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The Cultural Isolation of Providers and Educators Caused by Stigma and Compassion Fatigue when Serving Survivors of Invisible Wounds

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Introduction

I have always been interested in the social constructions of stigma and compassion. Why is it that we, as citizens of particular cultures, value different people in different ways? Why and how do we make valuations of difference and then judge a person's or group of people's worth, often devaluing them? Where do our valuations come from? How do we change our judgments as we become aware of the potential negative consequences of valuing others differently, aka othering? These questions describe *stigma*, a process of determining difference, us vs. them, and positioning others as below or above ourselves, a determination of status (see Emlet, in press; Link & Phelan, 2001). Stigma may be *self-stigma* (self-judgment around one's own worth), or it may be broader than that, applied beyond the self to populations which we inadvertently or purposely oppress. Stigma, and its resultant oppression, may also be systemic within the dominant society (Flanagan, Miller, & Davidson, 2009; Phelan, Lucas, Ridgeway, & Taylor, 2014) and practiced in our structures of education (e.g., Perlin, 2008) and health care (Feagin & Bennefield, 2014; Metzl & Hansen, 2014). Cook, Purdie-Vaughns, Meyer, and Busch (2014) described stigma as moving across and between intrapersonal, interpersonal, and structural layers.

By *oppression*, I mean that we negatively value other human beings and their contributions in such a way as to deny their basic humanity (United Nations General Assembly, UNGA, 1948), based upon where we ourselves are positioned within a system, such as by race, class, socio-economic status, job, gender, cultural values, and so forth. We may be positioned by birth, or our positionality may change with context (see Bronfenbrenner's, 1977, ecological systems theory)—not due to factors which we cannot control, such as race and age, but by how

we are reflected in a particular system, such as community. For instance, I may be positioned as a feminist leader in a community of women working against violence and stigma, which is positive, while in my family (of origin) system, I may be positioned as a feminist, which is stigmatized there. Under oppression, stigma places others or ourselves in a position of lowered status (Link & Phelan, 2001) and/or as outsiders. Thus, positionality—whether self-identified, bestowed by status, or externally imposed by the broader cultural context in which we live and in which we find identity—may influence how we make meaning of our own experiences and knowledge—and how we judge and silence others. Critical social theory (CST, to be examined in greater depth later in this work) situates the human within his/her own historical context and allows for transformational change (Bohman, 2005); CST provides a lens into understanding the systemic orientations which lead to stigma. Stigma may be viewed in contrast to compassion. Stigma may also be a source of trauma, defined medically as "as a physical or emotional injury" (medicinenet.com, 2012).

Compassion, also a socio-cultural construct, is one way to cope with stigma. Stark (2001), in his treatise on coping with and experiencing death during extreme adventures described compassion, for example, as a process called *Tonglen*, an exercise in giving and receiving among Tibetan Buddhists. It is an exchange. In the following passage, Adrian is dying on Annapurna, the "goddess of the harvest" (Stark, 2001, p. 72) and a mountain in the Karakorum Range in Nepal. It is the 10th highest mountain in the world. I am an armchair climber, so this process as definition intrigues me.

> …Mara imagined all of Adrian's suffering as a hot, black, grimy cloud of smoke. She inhaled that cloud of black smoke on her in-breath. She took the hot, black cloud into her own heart and drew it into the worst part of herself, the grasping, selfish part. Mara used

> that hot black cloud to destroy the part of her own soul that was selfish and grasping, purifying her own heart. Then she breathed out, exhaling to Adrian a cool, white, soothing light of peace and joy, that purified Adrian's negative karma, too. (Stark, 2001, p. 73)

In this case, compassion is personified as a midwife, "[easing] Adrian's passage into death" (Stark, p. 73). It is an exchange of energy—a taking away of the suffering of another into oneself and giving back peace. Compassion is a conscious, mindful act by a sentient being, which provides solace to the sufferer and expects nothing in return (Ricard, 2015).

Compassion also takes place in the living world, far before the pre-eminent expectation of death. Ricard (2015), who is a French translator for the Dalai Lama, quoted him as describing *the true basis for compassion* as, "Every sentient being, even my enemy fears suffering as I do and wants to be happy. This thought leads us to feel profoundly concerned for the happiness of others, be they friends or enemies" (p. 6). Ricard suggested that immediate presence with others, through kindness and action, represents compassion. Compassion requires the recognition of another's suffering and the desire to alleviate that suffering through action.

Combining the expectation of death and the desire to alleviate suffering in the present are found in Greek and other forms of tragedy. In ancient Greek tragedy, compassion meant to have pity and fear for the tragic hero's experience. The Chorus and the audience wish the best for the tragic hero, and that he/she will discern his/her situation and take action to alleviate the tragic flaw and the history behind it; they wish for the tragic hero to break the cycle of inter-generational trauma (L. Welch, personal communication, fall 2015). These responses are grounded in a complex environment of cultural beliefs and values, often grounded in spirituality.

Additionally, in many modes of spirituality, compassion means to empathize with

another's pain and to wish to alleviate it (Compson, 2015). The wish to dispel another's suffering may move the respondent from empathy to action. And, it may be instinctual (see Keltner, 2004; Seppala, 2013).

Moreover, compassion is both innate (Keltner, 2004) and, I argue, socially-constructed, as evidenced by shifting definitions over time—ranging from sharing in the suffering of another to recognition of pain from a place of power, from which one can absolve a person of their suffering, such as in the confessional (Oxford English Dictionary, OED, 2015). The innateness of compassion is not lost, but compassion may be weakened (J. Compson, personal communication, spring 2016) by intervening pressures of social constructs and historical contexts.

For instance, in the more recent westernized world, compassion has taken on disparate meanings. While still imbued with recognizing the suffering in others and having the desire to alleviate that suffering, sometimes power takes the forefront. The OED (2015) has documented compassion as being bestowed, the privilege of those in power, rather than reciprocal as described by Stark (2001). Nursing and educational research (e.g., Hatcher, Bride, Oh, King, & Catrett, 2011), among other disciplines, likewise document compassion as needing to be learned. Since the knowledge imbued by education is often proscribed by the dominant culture, and the knowledge lost or revised often comes from the same (see tenets of CST later in this paper), the power holders may be synonymous with the knowledge holders. Thus knowledge holders, such as caregivers and educators, may seem to hold the key to treating patients and other learners with compassion. Then, compassion becomes a learned behavior (Seppala, 2013), in addition to being power based. Weak training may equal less compassion, a measurable outcome.

Compassion also becomes commodified, as when one's reserves of compassion become

low, compassion fatigue may result. Compassion fatigue is often referred to as the "cost[s] of caring" for others (Figley, 1995/2002) in emotional, spiritual, and psychic pain. Its symptoms may be include decreased attention span, anger, inability to concentrate, depression, illness or apathy (Bride, 2007; Federal Employee Defense Services, 2011; Zerubavel & Wright, 2012) which could result in reduced levels of self-efficacy (Shoji et al., 2014), costs related to quality of life. LeDoux (2015) suggested that these costs are absorbed by the caregivers and the organization and negatively impact those being cared for (as reported by the Canadian Nurses Association in LeDoux, 2015). Often, however, these costs are measured economically, using metrics such as productivity, work time, and overuse of employee support systems (J. Meyer, personal communication, 2015).

Compassion fatigue has also become a recognized occupational hazards for professionals serving survivors of trauma whose wounds may be invisible (Hatcher et al., 2011) or visible. Professionals include psychotherapists, mental health professionals, and K-12 educators in the juvenile justice system (Hatcher et al., 2011), among others. The group also includes social workers (Bride, 2007) and law enforcement officers (Craun, Bourke, Bierie, & Williams, 2014), as well as emergency nurse personnel (Dominguez-Gomez & Rutledge, 2009). I suggest that the *professionals* also includes educators at all levels (pre-k through higher education, healthcare, and so forth).

The *costs of caring* cause many to leave the professions involved in care (personal communication, Honda, 26 April 2016). The National Child Traumatic Stress Network (NCTSN, 2011) suggested that we must address the problem of secondary traumatic stress (used by the NCTSN synonymously with compassion fatigue) from a systemic perspective. The Network suggested that we must have trauma-informed systems which:

- Recognize the impact of secondary trauma on the workforce.
- Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.
- Understand that trauma can shape the culture of the organization in the same way that trauma shapes the world view of individuals.
- Understand that a traumatized organization is less likely to identify its clients' past trauma or mitigate or prevent future trauma.
- Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices. (NCTSN, 2011, p. 5)

Ironically, the onus for coping with and healing from compassion fatigue and secondary traumatic stress remains on the individual provider/educator, who must remain effective or face losing his/her job or being referred to an internal employee assistance program (Rahman, personal communication, 2015). Little time is provided for professionals, during the work day, to decompress and to cope with secondary traumatic stress or compassion fatigue (Rahman, personal communication, 2015). Thus, it is crucial to talk with providers and educators, who may be in danger of compassion fatigue, about their own stigma and about their own coping mechanisms.

When Stigma and Compassion Fatigue Go Underground

Stigma and resultant compassion fatigue can be unrecognized or unacknowledged stressors for professionals who serve others suffering from invisible or visible trauma. Moreover, trauma, stigma, and compassion fatigue—and how service professionals interact with the students and clients who suffer from these conditions—are most often defined socio-culturally, especially by the dominant culture, whose institutions of higher learning have taught the

providers the rules of interaction and engagement (see hooks, 1994). Professional training, in its ivory tower of canonical tradition, may devalue multi-cultural knowledge and experience, placing this knowledge and experience into specific sub-cultures (hooks, 2003), further exacerbating potential or real stigma for the members of those cultures and for those who serve them.

Listening to, observing, or intervening repeatedly to care for another person experiencing trauma can be physically and emotionally exhausting, as well as time consuming. The provider (who may be a therapist, a physician, a teacher, a supervisor, a friend, or a family member (Figley, 1995)) may experience secondary traumatic stress or vicarious trauma when interacting with clients/students who suffer from invisible injuries (Bride, 2007; Hatcher et al., 2011; Wang, Strosky, & Fletes, 2014), for it is easy to be consumed by another's pain and to take it on as one's own (Bearse, McMinn, Seegobin, & Free, 2013; Potter, Pion, & Gentry, 2015), resulting in compassion fatigue. Likewise, a provider may come to notice, if not to resent, the time it takes to deal with these secondary emotions and life events well beyond the workday, i.e., his/her own life into which these feelings and experiences intrude, creating the platform for increased stigma against one's clients (why are they not healing faster?) and against oneself (why can't I just let it go?) (Miller & Kaiser, 2001; Zerobavel & Wright, 2012). Thus, the combination of the two stressors of bearing unrecognized stigma that the provider brings to the table and the provider experiencing compassion fatigue may result in a paradoxical relationship for the provider/educator with the client/student. The providers of services may both judge the clients/students, resulting in negative effects for the care recipients due to the relationship, and take on their pain, resulting in negative health effects for themselves. The providers may also feel conflicting judgments about their own efforts and the efforts of those whom they serve

toward their own healing and self-efficacy. The conflicts and paradoxes around stigma and compassion fatigue may force both conditions underground, thereby perpetuating them, and causing oppression and isolation. For instance, Wang et al., (2014) wrote about reduced interest in the client as a consequence of both exposure to trauma and of caring too much about the client's progress in healing. Over-exposure to another's trauma exemplifies one precursor to compassion fatigue, while caring to much about the client's progress in healing represents the basis for stigma, as the caring in situated in the provider's goals for the client and not in the client's goals for him/herself. Because the dominant norms of healing in western culture are based in cure (see Gawande, 2014) and providers' success in their job of treatment is based upon outcome metrics (see *ICD 9/10* conversation later in this paper), providers potentially-reduced metrics may result in both negative performance reviews, which are stigmatizing and may result in a pressure-oriented, oppressive work environment, and negative reactions from peers, resulting in isolation (see JM's comments in *Findings*).

Purpose of the Study

The purpose of this phenomenological study is to give voice to the lived experience of providers and educators regarding stigma and compassion fatigue. In this study, using critical social theory as a lens, I seek to understand how providers and educators experience and recognize the stigma they carry, their own compassion fatigue and what they do to stay healthy—including mental physical, emotional/psychological, intellectual, and spiritual health.

Philosophical Framework: Critical Social Theory

Critical social theory (CST) provides a lens through which we can analyze the construction of knowledge and meaning through socio-cultural experience, as well as the nature of the knowledge about and the meaning of that experience, including, but not limited to,

providers and educators who serve clients and students experiencing invisible wounds from trauma. Overall, CST is a dialogic, applied theory geared towards emancipating the oppressed through spoken and written critical thinking, reflection, and discourse, meant to provide hope (Freire, 1970/2000; Leonardo, 2004) and meant to lead to action (Hyter, 2014). Pedagogical critical social theory, central to educational leadership, is grounded in the idea of moving from "knowledge transmission to knowledge transformation" (Leonardo, 2004, p. 11). Depth of analysis allows one to engage in both knowledge transformation and socio-cultural change.

Freire (1970/2000) called the process of knowledge transmission—when grounded in the teacher-as-expert/student-as-recipient relationship and when divorced from a broader historical context—the *banking concept of education*, which he deemed to be an instrument of oppression (p. 71). Freire proposed that "filling the vessel," i.e., imbuing the student with knowledge that they should take to heart as defined by the dominant class, would increase the interest earned by the oppressors to maintain the status quo.

Interestingly, Freire's banking concept of education is also mirrored in theories of how humans learn, though the theories are not necessarily proscribed by his banking concept. For instance, in 1956, Bloom proposed that we, as humans (sentient beings), gain knowledge in a basically sequential, but still iterative manner, commonly known as *Bloom's cognitive taxonomy*. That is, we repeat the process of learning over and over again, sometimes going back to reconsider the original information, adding both depth and new learning. First, we gain basic information, such as vocabulary and facts (Bloom, 1956). Then, we learn what the information means. The process continues as we learn to apply the information, making choices about when to use it; analyze the results for what they tell us; synthesize the information for how it fits into the rest of our knowledge; and finally evaluate that information for its validity (Bloom, 1956).

Freire (1970/2000) suggested that when our learning and knowledge stem from the dominant culture, in whose interest it is to frame that information according to dominant norms, this process of learning "mirrors the oppressive society as a whole" (p. 73). Though Freire did not specifically call out Bloom's (1956) cognitive taxonomy, he did call attention to the danger of simply filling the empty vessel and adding interest through subsequent prescribed iterations of depth and breadth. Thus, I suggest that the most basic levels of cognitive knowledge acquisition (lower-order thinking, Gazzaniga, 2011)—information, definition, and application (Bloom, 1956)—form a foundation of human learning, easily promulgated by dominant systemic cultures. At the levels of analysis, synthesis, and evaluation (levels of more complex cognitive function and metacognition (Gazzaniga, 2011)), when students or the general populace (any learners) are told how to think about the knowledge they are being given and what it means, the more the dominant interest has been added and the less an actual critical thinking component has been added, making it more difficult to sort through the layers of learning to find and validate counter-narratives, which are often disguised by dominant cultural narratives (see Hyter, 2014; Leonardo, 2004).

In terms of stigma then, those who engage in dialectical (Freire, 1970/2000), interdisciplinary (Leonardo, 2004) and cross-cultural thinking (Hyter, 2014) may ironically be deemed subversive, anti-ideological, or agitative (see Agger, 1992, in Leonardo 2004). Thus, the oppressed, or those with less power, simply do not know what they are talking about, and the dominant culture can take a paternalistic or even violent stance towards their oppressed/stigmatized constituents. Additionally, the dominant ways of constructing knowledge and meaning create systemic norms over time, which are difficult to challenge; CST provides one avenue for change (Freire, 1998). Critical social theory creates a lens through which we can

challenge the status quo. Critical social theory, at its core, is a theory of liberation and humanization (Freire, 1998), through which giving voice to the experiential, essential, and intellectual/emotional/spiritual meaning of the othered (the oppressed) creates new ways of thinking, new paradigms (Freire, 1998; Bohman & Rehg, 2014), thus acknowledging that all bring knowledge to the dialogic table (Freire, 1970/2000). Hope results, an initial stage of change (Lewin, 1944; Prochaska & DiClemente, 1983, on *stages of behavioral change*; Whitelaw, Baldwin, Bunton, & Flynn, 2000).

Moreover, CST allows for the movement by individuals between systems. Looking at Bronfenbrenner's (1977) ecological systems theory, adds depth to the danger Freire (1970/2000) brings to light in his banking system of education. Bronfenbrenner (1977) suggested that we, as individuals, move in and out of different ecological systems depending upon our relationships and roles. At the center of the system is the individual—biological, intellectual, and emotional (Paquette & Ryan, 2000). Around the microsystem of the individual, is the mesosystem of family, neighbors, and community, then the exosystem of schools, church, local government, and around that the macrosystem of government, law, and culture; the final ecosystem is the global system (Paquette & Ryan, 2000). Based upon my work at Madigan Army Medical Center (MAMC, 2008-2014) at Joint Base Lewis McChord (JBLM), I suggest that there is also a chronos system, beyond basic chronology proposed by Bronfenbrenner (1977) and Paquette and Ryan (2000) and the historical context proposed by Silko (in her novels *Ceremony*, 1977, and *Almanac of the Dead*, 1991) and Smith (2013), which is culturally dependent and influences all of the systems across the lifetime. I suggest that oppressors move more easily among the systemic norms they have created—protected by their wealth and status, including their elite, dominant education—than those who are oppressed and stigmatized within these same systems.

However, one who wishes to move up in the normed culture, must show that he/she is a *good fit*, to use a popular criterion in the hiring world. Those who are stigmatized, who know or experience the systems differently, are denied access. Freire (1970/2000), in his text, *A Pedagogy of Hope,* addresses this insider-outsider positioning, as do Knaus and Brown (2016). A change in paradigmatic thinking allows for increased agency among the oppressed to work towards systemic change.

However, Kretzmann and McKnight (1993) proposed that even at the community level, when members come together for critical dialogue and action, they may discover connections to those with more power through community asset mapping. Community asset mapping is a process by which community members come together to define shared concerns, to identify and combine resources and strengths, and to critically engage in solution finding (Kretzmann & McKnight, 1993). By engaging in dialogue, stigmatized individuals and groups may critically engage in different ways of knowing, which counteracts the banking theory of education through praxis (Freire, 1970/2000). They may also have their experiences not only verified, but historically contextualized in relation to the oppressive culture. Then, by asset mapping, they can then move more readily across Bronfenbrenner's (1977) ecological systems to create social change.

Critical social theory, which is the lens through which this study will be analyzed, provides the basis for examining sigma, compassion, and compassion fatigue, all of which address the underlying theme of oppression. CST serves as theory from which other theories, specific to oppressed groups have been derived, such as critical race theory (Delgado & Stefancic, 2012) and critical feminist theory (Rich, 1971), among others. CST seemed to evolve from, and is related to Marxist theory (Eagleton, 1976), which presupposes that financial

systems, such as capitalism, create socio-economic strata, which then prioritize acceptable kinds of knowledge privileged by the dominant economic class. Over time, with Freire's (1970/2000) pedagogical overlay, CST allows for dialogic dissection and discovery of buried knowledge (*conscientizaçao*), upon which one may act (*praxis*) (Freire, 1970/2000; Freire, 1998; Bohman & Rehg, 2014).

Core Tenets of Critical Social Theory

When looking at stigma and compassion fatigue, through the lens of critical social theory, it is crucial to recognize that stigma, as defined by The National Center of Telehealth and Technology (T2, 2008), is an arbitrarily-created system of oppression. Likewise, I argue that compassion fatigue is symptomatic of that oppression. While working towards dialogic problem-identification and -solving and humanization for all, Freire (1970/2000) suggested that we must be aware that anti-dialogical, anti-democratic matrices of the oppressors are also framed by praxis (theory and action) by the elite for the elite, just as praxis for the oppressed frames the context of hope. Throughout my readings about critical social theory, I found three sets of tenets. Freire (1970/2000) framed his initial tenets around the negative influences of the oppressors on the elite, including conquest, the elite being a minority, manipulation of dominant mythology, cultural invasions, perceived cooperation, interest convergence (see also Delgado & Stefancic, 2012), and cultural synthesis to maintain the status quo. Freeman and Vasconcelos (2010) framed the tenets of critical social theory as facts which dictate analysis and problem-solving of oppressive systems though application and action. Finally, Hyter (2014) framed her tenets through the lens of a global communication framework. I have synthesized these scholars' and pedagogists' perspectives into 7 core tenets of critical social theory. For the purposes of this study, I used the following tenets to analyze the extant literature and the data which I collected:

1) Knowledge is based in a historical context. First, there is conquest. Conquest means ruling, dominating, and usurping the resources (including human) of other cultures for the over-takers benefit (e.g., oil and mineral rights for the U.S, power and ownership being valued over the sacredness of land for Native Americans). Freire (1970/2000) argued that conquest is a necessity for the elite. He pointed out that the oppressive elite are generally a minority group (such as the wealthy in the United States of America) which maintains its power through subordination, domination, and separation (through the creation of competing interests) in order to retain power—what he called *divide and rule* (p. 141). Hyter (2014) described this phenomenon systemically; Hyter wrote that inequities, promulgated by systemic oppressive structures, become entrenched and benefit the elite, while "marginalizing the many" (p. 109). Within this overlay of conquest, history is written by the winners. For instance, physical or socio-cultural conquest is necessary to establish the elite (Freire, 1970/2000) and its power over knowledge. Thus, history and its context shape the present, especially in how one perceives knowledge (Hyter, 2014), experience, and meaning.

2) "Acceptable" knowledge is defined by the systems of the dominant culture and serves to distort the knowledge and meaning-making of the oppressed. Dant (2003) wrote that "…[S]ystems like capitalism produce knowledge in such a ways as to obscure their oppressive consequences. Unjust practices and arrangements, therefore, do not manifest themselves in straightforward ways but become distorted and hidden over time within contextually and culturally embedded practices" (as qtd. in Freeman & Vasconcelos, 2010, p. 8). Ironically then, this knowledge becomes socially-constructed and value-laden (Freire, 1970/2000).

3) Knowledge and meaning-making are dynamic processes over time. This is my inference from studying Freire (1970/2000, 1998), Freeman and Vasconcelos (2010), and Hyter (2014),

among others around critical social theory. While the global world is changing, especially through technology, there are canons of thought which are changing more slowly. Knowledge and meaning-making are contextualized in history, and so we (me, the writer, and the reader) come full circle. We must include the present and consider the future. The interaction of contexts—the interdisciplinarity and intercommuniality—changes with time. Thus, our use of voice and praxis may also need to change, without giving up our meaning-making of experiences, our histories, other cultural conceptions of time and narrative, or hope.

4) Knowledge of the dominant culture revises the experiences and knowledge of the oppressed. This distortion of knowledge affects everyone (Freeman & Vasconcelos, 2010), for instance, through the manipulation of dominant mythology (Freire, 1970/2000). The American Dream, whereby all can succeed if they just work hard enough, provides a case in point. First, "American" is used to refer to the United States of America, when, in fact, the term refers to a whole hemisphere, making the dream feel more ubiquitous an experience than is factual, and simultaneously emphasizing the dominance of the United States of America. Secondly, the dream implies that if one is not successful, it is his/her own fault, thus negating the known (but often denied) experience of the glass ceiling for oppressed groups.

