978; Jankowski and Hooper, 2012). When the individual feels an emotional burden within the interpersonal setting, distancing oneself from others to diminish the emotional stress is described as an *emotional cutoff* (Kerr and Bowen, 1988; Jankowski and Hooper, 2012). The last dimension is called *Fusion with others* and reflects the individual's degree of closeness and enmeshment in the relationships (Kerr and Bowen, 1988; Jankowski and Hooper, 2012).

Being established in the family of origin, an individual's level of self-differentiation could be the determining factor for future relationships and psychological functioning (Kerr and Bowen, 1988; Peleg-Popko, 2002). Skowron and Friedlander (1998) claim that individuals high in the self-differentiation spectrum would posit more flexibility, better coping skills in stressful situations, and maintain the balance between emotionality and rationality when preserving the autonomy in the interpersonal relationships. From this perspective, the level of self-

differentiation is the determinant of the individual's reactions to life stressors and psychological functioning (Skowron and Friedlander, 1998; Bartle-Haring and Probst, 2004). Research conducted on self-differentiation reveals that the level of differentiation of self is related to psychological well-being (Skowron and Friedlander, 1998; Skowron, Holmes, and Sabatelli, 2003; Skowron, Stanley, and Shapiro, 2009), resilience (Hooper, Marotta, and Lanthier, 2008), and social adjustment (Hosseinizadeh, 2014). Lower levels of self-differentiation are related to anxiety (Peleg-Popko, 2004; Knauth, Skowron, and Escobar, 2006), depression (Simon, DiPlacido, and Conway, 2019), and interpersonal stress (Skowron, Stanley, and Shapiro, 2009). Additionally, the moderation effect of differentiation of self has been validated by Murdock and Gore (2004) in the relationship between perceived stress and psychological functioning.

1.5.2 Differentiation of Self and Compassion Fatigue

Personal traits of mental health professionals have been regarded as playing a significant influence in the relationship with clients (Lawson and Sivo, 1998), and these characteristics develop initially within the intergenerational environment of the family of origin (Bowen, 1978). There has been no research found directly investigating the relationship between differentiation of self and compassion fatigue. However, as the concept of self-differentiation is not limited to family contexts and is mostly related to the interpersonal relationships, examining the construct in the high emotion triggering interpersonal situations, such as in mental health professionals, would provide information on how the personal characteristics of professionals their responses to the adverse effects of their professions.

Bowen (1978) asserts that dealing with the needs of others within the emotional contexts would provoke anxiety. As a result of the increased anxiety, individuals choose to avoid distress by either distancing from the relationship or over-involving with the relationship to regulate the problem and extinguish the distress (Ferrera, 2014). Those reactions seem closely related to the symptoms of compassion fatigue in which the mental health professionals would try to distract themselves from the client or be overly involved in the client's narratives. The empathic ability and the empathic response of mental health professionals would provoke anxious feelings, especially when working with emotionally intense situations, just as it is in working

with trauma cases. One of the focuses of empathy research is how interpersonal self-other differentiation promotes the regulation of empathy in prosocial behaviors in contrast to personal distress (Decety and Jackson, 2004). Based on this perspective, in the emotionally triggering context when working with trauma survivors, differentiation of self could be the facilitator of managing the empathic responses by keeping the boundaries with clients and balancing the emotional and intellectual context. In other words, mental health professionals with higher levels of differentiation of self are more likely to distinguish their own experiences from their clients', effectively manage the interpersonal boundaries without being fused, and manage emotional reactions through their interactions, so that they could protect themselves from the adverse impact of secondary exposure to traumatic narratives.

Differentiation of self has been studied as a factor predicting countertransference management of psychotherapists. Fatter and Hayes (2013) conducted a study with 78 therapist trainees to investigate the predicting factors for countertransference management. They concluded that even though the overall level of self-differentiation did not significantly predict countertransference management, therapists who reported high in the I-position domain demonstrated better management of emotional stress, as evaluated with countertransference behaviors. They asserted that maintaining a sense of autonomy would decrease the anxiety triggered during the sessions with clients (Fatter and Hayes, 2013). Consistently, the study conducted by Connery and Murdock (2019) revealed that therapists who reported higher levels of differentiation of self demonstrated less overinvolved and under-involved countertransference feelings and behaviors toward their clients. These findings indicate that differentiation of self has a protective role against the harmful consequences that psychotherapists might experience about their clients. Moreover, differentiation of self can provide better management of closeness and distance in therapeutic encounters and protect the therapists from the intensity of feelings evoked by the client's narratives.

Moreover, emotional separation, which is similar to differentiation of self, reflects being separated from the emotional perspectives from other individiduals. In a study with conducted with 171 social workers Thomas and Otis (2010) have found that emotional separation negatively predicted the level of compassion fatigue and

burnout, however positively predicted compassion satisfaction. They concluded that when the professionals could balance the empathic concern and emotional separation they could lower the risk for compassion fatigue and burnout, and increase the possibility of compassion satisfaction.

Differentiation of self has also been found as a protective factor for the effects of secondary exposure to trauma. Halevi and Idisis (2018) investigated the relationship between differentiation of self and vicarious trauma with a sample of 134 therapists and concluded that both interpersonal and intrapersonal dimensions of self-differentiation significantly predict lower levels of vicarious trauma in therapists. They presumed that differentiation of self as a personal characteristic of the therapists would bring clear boundaries, better adjustment, and effective coping under stressful situations without being overwhelmed and remain autonomous in their relationship with clients.

According to Halevi and Idisis (2018), when therapists are under stress, a high level of self-differentiation promotes maintaining a clear sense of self and efficient coping. With the ability to separate the emotional experiences of their clients, therapists could benefit from preserving definite and adjustable boundaries. They also assert that therapists' separation of their own emotional experience from the clients' emotional states reduces the adverse reactions towards the exposure to unpleasant narratives emerging in therapeutic context (Halevi and Idisis, 2018). In conclusion, improving mental health professionals' self-differentiation could assist them to maintain separation without overidentification with the clients' emotional world while working with clients' traumatic and emotionally triggering experiences.

1.6 Aim of The Study

Mental health professionals witness traumatic events in the stories of their clients who are consulting them for treatment. Being empathically engaged with such traumatic stories throughout the therapeutic process leaves mental health professionals vulnerable to the contagious impact of traumatic narratives (Herman, 2015). Empathic engagement with the client leads to experiencing the emotional distress of clients and might contribute to the development of compassion fatigue (Figley, 2002). Even though there is a substantial amount of research conducted on

compassion fatigue, most of the studies focus on identifying the prevalence rates, and risk factors associated with demographic or workplace-related components. However, in the current study, the impact of inner psychological experiences of mental health professionals, namely emotion regulation difficulties and differentiation of self levels will be explored.

Personal trauma history and the level of trauma exposure are suggested to be the risk factors that contribute to the development of compassion fatigue, which elicits difficulties in empathic reactions (Figley, 2002). However, there are inconsistent findings with regards to the impact of the level of trauma exposure and personal trauma history. Some studies found that personal trauma history, especially childhood trauma, and the level of trauma exposure of mental health professionals contribute to the development of compassion fatigue, however, some studies did not validate these results (Ray et al., 2013, Sodeke-Gregson, Holttum, and Billings, 2013). There might be other factors, especially inner psychological experiences of mental health professionals when dealing with emotional difficulties, moderating the risk factors in their relationship with compassion fatigue. There is limited research investigating the impact of psychological variables of mental health professionals on the development of compassion fatigue.

The current study aims to investigate how mental health professionals' emotion regulation difficulties and self-differentiation levels moderate the relationship between personal trauma history and compassion fatigue and the level of trauma exposure and compassion fatigue. The moderating roles of emotion regulation and self-differentiation will also be explored in terms of burnout and compassion satisfaction.

Since not all professionals experience distress related to working with trauma, understanding the protective and risk factors remains important in secondary trauma research. Understanding the possible predictor and moderator factors that contribute to the adverse impact of trauma work would enable the practitioners to develop and implement protective strategies and include those strategies in the training programs for the mental health professionals. This study will provide a significant contribution to the field by investigating the predictive and moderating roles of emotion

regulation and self-differentiation on compassion fatigue, burnout, and compassion satisfaction.

1.6.1 Hypotheses

H1: A significant positive correlation is expected between childhood trauma and compassion fatigue, and between childhood trauma and burnout, whereas a significant negative correlation is expected between childhood trauma and compassion satisfaction.

H2: A significant positive correlation is expected between the level of trauma exposure and compassion fatigue, and between the level of trauma exposure and burnout, whereas a significant negative correlation is expected between the level of trauma exposure and compassion satisfaction.

H3: A significant positive correlation is expected between difficulties in emotion regulation and compassion fatigue, and between difficulties in emotion regulation and burnout, whereas a significant negative correlation is expected between difficulties in emotion regulation and compassion satisfaction.

H4: A significant negative correlation is expected between differentiation of self and compassion fatigue, and between differentiation of self and burnout, whereas a significant positive correlation is expected between differentiation of self and compassion satisfaction.

Group Differences Based on Receiving Work-Related Support and Trauma-specific Training

H5: Participants who received trauma-specific training are expected to show significantly low levels of compassion fatigue and burnout, and high levels of compassion satisfaction than those who do not receive trauma-specific training.

The Predictive Roles of Difficulties in Emotion Regulation and Self-Differentiation

H6: Difficulties in emotion regulation and differentiation of self are expected to significantly predict compassion fatigue, compassion satisfaction, and burnout.

Hypotheses on Moderating Roles of Difficulties in Emotion Regulation and Differentiation of Self

H7a: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between childhood trauma history and compassion fatigue.

H7b: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between childhood trauma history and burnout

H7c: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between the childhood trauma history and compassion satisfaction.

H8a: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between the level of trauma exposure and compassion fatigue.

H8b: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between the level of trauma exposure and burnout.

H8c: Difficulties in emotion regulation and differentiation of self are expected to moderate the relationship between the level of trauma exposure and compassion satisfaction.

CHAPTER 2: METHOD

2.1 Participants

Participants of this study consist of mental health professionals, including psychologists, psychological counselors, psychiatrists, and psychiatric nurses from various work conditions. 147 participants completed the online survey form. Three participants were excluded due to having another type of profession (one social worker and one sociologist) and being retired at the time of data collection. Before the data analysis, normality assumptions indicate that one participant reveals extreme values, and that participant was excluded from the data. Out of the 147 data collected, after excluding the above-mentioned participants, 127 were female, 15 male, and 1 non-binary, in total 143 participants were included in the study.

The age range of the participants was 23 to 62 (M= 31.85, SD= 7.67). Regards to their years of experience as a mental health professional, they vary from less than a year to 38 years (M= 7.61, SD= 7.04) and their experience year at their current work ranges from less than one year to 18 years (M= 3.08, SD= 3.45). The participants reported that their average work hours per week vary from 0 to 60 between 0 to 30 hours per week (M= 5.81, SD= 7.13). The participants were asked whether they receive any support as a part of their work when they have difficulties dealing with their clients. For the ones that responded 'Yes' to this question, they were also asked to identify which kind of support they receive. The answers were peer supervision, personal supervision, group supervision, and personal therapy, and the participants were informed that they could choose more than one of the support types they currently receive. Most of the participants responded by choosing more than one of the support types. For further analysis, a support score was calculated by adding the number of supports they receive. Higher scores mean that the participants are receiving more work-related support. The support scores vary from 0 to 4 (M= 1.67, SD= 1.07).

Frequency distributions of the demographic variables, including their gender, profession, education level, workplace characteristics, whether they get any professional support, whether they work with trauma survivors and whether they attained any trauma-specific training are given in Table 1.

Table 1. Descriptive Statistics of Participants

Variables		N	%
Gender	Female	127	88.8
	Male	15	10.5
	Non-binary	1	.7
Education Level			
	Bachelor's degree	40	28
	In Master's degree	34	23.8
	Master's degree	53	37.1
	In Ph.D. degree	8	5.6
	Ph.D. degree and above	8	5.6
Profession			
	Psychologist	85	59.4
	Psychologist (MA degree)	21	14.7
	Psychological Counselor	26	18.2
	Psychological Counselor (Ph.D. degree)	1	7
	Psychiatrist	6	4.2
	Psychiatric Nurse	4	2.8
Workplace			
	Public institution	31	21.7
	Private/shared practice	53	37.1
	Private hospital	2	1.4
	Public hospital	9	6.3
	Counseling center at university	11	7.7
	Private school	8	5.6
	Public school	13	9.1
	NGO's	8	5.6
	Online practice	5	3.5
	Other	3	2.1
Work-related support			
	Yes	124	88.7
	No	19	13.3

Table 1. Descriptive Statistics of Participants (Continued)

Types of Support			
	Peer supervision	99	69.2
	Individual supervision	61	42.7
	Group supervision	37	25.9
	Individual therapy	42	29.4
Working with trauma			
	Yes	110	76.9
	No	33	23.1
Trauma training			
	Yes	103	72
	No	40	28

2.2 Instruments

For investigating the hypothesis of the present study, an online survey package was presented to the participants including the Demographic Information Form and four measurement tools. All other measures used in this study have been used in previous research and their psychometric properties were found to be proper for further research. A demographic information form was developed for this study to assess the personal information of the participants. Professional Quality of Life Scale (ProQOL-IV) was used to assess the compassion fatigue level, Childhood Trauma Questionnaire was used to investigate the personal trauma history of participants, Differentiation of Self Inventory-Revised (DSI-R) was used to assess the self-differentiation level of participants, and Difficulties in Emotion Regulation Scale-Brief Form (DERS-16) was used to measure the level of difficulties in emotion regulation level of participants. This section will include a detailed examination of the scales used in the present study.

2.2.1 Demographic Information Form

The Demographic Information Form was developed by the researcher and developed to determine gender, age, profession, years of experience in the profession, age groups they work with, average work hours per week, current workplace, time of experience in the current workplace, work-related support systems, whether they encounter with traumatic experiences during their work and their trauma-specific training.

To gather information about the level of trauma exposure of participants, caseloads of trauma survivors, and the frequency of traumatic events they encountered in their work was obtained. Caseload with trauma survivors was gathered by asking the number of hours per week they work with trauma survivors. The frequency of traumatic events they encountered within 3 months was asked to obtain their level of exposure to different forms of traumatic events. The list of traumatic events has been adapted by adding and removing items from the Life Events Checklist for the Diagnostic Statistical Manual of Mental Disorders-5 (Weathers et al., 2013; Boysan et al., 2017). Thirteen traumatic events were presented to participants, and they were asked to rate the frequency from 0 (none) to 4 (always) which they encounter the histories from their clients within 3 months (MacRitchie and Leibowitz, 2010; Cemgil, 2019). The list of traumatic events includes the history of any type of accident or injury, sudden loss of a relative, natural disaster, physical assault, domestic violence or partner violence, sexual assault or sexual violence, childhood traumatic experiences, war-related traumatic events, any life-threatening health issue or surgery history, captivity history, torture history, community-based traumatic experiences, and any history injury to self or other individuals. They were also asked to rate any other type of traumatic event they listen to from their clients which were not included in the list. The level of exposure to the traumatic events within 3 months will be obtained by adding the scores of each type of traumatic event of participants. The scores will be ranged from 0 to 56 and higher scores will indicate a higher level of trauma exposure of participants within 3 months during their work.

