Forward-Facing Virtual Support Groups: An Exploration of Mental Health Clinicians' Perspectives on Peer-to-Peer Engagement

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Author Note

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Dedication

I dedicate this dissertation to my husband and children who have trekked alongside me on this long and arduous life stretching journey, beginning with my very first step into the academic abyss. To my loving and supportive husband, Douglas, who provided enthusiasm at the outset and steadfast tenderness and encouragement during times of exhaustion and moments of despair; there are no words to adequately articulate the depth of my gratitude for your support. You have never wavered in your dedication to our family and your confidence in my ability to achieve my life goals. To our wonderful and amazing children—Neil, Annie, Logan, and Tristan—who kept me from losing perspective of the most important tools of the climb: curiosity, connection, wanderlust, laughter, health, sustenance, and joy. You have kept me grounded in family, purpose, and passion for my life, and each of you has inspired me in your own unique way.

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Table of Contents

List of Tables and Figures

Abstract

This study explored the effects of a virtual peer-to-peer professional support group, forward-facing me (FFMe), for 10 mental health clinicians working in the human services arena. Based on the evidence-based forward-facing professional resilience (FFPR) training framework, this model pairs science-based and self-regulatory skills with intentional resilience living practices to mitigate compassion fatigue and burnout. The intent of this study was two-fold: to address the current gap in the availability of online clinician support groups emphasizing the efficacy of meeting in a virtual "in-vivo" setting, while discovering how participants experienced the peer-to-peer learning model, focused on integrating the *Tools of Hope* psycho-education and skills building practice. Using a qualitative framework—incorporating semistructured interviews based on descriptive phenomenological inquiry—the participants examined aspects of both compassion fatigue and satisfaction in cultivating professional self-care. Additionally, they shared lived experiences of moving through three phases—education/skills building, intentionality/self-regulation training, and connection/engagement—of the FFPR training, followed by six weekly encounters in the FFMe support group model. Five major themes emerged from the data. Although the first two focused on difficulties of working with clients in distress and navigating such challenges, the final three illuminated the strengths and successes of learning, practicing, and sharing new tools for sustainment in such work. The implications of these findings may provide further insight as to what constitutes best practices for safe, flexible, and effective virtual engagement platforms.

Keywords: virtual support groups, peer-to-peer learning model, vicarious trauma, moral distress, compassion fatigue, compassion satisfaction, vicarious resilience, professional resilience

Chapter 1

Caregivers who devote their life work to serving others in crisis and suffering are often met with the juxtaposition of both healing and hurt. Motivated by the desire to reduce the pain of clients and patients, clinicians may become disillusioned when they are personally exhausted and seek outlets for support (Lipsky, 2009). Although early studies focused on *who* is affected (i.e., primarily medical and mental healthcare workers) and *what* (i.e., the experience now known as vicarious traumatization and toxic stress leading to burnout), and later researchers honed in on *why* it occurs (i.e., essentially breakdown of the biological stress cycle and need for self-regulation and neuroceptive management), more recent theorists have recognized the demand for support programs to address such debilitating experiences (David, 2016; Gentry, 2021; Porges, 2004; Van der Kolk, 2015). Responding to this call for a collective and interactive space, as well as addressing the current gap in the availability of online clinical support groups, one such timely program—the forward-facing professional resilience (FFPR) training model and forward-facing me (FFMe) follow-up engagement group—explores the how-factor, providing virtual in-vivo space combined with Tools of Hope self-regulation coping skills for transforming suffering into meaningful growth and healing (Brackman, 2021; Gentry, 2021; Gentry & Monson, 2017).

Given the exponential burden placed on both the health and mental health care professions during this unprecedented time of COVID-19 global pandemic and economic crisis, it is evident that access to virtual support groups may play a significant role in providing such mechanisms for adaptive coping (Gonzalez et al., 2020). The need for virtual professional resilience training programs to counter the effects of toxic stress, compassion fatigue, and burnout are paramount for those individuals both entrenched in and newly entering the human services career field, especially when navigating the complexities of newly formed policy around

social distancing and safe options for connection and consultation (Miotto et al., 2020; Modesto-Lowe et al., 2021).

Although both tele-medicine and tele-mental health technologies are not new to service delivery, public health officials advise they have become more widely accepted in reducing barriers in the ever-evolving landscape of acceptable standards of patient and client care (Centers for Disease Control and Prevention, 2020). Likewise, online support groups—to include group therapy and telepsychology—are expanding as protective options to counter social isolation and clinicians' experience of feeling overwhelmed and alone in their work. With increased competency around legal and ethical provision of services, group therapists are finding the transition from in-person to online forums a viable and necessary alternative setting of care (Whittingham & Martin, 2020). Additionally, recent guidelines from the American Psychological Association (APA) encourage integrating discussion and brainstorming ways to ameliorate the negative impact of moral injury in the context of regular virtual group meetings for both clients and clinicians (APA, 2021).

Arriving at the intersection of personal, occupational, and socially related distress domains, practitioners and researchers acknowledge that caregivers are routinely faced with the multidimensional syndrome of burnout caused by physical and emotional exhaustion, potentially resulting in both personal and suboptimal patient care (Barak et al. 2008; Khasne et al., 2020; Luthar et al., 2019; Parker et al., 2017; Weingarten et al., 2020). Given the current global crisis, researchers forewarn that clinicians dealing with personal worries (i.e., fear of contracting the virus in the work place and spreading to a multigenerational home), patient and client concerns (i.e., social-distancing, ventilation, and disinfection guidelines), and societal factors (i.e., confusion around media and scientific versus political misinformation) may be faced with the

primary components of "burnout"—emotional exhaustion, depersonalization, and decreased sense of accomplishments (APA, 2021; Fumis et al., 2017; Nagoski & Nagoski, 2019; Trumello et al., 2020).

At this juncture, intentional replenishment of energy stores, including self-care and self-regulation as preventative primary objectives to negative outcomes, is critical for optimal functioning, as clinicians often become depleted without an understanding of the underlying mechanisms involved in such a conundrum (Gentry & Dietz, 2020; Perry & Winfrey, 2021; Posluns & Gall, 2020; Rupert & Dorociak, 2019). Empathy, the very essence that promotes the greatest compassionate connection—essentially suffering *with* others—is also the aspect of such work, if left unchecked, will undermine the professionals' ability for sustained success in the helping field (Thompson et al., 2014). This dilemma lends itself to the importance of supporting clinicians at the *reactive* level to promote healing of trauma already experienced, and perhaps even more importantly, to assess conditions from a *proactive* perspective, cultivating professional resilience and trauma-informed care from the outset of practice (Gentry & Dietz, 2020; Newell, 2017).

This study sought to highlight the early literature around the historical, theoretical, and empirical grounding from early trauma theorists to provide clarity and essential framework to the field of psycho-traumatology. Guided by former traumatic stress studies and speculations for understanding secondary trauma, insight was gained around the caregiver coping response to better conceptualize meaningful treatments. Additional research was explored to illuminate the biological underpinnings of the nervous system and instinctual fear-based reactions, providing further explanation for complex emotional states during perceived danger. Finally, this study introduced the FFPR training model and FFMe supportive engagement group to 10 novice and

seasoned mental health clinicians, in hopes of adding to previous research about the importance of informing transformative care at the educational, training, and proactive levels of instruction. The findings from this exploration hopefully increased the awareness around the caregivers' own traumatic stress and connection to the impact of *past*, painful experiences on the threat response system often activated in *present* physiological responses. It may also inform future trauma-informed professional development and continued support needs for clinicians serving previously traumatized populations, as well as recognize the collective trauma presently navigated in society around the COVID-19 global pandemic.

Background

Although the ethical imperative for psychologists and psychology doctoral students to practice proactive self-compassion, self-care and work-life balance has emerged in the current psychological literature, awareness around debilitating caregiving risks such as toxic stress, compassion fatigue, and burnout is not a new topic (Abramson, 2021). Magnified in the wake of the collective trauma of the COVID-19 global pandemic, medical and mental health clinicians both observed in their clients and their own lives awareness around what is now referred to as the "Trauma Trifecta," impacting three major areas that contribute to wellbeing or lack of it: physical health and safety, social and emotional wellness, and basic needs (Weingarten et al., 2020; Wilson, 2021). Caregiving professionals have long been known to be at risk for stress-related conditions; however, with the increased demand for mental health service provision both virtually and in-person, the necessity to establish clear work versus home boundaries, as well as prioritize safe and supportive space for clinicians to interact and engage has become an all-time premium. In fact, many have suggested the depth of a clinicians' resiliency—essentially positive

adaptation despite adversity—is dependent on having access to such supportive forums (Luthar & Cicchetti, 2000; Viswanathan et al., 2020).

Historical, Theoretical, and Empirical Overview

Entering the spotlight of the mental health field as recently as the 1980s, the study of traumatology began to illuminate the interconnectedness between shocking events (e.g., war, natural disaster, family abuse, vehicle accidents, death of a loved one) and the long-term psychological distress associated with attempting to cope with resulting symptomatology of extraordinary depression and debilitating anxiety (Figley, 1995). Despite Figley's (1995) assertion that awareness of human reaction to traumatic events could be traced back to the earliest medical writings of Kunus Pyrprus, published in 1900 BC in Egypt, it was not until the publication of the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual* (*DSM III*) in 1980 that posttraumatic stress disorder (PTSD) was first included as a diagnostic psychiatric disorder, complete with symptom criteria and treatment recommendations (APA, 1980; Friedman, 2013; Turnbull, 1998).

The historical significance of the PTSD entry to the *DSM-III* was the focus on the etiological agent as being external to the patient, rather than an internal weakness (or lacking adaptive capacity to cope with stress) as previously assumed (APA, 1980). Offering specific criteria (i.e., direct exposure, intrusiveness, avoidance, negative cognition and mood, alteration in arousal and reactivity), as well as aspects of duration, functionality, and exclusion (i.e., medication, medical illness, or substance use), helped to better assess the individual and develop valid and reliable psychometric and psychophysiological measurements (Friedman, 2013). A more recent study revealed the ongoing modification and revision of the *DSM* criteria not only to assess the patient more reliably and holistically, but also to provide efficacious treatment to

mitigate functional impairment (Kilpatrick et al., 2013). Although a global phenomenon, the naming of trauma over time has differed between countries, with some labeling it as medical diagnosis and others using a psychiatric diagnosis carrying a potentially more stigma related term (Schaufeli et al., 2009). Interestingly, despite the clear identification of symptomatology aligned with the PTSD diagnosis in all three previous versions of the DSM, early attention had only been placed on the individuals directly experiencing the trauma and neglected to recognize the secondary or vicarious trauma resulting from those in the caring roles.

In the most current *DSM* (*DSM*-5-TR), however, the secondary traumatic stress (STS) definition has been revised to entail the psychological phenomena of compassion stress (i.e., intrusive symptoms, avoidance, and hyperarousal) leading to compassion fatigue and is considered a stressor under one of the criteria for PTSD (APA, 2022). It now includes explanation of this potential etiological origin within its definition, stating "individuals must either have experienced a traumatic event themselves or been confronted with aversive details of a traumatic situation" (APA, 2022; Greinacher et al., 2019). This recognition is especially important as researchers observe the potential impact of coronavirus disease 2019 (COVID-19) on the mental well-being of healthcare professionals in their caring for individuals with symptomatology directly connected to psychological disorders and experiences related to the pandemic (Raudenská et al., 2020).