5) Those who challenge acceptable knowledge are stigmatized by the dominant culture. Freire (1970/2000) presented this tenet as perceived cooperation. That is, the dominant culture pretends to work with its subjects. However, the dominant become the *I* and the oppressed become the *you* (*thou* re Buber, 1953); I and thou, in this context, are not willing collaborators. *You* experience and perceive the world differently from what the *I* has proscribed. For instance, in education in the US, the *I* (the dominant voice of culture) has described the first Thanksgiving, now a national holiday, as pleasant and communal among the *discovers* of the *new* world, with

the indigenous peoples willingly sharing their food in celebration of the settlers arrival. In fact, when one reads the ship captains logs, the *I* raided the root cellars of the *you*, stealing their food stores (Bradford, 1620/1989a, 1620/1989b) and creating an us-and-them situation, which would eventually result in genocide (Silko, 1977; Silko, 1991; Welch, 1994). If one thinks of the *I* perspective as *me first/us first*, in dominant revisionist teaching as suggested by this perpetuated myth, it is easier to see how the dominant narrative shapes the oppressed peoples' experience and knowledge and negates their value. First peoples who challenge the myth of the first Thanksgiving are silenced by the myth taught in the schools. Thus, when indigenous peoples challenge the myth, they are dismissed as wrong. Being right, i.e., aligning with the dominant story, is valued over being wrong, thus stigmatizing those who are deemed misinformed.

6) Dialogic and dialectic conversations among the oppressed, and later with the oppressors, provide a way forward. Hyter (2014) suggested that dialectical thinking provides the opportunity to negate dominant-oriented perceptions and to change ways of thinking and meaning. Freire (1970/2000) suggested that dialectical dialogue raises from the subconscious to the conscious the experiences of the oppressed and provides opportunities to identify problems. Hyter (2014) built further upon the necessity of dialogue by proposing that in an interconnected, global world; humans must engage in dialogue about the "whole global system" (p. 109). She went on to say that problem-identification and problem-solving must cross disciplinary boundaries. Freire (1970/2000), Freeman and Vasconcelos (2010), and Hyter (2014) are supported by Habermas's (in Bohman & Rehg, 2014) early writing, in which he proposed three kinds of knowledge and meaning-making: empirical/scientific, self-reflection, and action-oriented. Dialogue is the beginning of action, as it moves from self-reflection into community interaction.

7) Democratic principles give voice to all in problem solving. Freire (1970/2000), like

Dewey (1929, as cited in MacIsaac, 1996) and Habermas (see MacIsaac, 1996) proposed that democratization is about hearing each other and coming to an understanding of each other. It is not about consensus; nor is it about voting, e.g., 49% to 51% results denoting the decision of the masses. Voting does not give voice to all (though it is better than not voting), and consensus does not acknowledge the dialectical experience of multiple voices in dialogue towards coming to an understanding about how each party feels, experiences, and makes meaning. Democratic principles then, are not about coming to agreement, but rather about coming to understanding. Freire (1970/2000), in his discussion about cultural synthesis, made the dangers of trying to reach agreement quite obvious. He suggested that cultural synthesis (as opposed to multi-cultural maintenance and respect) promotes the "why don't we all just get along?" proposal for problem-solving. What this means, according to Freire, is "why don't you just come around to my way of thinking?" as purported by the dominant culture. Instead, I suggest that dialectical dialogue promotes praxis, i.e. the combination of theory and action (Freeman & Vasconcelos, 2010; Freire, 1970/2000) among diverse oppressed members of society (or diverse members of the helping professions), thereby promoting democratization through acknowledgement of competing theories and actions.

Thus, dialogue is the key to enacting praxis and to changing how the oppressed and the oppressors perceive knowledge (Freeman & Vasconcelos, 2010; Freire, 1970/2000). Dialogue enacts, on an individual and community level, if not into further extension into Bronfenbrenner's (1977) ecological systems theory, the examination of what constitutes knowledge and how that knowledge is used to influence change in meaning-making. Knowledge is then expressed as praxis, which cannot be separated from action (Hyter, 2014).

The Contexts of Trauma, Stigma, and Compassion Fatigue

In this section, I examine how trauma, stigma, and compassion fatigue are positioned in the literature and in the workplace.

The Context of Trauma

Medically, *trauma* first refers to externally imposed conditions that result in bodily harm. Only in the second definition are psychic implications considered (http://medical-dictionary.thefreedictionary.com/trauma). Likewise, in the *DSM 5* (Diagnostic and Statistical Manual, 5th ed., American Psychological Association (APA), 2013), psychiatric disorders, such as post-traumatic stress disorder (PTSD), are secondary to physical exposure. These definitions presuppose that physical experience is a precursor to psychic wounds. This is but one example of how experience is denoted in the knowledge base. Physical experience is prioritized over emotional, intellectual, and spiritual experiences (Spector, 2013). However, the lasting effects of traumatic experience, well after the physical body seems to have healed, are often behavioral, cognitive, emotional, and somatic (e.g., physical repercussions from stress, such as sleeplessness and auto-immune disease) (FGF, behavioral neurologist, personal communication, 2010) and may result in diagnoses of personality disorders (D. K., neuropsychologist, personal communication, 2014).

It is important to keep these facts in mind when examining the experience of trauma, as resultant stigma is a reflection of meaning-making of experience, and thus, not necessarily physical. Of note, neurologists would argue that physical/psychic priorities are chicken-and-egg logic (FGF, personal communication, 2014), that there is one brain, one body reacting to trauma and that they are intimately tied together and that the bio-physiology of brain chemical reactions and even epi-genetics preclude the domination of one knowledge (bodily) over another (psychic) (Gazzaniga, 2011). Importantly, one must also acknowledge the broad frame of traumatic

experience. Trauma may include brain injury and its co-morbidities, e.g., post-traumatic stress, post-traumatic stress disorder, and moral injury (see Levine, *Waking the Tiger,* 1997; Turner, 2015). Trauma may also include abuse, neglect, and violence, whether overt or systemic (Bride, 2007; Hatcher et al., 2011; Hydon, Wong, Langley, Stein, & Katoaka, 2015)—and result in "humiliation, shame, and disgrace" (Hinshaw & Stier, 2008, as cited in Zerubavel & Wright, 2012, p. 484). And whether the traumas one experiences are physically-, psychologically-, spiritually-, or morally-induced, in dominant U.S. culture, we turn to medical, educational, and familial providers to cure us (see Gawande, 2014), Slowly, however, the practice of cure is being supplanted by practices of acknowledgement and acceptance, whereby the patient client describes the quality-of-life outcomes he/she would prefer (Gawande, 2014).

The Context of Stigma

While I initially framed stigma more broadly, I now situate stigma within the CST framework. *Stigma* are the filters, biases, pre-judgments, and ongoing judgements that providers carry into interactions with suffering students and clients, and have long been held by western cultures (if not other cultures) as "moral and physical blemishes" (Mosby's, 2009). Professionals (providers and educators) may purposefully, inadvertently, or through their own academic training, and further professional and cultural training, categorize those whom they serve by their conditions, stereotype them by their conditions, separate them from themselves from others as different, and finally act in conscious or unconscious manners to discriminate against those being served (T2, 2008). Ironically, providers and educators may also carry self-stigma into the work environment (Potter, Pion, & Gentry, 2015), i.e., the idea that they are not supposed to suffer as they listen to and care for their ailing clients/students. One might expect then, that providers are automatons, with a handy brick wall around them, with one-way valves allowing compassion to

permeate through their barriers to positively influence the clients, but to prevent the feelings and experiences of the patient/student from backwashing through the barrier. Being objective is a critical aspect of clinical training (Zerubavel & Wright, 2012), whether medical or educational. However, counter-transference may manifest among some providers or educators as they assist their clients/students (Zerubavel & Wright, 2012). Humans are feeling beings and not immune to empathic, reflexive suffering.

The context of stigma in a service environment: Micro-aggressions. Freire's (1970/2000) banking concept of education may lead us (the author/researcher—me and the reader) to an understanding of why stigma may be prevalent in service environments. In service environments, such as teaching, health and health education, social work, and even parenting or friendship, the desire is to help another person or persons to succeed by overcoming barriers (Bearse et al. 2013; Miller & Kaiser, 2001). When these barriers are externally imposed as social norms, i.e. the student/client is assumed to not have the knowledge or skills they need, the relationship between the provider and the student client can be automatically put into an us-and-them situation—the provider has the knowledge and the skills the recipient needs. The relationship can put the provider into the role of knowledge-holder. Then, it becomes the knowledge-holder's job to imbue the recipient with his/her knowledge and skills, and assumes that the recipient brings few if any strengths or knowledge to the table. The provider, the knowledge holder, must then fill the empty vessel of the student/client (see Freire, 1970/2000).

Over time, re the banking concept (Freire 1970/2000), as interest is earned in the passive knowledge account, the student/client will slowly change and become skilled in the areas in which the expert has deemed appropriate, due to his/her training and culture. Thus, the client/student is also passive under this scenario. The scenario of banking can then lead to micro-

aggressions perpetuated upon the learner (Nadal, 2011) by the teacher. When the student obeys the rules of the teacher's norms, the student is successful. When the student does not follow the advice given, the stigmatic divide between the teacher and student becomes exacerbated, and trauma may be re-experienced by either the teacher or the student (Nadal, 2011). For instance, a student may interpret a lesson through an analogy unforeseen by a teacher. Thus, the teacher may "grade" the student at a level less than is actually relevant to the student's understanding, such as an actual lower grade in the educational record or a diagnosis of *malingering* (using the system for one's own gain) by a psychologist, for example (Kelly, neuropsychologist, personal communication, 2008-2014).

Thus, unidentified stigma on the part of the culturally- or socially-defined knowledge holder may be expressed as micro-aggressions (Sue et al., 2011). Micro-aggressions are conscious or unconscious verbal and non-verbal comments, expressions, gestures, and actions which message social bias (Harden, 2014). Micro-aggressions may be couched passively-aggressively as compliments. They serve to further marginalize people and groups who already experience prejudice. Micro-aggressions are cumulative in their impact, as experienced by the recipient not the initiator (Harden, 2014). Moreover, micro-aggressive behaviors—when unrecognized, unexamined, and unchanged—may perpetuate false information (such as generalizations that all traumas are experienced identically) and may lessen empathic responses and compassion towards others (Spanierman, Armstrong, Poteat, & Beer, 2006; Sue, Lin, Torino, Capodilupo, & Rivera, 2009). Additionally, even when recognized and reflected upon, micro-aggressions may still be perpetuated though guilt (Zerubavel & Wright, 2012). Experiences from micro-aggressions in higher education or in the work environment may also become difficult to unpack.

In the context of understanding stigma, it is also necessary to consider compassion fatigue. As well, it is important to understand the constructs of secondary traumatic stress, vicarious trauma, and burnout as they relate to compassion fatigue. These terms are often used synonymously in the literature (e.g., Federal Employee Defense Services, 2011; Figley, 1995), and yet they are not the same. Since contextualizing key concepts may help writers and readers alike to formulate knowledge around experience for the making of meaning—individually and collectively—distinctions make a difference.

The Context of Compassion & Compassion Fatigue

Figley (1995) initially coined the term *secondary traumatic stress* (STS), which he later reframed as *compassion fatigue* (CF). He defined STS as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other" (Figley, 1995, as qtd, in Bercier & Maynard, 2015, p. 81). Importantly, his definition of *significant other* included all of the key stakeholders listed or implied in this paper, to include professionals, friends, and family members. Where his definition has become misused is in the efforts to *normalize* the reactions by providers to secondary stress. "Natural, consequent behaviors and emotions" are not necessarily normal or normed. Just ask any service member, rape victim, and survivor of abuse suffering from TBI or PTSD—if you tell him/her, "This a normal reaction to an abnormal situation," s/he may become very angry—the depth of suffering is not normal or s/he would not be seeking treatment (Kelly, personal communication, 2008-2014). Using *normal* vs *natural* imposes upon the sufferer a dominant logic and meaning-making which may not match his/her experience. *Normal* implies what one is supposed to feel re dominant cultural norms (D. K. personal communication, 2008-2014), while *natural* implies an expected and documented response (APA, *DSM 5*, 2013; Levine, 1997).

Compassion fatigue adds the value of compassion to the shared experience of secondary traumatic stress. Potter et al., (2015) went beyond Figley's (1995) synonymous definition of STS with compassion fatigue. They defined *compassion fatigue* as "the combination of secondary traumatic stress and burnout" (p. 83). Thus, compassion fatigue includes the perception of systemic supports in the work/home environment. As in Figley's (1995) definition, supports include not only colleagues, but friends and family members as well. Thus, the microcosmic support of a provider's experience with compassion fatigue is crucial to overall, long-term health. Burnout especially goes to work-place resources (Potter et al., 2015), of which compassion may not be one.

Potter et al. (2015) defined *burnout* as "a state of chronic exhaustion when caregivers' [providers] perceived demands outweigh perceived resources" (p. 84). Salloum, Kondrat, Johnco, and Olson (2015) referred to burnout as a syndrome, that is "A group of symptoms that collectively indicate or characterize a disease, psychological disorder, or other abnormal condition" (https://dictionary.search.yahoo.com/), thus medicalizing exhaustion and implying some sort of fault on the sufferer's end. When looking at knowledge through the status quo, providers who experience burnout are likely to be blamed rather than supported (Cook et al., 2014; Phelan, Lucas, Ridgeway, & Taylor, 2014). Their condition is deemed abnormal. The demands are simply job requirements, and one makes do with the resources at hand. Resources are allocated by the administrative system of an organization, whether that be the workplace, the family, or the broader resources of a community (Kretzmann & McKnight, 1993). How resources are perceived gives rise to knowledge about who is in charge and who has access (Metzl & Hansen, 2014). Perceived knowledge, then, informs the experience of the provider.

Pearlman and Saakvitne (1995) defined *vicarious trauma* as "the cumulative

transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with the client's traumatic material" (p. 31). What differs here from Figley's definition of compassion fatigue and secondary traumatic stress is their emphasis on the cumulative effect. In making meaning, perhaps vicarious trauma comes after secondary traumatic stress. That is, I suggest that secondary traumatic stress may be a more immediate reaction to a student's/client's lived experience as the provider hears about the experience. Vicarious trauma includes the inner experience of the provider to both the cumulative traumas of an individual client/student *and* the cumulative effect of dealing with multiple students'/clients' traumas over time in his/her professional and supportive roles.

Paradoxical Experiences

Health literacy. Health literacy may well be an unexplored factor in the continuance self-stigma of providers and in the stigma that they bring to the relational table of care around their own secondary traumatic stress, compassion fatigue, vicarious trauma, and burnout. It may be assumed by providers and other professionals that they are health literate. However, this assumption may cover a lack of knowledge, especially self-knowledge, around embedded assumptions regarding health, due to being in the profession. Health literacy is about knowledge for decision-making around health, and health promotion is about self-efficacy around the knowledge- and decision-making processes themselves—the skills required and enacted. *Health literacy* was defined in the Patient Protection and Affordable Care Act of 2010, Title V, as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions" (Centers for Disease Control and Prevention, CDC, 2013). However, this definition does not take into account the complex processes by which an individual obtains and analyzes health information given current

technology, nor does the definition take into account how the information is couched within the dominant culture and its delineation of what constitutes the knowledge that is to be comprehended, communicated, and used. Moreover, the definition leaves out the obligations of health, political, governing, and other systems within the context of health literacy. Appropriate health decisions are often governed by law, such as receiving vaccines in order to be able to attend school, including institutions of higher education, and appropriate public behaviors. A person suffering from invisible conditions or injuries, such as secondary traumatic stress, may exhibit anger or rage, which is considered socially inappropriate. The key ambiguity seems to be situated in the word "appropriate." International organizations, such as the World Health Organization (WHO, 1998) include communities as responsible for health and health literacy. Thus, providers and educators must attend to the underlying assumptions of "appropriate" and how these assumptions tie in to their own stigma and compassion fatigue.

The U.S. Department of Health and Human Services (USDHHS, 2010) reported that, "Limited health literacy has psychological costs. Adults with limited health literacy skills report feeling a sense of shame about their skill level" (p. 9). However, they go on to say that the shame may result from limited vocabulary or language skills. This limited viewpoint neglects the health literacy skills of highly educated people, who may also lack the specialized language or meaning-making skills to define their struggles with compassion fatigue, etc., as issues of health literacy. Providers, after all, are expected to know—they are the subject matter experts, so the potential for shame and self-stigma are increased, when they cannot self-diagnose (nor are they supposed to self-diagnose under various professional organization ethical guidelines (e.g., AMA, APA, MSW)).

Granted, as the USDHHS (2010) also reported, stigma/shame around low health literacy

most often affects adults over the age of 65 years, racial/ethnic groups other than white, recent refugees and immigrants to the U.S., people with less than a high school diploma or GED, people at or below the poverty level in the U.S. (which coincides with the "other than white" category above), and non-native speakers of English. Self-stigma is directly coupled with shame, and shame increases individuals' buy-in to oppressive structures. Providers included in these groups are adults over the age of 65 years, recent immigrants to the U.S., and multi-lingual providers for whom their first language is not English. These categories do not preclude highly-educated providers who attend to the health literacy of students/clients, but not to their own health literacy around exposure.

The USDHHS (2010) went on to report on items they had found to contribute to health illiteracy:

1. Technical and medical terminology in public communications
2. "Confusing or unnecessary statistics
3. "Nuanced or unclear recommendations and explanations of risk
4. "Over-reliance on written communication
5. "A focus on awareness and information rather than on action and behavior
6. "Limited use of cultural preferences when targeting and tailoring information and interventions (USDHHS, 2010, p. 18)

Taking these items one at a time: 1) not all providers are interdisciplinary experts; 2) not all providers are involved in quantitative research from which the statistics are derived; 3) living in the midst of nuance may preclude overt reality checks, such as self-care; 4) providers ignore written directives as often as patients/clients; 5) knowing may not result in behavioral change; and 6) perhaps most importantly, when personal and individual context are ignored, the

likelihood of the information being applicable may be negligible and unheard. When cultural and personal beliefs and values are ignored, stigma and concomitant suffering may also be increased.

Ironically, but not surprisingly, the Army Health Promotion Regulation 600-63 (Department of the Army, 2015) focuses generally on healthy behavior for families and service members who are *not* also service member providers. Because providers are excluded from the group of potential patients, even when they are military members with families, the Army regulation's focus adds to the potential stigma for providers when they experience secondary traumatic stress, compassion fatigue, vicarious trauma, and burnout. The regulation implies that providers should be immune to empathizing with, and being compassionate around the conditions of their clients. As Compson (2015) wrote, "Cynicism often manifests as depersonalization and describes the way that burnout appears in an interpersonal context" (p. 64; see also Maslach, Schaufeli, & Leiter, 2001, as ctd. in Compson, 2015), or, I would add, in an impersonal context. Thus, it is important to look at the health literacy assumptions of the provider as much as the health literacy of the patients especially when health literacy is depersonalized, as it may be in the case of providers.

Role expectations. Several areas of belief conflict exist around stigma and compassion fatigue in terms of professional role. These include systemic expectations from the organization or professional organization under which one works and which may be in conflict with one another (Bearse et al., 2013). For instance, a neuropsychologist, a mentor teacher, a professor, or a social worker may, in their respective service systems, act as leader, supervisor, trainer/educator, and evaluator—all of which may be positioned as leadership roles in the business system. A leader sets the tone of the system and may dictate the behaviors of those within the system (Covey, 1989/2004; Northouse, 2010; Schaeff & Fassell, 1988). As a

supervisor, one may have to manage the day-to-day decisions, which requires saying yes to some people and no to others, which can seem unfair and be interpreted as indicating preferential treatment (Northouse, 2010). Moreover, more experienced providers may mentor and teach their supervisees/mentees both how to navigate the system and what to do in certain situations with clients. As evaluators, depending on training and the tone of the workplace, they may be in charge of annual evaluations towards raises, which creates another power differential.

In terms of the professional organization, under which they serve, supervisors and employees are mandated reporters on their peers and supervisees (e.g., WAC 388-76-10673; WAC 246-16-210-220); thus as mandated reporters, they may feel they have to report a colleague for lateness, absenteeism, suspected substance abuse, and so forth—before checking to see what is going on with the employee. Then, a junior colleague or a peer may be labeled as unfit for the job and the profession and stigmatized for conditions caused by the systemic workplace environment (Nadal, 2011; Zerubavel & Wright, 2012), instead of being offered help.

These responses from a leader/supervisor may increase stigma and burnout, and increase isolation (Bearse, McMinn, Seegobin, & Free, 2013). A colleague, reported or not, may also be averse to seeking mental health services due to fear that a peer or a higher-up will find out (Bearse et al., 2013). Ironically, three-fourths of the mental health professionals in the US have sought therapy, in which is included the catalyzing events that lead them to their professional practices in the first place. Overall, gatekeeping functions of one professional over another (Zerubavel & Wright, 2012), especially regarding supervision and evaluation, reduces the potential for dialogue and ensuing advocacy and agency (Freire, 1970/2000). Gatekeeping closes and protects the dysfunctional system which has defined these competing roles. Dialogue and assistance, and the dismantling of the fear-based system, are necessary to reduce stigma and

compassion fatigue.

Spiritual-situatedness. Wang, Strosky, and Fletes (2014) suggested that intentionality around mitigating compassion fatigue should be included in the systemic responsibility to prevent and address indirect trauma. Individually, they found that chaplains, for instance, "[experienced] sustenance and nourishment in the work itself—moving in [towards the client], as opposed to away" (Wang et al., 2014, p. 283). In contrast, Dombo and Gray (2013, as ctd. in Wang et al., 2014) reported that generally a provider may become spiritually compromised when he/she no longer is able to use their tools to find "meaning" and "purpose" in working with a client when the counter-transference of suffering is too great (p. 283). At the lower end of the continuum, providers may experience spiritual discontent when service and support work conflict with, for example, Christian ideals (Wang et al., 2014, p. 284)—even though the "passion of the Christ may refer to the suffering of Christ" as he was executed (J. Thompson, personal communication, fall 2015). In summary, the skills provided by some religions, such as mindfulness and living a compassionate life, as well as a balanced life (Kerzin, 2015), may be superseded in the paradox of other religions and the provider's perceived or expected control over personal reactions to trauma due to spiritual situatedness.

Relational expectations. Positive relationships with others—such as in the family, the school system, and the professional setting—may be mediated by codes of silence (Zerubavel & Wright, 2012). Zerubavel and Wright (2012) suggested that a *conspiracy of silence* is created by "relevant stigma and social taboos" and the "scar the healer bears" (p, 484). The conspiracy of silence, thus, extends from the systemic into the personal realm—from, e.g., "Physician, heal thyself" (Luke 4:23, King James Version) to the intense pressure of putting oneself into the role of healer. As discussed earlier, looking at Gawande (2014), curing and healing may not even

meet the expectations of the sufferer/the client; he she may have a different goal for quality of life. For instance, a student or client who has experienced the trauma of rape may not wish to recreate the story of the trauma; however, they may wish to draw or write about the trauma less directly, to objectify it, and to be done with it. Art may not alleviate the trauma, but it may release the trauma for the experiencer. We (researcher and reader) must acknowledge that we, too may have different goals than cure for ourselves. We may choose to look to prevention interventions, such as mindfulness and other practices, or we may look to post-compassion-fatigue interventions. Creativity and personal choice are key to choosing interventions.