2.2.2 Childhood Trauma Questionnaire (CTQ)

Childhood Trauma Questionnaire (CTQ) was originally developed by Bernstein et al. (1994) to assess the sexual, physical, emotional abuse, and emotional and physical neglect that an individual might experience before the age of 20. The initial form included 53 items; however, the authors of the original form have constructed the short form of the questionnaire that includes 28 items under five subscales. The Likert-type scale is evaluated ranging from 0 to 5 (0= Never, 5= Very often). The total score is obtained by adding the total scores of each subscale. Items 2, 5, 7, 13, 19, 26, and 28 indicate positive statements and they are reversed coded when obtaining scores. Even though items 10, 16, and 22 have also positive statements

they are not reverse coded because they indicate the minimization of trauma. Items 3, 8, 14, 18, and 25 are scored under the Emotional Abuse subscale, 9, 11, 12, 15, and 17 are scored under the Physical Abuse subscale, 20, 21, 23, 24, and 27 are scored under Sexual Abuse subscale, 1, 2, 4, 6 and 26 are scored under Physical Neglect and 5, 7, 13, 19 and 28 are scored under Emotional Neglect subscale. Total scores from each subscale range between 5 to 25. The total score could be obtained between 25 to 125. The original form indicates .79-.94 Cronbach Alpha internal consistency coefficients.

Turkish reliability and validity studies were conducted by Şar, Öztürk, and İkikardeş (2012). The internal consistency coefficient of the total scale was found .93. For the subscales, the Cronbach Alpha internal consistency coefficients range from .80 to .90. For the current study, Cronbach Alpha coefficient ranges scores were found .83 for Emotional Abuse, .78 for Physical Abuse, .66 for Physical Neglect, .92 for Emotional Neglect, and .89 for Sexual Abuse subscales. The internal consistency coefficient is found to be .92 for the total scale.

2.2.3 Professional Quality of Life Questionnaire-IV (ProQOL-IV)

The professional Quality of Life Scale (ProQOL-IV) was developed by Stamm (2005) to evaluate the negative and positive aspects of working with individuals with traumatic and stressful experiences. The scale is a widely used measure for evaluating compassion fatigue and compassion satisfaction levels of professionals working with trauma survivors. The ProQOL-IV is a 30-item self-report measure with a 5-point Likert questionnaire that ranges from 1 (never) to 5 (very often) and asks individuals to rate their responses within 1 month period. There are three subscales of ProQOL and each subscale consists of 10 items. The first subscale is Compassion Satisfaction (CS) measures an individual's pleasure and satisfaction with their professional help to people they work with. Items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 assess compassion satisfaction. Cronbach Alpha internal consistency coefficient of the subscale is .87. The second subscale is Burnout, which includes items 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29. Cronbach Alpha internal consistency coefficient of the subscale is .72. Burnout is related to feelings of hopelessness and difficulties in coping with work-related performances. The final subscale is Compassion Fatigue and this evaluates symptoms as a reaction to working with

stressful events and the level of impact of indirect exposure to traumatic events. Items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 are developed to evaluate STS level. Cronbach Alpha internal consistency coefficient of the subscale is .80. Items 1, 4, 15, 17, and 29 should be reversed when scores are calculated.

The Turkish validity and reliability study of ProQOL IV was conducted by Yeşil et al. (2010). Cronbach Alpha internal consistency coefficients for subscales are calculated as .85 for Compassion Satisfaction, .62 for Burnout, and .84 for Compassion Fatigue subscales. The scale does not indicate a total score and higher levels from subscales reflect having higher levels of Compassion Satisfaction, Burnout, and Compassion Fatigue in the questionnaire. Cronbach Alpha scores were calculated as .89 for Compassion Satisfaction, .87 for Compassion Fatigue, and .75 for Burnout for the three subscales for the present study.

2.2.4 Differentiation of Self Inventory-Revised (DSI-R)

Based on Bowen's Family Systems Theory, the Differentiation of Self Inventory was developed to identify an individual's emotional functioning, autonomy, and intimacy in interpersonal relationships including the broader components. Skowron and Friedlander (1988) developed the inventory to assess the four dimensions of differentiation including Emotional Reactivity (ER), "I" Position (IP), Emotional Cutoff (EC), and Fusion with Others (FO). The FO subscale showed lower reliability for the initial inventory, and Skowron and Schmitt (2003) revised the subscale to strengthen its reliability. The revised version of DSI-R has 46 items assessing four subscales. The emotional Reactivity subscale consists of 11 items that assess an individual's reaction to the environmental stimuli whit regards to emotional lability, flooding, and hypersensitivity. The 11-item "I" Position subscale measures the individual's level of sense of self and ability to be connected to own opinions when pressured to do the opposite. The emotional Cutoff subscale has 12 items and assesses the individual's sense of threat of intimacy in interpersonal relationships and behavioral defenses, like distancing and denial due to the fear of engulfment. The Fusion with Others subscale includes 12 items and indicates emotional overinvolvement with others in the case of decision-making and overidentification with others. Higher scores indicate greater differentiation of self for total DSI-R, less ER, EC, and FO, and greater ability for the "I" Position. Cronbach Alpha internal

consistency coefficient ranges between .81 to .89 for the four subscales and .92 for a total score.

Işık and Bulduk (2015) conducted a validity and reliability study of the inventory in Turkish and found out that 46 items of DSI-R did not fit the data obtained from the Turkish sample. The psychometric properties of the shortened version (Drake, 2011) fit the data well and the Turkish version was adapted to the shortened 20-item and four subscales version. For the 20-item version, each subscale includes 5 items. Items, except 6, 10, 12, 13, and 19 (the items of the IR subscale) are reversed to obtain the scores. To gather the total DSI-R score, the scores of each subscale are calculated and added. Cronbach Alpha internal consistency coefficient for the total scale is reported as .81 for the Turkish shortened version. In this study, internal consistency coefficients were .68 for Emotional Reactivity, .72 for I Position, .71 for Emotional Cutoff, and, .78 for Fusion with Others subscales. The total Differentiation of Self Inventory revealed a .83 Cronbach Alpha internal consistency coefficient for the present study.

2.2.5 Difficulties in Emotion Regulation- Brief Form (DERS-16)

Difficulties in Emotion Regulation scale was first developed by Gratz and Roemer (2004) to evaluate emotion regulation difficulties of individuals more comprehensively. The 36-item self-report version consists of six subscales, including Awareness, Clarity, Non-acceptance, Strategies, Impulse, and Goals. Even though this six-factor structure conveys valid and reliable results, Bjureberg et al. (2016) developed a 16-item short version to utilize a more functional and effective tool. For the short version Awareness subscale was removed because this subscale has lower correlations with the other five subscales. The Clarity subscale (items 1,2) assesses lacking emotional clarity, the Goals (items 3,7, and 15) subscale evaluates difficulties in engaging with goal-directed behavior, the Impulse (items 4,8, and 11) subscale measures difficulties in impulse control, the Strategies subscale (items 5, 6, 12, 14, and 16) assesses limited access to effective emotion regulation strategies and the Non-acceptance subscale (items 9, 10, and 13) evaluates nonacceptance of emotional responses. This five-factor and 16-item version of the DERS Brief Form yielded a .92 Cronbach Alpha internal consistency coefficient.

The Turkish version of DERS-16 was developed by Yiğit and Yiğit (2017) and the Cronbach Alpha internal consistency coefficient was found as .92. The scale is a 5-point liker scale, ranging from 1 (almost never) to 5 (almost always) and higher scores gathered from the scale indicate a higher level of emotion dysregulation. In this study, the Cronbach Alpha coefficient was found to be .93 for the total DERS-16 scale.

2.3 Procedure

Data collection was performed online due to the Covid-19 pandemic was still a health issue for reaching the participants face to face. Thus, the online survey package was developed in Google Forms to reach the participants. Since the participants of the study consist of mental health professionals, the online survey link was shared through social media platforms, e-mail groups, and professional communication networks. The first part of the online form includes the Informed Consent Form, in which participants are informed about the aim, confidentiality, and voluntary participation of the study. The participants were told that their identifiable information will not be asked, and the data will be analyzed altogether, not individually. They were also informed that the information gathered from the study will be used only for academic purposes. They are told that they could leave the study at any stage. After presenting the informed consent form, they are asked whether they are willing to continue the study. By selecting the 'Yes' button they accepted that they are informed and willing to continue the study. The completion time of the study took approximately 15 minutes. Participants are presented first with the Demographic Information form, followed by the Difficulties in Emotion Regulation Brief Form, Childhood Trauma Questionnaire, Differentiation of Self Inventory-Revised, and Professional Quality of Life Questionnaire-IV.

2.4 Statistical Analysis

To analyze the hypothesis of the present study, the Statistical Package for Social Sciences version 20.0 (SPSS v.20.0) and PROCESS Macro version 4.0 (Hayes, 2022) were used. First of all the participant characteristics based on the demographic information questions were identified in terms of frequencies and percentages. Before initiating the main analysis, the data's accuracy was checked to identify whether there are any missing values. After controlling the data, Cronbach's alpha

internal consistency scores for the scales used in the present study were measured to examine whether the scores obtained from the present study's population were consistent with the reported reliability scores of earlier studies. As reported in the measurement section, all scales were found to have reliability scores consistent with the original studies.

Before conducting the main analysis of the study, the normality distribution of the continuous variables was examined. According to the normality distribution analysis, one participant was detected as revealing an extreme value and excluded from the data. For the remaining participants (N=143), skewness and kurtosis values are between the ranges of +/- 1.50. These values are accepted as satisfactory for the normal distribution of the data by Tabachnick and Fidell (2007).

For the descriptive statistics of the main variables of the study, mean, standard deviation, and minimum and maximum values were examined. To investigate the relationships between study variables Pearson correlation analysis was conducted. For comparing the groups with regards to receiving trauma-specific training T-test analyses were conducted to examine whether the groups differ in terms of compassion fatigue stress, burnout, and compassion satisfaction. To investigate whether difficulties in emotion regulation and differentiation of self predict compassion fatigue stress, burnout, and compassion satisfaction after controlling for both work-related variables and primary and trauma exposure, a three-step hierarchical regression analysis was conducted. The last part of the data analysis included an investigation of moderating effects of difficulties in emotion regulation and differentiation of self. Six separate moderation analyses were conducted using Model 2 of the moderation analysis introduced by PROCESS macro (Hayes, 2022). Firstly, moderating roles of two variables were investigated in the relationship between childhood trauma exposure and compassion fatigue stress, burnout, and compassion satisfaction. Then, the moderating roles of the two variables were investigated in the relationship between the level of trauma exposure and compassion fatigue stress, burnout, and compassion satisfaction.

CHAPTER 3: RESULTS

The data was examined through SPSS Version 20. After examining the descriptive analysis of all variables, Pearson Correlation Analysis was conducted to identify the relationships between study variables. Then, to investigate whether there is a difference between groups in terms of study variables, T-test analyses were conducted. Differences between receiving work-related support and trauma-specific training were examined in terms of compassion fatigue, burnout, and compassion satisfaction. Then, a three-step hierarchical regression analysis was performed to investigate whether difficulties in emotion regulation and differentiation of self predict compassion fatigue, burnout, and compassion after controlling for work-related variables and trauma exposure. For the last part of the analysis, six separate moderation analyses were conducted to investigate the moderating roles of difficulties in emotion regulation and differentiation of self in the relationship between childhood trauma, the level of trauma exposure and compassion fatigue, burnout, and compassion satisfaction.

3.1 Descriptive Analysis

Results of the descriptive analysis of study variables are presented in Table 1. Mean, standard deviation, minimum and maximum scores gathered from the scales assessing Compassion Satisfaction, Compassion fatigue, Burnout, childhood trauma, difficulties in emotion regulation, and level of differentiation of self will be given in Table 2.

Table 2. Mean, Standard Deviation, Minimum and Maximum Values of All Scales and Subscales

Variables	*M*	*SD*	Min.	Max.
Level of Trauma Exposure	16.60	11.01	0	53
Childhood Trauma	38.13	11.44	25	78
Difficulties in Emotion Regulation	31.01	10	18	65
Differentiation of Self	80.16	13.14	46	109
Compassion Fatigue	11.51	6.97	0	38
Burnout	16.89	6.79	2	37
Compassion Satisfaction	36.63	7.67	18	50

3.2 Reliability Analysis of The Study Variables

Internal consistency coefficients of the measures used in the study were calculated. The results indicated that all variables showed high Cronbach alpha coefficients in the current study. The comparison of the coefficients found in this study and the coefficients found in the validation study in the Turkish sample were given in Table 3.

Table 3. Reliability Results of the Measures of the Current Study

Measures	Cronbach's alpha coefficient (Turkish Reliability Study)	Cronbach's alpha coefficient (Current Study)
Professional Quality of Life		
Compassion Fatigue	.84	.97
Burnout	.62	.75
Compassion Satisfaction	.85	.89
Childhood Trauma Questionnaire		
Difficulties in Emotion Regulation Scale- Brief Form	.92	.93
Differentiation of Self Inventory-Revised	.81	.83

3.3 Main Analysis

3.3.1 Correlation Analysis Between Study Variables

Pearson Correlation analysis was conducted to investigate the relationships between the study variables: difficulties in emotion regulation, childhood trauma history, subscales of childhood trauma history, level of trauma exposure, differentiation of self, compassion fatigue, compassion satisfaction, and burnout. The results of the Pearson correlation analysis are given in Table 4.

There is not a statistically significant relationship between childhood trauma history and compassion fatigue $r = .094$, $p = .263$. There is a statistically significant positive and low relationship between childhood trauma history and burnout, $r = .185$, $p < .05$, indicating that as the level of childhood trauma history increases the level of burnout of participants also increases. Even though the negative trend

occurred between variables, no significant relationship was found between childhood trauma history and compassion satisfaction, r= -.032, p= .701.

There is a statistically significant positive and low relationship between the level of trauma exposure and compassion fatigue, r= .229, p< .01. This result indicates that the higher the participants are exposed to traumatic events, the higher compassion fatigue levels they experience. There is also a significant and positive relationship found between the level of trauma exposure and burnout r= .192, p< .05, indicating a low relationship. As the participants are exposed to more traumatic events, their burnout levels increase. There is no significant relationship found between the level of trauma exposure and compassion satisfaction r= .103, p= .223.

There is a statistically significant positive and high relationship between difficulties in emotion regulation and compassion fatigue r= .511, p< .01, indicating that as the level of difficulties in emotion regulation increases the level of compassion fatigue increases. There is also a positive and moderate relationship between difficulties in emotion regulation and burnout r= .479, p< .01. This correlation indicates that as the level of difficulties in emotion regulation increases, the burnout level of the participants also increases. Results indicate that difficulties in emotion regulation is negatively correlated with compassion satisfaction r= -.267, p< .01, indicating a low relationship. These results mean that high levels of difficulties in emotion regulation is related to low levels of compassion satisfaction.