STS and Compassion Fatigue in Mental Health Providers

With a gain in understanding around trauma and PTSD, which advanced rapidly in the 1990s, paralleled with the need for more effective treatment options to support the influx of combat veterans returning from extended tours of duty in Iraq and Afghanistan, Gentry (2021) explored the movement away from early "retraumatizing" modalities that focused on reexposure

to the initial trauma event, toward a treatment approach involving minimal distress. Today's trauma-informed modalities focus instead on incorporation of mindful relaxation and self-regulation for both client and caregiver, although this was not always the case (Kime, 2020; Steenkamp, 2020).

Early researchers noted the nearly timeless focus of traumatology alongside the newness of the field as a preparadigm state, suggesting additional study to be centered around not only the cost of caring of the supportive caregiver, but also the need for a clear definition of the transmission of trauma as covictimization conceptualized as secondary traumatic stress disorder (STSD) resulting in impairment of the therapist (Figley, 1982; Kuhn, 1970; Stamm, 2002). Figley (1982) first observed that such diagnoses were only applied to direct victims. He later suggested that the vulnerabilities and related stress experienced at the hands of healthcare professionals—STS or indirectly traumatized (later to be coined compassion fatigue)—was the syndrome that put most therapists at risk of burnout (Figley, 1995). Later comparison models highlighting the parallel symptoms and response patterns between PTSD and STSD, revealing the emotional contagion that is experienced when a clinician reacts to the clients' trauma, helped to emphasize the overlap of negative outcomes of caring for traumatized people (Miller et al., 1988).

Initially described in 1982 as the change in caregiver ability to feel empathy following emotional and physical exhaustion, Figley (2002) later discussed the concept of compassion fatigue as a multifactor model that emphasized the costs of caring, empathy, and emotional investments in helping the suffering. The model suggested psychotherapists with an ability to limit compassion stress, deal with traumatic memories, and more skillfully manage caseloads are more effective in avoiding compassion fatigue. Figley encouraged developing methods to

enhance satisfaction and learning by separating from work both physically and emotionally to feel renewed for sustained work in the helping profession. Now, viewed as a critical component of comprehensive client care and recognition of the professional responsibilities of the clinician, separate codes and guidelines serve to emphasize the importance and justification of self-care practice. To ensure optimal care of the client and clinician alike via focus on safeguarding welfare and reduction of harm resulting from exhaustion and burnout, such codes are listed in the Code of Ethics for access by helping professionals (ACA, 2014; APA, 2013, 2017; AAMFT, 2015; AMHCA, 2020; CAMFT, 2019; NASW, 2017).

Vicarious Traumatization in Providing Mental Health Care

Similar in its origin but more harmful in its effect on the caregiver, McCann and Pearlman (1990) presented a new constructivist self-development theory for understanding therapists' reaction to clients' traumatic narratives. Known as secondary or vicarious traumatization, this phenomenon addressed the disruptive experience encountered by therapists in their feelings of personal safety, power, independence, esteem, intimacy, and frame of reference, essentially provoking a change in the clinicians' worldview. Additionally, they discussed alternate means of transforming and integrating traumatic material to serve clients while still protecting clinicians from damaging effects. The authors suggested vicarious stress is the bidirectional accumulation of both clients' memories of traumatic material, as well as the effects on therapists' perspectives of the world. They emphasized it must be considered at three realms: personal, professional, and organizational (McCann & Pearlman, 1990).

Early exploration around the origin of secondary traumatization hypothesized distress could potentially be mediated by risk and resilience factors (i.e., therapists' and clients' personal characteristics, attempts to cope, and working environment) to distinguish effects of

countertransference, burnout, and secondary stress reactions (Dutton & Rubenstein, 1995; Figley, 1995). Using survey methodology and responses gained from therapists belonging to multiple international societies (e.g., traumatic stress, multiple personality and dissociation, marriage and family therapists) to assess personal and professional history, psychological symptoms, cognitive schema, coping behaviors and changes, it was determined those reporting secondary exposure would not only endorse a higher rate of distressful symptoms, but also noted that personal and contextual variables could potentially mediate the negative outcomes (Stamm, 1999). Results from this study both supported the predicted relationship between secondary exposure and distress symptoms based on responses from the Impact of Event Scale (measuring intrusion and avoidance) and Trauma Symptom Checklist (focused on dissociation and sleep disturbance), as well as indicated several variables to help mediate the potential distress (Elliot & Briere, 1992; Horowitz et al., 1979; Stamm, 1999).

Implications of such significant studies seeking methods to minimize the impact of secondary exposure to therapists suggested the following aspects for enhancing professional self-care: increased supervision, periodic trainings, social/professional networking, and caseload varying to include nontrauma cases (Dutton & Rubenstein, 1995; Figley, 1995; McCann & Pearlman, 1990). Limitations of early studies considered acute versus chronic nature of secondary trauma, sensitivity of the testing measures, and need for further investigation of the temporal relationship as well as other perspectives of symptom management (Stamm, 1999).

More recent studies focused not only on categorical symptomatology of STS of which caregivers are prone (i.e., intrusion, avoidance, distorted perceptions, and arousal/reactivity), but also the need to understand STS is more likely caused by the provider's interactions with the workplace environment, rather than as previously assumed as merely on the direct patient care

(Rhoton et al., 2019). Noting the underpinnings of presenting behaviors (e.g., irritability, fatigue, hopelessness, anxiety, dread, the desire to quit, and frequently changing jobs) that "swing like pendulums" (Rhoton et al., 2019, p. 15) between manifestations of depression and anxiety seen as natural and consequential to the work environment, the authors illuminated this previous misconception of the source of STS (Bride, 2004).

Bridging awareness between the environmental stressors (e.g., overwhelming demands of the healthcare system, scheduling, lack of funding, prejudicial evaluation of others, and agency politics) and findings some professionals enter the helping field with preexisting primary stress from their past, it became evident a synergistic effect resulted in exacerbating the effects of compassion fatigue of the caregiver (Gentry, 1999; Rhoton et al., 2019). Requiring programs that address both primary and secondary trauma of the caregiver, theorists began to explore supportive models that offered training as treatment options that sought to ameliorate the negative symptomatology while simultaneously developing skills of resiliency allowing one to remain in stressful work environments (Baranowsky et al., 2005). Training as treatment is defined as the process of enabling clinicians to not only learn the skills in reducing compassion fatigue in others, but also more importantly, enables them to reduce the negative effects of compassion fatigue in themselves. This process was introduced, described, and evaluated in an early addition of the Certified Compassion Fatigue Specialist Training Manual (Gentry et al., 2004).

Burnout, Toxic Stress, and Moral Distress

At the most extreme level, burnout first emerged as a social problem, rather than an academic construct, and importance in the workplace was first focused on by researchers in the 1970s, as professional and cultural discourse began to address the impact of emotional depletion,

loss of motivation, and reduced commitment of employees and volunteers working in high stress environments (Freudenberger, 1973, 1975; Maslach, 1976; Maslach & Schaufeli, 1993; Schaufeli et al., 2009). In an effort to more thoroughly understand the origin and underpinnings of the burnout concept, researchers provided an overview in a historical context—beginning with the roots of the concept embedded socially, economically, and culturally in the last century—potentially influencing the multidimensional phenomenon of wearing out as well as "detached concern and dehumanization in self-defense" that had resulted from the transformation of our previous industrial societies into economies based on human service delivery (Maslach, 1976; Miller et al., 1988). As a result, it was suggested psychological pressures may have translated into a condition of stress response—expressed as burnout—coined in 1974 by clinical psychologist Freudenberger and described as the state of becoming exhausted by making excessive demands on energy, strength, or resources in the workplace. His work was later attributed to the concept of burnout syndrome. It is noteworthy that many scientists and clinicians remain in heated debate whether burnout syndrome should be considered a valid mental health diagnosis (Heinemann & Heinemann, 2017).

Considered further as the increasing erosion of a positive psychological state in the helping professions—due to the negative effects employees experienced from the demands of human service work over time—the term burnout was often used to describe the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment for those who do people work of some kind (Maslach, 1976). Early research quickly revealed consequences of burnout often led to a deterioration in the quality of care or service provided, as well as resulted in job turnover, absenteeism, and low morale (Freudenberg, 1975; Maslach & Pines, 1977). Furthermore, burnout appeared to be correlated with additional factors, such a personal distress,

physical exhaustion, insomnia, and increased use of alcohol and drugs, and marital and family problems, which led to consideration of supportive structures (via staff enrichment programs) and postulation of measurement tools (e.g., the Maslach Burnout Inventory) to better recognize the approaching signs, as well as provide help for the workers in advance of the burnout syndrome (Freudenberg, 1973; Maslach & Jackson, 1981).

Moral distress, which is highly correlated with burnout, is the inability of the clinician to act according to his or her core values and perceived obligations due to internal and external constraints of the context (often a medical or mental health setting) in which they are providing care. It is characterized by the "rightness" or "wrongness" of decisions, treatments, or procedures, while feeling powerless to change situations they perceive as morally wrong (Fourie, 2017; Fumis et al., 2017). Moral distress was found to be especially concerning during the COVID-19 global pandemic, and recent researchers not only found significant levels of psychological distress in exploring five main categories—moral-constraint, moral-uncertainty, moral-dilemma, moral-conflict, and moral-tension—but also found psychological distress to be observed across all professional disciplines of caregiving (Epstein et al., 2019; Morley et al., 2020). Examples of scenarios faced during the COVID-19 global pandemic that may have led to moral distress were (a) telling families they cannot visit and witnessing patients die alone, (b) treating patients without proper protective gear due to shortages, and (c) abandoning bedsides and proper protocols due to high patient volume and low resources (Mooney, 2021). Although the aforementioned examples may have been common to the medical or healthcare worker, ethical dilemmas were experienced across the caregiving profession. Additionally, although the source of moral distress is often differentiated in terms of constraint versus uncertainty and focused on the wellbeing of the patient, awareness and concern of the intensified distress during

the global pandemic was expanded to include the impact on the health professional as well (Spilg et al., 2022).

A more recent study by Franke (2014) focused on the debilitating effects that may be triggered when caring for traumatized clients. Now known as toxic stress—resulting from prolonged activation of the stress response systems in the absence of supportive and protective relationships during childhood—Franke also sought to explore the underlying mechanisms of the causes, as well as to discover the means to mitigate such effects in an effort to support clinicians in remaining in such critical work well into adulthood. Illuminated by the early work on adverse childhood experiences (ACEs) by Dr. Vincent Felitti, Chief of Kaiser Permanente's Department of Preventive Medicine in San Diego, who sought to better understand the powerful relationship between negative childhood experiences and later adult emotional and physical health, it was discovered when considering three primary factors from early life (i.e., abuse, neglect, and household dysfunction), it became evident some healthcare workers may be more prone to STS (Felitti, 2002).

Additional research found exposure to trauma-related material in both professional coursework and in the training field also revealed a higher risk for reactivation and retraumatization for STS symptoms (Butler et al., 2018); ongoing studies have continued to explore the biological impacts of ACEs and the mechanisms of mediation between early life stressors and poor physical and mental health disparities in adulthood (Ridout, 2018). Because increased prevalence of ACEs may result in autonomic nervous system (ANS) dysregulation leading to a hyper-state of threat response (known as dysautonomia), it is essential for clinicians to be aware that earlier life experiences may actually thwart one's health in the service to survival (Dani et al., 2021). Awareness of this connection will be helpful as clinicians move to

further understanding of the biological stress cycle and how stressors experienced in everyday lives may activate neurological and physiological shifts triggered by the perceived threats and traumatic "footprints" from earlier in life (Felitti, 2009; Nagoski & Nagoski, 2019).