Preventions, Interventions, and Compassion Satisfaction

Compassion satisfaction—the feeling of actually being able to help a client or student, and to understand their feelings and to feel good about it (Gawande, 2014; Ricard, 2015)—is a less researched and less discussed construct in the arenas of secondary traumatic stress, compassion fatigue, vicarious trauma, burnout, and sequelae. I emphasize that, if we only look to resilience within the system of the status quo (as supported by social critical theory), that we may simply be asking ourselves and others to function better within a flawed (or colonial) system. I believe that I must actively use this critical social theory lens when examining the literature of prevention and intervention around stigma and compassion fatigue as I continue forward in my research. To achieve compassion satisfaction, perhaps we must be more reflective and mindful.

Underpinning reflection and mindfulness, however, are systemic structures which dictate how and which clients/students are treated. The International Classification of Diseases codes (the *ICD 9* and the *ICD 10* are currently in use) determine who will be paid for which trauma services and which clients will benefit from having these services paid for (National Center for Health Statistics [NCHS], 2015). The ICD 9/10 are insurance payment codes, which describe

primarily acute care, rather than ongoing care. Pollock (n.d.) suggested that it is primarily hospitals, emergency personal, and public health agencies which submit to trauma registries the statistics which are then compiled. Not all traumas, particularly traumas of living one's life, fall within the parameters of these registries. For instance, Pollock (n.d.) suggested that most traumas recorded on the registry are not only acute, but life threatening. While the registry then serves as a surveillance mechanism and database for practitioners and researchers (Pollock, n.d.), it has little to do with individual and community health. I suggest that the registries have little to do with unreported trauma data (which are underground and rampant). Unreported trauma data and recovery from stigma related to reported trauma data and compassion fatigue vs. unreported trauma data are then unsupported within the insurance coverage and payment mechanisms for care, at least in the US. Thus, unreported exposure to this exacerbated, systemic stigma, and the inability to prove workplace trauma via compassion fatigue, may have the added effect of denying paid providers their due through workman's compensation for injury.

Prevention and intervention. Hydon et al. (2015) have studied STS, CF, and PTSD among educators. They defined compassion fatigue in terms of counter-transference:

> An emotional state with negative psychological and physical consequences that emanate from acute or prolonged caregiving of people stricken by intense trauma, suffering or misfortune. Compassion fatigue occurs when emotional boundaries become blurred and the caregiver unconsciously absorbs the distress, anxiety, fears, and trauma of the patient. (p. 323)

I offer that compassion fatigue is more than that encompassed by the Freudian terms of *transference* and *countertransference*. The absorption may come from culture and society as well—the expectations under which one lives. For instance, Miller and Kaiser (2001) offered

that we, as humans, have the option of cognitive responses to the stressors in our lives. If we return to Bronfenbrenner (1977), then we have the ability to move across and to analyze structures and systems in which we live and function. If we consider Freire (1970/2000), it means that we can create our own freedom and democracy through dialogic problem-solving around liberation from the status quo.

Miller and Kaiser framed stigmatization as a form of stress, which has repercussions on the body (as ctd. in Joels & Baram, 2009), including brain function at chemical and hormonal levels, as well as neuro-functionality in the spacial and temporal domains. We have one brain and one body, which function in concert (F. G. Flynn, personal communication, 2008), not as separate entities. Thus, emotional distress affects coordination and memory.

But we do tend to separate the mind from the brain, and the brain from the body as Gazzaniga (2014) pointed out so well in his recent research memoir. He showed that the brain may be able to overcome the physical distress of stress; he also addressed the communication between the brain and the body's ability to respond to cues, especially in knowledge formation (Gazzaniga, 2014). He did not, however, go on to address the communication between body and brain as Flynn did, regarding disease (see Bearse et al., 2013; Wang et al., 2014; Zerubavel & Wright, 2012). The point is that both scholars focused on a holistic perspective which is often ignored in both prevention (and intervention) due to sequelae of stigma and compassion fatigue. So, in the research, holistic preventions include mindfulness training (Compson, 2015; Wang et al., 2014), resiliency training (Potter et al., 2015), and professional development (Hydon et al., 2015).

The primary interventions to move from stigma and compassion fatigue towards compassion satisfaction are about knowledge and knowledge formation, and not about skills or

practices (Bercier & Maynard, 2015; Decker, Brown, Ong, & Stiney-Ziskind, 2015; Shoji et al., 2014; Wang et al., 2014). However, skills are often taught as a panacea, rather than using dialogue to make meaning of the experiences of stigma and compassion fatigue. Thus, intervention often happens when one is well along in the developmental processes of meaning making. Potter et al. (2015) suggested that behavioral interventions—"self-regulation, intentionality, perceptual maturation, connection, and self-care" (p. 84)—be taught to all staff; their program should be centered around mindfulness education and practice, which are life-long endeavors. Cognitive behavioral therapy, and aligned therapies, become useful in adapting behaviors and attitudes. For instance, Potter and colleagues (2015) used narrative analysis to get at the experiences around compassion fatigue of oncology nurses, i.e., they educated the nurses about compassion fatigue and then had them write. Decker et al. (2015) also focused on mindfulness as a way to increase compassion satisfaction, thereby bringing the social worker, in this case, back into balance. Decker et al. (2015) defined balance as a measure of health in which the social worker felt composed. Salloum et al. (2015) emphasized self-care as an important intervention, which of course requires finding time within and outside the system for that work. Bercier and Maynard (2015) completed a systematic review to "synthesize intervention research" (p. 83), and found that art therapy was conducive to healing overall, but that many studies did not reveal statistically significant results. They also found that workplace systems varied in their willingness to provide time for workers to participate in educational and other interventions.

Rationale for Study

Compassion fatigue is a commonly recognized effect among providers and educators working with clients who have experienced first-hand trauma (Figley, 1992/1995). However, while recognized as an effect, little research exists on how providers and educators choose to

acknowledge and deal with their own secondary traumatic sequelae, e.g., compassion fatigue, and why (Bercier & Maynard, 2015). Even less recognized and examined is how the practitioners and educators examine their own biases regarding the experiences of their patients, their students, and themselves. I suggest that untreated secondary trauma can exacerbate stigma brought to the relationship (see Zerubavel & Wright, 2012). Among providers who value compassion as central to their way of being in the world, secondary traumatic stress often metamorphoses into compassion fatigue, and may cause professional, personal, or cultural isolation.

More specifically, little is known about the impact of secondary traumatic stress or compassion fatigue on post-secondary educators or those who teach outside the traditional higher education system, such as in prisons or as private tutors. The same may be said for mental health practitioners who treat and teach (heath education and promotion) through private practice, especially those who treat current and former military members in the civilian world.

Research Questions

For this phenomenological study, regarding the potential isolation of providers caused by stigma and compassion fatigue around working with traumatized patients/students, through the lens of critical social theory, I ask:

How do providers/educators experience and recognize the stigma they carry into the helping relationship?

How do providers/educators experience and recognize their own compassion fatigue and sequelae (secondary traumatic stress, vicarious trauma, burnout) which they experience through the helping relationship?

How do providers/educators express and heal from the cultural isolation and subsequent

recognition of their own stigma and compassion fatigue brought on by their own relationships to those who they are serving?

Phenomenology: The Study of Experience

Phenomenology provides an avenue by which to research and document the experiences of providers and educators, expanding upon the extant literature. Phenomenology is both a branch of philosophy and a qualitative research methodology. That is, how one thinks as a phenomenologist informs how one researches and interprets phenomena and their meaning, as well as how a phenomenon itself gives meaning to the experiencer (which he/she can articulate as a conscious thought). While the roots of phenomenology as a practice can be traced as far back as Plato's "Parable of the Cave," I ground my discussion of phenomenology as a practice in the 20th and 21st centuries of western thought in industrialized nations, especially in the US, the location of my study.

Phenomenology assumes that we *consciously* make meaning of the things within, the stuff of, our lived experiences. Phenomenology asks how things appear to the conscious mind. Ryman and Fulfer (2013) defined phenomenological study as "describing the structures of lived experience by pushing past the assumptions we tend to bring to experience" (para. 1). While Thus, phenomenology is also a deeply critical practice in action and in analysis. Practitioners must get at the experience itself and consider its meaning to the participants (including themselves) in the experience, as the participants describe it. Phenomenology collects descriptions of experience and uses descriptive analysis (Daniels, 2005) and textual analysis to get at the essence of the experience. Existentially, Daniels (2005) suggested that phenomenology asks (and attempts to answer): "a. What is distinct in each person's experience [?], and b. What is common to the experiences of groups of people who have shared the same events or

circumstances [?]" (para. 4). Phenomenology can address both internal conscious thought processes and external behaviors (Daniels, 2005), For example, "I feel fear," can address what words describe or characterize the fear, and what that fear looks like in action. It can also address the mining of the subconscious to bring to conscious awareness some sense-making of experience.

Feminist phenomenologists have argued that experience is also gendered. More recently, feminist phenomenologists have added to the discussion by adding *interdisciplinarity* into the dialogic mix (Simms & Starwarska, 2013). In the above discussion, it is easy to see how literary scholars might use phenomenology to get at experience and meaning through textual analysis of stories, poems, and essays, for instance. Likewise, it is relatively straightforward to use phenomenology in a psychological treatment context. Gender is both an experience and a lens that colors the meaning of the person in the experience (Bem, 1993). Race, as used by critical race theorists, is another (Delgado & Stefancic, 2012). Examining lenses which we and our participants hold brings "richness and complexity" to our experiences and meaning making (Simms & Stawarska, 2013, p. 6). Simms and Stawarska (2013) wrote that:

> Feminist phenomenology is interdisciplinary as long as it intersects the methods and approaches of reflective and empirical disciplines, and ties theoretical study with practical relevance (such as in therapeutic practice, or in concerns about the ethical and political backdrop, and implications of phenomenological claims). (p. 8)

Application of Phenomenology to Research Practice

So, in application, the phenomenological researcher firsts examines his/her own biases that s/he brings to the research setting, both generally and around a particular phenomenon. Then the phenomenological researcher collects the texts that describe the experiences of the

participant, whether through previously published documents or by creating texts through interview and transcription processes. During the interview process, the researcher might also "push back"—seeking deeper description, clarification, and epiphanies from the key informant—as part of the research, therapeutic, and/or teaching processes. The participant may notice themes in his/her own verbalizations of experience. (This practice is called dialogic phenomenology (Daniels, 2005; Smith, 2013; see also Freire, 1970/2000)). The acquisition of the knowledge of the mind, simultaneous to the creation of knowledge and the re-acquisition of memory, is key to the dialogic practice when working face to face (see Thomasson, 2005).

Finally, the phenomenological researcher analyzes the data. While themes may appear, among an individual participant's experience and how s/he makes meaning of that experience, and between narratives and dissections of experience in the meaning-making process around a particular phenomenon, the goal of the researcher is not data reduction through coding (see Miles & Huberman, 1994). Rather the goal is a depth and breadth of understanding of the experience as lived by the individuals and the group and the *conscientizaçao* (see Freire, 1970/2000, p. 67) of that experience. Thus, sub-phenomena may arise during the discursive and iterative analytic processes. The phenomenological researcher realizes that "because of the open-ended nature of experience and of meaning [over time], the knowledge [accrued from the study] is always unfinished and incomplete" (Philosophical Research Online, 2015, summary).

Why Phenomenology

Phenomenology links nicely with critical social theory. Participants come with a history, which will naturally contextualize their experiences. Participants may or may not describe their experiences, their knowledge, in terms of dominant social and cultural mores, dependent upon their positionality. Likewise, dialogue is dynamic and interactive, which will facilitate the

melding of past, within present and future, as participants voice their experiences. Because the participants/key informants, as described in the *methods* section, move in and out of the dominant culture in their work, they understand how dominant mythology around education and what is proper can frame (or misframe) the knowledge and experiences of their students/clients with invisible traumas. Dialogic phenomenology, like critical social theory, can provide a way forward from stigma and its resultant oppression by reframing knowledge in the voices of the experiencers.

Methods

Sample: Key Informants

Using a convenience sample and snowball sampling, I sought out adult providers and educators—already advanced in their careers, who I knew to have already thought deeply about compassion, stigma, and compassion fatigue in their professional roles—though they may have used slightly different terms. These key informants already had strong support systems in place for dealing with stigma, compassion fatigue, and their own and others' traumatic experiences or invisible wounds. Feminist phenomenology supports the use of interdisciplinary key informants (Simms & Starwarska, 2013),

JM is a retired professor of literature in English, post-eastern bloc film, and writing. She is a poet and scholarly writer, currently writing about the Harlem Renaissance and the impact of literary magazines during modernism, in addition to her poetry. Literary criticism, film criticism, politics, and critical race theory inform her work. She has several books to her name, in a variety of genres. JM, approaching 60 years-old, worked in the United States university and college systems, as well as internationally, during her 27-year career. She cares deeply about the nature of knowledge, voice, and diversity.

RJJ is a retired flight attendant, who went on to a career in psychology. She has a history of 24 years of active suicidality, and additionally describes herself as a non-active alcoholic and addict. Her ethics require her to admit her self-perceived health risks. She was CEO of a non-profit organization for many years, serving military members and their families, who were seeking help outside the military system around stigma, traumatic brain injury, post-traumatic stress disorder, and suicidality—most recently during the global war on terror (GWOT). She currently works with clients, some high-profile, around suicidality. She does not charge for her services and interviews all clients before agreeing to work with them. Approaching 70 years-of-age, she feels directed by God to follow her mission. RJJ also has a strong support system.

PU, a poet, environmental writer, autobiographer, and editor recently walked away from a tenure-track position at a college in the western United States due to systemic dysfunctionality. PU is widely published, thinking deeply and putting her voice "out there," without fear of repercussion. She has worked with students/clients from around the world, including students incarcerated on death row in the United States. As an activist, she has thought deeply about human and animal rights during her many-yeared career. She has considered stigma and compassion, and the critical need for hearing and recording voice to initiate change.

WPR is a poet and author of many books. He has taught in public schools, Indian boarding schools, on the reservation, in Appalachia, and in the Deep South, often as a poet in the schools. Before entering the ivory tower of higher education, he says he was a "cultural commuter," working underground in the mines. While retired from higher education, WPR continues to read, write, perform, and teach less formally and in venues more of his choosing.

Human Subjects Considerations

Human subjects' considerations include ethics around confidentiality and protection of

key informants (American Psychological Association, APA, 2016).

Confidentiality. I sought and obtained informed consent from interviewees regarding the study, demographics, interview content, and using relevant writings, performances, readings, and/or interviews as identified by the key informants. Pseudonyms have been used in all data collection and written or oral analyses.

All data have been stored digitally in a password-protected environment. Some data have been stored in print in a locked environment, to which only the researcher (me) has access.

Protection of human subjects. I confirmed with each key informant that he/she had an ongoing professional and personal support system. Based upon the key informant's location, I additionally provided professional local resources around trauma should the participants need additional supports due to triggers within the content which we were discussing.

Data Collection

Over the course of a month, I conducted in-depth interviews, with follow-up communication with the key informants. Interviews were open-ended, confidential, and conducted via email, phone, or in person, dependent upon the convenience of the interviewee.

Interview questions. I first collected demographics to confirm general ages, roles as providers or educators, and brief biographical profiles in order to confirm that the interviewees fit the convenience sample parameters of my study (Berg & Lune, 2012). Then, keeping within the phenomenological research tradition, I asked open-ended questions in order to initiate breadth and depth of conversation (Berg & Lune, 2012) between myself and the key informants around the key informants' personal experiences with compassion, stigma, compassion fatigue, cultural isolation, and their methods of coping. I also asked about the people with whom they had worked.

Dialogic phenomenology guided the interviews (Daniels, 2005). Stolorow (2004) framed dialogic phenomenology in Lacanian terms around the dialogue that takes place in therapy, a verbal interplay between the interviewer and the client. Since phenomenology studies the personal experience in order to "gain understanding of the experiential world" (Stolorow, 2004, p. 669), and dialogic phenomenology does this through conversation, themes naturally arise in conversation, as the interviewees hit upon related experiences and make sense of them (Stolorow, 2004) through critical conversation. General open-ended questions included:

1) Please describe you role as a provider or educator serving clients/students who have survived invisible traumas.
2) Please describe your understanding of stigma.
3) How have you experienced stigma in your work as a provider or as an educator?
4) What stigma or filters of your own have you come to recognize over your career? Please give examples.
5) Please describe you understanding of compassion fatigue.
6) How have you experienced compassion fatigue in your work as a provider or as an educator?
7) How have your experiences with stigma and compassion fatigue impacted your work?
8) Have you had to deal with cultural isolation in your work as a result of stigma and compassion fatigue? Please describe.
9) What self- and external interventions have you used to cope?

Key informants had the option to provide relevant writings, performances, readings, and/or other interviews (see Berg & Lune, 2012, on *archival* strategies) as they saw fit, which I also analyzed

through the research tradition of phenomenology and the lens of critical social theory. After each interview, I wrote down my impressions and responses.

As the researcher, per phenomenology, I kept a research journal in which I addressed my own core assumptions, responses to the content of the interviews, the affective elements of the interviews, and competing data (Berg & Lune, 2012; Simms & Starwarska, 2013). In my own writing, I reflected upon my personal experiences, reactions, and meaning-making over the time of the study using the lenses of phenomenology and critical social theory. Additionally, as I gained experience in interviewing, the interviews became more conversational.

Follow-up interviews were optional. Most follow-up conversations took place through email and concerned brief clarifications on my part and additions the interviewees wished to make on their parts.

Research environment. While the data collection environment was primarily digital, and I made every effort to maintain confidentiality as I used technology, my goal was to make the interpersonal aspect of the data collection, via interviews, intimate and trusting. Thus, I answered questions up front and offered opportunities for commentary and additions on the back side of the interviews. Additionally, all key informants expressed interest in seeing the end result of the research, which I will provide to them upon completion and acceptance by my committee. I am not asking, however, for corrections or perceptions of accuracy as memories are selective (see Bauml & Samenieh, 2012, on how retrieval can trigger additional remembered experiences) and knowledge grows and changes over time (Freire, 1970/2000), as noted in the key tenets of critical social theory. Thus, the interview content is time-specific.

JM. JM and I met in her new home in a small coastal port in the Pacific Northwest. Like her previous home along the Puget Sound, this one had many levels. It was open and welcoming.

We sat at her round dining table, just off the kitchen, with views of the Puget Sound, the Northern Cascades, and another larger port to the south. Our plan was to catch up a bit and then to commence with the interview.

JM had read and signed the informed consent form for the IRB and had no questions regarding the informed consent. She did ask whether or not I had a hypothesis and expected outcomes for my study. So, I explained the nature of qualitative research and specifically phenomenology, which seeks to document the lived experiences of interviewees in their own voices. Once she understood this construct, she was ready to begin the interview. She had made initial notes on her responses to the interview questions, and we proceeded from there. I did admit to JM that the term "Cultural Isolation" in the title was probably an assumption on my part. I used a digital recorder to capture the interview.

Later that evening, we had a follow-up interview as we walked the beach around the lighthouse. Our concern for the rapid erosion of the beaches, caused by the violent storms of the previous winter echoed the content of our conversation. I did not record this follow-up interview, but captured it later in notes and reflections. Thus, a transcript is not available for this time.

Finally, we followed up with each other by email.

RJJ. RJJ and I met in the office behind her home for the purposes of this interview. To maintain the privacy of clients, she asks them (and asked me) to park along the street, being careful not to block her neighbors' driveways or walkways. To access her office, one ascends the driveway, circumvents the garage and follows the ramps to a welcoming small building, fronted by windows which overlook her well-tended gardens, but which allow no street view.

RJJ was seated at her card table doing email and working on her new book. Her desk was to the left of the table and to the right she had a love seat and a one-person chair, allowing for

guests and clients to choose a comfortable seat. Between her and clients were a coffee table with potential activities to complete with clients, such as a box with small folded pieces of paper. The set-up allowed RJJ first access to the door. Her keys were in the door, where she preferred they remain. Perhaps her keys were in the door for convenience; but it did occur to me that she could escape and lock a client in should he/she become violent or otherwise untenable. However, RJJ is disabled and uses two bright purple canes—very regal—so it is unlikely that she could make it to the door before her clients/guests.

RJJ asked for clarification on my study as she was worried about skewing my data. This conversation is part of the transcripts.

I captured this interview using my android phone.

We followed up on our conversation by email since we felt we knew each other well enough to discern tone, and since we trusted each other enough to make emendations when we thought one another may have misunderstood our respective points.

PU and WPR. PU and WPR, a married couple, and both writers, as were my other two key informants, met with me over the phone. I had provided, PU, my original interviewee, with the interview questions up front. She and her partner WPU had written about and discussed the questions at length, and so I was able to conduct a tandem, 3-way interview.

I was in a small office—not my own—at the University of Washington Tacoma, where I work as the Teaching English Language Learners (TELL) project coordinator. My supervisor, the primary investigator (PI) of the grant, needed my office for a "zoom" meeting. I dialed PU and WPR from the office down the hall, not knowing whether we would be interrupted and not knowing, at the time, that I would have the delightful opportunity to interview them both. The office was small and quiet, though it had a window. I made certain to sit by the phone, at the

desk, which was clearly most seldom used, so that if any of the occupants (also on the grant) came in, I would interfere as little as possible with their work.

WPR and PU were in their living room, also on speaker phone, relaxed, drinking coffee, and with WPR's dog present. PU and WPR have always had dogs—never cats, like JM whose cats were also present during our interview—and the dogs have always participated in human interactions, as his wolf hound did this day of the interview. Such love and acceptance of the four-legged was delightful. He clearly responded to the tenor of the conversation with his *rfffs* and nuzzling. We were occasionally interrupted by entrances into the office in which I was situated and phone calls at PU and WPU's house, but they did not seem to interrupt the flow of our conversation. We were all relaxed and happy to reconnect after many years. Follow-up was through email.

Data Analysis

Recording and transcription. Interview content was recorded digitally. Transcription was provide by Rev.com. Out of San Francisco, rev.com is a professional organization, which follows the guidelines of research, medical, and legal transcription regarding confidentiality (Rev.com, 2016).

Discussion and coding. In this phenomenological study, four key tools guided the data analysis, with critical social theory underlying my thought process: primarily 1) thematic coding (Miles, Huberman, & Saldana, 2013; Saldana, 2013); as well as some 2) textual analysis of relevant writings, performances, readings, and/or interviews as identified by the key informants (Barthes, 1966; Fish, 1980); 3) semiotics (Barthes, 1966; de Man, 1979); and always 4) researcher reflection (Berg & Lune, 2012). I actively sought competing data and explanations (Berg & Lune, 2012).

After rereading the transcripts of the interviews and writing up the key informant biographical sketches and my impressions from the first two interviews, I sought a meeting with a trusted faculty member with whom I could discuss initial details and meta-impressions. As we talked, I was able to discern an initial model connecting the contributions by the key informants--including definitions, elements of self-stigma, a systemic component around environment, very clear self-care strategies, and a western world view behind their experiences and definitions.