There is a significant negative and moderate relationship between the level of differentiation of self and compassion fatigue r= -.459, p< .01. With the increase in the level of self-differentiation, participants show lower levels of compassion fatigue. There is also a significant negative and moderate relationship was found between the level of differentiation of self and burnout, r= -.455, p< .01. as the levels of differentiation of self increase in participants, their burnout scores decrease. There is a statistically significant positive and low relationship between the level of differentiation of self and compassion satisfaction r= .299, p< .05. This relationship indicates that as the level of differentiation of self increases the participant's compassion satisfaction also increases.

Additional correlation analysis between compassion satisfaction, compassion fatigue, and burnout was conducted to investigate the relationship of variables with each other. There is a negative and low significant relationship between compassion satisfaction and compassion fatigue, $r = -.253$, $p < .01$, and a negative and high relationship between compassion satisfaction and burnout, $r = -.645$, $p < .01$. These results indicate that as the level of compassion satisfaction increases, the level of compassion fatigue and burnout levels decreases. There was also a positive and high relationship found between compassion fatigue and burnout, $r = .630$, $p < .01$, meaning that as the compassion fatigue levels increase the levels of burnout of the participants also increase.

Table 4. Pearson's Correlation Analysis Results for the Variables

	1	2	3	4	5	6	7	8	9	10	11	12
1.DERS	-											
2.CTQ	.217**	-										
3.EA	.258**	.867**	-									
4.PA	.073	.655**	.533**	-								
5.PN	.202*	.639**	.405**	.349**	-							
6.EN	.168*	.865**	.688**	.419**	.464**	-						
7.SA	.070	.624**	.426**	.351	.371**	.354**	-					
8. LTE	-.035	.044	.079	-.103	-.103	-.019	.152	-				
9. DSI-R	-.590**	-.354**	-.325**	-.099	-270**	-.329**	-.217**	.087	-			
10. CS	-.267**	-.032	.026	.028	-.024	-.073	-.052	.103	.299**	-		
11.CF	.511**	.094	.138	.103	.133	-.048	.127	.229**	-.459**	-.253**	-	
12.BO	.479**	.185*	.188*	.060	.133	.177*	.079	.192*	-.455**	-.645**	.630**	-

***p< .01, *p< .05* (two-tailed); DERS-16: Difficulties in Emotion Regulation, CTQ: Childhood Trauma Questionnaire, EA: CTQ Emotional Abuse Subscale, PA: CTQ Physical Abuse Subscale, PN: CTQ Physical Neglect Subscale, EN: CTQ Emotional Neglect Subscale, SA: CTQ Sexual Abuse Subscale, LTE: Level of Trauma Exposure, DSI-R: Differentiation of Self Inventory, CS: Compassion Satisfaction, CF: Compassion Fatigue, BO: Burnout.

3.3.2 Differences Between Groups Receiving Trauma-specific Training

An independent t-test was conducted to test whether the levels of compassion fatigue, compassion satisfaction, and burnout significantly differ in receiving trauma-specific training. Participants were asked to respond 'Yes' or 'No' to the question if they ever had training that focused on trauma. As presented in Table 5, there is not a significant difference between individuals who have or have not received trauma-specific training and compassion fatigue, $t(141)= -.389$, $p= .698$, and burnout, $t(141)= -1.530$, $p= .128$. However, individuals who received trauma-specific training reported more compassion satisfaction (M=37.51, SD=7.40) than individuals who did not receive any training related to trauma (M=34.35, SD=7.98), which revealed a significant difference between the groups, $t(141)= 2.245$, $p<.05$.

Table 5. Independent T-test Analysis Comparing the Groups in terms of Receiving Trauma-specific Training

	Trauma-specific training	*N*	Mean	SD	*t*	*df*	*p*
Compassion Fatigue	Yes	103	11.37	7.19	-.389	141	.698
	No	40	11.88	6.41			
Compassion Satisfaction	Yes	103	37.51	7.40	2.245	141	.026*
	No	40	34.35	7.98			
Burnout	Yes	103	16.35	6.37	-1.530	141	.128
	No	40	18.28	7.68			

Note. $p<.05$*(two-tailed), CF: Compassion Fatigue, CS: Compassion Satisfaction, BO: Burnout

3.3.3 Hierarchical Regression Analysis of Study Variables

A three-step hierarchical regression analysis was conducted to identify the predictive role of Difficulties in Emotion Regulation and Differentiation of Self on Compassion Satisfaction, Compassion Fatigue, and Burnout.

Years of experience, workload, caseload, and work-related support were introduced as the control and work-related variables. The workload was identified as total working hours with clients per week, the caseload indicates the total working hours with clients with traumatic histories, and work-related support was composed of the participant's total scores of support which are identified as having personal, peer, or group supervision or going to personal therapy. In the second cluster,

childhood trauma history was introduced as the participants' personal trauma history, and their level of trauma exposure indicates their frequency of working with clients who have traumatic histories within the three months. Difficulties in emotion regulation and differentiation of self scores were entered as the third cluster for the regression analysis and indicated the participants' variables. The results of the hierarchical regression analysis of the study were given in Table 6 below.

To examine the predictors of compassion fatigue, a three-step hierarchical regression analysis was conducted. In step 1, years of experience, workload, caseload, and work-related support explained 4% of the variation in compassion fatigue but did not significantly predict the regression model, R^2= .043, F(4,138)= 1.545, p= .192. For the second step, personal trauma history and level of trauma exposure added 4% additional variance to the model, however, this model did not significantly predict the compassion fatigue either, R^2= .077, F(6,136)= 1.884, p= .088. To evaluate the predictive role of difficulties in emotion regulation and differentiation of self, those two variables were added to the model at the last step. Adding the variables to the model accounted for a 32% additional variation for compassion fatigue. Introducing all variables explained 40% of the variation and contributed significantly to the regression model, R^2= .400, F(8,134)= 11.171, p< .001. When the coefficients of each variable were examined, work-related support significantly predicts compassion fatigue (β= .151, p < .05), indicating that as the number of work-related support increases, compassion fatigue increases also. The level of trauma exposure also significantly predicts compassion fatigue (β= .240, p < .01). The results mean that as the level of exposure to traumatic stories increases, there is an increase in the level of compassion fatigue. Compassion fatigue is also predicted by difficulties in emotion regulation, (β= .377, p < .001), indicating that when difficulties in emotion regulation increase, compassion fatigue increases also. Lastly, differentiation of self significantly predicts compassion fatigue, (β= -.329, p < .001). The negative beta value indicates that as the level of differentiation of self increases, compassion fatigue level decreases. According to the standardized beta values of the variables, it can be inferred that difficulties in emotion regulation were the most substantive predictor of compassion fatigue, followed by differentiation of self, level of trauma exposure, and work-related support.

A three-step hierarchical regression analysis was also conducted to evaluate the predictor variables of burnout. In step 1, years of experience, workload, caseload, and work-related support accounted for a 12% variation in burnout and contributed significantly to the regression model, R^2= .124, F(4, 138)= 4.878, p< .01. Introducing personal trauma history and level of trauma exposure account for a 3% additional variation in burnout. This model contributed significantly to predicting burnout, R^2= .150, F(6,136)= 4.006, p< .01. For the third step difficulties in emotion regulation and differentiation of self were added to the model and adding the variables to the model explained an additional 24% variation in burnout. The overall model explained 39% variation of burnout and contributed significantly to the hierarchical regression, R^2= .393, F(8, 134)= 10.823, p< .001. The unique predictors of burnout were examined. The results indicated that workload significantly predicts burnout, (β= .252, p < .05), indicating that as the weekly working hours of participants increase, their level of burnout increases also. Difficulties in emotion regulation also predicted burnout (β= .308, p < .001). This result indicates that when the difficulties in emotion regulation scores increase, burnout scores increase also. Lastly, differentiation of self predicted burnout (β= -.306, p < .01), indicating that burnout scores decrease as the level of differentiation of self scores increases. The standardized beta values reveal that difficulties in emotion regulation was the most significant predictor of burnout, followed by differentiation of self and workload.

Three-step hierarchical regression analysis was conducted to examine whether difficulties in emotion regulation and differentiation of self predict compassion satisfaction of mental health professionals. The hierarchical multiple regression revealed that at stage 1, years of experience, workload, caseload, and work-related support explained 4% variation but did not significantly contribute to the regression model, R^2= .038, F(4,138)= 1.359, p= .252. In the second step, after adding personal trauma history and level of trauma exposure the model explained a 5% variation in compassion satisfaction however the model did not significantly predict compassion satisfaction, R^2= .046, F(6,136)= 1.081, p= .377. In Step 3, difficulties in emotion regulation and differentiation of self were added to the model. The introduction of all variables explained a 13 % of variation in compassion satisfaction and significantly contributed to the model, R^2= .126, F(8,134)= 2.413, p< .05. When we examine the

contribution of each variable in the model, differentiation of self was the only significant variable that predicts compassion satisfaction (β = .223, p < .05) indicating that as the level of differentiation of self increases, compassion satisfaction also increases.

Table 6. Hierarchical Regression Analysis Predicting Compassion fatigue, Compassion Satisfaction, and Burnout

	Compassion Satisfaction				Compassion Fatigue				Burnout			
	b	*SE B*	*ß*	*P*	*b*	*SE B*	*ß*	*p*	*b*	*SE B*	*ß*	*p*
Step 1												
Years of experience	.204	.099	.187	.041*	-.138	.089	-.139	.125	-.269	.083	-.279	.002**
Workload	-.027	.057	-.046	.635	.010	.052	.019	.844	.117	.048	.224	.017*
Caseload	.086	.103	.080	.401	.146	.093	.149	.118	.100	.087	.105	.249
Work related support	.389	.654	.054	.552	.297	.592	.046	.616	-.156	.552	-.025	.778
Step 2												
Years of experience	.214	.100	.196	.035*	-.107	.090	-.108	.233	-.243	.084	-.252	.004**
Workload	-.026	.058	-.044	.655	.006	.052	.011	.911	.109	.048	.209	.025*
Caseload	.019	.123	.018	.878	.022	.110	.022	.842	.032	.103	.034	.756
Work related support	.361	.659	.050	.585	.327	.588	.050	.580	-.078	.550	-.012	.887
Childhood Trauma	-.013	.057	-.019	.823	.050	.051	.081	.333	.082	.048	.139	.087
Trauma Exposure	.074	.072	.106	.311	.131	.065	.206	.046*	.068	.061	.110	.264
Step 3												
Years of experience	.116	.101	.107	.250	.064	.076	.064	.402	-.097	.074	-.101	.194
Workload	-.043	.056	-.073	.445	.031	.042	.058	.465	.131	.041	.252	.002**
Caseload	.019	.119	.017	.876	.028	.089	.029	.751	.036	.087	.038	.678
Work related support	.002	.643	.000	.998	.984	.484	.151	.044*	.477	.475	.075	.317
Childhood Trauma	.056	.059	.084	.340	-.066	.044	-.108	.141	-.017	.043	-.029	.696
Trauma Exposure	.059	.070	.085	.400	.152	.053	.240	.005**	.087	.052	.141	.096
Emotion Regulation Difficulties	-.101	.077	-.131	.195	.263	.058	.377	.000***	.209	.057	.308	.000***
Differentiation of Self	.130	.063	.223	.041*	-.175	.047	-.329	.000***	-.158	.046	-.306	.001**

*Note. *** p<.001, **p< .01, *p< .05;* Workload: average work hour per week, Caseload: average workhour with trauma cases

3.3.4 Moderating Role of Difficulties in Emotion Regulation and Differentiation of Self

This section includes examining the moderating roles of difficulties in emotion regulation and differentiation of self based upon the two different hypotheses which examine personal trauma history (childhood trauma history) and level of trauma exposure as separate independent variables. Compassion fatigue is the initial dependent variable of the study, but burnout and compassion satisfaction variables were also included in the moderation analysis. To investigate the moderating roles of two variables, Model 2 of the PROCESS macro (Hayes, 2022) was conducted, and two variables were entered into the moderation analysis simultaneously to examine the interactions with predicting and outcome variables. Each moderation analysis will be presented separately.

Moderating Role of Difficulties in Emotion Regulation and Differentiation of Self Between Childhood Trauma History and Compassion fatigue, Burnout, and Compassion Satisfaction

Three different moderation analyses were conducted to investigate the moderating role of difficulties in emotion and differentiation of self in the relationship between personal trauma history (childhood trauma history) and compassion fatigue, burnout, and compassion satisfaction. The moderation model is presented in Figure 1 below.

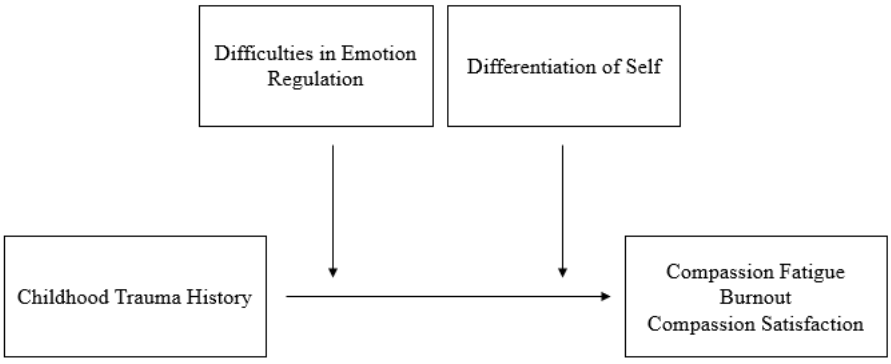

Figure 1. Moderation Model (Model 2) Presenting Moderating Roles of Difficulties in Emotion Regulation and Differentiation of Self

The first moderation analysis was conducted to investigate whether difficulties in emotion regulation and differentiation of self moderate the relationship between personal trauma history and compassion fatigue. The moderation analysis indicates that the overall model explains 34% of the variance in compassion fatigue and is statistically significant, R^2= .336, F(5, 137)= 13.838, p< .001. The moderation effect of difficulties in emotion regulation uniquely accounts for a .02 variance, ΔR^2= .002, F(1,137)= .345, p= .559, and difficulties in emotion regulation did not moderate the relationship between childhood trauma history and compassion fatigue, b= .003, p= .559. On the other hand, the interaction of childhood trauma history and differentiation of self explained a 3% variance in compassion fatigue, ΔR^2= .026 F(1,137)= 5.345, p< .05. Differentiation of self moderated the relationship between childhood trauma history and compassion fatigue, b= .010, p< .05. Examination of the interaction reveals that at lower levels of differentiation of self, childhood trauma has significant and negative relationship with compassion fatigue. The interaction of childhood trauma, difficulties in emotion regulation, and differentiation of self accounted for an additional 3% variance in compassion fatigue. This indicates a significant interaction of the variables on compassion fatigue, ΔR^2= .031, F(2,137)= 3.162, p< .05. The results indicate that the interaction of low levels of differentiation of self and moderate and high levels of difficulties in emotion regulation moderated the relationship between childhood trauma history and compassion fatigue. The moderation graph showing the interactions of the variables was presented in Figure 2.