Body–Brain Connections

Following the 1970s, when the conceptual framework of PTSD was put in place, many psychologists began to see a radical shift in how they viewed their patients. As recalled by one expert in the trauma field, Bessel van der Kolk (2015), MD, in his early work at the Veteran's Administration (VA), "there was an explosion of research and attempts to find effective treatments, whereas in the early days, [the veterans] were labeled with all sorts of diagnoses—alcoholism, substance abuse, depression, mood disorders, even schizophrenia" (p. 19). He shared his own fundamental shift in developing methods that have since helped thousands of trauma survivors' use their brain's own natural neuroplasticity in the present, as well as finding agency in moving on with their lives (van der Kolk, 2015). As a clinician, researcher, and teacher, his integrative techniques broadly included self-regulation, taking steps toward self-empowerment, expressing inner experience, and integrating the entire individuals' senses through rhythm (Buczyski & van der Kolk, 2015). With additional understanding that individuals experiencing complex trauma exposure are placed at higher risk for cumulative impairment (i.e., psychiatric and addictive disorders; chronic medical illness; legal, vocational, and family problems), van der Kolk viewed recovery as addressing the far-ranging trauma from multiple therapeutic perspectives (Cook et al., 2005).

Other researchers, such as Porges (2009), provided a glimpse into the neurophysiological window of the autonomic nervous system, and offered his view called the polyvagal theory (referring to many branches of the vagus nerve) that built on the Darwin's pneumogastric nerve

theory and suggested the connection between numerous organs, including the brain, lungs, heart, stomach, and intestines. This newly sophisticated understanding of interplay between the visceral experiences of one's own bodies during interactions with others provided insight into novel approaches that could be focused on strengthening and healing the body's system by regulating the natural tendency of "fight or flight" arousal response by encouraging desired biobehavioral processes (Porges, 2007).

With an even deeper look into the biological stress cycle and need for self-regulation and neuroceptive management, additional scientists focused on the neural circuitry of the emotional brain. In his book *Anxious*, JLeDoux (2015) highlighted the interactive role of the mind and brain in the generation of both unconscious and defensive responses and consciously expressed anxiety. He asserted fear and anxiety can both be understood from the perspective of "defensive survival circuitry" (LeDoux, 2015, p. 43), rather than merely as emotions or feelings. He further explained that the emotional brain could detect danger even before the individual experienced the associated feelings (of fear or anxiety) and initiated the physical responses (e.g., heart palpitations, sweaty palms, muscle tension). LeDoux's work suggested many common psychiatric problems (e.g., phobias or PTSD) are actually "malfunctions" in the way emotional systems are learned, and, having an understanding of how these mechanisms normally work might have important consequences for how psychologists view themselves, as well as treat clients suffering with emotional disorders (LeDoux, 1996).

Future Paths for Those Providing Treatment for Trauma or PTSD

With advanced awareness of associations between symptomatology of STS (i.e., anxiety, irritability, compulsivity, and fatigue) and painful past learning that often intrudes into the present moment of the caregiver when feeling threatened, psychologists and researchers are able

to both name and explain the underlying dynamics causing the distress. For example, traumagenesis is the term to help explain the physiological phenomenon that occurs when people experience sensory similarities (e.g., smells, images, tastes, sounds) in the present moment as a felt sense of perceived danger, just as they did during the actual early life traumatic event (Gentry & Monson, 2017). In this way, clinicians can better understand the relationship between the STS (stemming from sensorial memories from difficult events in earlier life) and the burnout that often results from interaction and automatic reaction in the present stressful workplace environments (Gentry & Monson, 2017; Read et al., 2014). Given this potential, it is imperative for clinicians entering the helping professions to be aware of their own ACEs and the relationship with STS symptoms (Butler et al., 2018).

Recognizing this tendency to pair past, painful learning with STS, reciprocal inhibition evolved as an area of psychological research that recognizes the need to confront perceived threats in a relaxed body, rather than attempting to confront with brute force (Gentry, 2020). Discovered by Wolpe (1995) as a behavioral dynamic and explained as the relationship between the conditioned stimulus (i.e., perceived threat) and conditioned response (i.e., aroused autonomic nervous system leading to anxiety), Wolpe was able to show that through systematic desensitization and learning relaxation techniques, one could extinguish the negative symptoms of the former anxiety provoking situations. Wolpe's methods have since been credited as the "engine" of many future psychotherapeutic treatments for anxiety and trauma (Gentry, 2020).

Other prior methods using imagined (i.e., fantasy flooding) and prescribed cues (i.e., implosive therapy) have also been examined in the realm of desensitization methods (Boudewyns & Shipley, 1984); however, Boudewyns's inconsistency with the use of relaxation paired with exposure to verbalize the perceived threat have led others to consider a different

approach (Gentry, 2020). Instead, many researchers recognize the properties of the Yerkes-Dodson Law and the need for a certain level of eustress ("good stress") which allows the person to confront the perceived threat in a relaxed body, reducing the level of distress ("bad" anxiety provoking and fear arousing) and supporting enhanced occupational performance (LeFevre et al., 2003).

Viewing Anatovsky's (1987) salutogenic model of health versus illness as an alternative approach to seeing health as a continuum rather than as a dichotomy, the concepts around resistance resources are described, noting the potential for individuals to make sense of stressors and endure difficult life circumstances, leading to meaning and management of negative symptomatology. Guided by such tenets, current trauma therapies are focused on effective treatments to comprehensively explore (rather than attempt to cure): cognitive restructuring and psychoeducation, a deliberate and continually improving therapeutic relationship, relaxation and self-regulation, and exposure via narrative of traumatic experiences (Gentry et al., 2017). Using both interoception (i.e., awareness of subtle sensory, body-based feelings) and neuroception (i.e., the capacity to evaluate relative danger and safety in one's environment), current trauma-informed researchers hypothesize that effective treatment models must integrate development of emotional resilience with the ability to self-regulate as the means to overcome and flourish in moments of life distress (Ceunen et al., 2016; Porges, 2004; Rhoton et al., 2019; Van der Kolk, 2006).

FFPR Training Programs

Developed in 1998 by Dr. Eric Gentry and associates (Anna Baranowsky, PhD and Kathleen Dunning, MSW), the Accelerated Recovery Program was the first evidence-based treatment for the symptoms of compassion fatigue. In 1999, Gentry developed the first single-

day professional resilience training designed to simultaneously lessen symptoms of compassion fatigue and toxic stress, prevent future work-related stress, and optimize professional functioning (Gentry et al., 1999). Since then, he has published multiple peer-reviewed studies detailing the effectiveness of his modality (Gentry & Dietz, 2020). The most recent emphasis of Gentry's 35 years of lifetime work has culminated in his assertion that "although [healthcare providers] may not be able to avoid environments toxic to mental health and well-being, it is necessary to develop immunity needed to continue the work without becoming 'ill'" (Gentry & Monson, 2017, p. 50). In this regard, Gentry created FFPR and developed five resilience skills (or antibodies) that have been demonstrated to provide the professionals with immunity while working in these spaces. These five professional resilience skill categories (i.e., innoculations) are (a) self-regulation, (b) intentionality, (c) perceptual maturation, (d) connection and support, and (e) self-care and revitalization (Gentry & Deitz, 2020; Gentry & Monson, 2017). Each of the skills learned in the training are meant to be incorporated in the professional workspace, as well as integrated in personal life of the clinician. The FFPR training program is now available via a web-based platform on multiple online domains.

FFMe Engagement/Support Group

Created for the clinicians seeking support, opportunity for engagement, and practice with skill building for resilience during times of adversity, this weekly 90-minute online gathering involves the combination of self-regulatory skills paired with principle-based living. Each group is limited to 12 participants and takes place for a 6-week period. In addition to completing and sharing a personal purpose/mission (i.e., covenant) and principles (i.e., code of honor), explained in the FFPR program, each participant then had the opportunity to share successes and challenges experienced along their journey and report to the group how their level of compassion

fatigue and satisfaction has been altered by practicing the tools of hope throughout the previous week in their daily life and during clinical care (Gentry et al., 2020).

Statement of the Problem

Although a plethora of caregiver support programs can be easily found by a simple online search to reveal an endless list of options (e.g., Alzheimer's and dementia, autism and learning disability, gender and sexuality, stroke and heart attack, substance use and addiction, Parkinson's and cancer, veteran caregiver) that are held both in-person and virtually, fewer programs are available to support the mental health caregivers' need for purposeful and supportive engagement. Although there are both informal and formal peer support groups generally available within the professional settings as part of employee assistance programs, the meetings are often not open for public membership and require employment status to attend (SAMHSA, 2022).

An example of an in-house program is the Center for Professionalism and Peer Support, created in 2008 at Brigham and Women's Hospital, Boston, was developed to educate the hospital community regarding professionalism and manage unprofessional behavior (Shapiro et al., 2014). This program offers trained peer support in reaching out to impacted colleagues that have an unexpected clinical outcome, personal loss, or other life stressor.

An example of a previously closed employee assistance programs group that is now an open resource is the RISE (Resilience in Stressful Events): Caring for the Caregiver program, which attends to the second victims—employees experiencing distress following patients' adverse events (Edress et al., 2016). RISE, which was initially formed specifically for John Hopkins Medicine employees, is now run by volunteer peer–responders (e.g., chaplains,

counselors, doctors) who carry pagers and are available 24/7 to meet with providers in acute need of processing a difficult workplace event.

More recently, the military has recognized the need for such programs and has emphasized the inclusion of peer support programs across the military healthcare system to promote workforce wellness for clinicians during times of heightened stress and vulnerability (Keyser et al., 2021). In addition, “Buddy Care: A Peer-to-Peer Intervention” has been piloted as a preventative project to decrease occupational stress in the overseas military arenas (Villaruz Fisak et al., 2020). As well, the Department of Defense has implemented family and community assistance via peer-to-peer support which is available to all service members and spouse throughout active-duty service (Military OneSource, 2020). Similar in approach to the peer support programs of the military, the Academy Hour peer support for first responders training program offers mental health training to better support law enforcement officers and first responders both on and off the job. The Academy Hour certification is available for both counselor level and nonclinicians and provides 24/7 care to individuals in need (Academy Hour, 2023).

Even though options for supportive and educational mental health groups are increasing, this researcher was able to find little evidence of programs aligned with the training as treatment model, which makes the FFMe groups a unique consideration for what might be helpful in future peer-to-peer program formation. Moreover, because the peer-to-peer framework is less formal in nature than the structure of therapeutic or mutual support groups, they have been found—unsurprisingly during the intensive burden on clinicians to carry heavier caseloads and the isolative nature of tele-mental health during the COVID-19 global pandemic—to promote a sense of community, collegiality, and connection (Miu et al., 2022).

Despite similar characteristics between peer-to-peer, therapy, and mutually led support groups for clinicians to attend, there are also distinct differences. For example, therapy groups are facilitated by mental health professionals who bring several people together and provide treatment related to a similar condition. Because therapy is being providing to the entire group, rather than individually, specific techniques, processes, and strategies must be employed, and the leaders of such groups are encouraged to have specialized training in areas of group development related to cohesion, identity and repair ruptures, diversity, and conflict resolution (Novotney, 2019). This training helps to maintain calm when problems arise among group members. In contrast, mutual support groups are peer-led, and, although the facilitators receive training to maintain the agenda of the group, they do not give advice or act as mental health professionals.