Upon completion of four interviews, I reviewed my own notes, writings, and contributions to the conversations, and began the coding process. Essentially, I followed the process of identifying codes, grouping into categories, discerning meta-level themes and then repeating the process (Miles, Huberman, & Saldana, 2013; Saldana, 2013). Additionally, I used a set of colored pens to mark the text, wrote marginalia, and took copious notes. I specifically chose to hand code because it slowed me down enough to increase my reflectiveness. Hand coding also increased my ability to be mindful and recursive about the process by having hard copy in front of me—the words of respected peers, their voices, their tone, and intimate details about hard questions. I wanted my interaction with the text to be as personal as my interactions with the interviewees during data collection. I did not want a computer program to organize my thinking for me. This is not to say that computerized data-mining is not useful in coding, but simply that my purpose went beyond physical words to the phenomenological imperatives of giving voice and making meaning (see Ryman & Fulfer, 2013).

Additionally, I based my data analysis in critical social theory. As I looked at the data from my key informants, I considered the CST tenets that:

1) *Knowledge is based in a historical context;*
2) *"Acceptable" knowledge is defined by the systems of the dominant culture and serves to*

distort the knowledge and meaning-making of the oppressed;

3) *Knowledge and meaning-making are dynamic processes over time*;
4) *Knowledge of the dominant culture revises the experiences and knowledge of the oppressed;*
5) *Those who challenge acceptable knowledge are stigmatized by the dominant culture;*
6) *Dialogic and dialectic conversations among the oppressed, and later with the oppressors, provide a way forward; and*
7) *Democratic principles give voice to all in problem solving.*

I used the tents of CST to inform my listening to the taped interviews and to guide my analysis of the transcripts and additional input and writings, which the key informants provided.

Findings

Not surprisingly, the themes which emerged from the conversations were grouped around the interview questions themselves, and included stigma, compassion, the knowledge of trauma, compassion fatigue, cultural isolation, and coping mechanisms/healing.

Stigma

Each key informant defined the key terms in his/her own way. JM described stigma "as a socially-applied censure based on a perceived quality or trait." She noted examples of military members being "in a perceived category" and gay persons "stigmatized because of perceptions." Moreover, she found the *censure* piece to be the most problematic—that "being dependent on a precondition or perception…makes [stigma] harder to deal with because it's hard to change people's minds to deal with [stigma]." RJJ described stigma as outright prejudice. In her context of suicidality, she brought to the fore the dominant culture of U.S. psychology's need to find a diagnosis, thereby labelling the potential suicidee as both broken and medically fixable. PU

described stigma in terms of shame and blaming the victim. WPR defined stigma using historical and cultural contexts.

JM. JM described the stigma, which she brought to the table as a professor, citizen, and family member, as challenging. However, she was open to listening, to gaining new knowledge and perspectives. JM acknowledged that her own experiences were not enough to expand her knowledge. While she has much formal education—an MA, MFA and PhD—she grew up on a farm, which gave her a deep compassion for mammals, though perhaps less for human beings, which has informed her interpretation of her own knowledge, i.e., how she makes meaning of stigma and how she acts and has acted upon it. In this context, she defined the stigma she brought or brings to the table as *biases* and *attitudes*: "In terms of my own biases, I've had to work through my own attitudes."

Regarding the military, JM's first revealed bias, (meaning that she was anti-military), was when she revealed that she was a child of the Vietnam era. "[I have] a great deal of skepticism about political leadership that leads us into conflicts…for reasons that don't seem terribly valid." Her father was a veteran (conflict unnamed), her cousin served in Vietnam, and her brother "joined the army to get a degree" and eventually became an officer. She said of her brother:

> *That made me think. I was much more able to not have that [being in the military] be an issue, but I did not know anything about it when I first started [to think about military service and military members]…people who are sort of plopped into a situation where they don't have much control, and they're told to do things that many of them would prefer not to do.*

JM asked, "Who are we [the United States military] going to invade tomorrow?"

Regarding military, JM also had a strong reaction against peer professors who wanted

control in the classroom, especially for Reserve Officer Training Corps (ROTC) students. One peer professor said, "If you are going to be gone for *that* organization, you can't make up the work. It counts as an absence." Likewise, students involved in sports, whose scholarships were paying their way, JM reacted negatively against non-supportive peer professors, who said, "It's an absence; you can't make up the work" when student athletes would have to go to Florida, e.g., for a game. JM's response was, "I find it very distasteful." JM also admitted that her peer response in the case of student athletes might have been gender-, i.e., male-related. So, while JM did not identify negative peer responses to certain groups of students, these responses clearly played into her biases against peers.

Regarding hunting, JM's second revealed bias, she was particularly avid against hunting, in general, and against trophy hunters, in particular. Her cousin "trophy hunts and that irritates me greatly." However, he told her, "You have to love the animal to know it so well, to know its habitat, to know its behaviors, so that you can effectively hunt it." She commented that, "Whatever switch trips in his head, doesn't trip in mine." "But because I talked to him, I …no longer dismissed my students [who hunt] in class, talking about [hunting] as an aspect of who they are, family relationships, things they know." JM had never dismissed them to their faces, only in her mind.

JM's third bias had to do with experience and inexperience around student revelations in the classroom. Here, her initial biases or stigma centered around how to deal with negative comments by students around sexual orientation, military membership, race, and perceived disability. She wanted to confront students whose knowledge of diversity contradicted her own, but how to do that politely and effectively caused her consternation. While I will provide examples here, much of this leads to the findings around cultural isolation, which I will take up

later. JM reported, "I remember one girl with brown hair said something really homophobic, and I was completely blindsided…I don't think I said anything helpful."

JM did admit certain ironies between her life practices and the stigma she brings to the table. For instance, she is an omnivore, while being biased against hunting. This indicates that she is reflective about her own stigma that she is working to not practice. We are fallible, contradictory humans, after all.

RJJ. RJJ's focus was suicidality. She defined stigma especially as that experienced by her clients, whom she never called *patients*, as she viewed the term stigmatizing and causing an *us-and-them* situation in the healing relationship, especially through former relationships they had had in the context of prejudice and power. RJJ aligned stigma with prejudice. She said, "I know that people who have tried to access care have met up with so much prejudice that they simply will not reveal their suicidality…they've been so stigmatized in the past." Stigma around suicidality was defined by a DSM diagnosis—"crazy or nuts or depressed or mentally ill or bipolar or, God forbid, borderline personality disorder or OCD [obsessive compulsive disorder]." She continued: "You have to have some DSM diagnosis," she said, referring to the medical and medicalized mental health systems in which her clients had previously been treated.

The *DSM IV* and now *5* is the American Psychological Association's *Diagnostic and Statistical Manual* (note: the APA has changed from roman numerals to ordinals for the current publication). Its purpose is to provide social workers, psychologists, neuropsychologists, and other mental health providers with algorithms by which to diagnose mental health problems and diseases (APA, 2000/2013). The algorithms, as in math, are predicated upon perceived conditions, which then lead to a diagnosis and procedure of cure (APA, 2000/2013). Each step of the algorithm requires a yes or no answer from the diagnostician. The *DSM* only takes into

account the accepted knowledge of the dominant medicalized culture, rather than the meaning-making of the experiencer. The process then, of diagnosis and treatment, usurps the identity of a person and replaces that identity with his/her condition (see, e.g., Flanagan, Miller, & Davidson 2009). With a diagnosis, the *DSM* thereby distorts the knowledge of the oppressed, in this case, the person who is suicidal, creating an unjust practice of incarceration, a.k.a. hospitalization, because once signed in, only another person from the outside can sign z patient out (R.H., nurse, personal communication, fall 2015).

RJJ also described stigma in other terms of systemic prejudice: "People ask me all the time, 'Where do I go?'" She replies, "Well do yourself a favor and don't go to a suicide support group…You won't find any help there. You will find more stigma, more shame, more blame, more guilt, more pain." Thus, RJJ's definition of stigma included its repercussions—shame, blame, guilt, and pain. Stigma is not only prejudice; it is the negative impact on a person's self-worth. Following CST, knowledge of the dominant culture revises the experiences and knowledge of the oppressed (Freeman & Vasconcelos, 2010; Freire, 1970/2000) re suicidality. RJJ commented that, "The American Association of Suicidology is one of the very worst blame, shame groups there is…They're so into labelling."

RJJ's experience with her own stigmas brought to the table were mostly around her own healing. She expressed that she had to figure out, write about, and get beyond her own "shame and blame." Primarily, RJJ, by self-report, brought to the table self-stigma rather than stigma against others. Additionally, she shared challenges by clients, when she would misconstrue her own knowledge or experience. For instance, she shared with me at the time of our interview, that she was working with a young woman and referred to herself (JRR) as recovered—"You know when I used to be suicidal…,[I said], and she [my 13-year-old client] goes, 'Wait a minute. You

are still suicidal.'" RJJ experienced denial, another form of stigma. Overall, these processes allowed her to recognize stigma within the cultures she worked and within herself.

Finally, RJJ did analyze her relationship to her religion and to a Christian God in our conversation. During her interview, she was very clear about her mission being driven by God: "…in prayer meditation, the message came from the Lord very clearly, '[RJJ], you cannot discriminate. If you truly want to be able to eradicate suicide in the world, you got to have absolutely no barriers whatsoever.'" She also realized that she had to come to grips with the fact that the hold her love for her biological father, and hence his Christian Science religion, were killing her. RJJ wrote, "During my second psych ward stay, I realized that the shame and guilt heaped on me by Christian Science was killing me." Her trauma had been caused, in part, by being raped at 19 years of age, which was not acknowledged by her father's church. RJJ wrote, "At that point, I initiated the quest for the God *I* needed" (also stated verbally), though her knowledge around spirituality would be a long time in developing. First, she had to give up her family's dominant spirituality, Christian Science, and its teachings, in order to honor her own knowledge and experiences and to move forward from the stigma of rape.

RJJ was able to identify the stigma around suicide in those she chose to help because of the stigma she herself had experienced in being both someone who suffers from suicidality and from her professional work with others who have experienced the same stigmas. She initially tried to work within the professional system of agencies and professional organizations, but recognized that she had been buying into the very organizations which most promoted stigma through shame and blame. Her prior buy-in caused her to look closely into her own paradox of trying to educate and change systemic stigma from within, when she was aware that the stigma was so systemically ingrained that she had to create a new system, which she did. She now

works from *within* the context of those who are suicidal instead of from *without*, i.e., from the perspective of the systems which attempt to diagnose the underlying causes of suicidality and cure it. RJJ educates and promotes change around negative stigma from the inside out (for analogous examples of outside in vs. inside out, see Knaus & Brown, 2016).

PU. PU immediately linked stigma with trauma and the freedom to speak about one's experiences. She said, "Stigma is a…negative thing that separates you from the group around you. Because you have done something [perceived as] negative, you become the person who is ostracized." PU immediately launched into shame and the story of a student who had been raped, and who, even in a memoir writing class, was so ashamed that she could not use the word *rape* in her memoir. Stigma caused the writer shame and made her feel at fault as the victim/survivor of rape.

PU also reflected upon the stigma she triggered in others against herself as representative of the stigma she brought to the teaching table. Particularly through her work with incarcerated men "in a maximum security prison in upstate New York," PU was seen for her external appearance, an extremely beautiful (my words), "blonde, white woman." "I have always had to overcome the fact that I'm a woman in front of a class because students initially respond to a woman in a different way than they respond to a man," she said. Responding to a question about whether she had ever asked whether her blondness and whiteness were overcome in any of her teaching situations, PU replied, "I did [ask] in one of my classes, and my blonde hair [had become] invisible, so that made me really happy."

PU went on to admit her struggles with other levels of socio-economic status (SES): "I walk into a classroom as somebody com[ing] from very hardy beginnings. And so they could see that. And that's how I establish rapport with students. I have a much harder time with upper

middle class students." She admitted:

> *...I have an incredible about of prejudice with[in] myself that I bring into the classroom that I [have] had to overcome in myself and learn how to censor myself. For instance, with pro-gun NRA supporters, terribly conservative macho students, evangelical Christian students. I've had to really, really, really think about how I speak to them and how I look at their writing and not to be prejudiced against their writing.*

Through paying attention and being in the teaching moment, a form of mindfulness, PU has been successful in addressing her own stigma that she brings to the table. She shared: "I actually had one…[a young woman] who came up to me one day and just gave me a big hug and said, 'Thanks for being Christian.'"

So PU was able to conflate the stigma she experienced from students with the stigma she knows that she brings into the classroom.

WPR. WPR described stigma through story. He used the words *disciplining* and *pigeon-holing* as synonymous for stigma when he shared this story about teaching. He thought he was going on a reading tour. Instead, WPR was taken to an Indian boarding school for Navajo and Hopi children.

> *So we walked down the hallway toward this fourth grade and as we approached the door we can hear the teacher saying, "Now students, this morning, you're going to have guests, but they're poets so you don't really have to take any notes or pay any attention." It was late, late for us to stop. We go right around the corner and there they were, each student just staring at the people they weren't supposed to have to listen to. And the teacher, a lady who was probably in the late 60s, [a] teacher cranking with silver pawn jewelry and native dress—but was a white woman—turns to us and says,*

"These students are fourth-graders, but they're Indians, you shouldn't count on much from them."

But I told the kids—I said, "Okay so we're poets and you're not supposed to listen to us. Your Indians so we're not supposed to expect much from you. I think we're going to have a good time." And all those little heads that had fallen down onto the desk, you know, like sunflowers, suddenly rose up and we had a hell of a good day. I didn't have a second act, but I made one up very quickly. ...I was so appalled at what these students were being subjected to by way of the disciplining and what was about to be—the disciplining and the pigeonholing and all that of the teacher, a veteran teacher no less. The tenderness and eagerness of these little children who wanted nothing more than to [for you to] give them a chance; [then] you couldn't stop them.

WPR did not share much in the way of stigma he had brought to the table nor much information about the ironies of such stigma. His focus seemed to have always been understanding those who have been positioned differently from himself. His awareness was sharp and reflective.

WPR was keen to bring a different spin on stigma to our conversation. Like Compson (2015), he had another take—that the stigma we were talking about was very western and did not necessarily represent how stigma has been defined within various cultures. For instance, in Christian culture, he shared:

...Mark of Divine favored imitating the wounds of Christ that appear magically on the body [stigmata], for instance the dead bodies of Saint Francis…and any number of other saints. It came to be a mark. And also, by the way, it's not unlike what [for] the favor of the gods is deadly.

Regarding Aztec and ancient Greek culture, he related, "Whether it's with the Aztecs and the favorite virgins …or the Ancient Greeks on the island nation of Minos—the virgin being sacrificed to the minotaur. It was a blessing. It was also a curse." WPR emphasized, "And the blessing sets you apart [like stigma]. In our culture, we've lost the sense of it [stigma] being a blessing, and we've only retained the sense of it being something that sets you apart—a kind of curse that."

So, being a virgin was a blessing. But, ironically, being a virgin caused one's death. Is this naming a blessing or a curse? Regardless, the dominant culture felt, systemically, that sacrificing the virgin was positive. The virgin may not have felt her death so positively. Certainly, the virgin was othered and falsely elevated in position to rationalize her death. WPR hit upon prejudice as the ultimate stigma, while remaining aware of the change in definitions over time.

Compassion

My interviewees described compassion from a variety of perspectives. However, on compassion, each key informant was less effusive. Perhaps this is because *stigma*, and its relationship to prejudice and inhumanity, pushes more buttons than a positive term like *compassion*. Compassion and compassionate acts were used universally among my key informants as positives. All of my key informants described their acts of compassion, which demonstrated living a compassionate life (Kerzin, 2015). JM essentially described compassion as a behavior learned in the home. RJJ distinguished compassion from altruism, which she adamantly insisted does not exist. Both JM and JRR addressed compassion as actions, rather than as a theoretical construct. PU aligned compassion with nurturing, especially around alleviating suffering. WPR put compassion on a continuum with empathy. As well, he did not describe

himself as compassionate, but demonstrated, like the others, through story how he moves through the world.

JM. JM said, "I was not raised in a compassionate home." She described being in graduate school before learning that parents could show compassion by listening to their children: "I remember being surprised in grad school, when a friend of my who had a young son said…they were talking about some issue…'I just waited to hear what he was going to say,' her friend said." One can picture the mother on the edge of her seat, leaning in towards her son in anticipation, interested in the ideas her son was formulating. JM thought and said, "A parent would do that?"

She described herself and her mother and the messages she received: "I think I was always a selfish, mean sort of person," equating boundaries with a lack of compassion. "While I don't want to blame it all on my Mom—I know she had a very hard upbringing—and a lot of it just marched right on into our household."

JM's experience as a compassionate colleague was removed from her experience in the family home, though both seemed grounded in pain. When describing a time when she was denied tenured to a particular institution of higher education, she said: "Actually, I am proud that I've learned from that pain, so that when I had friends who were kicked in the teeth and other places, I was able to reach out to them, knowing that their friends [allies] were few and far between." This brings to mind Ricard's (2015) quotation from the French philosopher, Christophe Andre, "The more lucid we are about the world, […] seeing it as it really is, the easier it is to accept that we cannot face all the suffering…unless we have this strength and this gentleness" (p. 64).

JM defined her actions as friendship, not as compassion. From my perspective, they are

quite close. JM continued, "When you get into in trouble, you find out who your friends are. Because that was very important to me; I was there at least for some other people." JM recognized their pain and was helping them through it.

Somewhere and somehow JM had been given a very powerful message about compassion, and she believed even at retirement age, that compassion was a quality she did not possess for other humans, only animals.

JRR. JRR also expressed that she was compassionate through her articulation of her actions, rather than defining the term and then placing herself within the in-group or the out-group around having the characteristic of compassion. "It's all about acceptance, "she said.

> *The isolation—that is what really kills you. That's one reason people say to me, "Why do you teach how to form a support group for your clients?" Well, as soon as my client says the magic words, "This is so hard to do by myself," that's when I jump in and say, "You don't have to do it by yourself." When they form a support group—it can be anybody who really wants to be involved in it.*

JRR first learned to create a support group for herself as well. She described a time, when she was actively suicidal, that she had a list of friends to call, and they would call her as well. One friend would take her out, even if JRR had said "no" on the phone. Her friend would show up anyway and take her to her appointments, to the store, or to lunch, just to get JRR moving through life again.

JRR never did get around to talking about the *concept* of compassion because she describes herself as action-oriented. JRR did not view herself as a theorist. Even in her bio-physiology of suicidality, she fomented action for her clients and readers. For JRR compassion was and is a way of life: RJJ lives compassion and helps others to live in compassion, for

themselves first and then for others. Notably, all of my key informants focused on acts of compassion.

PU. PU described compassion as attending to students' experiences and what is meaningful to them.

> *[In] my maximum security prison [notice the ownership, even though this was PU's place of service, not her own place of incarceration], most of my students were black, and most of them came from an urban setting. They were urban black, and they were urban poor black. So you don't bring John Hollander or a Yeat's poem into class to discuss. You just don't do that. So you bring in something that's really relevant that they will be able to talk about, that we can have a discussion about right away.*

PU also related, "I have a poem called, 'Parole' that always opens up a lot of talk, whether it be on reservations or in the prison setting." PU went on to explain why teaching with appropriate content creates trust, which is related to being able to give and to receive compassion (Ricard, 2014). "It's a rather long poem about a student of mine who got AIDS, and the way I dealt with that. It's an emotional poem, so it speaks to them on an emotional level." Her comments suggested that compassion is not an intellectual act, even though in some circles (see Bronfenbrenner, 1977), compassion may be a social (thereby systemic) construct and value. She went on to explain how race, and by extension, oppression, play into compassion: "Also, I don't bring in a lot of materials just by white people. I always bring in materials that are culturally relevant or regionally relevant to the people." In referring to "the people," PU acknowledged community as important to experience and meaning making.

Additionally, PU explained how horizontal connections, without any inclination towards micro-aggressions (Harden, 2015), moved her towards rapport-building. I argue that this is

compassionate pedagogy (see Baloche, 2016, on equity pedagogy) and based upon equity and compassion for an individual's or a group's situatedness. PU said:

> *It's really important to me to establish instant rapport with my students, and it does happen. I don't know how, but I think it's because of the material…that I bring into the classroom…I don't ever want to present myself as being anything but another writer. We are all writers here to discuss our work. We all pray towards the one good poem that we're going to write in our lives.*

Thus, PU is not the only expert in the room. Compassion requires the understanding that the student/client is the expert on his/her own life and what his/her experiences mean. PU said, "We're all subject to all kinds of things [including suffering, for which compassion may be the only appropriate response [see Ricard, 2015]. I'm not a walking encyclopedia, and I'm not a walking anthology."

Essentially, PU identified key constructs of equity pedagogy—cultural competence, critical consciousness (see Freire, 1970/2000), and culturally-relevant pedagogy (Jackson, 2013)—as crucial to compassion in the teaching environment. Additionally, through her compassionate acts in the teaching and learning environment, PU examined her own dispositions, awareness of status, visibility and invisibility, and structural issues (Baloche, 2016) as undergirding compassion as action.

WPR. Deep description (Merleau-Ponty, as cited in Smith, 2013), and some philosophy, informed WPR's ideas around compassion along a continuum. Empathy, as he described it, was an emotion, and compassion, was about setting his own preferences aside and providing structures within which others could express their voices. For instance, he related:

> *One formulation, for what some of the things are that involve both [the] subject-*

matter of a poem and the form of a poem, came in from a fourth-grader in a class in Oregon. It was anonymous what he turned in. But it's a four-line poem based on the handbook, Wishes, Lies, and Dreams. *…One of his [the author of* Wishes, Lies, and Dreams*] formulas was to have the kids write a poem that follows this formula. And I tend to be against formulas until I saw what happened. This formula was, "I used to be, and now I am." Okay, so here's the poem by a fourth-grader, don't know whether it was a boy or a girl. That's one of the marvelous parts about it.*

I used to be a door, but my parents slammed me shut.

Now, I am a secret room, all lit up, waiting to be found.

…Wouldn't you know that it's a cry from the heart, but it's not a despairing cry.

WPU understood, through his compassionate act of giving voice, that he also did not need to intervene in this fourth-grader's suffering. The child was finding solution through expression.

WPU also expressed his experience enacting compassion as "the courage of patience," which I suggested was a form of self-compassion. His wife, PU, interjected, "Exactly, and to end with beauty. I like what Joy Harjo said, 'We must turn water into food.'"

Finally, WPU expressed compassion as the dissipation of anger. He had been working with a student at a college in New York City. She was always late to class, so he invited her in to office hours, which probably felt like being called to the principal's office.

When she came up to me, I realized that she was a student who was probably [an]*immigrant or* [the] *child of an immigrant which many of the students were at Hunter and that she looked harried; she looked worried. And I immediately wanted her not to worry because I didn't want to punish her or anything. I just wanted to know and I asked her, I said I noticed you come late to class and you always come the same 20 minutes*

> *late. And I said, can you tell me what's going on? And she got tears in her eyes and then she swallowed them so to speak and had an awkward expression. She just bucked up and explained to me her situation. And her situation was that her husband had AIDS and was bedridden in the house with two kids that had HIV also.*
>
> *... I was so glad on that day that even though I was irritated enough to ask her to talk to me about it, my anger was dissipated by the time the end of class was there. Because I could have shut her down accidentally and horribly. And she is exactly the kind of person that I wanted in that class and any class. And someone who clearly wants to improve herself and is being a hero, a real hero of her family.*

WPU remained humble, as did all of my key informants, around compassion. He did not describe himself as compassionate, but demonstrated through story how he moves through the world.