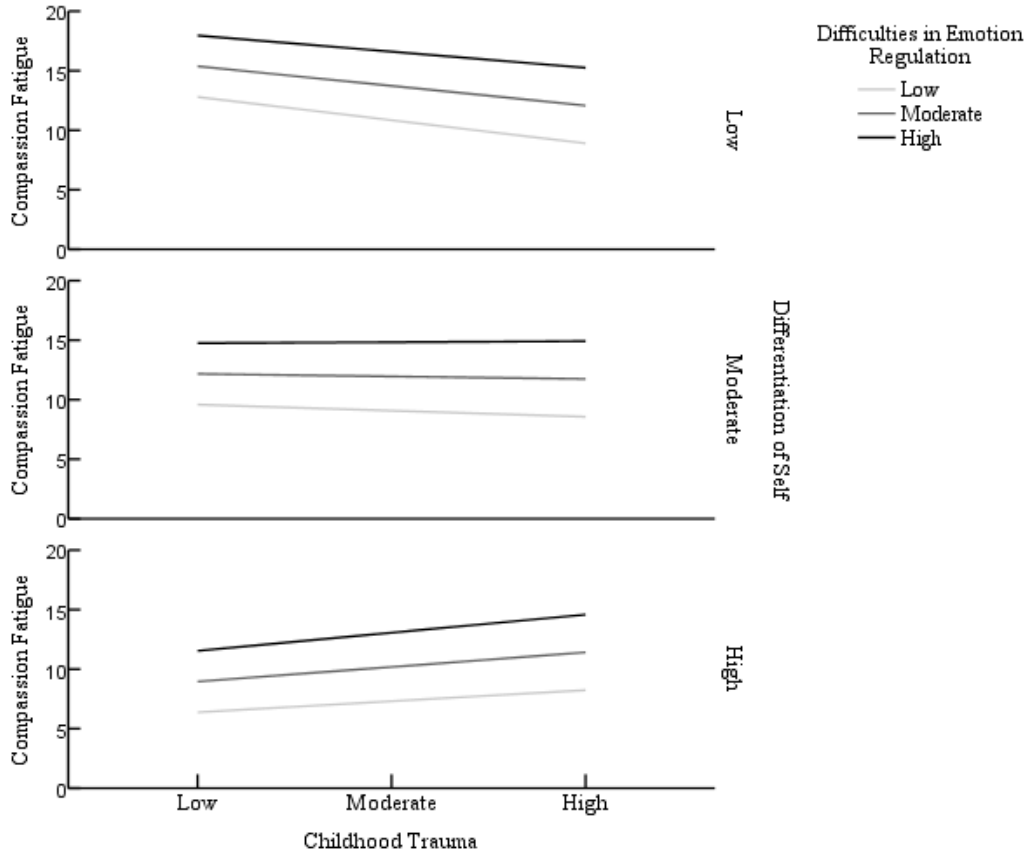

Figure 2. Moderation Plot for Interaction between Childhood Trauma, Difficulties in Emotion Regulation, and Differentiation of Self on Compassion Fatigue

The second moderation analysis was conducted to investigate whether difficulties in emotion regulation and differentiation of self moderated the relationship between childhood trauma history and burnout. The moderation analysis revealed that the overall model explained a 31% variation of the burnout variable, R^2= .314, F(5, 137)= 12.547, p< .001. Difficulties in emotion regulation moderated the relationship between childhood trauma history and burnout, b= .011, p< .05, and accounted for a 3% variation in burnout, ΔR^2= .032, F(1, 137)= 6.381, p< .05. When the interaction effect of difficulties in emotion regulation was examined, the results revealed that childhood trauma history had a significant relationship with burnout at moderate and high levels of difficulties in emotion regulation. Differentiation of self also moderated the relationship between childhood trauma history and burnout, b= .010, p< .05, and explained a 3% of the variance in burnout, ΔR^2= .029, F(1,137)= 5.837, p< .05. The results revealed that at the lowest levels of differentiation of self there is

a significant relationship between childhood trauma and burnout. The interaction of childhood trauma history, difficulties in emotion regulation, and differentiation of self was significant and explained 4% of the variation in burnout, $\Delta R^2 = .038$, $F(2,137) = 3.831$, $p < .05$. The interaction of low levels of differentiation of self and moderate and high levels of difficulties in emotion regulation significantly moderated the relationship between childhood trauma history and burnout. Figure 3. shows the interaction graph of the variables.

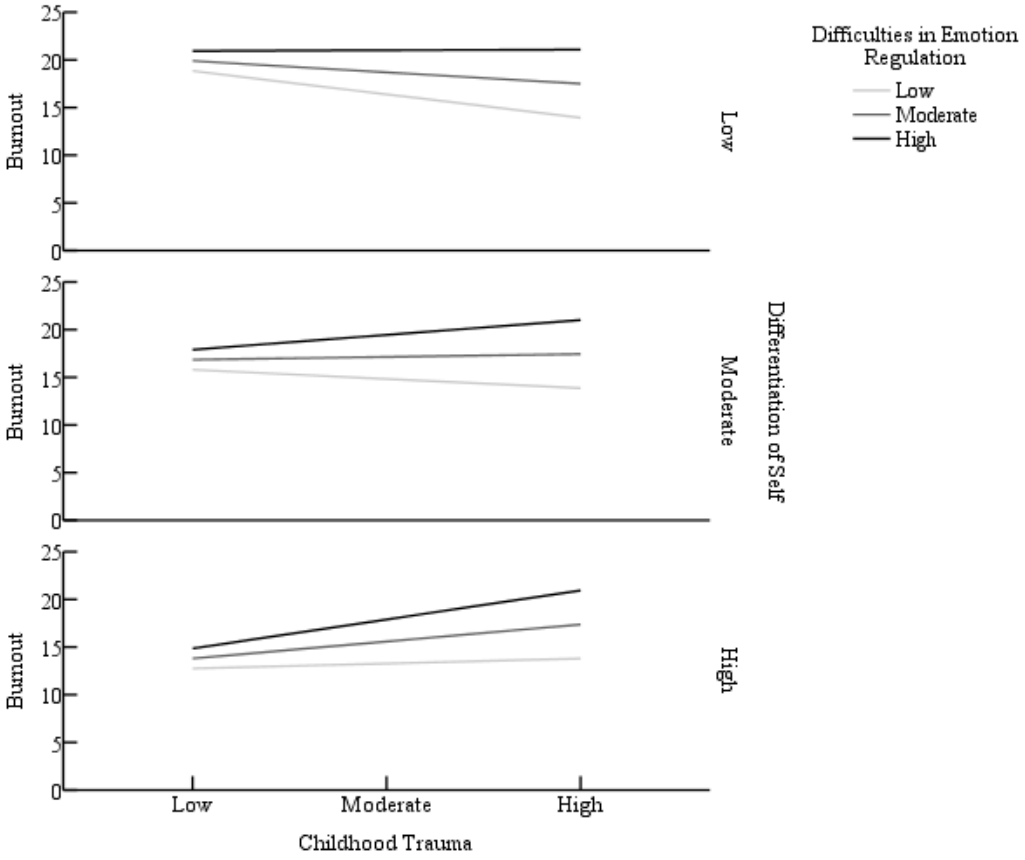

Figure 3. Moderation Plot for Interaction between Childhood Trauma, Difficulties in Emotion Regulation, and Differentiation of Self on Burnout

The third moderation analysis was conducted to investigate the moderating roles of difficulties in emotion regulation and differentiation of self in the relationship between childhood trauma history and compassion satisfaction. The overall model explained a 12% variation in compassion satisfaction, $R^2 = .117$, $F(5,137) = 3.643$, $p < .01$. When the unique moderation effects were investigated, the results revealed that

difficulties in emotion regulation did not moderate the relationship between childhood trauma history and compassion satisfaction, b= -.007, p= .249. Moreover, differentiation of self also did not moderate the relationship between childhood trauma history and compassion satisfaction, b= -.005, p= .350. The combination of both difficulties of emotion regulation and differentiation of self also did not significantly interact with childhood trauma history and compassion satisfaction, ΔR^2= .009, $F(2, 137)$= .718, p= .490. These results indicate that both difficulties in emotion regulation and differentiation of self did not have a moderating role in the relationship between childhood trauma history and compassion satisfaction.

Moderating Role of Difficulties in Emotion Regulation and Differentiation of Self Between Level of Trauma Exposure and Compassion fatigue, Burnout, and Compassion Satisfaction

To examine the moderating role of difficulties in emotion regulation and differentiation of self on the relationship between the level of trauma exposure and compassion fatigue, burnout, and compassion satisfaction three separate moderation analyses were conducted. The model of the moderation analysis was presented in Figure 4.

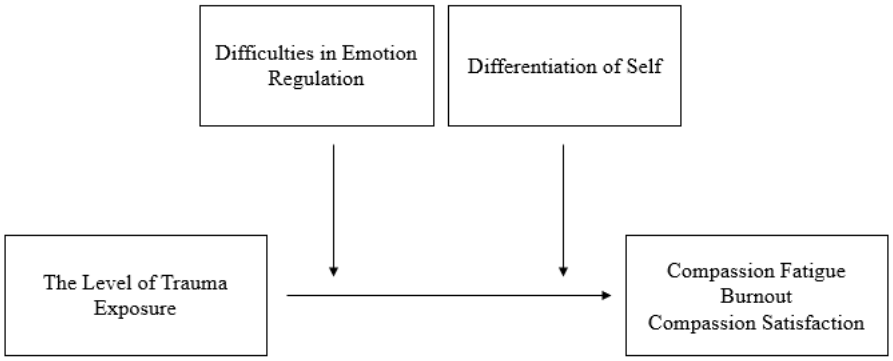

Figure 4. Moderation Model (Model 2) Presenting Moderating Roles of Difficulties in Emotion Regulation and Differentiation of Self

The first moderation analysis was conducted to investigate whether difficulties in emotion regulation and differentiation of self moderate the relationship between the level of trauma exposure and compassion fatigue. The total model explained a 43% of variation in compassion fatigue, R^2= .429, F(5, 137)= 20.560, p< .001. There is a significant moderation effect of difficulties in emotion regulation on the relationship between the level of trauma exposure and compassion fatigue, b= .021, p< .01, and this interaction explained a 6% of the variation in compassion fatigue, ΔR^2= .060 F(1,137)= 14.410, p< .01. Moderate and high levels of difficulties in emotion regulation had a significant moderating role in the relationship between the level of trauma exposure and compassion fatigue. Differentiation of self also moderated the relationship between the level of trauma exposure and compassion fatigue, b= .010, p< .05. This model explained a 3% of variation in compassion fatigue, ΔR^2= .027, F(1,137)= 6.498, p< .05. When the conditional effects were examined, the results revealed that low and moderate levels of differentiation of self had a significant moderating role in the relationship between the level of trauma exposure and compassion fatigue. When both difficulties in emotion regulation and differentiation of self in the model, the interaction with the level of trauma exposure resulted in an explanation of a 6% variation in compassion fatigue, ΔR^2= .060, F(2,137)= 7.218, p< .01. The interaction effect of both moderating variables revealed that when the difficulties in emotion regulation was in the model, there was a significant interaction between the level of trauma exposure and compassion fatigue, on each level of differentiation of self. The moderation graph was presented in Figure 5.

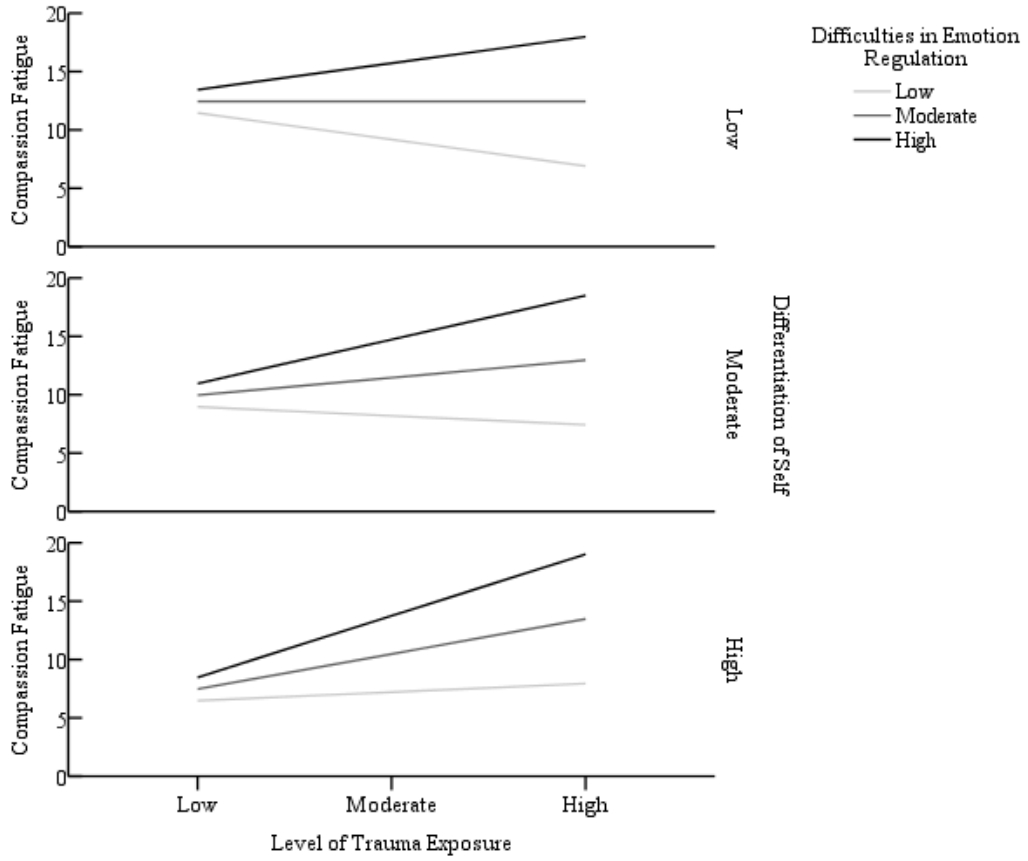

Figure 5. Moderation Plot for Interaction between the Level of Trauma Exposure, Difficulties in Emotion Regulation, and Differentiation of Self on Compassion Fatigue

The second moderation analysis was conducted to investigate the moderating roles of difficulties in emotion regulation and differentiation of self on the relationship between the level of trauma exposure and burnout. When all the variables were included in the model, there was a 33% of variation explained in burnout, R^2= .331, F(5, 137)= 13.547, p< .001. The results indicated that neither difficulties in emotion regulation, b= .005, p= .380, nor differentiation of self, b= .004, p= .458 did not moderate the relationship between the level of trauma exposure and burnout. When both moderators are in the model the interaction was also not statistically significant, ΔR^2= .004, F(2,137)= .404, p= .669. These results indicate that difficulties in emotion regulation and differentiation of self did not have a moderating role in the level of trauma exposure and burnout.