Similarly, although peer-to-peer engagement is led by mental health professionals, they do not provide therapeutic feedback or advice in any way. Each attendee of the group, including the facilitator, is encouraged to verbalize professional successes and challenges of the previous week, and the purpose of both the facilitator and fellow attendees is to provide a safe and supportive emotional sharing environment (Hoy, 2022). This differs from therapy or mutually led support groups as other participants in the room receive minimal feedback. In this way, because the role of the facilitator in the peer-to-peer engagement forum is primarily one of holding safe space for clinicians to express difficulties in their profession, it ensures the dynamic of the groups remains one of open processing, rather than leaning toward a therapeutic group dynamic where there might be expectation of feedback or group cohesion (Marmarosh, 2018).

Listservs are another source of accessing supportive engagement for mental health professionals that have expanded in the use of technology to locate virtual peer-led and discussion groups and apps (NAMI, 2022). Invented in 1986 by Eric Thomas as the first email

management software (primarily for discussion groups to take place within a company), technology has since taken hold in universities, political and religious interest groups, nonprofit organizations, and various groups forming electronic mailing lists to stay connected in the world-wide forum (McCartney, 2022). Even though listservs provide professionals with similar interests an electronic forum to ask questions, make requests, share resources and information within a broad community, they are not intended to promote in-depth analysis or guidance for individuals. They are more so a forum for offering feedback and soliciting general professional advice (Kurtz-Rossi et al., 2017).

With emerging awareness around the necessity for effective and positive social network interventions to increase mental health and well-being, it has become evident that there is incremental movement toward discovering new paths for both primary and secondary trauma treatments for clients and caregivers alike (Quitangon, 2019; Swinkles et al., 2020). Noting one systematic review, some researchers focused on resilience and risk factors via cross-section study designs, and others contend that future research should focus on longitudinal designs and preventative as well as curative interventions (Greinacher et al., 2019). Although previous researchers have recognized the need for supportive in-person and onsite programs to address debilitating response patterns found in those working with traumatized clients—especially with military health professionals, emergency medical clinicians, and natural disaster responders (Clifford, 2014; Posselt et al., 2020; Walker, 2011), increasing demand for programs to include virtual options for caregivers to meet safely and effectively has become even more apparent (APA, 2021). Further inquiry revealed more Americans sought help for health behaviors through self-help than through all other forms of professionally designed programs. One particular study noted mutual support groups, involving little or no cost, have had a powerful effect on mental

and physical health. The author noted future work will focus on whether patterns of support seeking will be similar for both real-world versus computer-based virtual support groups (Davison, 2000).

Additionally, ample current studies have revealed prolonged experiences of stress and anxiety at the workplace, without a mechanism to counter such effects, can culminate in psychological distress. This finding underscores the need for understanding and mitigation of the impact on caregivers, many whose mental and physical health were already vulnerable before COVID-19-19 (Adams & Walls, 2020; Bueno & Barrientos-rigo, 2021; Park, 2021; Zhao et al., 2020). One significant study offering telehealth peer support and individual counseling for frontline healthcare workers during the pandemic, concluded video conferencing was found to be a useful model that other centers might adapt going forward (Viswanathan et al., 2020). The authors noted the importance of having the space for expression of feelings, peer support, consensual validation, and peer-learning as primary factors in the success of the intervention.

Purpose and Significance of the Study

The purpose of this study was to explore the effects of a virtual peer-to-peer professional engagement group, FFMe for mental health clinicians in the human services arena. Based on the evidence-based FFPR training framework, this model pairs science-based and self-regulatory skills with intentional resilience living practices to mitigate moral distress and burnout. Given this interactive space, the individuals met weekly (for 6 consecutive weeks) in a virtual forum to engage with other mental health care clinicians and discuss both successes and challenges specific to intentionality and self-regulation practice experienced throughout the previous week. This study not only sought to address the current gap in the availability of online clinical support groups, it also emphasized one such timely program—the FFPR training model and FFMe

engagement group—as a means to mitigate toxic stress and burnout. Situated in the context of virtual "in-vivo" practice, this study aimed to learn how both novice and seasoned participants experienced the peer-to-peer learning model, focused on integrating the *Tools of Hope* psycho-education and skills building practice as a source of both personal and professional resilience.

The findings from this exploration may increase the awareness around the caregivers' own traumatic stress and connection to the impact of past, painful experiences on the threat response system often activated in present physiological responses. It may also inform future trauma-informed professional development and illuminate continued support needs for clinicians serving traumatized populations, as well as recognize the collective trauma presently navigated in society around the COVID-19 global pandemic. Finally, the outcomes may provide further insight as to what constitutes best practices for safe, flexible, and effective virtual engagement platforms, which may likely become more common as a future means of mental health clinician connection and support.

Research Question and Study Aims

The purpose of this study was to examine the role of a virtual professional resilience training model (via the web based FFPR training and online FFMe engagement/support groups) as a potential mediator between vicarious traumatization and both compassion fatigue/moral distress and compassion satisfaction/growth for mental health clinicians.

- Research Question: How does professional resilience training, followed by a 6-week virtual support/engagement group mediate the relationship between vicarious traumatization and both compassion fatigue/moral distress and compassion satisfaction/growth for mental health clinicians?

- Aim 1: Obtain a greater understanding of mental health clinicians' lived experience of working with clients in distress.
- Aim 2: Gather participants' perspectives while moving through three phases—education/skills building, intentionality/self-regulation training, and connection/engagement—of the FFPR training and FFMe support groups.
- Aim 3: Explore meaning derived from participating and sharing in the weekly FFMe peer-to-peer support groups.
- Aim 4: Develop conversation around meaning gained for sustained work with populations processing traumatic life events.
- Aim 5: Examine elements of online peer-to-peer engagement sessions that may inform future virtual support groups.

Chapter 2

Theoretical Framework

Using a qualitative framework, incorporating semistructured interviews based on descriptive phenomenological inquiry, study participants (mental health clinicians) examined their capacity for empathy, level of moral distress and compassion fatigue due to vicarious traumatization, as well as their level of compassion satisfaction in cultivating professional self-care. Additionally, they shared and described their lived experience of moving through three phases—education/skills building, intentionality/self-regulation training, and connection/engagement—of the forward-facing professional resilience (FFPR) training and forward-facing me (FFMe) support group model. Qualitative assessment was employed to integrate the relationship between personal and occupational trauma-related symptomatology and burnout and identify personal and professional life goals. Additional descriptive data collection was also captured during discussion and participant observations (following the virtual engagement/support groups), in an effort to gain a deeper understanding at the experiential level of the participants related to the phenomena under study.

Methodology and Research Design

Viewing methodology as a bridge linking epistemology (i.e., understanding gained from investigation of justified belief versus opinion) and method of exploration (essentially the theoretical framework of defining the problem and how to approach the solution), this study homed in on the qualitative vantage points and illuminated common themes that allowed for a more complete analysis (Teddie et al., 2008). In doing so, this study used a multimethod approach (via interview and observation)—involving an interpretive, naturalistic approach to its subject matter—wherein the data were collected and examined within the overarching social

science theory, in an effort to better understand and explain the relationship variables (Creswell & Creswell, 2018). For the focus of this study, the goal was to discern the effectiveness of the experiential learning via a training-in-treatment based model.

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Participants

The target population for this study was experienced, licensed practitioners or novice practitioners (i.e., students in graduate training programs who were working in the capacity of practicum or internship placements) who had an interest in furthering their learning around the respective FFPR and FFMe treatment model. Workplace locations ranged from private practices, medical facilities, mental health outpatient and mobile clinics, and nonprofit social service agencies that provide therapy to those who have experienced trauma. A broad range in professional roles and agency sites was helpful in determining potential differences between supportive resources provided at respective locations of care, as well as level of experience in the field between novice clinicians and graduate student themes versus seasoned clinicians.

All participants selected currently worked in mental health related clinical roles (e.g., psychology, social work, mental health counseling, behavioral coaching, marriage and family therapy). Participants for this study were recruited via a combination of purposive and snowball sampling. Based on the purposive sampling framework, the participants were deliberately chosen based on criteria representative of the mental health professional domain. Additionally, the snowball recruitment method was helpful in seeking friends and colleagues in the networks of the initial participants recruited. This combination of sampling provided a broader reaching element, as well as a greater level of in-depth and detailed inquiry about the phenomenon (in this case, interest in peer-to-peer/training-in-treatment model) under investigation.

The researcher circulated informational correspondence (including invitation) to colleagues to encourage potential participants who might have an interest in the interview process (see Appendix A). The invitation contained the following: (a) the researcher's contact information, (b) a description of the study, (c) eligibility requirements, (d) explanation of what is

required of the participants, and (d) the potential costs and benefits associated with participation in the study. Participants who expressed interest in the study were contacted and scheduled for an informational interview. All prestudy sessions were completed remotely using HIPAA-compliant videoconferencing platforms.

Interviews were audio recorded on the researcher's laptop for the purposes of transcription at a later time. Once the transcription step was completed, the researcher then transferred all recordings onto a password protected external flash drive. The USB flash drive was stored in a locked filing cabinet for the entirety of the research study process. Prior to entering the study, all participants were asked to review and sign a consent document, informing them of their rights, including their ability to withdraw from participating in the study at any time and with no repercussions (see Appendix B). The consent form outlined the potential benefits and risks of taking part in the study, and participants were encouraged to communicate questions or concerns prior to signing and beginning steps in the study process.

Recruitment

Participants of all genders, ages, and ethnicity were recruited via written communication (e.g., personal, practicum site, and school email), and/or word of mouth with those working within the mental health field (i.e., private practice consortiums, community mental health centers, and university students and alumni). This study was void of deception, and there were no incentives or compensation provided for completion of either the FFPR training or the FFMe engagement groups. Participants were made aware that both the FFPR and FFMe groups were provided free of charge. Additionally, participation was voluntary, and all individuals were informed that they may choose to withdraw from the study at any time.

Because phenomenology was used as the overarching framework for gaining insight to the lived experience of the participants as they practiced the forward-facing Tools of Hope in their personal and clinical lives, it was essential to recruit clinicians with willingness to both engage in and report on the entirety of the lengthy program. The interested clinicians were made aware that participation in the study would include semistructured interviews, observations, discussions, support groups, and analysis of notes to understand the views and perspectives more fully of their learning and lived experiences practicing the FFPR approach to self-regulation when providing trauma-informed care.

Participants were informed that the cumulative data collection of both individual interviews and observation notes taken before and after completion of the 6-week support groups would be involved in the process. As well, the strategy of bracketing (i.e., attending to the researcher's biases assumptions in avoiding influencing the participants' responses) and reflexivity (i.e., recognizing the researcher's positionality as a fellow clinician) was used to ensure validity during analysis. Additionally, to meet the requirements of triangulation (i.e., referring to the use of multiple methods or data sources to ensure a comprehensive understanding of the phenomenon), both method and investigator triangulation was used in this study (Carter et al., 2014). For the method triangulation aspect, a combination of interviews, observations, and field notes were considered, and for the investigator triangulation strategy, two additional coders (i.e., recent PsyD graduates, both familiar with qualitative research) were involved to provide confirmation of selected codes, as well as multiples observations and perspectives.