For all, compassion was imbedded with their professional service as educators and as a psychologist/educator. I should note that the psychologist also taught formally, and saw herself as an educator in her role as therapist as well. Not surprisingly, the key informants' experiences around compassion coincided with their students/clients experiences around stigma and trauma. The action part of their compassion came from giving others the chance to just be, existentially and essentially (Sartre, 1943/1956). That permission gave the students/clients an ok place to be with their knowledge, and it often gave them voice, sometimes from hearing voices that they could relate to, and always by being encouraged to be themselves. As demonstrated with JM, the lack of compassion training in the home and /or school environments does not necessarily preclude one from living a compassionate life (Seppala, 2013). However, that experiences of the key informants do raise the question of how structural educational concerns inform the relationships in the classroom. I will address this in the *Implications for Educational Leadership*

section.

The Knowledge of Trauma: Innocence Lost through Violence

All my key informants were very forthcoming about identifying the prevalence of trauma among those whom they served and had many, many stories to relate. Recall that trauma is pervasive across SES (American Psychological Association [APA], 2016) and that exposure to trauma has been documented as an occupational hazard among service professionals (Figley, 1995; Potter et al., 2015). Trauma comes from violence, whether that violence is perpetrated physically or psychologically (e.g., Chesler, 1986, Faludi, 1991). Positionality, as dictated by factors of race, gender, ethnicity, and poverty, for example, does, as well, increase community and individual exposure to violence and subsequent trauma (APA, 2016).

JM spent 20 years at a very white, upper middle class university in the Midwest. Few students of color were present on the campus, and even fewer students from poverty. JRR spent eight years working with military members, across SES, and more recently with community members often referred to her by other psychologists. JRR does not charge for her services, so she does not ask about her clients' SES, unless they bring it up. As poets in the schools and professors, PU and WPR were often sent to rural, reservation, and impoverished areas—low SES--where most of their stories came from. Students' experiences with violence were frequent, exposing all four key informants to the invisible, and sometimes visible, wounds of others during the course of their life's work. The levels of pain around trauma are evident in all of their stories.

JM. "'Babies fell apart in my hands.' That's what he said." JM did not know what to make of this comment, but respectfully listened to the student, and she shared that he seemed satisfied with her respect and with her listening. However, there were few colleagues with whom she could debrief. The general response from administration was more "You can't be letting

people say things like that in class. It upsets the other students." She reported that administrators and colleagues erred on the side of silencing students and, by extension, professors.

JM also encountered a student who, in a film class after watching *Psycho,* reported that her sister had been killed in a shower. JM also told me, "In a travel writing class, I had another student who had lost a brother...her parents had bought her a Volvo because her brother had been killed in an auto accident, and they wanted the safest car on the road [for her]." These two incidents are examples of how unexpectedly and how frequently trauma raises its head in the everyday classroom.

And then there was potential self-harm, if not suicide. JM said:

> *I had one highly functioning autistic student just a few years ago. … But in that class ... It was like half way through, she's getting sophomore slump and every day is when she just wants to eat worms, like all of us. Because of my unfamiliarity with that disorder* [autism], *I don't know that much about her state; there [were] times when she scared me. At one time, she was tired about something, something was frustrating her, and she was standing at the edge of the stair case and like, "I think I'm going to jump off of here."*

JM told the student that she did not have to come to class, but she would appreciate it if the student would sit on a nearby bench for the duration of class. Of course, JM was worried throughout the session that this student would harm herself, but JM chose to rely on their mutually respectful relationship and chose to not report her to either 911 or to the administration. The suicidal student was still on the bench when JM came out of class.

What is clear is that JM learned from her experiences. She related the above stories fairly calmly. However, little professional development or peer support were offered. Dealing with

overt verbal violence in the classroom and from student to student was more difficult for JM to manage, especially early in her teaching career. She related the following experiences in dealing with homophobia in the course of her teaching.

An off the cuff remark by some student [could] flip me into a mood, especially earlier in my career, when I did not know how to deal with overt homophobia, when it suddenly pop[ped] out of a student's mouth, and I [knew] I [had] gay students. What to do?

...Once in a while [even now], I'll say the wrong thing, something more general than helpful like, "These opinions aren't the only story here."

JM turned to me and said, "You have to be polite in class, insofar as you can. That's usually where you get blind-sided." JM then returned to her experience and her frustration with herself at not being always able to control verbal violence among students: "I remember one girl with brown hair said something really homophobic." It was as if JM could picture the young woman in her seat and was reliving the memory in its telling. "I was completely blindsided by it," she said. "I don't think I said anything helpful."

JM also witnessed micro-aggressions, another form of violence, from some of her peers wielding power, simply because they could. For example, she observed generic violence through policy against students who were ROTC or athletes. "Well, this other colleague of mine would have ROTC students in her class and say things like, 'If you are going to be gone for *that* organization [emphasis JM's], you can't make up the work. It counts as an absence.' She would also do that for sports teams."

Thus, was JM continuously exposed to trauma in her work. While she could recognize it, the trauma in the past and the pain being experienced from the trauma in the present, she let her students name it uninterrupted. Trauma perpetuated by systemic violence was more difficult to

confront and for JM to relieve the inherent suffering caused by it.

RJJ. RJJ expected to encounter trauma in her daily work, as her mission is to prevent and eradicate suicide from the world.

> *I've met with lots of people who have said, "My partner killed himself and I find myself now wanting to kill myself," and I ask them, "What's stopped you from doing that?" They say, "Well, I really don't see how it would do any good. I just don't know how to get out of this pain."*

Regarding another client, RJJ shared the silencing effect of dominant mores in the US, where trauma, pain, and suicide are taboo topics. She said; "... I have a 70-year-old that I'm seeing right now who has only admitted his suicidality just a few months ago." He had been in pain since early childhood, suffering psychological trauma from within the family and community systems. RJJ quoted him as saying, "I actually contemplate killing myself, and I don't remember the last time I actually contemplated that but I remember when I was a little kid thinking, 'Is this all there is? Is this it?'" She commented: "…and [he] knew that he never belonged. He felt he never deserved life. [His was] a tremendously traumatic past. Like we know, trauma is very subjective. He didn't ever look at it that way."

RJJ also reflected her understanding that the violence and its resultant pain can be embedded in cultural belief systems, not just cultural etiquette. For instance, she related her analysis of a Korean adult who suicided (not one of her clients).

> *... remember that Korean ferryboat; not the ferryboat captain, but the ferryboat that went down and all the school children died in it or a good many of them ... I think all of them died—I'm not sure, and the guy that was responsible for putting them on that ferry didn't have anything to do with the actual ferryboat itself but he felt responsible for the death of*

all those children and he suicided, because it was the only way he thought he could make amends for [the deaths and his shame and guilt].

RJJ knew his death came from values, such as responsibility, that he had absorbed by being a Korean in Korea, even when the value and the dictated response made little sense outside of his context. RJJ said, "It [suicide] was socially acceptable on that regard but still not individually acceptable. I can guarantee you, that his family, if they'd had a choice to say whether he should kill himself or not they probably would have said, 'Absolutely not. You're not responsible, buddy.'"

Given these experiences to which RJJ gave voice, we must be constantly vigilant about what knowledge and ways of being that we take in as our own. Bronfenbrenner's (1977) ecological systems theory reminds us (the reader and me) that although we may encounter individuals in our work, the individuals interact with other systems, such as community and culture over time; the sphere of influence may be stronger for systems grounded in power than the individual's reciprocal influence on the systems. Likewise, through the lens of critical social theory, knowledge is revised by the dominant culture, so the messages individuals receive may not accurately reflect their own knowledge gleaned from their experiences. RJJ reminded me of her take on how media influences learning, trauma, and suffering, "GIGO. Garbage in; garbage out." She went on, "I have a lot of brainiacs [brainiac clients] who think, 'Well, now that I've learned this [such as to form a support groups from reading her book], everything's okay.'" "No!" she said.

RJJ turned to primetime TV and its negative system of influence: "I even asked this to my husband the other day, he was getting really depressed about something and I said, 'Let me ask you this, what have you been watching lately on your laptop? What are you watching?'" He

was watching shows like *CSI: Special Victims Unit*—lots of violence, death, and incarceration. She explained that the individual is responsible for attending to what he/she takes in from more dominant systems, not in a blame-the-victim or the client-is-at-fault kind of way, but in a being mindful way. She continued:

> *If you are not vigilant for the rest of your life, let me tell you something, all those things that have given you trouble are in the closet doing push-ups because you're not paying attention. What you got to do is keep all the closet doors open, and keep looking at things; what you are stuffing in there.*

RJJ's insight reminds me of Anne Lamott's (1995) insight, "if there are rooms in the castle which you have not explored, you must. Otherwise, you are simply rearranging the furniture" (paraphrased fairly closely).

RJJ practices dialogue with her clients. She gets them to tell the stories of their experiences and to make meaning of them. Stolorow (2004) called this "psychoanalytic phenomenology" (p. 668). RJJ calls it motivational interviewing. What is interesting is that both RJJ and Stolorow (2004) have found support for themselves and for their clients in understanding the emotions and their relationships to the physical body. RJJ grounds her work in neuroscience as she works daily with clients who have invisible wounds.

PU. PU identified the suffering in her students before turning to name the traumas, "The students that I had, I don't know if you call these invisible traumas or not, or visible and invisible traumas--these students suffered." While PU did not initially address SES, she was certainly aware of positionality, including SES. She related: "Many of the students I had were war veterans. Students suffered emotional trauma from child molestation to bullying to rape to gang

violence. All of the gambit, it ran a gambit because I taught in so many different venues to so many different students."

PU shared the physically visible trauma of one young student: "Well that student, who never wrote and never talked in class, wrote a poem the first day and it was called "The No Face Man." It was about the time when he was a child when he was severely burned on his face."

She shared, "It was such a huge trauma all around me." PU continued, "We don't have a common experience space to talk from or speak from" referring to the trauma caused from within the school system itself. Many times, those who become educators are those who found solace in learning and studying; they found, in school, a place where they were accepted and even excelled, or they found a place into which they could escape from their own traumatic experiences and be themselves. Thus, PU experienced a dissonance between her own learning experiences and those of her students. She could also see some differences in natal positionality, some of which she and her students shared, such as poverty, and some which they did not, such as race and gender. So she continually sought to bridge the experiential gap by bringing in appropriate materials and by not over-dressing, as if she was wealthy.

In contrast, PU related that "Right now I have a student who grew up in a very upper-middle-class home who lived the country club life… She also suffered terrible physical abuse from her father." PU shared that she could not relate to the upper middle-class lifestyle, but that could give her student room to express herself safely.

WPR. WPR experienced some systemic traumas of his own, couched in diversity practices. For instance, in one interview situation, he was invited to interview because, as the department chair said, "We thought you were Black." The search committee had made this

assumption based upon his name, his place of birth, and where he had so far chosen to ply his trade.

Additionally, WPR commented on the systemic traumas caused by poverty. He said, "I realized how poor they were." As a visiting writer, and in a university classroom, it is not the norm to bring food, so that students can focus on learning. One only needs to look at the OPSI (2014-2015) most recent data on school districts in the South Puget Sound, to realize the huge numbers of students who rely upon their schools for food, as evidenced by the free and reduced lunch data. Note that these data are often under-reported, as not all parents, such as non-native speakers of English, may understand that they can apply for help with food for their children during the school day. As well, once a family reaches the dividing line for acceptance into a free and reduced lunch program for their children does not mean that they have the resources to feed their children adequately for their brains to work and for their children to concentrate—it just means that they are no longer eligible. Finally, applying for free and reduced lunches means that a family must admit poverty, which bears a stigma of its own.

Another systemic issue which WPR broached was bullying. With a group of young students, he again breached his own stigma against using formulas for poetry writing and employed the formula, *I am an X; then say what happens because of this identity.*. I find this particular formula fascinating because it asks the writer to make a metaphor and then to make meaning from that metaphor, which is what this study is all about. One student wrote, "I am a football. People like to kick me around." Painful.

The final traumatic example WPR considered was identity and performance. He said, "I was terrified of the idea of standing in front of anybody, saying anything," about himself. Yet the standard of US education is performance (US Department of Education, 2016), whether through

excelling on a standardized test or by being expected to be the best in sports, drama, etc. Public speaking classes force students to perform and to excel; the students are graded upon excellence in articulation, innovation, being within the time frame of the speech, and so forth. Yet, not all cultures value individualized excellence; rather, they may value process—e.g., the growing skills of children into community members and the continuation of culture (Pughe, 1986, Indigenous pedagogy designs for Medicine Creek Tribal College).

Additionally, regarding trauma, my key informants and I discussed the paradox of when to report and when to not report. Each interviewee chose how to maneuver within the systems in which they worked, and which designated them, under US Federal law and state laws (e.g., 42 U.S.C. § 13031 [children]; The Elder Justice Act of 2010; RCW 27.40 [children]; WAC 388-101-4150 [vulnerable adults]), as mandated reporters (see Flaherty, 2015 [college students]; Flanagan et al., 2009 [systemic pressures on practitioners]).

JM reported, regarding her potentially suicidal student above, "I could have been fired," yet she still gave her student room. RJJ said, "It's about acceptance [of the person who is suicidal]." She talked about systemic dysfunction when clients were incarcerated, saying, "One of the patients said to me when he went into the hospital for his suicide attempt, the psychiatric nurse came up to him and said, 'How can you do this to your children?'" She implied, not subtly, that all mandated reporting and incarceration are not helpful; however, she did not say that she would never use her mandated reporter status to help someone in grave danger of death.

In contrast to RJJ and LM, PU simply refused to sign the paper from her university which stated that she was a mandated reporter and would comply with the explicit directives around being a mandated reporter. She said, since she chose to leave the tenured position, "They probably would have fired me…anyway." In support, she related, "I was appalled because my

job as a teacher has been to, not to counsel students, but to direct them to counseling. And to be able to talk to someone they trust," as if educators are not among the group of trustworthy folks. "The next week, here's a girl who comes to talk to me about being raped. Well, I didn't turn her in. I allowed her to talk to me."

What follows in an excerpt from our interview transcript.

PU (female): She needed to talk. She needed to get it out there. And she did. She's counseling on her own. It's something I think just the two of us she should have done that anyway, but I think just being able to talk to a teacher that she admired and trusted helped, you know that helped.

BGP interviewer: Right and so that's part of the stigma of the workplace that we have these built-in systems that create artificially clear lines between professions. So I can't tell you how many times I've been told as a teacher and as a professor, you are not a social worker.

PU (female): Right. Exactly. Well, yes, we are social workers. I'm sorry.

PU's need to apologize shows how systemically inbred is the territoriality among profession and the potential harm it can do to students when one is required to report their confidences.

WPR did not comment, in particular, about mandated reporting. Instead he talked about the role of the teacher vs the role of the syllabus, which also decries the uniqueness of the student and the student-professor relationship. WPR said, "A teacher should be someone who's educating himself in public." This means that teachers take risks and are vulnerable. In contrast, the syllabus can undermine the risk-taking and conform to regimentation of the dominant culture in higher education, WPR said, sarcastically, "I love the regimentation of cultural artifacts, like

knee-jerk patriotism and conformity…not violating the borders because you know that supposedly that's not going to help you." He continued, "The sentiment comes from without; it comes from the culture [of the system], instead of the individual self-defining…One of the things on the syllabus is that it reminds me very much of what happens in prisons to keep prisoners from getting together and expressing whatever discontents they have. You just have to keep them busy. His wife, PU chimed in, "[When] you have that regimentation, then you don't have the validity of discovering things together as teacher and as a student. That's the most wonderful thing to me is when we discover things together. We learn something new together." WPR agreed.

Compassion Fatigue

Sometimes, it is the prescriptive, unexamined nature of a system's ethics and the fear of litigation due to the embeddedness of the dominant cultural mores in law which force resultant compassion fatigue and cultural isolation.

All of my key informants understood compassion fatigue, if not in themselves, in others. It was not a term all of them had heard, but it resonated with them. JM experienced compassion fatigue as exhaustion and pain. JM also conflated compassion fatigue with empathy fatigue and described her responses as being closely related to cultural isolation, which I will take up in the next section. RJJ experienced compassion fatigue when clients refused to engage in their part of the work. PU also conflated compassion fatigue with empathy fatigue. WPR described compassion fatigue in terms of the systems he worked within, rather than about himself. Perhaps because we (the researcher and the key informants) got stuck on the questions which most interested the interviewees, there is less, though still important data on compassion fatigue. Interestingly, the female interviewees experienced compassion fatigue related to physical pain.

The one male interviewee did not. Instead, WPR sought a positive spin on his experiences.

Because the convenience sample was small, and I was interested in them voicing their experiences, this observation is not generalizable, as the rest of the data are not, but it would be an interesting study in the future. The Intertribal Medicine Wheel (K. R., president of Medicine Creek Tribal college, et al, personal communication, circa 1996)—the version I use originates from indigenous peoples in North America--provides an interesting schematic from which to view this seeming gender imbalance, especially when looking at the impact of imbalance on physical health (see Figure 1). The Intertribal Medicine Wheel represents individual, community, and cultural health as a balance among physical, spiritual, emotional, and intellectual health across races (K. R., president of Medicine Creek Tribal college, et al, personal communication, circa 1996). While the wheel is depicted in the four colors of races (Red, Yellow, Black and White), tribal elders and scholars have not yet associated race, sex or gender-preference with any one attribute of health or balance (K. R., president of Medicine Creek Tribal college, et al, personal communication, circa 1996).

My point in bringing in the Intertribal Medicine wheel is to remind me and the readers that there are many ways of interpreting knowledge, experience, and culture, which are outside the norm of the dominant culture, thus tying my key informants' stories directly to critical social theory and to acknowledge their value in and of themselves. How each key informant connects to his/her passion can form the crux of meaning-making.

JM. JM's first identification of compassion fatigue had to do with organizational structures. Years ago, I had shared with JM Anne Wilson Schaef's (with Diane Fassel, 1998), *The Addictive Organization*. Regarding compassion fatigue, JM referenced the influence of her university, saying, "Because of my job that I left, before I moved here, [I] had many issues."

Here, she noted the personal impacts of a job. She continued, "[When I went to my new job], it was another addictive organization."

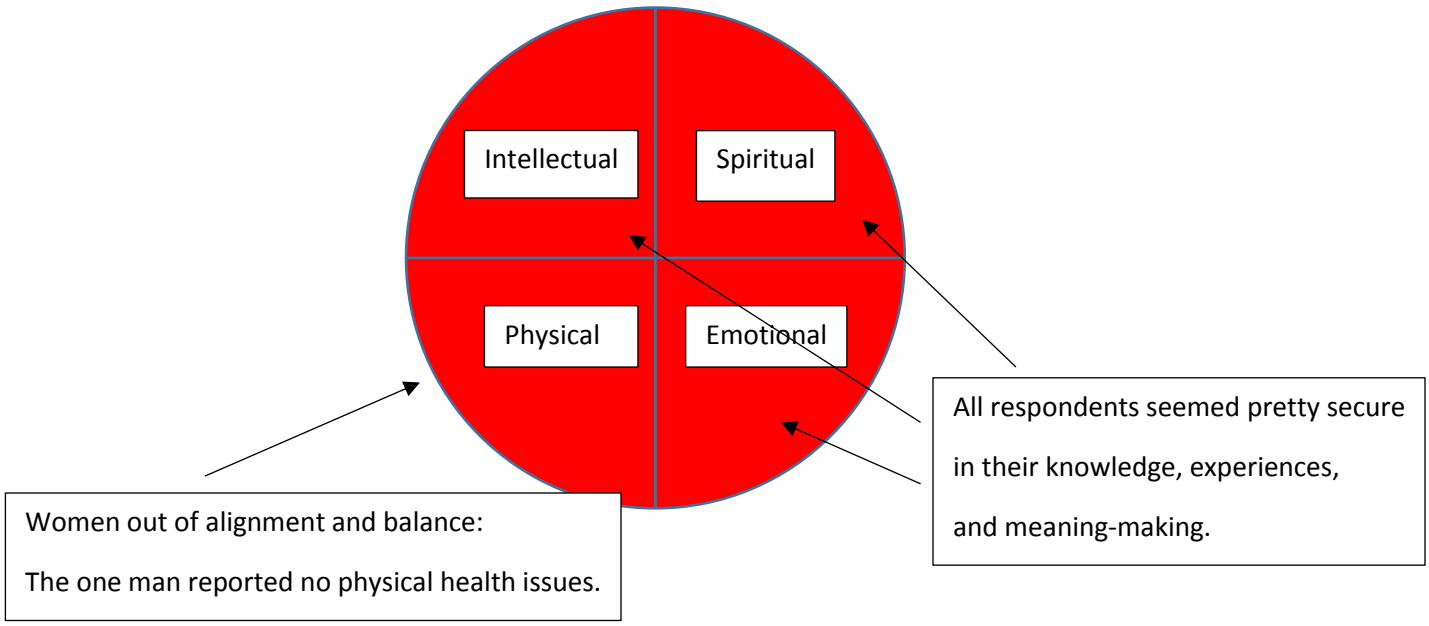

Figure 2. The Intertribal Medicine Wheel

Schaef and Fassel (1998) defined an addictive organization as "the operational style of the company" (p. 43). The characteristics of an addictive organization resemble those of an individual addict (Schaef & Fassel, 1988): 1) *Denial*: Sure, we have problems, but they are not so different from other organizations, thereby creating norms of dysfunction, such as judging, stigmatizing, abusing, and isolating employees; 2) *Confusion:* Employees spend an inordinate amount of time trying to figure out what is going on, trying to predict what will happen next, and trying to make plans for how to deal with the next dysfunctional situation; 3) *Self-centeredness:* The organization and its leader are the center of the universe; therefore every action and situation are either for or against the CEO and the organization—dualism reigns; nuance is expunged from

the environment; 3) *Dishonesty:* e.g., lie about the criteria for success—hide data, dress for success, etc.—"Addicts lie to themselves. [They] lie to people around them…and they lie to the world at large" (p. 63)—the organization misrepresents itself to its employees and to outsiders; 4) *Perfectionism:* the notion that trying is enough, without reference impact (vs. intent)—our mission is a good one; 5) *Illusion of control:* being out of touch with the real world and the influence over the real world—the illusion that the organization is making a real difference, without any harm attached to its actions; and 6) *Ethical deterioration:* being "spiritually bankrupt" (p. 67)—"refusing to let information in that would alter the addictive paradigm" (p. 67). The addictive organization seeks to form cultural norms which give it false power. There is a corporation system [which may be a reflection of dominant society], which is different from the world many women and minorities inhabit" (Schaef & Fassel, 1998, p. 43): "Organizations themselves function as addicts, and because they are not aware of their functioning, become key building blocks in an addictive society, even when this dramatically contradicts their espoused mission or reason for existence" (Schaef & Fassel, 1998, p. 54). While it is beyond the scope of this narrative to delve further into the metaphor of addiction and systems, it is critical to acknowledge JM's experience and to understand that systemic dysfunction intersects with human beings who transverse the systems on a daily basis (see Bronfenbrenner, 1977), and that this interaction can exacerbate compassion fatigue. As well, to me it suggests that the Intertribal Medicine Wheel can apply to communities and to organizations as well, as a model for balance among constituents and as a model for self-critique.