The third moderation analysis examined the moderating roles of difficulties in emotion regulation and differentiation of self in the relationship between the level of trauma exposure and compassion satisfaction. The overall model explained 11% of the variation in compassion satisfaction, R^2= .109, F(5,137)= 3.348, p< .01. The results indicate that difficulties in emotion regulation did not significantly moderate the relationship between the level of trauma exposure and compassion satisfaction, b= -.003, p= .735. Differentiation of self also did not significantly moderate the relationship between the level of trauma exposure and compassion satisfaction, b= -.001, p= .880. The interaction of difficulties in emotion regulation and differentiation of self did not significantly contribute to the relationship between the level of trauma exposure and compassion satisfaction, ΔR^2= .001, F(2,137)= .065, p= .937. The moderation analysis revealed that none of the moderating variables had a moderating role in the relationship between the level of trauma exposure and compassion satisfaction.

3.4 Summary of The Results

This section includes a summary of the results of the hypothesis investigated in this current study. Results indicated that childhood trauma did not reveal a significant relationship between compassion fatigue and compassion satisfaction, however, there was a significant positive relationship between childhood trauma and burnout. Additionally, the Emotional Abuse and Emotional Neglect subscales of the Childhood Trauma Questionnaire revealed a significant and positive correlation with burnout. As the second hypothesis of the study, there was a significant and positive relationship between the level of trauma exposure and compassion fatigue and burnout. There was a significant and positive relationship between difficulties in emotion regulation and compassion fatigue and burnout. These results indicate that as the emotion regulation difficulties increase, the levels of compassion fatigue and burnout also increase. Difficulties in emotion regulation are also significantly and negatively related to compassion satisfaction, and this means that as the level of difficulties in emotion regulation decreases the level of compassion satisfaction increases. Differentiation of self is also significantly and negatively correlated with compassion fatigue and burnout, which indicates that when the level of differentiation of self increases, the levels of compassion fatigue and burnout decrease. There was a significant and positive relationship between compassion

satisfaction and differentiation of self. The results indicated that when the level of differentiation of self increases, the compassion satisfaction increases also.

When the groups are compared in terms of receiving trauma-specific training, receiving trauma-specific training significantly differed in terms of compassion satisfaction. These results indicate that participants who received trauma-specific training had more compassion satisfaction than the ones who did not receive trauma-specific training.

Testing the predicting roles of emotion regulation and differentiation of self on compassion fatigue, burnout, and compassion satisfaction with three-step hierarchical regression analysis, it was revealed that both difficulties in emotion regulation and differentiation of self significantly predicted compassion fatigue and burnout. However, only differentiation of self significantly predicted compassion satisfaction.

The moderation analysis revealed that differentiation of self significantly moderated the relationship between childhood trauma and compassion fatigue. In low levels of differentiation of self, a significant relationship between variables was observed. Additionally, low levels of differentiation of self and moderate and high levels of difficulties in emotion regulation significantly interacted with childhood trauma and compassion fatigue. Low levels of differentiation of self and moderate and high levels of difficulties in emotion regulation also moderated the relationship between childhood trauma and burnout. However, there was no moderation effect was found in the moderator variables in the relationship between childhood trauma and compassion satisfaction.

The relationship between the level of trauma exposure and compassion fatigue was significantly moderated with both difficulties in emotion regulation and differentiation of self. A significant effect was found on moderate and high levels of difficulties in emotion regulation and low and moderate levels of differentiation of self. However, the impact of difficulties in emotion regulation was stronger in the relationship between the level of trauma exposure and compassion fatigue. There

were no moderation effects were found in the moderator variables in the relationship between the level of trauma exposure and burnout and compassion satisfaction.

CHAPTER 4: DISCUSSION

This study aims to investigate factors influencing compassion fatigue experiences of mental health professionals who are exposed to clients' traumatic narratives as a part of their profession. The focus of the study is to explore how the relationship between trauma experiences (i.e childhood trauma history and the level of trauma exposure) and compassion fatigue is moderated by emotion regulation difficulties and differentiation of self. Along with compassion fatigue, the impact of those variables on burnout and compassion satisfaction are also investigated. In this chapter, the results will be discussed within the framework of the compassion fatigue model. The discussion will follow the order of the results chapter. As of last, the strengths, limitations, and suggestions for future research will also be included in this section.

4.1 The Findings of the Relationship Between the Study Variables

The participants' scores on compassion fatigue, burnout, and compassion satisfaction were examined in terms of childhood trauma history, the level of trauma exposure, difficulties in emotion regulation, and differentiation of self.

4.1.1 Relationships with Childhood Trauma History

Compassion Fatigue:

For the current study, the childhood trauma history of the mental health professionals was expected to have a significant and positive relationship with compassion fatigue. Even though the relationship revealed a positive trend, was non-significant. The personal trauma history of the clinician is one of the risk factors for compassion fatigue (Figley, 2002; Killian, 2008). Individuals with a trauma history could be more susceptible to the following psychological distortions (McFarlane and Yehuda, 2007). Especially, individuals experiencing early traumatic experiences leave individuals vulnerable to the possible psychological strains in adult life (Drapeau and Perry, 2004; Kim, Talbot, and Cicchetti, 2009; Şar, 2011). Childhood trauma history of professionals has also been presented as a risk factor for secondary traumatization (Nelson-Gardell and Harris, 2003), vicarious traumatization (Dunkley and Whelan, 2006), and compassion fatigue (La Mott and Martin, 2017). In this study, childhood trauma history was determined as the personal trauma history of

mental health professionals, because of the cumulative and sustained consequences of early adverse life events.

The non-significant results could be discussed by various explanations. In this sample, participants could have resolved their compassion fatigue symptoms even though they have a previous history of trauma. Clinicians might have developed resiliency towards their traumatic experiences and become able to effectively overcome the impact of their clients' traumatic narratives (Jenkins et al., 2011). Furthermore, they might have an ability to reflect on clients' traumatic material at a healthy empathic distance based on learning how to manage traumatic material through their own experiences (Martin-Cuellar et al., 2018).

Burnout:

The results revealed that childhood trauma history is only associated with burnout levels of the participants. As was expected childhood trauma history was positively and significantly related to burnout. Previous research indicated that adverse experiences in childhood increased the risk for burnout in mental health professionals (Canfield, 2005; Parker et al., 2022). Having a history of childhood trauma could hinder the implementation of effective coping strategies when encountering stressful situations (Ayres, 2020), so participants of the current study with a childhood trauma history might be strained to apply preventive strategies, such as social support or self-care, to dispose of burnout.

One explanation for the non-significant results between childhood trauma history and compassion fatigue could be explained by the significant results of the relationship with burnout. Burnout scores of the participants were higher in this sample than the compassion fatigue scores. This study revealed that burnout and compassion fatigue could be distinct constructs and influenced by different factors. Moreover, burnout symptoms are cumulative responses to the work-related strains, whereas compassion fatigue has a more rapid onset and can be treated conveniently if detected earlier (Newell and MacNeil, 2010). Thus, the mental health professionals of the current study might have resolved their compassion fatigue symptoms by being aware of their reactions and effectively detaching themselves from clients'

trauma. However, the influence of childhood trauma on burnout might continue due to the prolonged exposure to work-related strain.

Compassion Satisfaction

Contrary to the hypothesis, the study revealed a non-significant relationship between childhood trauma history and compassion satisfaction. The findings of the study are consistent with the previous research that revealed the non-significant relationship between personal trauma and compassion satisfaction (Killian, 2008; Thomas and Otis, 2010; Martin-Cuellar et al., 2018). On the other hand, some studies revealed that childhood adversities were positively correlated with compassion satisfaction and these results were explained by personal growth that might enhance the sense of achievement with the work (Howard et al., 2015; Brown et al., 2022). Thus, more depth examination is needed to investigate the impact of childhood trauma on compassion satisfaction by including different variables.

4.1.2 Relationships with the Level of Trauma Exposure

The current study investigated the relationship between the level of trauma exposure, as conceptualized by the frequency of mental health professionals' exposure to traumatic events from their clients within three months, and compassion fatigue, burnout, and compassion satisfaction.

Compassion Fatigue

The level of trauma exposure was significantly and positively correlated with compassion fatigue as was expected. The positive correlation of this study supports Figley's (2002) compassion fatigue model by indicating that the mental health professionals' level of exposure to traumatic events increases, they are more likely to experience compassion fatigue. Moreover, Figley (2002) also indicates that prolonged exposure to clients' suffering also increases the possibility of the development of compassion fatigue. In the current study, the exposure levels were assessed through the frequency of mental health professionals' exposure to their clients' traumatic narratives. Research examining the exposure levels of professionals generally assesses the exposure based on their trauma caseloads levels through the percentages or number of hours of trauma cases that professionals encounter weekly. Studies indicate that increase in traumatic caseloads put mental

health professionals at risk for compassion fatigue (Steed and Bicknell, 2001; Sprang, Clark, and Whitt-Woosley, 2007; Craig and Sprang, 2010). Moreover, it has been suggested that decreasing trauma cases, and diversifying the caseload by not only focusing on traumatic experiences would prevent the undesirable impact on mental health professionals (Figley and Figley, 2017).

Burnout

As expected, the result of the current study revealed that burnout is positively correlated with the level of trauma exposure of mental health professionals. Burnout is characterized by psychological and emotional exhaustion with feelings of hopelessness and difficulties in implementing the work effectively (Turgoose and Maddox, 2017). Moreover, burnout is mostly associated with external factors, such as workloads and a non-supportive work environment rather than resulting from interpersonal interactions with clients. Turgoose and Maddox (2017) indicate that compassion fatigue and burnout have significant interactions. The emotional demands of the work could be one common factor between constructs. A positive association between compassion fatigue and burnout was also found in the current study. Thus, mental health professionals with high exposure to traumatic narratives could also be at risk for burnout because of the conceptual overlap and possible common risk factors between the constructs. Prolonged exposure to traumatic experiences might develop emotional depletion and exhaustion in mental health professionals which are the prominent characteristics of burnout (Maslach, 1982; Turgoose and Maddox, 2017).

Compassion Satisfaction

Even though it was expected to have a significant and negative relationship, no significant relationship between the level of trauma exposure and compassion satisfaction was found. Compassion satisfaction is generally associated with the pleasure of being able to help and contribute effectively to individuals' lives and the feeling of accomplishment of the work (Figley and Stamm, 1996; Turgoose and Maddox, 2017). Even though the non-significant results, the positive trend might indicate that mental health professionals could acquire new treatment techniques and effectively manage their relationship with the clients by working extendedly with the traumatic narratives. Thus, they might eventually feel a sense of achievement which

is the prerequisite for compassion satisfaction by being aware of how to manage the distress elicited by the traumatic stories. Moreover, compassion satisfaction was found to be related to various factors, such as specialized trauma training (Sprang, Clark and Whitt-Woosley, 2007), personal therapy or supervision (Linley and Joseph, 2007), and years of experience (Ray et al., 2013). These findings indicate that compassion satisfaction might not be solely related to the extent of exposure to traumatic experiences, but other factors might determine the development of satisfaction with work.

4.1.3 Relationships with Difficulties in Emotion Regulation

Compassion Fatigue

In line with the hypothesis, the results of the study indicated that there is a significant and positive relationship between the level of emotion regulation difficulties and the level of compassion fatigue of mental health professionals. There is limited research examining the role of emotion regulation and the impact of secondary exposure to trauma. Măirean (2016) has revealed that cognitive reappraisal, the positive emotion regulation strategy related to changing the meaning of a situation and its emotional impact, was negatively correlated with secondary traumatic stress. Moreover, Benuto et al. (2020) suggest that the impact of secondary traumatic stress on maladaptive coping was mediated by emotion regulation difficulties. This study suggests that emotion regulation difficulties inhibit the professionals from the adverse coping strategies which increase their secondary trauma reactions. The results of the current study suggest that mental health professionals who experience difficulties in emotion regulation might be more prone to adverse impacts from the traumatic narratives that tend to trigger undesirable emotional experiences.

Burnout

The relationship between burnout and difficulties in emotion regulation also revealed a significant and positive correlation, as it was hypothesized. Burnout is characterized by emotional and physical responses to the work demands and work-related responsibilities (Salston and Figley, 2003). Burnout is a multifaceted construct that can be observed in various professions providing services in interaction with individuals. A systematic review including doctors revealed that

burnout was positively correlated with ineffective emotion regulation strategies and could be decreased using adaptive emotion regulation skills (Jackson-Koku and Grime, 2019). Mental health professionals could be more susceptible to burnout due to the close and emotionally intense relationship with their clients (Newton et al., 2020). In a study conducted with counselors, higher cognitive reappraisal as a functional emotion regulation strategy was found to be correlated with lesser degrees of burnout (Newton et al., 2020).

Compassion Satisfaction

Compassion satisfaction was expected to have a negative and significant relationship with emotion regulation difficulties, which was supported in the current study. Compassion satisfaction is considered nearly the opposite of compassion fatigue, referring to the sense of achievement and fulfillment of the work and increased self-worth (Ludick and Figley, 2017). Mental health professionals who work in emotionally triggering environments might experience strain and a low sense of achievement if they are unable to effectively reflect on their emotions. On the other hand, the professionals who are aware of and able to regulate their emotions thus could benefit from the satisfactory sides of their interaction with clients. Cognitive reappraisal, as an emotion regulation strategy, was found to have a positive relationship with compassion satisfaction (Măirean, 2016). The healthcare providers who were able to change the meaning of the situation and their emotional responses were able to experience higher levels of compassion satisfaction. In a study, compassion satisfaction was found to be the mediator between cognitive appraisal, and psychological wellbeing. This finding indicates that when the professionals interpret the stressful situation as less threatening, they could experience satisfaction with their work (Amjad, Abbasi, and Ijaz, 2020).

4.1.4 Relationships with Differentiation of Self

Another personal resource that mental health professionals could benefit from when working empathically with clients with traumatic experiences is defined as self-differentiation for this current study.

Compassion Fatigue

As was expected high level of differentiation of self was found to be negatively and significantly correlated to compassion fatigue. Halevi and Idisis (2018) conducted a study with 134 mental health therapists to investigate whether dimensions of differentiation of self predicted vicarious trauma. They concluded that high levels of self-differentiation provided preventive resources for mental health professionals which enabled them to protect clear and flexible boundaries which emotionally separate them to reduce vicarious arousal. In a similar vein, the study conducted with social workers revealed that high levels of self-differentiation decrease the likelihood of compassion fatigue (Finzi-Dottan and Kormosh, 2017). As suggested by Bowen, self-differentiation provides self-regulation and the ability to effectively function during stressful situations. Thus, mental health professionals with high levels of self-differentiation could separate themselves from their clients' emotional responses and use empathic interaction without overidentification. Similarly, researchers suggest that self-differentiation provides a reflection of the situations in an observer position facilitating a healthy distance in empathic engagement with the minimization of aversive responses (Jackson et al., 2006; Lamm et al., 2007; Thomas and Otis, 2010).