To further ensure as neutral a stance as possible in the study process, the researcher fulfilled only the roles of the following: recruitment of the participants, delivery of the semistructured interview processes, and analysis of the collected data. Whereas, the treatment

portion of the study was conducted by both the creator of the Forward-Facing Professional Resilience Training Webinar, Eric Gentry, PhD, and the 6 weeks of FFMe peer-to-peer engagements groups were led by his associate, Jenny Brackman (Gentry, 2022, 2023). In an effort to remain outside of the scope of participant influence, the researcher strived to maintain an unbiased position throughout the data collection and study process.

Demographic Questionnaire

Each participant was asked to complete a questionnaire collecting various aspects of demographic information, related to age, gender, education, professional identity, and years of experience. Additional questions were asked related to aspects of the respective workplace, such as amount and quality of supervision, percentage of caseload focused on traumatized clients, availability of self-care, social support, and access to personal therapy (see Appendix C).

Qualitative Methodology

Phenomenology—essentially, a way of thinking about knowledge from both a philosophical point of view and method of inquiry—was used in this study to gain insights into the lived experience of the participants as they practice the forward-facing tools of hope in their personal and clinical lives (Qutoshi, 2018). This approach, focused on the experiential aspects of the individual, considers how the phenomena is experienced at the time it occurs, rather than the meaning often later ascribed to it. Using methods to include semistructured interviews, observations, discussions, support groups, and analysis of notes, the focus was on gaining an in-depth understanding of the phenomena embedded within the research participants' views and perspectives of both learning and lived experience of practicing the forward-facing approach to self-regulation in the face of providing trauma-informed care. Following the cumulative data

collection of both individual interviews and observation notes taken after the six weekly support group interviews, the strategy of bracketing was used to ensure validity during analysis.

Philosophical Worldview

The social constructivist worldview was evident in this project, as the focal point of inquiry was based on the specific contexts in which the individuals live and work, deriving meaning-making formed through the collaborative discussions and interactions of the participants as they moved through the peer-to-peer treatment model. Additionally, it was recognized the researcher's own background, culture, and experience shapes their interpretation as they moved through the inquiry, attempting to make sense of the data obtained (Creswell & Creswell, 2018).

Data Collection Process and Procedures

The design of this study was a multimethod framework (involving both discussion and observation), using responses collected from semistructured interviews based on phenomenological inquiry. Qualitative discussion was focused on the clinicians' current levels of compassion fatigue and compassion satisfaction, as they moved through weekly practice and engagement groups. Qualitative data were obtained via semistructured, virtual face-to-face, audio/video-recorded interviews, which was conducted in a secured online format.

Participants were provided with an informed consent describing the study, and time was provided for explanation as well as inquiry prior to signing, granting permission to take part in all aspects of data collection. Each participant was assigned a participant identification number (e.g., P1, P2, P3) then scheduled for an individual session that took place in a private virtual meeting (via "Zoom" platform). Semistructured interview questions were designed and led by the study facilitator (see Appendix D), and all were recorded and transcribed via the "Trint"

application. Transcribed interviews were later coded by ATLAS.ti data analysis and research software, to draw out common themes and meanings of the discussions. Additionally, to provide common language for discussion of various trauma related terms throughout the interviews and study process, participants were provided with definition of terms for clarity and understanding (see Appendix E).

Credibility, Validity, and Reliability

To further internal validity, member checks were conducted during the study interviews to determine if the researcher's interpretation of participants' responses were in alignment with their experiences. Additionally, transcripts of interviews were made available to promote reliability and corroboration with participants. Bracketing was attended to by the researcher's awareness of personal biases and assumptions and avoidance of influencing participant response. Reflexivity was also considered, as the researcher recognized positionality as a fellow clinician in the caregiving profession.

Because the facilitator of the study was also a peer clinician, it was essential to maintain a role of neutral guide through each step of the study process. The facilitator was intentional about maintaining a nonreactive verbal and facial response to interview questions, to avoid influencing the answers of the participants. Additionally, throughout the interviews, the responses of the interviewees were reflected and clarified to ensure full understanding for meaning and accuracy. Alternate significant themes and foci (outside of main questioning) were noted for later reference. Findings from combined data were interpreted and summarized, seeking a greater understanding of the need for increased supportive virtual services and broadening the research topic in question.

Protection of Human Subjects

Potential participants were screened in advance and provided guidelines regarding awareness of study focus, expectations of attendance and survey completion, provision of incentive, privacy of information, and voluntary nature of involvement. An informed consent form was completed prior to the study initiation and participants were offered the opportunity to ask questions of the researcher at any time during the study. Participants were also provided a copy of the consent form.

Individuals were provided options to access emotional support should they experience discomfort during their experience in the study. The participants were also encouraged to seek out therapy support referrals via online forums (e.g., Psychology Today), contact the local crisis hotline, or talking with the principal investigator for a counseling referral.

Chapter 3

Analytic Strategy

This chapter investigates the lived experience of 10 mental health clinicians as they moved through the three phases—education/skills building, intentionality/self-regulation training, and connection/engagement—of the forward-facing professional resilience (FFPR) online training, followed by six weekly encounters in the forward-facing me (FFMe) virtual peer-to-peer support group model. Using a descriptive phenomenological research design, semistructured interviews were conducted to better understand the synthesis and meaning of how the participants experienced both the FFPR and FFMe processes. The present study also explored and elaborated on the challenges and obstacles each individual had faced in finding previous options to mitigate compassion fatigue and burnout in their respective arenas of human service work, as well as successes and relief with the newly obtained tools of supportive self-care.

Based on the philosophy and historical components of Edmund Husserl, who was considered the father of phenomenology, the interviewing format incorporated elements of his 1970's publication of *Logical Investigations,* which introduced both a novel way of examining and studying the conscious experience, as well as a method with three primary steps for analysis (Giorgi et al., 2017; Thoibisana, 2016). Husserl proposed the first step requires the individual to provide a personal description of their experience, as this allows a self-reflective dimension that would otherwise be inaccessible to the researcher. Secondly, he theorized the researcher must have a "transcendental attitude," which he described as a special method of *eidetic reduction*, whereby the goal is to identify via "essentially seeing" (Majolina, 2016, p. 164) the basic components of the phenomena reported. Thirdly, the researcher is required to seek the essence of the experiences described to more fully communicate them to others (Giorgi et al., 2017).

Similarly in this study, Husserl's three-step approach was used to first gather the narratives of each of the participants, next code the common elements of the descriptions, and, ultimately, report outstanding meaningful themes that may enhance the experience of future peer-to-peer support groups.

The qualitative analyses of the 10 semistructured interviews investigated the following five aims in an attempt to learn how the participants' professional resilience training, followed by a 6-week virtual support/engagement group might impact the relationship between vicarious traumatization and both compassion fatigue/moral distress and compassion satisfaction/growth for mental health clinicians.

- Aim 1: Obtained a greater understanding of the mental health clinicians' experience of working with clients in distress.
- Aim 2: Gathered participants' perspectives as they move through the three phases—education/skills building, intentionality/self-regulation training, and connection/engagement—of the FFPR training and FFMe support groups.
- Aim 3: Explored the meaning derived from participating and sharing in the weekly FFMe peer-to-peer support groups.
- Aim 4: Developed a conversation around the meaning gained for sustained work with populations processing traumatic life events.
- Aim 5: Examined the elements of the online peer-to-peer engagement sessions that may inform future virtual support groups.

The initial preintervention interviews were focused on areas such as background information related to mental health career role and focus, professional experience, challenges and successes with self-care options, and motivations for taking part in the study. The

information collected from the pre-intervention meetings also helped to discern whether the individual was a good fit for the study, considering criteria such as level of education and arena of work, availability, and time commitment to fulfill multiple weeks in the study, and previous knowledge and exposure to the Forward-Facing trauma focused trainings and care models.

In follow up, the posttreatment discussions emphasized which aspects of the study (i.e., sharing a personal purpose/mission "Covenant" and principles "Code of Honor," practicing self-regulation and grounding exercises "Tools of Hope," and weekly reflection/reporting to the peer-to-peer support group) were most challenging and helpful throughout their participation. The participants were also encouraged to reflect on their personal lived experience of moving through the three phases—education/skills building, intentionality/self-regulation training, and connection/engagement of the program—as well as their reactions to witnessing other participants' sharing. From such inquiry, both primary (base) and secondary (subthemes) emerged to provide insight as to (a) the potential impetus for mental health clinicians to seek support groups, (b) the elements of the FFPR training and FFMe virtual peer-to-peer engagements that were both challenging and meaningful, and (c) aspects of the process that might inform future online support forums.

Participant Demographics

The group of participants was comprised of 10 individuals, seven self-identifying as female and three as male, all of whom consented to participate in the research study. Their ages ranged from 28–57. The participants ascribed their racial groups as Caucasian, Asian, and multiracial, and they reported ethnicities as Scandinavian, Hispanic, Filipino, and White, non-Hispanic. All 10 participants were currently employed in mental health arenas, and the majority

had a master's level of education and were licensed in their field of specialty. Seven of the 10 participants endorsed working in the mental health field for more than 6 years.

Most participants were licensed mental health clinicians and worked in areas of care that stretched across broad domains of outpatient community mental health, behavioral health, inpatient addictions treatment and rehabilitation, marriage and family therapy, trauma-focused therapy, life and reflexology coaching. Access to services was provided via individual, couples, family, and groups, as well as in-person, telehealth, hybrid, and mobile medication assisted treatment (MAT) options. Service and agency locations were in multiple geographic locations across the United States (i.e., Florida, Kentucky, Louisiana, Tennessee, and Washington), Canada, Philippines, and Norway.

Common to all of the participants was their motivation for entering their respective helping profession (e.g., desire to help and advocate for others, sense of life calling and purpose, and confidence in skills to support clients), as well as negative symptoms resulting from working with distressed individuals (i.e., exhaustion, mood changes, insomnia, and somatic symptoms). Additionally, they all shared a similar experience of awareness of vicarious trauma and sense of nearing burnout, and they found themselves enticed to take part in the study to gain more knowledge related to both the causes of compassion fatigue related to work stress, and curiosity about new coping mechanisms available to restore energy and satisfaction in their professions. Interestingly, although each of the individuals endorsed having active "self-care" routines and multiple avenues for intentional stress release (e.g., fitness/exercise, yoga/meditation and mindfulness retreats, music/art and playing guitar, reading and listening to podcasts, and socializing and spending time with friends), none had been successful in finding ways to either

reduce the negative effects of their distressful work or preemptively mitigate further depletion of their energy stores.

When asked about challenges the participants had encountered in seeking options for self-care, responses were centered around availability of time, logistics for arranging childcare, finances, scheduling and time commitment, and feelings of guilt (primarily for spending personal time away from children or significant others). All of the participants noted they did not have access presently to any form of supportive online resources provided via their worksite locations; however, if given the opportunity in the future, they would be interested in attending such forums. There were only slight hesitations mentioned (e.g., need for safety guidelines when discussing vulnerable topics with fellow employees, worry about negative ramifications of transparency with coworkers, and concern for stigma attached to being seen as "weak") Nonetheless, all expressed the necessity for supportive forums and the interest in using the resources if made available.