JM also shared that compassion fatigue results from a lack of support and misperceptions about credentials, of which one is proud, not just from over-exposure to the trauma of students with whom one interacts. For instance, she said,

> *This other colleague of mine thought that the MFA that she had was exactly equivalent to a PhD because someone had told her that and because that was in the context of everyone where she was arguing for better pay and more security people. There's that argument that's good, but to claim they are exactly equivalent shows that she does not understand the kinds of work that additionally happens for a PhD because there is much more in-depth work on some things. She would not credit the difference.*

JM also had an MFA, so she understood the difference between an MFA and a PhD from her experiential point of view. Yet, clearly, she wanted the acknowledgement from her peer, which was not forthcoming, and because tenure was based upon her PhD and not upon her MFA, upon a different set of criteria. Thus, for JM compassion fatigue had a systemic source, regarding the norms of what certain degrees mean, as well as a personal source of exhaustion. Her compassion fatigue was integrally linked to her experienced lack of support from colleagues.

JM shared, "I do become tired just from the sheer work." She also shared her take on empathy fatigue, particularly as it has to do with her energy expended on grading and commenting on her students' papers. First, JM likened the difference between empathy and compassion: "I do see the difference between them [empathy and compassion] as compassion more of a, "Can we work on this?" Empathy is trying to put oneself in another's shoes just to understand"

JM went on to explain empathy fatigue in teaching writing as the continual need to encourage students to grow in their writing. I actually view this as compassion fatigue, as the commentary includes the need to alleviate suffering, though the students may not know they are suffering—just working hard.

> *I can get tired of that, too, because in our intellectual work I do that so much. I*

think, probably, some of it comes straight out of having to grade so many papers. Having moved from, in the style of my grading, and this is mundane, but I think it relates, to trying to crack what the writer's trying to say in these freshman essays or sophomore essays, to say something to them that will relate to them where they are in an encouraging way, which isn't necessarily compassion.

I think it's more empathetic to say, "I really like the second example," even though the rest of it is really incoherent, and kindly try to say, "These are the top two things you might want to work on." Framing that becomes very tiring…I see it as good writing because I'm writing most of these comments. It's, of course, filtered into my speech. I've tried to learn to say things in a better way even though I still have a lot of trouble with it. I get tired of doing it.

JM's fatigue is represented by her need to just read a thriller or a mystery novel, or anything that does not take intellectual energy. Sheer entertainment will fit the bill.

Sometimes I just want TV-with-pages [my phrase, which JM has adopted over time] *or sheer stimulation; it's just like, "I'm going to read this article about curling or something," or just watch the Olympics for three weeks or whatever it is.*

Finally, JM shared compassion fatigue as a violation of ethical boundaries between teacher and student, having to fight a systemic lack of boundaries at her university of tenure. JM said, "I became suspicious of institutional urges, in the case of my last position, to be really super buddy-buddy with students. The standards [were] set by people who were not me." She continued, quite passionately on this point, saying, "There was this pervasive, [the practice that] 'We're all friends here, and it's this wonderful little family,'" which was in sharp contrast to her experience with the prejudice of some colleagues against ROTC and athlete students. She said,

of her departmental colleagues, "Some people just totally bought that. They wanted to bud around with their students all the time. Their students were their best friends," clearly distressed. Her comments reminded me of the 1970s and 1980s when some professors and doctoral teaching assistants felt few qualms about drinking with, dating, and sleeping with their students (personal observation). In graduate school, because applications and acceptance into a program required choosing the person a student would kill to study with, and vice versa, it may have been less problematic, though there was still a power differential present. However, with undergraduate students, I believe one must question the motivation to be too close.

JM couched the pressure to be "super buddy-buddy" within her own comfort zone. Her perspective meant that she had to continually and overtly be outside the norms of her department. She said,

> *That's not me. Number one, we [the students and I] don't have that kind of rapport. Number two, it's not appropriate really because boundaries…There are certain boundaries I have. I don't want to do some of those things. Then, of course, you can get in trouble with some of those things, [i.e. being in too personal of a relationship with one's students], …[like getting fired]*.

JM was not empathetic with her colleagues around their behavioral norms within the favored buddy-buddy system regarding their undergraduate students. She acknowledged that "Some students give you signals to find out if you want to be budsy or not. There were a few students with whom [I had] a rapport because they recognized king of a kindred spirit in me," but the rapport was around compassion and teaching and learning, not being buddies for the sake of being buddies. JM recognized that we [teachers of many sorts] have students with whom we connect, and that students connected to her by her really listening to them, but being fast friends

with students was not the core of her teaching ethic. She did not find this ethic antithetical to respecting her students privacy, when they needed her to let them just be (e.g., autism and potential suicidality), or when they need her help to navigate the systems ROTC and athletic scholarships, within the context of academia.

Nor did JM want to spend all of her free time socializing only with her colleagues. She said, "I ended up withdrawing…from that culture partly, too, because if you are a squeaky wheel about some things [such as fairness and inclusion for all students], eventually the dean [and others] won't listen to you." JM has and had a broader range of interests. It was a challenge for JM to navigate this system of norms, especially when the system decried a personal life, with personal privacy. She commented, "They didn't really want me, and I really didn't want them." JM's experiences with compassion fatigue were often associated with the sometimes dysfunctional norms of the system within which she works, and which was narrower than the systems she chose to interact with more broadly (see Bronfenbrenner, 1977).

In terms of critical social theory, the systems within which she worked, were trying to pressure JM into conforming with their knowledge and their norms, which caused compassion and empathy fatigue. Her experience with exhaustion is only sometimes mentioned in the extant literature in relation to compassion fatigue (e.g., Hydon et al., 2015; Potter et al., 2015).

RJJ. RJJ's experiences of compassion fatigue were confounded when clients bought into the status quo of the medical model--having a diagnosis and expect her to cure them. She shared:

People come in here and they say, "What is my diagnosis?"

I say, "I have no idea. What do you think your diagnosis is? Is it important? You need a diagnosis? You're going to write it down?"

Because we're trained to need a diagnosis so we can find a cure.

I would say to them, I say, "Well, what do you think your diagnosis is?"

Well, everybody says, "I'm depressed."

They say, "You're going around circles."

I say, "No. What you want is to put a label on you and I'm not going to put a label on you because there ain't nothing wrong with you. There is nothing wrong with you."

For RJJ, conditions do not represent the identity of a person, nor do they establish his/her worth as a human being. Validity of the person, for her, is not congruent with diagnosis; in fact, she shared that labeling, through diagnosis, can diminish a person. Thus, RJJ has little patience for the exosystemic and learned needs for labeling. This impatience feeds into her choices of clients. While, RJJ is willing to work with many people with suicidality, those her want her to produce a "magic bullet" or cure, may not find themselves in her circle of care.

Regarding compassion fatigue, RJJ said, "I would love to say that I don't suffer from compassion fatigue. I don't know whether it's compassion fatigue." And then she shared this story:

Just recently, I've been working with a young woman for a year and a half and I have successfully gotten her from being probably the most suicidal person that I've ever worked with to being someone who really understood her suicidality and really had control of it and was starting to move forward in her life and then she took this massive step back. She expected me to wave a magic wand and make it all better.

Their negotiations were complicated by email correspondence.

…and I told her that I was sorry and until she had a way to communicate with me, we could not do it by email because I said, "Your explanation here on email is getting all confused because you're reading my comments in the mood that you're in; I'm reading

your comments in the mood that I'm in; and I'm not sure that we're even on the same page here."

Finally, RJJ reported,

She just sent me back an email, "So this is how you dismiss me?" and I thought, "You see. You know, my information about this email stuff is valid." Email is not a good way of dealing with these kinds of issues and I told her, I said, "I can't do this anymore," so she saw that as me just cutting her off. I said, "You see? This is why. This is exactly why." I said, "I am not abandoning you," and I said, "You've already told me you have no gas to get to me, you have no minutes on your phone, and I said we cannot do this on email. It's just not going to work." The questions is, where is she using her minutes on her phone? She's got to make a commitment to calling me and using 50 minutes or an hour and a half on the phone to me, but she won't do that. She wants me to wave a wand.

RJJ's compassion seemed to end when there was no reciprocity in the relationship between provider and client, teacher and learner. RJJ is not a fixer, she is a co-conspirator towards life.

This client, whose story is related above, is a far from isolated incident. Rather, it is a norm (F. G. F., L. J., & D. K., personal communication, 2008-2014), which demonstrates the need for RJJ's strong boundaries around service and self-protection from compassion fatigue. She said:

The next day, a girl, who is another individual, says, "You have to fix me. It's all a society's fault that I'm this way. You have to fix me." I said, "No. Mm-mm, I don't have any way to fix you. It's up to you," and I said, "I'm here, that's all I can say."

RJJ also acknowledged fatigue in her professional life around public speaking and stigma, which I liken to compassion fatigue. One tries to share the good news that suicidality can

be a non-fatal condition (Jensen, 2012) and to educate those who purport to be most concerned about suicide. JRR had been invited to speak at JBLM about suicidality during national suicide awareness month—September of each year. The joint forces, especially the army, had initiatives to reduce suicides among military members returning from combat in the Global War on Terror (GWOT, Ritchie et al, n.d.). JBLM and MAMC dedicate one day each year to suicide prevention education. RJJ shared this story, which emphasizes the systemic catalysts to compassion fatigue and their relation to stigma:

> *You know last September, during the Suicide Prevention month, I was asked to speak at JBLM. Stephanie Brookes brought up my name and said, "She [RJJ] would be good [as a speaker/trainer] for this day of suicide prevention." She told them that Randi won't speak for free. That's it. And I told them, "Okay, if you want me to come and talk, an hour talk is $1,500." The reason why I got that money upfront was because...I knew that I would get my money upfront, but I was going to go there…When I got there, they [the organizers] had all the vendors upfront of the French theater, and it was all nicely done, and I got all mic'ed up and tested and everything. Nine o'clock came, and there was no one there; 9:30 came, and there was no one there; 10 o'clock came, when I was supposed to talk, [and] there was still no one there.*
>
> *Here's how dedicated and how strong the stigma is in the military. They paid me $1,500 to go out there and talk to 8 people who weren't even the people that they wanted to hear anything. That's how strong the stigma is, that no one wanted to be seen even approaching that theater. Does that mean there is no suicidality on that base? No.*

While RJJ agreed during our conversation that there is always value in speaking to a few people, as the word spreads and more may show up the next time, a systemic lack of support

can lead to compassion fatigue—not for the individuals who need the information, but as an overall reaction to the stated support, which in fact is not forthcoming. In this instance, it is not that there was no advertising and marketing done for the event, because there was. What was lacking was Command support. RJJ said, "The stigma is so strong and continues to be strong, that without a mandatory requirement, everyone is terrified to show up, and that's the bottom line." The event was not mandatory for military members indicating lack of systemic support and resulting in RJJ's frustration. Thus, these results for RJJ may indicate *frustration* as an elements of compassion fatigue, not previously mentioned in the literature.

What is exhausting, re compassion fatigue, is that RJJ has spent many years of her life serving military members and their families "off the grid," i.e. when military members and their families felt that the stigma was too great to be served for PTSD, TBI, and/or suicidality within the military system, they sought out the services of *The Soldiers' Project*. To be invited as a paid professional to the base of a major employer in the Pacific Northwest and the location of I Corps, and to not have the support of Command, can only exacerbate compassion fatigue (Bearse et al., 2013). So the compassion fatigue is not about the Soldiers; what may result from a lack of resource support-- especially around humans, and which includes audiences--is burnout (Ledoux, 2015; Potter et al., 2015; Salloum et al., 2015).

PU. PU endorsed compassion fatigue in relation to her own health. She said, "I don't know if it's compassion fatigue or empathy fatigue because I get a little confused. I did suffer from that teaching in prison. Sometimes, I would feel as if my soul was sucked dry." She continued on to say that, "It was just too much. Sometimes, I would just come home and collapse and think, 'Why am I doing this? Can I actually finish out the semester? Will I survive this?'

That's what I think of when I think of compassion or empathy fatigue." She likened her exhaustion to surviving chemotherapy, which she has and which she shared.

In PU's recount, it is important to remember that compassion fatigue has been chalked up to being simply a cost of being in the service industry (Figley, 2002), which is not acceptable. Through the lens of critical social theory, to cause declining health, simply by virtue of one's position, is unacceptable. The voices of the workers must be asked for and heard, in order to increase agency and the potential for humane change (UNGA, 1948).

WPR. WPR framed his notion of compassion fatigue by examining the power and responsibility of the individual with what he/she is willing to do within the system in which he/she works. To him, the learners were core and grounded in positionality. Leading to his comment, PU, his co-interviewee and wife, had said, "Well, the only way that we can actually effectively build bridges between races and genders is to be in the classroom. There's such an effective tool if we approach it with humility and being open to learn [from our students]." He replied, "The power of the teacher is very much inflaming a balance with what you permit yourself and what you permit them [the educational system and the students] and what you bring into the game. The more you can bring in of yourself, the more they [mostly the students] all bring in of themselves." So, to WPR, his focus was not on compassion fatigue, but how to act to prevent fatigue in students around learning and in teachers around teaching and learning.

Cultural Isolation

Cultural isolation is not so easily parsed from the experiences of bringing stigma to the table in one's professional interactions with clients/students who have or are experiencing invisible wounds from trauma, and experiencing compassion or empathy fatigue as my key informants have described them. Cultural isolation is bound by systemic norms which have

already entered the conversation), a degree of bullying by those who are dominant in the system (by way of analogy, see Cohen & Brooks, 2014), and a degree of testing to see if one really belongs in an elite system (see Knaus & Brown, II, 2016, also by analogy). Thus, cultural isolation is directly related to the oppressor oppressed relationship (Freire, 1970/2000). Ironically, all interviewees were much more aware of their systemic cultural isolation than they were of their personal compassion/empathy fatigue. It was easier for them to name systemic influences and to give examples of cultural isolation than it was for them to name their personal compassion fatigue and to describe examples of compassion fatigue.

JM. In two teaching situations, JM found herself outside of a systemic in-group. At her first assignment after her PhD, she was denied tenure. She was judged by colleagues within and outside of the department. She said, "The way some people would treat me then [was], suddenly, as if I had leprosy."

In Hungary, where she served as a Fulbright scholar, studying Hungarian film, her stories suggested that she was completely accepted. Perhaps this acceptance was due to her elite status among scholars, with the Fulbright appellation. Or perhaps her acceptance was more internalized; JM was pursuing a personal passion and exploring a new culture.

Then JM came back to the United States, to the Midwest. At that university, as described above, JM was pressured to have more personal relationships with students than those congruent with her own values, and she was pressured to have more social interactions with her colleagues than she found healthy or tolerable. She said,

> *As a creative writer [poet] and scholar, some people don't take that seriously. Being super-buddies with students was excessive. When I didn't do it, I was seen as insufficiently committed. There was not really a sense of balancing one's work life*

[teaching and publishing].

JM's own values around teaching, scholarship, and creative writing caused a rift between her and her colleagues—ousting her from the in group. Thus, she was isolated culturally, perhaps for the same reasons she was hired in the first place. While JM was in this position, she published two books, one of poetry with other women and a book based upon her PhD dissertation. She also went on to publish numerous articles and book chapters, which she continues to do in retirement.

Additionally, JM experienced professional jealousy due to her research and publishing. She said, "In terms of isolation, because I was a productive writer, there was a lot of jealousy." However, just as JM was cautious about protecting her students, she was a bit reticent to pin down her colleagues attitudes; she struggled to clearly link her experiences across the themes we had been discussing, sometimes blaming herself.

> *Productive and publishing. I'm sure the jealousy ... Because it's hard, as you know. So people would ... Part of it would be that they were jealous of me. So, then I was targeted by some people, again. I think, "Is it my manner that calls it upon me?" I don't know, but there was a person there who was as bad as some persons you may have known in the past. It set me apart because people were spending all their time having parties for students and being buddsies. That was their excuse, if you will, for not really wanting to make the effort to do writing). Maybe they didn't care about it [publishing] that much. That's okay. But, then, to push me out...That's what happened…It's okay. It is what it is.*

JM's use of the word *again*, "I was targeted by some people, again," exemplified her meta-consciousness that these behaviors, and JM's making meaning from her own words found her interpretation to be less individualized than systemic.

JRR. JRR's experiences with cultural isolation were also conflated with the her

experiences with stigma and compassion fatigue, which I have described above: the refusal of the American Society of Suicidality to acknowledge her book; the passive-aggressive lack of Command support to voluntarily release military members to attend her talk at JBLM during National Suicide Awareness Month, during which training is mandatory for all soldiers and civilian personnel; and her decision to open her own counseling business for persons suffering from suicidality and to not charge for her services. Cultural isolation, however, came with a cost, and it is most evident in her withdrawal from *The Soldiers' Project*, a non-profit service attending to military members with invisible wounds, such as TBI and PTSD, outside of the military system, so as to provide non-judgmental and confidential services to them.

RJJ founded and directed the *The Soldiers' Project* for many years. It was work grounded in the passion of service, but she left due to personal and professional ethics, which also caused her to feel outside of the organization.

> *I don't know what happened to* The Soldiers' Project*; they're kind of gone now...I left several years ago, and they've gone through several different people at the helm. All, I know is that I haven't heard from anybody except asking for donations. I say, "No way. I donate my time." I got out of there because I felt it was not on the level [as a responsible organization].*

Sometimes, as critical social theory suggests, economics can drive an organization, rather than ethics or service (see Eagleton, 1976; J. M., MD, personal communication, 2015). RJJ went on to say how corporate and financial structure drove *The Soldiers' Project*, causing her to be isolated from the board and from the accountants, which drove the derivative corporate cultural system, rather than the service-oriented and community educational systems she had signed on for, and which she ran. JRR related that:

> *Something was going on. They were not using the money for what it was designed to be used for or agreed to be used for. Something was up. I didn't know what…simply because I could never get straight answers from anybody. I never saw a budget; I never saw rendering of any money; I didn't know where it was going or where it was coming from. We* [the service professionals] *never saw a bottom line, and even the report they* [presumably the bean counters] *sent out—it didn't say anything. I brought this* [the report] *over to my accountant, and I said, "Look at this." He said, "This is the most spurious thing I have seen in a long time. This is laughable. It's ridiculous."*

RJJ agreed that the report was, in her words, "Crap." In an organization she had helped to found, she was isolated from the culture of its financial mechanisms, which seemed to be in direct conflict with the mission, visions, and values of the organization—service for military warriors, veterans, and their families. Confidentiality in service had been usurped by the financial powers from service providers, including educational leaders, such as RJJ. The usurpation of financial power, which then includes the usurpation of shared knowledge, is a foundational element of critical social theory, which calls for dialogue and veracity (Berg & Lune, 2012; Freire, 1970/2000).

Still, JRR said, looking at the positive side of her service before cultural, systemic isolation, "I still probably have 10 people from *The Soldiers' Project*…that check in with me every now and then, and they are all over the world now." Her ethics of honesty, transparency, and authenticity (Jansen Kramer, JR, 2011) have sustained her in moving forward to fulfill her mission of eradicating suicidality from the world through one-on-one service.

PU. PU experienced cultural isolation through positionality more than anything—her growing up in an impoverished immigrant family home, her exposure to multiple languages in

her upbringing, her being a pretty white woman—combined with her ethic to put her students first, especially in her need to create a connection between them and the material she was teaching, if not between her students and herself. I have already reported upon PU's femaleness, whiteness, and blondeness, though I should share that she said:

> *I am culturally isolated because of that [from her students and the systems within which they reside], and it's something I have to overcome in order for them to trust me and in order for them to know that I am not the stereotype that they have come to associate with a blonde young woman or a blonde woman. And that's a big stereotype.*

In this, PU was culturally isolated from her students' individual, family, and community systems, rather than from the other more formal educational systems within which she worked.

PU also acknowledged the invisibility of her students as part of her own cultural isolation. She said, "You see those students, and so many of them are invisible" in the educational system and in the broader, dominant cultural community. In working towards her students sense of their own worth and visibility, PU may have been isolating herself from the dominant systems, as a reflection of her ethics and her passion. For example, PU acknowledged the role of the syllabus, at least in higher education, as contributing to the problem of cultural isolation. "I think with the evidence of standardized education and [the] standardized syllabus, that [it] is just a disaster….Can we just read some poems?" The standardized syllabi and curricula served to isolate her and her students from the real work at hand—getting excited about learning and creating in a meaningful way, a way that resonated between co-learners, teacher and student. Standardized curricula prevent the individualized and cultural ways of making meaning among different disciplines, and more importantly, among different students (e.g., see McGee & Banks on equity pedagogy, 1995). Thus, standardization isolates the teacher and the learners

from making their own meanings from experiences, rather guiding them toward making the meanings which the dominant culture prescribes (Freire, 1970/2000, McGee & Banks, 1995) through educational systems. Thus, PU's experiences of cultural isolation were communal in the classroom. Her stories bear witness to these phenomena.

WPR. WPR described his experiences with cultural isolation through his chosen role as a "cultural commuter." In our conversation, throughout the odyssey of his career (though I am not sure that Odysseus's metaphorical coming home to Penelope and their kingdom were a part of the impetus for the journey), he has used poetry as the bridge to prevent cultural isolation between himself and his students, just as Homer used poetry as a bridge between himself and his audiences. This is not to say that WPR did not experience systemic cultural isolation, but that he chose an active response (as did each of the other key respondents in his/her own way) to prevent cultural isolation and to integrate himself into the community, when he himself was an outsider. Whether this response is part of white male privilege is hard to tell. I believe that, as with the other three key respondents, that his integration into the community through poetry (in WPR's case) reflects his own ethic about how to move through the world. WPR related:

> *…and working for the good part of a decade with children on reservations and kids of Vietnam War veterans, Vietnamese in Galveston—a bunch of them live there—I realized how important poetry was. You know, how much more important than I've ever known just by taking those courses at this or that university and talking with this or that poet, which I enjoyed fine. But it wasn't enough until I realized what a great need that [poetry] could fill in a person's life—not just to read it, but to also not be afraid of it and maybe to write something—it didn't matter whether it was poetry or not. But to have that feeling that you get when you write a paragraph about that pie you were eating or whatever,*

> *even something awful. What happens when you put that magic circle around whatever it is you've written? It becomes another kind of shining in your life even if it's a dark shining, it's a shining. You have the power over experience. To understand it, not to change it so much, maybe--but to change your understanding of it, fascinating stuff.*

WPR distinguished between the niceties of cultural isolation in the university and the connection with communities through poetry. He also articulated, by example, how powerful and necessary it is to be in charge of the knowledge you gain from your own experience (Freeman & Vasconcelos, 2010).

Coping & Thriving

Despite the usually systemic cultural isolation caused by the stigma and compassion fatigue when serving survivors of visible and invisible traumas, all of my key informants have remained dedicated and passionate about their careers and service. Despite stigma, compassion fatigue, and cultural isolation, all of my key informants have found effective coping and protective mechanisms, primarily because they have chosen to move slightly outside of, or have always been somewhat removed from, the dominant structures. Additionally, my interviewees have found attitudes (or dispositions, to use educational language), which serve them well. They have found grace in serving their students/clients by bucking the systems which confined them (both the key informants and for their clients/students), and put positional equity and empowerment to the front, through giving voice.