Burnout

Along with the hypothesis, the findings of the study revealed that self-differentiation was negatively and significantly related to burnout. There is limited research examining the level of self-differentiation and burnout. However, as a similar construct emotional separation, which covers self-differentiation in interpersonal interactions, was found to be negatively associated with burnout. In a study with social workers, Corcoran (1989) suggested that emotional separation and burnout were negatively related. The results of the study indicated that when the professionals remain separate from the emotional world of their clients would experience fewer adverse reactions through empathic interactions. Similarly, Thomas and Otis (2010) also revealed that higher levels of emotional separation were strongly associated with lower levels of burnout in a sample of social workers. Even (2002) found out that a higher level of self-differentiation of therapists indicated a decreasing effect on burnout, indicating that the level of self-differentiation

prevented the deleterious impact of work-related strain by providing a healthy separation in stressful work conditions.

Compassion Satisfaction

Compassion satisfaction was positively and significantly correlated with differentiation of self, as was expected. Emotional separation was found to be positively correlated to compassion satisfaction (Thomas and Otis, 2010). Moreover, compassion satisfaction was found to be positively associated with self-differentiation in a study that investigate how professionals' level of self-differentiation impacts their compassion outcomes (Finzi-Dottan and Kormosh, 2017). These results suggest that mental health professionals with the ability to differentiate themselves from the stressful conditions by keeping healthy boundaries could experience satisfaction from their work. Furthermore, Figley (2002) suggests in his compassion fatigue resilience model that when the clinicians could detach themselves from the clients' traumatic experiences, they would experience more satisfaction with their work due to lessened emotional distress. Besides, increasing compassion satisfaction could lead to decreasing the undesirable consequences of working with trauma survivors (Figley, 2002).

4.2 The Findings of the Group Differences Based on Receiving Trauma-Specific Training

To investigate whether mental health professionals who received trauma-specific training would experience less compassion fatigue and burnout, and more compassion satisfaction than the ones who did not receive training, the differences between the groups were investigated.

Contrary to the hypothesis there were no significant differences between groups in compassion fatigue and burnout outcomes in terms of receiving trauma-specific training. The non-significant difference in compassion fatigue and burnout outcomes could be related to the quality and quantity of the trauma-specific training. One possibility is that mental health professionals could acquire techniques in their treatment strategies for traumatic narratives. Radey and Figley (2007) assert that training programs should include self-care strategies to raise awareness of the negative impact of trauma work. If the training does not cover how to manage the

impact of trauma work, mental health professionals would not implement self-care strategies for themselves and might not be aware of the undesirable consequences. Thus, even though they receive trauma-specific training and acquire how to work with traumatic narratives, they might be indifferent in terms of compassion fatigue and burnout from the ones who did not receive any training.

On the other hand, mental health professionals who received trauma-specific training scored significantly high on compassion satisfaction outcomes. This study revealed an expected result as discussed in the literature that specialized trauma training could enhance the possibility of compassion satisfaction of mental health professionals (Sprang, Clark, and Whitt-Woosley, 2007; Craig and Sprang, 2010). Greenwald et al. (2008) suggest that effective training in the field of trauma leads professionals to experience lesser degrees of distress, more empathy, and more competency when they are providing services to their clients. They also conclude that trauma-specific training decreases the adverse impact of the work. Knight (2010) also claims that an adequate amount of training on trauma prepares the professionals to implement effective strategies for the clients, but more importantly provides approaches to address the impact of re-traumatization. Research investigating the role of trauma-specific training reveals parallel results. In a study with a sample of 1121 mental health providers Sprang, Clark, and Whitt-Woosley (2007) investigated whether special trauma training predicts compassion fatigue, burnout, and compassion satisfaction. They found similar results to Ortlepp and Friedman (2002) indicating that specialized trauma training increased compassion satisfaction and had a decreasing impact on compassion fatigue and burnout. They concluded that the compassion satisfaction levels might be enhanced with the self-efficacy and sense of achievement cultivated by the specialized training. This is in line with the definition of compassion satisfaction reflecting the sense of achievement that mental health professionals experience when working in the trauma field (Radey and Figley, 2007). Moreover, specialized training might provide a supportive environment and professional network to discuss the adverse impact of trauma work (Sprang, Clark, and Whitt-Woosley, 2007).

4.3 The Findings of the Predictive Role of Difficulties in Emotion Regulation and Differentiation of Self

This study aimed to investigate whether difficulties in emotion regulation and differentiation of self would predict compassion fatigue, burnout, and compassion satisfaction after accounting for occupational variables and trauma experiences. For the current study emotion regulation difficulties and differentiation of self were expected to significantly predict compassion fatigue, burnout, and compassion satisfaction.

Compassion Fatigue

Results of the hierarchical regression analysis revealed that contrary to the literature years of experience, workload, caseload, and work-related support did not predict compassion fatigue in the first cluster of analysis. When childhood trauma and the level of trauma exposure of mental health professionals were added to the model only the level of trauma exposure was found to be the predictor of compassion fatigue. Early studies focused on examining the exposure to trauma through the average hours of trauma cases mental health professionals work with and found that the more trauma cases the mental health professionals have the more likely they experience compassion fatigue. However, in this study, the level of trauma exposure was examined through the frequency of encountering traumatic narratives within three months of the work routine. The results indicated that not the caseloads as quantified by the average hours working with trauma cases predicted compassion fatigue, but the frequency of exposure was found as a predictor. Dutton and Rubinstein (1995) indicated that frequency, nature of the event, duration, and severity of direct interaction with the clients are perceived experiences that could change the reactions of mental health professionals (Cerney, 1995; MacRitchie and Leibowitz, 2010). Thus, by investigating the frequency of diverse traumatic events that mental health professionals encounter, the current study covered the subjective perception of mental health professionals regarding traumatic events.

In the third step of the hierarchical regression analysis, work-related support, the level of trauma exposure, difficulties in emotion regulation, and self-differentiation significantly predicted compassion fatigue. Results indicated that when mental health professionals can identify, accept, and adaptively regulate their emotions, and

differentiate themselves by protecting boundaries when separating themselves from the emotional world of their clients, they were less likely to experience compassion fatigue. Another significant finding was that other than the introduced predictors of compassion fatigue in the literature, the inner experiences of mental health professionals could also contribute to the development of compassion fatigue. Even though these two constructs have not been addressed extendedly throughout the literature, studies identified emotion regulation (Măirean 2016; Cemgil, 2019; Amjad, Abbasi, and Ijaz, 2020) and differentiation of self (Purvis, 2017; Halevi and Idisis, 2018; Taylor, 2021) as the predictors of compassion fatigue and vicarious trauma. Emotion regulation and self-differentiation are identified as the strong regulating mechanisms for the distress elicited through empathic connection (Lamm, Batson, and Decety, 2007). Regulation of the empathic response in the interaction with clients protects mental health professionals from the adverse impact of traumatic encounters eliciting high emotional strain.

The results revealed that when emotion regulation difficulties and self-differentiation were entered into the regression analysis, work-related support significantly but positively predicted compassion fatigue. Throughout the literature work-related support decreases the negative impact of working with traumatic narratives (Creamer and Liddle, 2005; Zara and İçöz, 2011; Cieslak et al., 2014; Kanno, Kim, and Constance-Huggins, 2016; Dehlin and Lundh, 2018). The support through supervision or personal therapy is believed to provide an environment to discuss the emotional intensity of being exposed to traumatic narratives (Bell, Kulkarni, and Dalton, 2003; Barrett and Barber, 2005). However, there is a possibility that mental health professionals would not discuss their emotional states through their supervision or personal therapy. Moreover, the literature suggests that supervisors should also be aware of the adverse impact of trauma work and provide information for the professionals providing counseling to traumatized clients (Merriman, 2015). The services offered to professionals might not be adequate to meet the demands of working with trauma narratives (Goddard and Hunt, 2011; Knight, 2004).

Burnout

Three-step hierarchical regression analysis revealed that years of experience and workload are the predictors of burnout, indicating that more experienced professionals were less likely to experience burnout, and an increase in workload escalated the likelihood of burnout. Studies have found that workload is a strong predictor of burnout (Jovanovic et al., 2016; Kim et al., 2018; Yang and Hayes, 2020). The workload might decrease the sense of achievement due to the overreaching demands of the job and decrease the effectiveness. Norcross and VanDen Bos (2018) suggest that mental health professionals balance their schedules and reduce work-related demands to mitigate the effects of burnout and increase the effectiveness of client interactions.

The current study revealed that years of experience were a significant and negative predictor of burnout. Throughout the literature, it was suggested that higher years of experience had a lowering effect on burnout (Eastwood and Ecklund, 2008; Van Hook and Rothenberg, 2009). Mental health professionals could have gained more effective ways of coping and managing the work demands as they got experienced in their professions. However, in the current study when the difficulties in emotion regulation and self-differentiation were entered into the model the predicting role of years of experience on burnout diminished. Difficulties in emotion regulation and self-differentiation significantly predicted burnout. Difficulties in emotion regulation (Cemgil, 2019) and emotional separation, which is related to self-differentiation (Thomas and Otis, 2010) were found to be predictors of burnout. Mental health professionals might have acquired skills through their experience to regulate their emotions and detach themselves from the stressful demands in either client interactions or the work environment. Thus, not the experience year solely predicted the level of burnout in mental health professionals, but their inner emotional experiences, as reflected in their emotion regulation abilities and self-differentiation levels, might have more impact on the development of burnout.

Compassion Satisfaction

When the regression analysis was investigated for compassion satisfaction, the results revealed that years of experience significantly and positively predicted compassion satisfaction. When mental health professionals gain more experience in

their work, they can experience more sense of achievement and satisfaction. These findings were in line with the earlier research suggesting the maturity and clinical experience of mental health professionals could serve as a buffering factor for the detrimental consequences of secondary exposure to trauma, but also enhancing factor for the satisfactory outcomes when working in the field (Cunningham, 2003; Sprang, Clark, and Whitt-Woosley, 2007; Craig and Sprang, 2010). On the other hand, the results of this current study revealed that when difficulties in emotion regulation and self-differentiation were entered into the model, only self-differentiation significantly and positively predicted compassion satisfaction. Higher levels of self-differentiation have been associated with increasing positive well-being outcomes in individuals (Skowron and Friedlander, 1998; Skowron, Holmes, and Sabatelli, 2003; Skowron, Stanley, and Shapiro, 2009). According to the results, mental health professionals who have higher levels of self-differentiation could benefit from the satisfactory elements of their work due to their ability to balance self and other boundaries, and to stay calm in anxiety-triggering situations in interactions with their clients. Differentiation of self also decreased the predictive role of experience year in the current study. Rather than having more experience in the work, keeping the balance with emotional distance enables professionals to intellectually identify the needs and decide clearly on the strategies which might be helpful for the clients. Being able to distance themselves from the clients' emotional experiences would enhance the likelihood of professionals' ability to provide effective treatment for their clients which in turn experienced as satisfaction with the work.

4.4 The Moderating Role of Difficulties in Emotion Regulation and Differentiation of Self

Research on compassion fatigue, burnout, and compassion satisfaction revealed contradictory results examining the role of childhood trauma history and the level of trauma exposure. Thus, for the current study difficulties in emotion regulation and differentiation of self were expected to moderate the relationship between mental health professionals' trauma experiences and compassion fatigue, burnout, and compassion satisfaction.

4.4.1 Moderation Results in the Relationship between Childhood Trauma and Compassion Fatigue, Burnout, and Compassion Satisfaction

The first moderation analysis was conducted to investigate whether difficulties in emotion regulation and self-differentiation moderate the relationship between childhood trauma history, compassion fatigue, burnout, and compassion satisfaction.

Results revealed that the low levels of differentiation of self significantly and positively moderated the relationship between childhood trauma history and compassion fatigue. Throughout the literature, having a history of childhood trauma is considered a risk factor for the development of compassion fatigue (Nelson-Gardell and Harris, 2003; Newell and MacNeil, 2010). Having a history of trauma puts mental health professionals at risk of re-experiencing the traumatic memories with the interaction of the clients' trauma and increases the emotional distress (Figley and Figley, 2017). However, as it was found in the current study, differentiation of self enhances building healthy boundaries and detachment from anxiety-triggering situations (Skowron and Friedlander, 1998; Peleg-Popko, 2004). Thus, mental health professionals with a history of trauma with the ability to separate themselves from clients' emotional world would lessen overidentification and experience lower degrees of compassion fatigue.

Childhood trauma history is associated with adverse outcomes for mental health in adult years (Drapeau and Perry, 2004; Kim, Talbot, and Ciccihetti, 2009). Thus, childhood trauma history was expected to be positively related to compassion fatigue outcomes, but this relationship was not supported by the correlation and regression analysis. However, in the moderation analysis lower levels of childhood trauma history was negatively related to compassion fatigue. Professionals with a history of trauma could have gained resiliency to remain separate from the harmful impact of further stressors. Resiliency is the ability to comprehend and adapt to adverse life events (Luthar, Cicchetti, and Becker, 2000). Individuals who experienced adversities in their lives are more able to detect the possible harmful impacts of their environment (Smith et al., 2008). Thus, mental health professionals might gain the ability to assess the stressful events, detach themselves from adverse situations, and might enhance their self-differentiation capacities to protect themselves. The ones with low levels of childhood trauma might encounter traumatic narratives without

being prepared for the consequences of such experiences as opposed to the professionals with high levels of childhood trauma. On the other hand, enhanced self-differentiation capacities provide a protective mechanism, regardless of their childhood trauma histories, since it was found that at low levels of self-differentiation professionals exhibited an increase in compassion fatigue outcomes. Self-differentiation would buffer the impact of childhood trauma histories eliciting the empathic strain on mental health professionals

On the other hand, difficulties in emotion regulation did not moderate the relationship between childhood trauma and compassion fatigue, however, the interaction of both self-differentiation and emotion regulation had a significant effect. Moderate and high levels of difficulties in emotion regulation and low differentiation of self were the significant moderators. Both, emotion regulation and self-differentiation are associated with emotional separation enabling individuals to regulate themselves to reduce anxiety in stressful situations (Kerr and Bowen, 1988; Yavuz Güler and Karaca, 2021). Moreover, personal trauma history might elicit adverse empathic reactions, such as the inability to detect own emotions or increased overidentification with the clients' emotional states. Emotion regulation and self-differentiation are the constructs that explain how personal distress and emotional strain could be managed in the presence of empathic interactions (Lamm, Batson, and Decety, 2007). Thus, mental health professionals who are aware of, accept, and effectively regulate their own emotions, and distinguish their emotions from the clients by distancing themselves from their clients' emotional experiences might diminish the impact of their personal trauma history on the development of compassion fatigue.