Rather than using the participants' real names, they were given pseudonyms to protect their anonymity. Additionally, any details of the persons' life and professional description that might lend themselves to identification were instead grouped with the others to maintain confidentiality and privacy. See Table 1 for participant demographic information.

Table 1

Participant Demographics

	Variables							
Participants	Gender	Age (years)	Years in field	Race	Educational degree	Identified professional credential	Field of work	Percent client trauma
Sophia	Female	28	6–10	White	Master of Science in Addictions Counseling	LMHC-SUDP	Behavioral health addictions	100
Rosalina	Female	37	6–10	Hispanic	Master of Social Work	LCSW	Outpatient substance treatment	75
Robin	Female	34	6–10	White	Master of Mental Health Counseling	LMHC-CCTP	Mobile health opiate treatment	80
Phyllis	Female	57	11–15	White	Master of Science in Addictions Counseling	LMHC-SUDP	Telehealth medication assisted treatment (mat)	100
Micca	Female	43	0–5	White	Master of Social Work	LCSW	Sexual assault survivors advocacy	100
Paulo	Male	37	6–10	Asian	Bachelor in Science Nursing, Geriatric Addictions Rehabilitation	BSN, Certified Trauma Life Coach	Nursing for in-home addictions rehab trauma life coach	90
Derrick	Male	48	6–10	White	Master of Arts in Family and Marriage Therapy	LMFT	Family therapist	25
Bobbie	Female	37	0–5	White	Counseling Psychologist Marriage and Family Therapy	PsyD LMHC-A	Marriage and family therapy	20
Natalia	Female	42	11-15	White	Reflexologist and Trauma Life Coach	ARCB Certified	Reflexology trauma life coach	40
Laurencio	Male	29	0–5	Hispanic	Master of Mental Health Counseling	LMHC-A	Individual therapy	35

Note. This table illustrated participant demographic information that was reported at the time of each interview. Common characteristics include age (i.e., 28 years and older), gender (i.e., majority female), race (i.e., self-identify as White and non-Hispanic), time in profession (i.e., greater than 6 years), and level of education (i.e., master degree or higher).

[a] For the variable of Percent Client Trauma, the percentage represents the estimated amount of the clinicians' caseload that involves clients with trauma-related life challenges. 0% indicates that no clients are dealing with traumatic events, and 100% signifies that all clients are engaging in trauma processing. Participants were asked to assign a percentage to describe the amount of their caseload that was currently requiring trauma-focused therapeutic care.

Descriptions of the Participants

Sophia. Sophia was a 28-year-old single woman. Sophia was born in the Pacific Northwest region of the United States and has continued to live and work in the Seattle area. She was currently employed full-time with an informational technology agency, focused on forums for efficient, thorough, and ethical clinical documentation, insurance billing, and credentialing applications. Additionally, she volunteered with a local Kitsap County agency that supports survivors of rape and sexual assault. Sophia noted all the clients were working through high levels of trauma. Sophia became interested in the field of psychology during high school, and, immediately after graduation, enrolled in a program to obtain a certificate in substance use treatment. Sophia returned to college to complete a bachelor of arts degree in psychology while simultaneously working in both inpatient and outpatient treatment settings for a prison and community health agency. She recently completed a master of science in addictions counseling degree and was especially interested in the intersection between trauma, substance use, and mental health challenges, using compassionate inquiry (CI) by Dr. Gabor Maté; she hoped to use both her academic skills and hands-on work experience to influence the courts in providing greater supportive resources for the clients she accompanies to court proceedings.

Sophia described the greatest satisfaction in her work was "seeing the transformation of clients as they move from a place of brokenness and trauma to a space of strength and resilience." She noted the most challenging moments in her work are related to scheduling and trying to fit all of the clients in one day. Sophia defined her experience of compassion fatigue as "over-exertion of energy, running out of spoons, and an absolute feeling of being overwhelmed." She currently used multiple forms of self-care, such as coloring, longboarding, reading, and playing guitar as her go-to activities for stress release. Sophia was enticed to take part in the

study to gain a greater depth of psychoeducation around clinician secondary trauma and was especially excited to learn new tools for her own stress relief.

Rosalina. Rosalina was a 37-year-old married woman, with one small child. Rosalina was born in the Midwest region of the United States and continues to live and work in the Tennessee area. She was currently employed full-time with an outpatient substance treatment facility attached to a medical center, which integrated direct mental health support in tandem with behavioral addictions care. Rosalina noted most of her clients were processing some level of trauma in their lives. Rosalina became interested in the field of psychology while completing college classes in her undergraduate degree, then continued her education in social work studies until finally completing her master of social work degree. Following graduation, she continued to pursue learning in various therapeutic modalities (e.g., trauma-focused cognitive behavioral therapy and eye movement desensitization and processing) and recently became enticed with learning more about the forward-facing trauma therapy (FFTT) framework of care.

Rosalina noted the most gratifying aspect of her current work was "helping others learn the skills to heal and repair their life traumas." She expressed the most difficult part of her work was when "people resist change by not using the interventions provided." Rosalina described her awareness of compassion fatigue as "heightened anxiety; feeling indifferent to the patient's emotional pain; noticing zero empathy." She enjoyed spending time with partner and friends "usually having drinks" as her primary source of countering her fatigue. Rosalina also desired opportunity to return to the gym, although she "struggles with guilt and feeling indulgent" when taking time away from being with her 2-year-old son. She noted the challenge of the logistics in arranging childcare often left her feeling "resentful and angry." Rosalina became interested in

taking part in the study as an extension to her previous familiarity with the FFTT modality. She hoped to gain new skills to reduce her stress level and work fatigue.

Robin. Robin was 34-year-old woman. Robin grew up in Florida and continued to work in the Jacksonville area. She recently moved into a supervisory/director role for an addictions' treatment facility. Prior to this position, she worked for 8 years on a mobile health opiate treatment support team, providing direct support in her local community. Robin worked with a broad population of adults, ages 18–71 years old. She noted most of her clients were dealing with trauma-related challenges in their lives. Robin expressed her initial interest in the mental health field stemmed from early work as a medical assistant. She returned to school and earned a master of science in mental health counseling. Robin reported her therapeutic work was guided by Yalom's existential psychotherapy, Linehan's dialectical behavior therapy, solution-focused brief therapy, and polyvagal theory.

Robin expressed her favorite moments are "having meaningful conversations with clients; the ability to 'be in the moment' with people; planting the seeds of change, and witnessing courage when others are struggling." Her most difficult moments are related to "balancing administrative tasks with being mindful of the numerous quantity/quality of the clinical work being required." She noticed her compassion fatigue increasing when she felt "tired, drained and not always understanding why." Robin sought her greatest source of self-care through social supports, especially family and close friends. She became curious about taking part in the study as a means to bolster her connection with other peers that are doing similar human service work. She hoped to learn new skills and options for healthy coping mechanisms to counter her feelings of being overwhelmed the expectations of her new role.

Phyllis. Phyllis was a 57-year-old woman. Phyllis grew up and still lived in Central Kentucky, although the company she worked for was headquartered in Connecticut. Phyllis provided tele-mental health services focused on medically assisted therapy for clients engaged in treatment for substance use disorders, as well as to sustain recovery and prevent overdose. Her client population was broad, and she met with adolescents, adults, and geriatric patients. Phyllis noted each of her clients had some area of trauma focus in their life. Phyllis's education was primarily centered around addictions work, and she held a master of science in addictions counseling. Her primary therapeutic frameworks were cognitive behavioral therapy, motivational interviewing, strengths-based approach, and harm reduction.

Phyllis's most fulfilling moments were "when the clients really 'get' something they didn't understand previously." Phyllis also noted a "desire to help other people as a means to heal layers of historical trauma in [her] own life." She described her most challenging times result from the "unrealistic expectations placed when having too many clients and not enough time to perform duties; the pace can sometimes be unbearable!" Phyllis defined compassion fatigue by stating, "feeling I have too much in my head; a sort of vibration in my body; tiredness; feeling less caring, and hoping someone will no show." Phyllis's favorite forms of self-care were yoga and meditation. She was motivated to join the study upon learning there would be space available to share with other clinicians struggling with similar issues. Phyllis hoped to gain ideas for better ways to counter the negative symptoms experienced in her line of work.

Micca. Micca was a 43-year-old married woman with two young children. Micca had lived in Washington state her entire life. She currently worked with survivors of sexual assault at an agency that provided advocacy, resources, and supportive counseling services. Micca noted all her clients were working with extreme trauma in their situations. Her primary role entailed

completing forensic interviews upon intake for each individual that presented for care. Micca attended the University of Washington for her undergraduate work and focused on human services in her degree planning. Upon seeing a Facebook post stating, “Use your life in service,” she returned to school to complete her master of social work degree at the University of Southern California, and returned to the Pacific Northwest for family and career. Micca looked to her main therapeutic theories of trauma-focused cognitive behavioral therapy and polyvagal therapy to guide her work.

Micca shared the most enjoyable parts of her work involved “allowing the space for the clients to be seen and heard; not so much the big break-throughs, but rather the small moments of success.” She noted her most challenging times were generally due to a lack of resources available to provide the level of support needed. Micca characterized her idea of compassion fatigue as “feeling depleted; zoning out and not having anything left to give to others.” Micca informed her best choice for self-care was always exercise focused, although she struggled with both the cost and time involved in attending on a regular basis. She also used reading, podcasts, and mindfulness daily. She decided to join the study after hearing about the peer-to-peer support group option from a fellow clinician. Micca was longing to feel more connected to other clinicians after feeling isolated during many months of the COVID-19 global pandemic.

Paulo. Paulo was a 37-year-old transgender partnered male, who grew up in the Philippines. Paulo’s current residence was in Canada, and he had worked for the same mental health agency for the past 6 years—providing in-home support for elderly patients struggling with addiction issues. Paulo’s population was primarily geriatric, and his oldest client was 97 years old. Paulo noted almost all his clients were dealing with trauma-related issues in their lives. Paulo completed his undergraduate education in nursing. He then became interested in trauma

support training and completed training to become a certified trauma life coach. Paulo stated his primary mental health theories were trauma-informed care, compassionate inquiry, and the Salutogenic model. Paulo shared his most satisfying moments of work were "when the clients ask to do a family session and really open up." He noted his most challenging moments were those times when he "can't stop thinking about the clients long after they have left the session." Paulo reported his compassion fatigue presenting itself as "irritability, doubting if this is the right profession for [him]; and extreme exhaustion." He described his daily self-care routines involving a mix of yoga, meditation, visual affirmations, journaling, and reading. Paulo was excited to learn about the study and the incorporation of psychoeducation with practical coping techniques to counter burnout he was worried about facing with prolonged work in the field.

Derrick. Derrick was a single 48-year-old man. He grew up in the Pacific Northwest and currently worked as a family therapist in Seattle area for about 9 years. His earliest work was in community counseling, and he decided to return to school to earn a master of arts in family and marriage therapy, so he could practice independently. Derrick held a full-time caseload under the umbrella of a larger mental health agency. He enjoyed a high level of work autonomy while having other colleagues close by for collaboration when needed. Derrick worked with a broad range of clients—from children to senior-aged—and he most enjoyed working with entire families. He noted only a small percentage of his clients were trauma-focused in their care. Derrick described his therapeutic framework as "eclectic," combining energy psychology, wilderness therapy, [cognitive behavioral therapy], and narrative therapy for his best outcomes.