In fact, my key informants all have found ways to cope and to thrive in dominant systems which would have preferred to shut them down. JM moved, physically and spiritually, away from the social system of peers in order to have some quiet space. RJJ followed her heart and her mission, which came from her God. PU guided her practice through building trust and

confidentiality. And WPR has remained a cultural transient. All have also devoted their lives, not just their careers, to providing voice to the silenced and have modeled voice through their own writing, teaching, counseling, and service. The tone and metaphors of their contributions to our conversations are replete with hope. Their actions have been pragmatic and praxis-oriented in answering the research questions:

How do providers/educators experience and recognize the stigma they carry into the helping relationship?

How do providers/educators experience and recognize their own compassion fatigue and sequelae (secondary traumatic stress, vicarious trauma, burnout) which they experience through the helping relationship?

How do providers/educators express and heal from the cultural isolation and subsequent recognition of their own stigma and compassion fatigue brought on by their own relationships to those who they are serving?

In fact, in answering these research questions, especially the third remaining question, tone, metaphor, and pragmatism are central. Behind the tone, metaphor, and pragmatism is pride, not *hubris* (a tragic flaw, a blinding pride that rests within the ego and lacks all humility), but satisfaction in having served others as well as possible and having learned from the process, despite some suffering which may have been incurred to the self, i.e., compassion satisfaction (Seppala, 2013).

Tone. Throughout our interview and follow-up conversations, JM's tone was one of serious consideration. She cared about the topics of stigma, compassion fatigue, experienced trauma–visible or invisible, and how they impacted herself and her students around cultural isolation. Her tone reflected the CST tenet that, "3) Knowledge and meaning-making are

dynamic processes over time" (see p. 15, this manuscript). She said, "It relates to trying to crack what the writer's trying to say in these freshmen essays or sophomore essays, to say something to [him/her] that will relate to [the writer] where [he/she is at] in an encouraging way," to not shut the writer down.

JRR's tone was more emphatic, a this-cannot-continue message, and I will continue to do something about it. Her tone reflected the CST tenets: 2) "'Acceptable' knowledge is defined by the systems of the dominant culture and serves to distort the knowledge and meaning-making of the oppressed" (p. 15, this manuscript), and "5) Those who challenge acceptable knowledge are stigmatized by the dominant culture" (p. 15, this manuscript), especially around suicide and challenging the medical model of practice around suicide.

PU's tone was gentle, considered, and moving. She suggested that, "4) Knowledge of the dominant culture revises the experiences and knowledge of the oppressed" (p. 16, this manuscript), by always bringing in culturally-appropriate and -meaningful content to her students.

WPR's tone was grounded in story and philosophy, primarily non-judgmental, sometimes bearing surprise and always with generosity and humility. WPR's tone was grounded in tenet 6 of critical social theory, "Dialogic and dialectical conversations among the oppressed…provide a way forward" (p. 16, this manuscript). He said:

> *When I realized how poor they [the students in Greenwood, Mississippi] were and how excited they got, I spent the whole first day talking about anything they wanted to ask me—about the rest of the world basically. And then I gave them an assignment at the end of the day because I knew by now, working for several black schools, they like fun. So, I gave them a very simple ballad formula and asked them to do what they could overnight*

and bring it in. I mentioned several songs I knew [from Mississippi Delta Blues]. They knew ballad forms; so when they come in the next day, everybody has a poem. Everybody has a poem! Nobody didn't finish their poem. Nobody was working on their poem. They all had a poem!

All four interviewees seemed in concert in their tone and content with the ideas that conquerors, oppressors, and/or colonizers (often synonymous) create knowledge which is grounded in historical context (see p. 14, this manuscript) and which impacts the potential efficacy of teachers/psychologists serving those who have experienced trauma—that in moving forward, through equity pedagogy (among other possibilities), "Democratic principles give voice to all in problem solving" (see p. 17, this manuscript).

Metaphor. Roland Barthes (1966), Susan Sontag (1978, 1989), and Paul de Man (1979) used structural analysis, metaphor, and textual analysis in their modes of literary criticism to remind us (the researcher and the reader) that the ways in which authors and key informants tell their stories are rife with symbols and metaphors, which color our shared understanding of their meaning making. Briefly, structural analysis gets at signs (symbols and cognitive concepts) and signifiers (words) to extract the meaning behind the related experiences of the narrator (key informant) (Kaplan, 1986). Sontag (1978, 1989) couched in metaphor how she viewed the dominant culture's influence in interpreting the meanings of illness and health through metaphor, which are central to stigma, compassion fatigue, and cultural isolation in this paper. De Man, like Barthes, examined semiotics as critical to understanding text, in this case transcripts and written contributions from key informants. Additionally, Bolman and Deal (2008) suggested that how one views the organizations or settings within which one functions (again the key informants) could be interpreted through a symbolic frame, which included metaphor. Critical social theory

provides the lens through which to examine my key informants' metaphors. Thus, I offer here the metaphors I have found within the transcriptions and notes provided by my key informants.

JM's central metaphors were *fairness in action* and *artificiality*. In terms of critical social theory, fairness in action meant to JM to challenge the historical context of the university curricula and to bring prejudice into play in classroom conversations, to challenge societally- and historically-based assumptions with students who might not have thought about such things and some of whom seemed to have been prone to stigmatizing others (Nadal, 2011). She used the democratic voice in the classroom and individually (CST, tenet 7, p. 17, this manuscript) to problem solve when she could, such as with Natalie, who wanted to jump off of the stairs.

In terms of artificiality, she challenged her power-wielding peers and chose to distinguish herself and her pedagogy from theirs—at some risk to herself and her career—and to place her students' knowledge and experience as important in the context of the higher educational environment—a changing-up from CST tenet 1, "Knowledge is based in historical context," by valuing her students' experiences and choices within both higher education and their own contexts. Metaphorically, JM aligned fairness in action with respect, and she aligned artificiality with false relationships.

JRR's primary metaphor was an antithetical metaphor. Her main point, metaphorically, was that an experience of suicidality in the personal realm does not need to make one "crazy" in the realm of psychology realm; thus experience is not diagnosis, experience is not flaw, experience is not illness nor needing to be fixed. CST suggests that experience as diagnosis and flaw capture only the narratives of the dominant curative culture in healing.

PU chose "a sacred space," *humility*, and *gift* as metaphors. (Think of Susan Sontag's, *Illness as Metaphor*, 1978, and *AIDs and its Metaphors*, 1989, by way of broad examples).

During our interview, WPR took over from me and said to PU, "You're talking about the place in yourself. You said you would tell the students, young students, the grad students--there's a place in you no one can harm." She responded:

> *Right that you can go to whenever you feel like that you are being [dismissed, where] you feel like you might find yourself. You can go there, and you can be safe. It's just creating a sacred space inside of yourself that you create and nobody can take away from you--no matter what they do or what they say to you. That's* your *self. Your best self is always there, and you can always access it.*

Continuing with place and regarding humility, PU said, "The only way we can actually, effectively build bridges between races and genders is to be in the classroom. *There* [the classroom] is such an effective tool if we approach it with humility and [be] open to learning about [those whom we teach]."

Finally, poetry is a gift. She said, "[We] try to find the best quality way that we can—with the purpose of not just making something beautiful, but also making something meaningful and beautiful." She helps her students to access this gift, so the writing itself becomes a kind of dialogue. PU found writing to be a form of dialogue in CST terms.

WPR's metaphor was *evocation*, through "a little brush fire starting" and "serial response." Before our interview, he wrote and then read to me during the interview:

> *The literature classes and the creative writing classes both tend to be subject matters that evoke strong responses from the students. Some of whom share those responses in the class and some of whom, of course, keep it on the page. When they do share it, when they have shared it in class it's almost always been with the effect of galvanizing the other students in the class. Especially the younger students who open up some aspect of their*

lives including things like a death of a parent or suicide in the family or just evidence of poverty of a strong wish. It's like a little brush fire starting and it will spread throughout the class so that in the next class meeting other students will also come forward and talk about things that are trauma of a kind.

So dialogue on the page becomes dialogue in the classroom. He continued:

On the reservations, the Hopi and Navajo and Northern Cheyenne and so on--the students there, I didn't have a chance to go to office hours with. So, in classes, I would often invite them to talk more about what was going on in their homes and once one broke through, others would tend to do the same thing. There would be an initial, usually an initial hesitance to do that for tribal reasons or personal reasons. But once somebody came through with a story or with a wish or a dream or a vision in the form of an image and a poem or whatever, it would tend to open everyone up. It was beautiful kind of serial response that happened. That's it.

Pragmatism and healing. For my key informants, pragmatism was about safety and self-healing, beauty and comedy. Their pragmatism demonstrated Freire's (1970/2000) praxis—a core foundation of CST—as reflection, naming, and *conscientizaçao* were followed by, or embroiled within, action.

JM and her husband moved their residence away from the university at which JM taught to avoid the overkill of too much time spent with one's colleagues. JM explained:

Then we [JM and her husband] moved out of town, too, I think a healthy psychological distance rather than being right in town and part of the group that gets together all the time and does things all the time together in a big heap [was necessary].

Additionally, JM sought out other companions, through drama coaching and a running group. These friends gave her renewed energy, from the deleterious effects of systemic stigma and from

compassion fatigue, though the healing was indirect. It took the form of "trash-talking." *Trash talking* is a slang communication through which close friends may *dis* [disrespect] each other humorously and without repercussions, especially during competition. It may also include putting oneself above another competitor in terms of skill. Trash talk is generally considered friendly and non-abusive, though its repercussions are up for debate as to whether or not trash talk is little-concealed and accepted micro-aggressiveness (Angelou, public performance, c. 1986; Sue et al., 2011). The context of trash talk is cultural and fairly intimate. The context for JM was that trash talk took place outside of the classroom, among friends, and would have been inappropriate within the politeness of the classroom. Trash talk is culturally situated.

JM said:

> *Actually, having my running buddies, where I was living, kept me sane. At work, things were going from ... It [was] just because this in group/out group. Of course, I was out, and the in group was running things and then bitching about me because I didn't do things that they didn't let me in on. It wasn't healthy at all. They were what helped me in many ways to have a creative outlet on one hand, a physical outlet on the other.*

JM was unusually effusive about her pragmatic protective mechanisms. (On other interview topics, and in general, she was more brief.) She reported, re learning to trash talk:

> *I just now remembered that I spent quite a few years working with a theater group as a drama coach...Spending many hours in rehearsal taught me about dramatic structure, theatrical procedures, and how actors do it. I loved having that knowledge. I loved seeing pretty good student actors working through what they were doing and having it all work at the end. It was like magic, the magic of theater. But then, of course, the rehearsals at*

night when everybody's bitching and crabby or trash talking—it just gave me more confidence, so I don't care about trash talking anymore.

Even in her running group (they did marathons for the Leukemia & Lymphoma Society to raise money), she learned a confidence that extended into her family relationships. She said:

… the running group … You get so used to trash talk that it changed my confidence level which I notice when I'm talking with my siblings, who also don't pay that much attention to me and I used to be very intimated by, etc. Now I just don't really care that much. We don't have that much in common, okay? I'm okay in the world because I had these groups where I...Pretty much people just hung out with what they were.

Finding her own path, and creating a new context from which to speak with others in different situations, allowed JM to learn and to divorce herself from (if not heal from) stigma, compassion fatigue, and cultural isolation.

After learning to let others help her and to form a support group, which I have discussed earlier in this paper, RJJ found solace and pride in giving herself credit, at least in practicing to give herself credit for some beauty she put into the world. She and I share a love of gardening, so naturally, when talking about garbage in/garbage out, we came to beauty in/beauty out. I had commented on RJJ's amazing yard and gardens (mostly gardens, little grass): To me, beauty is central. Maybe that's because I'm a poet or because I like pretty rocks or whatever. She responded:

Yeah, and you'll have to do things that rejuvenate you. Like I went out in the yard, I got this much cleared out, I got that much cleared out. One thing my husband always said when we first got married 30 years ago, "I hate [housework]; I love gardening." When we first got married, he'd come out in the yard and he'd say, "Okay. That looks

gorgeous." He'd say, "Tell me everything you did."

I would say, "Well, but I've got this one ..."

"Oh, no," [he'd say], "I want to know what you did. I want you to take me on a tour and show me what you did."

[I'd say], "Well, I did this over here, but this over here ..." and [he would reply], "I don't want to hear what you've got left to do. What I want you to do is tell me what you did."

His advice was: "This is gorgeous. This is absolutely beautiful. It looks like it should in Better Homes and Gardens *[a magazine]." He said, "Now what you have to do is after you do this work, you need to stand back and take it all in and say how wonderful it is and how beautiful it is, and how much work you did," and he said, "And before you put all your tools away, you have to take the time out to do that." He said, "Because if you're constantly always seeing that area that's left to do, you will never benefit from all this area that you did."*

Now her neighbor teases RJJ. "She'd see me a lot of time out front of my rock garden, right there in the front of the yard and just looking at it. She'd yell out from her balcony, 'Are you out there admiring yourself again?' I'd say, 'Yes. It's what I'm doing.'" The dialogue raised her awareness, her conscious knowledge, and her meaning making (Freire, 1970/2000).

RJJ's message in healing is this, "That's part of our work; it is to teach people that [discipline and joy in working towards beauty are valuable]. But to RJJ, humor is more pragmatically healing than beauty, at least on a daily basis. "Comedy is like an elixir…Norman Cousins and Bernie Siegel, all of them say the same thing; that [when] you want to get well, you just watch one comedy after another. You feed your mind only endorphins, and you will get

well. It's absolutely true."

PU's pragmatism for staying healthy and centered, continuing to be able to do her work, involved drive and stamina. She told me, "You read student poems that they [submitted], or you take a walk, and you start getting your strength back." In this comment, PU was separating the place of teaching from the act of teaching. She continued, "Then you just come back and do it again. You just have to because you're driven to do that. I am driven to do that."

Regarding stamina when teaching in an unhealthy environment, PU related, "It was almost like going through chemo. It just lays you flat." PU speaks from experience, having survived stage 4 ovarian cancer. She continued, "You don't know if you're gonna survive, and it smashed you down. Then you get up, and there's a hummingbird." The beauty and awe of nature have always played into PU's drive and stamina; they feed her and add to her health. She implied resilience through external natural stimuli, but never used the word, *resilience.*

Interestingly, no one but me, the researcher, talked about resilience as a way of coping and healing. I said, "I think that often we ask people to be resilient or we teach resilience and this happened a lot in the military, but that we're asking them [military and family members, as well as providers] to be resilient within the system that caused them the trauma." PU's response, was, "Oh. Jesus, Yes."

WPR suggested that writers have the opportunity to confront trauma through dialogue. He said:

> *…writers and artist tend to thrive, ironically or maybe necessarily, on what past trauma wound, psychic wounds, bad experience—sometimes it's genetic or racial or cultural. But the sharing itself almost never backfires that makes [the experience itself] standout in a bad way. I'd say 95% of the time, maybe more, it makes that student a stronger presence*

both in his or her own life and in the lives of the students around [him/her].

While the dialogue in this case is written, it does enter into the greater conversation of the classroom and publication. And dialogue, through which we can acknowledge and make meaning of our experiences, is the way forward from oppression. It changes the historical and contemporary contexts and provides a new context.

WPR also mentioned his cultural commuting as a way of learning and surviving. Curiosity and respect were both key to this ongoing experience. He said:

> *It was back and forth [between blue collar work and the ivory tower of academia] for a while, and it was interesting because the people at Amherst [an elite Ivy League school in New England] would have no comprehension whatsoever. Why on earth would you do a thing like that? But the people in the mines were curious. When they asked, it wasn't with a judgment behind it, it was with curiosity behind it. They wanted to know more about that world and me as somebody who is a visitor from Mars. And when I finally resigned myself on the century side because I needed to have job, a steady job and so on and so on, I was really glad I had enough experience doing other kinds of living as on the gulf and to bring some of those things into the classroom and working with children, for instance. I did that after I had a Rockefeller [a very prestigious writing award] and so on, as a beginning teacher and writer.*

WPR was compelled to hear about and to be in the contexts of others, who were not him, to join them and to document their voices in their own words, to keep himself humble in his rarified world of power and privilege. He said, “If you’re working out of duty, they’re [the students and audiences] going to respond out of duty, and there’s not much ecstasy in that.”

Implications for Educational Leadership

The purpose of this phenomenological study was to give voice to the lived experience of providers and educators regarding stigma and compassion fatigue. In this study, using critical social theory as a lens, I sought to understand how providers and educators experience and recognize the stigma they carry, their own compassion fatigue, and what they do to stay healthy--including mental physical, emotional/psychological, intellectual, and spiritual health. I have also sought to understand, through a convenience sample (very specifically chosen) to find out if and how their responses to their own stigma and compassion fatigue have culturally isolated them. I have done that—for four people, who were generous to me with their time, stories, and reflections upon those from which they have made and found meaning. And, I note that phenomenological research, as a qualitative method, is not generalizable to a broader population (Berg & Lune, 2012). So, I ask you, my readers, what difference does my study make to you? Can you see yourself in the experiences of those who have shared their experiences and meaning-making? Do their stories and insights, in any way, change how you see yourself moving through and acting in the world? This change, of course, would be the best outcome of my work. Still, if this work causes you to pause and to think, then this is the beginning of action, and I have done my job.

First, I hope that you can recognize yourself in this paper, as an educator in the broadest sense of the term—whether you are formally deemed a professor, a teacher, a medical provider, a mental health provider, a parent, a community member, a mentor, or find yourself among the many more service providers who care for and educate people who have experienced invisible and visible traumatic wounds. I also hope that, through the stories of the prestigious practitioners I have interviewed, that you come to realize, as I have, that we all bring stigma to the table in our professions. How we think about stigma and make meaning of it, honestly and authentically, can

change our knowledge bases and ways of being in the world. How we think about, experience, and act upon compassion and compassion fatigue can change the lives of ourselves and others. And, when we think about how we have been culturally isolated, in the workplace or otherwise, we can increase our abilities to self-protect or heal, and we can increase our compassion for those who are oppressed through positionality in relation to the dominant culture, and begin to make change.

Critical social theory (CST) reminds us that:

1) *Knowledge is based in a historical context* (Freire, 1970/2000; Hyter, 2014). We each come to the teaching and learning table with a past, which is based upon the culture and positions in which we live. Each of my key informants has generously shared his/her contextualization.

2) *"Acceptable" knowledge is defined by systems of the dominant culture and serves to distort the meaning-making of the oppressed* (Dant, 2003; Freire, 1970/2000; Freeman & Vasconcelos, 2010). My key informants have demonstrated how their own stigma, as well as the stigma they have experienced, has stemmed from cultural/historical context, creating an us-and-them (see Emlet, in press; Link & Phelan, 2001; T2, 2008), insider/outsider (Knaus & Brown II, 2016) oppositional stance among power-holders and their students/clients. My key informants have also told how the systems in which they have worked have tried to distort the meanings of their experiences.

3) *Knowledge and meaning-making are dynamic processes over time* (Freire, 1970/2000, 1998). Our knowledge, and our responses to it, change as we age (Erikson, 1959/1980). But the dynamics of knowledge and meaning making are also housed in memory, neurologically and bio-physiologically (Bauml & Samenieh, 2012; JRR, 2012). Memories include emotions (Flynn & Kelly, personal communication, 2008-2014), which influence meaning-making. The key

informants of this study were well along in their careers and some were retired. I selected them because they have thought at length about stigma, compassion, compassion fatigue, cultural isolation, and the impact upon their practices, as shared above. We (readers and me) would each do well to reflect upon how our ideas and practices have changed over time. If our practices, as reflected by our knowledge and meaning-making have not changed over time, perhaps the lack of change is an issue each of us should take up.

4) *Knowledge of the dominant culture revises the experiences and knowledge of the oppressed* (Freire, 1970/2000; Freeman & Vasconcelos, 2010). When one is taught to view themselves through the eyes of another group, those in power, self-esteem, self-efficacy, and even identity can be lost. For instance, Biko (1978) wrote that:

> Double consciousness is knowing the particularity of the white world in the face of its enforced claim to universality. Double consciousness is knowing the history offered up to black people—its many interpretations and echoes of white superiority and black inferiority, of white heroism and black cowardice, and even the temporal and geographical location of history's beginning as a step off of the African continent—is a falsehood that blacks are forced to treat as truth in so many countless ways. Double consciousness, in other words, is knowing a lie while living its contradiction. (n.p.)

Each of my key informants addressed dualities of knowledge and experience between dominant cultures and oppressed cultures within the U.S.: black/white, indigenous/colonizer, poor/middle class, disabled/normal, and so forth. However, each key informant delved deeper to provide deep description about how these visible dualities conspired to negate the dialectical approach of dialogue to inform knowledge and action (Freire, 1970/2000). Can we say the same of ourselves, me and you the readers? Have we thought as deeply as these key informants about

the process and impact of our work within the constructs of the knowledge of the dominant culture? We must.

5) *Those who challenge acceptable knowledge are stigmatized by the dominant culture* (Bohman & Rehg, 2014; Buber, 1853; Freeman & Vasconcelos, 2010; Freire, 1970/2000; Hyter, 2014). All of my key informants challenged the status quo by infusing their curricula with culturally-appropriate content and pedagogy for those with whom they were working. Each then experienced cultural isolation within the dominant system due to their actions and opinions. Each key informant was also able to identify what systemic mores were contraindicated to learning for their students and for acceptance of themselves as peers. As a white male, WPR experienced seemingly less cultural isolation than the women who were his peers, but he was still able to readily identify the systemic structures which interfered with his students' learning. So, I ask you my readers, in a call to action, are you willing to be stigmatized? Are you willing to stand up against the dominant culture to allow your students/clients their voices and knowledge? I am.

6) *Dialogic and dialectic conversations among the oppressed and later with the oppressors provide a way forward* (Bohman & Rehg, 2014; Freeman & Vasconcelos, 2010; Freire, 1970/2000; Hyter, 2014). This research did not extend to the oppressors, as a group, though key informants did acknowledge their privilege and positionality. So, the key informants stand as oppressors, individually; that is each key informant recognized when he/she was outside the group of students/clients he/she was serving, in a position of privilege or power, while not identifying with the dominant culture as oppressive. In fairness, I must say, that I did not construct the interviews and follow-ups in such a way as to be combative over oppression; instead, I let each participant share his/her stories and allowed the experiences to speak for themselves. Additionally, each key informant was also able to place themselves within a non-

dominant group. Thus, their experiences sometimes intersected, analogously with the students/clients whom they served.

What each key informant taught me was that you have to provide a way in, a trigger or a safe opening, for your students/clients to respond. Only then can the dialogue begin. Often the dialogue is dialectical because so many experiences and voices come to the fore. My key informants taught me that this is what is exciting, that this results in important work and important voices speaking.

7) *Democratic principles give voice to all in problem solving* (Freeman & Vasconcelos, 2010; Freire, 1970/2000; MacIsaac, 1996). As discussed earlier in this conversation, democratic principles are not about majority rules. That is, 51% deciding over 49% does not take into account the voices of the populace, dominant or not. Instead, democratic principles means coming to an understanding. Each of my key informants worked hard to come to an understanding, a connection, with their students/clients and with themselves.

JM said, "Dead in the water…old, female, who cares? I have found in my research [and teaching], you have people who believe certain things."

RJJ said, when giving a presentation, "Please keep your questions [until the end]…oh, never mind."

PU said, "We are all here to discuss our work."

WPR said, "You just had to figure out how to make the mesh [the dialogue] an effective one." When democratic dialogue worked, he said, it was one of the most touching experiences I have ever had." Thus, all key informants observed and enacted key democratic principles (Freire, 1970/2000) and fought hard for their students/clients to be able to do the same, within their own cultures.