Difficulties in emotion regulation and differentiation of self significantly moderated the relationship between childhood trauma history and burnout. Studies on childhood trauma suggest that childhood adversities might interfere with the later experiences of emotions, such as having difficulties in recognizing and describing emotional states, aloofness in affective experiences, and consequently difficulties in interpersonal relationships (Paivio and Laurent, 2001). Moreover, individuals with emotion regulation difficulties experience struggles in coping with the demands of life (Mennin et al., 2007). Moreover, differentiation of self enables professionals to

overcome stressful situations at a healthy distance in interpersonal relations. The results of this current study revealed that professionals with childhood trauma history experienced more burnout when they had higher emotion regulation difficulties and lower levels of self-differentiation. Thus, these results suggest that mental health professionals with a history of trauma could be more prone to experience burnout, which is a result of emotional exhaustion from the demands of the work when they experience emotion regulation difficulties and lower levels of self-differentiation.

Neither difficulties in emotion regulation nor self-differentiation moderated the relationship between childhood trauma history and compassion satisfaction. The results of the analysis revealed that only self-differentiation was a strong predictor of compassion satisfaction and the relationship between childhood trauma and compassion satisfaction was non-significant. The non-significant results might depend on that personal trauma history is not a strong predictor of compassion satisfaction as in line with the previous studies (Thomas and Otis, 2010; Martin-Cuellar et al., 2018). One possible explanation for the findings might be that emotion regulation and self-differentiation could be protective against the adverse outcomes, however, might not foster positive changes in the presence of personal traumatic experiences.

4.4.2 Moderation Results in the Relationship between the Level of Trauma Exposure and Compassion Fatigue, Burnout, and Compassion Satisfaction

The second moderation analysis was conducted to investigate whether difficulties in emotion regulation and self-differentiation would moderate the relationship between the level of trauma exposure and compassion fatigue, burnout, and compassion satisfaction.

Results revealed that both difficulties in emotion regulation and self-differentiation moderated the relationship between the level of trauma exposure and compassion fatigue. Mental health professionals with high emotional empathy could experience congruence in the affective responses of their clients to understand their internal world (Corcoran, 1983; Hatfield, Rapson, and Le, 2011). Stebnicki (2008) suggests that having lesser degrees of emotional separation and emotion regulation increases mental health professionals' vulnerability because of overidentification

with the emotional states of clients, inability to detect and reflect on their own emotions, and lack of building an empathic distance. Exposing high amounts of traumatic narratives with empathy, mental health professionals are at risk of experiencing increased emotionality due to an urge to diminish the suffering of their clients. Moreover, as suggested by Figley and Figley (2017) to develop resiliency towards compassion fatigue, practitioners should be able to disengage from the traumatic memories. Emotion regulation abilities and self-differentiation capacities would protect them to reflect their clients at a healthy distance with emotional awareness and provide a reduction in their increased emotional arousal.

However, the moderation effect was similar on both three levels of self-differentiation. One possible explanation is that the determinant of the significance of the levels of self-differentiation could depend on the moderate and high levels of emotion regulation difficulties. Studies indicate that emotion regulation and self-differentiation are related to each other, indicating that more differentiated individuals can regulate their emotions (Rodrigues, 2016; Yavuz Güler and Karaca, 2021). Emotional distress elicited through the clients' trauma could be managed through the emotion regulation abilities and provide mental health professionals to reflect effectively on their empathic response without getting fused with the clients' emotional states. They might become able to diminish the impact of traumatic narratives and protect themselves from developing compassion fatigue symptoms.

Results revealed that neither emotion regulation nor self-differentiation significantly moderated the impact of the level of trauma exposure on both burnout and compassion satisfaction. Even though high levels of trauma exposure do not directly predict burnout, there is a possibility that higher caseloads increase the risk for work-related distress in mental health professionals (Turgoose and Maddox, 2017). On the other hand, compassion satisfaction could be improved by the reduction in trauma cases (Figley and Figley, 2017). The analysis of the current study revealed that both emotion regulation and self-differentiation were the strong predictors of burnout, indicating that lower levels of emotion regulation difficulties and higher levels of self-differentiation could mitigate burnout symptoms. Moreover, higher levels of self-differentiation and lower levels of difficulties in emotion regulation were also related to compassion satisfaction outcomes. This might be

concluded as the emotional regulation and self-differentiation abilities of the mental health professionals could act as a protective mechanism for burnout and enhance compassion satisfaction regardless of their exposure to traumatic narratives.

4.5 Limitations of the Study and Future Recommendations

Besides providing contributions to the literature the current study has limitations to be considered for the interpretation of the findings. Moreover, discussing the limitations could provide suggestions to be appraised for future studies.

The first limitation to be considered is the sample size and the distribution of the participant characteristics. Mental health professionals were reached through snowball sampling. The online survey package was shared via professional networks, including e-mail groups, social media platforms, and communication channels that consisted of the professionals working in mental the health field. Even though the online survey package reached more numbers of professionals than expected, the response rates remained quite low for the study. 147 participants completed the total survey and with the exclusion of four participants, the remaining sample was 143. Moreover, participants demographic characteristics based on profession, gender, receiving work-related support, and receiving trauma-specific training were not equally distributed. The participants were mostly female, psychologists, receiving support and receiving trauma-specific training, which all could impact findings. Over the literature, especially adverse symptoms of secondary traumatization were found to be high in females (Sprang, Clark, and Whitt-Woosley., 2007; Rossi et al., 2012), and low in psychologists (Zara and İçöz, 2015), and professionals receiving work-related support (Kanno, Kim, and Constance-Huggins, 2016), and receiving trauma-specific training (Sprang, Clark, and Witt-Woosley, 2007). More importantly, these findings do not represent the whole characteristics of mental health professionals and cannot be generalizable to the professionals working in the field. Thus, for future studies, designing the study with higher numbers of participants and equal distribution of the demographic variables enable researchers to infer the results more accurately and expand the understanding of the compassion fatigue, burnout, and compassion satisfaction literature in a more comprehensive and generalizable manner.

The cross-sectional design is another limitation. The data was collected from a limited period and represents only a certain section of the participants' overall experiences on compassion fatigue, burnout, and compassion satisfaction. Those experiences might transform over time due to changes in mental health professionals' personal and professional environments. For example, the life challenges, changes in the work environment, or changes in the clients' characteristics might impact the mental health professionals' experiences. For future studies, longitudinal designs could be more informative to observe the mental health professionals' experiences of compassion fatigue, burnout, and compassion satisfaction over time by including the changes in personal lives and professional environments of the mental health professionals.

Parallel to the limitation of the cross-sectional design of the study, another limitation is using a quantitative design. Because of self-report measures, response to the questions about compassion fatigue experiences might not reflect the subjective experiences when they are working with the trauma survivors. Self-report measures limit the ability to investigate the unique experiences of participants, therefore interfering with observing the reflections of the participants on their experiences. Qualitative designs would be more informative on how mental health professionals identify and reflect on their own experiences. Following quantitative design, the chosen measurement tools for data collection could be another limitation. There are still overlapping factors regarding secondary exposure to trauma. This study only included assessing compassion fatigue, burnout, and compassion satisfaction experiences by using the Professional Quality of Life Scale. Even though this scale is widely used throughout the literature, does not include assessing the overall change that mental health professionals might experience. Thus, including the examination of possible psychological changes would provide a comprehensive understanding of the secondary traumatization literature. When all those limitations were considered, future studies could design qualitative research to investigate the subjective experiences of mental health professionals and might include different measurement tools to understand secondary traumatization within a comprehensive framework.

The last limitation of this current study is assessing the personal trauma history of participants only by their childhood traumatic experiences. The findings revealed that

childhood trauma might not be a predictive factor for the outcome variables of the study. Including recent traumatic experiences, could be more informative to understand the development of compassion fatigue. Mental health professionals are also prone to experiencing traumatic experiences in their personal lives as their clients. Thus, those experiences might change the flow of their interaction as they are sharing the same reality. For future studies, it is recommended to assess both childhood and adulthood traumatic experiences to understand how personal traumatic experiences could impact the mental health professionals' adverse reactions to their clients' narratives.

CHAPTER 5: CONCLUSION

This study investigated traumatic experiences of mental health professionals in the relationship between compassion fatigue, burnout, and compassion satisfaction with the moderating roles of difficulties in emotion regulation and self-differentiation. This study contributed unique findings to the compassion fatigue literature.

The findings indicated that difficulties in emotion regulation and self-differentiation were the strong predictors of compassion fatigue. Mental health professionals who scored high on emotion regulation difficulties and low on self-differentiation presented increased compassion fatigue and burnout symptoms. On the other hand, self-differentiation was also the predictor of compassion satisfaction. Most of the research conducted in this field focuses on the predictive factors associated with demographic variables or workplace conditions of mental health professionals. Thus, there is limited research examining the inner psychological experiences which might contribute to mental health professionals' reactions to the traumatic narratives. The significant findings of the current study revealed that focusing on the inner experiences of mental health professionals could provide an advanced and comprehensive understanding of the impact of trauma work.

Furthermore, as it was aimed for the current study, emotion regulation difficulties and self-differentiation moderated the relationship between trauma experiences and compassion fatigue. As the empathy research asserts that emotion regulation and self-differentiation are the two possible factors that enhance the effective empathic connection (Decety and Lamm,2006). The results indicate that emotion regulation abilities and separation from traumatic memories could enhance the effective empathic interaction for mental health professionals.

Lastly, this study also provided contributions to the distinctions and similarities between compassion fatigue, burnout, and compassion satisfaction. The findings revealed that there might be distinct processes influencing mental health professionals on the positive and negative aspects of trauma work. even though emotion regulation difficulties and self-differentiation were the protective factors for

compassion fatigue, insignificant results on moderation analysis might indicate that there are other explanations for the development of burnout and compassion satisfaction.

Sometimes it is taboo for mental health professionals to talk about the negative aspects of their work. However, mental health professionals are also impacted by their interactions with clients and their subjective characteristics might influence the course of the relationship. Thus, conducting the study by examining the inner psychological factors of mental health professionals regarding compassion fatigue and related constructs provides an advanced and depth understanding. Moreover, examination of compassion fatigue including extended aspects would raise awareness. Awareness and knowledge of the possible risk and protective factors would pave the way to the recommendation and implementation of techniques to reduce compassion fatigue and burnout while increasing the level of compassion satisfaction. Therefore, individuals, organizations, and training programs could include the subjects in their curriculum and provide a base for preventing the undesirable impact of client interactions.

Harrison and Westwood (2009) suggest that 'exquisite empathy' protects professionals from the adverse impact of their work. They indicate that when professionals through their empathic connection do not fuse or be overinvolved in their clients' expressions could benefit from the satisfactory elements of their work and make clear boundaries by reflecting on their emotional processes. Regarding the findings of the current study, emotion regulation difficulties and self-differentiation could be targeted within the regular supervision and personal therapy sessions of mental health professionals. Moreover, training programs, supervisors, and the curriculum of the formal training programs would provide specialized space on the issue of secondary traumatization to raise awareness and provide specialized techniques for the trainees. They might also address the possible risk factors by observing the mental health professionals who experience difficulties in emotional areas. Research also indicates that self-care strategies could be included in the curriculums of both trauma-specialized training and training programs as the self-care of professionals is found to be a protective factor for empathy-based stress (Ludick and Figley, 2017). Most of the training programs focus on implementing

mindfulness practices. However, training programs could address emotion regulation and self-differentiation through their courses. Especially for the organizations and training programs, group sessions to reflect on the emotional separation of mental health professionals could be implemented to avoid harmful impacts of trauma work. Moreover, providing possible detachment and emotion regulation strategies could enhance the professionals' awareness of their emotional states and might enhance their ability to protect the boundaries with their clients' emotional world (Harrison and Westwood, 2009) and indirectly enhance the implementation of self-care strategies.

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APPENDICES

Appendix-A: Ethics Committee Approval

SAYI : B.30.2.İEÜ.0.05.05-**020**-*195* 24.02.2022

KONU : Etik Kurul Kararı hk.

Sayın Prof. Dr. Falih Köksal ve Kübra Yıldırım Zeren

"Understanding the Impact of Traumatic Narratives on Mental Health Workers: Self-Differentiation and Emotion Regulation as Moderators Between Personal Trauma History, Level of Trauma Exposure and Compassion Fatigue" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 24.02.2022 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir.

Sonuçta 24.02.2022 tarihinde **"Understanding the Impact of Traumatic Narratives on Mental Health Workers: Self-Differentiation and Emotion Regulation as Moderators Between Personal Trauma History, Level of Trauma Exposure and Compassion Fatigue"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

Appendix-B: Participant Consent Form

Katılımcı Bilgilendirme Formu

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı kapsamında, Prof. Dr. Falih Köksal danışmanlığında, Kübra Yıldırım Zeren tarafından yürütülmektedir. Bu form size çalışma koşulları hakkında bilgilendirmek için hazırlanmıştır. Bu çalışmanın amacı ruh sağlığı uzmanlarında (psikolog, psikolojik danışman ve psikiyatrist), travmatik deneyimlere dolaylı olarak maruz kalmanın etkilerinin ve bireylerin deneyimlerinin anlaşılmasıdır. Bu çalışmayla birlikte olası koruyucu faktörlerin ortaya koyulması açısında fayda sağlanacağı düşünülmektedir.

Araştırmaya katılım tamamen gönüllülük esasına dayanmaktadır. Herhangi bir sebeple çalışmaya katılmayı reddedebilir veya çalışmadan çekilebilirsiniz. Ancak, çalışmanın amacına ulşabilmesi için sizden bütün sorulara eksiksiz yanıt vermeniz beklenmektedir.

Katılmayı kabul ederseniz toplamda yaklaşık 15-20 dakika sürecek bu çalışmada sizden anketteki soruları yanıtlamanız istenecektir. Soruların doğru ya da yanlış bir cevabı yoktur. Her bir soruyu okuyup, kendiniz için en doğru cevabı verecek şekilde yanıtlamanız araştırmanın güvenirliği açısından önemlidir. Bu araştırma anketinin hiçbir aşamasında sizden kimlik bilgileriniz veya kişisel olarak tanınmanıza yol açacak bilgiler istenmeyecektir. Verdiğiniz yanıtlar gizli tutulacak, bu bilgilere yalnızca araştırmacılar ulaşabilecektir. Her bir katılımcıdan toplanan veriler toplu olarak değerlendirilecek, bilimsel yayınlar ve akademik amaçlar için kullanılacaktır.

Araştırmayla ilgili herhangi bir sorunuz olması durumunda Psk. Kübra Yıldırım Zeren'e e-posta adresinden ulaşabilirsiniz.

Çalışmaya katılımınız için şimdiden teşekkür ederiz.