Derrick expressed feeling the most joy in his work when seeing positive movement and healing relationally between family members. His most challenging days involved feeling exhausted, mood changes, and nearing burnout, and he often takes mental health days to recover

from feeling overwhelmed. Derrick defined his understanding of compassion fatigue as “feeling vulnerable to the effects of the work.” Derrick engaged in fitness/exercise, nutrition, meditation, acupuncture and massage, and spiritual retreat as his main strategies for countering work-related stress. Derrick was enticed to join the study when he learned it would satisfy his continuing educational requirement for the licensure period. He was also interested in learning more about the FFPR model of care.

Bobbie. Bobbie was a 37-year-old married female with two teenaged children. Bobbie was new to the mental health field and had only begun working directly with clients during the last three years. She previously worked as an insurance adjuster and did dispute resolution for approximately 10 years. Bobbie noticed the depth of meaning when working with people in their time of need and struggle—whether it was their house just burned down, or their kid just got into a really bad car accident, or they had to make a claim on their life insurance because their loved one had passed away—and found it fulfilling to work with anybody that was going through a hard time. She recalled finding enjoyment in hearing their stories and supporting them during difficult life moments.

She decided to return to school and completed her undergraduate education in psychology, then went on to enter a doctoral program in counseling psychology (PsyD). She recently graduated and was working toward becoming licensed in the state of Washington. Bobbie worked for an on-campus mental health center, and she met with all her clients virtually. Her clients were primarily adults, and she specialized in couples and relationship challenges. Bobbie’s therapeutic framework was guided by the Gottman method of couples’ therapy, as well as person-centered therapy and eye movement desensitization and processing. She noted only a small percentage of her clients were working through trauma-focused scenarios.

Bobbie shared the most enjoyable aspects of her work were connected to seeing the progress and healing firsthand with her clients. Her most difficult moments were witnessing the devastation when couples were unable to repair from relational rupture, and she often experienced headaches, stomach aches, mood changes, and exhaustion. She described her biggest challenge was working with people who "really don't want to get better; they just want a place to vent, or they want a place to kind of say 'do this for me.'" Bobbie described her experience of compassion fatigue as "having no time to recover" from the amount of clients on her caseload and paperwork to be done. Bobbie enjoyed spending time with her family, prayer, meditation, and camping as her favorite means of rekindling her energy resources. She was interested in joining the study out of curiosity to learn more about both the FFTT and FFPR modalities. Bobbie was hoping to increase her learning around adaptive coping tools to share with her client's experiencing difficulty with self-regulation and calming.

Natalia. Natalia was a 42-year-old married woman. She was born in Slovakia and currently lived in Norway with her husband and stepdaughter. Her earliest work was in hotel management, which she studied directly after graduating from high school and worked in for the past 20 years. She recently returned to school to become certified as both a reflexologist and trauma life coach, and she has worked in direct client care for the past 3 years. Natalia primarily uses FFTT in her work with clients experiencing complex posttraumatic stress disorder, which is a condition where one experiences similar symptomatology of posttraumatic stress disorder, often associated with multiple traumatic scenarios that occurred during childhood. Natalia described her clients as mostly women and about half of her caseload as dealing with some level of life trauma.

Natalia's most satisfying moments of her work involved "helping people to see themselves in a different light and find their inner beauty." She described her most difficult challenges were "staying regulated throughout the client's processing." Natalia described her feelings of compassion fatigue by stating, "When I am too compassionate, and I think too much about other peoples' problems and use too much energy and thinking space on them; this impacts me negatively, as it imposes on my personal time." She used meditation, eating healthy, and talking/processing with peer clinicians as her primary source of self-care activity. She reported "zero hesitation" to join the study, as she was already familiar with the FFTT modality and excited to learn about the FFPR online peer-to-peer support group.

Laurencio. Laurencio was a 29-year-old Hispanic male, who was married with one young child. He was brought up on the West Coast in Southern California, although he currently lived and worked in Louisiana. Laurencio previously worked with individuals struggling with mental health and addiction issues in the community health arena. This work motivated him to return to the educational arena to complete an undergraduate psychology degree, leading to a doctoral degree in clinical psychology (PsyD). Laurencio was currently in his 7th year of his program, and he was hoping to enter an internship focused on psychological testing for neuro-diverse clients. He was in the middle of his preinternship, working for a mental health agency—seeing all his clients virtually while he completed the steps in the final internship process. Laurencio noted about one third of his caseload required trauma-focused care, and his primary therapeutic modality was based on Freud's psychoanalytic theory.

Laurencio's most gratifying aspects of work were focused on psychological testing of clients. He enjoyed assisting clients and families with figuring out if there was a "diagnostic reason or explanation" to help explain the behaviors being exhibited. His preinternship was spent

being solely focused on the testing portion to determine autism spectrum disorder, attention-deficit/hyperactivity disorder, and specific learning disorders (i.e., dyslexia, dysgraphia, and dyscalculia), and he hoped to one day become the director of his current agency. Laurencio's most challenging times were balancing "being the breadwinner of [his] family, while simultaneously finding the time to complete the myriad of demands in [his] academic program." He noted often feeling overwhelmed and exhausted and realizing the toll that such work might be taking on his personal and family's well-being. Laurencio described his experience of compassion fatigue as "never finding the balance between family, work, school, and personal needs and always feeling like [he is] coming up short in one or more areas." He described his main source of self-care by stating, "Hanging out with my kid; we love to go for walks, blow bubbles, and sing songs . . . I just wish I had more time to spend with him." Laurencio joined the study "out of pure curiosity" to learn more about both the FFTT and FFPR work that he had heard about from a peer clinician. He noted a desire to find anything to help alleviate the stress and overwhelm he was currently experiencing.

Data Analysis Procedures

Coding Process

In maintaining fidelity with the framework of descriptive phenomenological methodology, descriptive coding was applied to each participants' responses to provide a basic vocabulary for categorizing and analyzing the narrative data collected. Descriptive coding is recommended as an appropriate means to chart longitudinal participant change, as well as discern general reflective questions, such as "What is going on [or being experienced] here?" (Turner, 1994). Additionally, it offers a foundation for qualitative summaries when employing

larger projects, as well as assists the reader in seeing and hearing what the researcher saw and heard during the interview process (Hammersley & Atkinson, 2019; Wolcott, 1994).

To carry out this process, each audio-recorded interview was transcribed verbatim and read in its entirety. The audio files were digitally analyzed using the CAQDAS (computer-assisted qualitative data analysis software) program—ATLAS.ti. Such voice-to-text software programs alleviate the burden of manual transcription and assist the researcher in homing in on the relevant text or key moments as the most significant passages of the data (Stonehouse, 2019; Sullivan, 2012). CAQDAS coding does not actually code the data; rather, it serves to store, organize, and manage the data for further human analysis and reflection (Saldaña, 2021). Member checking was also employed as a means to ensure validity. Participants were offered a final transcription of their narrative interview and asked to respond with any discrepancies noted.

The first cycle of coding was focused on the preliminary or initial coding phase. Considered as the warming up stage, this involved familiarizing with the collected data and initiating the basic analytic process, which entailed separating the bulk of raw data passages into stanzas and isolated units (Saldaña, 2021). This level included the formation of preliminary (multiword) codes—highlighting significant quotes or passages from the raw data—via the means of in vivo coding, which uses words from the actual participants' language. This step was followed with holistic coding, creating single-word codes to capture a sense of each larger unit of data, possibly leading to future categories (Salma, 2014). The final coding procedure used a "lumping" framework (also known as macro-coding), which captures the essence of the entire excerpt in a single code and ultimately leads to the emergence of categories and theme formation (Saldaña, 2021). This allows broad categories that may include important features, despite their slight contextual differences. See Table 2 for the coding stages.

Table 2

Stages of Data Analysis

Coding process
1. Transcribe participant interviews
2. Member checking
3. Preliminary/Initial coding (using Holistic or macro-coding)
4. Revision of initial codes
5. Secondary coding (using Patterned/Focused coding)
6. Revision of focused codes
7. Grouping of codes into thematic categories (using Inductive framework)
8. Peer debriefing
9. Revision of thematic categories
10. Inter-coder agreement

Note. Coding process was primarily guided by Saldaña (2021) and Salma (2014).

The second cycle of coding was performed using pattern coding (grouping summaries into smaller themes and constructs) and focused coding (categorizing the most frequent coded data for themes or conceptual similarity) in an effort to reorganize and condense the final codes gathered from the preliminary coding (Salma, 2014). Using an inductive coding framework, the analytic approach "maintains as open a mind as possible" (Saldaña, 2021, p. 41), allowing for the spontaneous surfacing of codes and themes. The final steps of coding were a combination of looking at the data line-by-line, dividing the essential units into manageable chunks and columns, sorting the codes into provisional categories and themes, and ultimately translating the meaning the researcher sensed was being conveyed. Upon completion of the first cycle coding, there were 259 preliminary codes. These 259 were condensed into 54 final codes, which were then encapsulated in 16 subthemes and five major themes (see Appendix F). The final themes were extracted from each transcript independently and strategically chosen to describe the concept of topic under investigation. This thematizing was done upon completion of the focused

coding process, as a suggested step in the research design (Brinkman & Kvale, 2015). Although some subthemes were apparent, only those occurring most frequently and consistently were retained for final coding. Additionally, clean verbatim transcription was applied to increase fluency and reduce filler words, repeated words, or stutters (e.g., "yeah," "uh-huh," "like," "uhm," or "you know") that did not add or change the meaning of the direct quote. This step both preserved the authentic voice of the participant and only omitted such words and phrases that may have detracted from the readers comprehension of the research findings.

Validity and Reliability Measures

Member Checking

Upon completion of the final interviews, the audio recordings were transcribed into written transcripts via the "ATLAS.ti" data analysis and research software. Each participant was offered a transcript of the recorded interview session and assured that study outcomes would be provided at the completion of the study. All participants expressed interest in reading the final study report; however, none of the participants requested a copy of their respective interview session.

Peer Debriefing and Peer Coding

In an effort to maintain credibility and trustworthiness of the researcher's interpretations of the data, two peer debriefers/coders were enlisted to confirm that the findings and analyses were worthy, honest, and believable. According to Spall (1998), the process of debriefing is a critical component during the investigation process, as it seeks to make the researcher cognizant of personal biases related to individual values and perspectives, legal and ethical considerations, and tests the emerging themes of the data. It is suggested that peer debriefers have training and experience in qualitative research; however, they may not have a specific interest in the

respective study. Peer debriefers/coders are essential in the mitigation of potential biases—including issues of gender, power, and organizational politics—that may cloud the interpretation of the findings (Cooper et al., 1997).

Both colleagues selected as peer debriefers/coders for the study were engaged in qualitative research for their own respective PsyD graduate programs. One of the debriefers (an insider) was scheduled to graduate soon from Northwest University's PsyD program and had a fair amount of knowledge of the current research study, whereas the second debriefer (an "outsider") had already graduated from Northwest University's PsyD program and less familiarity with the research topic. Viewed as necessary to enhance the credibility or truth value of a qualitative study by providing an external check to an internal process, the debriefers were instrumental in helping the researcher see personal aspects—both virtues and pitfalls that may have been unintentionally interjected in the coding realm (Lincoln & Guba, 1985). Neither had personal interest nor partiality in the critique of the coding process related to the study topic. Debriefing meetings were virtually and included the following elements of discussion related to semistructured interviewing and coding: (a) critiquing the data collection method and interview transcript, (b) looking for areas where participants' perspectives were overlooked, (c) searching for areas that need more detailed descriptions, and (d) reviewing the coding process and evaluating the analytic techniques (Adams, 2015; Ho, 2022). Both debriefers found the researcher's coding and theme analyses to be credible, suitable, and with fidelity to the interview transcripts.