What I have learned from my key informants and what I hope resonates with you, my readers, is that each professional I interviewed practiced equity pedagogy, though none of them named it or felt the need to categorize their teaching and service within a framework, which makes their work all the more powerful. Equity pedagogy is about balance (see figure 1, the Intertribal Medicine Wheel). Equity pedagogy is embedded within cultural relevance and critical consciousness (Jackson, 2013), and thus aligned with critical social theory. Equity pedagogy is creating a classroom environment, through teaching strategies that honors diversity (Banks & Banks, 2016). Banks (1993, as ctd. in Baloche, 2014) wrote:

> Equity pedagogy exists when teachers use techniques and teaching methods that facilitate the academic achievement of students from diverse racial and ethnic groups and from all social classes. Using teaching techniques that cater to the learning and cultural style of diverse groups and using the techniques of cooperative learning are some of the ways that teachers have found effective with students from diverse racial, ethnic, and language groups. (p. 206)

Each of my key informants attended to the diversity of students in their classrooms and/or clinical spaces. Additionally, each of my key informants brought in content which was culturally relevant to their students/clients and which sometimes challenged their (the students' and the teachers'/psychologists') thinking.

So, first, we must document and record the experiences of others. We must honor their voices. Then we must figure out a way to honor their experiences and to inculcate change. Each of my key informant has offered ways to teach and to serve in a culturally-appropriate manner. We can learn from them.

Additionally, we can acknowledge that giving voice to experience is the first in-road to

change. For instance, Cook et al. (2014) suggested that interventions should take place across ecological systems, as described by Bronfenbrenner, 1977); they depict the intrapersonal at the center of the systems, then the interpersonal, and finally surrounded by the structural. Certainly, the storytelling in this research took place at the interpersonal level as it involved both researcher and key informants. However, all of the key informants did some work at the intrapersonal level before the interviews through thinking, writing, and/or conversation. Some even read my research proposal. All had read the questions and the informed consent form. Thus, their memories were at least triggered before the interviews (Bauml & Samenieh, 2012). Guided by the key informants' *conscientizaçao* (Freire, 1970/2000), they each chose how closely they wanted to be and to engage in this study.

Key findings, which may inform the practice of equity pedagogy as a result of connecting to these key informants' experiences and meaning making may include, among others which you, my readers, may have yourselves discerned:

- Phenomenology, dialogue, and the critical social theory lens are key to unearthing and naming the experiences and meaning of educators'/psychologists who may have gone underground to continue to do their work well, outside of dominant cultural norms and expectations.
- Sometimes, it is the prescriptive, unexamined nature of a system's ethics and the fear of litigation, due to the embeddedness of the dominant cultural mores in law, which force amazing educators into resultant compassion fatigue and cultural isolation.
- The Buddhist perspective on compassion and balance and the Native American medicine wheel perspectives on balance in health and among races, as constructs, provide insight into a lack of balance of healthy, choice-making options for educators/psychologists who

work with trauma-informed students and clients

- Seasoned professionals provide insight into dysfunctional systems of education and ways to work around the dysfunction while remaining true to their own ethics and values, creating a context in which they are able to continue to serve students/clients who have suffered from invisible wounds.
- Frustration may be an undocumented element of compassion fatigue.

It has been my delight, as a researcher, to have been able to engage in conversation with my key informants around topics central to their experiences as educational and psychological professionals—stigma, compassion fatigue, cultural isolation, and healing. I value that I have been able to give them a forum, which I have reported upon here, which gives voice to their many experiences and meaning-making around these topics. Phenomenology as methodology provided this rare and safe experience. Critical social theory has allowed me to explore my own understanding of their experiences and meaning making. More phenomenological research is now needed into the experiences of seasoned educator and psychologists into compassion satisfaction.

References

42 U.S.C. § 13031 [children]

Angelou, M. (c. 1986). [Public performance, Temple Theater, Tacoma, WA].

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). http://dx.doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). doi:10.1176/appi.books.9780890423349.

American Psychological Association. (2016). *Violence & Socioeconomic Status* [fact sheet]. Retrieved from: http://www.apa.org/pi/ses/resources/publications/factsheet-violence.aspx

Axtel, J. (1992). Colonial America without the Indians: Counterfactual reflections. In R. L. Nichols (Ed.), *The American Indian: Past and present* (4th ed., pp. 1-13). New York, NY: McGraw-Hill.

Baloche, L. (2014). Everybody has a story: Storytelling as a community building exploration of equity and access. *Intercultural Education, 25*(3), 206-215. doi: 10.1080/14675986.2014.905240

Banks, C. A. M., & Banks, J. A. (1995). Equity pedagogy: An essential component of multicultural education. *Theory into Practice*, *34*(3), 152-158.

Barthes, R. (1966). Introduction to the structural analysis of narratives. . In C. Kaplan (Ed., 1986), *Criticism: The major statements* (pp. 555-589). New York, NY: St. Martin's.

Bauml, K-H. T., & Samenieh, A. (2012). Selective memory retrieval can impair and improve retrieval of other memories [Research report]. *Journal of Experimental Psychology, 38*(2), 488-494. doi: 10.1037/a0025683

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice*, *44*(3), 150-

157. doi: 10.1037/a0031182

Bem, S. L. (1993). *The lenses of gender: Transforming the debate on sexual inequality*. New Haven, CT: Yale University Press

Bercier, M. L., & Maynard, B. R. (2015). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice, 25*(1), 81-89.

Berg, B. L., & Lune, H. (2012). *Qualitative research methods for the social sciences* (8th ed., international ed.) Upper Saddle River, NJ: Pearson.

Biko, N. M. (1978). *I write what I like*. London, UK: Bowerdean Press.

Bloom, B. (1956). *Taxonomy of educational objectives: The classification of educational goals* (D. R. Krathwohl, Ed.) New York, NY: Longmans/Green.

Bohman, J., & Rehg, W. (2014). Jurgen Habermas. *Stanford Encyclopedia of Philosophy*. Retrieved from http://plato.stanford.edu/entries/habermas/ (Original work published May 17, 2007)

Bohman, L. G. (2005). We, heirs of enlightenment: Critical theory, democracy and social science. *International Journal of Philosophical Studies*, *13*(3), 353-377.

Bolman, L. G., & Deal, T. E. (2008). *Reframing organizations: Artistry, choice, and leadership* (4th ed.). San Francisco, CA: Wiley.

Bradford, W. (1620/1989a). Book I, Chapter X. Showing how they sought out a place of habitation; and what befell them thereabout. In F. Murphy, Ed., *The Norton anthology of American literature* (3rd ed. shorter, pp. 38-43). New York, NY: Norton.

Bradford, W. (1620/1989b). Book I, Chapter XII. Anno 1621 [First Thanksgiving]. In F.

Murphy, Ed., *The Norton anthology of American literature* (3rd ed. shorter, p. 43). New York, NY: Norton.

Bride, B. E. (2007). Prevalence of secondary trauma among social workers. *Social Work, 52*(1), 63-70.

Bronfenbrenner, U. (1977, July). Toward an experimental ecology of human development. *American Psychologist*, 513-531.

Buber, M. (1953). *I and thou*. Translated by Walter Kaufmann, 1970. New York, NY: Scribner.

Centers for Disease Control and Prevention (CDC). (2013). *Coping with stress*. Retrieved from http://www.cdc.gov/Features/CopingWithStress/index.html

Chesler, P. (1986). *Mothers on trial: The battle for children and custody*. New York, NY: McGraw-Hill.

Cohen, J. W., & Brooks, R. A. (2014). *Confronting school bullying: Kids, culture, and the making of a social problem*. Boulder, CO: Lynne Reinner.

Compassion. (2015). In *Oxford English Dictionary online*. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/compassion

Compson, J. (2015). The CARE heuristic for addressing burnout in nurses. *Journal of Nursing Education and Practice, 5*(7), 63-74. doi: 10.5439/jnep.v5n7p63

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. A. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science & Medicine, 103*, 101-109. doi: 10.1016/j.socscimed.2013.09.023

Covey, S. R. (1989/2004). *The 7 habits of highly effective people: Powerful lessons in personal change.* New York, NY: Free Press.

Craun, S. W., Bourke, M. L., Bierie, D. M., & Williams, K. S. (2014). A longitudinal

examination of secondary traumatic stress among law enforcement. *Victims and Offenders, 9*, 299-316. doi: 10.1080/15564886.2013.848828

Crosby, Jr., A. W. (1992). Virgin soil epidemics as a factor in aboriginal depopulation in America. In R. L. Nichols (Ed.), *The American Indian: Past and present* (4th ed., pp. 14-21). New York, NY: McGraw-Hill.

Daniels, V. 2005. Lecture on phenomenology. Retrieved from http://www.sonoma.edu/users/d/daniels/phenomlect.html

De Man, P. (1979). Semiology and rhetoric. In C. Kaplan, 1986, *Criticism: The major statements,* New York, NY: St. Martin's., (pp. 606-622).

Decker, J. T., Brown, J. L. C., Ong, J., & Stiney-Ziskind, C. A. (2015). Mindfulness, compassion fatigue, and compassion satisfaction among social work interns. *Social Work & Christianity*, *42*(1), 28-42.

Delgado, R., & Stefancic, J. (2012). *Critical race theory: An introduction.* New York, NY: NYU Press.

Department of the Army. (2015). *Army Health Promotion* [Army Regulation 600-63]. Washington, DC: Author.

Dominguez-Gomez, E., & Rutledge, D. N. (2009). Prevalence of secondary traumatic stress among emergency nurses. *Journal of Emergency Nursing*, *35*(3), 199-204. doi: 10.1016/j.jen.2008.05.003

Eagleton, T. (1976). Marxism and literary criticism, In C. Kaplan (Ed., 1986), *Criticism: The major statements* (pp. 532-554). New York, NY: St. Martin's.

Emlet, C. (in press). Stigma in an aging context. In M Brennan-Ing & R. F. Demarco (Eds.), *HIV and aging.* Basel, SW: Karger.

Erikson, E. H. (1959/1980). *Identity and the life cycle*. New York, NY: Norton.

Faludi, S. (1991). *Backlash: The undeclared war against American women*. New York, NY: Crown.

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine, 103,* 7-14. doi: 10.1016/j.socscimed.2013.09.006

Federal Employee Defense Services. (2011, May 19). The cause and effect of secondary traumatic stress. *The Spotlight.*

Figley, C. (1995). Compassion fatigue: Coping with secondary traumatic stress in those who treat the traumatized. In C. Figley (Ed.), *Compassion fatigue as secondary traumatic stress disorder: An overview* (pp. 1-20). New York, NY: Brunner.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441. doi: 10.1002/jclp.10090

Fish, S. (1980). Is there a text in this class? In C. Kaplan, 1986, *Criticism: The major statements* (pp. 623-638). New York, NY: St. Martin's.

Flaherty, C. (2015). https://www.insidehighered.com/news/2015/02/04/faculty-members-object-new-policies-making-all-professors-mandatory-reporters-sexual

Flanagan, E. H., Miller, R., & Davidson, L. (2009). "Unfortunately, we treat the chart:" Sources of stigma in mental health settings. *Psychiatric Quarterly, 80,* 55-64. doi: 10.1007/s11126-009-9093-7

Freeman, M., & Vasconcelos, E. F. S. (2010). Critical social theory: Core tenets, inherent issues. In M. Freeman (Ed.), *Critical social theory and evaluation practice*. *New Directions for Evaluation*, 127, 7-19.

Freire, P. (1970/2000). *A pedagogy of the oppressed.* Reprinted in 2012, New York, NY:

Bloomsbury Academic.

Freire, P. (1998). Cultural action and conscientization. *Harvard Educational Review*, *68*(4), 499-521.

Gawande, A. (2014). *Being mortal: Medicine and what matters in the end.* New York, NY: Metropolitan Books.

Gazzaniga, M. S. (2011). *Who's in charge? Free will and the science of the brain* [The Gifford Lectures, 2009]. New York, NY: Harper Collins.

Greene, J. D. (2014, July). Beyond point-and-shoot morality: Why cognitive (neuro) science matters for ethics. *Ethic*, *124*(4), 695-726. doi: 10.1086/675875

Harden, Y. (2015, Winter). *Good intentions aren't enough: The damaging effects of micro-aggressions* [Oppression Know More 2015 Diversity Summit, conference presentation, University of Washington Tacoma 20 February 2015, unpublished].

Hatcher, S. S., Bride, B. E., Oh, H., King, D. M., & Catrett, J. F. (2011). *Journal of Correctional Health Care*, *17*(3), 208-217.

hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom.* New York, NY: Routledge.

hooks, b. (2003). *Teaching community: A pedagogy of hope*. New York, NY: Routledge.

Hydon, S., Wong, M., Langley, A. K., Stein, B. D., & Katoaka, S. H. (2015). Preventing secondary traumatic stress in educator. *Child Adolescent Psychiatric Clinic North America*, 319-333.

Hyter, Y. (2014). A conceptual framework for responsive global engagement in communication sciences and disorders. *Topics in Language Disorders*, *34*(2), 103-120. doi: 10.1097/TLD.0000000000000015

Jackson, C. (2013). Elementary mathematics teachers' knowledge of equity pedagogy. *Current Issues in Education, 16*(1), 1-13.

Jansen Kraemer, Jr., H. M. (2011). *From values to action: The four principles of values-based leadership.* San Francisco, CA: Jossey-Bass.

Jensen, R. J. (2012). *Just because you're suicidal doesn't mean you're crazy! The psychobiology and suicide*. Kearney, NE: Morris.

Joels, M., & Baram, T. Z. (2009). The neuro-symphony of stress. *National Review of Neuroscience, 10*(6), 459-466. doi: 10.1038/nrn2632

Kaplan, C. (1986). *Criticism: The major statements* (2nd ed.). New York, NY: St. Martin's.

Keltner, D. (2004, March 1). The compassionate instinct. Retrieved from http://greatergood.berkeley.edu/article/item/the_compassionate_instinct

Kerzin, B. (2015). *Living a compassionate life* [Lecture given at the University of Washington Tacoma].

Knaus, C. B., & Brown, II, M. C. (2016). *Whiteness is the new South Africa: Qualitative research on post-apartheid racism.* In *Critical qualitative research: Critical issues for learning and teaching* (S. R. Steinber, Series Ed., Vol 17). New York, NY: Peter Lang.

Kretzmann, J. P., & McKnight, J. L. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Evanston, IL: The Asset-Based Community Development Institute, School of Education and Social Policy, Northwestern University.

Lamott, A. (1995). *Bird by bird*: *Some instructions on writing and life*. New York, NY: Anchor.

LeDoux, K. (2015). Understanding compassion fatigue: Understanding compassion. *Journal of Advanced Nursing, 71*(9), 2041-2050. doi: 10.1111/jan.12686

Leonardo, Z. (2004). Critical social theory and transformative knowledge: The functions of criticism in quality education. *Educational Researcher* [themed issue: Disciplinary knowledge and quality education, part 2], *33*(6), 11-18.

Levine, P. A., & Frederik, A. (contributor). (1997). *Waking the tiger: Healing Trauma*. Berkley, CA: North Atlantic Books.

Lewin, K. (1944). The dynamics of group action. *Educational Leadership, I*(4), 195-200.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.

MacIsaac, D. (1996). *The critical theory of Jurgen Habermas*. Retrieved from http://physicsed.buffalostate.edu/danowner/habcritthy.html

Metzel, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*, 126-133. doi: 10.1016/j.socscimed.2013.06.032

Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Los Angeles, CA: Sage.

Miles, M. B., Huberman, A. M., & Saldana, J. (2013). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Los Angeles, CA: Sage.

Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues*, *57*(1), 73-92.

Mosby's Medical Dictionary. (2009). *Stigma.* Elsevier. Retrieved from the Madigan Army Medical Center library web site.

Nadal, K. L. (2011). The racial and ethnic micro-aggressions scale (REMS): Construction, reliability, and validity. *Journal of Counseling Psychology, 58*(4), 470-480. doi:

10.1037/a0025193

National Center for Health Statistics (NCHS) & the Centers for Medicare and Medicaid Services. (2015). *ICD-9-CM- Volumes 1, 2, &3*. Hyattsville, MD: Authors. Retrieved from: STAT!Ref Online Electronic Medical Library. https://online.statref.com/Document.aspx?=fxld=110&docIt=1

National Center for Telehealth and Technology (T2). (2008). *Stigma*. Tacoma, WA: Afterdeployment.org

National Child Traumatic Stress Network (NCTSN). (2011). *Secondary traumatic stress: A fact sheet for child-serving professionals*. Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress.

Northouse, P. G. (2010). *Leadership: Theory and practice* (5th ed.). Thousand Oaks, CA: Sage.

Paquette, D., & Ryan, J. (2000). *Bronfenbrenner's ecological systems theory.* Retrieved from http://www.floridahealth.gov/alternatesites/cms-kids/providers/early_steps/training/documents/bronfenbrenners_ecological.pdf

Patient Protection and Affordable Care Act of 2010, Title V.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York, NY: Norton**.**

Perlin, M. L. (2008). "Simplify you, Classify You": Stigma, stereotypes, and civil rights in disability classification systems. *Georgia State Law Review*, *25*(3), 607-637. Retrieved from: http://readingroom.law.gsu.edu/gsulr/vol25/iss3/6

Phelan, J.C., Lucas, J. W. Ridgeway, C. L., & Taylor, C. J. (2014). Stigma, status, and population health. *Social Science & Medicine*, *103*, 15-23. doi: 10.1016/j.socscimed.2013.10.004

Philosophical research online. (2015). Summary.

Pollock, D. A. (n.d.). Trauma registries and public health surveillance of injuries. Retrieved from cdc.gov

Potter, P., Pion, S., & Gentry, E. (2015). Compassion fatigue resiliency training: the experience of facilitators. *The Journal of Continuing education in Nursing*, *46*(2), 83-88.

Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*(3), 390-395.

Ricard, M. (2013/2015). *Altruism: The power of compassion to change yourself and the world* (C. Mandell & S. Gordon, trans.). New York, NY: Little Brown.

Rich, A. (1979). *On lies, secrets, and silence: Selected prose 1966-1978*. New York, NY: Norton.

Ryman, E., & Fulfer (2013, July). What is feminist phenomenology? *Reflections from the Future Directions in Feminist Phenomenology Conference.* London, ON, CA: Western University, Department of Philosophy, Rotman Institute of Philosophy.

Saldana, J. (2013) *The coding manual for qualitative researchers* (2nd ed). Thousand Oaks, CA: Sage.

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54-61.

Sartre, J. P. (1943/1956). *Being and nothingness* (H. Barnes, trans.). London, UK: Routledge.

Schaef, A. W., & Fassel, D. (1988). *The addictive organization*. New York, NY: Harper & Row.

Seppala, E. (2013, May/June). The compassionate mind: Science shows why it's healthy and

how it spreads. *Observer*, *26*(5), 1-5. Retrieved from http://www.psychologicalscience.org/index.php/publications/observer/2013/may-june-13/the-compassionate-min.d.html

Shoji, K., Bock. J. Cieslak, R., Zukowska, K., Luszczynska, A., & Benight, C. C. (2014). Cultivating secondary traumatic growth among healthcare workers: The role of social support and self-efficacy. *Journal of Clinical Psychology, 70*(9), 831-846.

Silko, L. M. (1977). *Ceremony*. New York, NY: Penguin.

Silko, L. M. (1991). *Almanac of the dead*. New York, NY: Simon & Schuster.

Simms, E-M., & Starwarska, B. (2013). Introduction: Concepts and methods in interdisciplinary feminist phenomenology. *Janus Head: Journal of Interdisciplinary Studies in Literature, Continental Philosophy, Phenomenological Psychology, and the Arts*, 6-16. Retrieved from http://www.janushead.org/

Smith, D. W. (2013). Phenomenology. In *The Stanford encyclopedia of philosophy* (2014). Palo Alto, CA: The Metaphysics Research Lab, Center for the Study of Language and Information (CSLI), Stanford University. Retrieved from http://plato.stanford.edu/entries/phenomenology/#Aca

Sontag, S. (1978). *Illness as Metaphor*. New York, NY: Vintage.

Sontag, S. (1989). *AIDS and its metaphors*. New York, NY: Farrar, Straus, & Giroux.

Spanierman, L. B., Armstrong, P. I. Poteat, V. P.., & Beer, A. M. (2006). Psychological cost of racism to Whites: Exploring patterns through cluster analysis. *Journal of Counseling Psychology, 53*, 434-441.

Spector, R. E. (2013). *Cultural diversity in health and illness* (8th ed.). Needham, MA: Pearson.

Stark, P. (2001). Arching toward the clear light: Mountain sickness. In *Last breath: Cautionary*

tales from the limits of human endurance (pp. 45-79). New York, NY: Ballantine.

Stolorow, R. D. (2004). The relevance of early Lacan for psychoanalytic phenomenology and contextualism [Preliminary communication]. *Psychoanalytic Psychology*, *21*(4), 668-672. doi: 10.1037/0736-9735.21.4.668

Sue, D. W., Lin, A. I., Torino, G. C., Capodilupo, C. M., & Rivera, D. P. (2009). Racial microaggressions and difficult dialogues on race in the classroom, *Cultural Diversity and Ethnic Minority Psychology*, *15*(2), 183-190. doi: 10.1037/a0014191

Sue, D. W., Torino, G. C., Capodilupo, C. M., Rivera, D. P., & Lin, A. I. (2009). How white faculty perceive and react to different dialogues on race: Implications for education and training. *The Counseling Psychologist*, *37*(8), 1090-1115. doi: 10.1177/0011000009340443

The Elder Justice Act. (2010).

The Joint Commission (TJC). (2013-2014). *Standards and Elements of Performance*. [available through subscription only: www.jointcommission.org] Oakbrook Terrace, IL and Washington, DC: Author.

Thomasson, A. L. (2005). First person knowledge in phenomenology [Chapter 5, available online]. Abramis CO, UK: Kluwer Academic.

Trauma. (2012). Medicinenet.com

Turner, C. B. (2015, spring). A "soul wound": Moving beyond PTSD to moral injury [a poster session and paper presentation]. Tacoma, WA: University of Washington Tacoma, Social Work Program.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy. Washington, DC:

Author. Retrieved from http://docplayer.net/12143-National-action-plan-to-improve-health-literacy.html

United Nations General Assembly. (1948), December 10). *The Universal Declaration of Human Rights* [General Assembly resolution 217A]. Paris, FR: Author.

WAC 246-16-210-220.

WAC 388-76-10673.

WAC 388-101-4150 [vulnerable adults].

Wang, D. C., Strosky, D., & Fletes, A. (2014). Secondary and vicarious trauma: Implications for faith and clinical practice. *Journal of Psychology and Christianity*, *33*(3), 281-286.

Welch, J., & Stekler, P. (1994). *Killing Custer: The battle of the Little Bighorn and the fate of the Plains Indians*. New York, NY: Norton.

Whitelaw, S., Balwin, S., Bunton, R., & Flynn, D. (2000). The status of evidence and outcomes in stages of change research. *Health Education Research*, *15*(6), 707-718.

World Health Organization. (1998). *Health literacy*. Retrieved from www.who.int

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482-491. doi: 10.1037/a0027824

Appendix A: Logic Model