Bu çalışmaya tamamen gönüllü olarak katılmayı kabul ediyorum ve verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

EVET

HAYIR

Appendix-C: Demographic Information Form

Demografik Bilgi Formu

1) Cinsiyet:
   ___Kadın
   ___Erkek
   ___Belirtmek istemiyorum
2) Yaşınız: ___
3) Öğrenim durumunuz:
   ___Lisans
   ___Yüksek Lisans
   ___Doktora ve üstü
4) Mesleğiniz: ___
5) Meslekte deneyim yılınız? ___ (yıl) ___ (ay)
6) Hangi yaş gruplarıyla çalışıyorsunuz? Birden fazla seçenek işaretleyebilirsiniz.
   ___Çocuklar
   ___Ergenler/Gençler
   ___Yetişkinler
   ___Yaşlılar
7) Haftada ortalama kaç saat çalışıyorsunuz? ___ (saat)
8) Çalışma ortamınızı nasıl tanımlarsınız?
   ___Kamu kurumu
   ___Bireysel/ paylaşımlı ofis
   ___Özel hastane
   ___Devlet hastanesi
   ___Özel okul
   ___Devlet okulu
   ___Sivil Toplum Kuruluşu
   ___Diğer (lütfen belirtiniz):
9) Şu anda çalıştığınız kurumda ne kadar süredir çalışıyorsunuz? ___(ay___(yıl)
10) Çalışırken zorlandığınız durumlarda destek alıyor musunuz?
   ___Evet
   ___Hayır

11) Cevabınız evet ise, aşağıdaki destek sistemlerinden hangilerini kullanıyorsunuz?

___ Akran süpervizyonu

___ Süpervizyon (Bireysel/ Grup)

___ Bireysel terapi

12) Çalıştığınız kurumda travmatik deneyimi olan kişiler ile çalışıyor musunuz?

___Evet

___Hayır

13) Cevabınız evet ise haftada ortalama kaç saat travma deneyimi olan kişiler ile çalışıyorsunuz? ___ (saat)

14) Aşağıda insanların başına gelebilecek çeşitli olayların listesi verilmiştir. Bu liste içerisinde yer alan olayları danışanlarınızdan son 3 ayda ne sıklıkta dinlediğinizi lüften belirtiniz.

0 (hiçbir zaman) ---1 (nadiren) --- 2 (ara sıra) --- 3 (sık sık) --- 4 (her zaman)

___Ciddi bir kaza veya yaralanma öyküsü

___Ani yakın kaybı (örn: intihar, kaza, hastalık)

___Doğal afet (deprem, sel vb.)

___Fiziksel saldırı öyküsü (örneğin; saldırıya uğrama)

___Partner şiddeti / aile içi şiddet öyküsü (örneğin; fiziksel şidde

___Cinsel saldırı / cinsel şiddet öyküsü

___Çocukluk çağı travmatik deneyimler (örneğin; ihmal / istismar öyküsü)

___Bir savaş bölgesinde çatışmaya girme veya ateş altında kalma

___Yaşamı tehdit eden bir sağlık sorunu ya da ameliyat

___Hapis edilme, esir tutulma öyküsü

___İşkence öyküsü

___Toplumsal travmatik deneyim (örn. bombalı, silahlı saldırı)

___Kendine ya da bir başkasına zarar verme öyküsü

___ Diğer (Lütfen belirtiniz):

Appendix-D: Childhood Trauma Questionnaire (CTQ)

Çocukluk Çağı Ruhsal Travma Ölçeği

Bu sorular **çocukluğunuzda ve ilk gençliğinizde** (20 yaşından önce) başınıza gelmiş olabilecek bazı olaylar hakkındadır. Her bir soru için sizin durumunuza uyan rakamı işaretleyiniz. Sorulardan bazıları özel yaşamınızla ilgilidir; lütfen elinizden geldiğince gerçeğe uygun yanıt veriniz.

Yanıtlarınız gizli tutulacaktır.

1. Hiçbir Zaman 2. Nadiren 3. Kimi zaman 4. Sık olarak 5. Çok sık

Çocukluğumda ya da ilk gençliğimde…

1. Evde yeterli yemek olmadığından aç kalırdım.
2. Benim bakımımı ve güvenliğimi üstlenen birinin olduğunu biliyordum.
3. Ailemdekiler bana "salak", "beceriksiz" ya da "tipsiz" gibi sıfatlarla seslenirlerdi.
4. Anne ve babam ailelerine bakamayacak kadar sıklıkla sarhoş olur ya da uyuşturucu alırlardı.
5. Ailemde önemli ve özel biri olduğum duygusunu hissetmeme yardımcı olan biri vardı.
6. Yırtık, sökük ya da kirli giysiler içersinde dolaşmak zorunda kalırdım.
7. Sevildiğimi hissediyordum.
8. Anne ve babamın benim doğmuş olmamı istemediklerini düşünüyordum.
9. Ailemden birisi bana öyle kötü vurmuştu ki doktora ya da hastaneye gitmem gerekmişti.
10. Ailemde başka türlü olmasını istediğim bir şey yoktu.
11. Ailemdekiler bana o kadar şiddetle vuruyorlardı ki vücudumda morartı ya da sıyrıklar oluyordu.
12. Kayış, sopa, kordon ya da başka sert bir cisimle vurularak cezalandırılıyordum.
13. Ailemdekiler birbirlerine ilgi gösterirlerdi.
14. Ailemdekiler bana kırıcı ya da saldırganca sözler söylerlerdi.
15. Vücutça kötüye kullanılmış olduğuma (dövülme,itilip kakılma vb.) inanıyorum.
16. Çocukluğum mükemmeldi.
17. Bana o kadar kötü vuruluyor ya da dövülüyordum ki öğretmen, komşu ya da bir doktorun bunu farkettiği oluyordu.
18. Ailemde birisi benden nefret ederdi.

19. Ailemdekiler kendilerini birbirlerine yakın hissederlerdi.

20. Birisi bana cinsel amaçla dokundu ya da kendisine dokunmamı istedi.

21. Kendisi ile cinsel temas kurmadığım takdirde beni yaralamakla ya da benim hakkımda yalanlar söylemekle tehdit eden birisi vardı.

22. Benim ailem dünyanın en iyisiydi.

23. Birisi beni cinsel şeyler yapmaya ya da cinsel şeylere bakmaya zorladı.

24. Birisi bana cinsel tacizde bulundu.

25. Duygusal bakımdan kötüye kullanılmış olduğuma (hakaret, aşağılama vb.) inanıyorum.

26. İhtiyacım olduğunda beni doktora götürecek birisi vardı.

27. Cinsel bakımdan kötüye kullanılmış olduğuma inanıyorum.

28. Ailem benim için bir güç ve destek kaynağı idi.

Appendix- E: Professional Quality of Life Scale (PROQL-IV)

Çalışanlar için Yaşam Kalitesi Ölçeği

Yaptığımız işin veya mesleğin gereği olarak insanlara yardım etmek, onların yaşantısıyla doğrudan temasa geçmemizi sağlar. Duygularımız ya da yaşanılan acıyı paylaşabilmemiz ve hissedebilmemiz yardım ettiğimiz kişinin olumlu ve olumsuz yaşantılarından veya durumundan etkilenecektir. Mesleğinizin özelliklerinden kaynaklanabilecek olumlu ve olumsuz deneyimleriniz hakkında sorular sormak istiyoruz. Lütfen, her soruyu içinde bulunduğunuz durumu göz önüne alarak değerlendiriniz. GEÇTİĞİMİZ SON BİR AYDAKİ duygu ve düşüncelerinizi dikkate alarak içinde bulunduğunuz durumu ne kadar sıklıkla yaşadığınızı 1 ile 5 arasındaki rakamlardan herhangi birini seçerek yanıtlayınız. Katkılarınız için teşekkür ederiz.

1 = Hiçbir zaman 2= Nadiren 3= Bazen 4= Sık sık 5= Her Zaman

1. Kendimi mutlu hissediyorum.
2. Yardım ettiğim kişiler zihnimi aşırı mutlu ediyor.
3. İnsanlara yardım edebiliyor olmaktan memnun oluyorum
4. Başkalarıyla ilişki kurabildiğimi hissediyorum.
5. Ani ya da beklenmedik ses duyunca sıçrıyor ya da ürküyorum
6. Başkalarına yardım ettikten sonra kendimi daha güçlü hissediyorum
7. Yardım eden rolümle kendi özel hayatımı birbirinden ayırmakta zorlanıyorum
8. Yardım ettiğim kişinin yaşadığı çok acı bir olay uykumun bozulmasına neden oluyor
9. Yardım ettiğim kişilerin yaşadığı stresin bana da geçebileceğini düşünüyorum
10. Yardım eden olarak kendimi kapana sıkışmış gibi hissediyorum
11. Yardım için yaptığım çalışmalarımdan dolayı zaman zaman kendimi zorda hissediyorum
12. İşimi seviyorum
13. Yardım eden olmanın sonucunda kendimi çökkün hissediyorum
14. Yardım ettiğim kişilerin başlarından geçen çok acı yaşantıları sanki kendim yaşıyormuş gibi hissettiğim oluyor
15. Bana güç veren inançlarım var
16. Bildiğim yardım yöntemlerini ne kadar çok kullanabilirsem o kadar iyi hissediyorum
17. Her zaman olmak istediğim gibi bir insanım

18. İşim beni tatmin ediyor
19. Kendimi tükenmiş hissediyorum
20. Yardım ettiğim kişiler ve onlara yaptığım yardımlarla ilgili olumlu düşünce ve duygular taşıyorum
21. Yaptığım işin yoğunluğu veya yardım ettiğim kişilerin çokluğu gibi nedenlerle kendimi tükenmiş hissediyorum
22. İşimde yaptıklarımla bir fark yaratabileceğime inanıyorum
23. Bana, yardım ettiğim insanların korku verici yaşantılarını hatırlattığı için çeşitli etkinlik ve durumlarda bulunmaktan kaçınıyorum
24. Yardım edebildiğim durumlardan gurur duyuyorum
25. Yardım etmemin sonucu olarak sıkıntı verici veya korkutucu düşüncelerim oluyor
26. Çalışma sisteminden dolayı kendimi çıkmaza girmiş gibi hissediyorum
27. Yardım eden olarak kendimi 'başarılı' hissediyorum
28. Travma deneyimi olan kişilerle yaptığım çalışmaların önemli bölümlerini hatırlayamıyorum
29. Çok hassas bir insanım
30. Bu işi seçtiğim için mutluyum.

Appendix-F: Difficulties in Emotion Regulation Brief Form (DERS-16)

Duygu Düzenleme Güçlükleri Ölçeği-Kısa Formu (DDGÖ-16)

Aşağıda insanların duygularını kontrol etmekte kullandıkları bazı yöntemler verilmiştir. Lütfen her durumu dikkatlice okuyunuz ve her birinin sizin için ne kadar doğru olduğunu içtenlikle değerlendiriniz ve size en uygun cevabı işaretleyiniz.

1= Hemen hemen hiç	2= Bazen	3= Yaklaşık yarı yarıya	4= Çoğu zaman	5= Hemen hemen her zaman

1. Duygularıma bir anlam vermekte zorlanırım.
2. Ne hissettiğim konusunda karmaşa yaşarım.
3. Kendimi kötü hissettiğimde işlerimi bitirmekte zorlanırım.
4. Kendimi kötü hissettiğimde kontrolden çıkarım.
5. Kendimi kötü hissettiğimde uzun süre böyle kalacağına inanırım.
6. Kendimi kötü hissetmenin yoğun depresif duyguyla sonuçlanacağına inanırım.
7. Kendimi kötü hissederken başka şeylere odaklanmakta zorlanırım.
8. Kendimi kötü hissederken kontrolden çıktığım korkusu yaşarım.
9. Kendimi kötü hissettiğimde bu duygumdan dolayı kendimden utanırım.
10. Kendimi kötü hissettiğimde zayıf biri olduğum duygusuna kapılırım.
11. Kendimi kötü hissettiğimde davranışlarımı kontrol etmekte zorlanırım.
12. Kendimi kötü hissettiğimde daha iyi hissetmem için yapabileceğim bir şey olmadığına inanırım.
13. Kendimi kötü hissettiğimde böyle hissettiğim için kendimden rahatsız olurum.
14. Kendimi kötü hissettiğimde kendimle ilgili olarak çok fazla endişelenmeye başlarım.
15. Kendimi kötü hissettiğimde başka bir şey düşünmekte zorlanırım.
16. Kendimi kötü hissettiğimde duygularım dayanılmaz olur.

Appendix-G: Differentiation of Self Inventroy-Revised (DSI-R)

Benliğin Ayrımlaşması Ölçeği

Aşağıda kendinizle ve başkalarıyla olan ilişkilerinize yönelik düşünce ve duygularınızı içeren ifadeler yer almaktadır. Sizden istenen her bir ifadeyi dikkatlice okuyarak 1'den 6'ya kadar olan seçeneklerden sizi en iyi ifade eden seçeneği işaretlemenizdir. Eğer herhangi bir madde sizinle direkt ilgili gözükmüyorsa (örn., şu anda bir eşiniz/partneriniz yoksa), olması halinde nasıl düşünüp davranabileceğinizle ilgili en iyi tahmininizi belirtiniz. İçten yanıtlarınız için teşekkür ederiz.

1= Hiç uygun değil --2-- --3-- --4-- --5-- 6= Çok uygun

1. Ailemin yanındayken genellikle kendimi kısıtlanmış hissederim
2. Önemli bir işe ya da göreve başlarken genellikle başkalarının cesaretlendirmesine ihtiyaç duyarım
3. İnsanlar benimle yakınlık kurmaya çalıştıklarında, kendimi onlardan uzak tutarım.
4. İnsanlar benimle yakınlık kurmaya çalıştıklarında, bundan genellikle rahatsızlık duyarım.
5. Hemen hemen hayatımdaki herkesten onay alma ihtiyacı hissederim.
6. Değiştiremeyeceğim şeyler için üzülmenin anlamı yok.
7. Yakın ilişkilerimde kısıtlanma kaygısı yaşarım.
8. Eleştirilmek beni oldukça rahatsız eder.
9. Ebeveynimin beklentilerine göre yaşamaya çalışırım.
10. Kendimi olduğum gibi kabul ederim.
11. Eşimle/ partnerimle bir tartışma yaşarsam, tüm gün bu tartışma üzerine düşünürüm.
12. Başkaları tarafından baskı altında olduğumu hissettiğim zamanlarda bile onlara 'hayır' diyebilirim.
13. Yaptığım şeyin doğru olduğunu düşünüyorsam başkalarının ne dediğini pek de umursamam.
14. Bir karar alırken danışacağım birileri yoksa kolay kolay karar veremem.
15. Başkaları tarafından incitilmek beni aşırı derecede rahatsız eder.
16. Eşimin/partnerimin yoğun ilgisi beni bunaltır.

17. İnsanlar üzerindeki izlenimimi merak ederim.
18. Duygularımı genellikle çevremdekilerden daha yoğun yaşarım.
19. Hayatımda ne olursa olsun, kendimle ilgili düşüncelerimden asla taviz vermem.
20. Ebeveynlerimin fikrini almadan karar veremem.