Inter-Coder Agreement

Inter-coder agreement (ICA) is the extent to which discrepancies between two or more coders are able to be reconciled—especially given a scenario where one coder may be more

knowledgeable about the study topic, such as in this study. ICA is essential when coding in-depth semistructured interview transcripts and seeks to ensure a reasonable level of confidence that coding would be reproducible, despite the level of familiarity with the given topic (Campbell et al., 2013). Inter-coder reliability (ICR) is the measure of agreement between various coders of the same content is important in qualitative research for purposes of improving "systematicity, communicability, and transparency of the coding process" (O'Connor & Joffe, 2020, Abstract).

Interrater reliability for this study was calculated using Cohen's kappa calculation, which is a statistical coefficient that represents the degree of accuracy and reliability in a statistical classification. It measures the degree of agreement between the choices made by two (or more) independent judges (Landis, 1977). Cohen's kapa is an important measurement in behavioral and social sciences for nominal classification (Warrens, 2015). For this study, the initial round of ICR between the peer debriefers resulted in a Cohen's weighted kappa of 0.41, indicating a moderate level of agreement at the lower end of the scale. This was likely impacted due to the second debriefer's tendency to code a greater number of responses, as well as both debriefers selecting codes that were only slightly varied in description. After further discussion and a second round of ICR comparison, however, both researchers reached a higher level of agreement and a Cohen's weighted kappa of 0.79, equating to a substantial level of agreement. Researchers have indicated multiple factors may influence the kappa value, such as observer accuracy and bias, and number and prevalence of codes in the set, which appeared to have influenced this result (Chen, 2019).

Findings and Emergence of Thematic Categories

Although there were many powerful life stories shared within the individual transcripts that elicited potential for the creation of further themes, the priority was given to those most

prevalent between participants and condensed to place emphasis on the topics, responses, and patterns of meaning that came up repeatedly. In this study, five main ideas emerged, generating new insights and concepts from the data:

- Theme 1: Clinicians' lived experience of working with clients in distress.
- Theme 2: Participants perspectives while moving through the three phases—educational/skills building, intentionality/self-regulation training, and connection/engagement—of the FFPR Training and FFMe Support Groups.
- Theme 3: Meaning derived from participating in the weekly peer-to-peer engagement groups.
- Theme 4: Tools gained for sustained work with serving populations processing traumatic life events.
- Theme 5: Elements of the FFPR and FFMe sessions that may inform future virtual support groups.

The following sections further detail and explain these themes, using a descriptive phenomenological framework to better understand the synthesis and meaning of how the participants experienced both the FFPR and FFMe processes.

Theme 1: Clinicians' Lived Experience of Working With Clients in Distress

The participants' accounts of their lived experience of working with distressed clients revealed both commonalities, as well as a myriad of different precipitants that eventually led them to seek both information and support for their own negative symptoms. All participants shared their passionate desire to work with vulnerable populations. They felt a similar attraction and were drawn to provide care and mental health support in hopes of bettering the lives of their clients. Interestingly and unexpectedly, however, each of the participants expressed a point of

bewilderment and self-doubt, upon reaching a space of exhaustion and feeling overwhelmed in their work they so dearly loved.

Effects of Working With Populations Processing Traumatic Life Events. Although initial participant reports were focused on caseloads—both high in number and level of client acuity—later discussion moved to complexity due to multi-layered diagnoses. Sophia offered a description of her work environment by stating:

> From the therapy aspect, we have a human trafficking court, so I see all those clients and we have behavioral health court and then drug court. So, any of the clients that need trauma therapy and are interested in trauma support, they come to me.

Some participants described awareness of mood dysregulation and physical fatigue from meeting the needs of having complex caseloads, and others noted existential challenges of pondering the possible need of a career change. Rosalina described such feelings as she transitioned from a supervisory position to a more clinical-focused role, stating:

> Feeling like I'm not as engaged in my work as I was [previously] when I started this position, and I was working in an outpatient substance use facility as a supervisor and I was excited that I was going to get more involved with clinical skills and learning different interventions and techniques. And then, as time went on, I just started to feel a very big shift, and my mood became more irritable. I started to wonder, Is this the right field for me? Do I really like this anymore? Realizing that trauma is hard—not that it's so hard that I just stop, but it's hard and I was feeling very defeated.

Other participants recognized a similar internal response and looked to potential causes in the workplace environment that might be lending to the experience. They also noted uncharacteristic behaviors, as Rosaline stated:

> I've been really struggling at my current job, and I've been really trying to understand what is it about my job that I feel I'm coming home exhausted? Or I wake up feeling like it's doomsday? I'm looking at my schedule and glad my first patient cancelled, or I come in super late.

Search for Sustainment. As participants began to recognize a shift in their own moods, they also noted the personal toll and impact that working in a prolonged stress-filled environment was having on their families. Several participants addressed this conundrum. As Micca recalled, "During COVID-19, I shifted into a supervisory position and felt very overwhelmed. And then on top of everything else, being a single parent with kids and just trying to manage and figure everything out." Others noted having awareness of the potential for burnout without enough time available for proper personal care. Many used leave time just to take days off for the sole purpose of recovering from the stressors of the previous workweek. As Derrick noted:

> When I was in community mental health when I first started in this career field, I could go a solid 8 weeks, but then I would have to take at least the day off and get extra rest on the weekend. So, I started to wonder, 'Why use that [vacation/leave time] for self-care?'

With the inception of virtual tele-work options to meet the exponential demands of mental health support needs during the COVID-19 global pandemic, several participants transitioned to working from home as a means of efficiency to reduce transportation and commute time and cost and to avoid exposure to infection for themselves and medically vulnerable family members. Phyllis described the pros and cons of working from home and distancing from clients and peers, stating:

> Early on, I worked in community, so I saw a constant flow of just really damaged people. But now, I do mental health and substance abuse counseling via telehealth for an agency

> headquartered in Connecticut. I am actually in central Kentucky, but there is not a brick-and-mortar building, so there is a level of emotional distancing in providing substance abuse (like medically assisted care) and mental health counseling virtually.

The participants juggling multiple areas of demands and struggling to find a work–life balance were most significantly affected. Laurencio provided the following personal account:

> The most difficult part for me is navigating the myriad of pressures on me at this time: academic expectations, caseload and documentation demands, and trying to provide for my family financially. I already feel so overwhelmed and no sign of relief in sight!

Motivation for Peer-to-Peer Groups. The motivation to seek relief from feeling overwhelmed and to find a supportive space of sharing with colleagues was common among all participants. Enticed by the idea of stretching herself both clinically and personally, Micca expressed her decision to join the peer-to-peer study by stating:

> I feel like I needed this experience, because it made me step outside of my comfort zone. I guess being on the clinical side of things, I'm usually the one that is directing, so it took that pressure off of me and so I just had to be. I just had to come in and be vulnerable in sharing my successes and challenges. That was something that I committed to from the get-go. I was going to be as honest as I could and just share.

Others described having a desire for symptom alleviation as their primary impetus for signing up for the groups in hopes they would begin to heal from the long-lasting effects of vicarious traumatization that had begun to grip them. Robin shared her thought process by stating:

> I think my motivation for attending the peer-to-peer groups goes back to dealing with imposter syndrome and trying to really heal from delayed grief of trauma responses from

> prior crisis work that I had done. I tried to be really authentic and allow that space to take shape, versus letting the [emotional] triggers and dysregulation take hold.

See Table 3 for additional information about this theme.

Table 3

Theme 1: Clinicians' Lived Experience of Working With Clients in Distress

Participant responses	Preliminary codes	Final codes	Subthemes
From the therapy aspect, we have a human trafficking court, so I see all those clients and we have behavioral health court and then drug court and so any of the clients that need trauma therapy and are interested in trauma therapy, they come to see me. (Sophia)	Working with complex trauma clients	Complex caseloads	Effects of working with traumatized populations
I've been really struggling, you know, at my current job, and I've been really trying to understand, like, what is it about my job that I feel I'm coming home exhausted? Or I wake up feeling like it's doomsday? I'm looking at my schedule and glad my first patient cancelled, or I come in super late. (Rosalina)	Feelings of exhaustion and changes in mood	Mood dysregulation	
Feeling like I'm not as engaged in my work as I was a year and a half ago when I started this position and I was working in an outpatient substance use facility as a supervisor and I was excited that I was going to get more involved with clinical skills and learning different interventions and techniques. And then as time went on, I just started to feel a very big shift in my mood became more irritable. I started to wonder, 'Is this the right field for me? Do I really like this anymore? Realizing	Awareness of shift in mood and level of engagement	Self-doubt related to career focus	

Participant responses	Preliminary codes	Final codes	Subthemes
that trauma is hard—not that it's so hard that I just stop, but it's hard and feeling very defeated. (Rosalina)			
Early on, I worked in community mental health, so I saw a constant flow of just really damaged people. But, now, I do mental health and substance abuse counseling via telehealth for an agency headquartered in Connecticut. I am actually in central Kentucky, but there is no brick and mortar building, so there is a level of emotional distancing in providing substance abuse (like medically assisted care) and mental health counseling virtually. (Phyllis)	Telehealth and emotional distancing from clients and peers; awareness of pros/cons of telehealth	Need for connection / collaboration	Search for Sustainment
When I was in community mental health when I first started, I could go a solid 8 weeks, but then I would have to take at least the day off and get an extra rest on the weekend. So, I started to wonder, 'Why use that for self-care?' (Derrick)	Awareness of potential for burnout without enough self-care	Need for recovery	
During COVID-19, I shifted into a supervisory position and feeling very overwhelmed. And then on top of everything else, being a single parent and kids and, you know, just trying to manage and figure everything out. (Micca)	Overwhelm in managing multiple roles	Desire for stress relief	
I feel it is important to be authentic with my clients, which can take a toll on me. Sometimes I feel it is necessary to share my weaknesses and failures in self-regulating. For example, a client might ask, 'Can you help me get through this moment?' And I will be authentic and say that I was just there; and that's a big thing for me to just be honest and just be with the client. (Paulo)	Importance of being authentic with clients	Toll of authenticity	

Participant responses	Preliminary codes	Final codes	Subthemes
The most difficult part for me is navigating the myriad of pressures on me at this time: academic expectations, caseload and documentation demands, and trying to provide for my family financially. I already feel so overwhelmed and no sign of relief in sight! (Laurencio)	Work–life imbalance and desire for relief	Relief	
I think my motivation for attending the peer-to-peer groups goes back to dealing with impostor syndrome and trying to really heal from delayed grief or trauma responses from prior crisis work that I had done. I tried to be really authentic and allow, you know, that space to take shape versus letting the triggers and dysregulation take hold. (Robin)	Feelings of imposter syndrome and secondary trauma response	Desire for symptom alleviation	Motivation for peer-to-peer groups
Feel like I needed this experience, because it made me step outside of my comfort zone. I guess being on the clinical side of things, I'm usually the one that is directing, so it took that pressure off of me and so I just had to be; I just had to come in and be and be vulnerable in sharing my successes and challenges. That was something that I committed to from the get go. I was going to be as honest as I could and just share. (Micca)	Desire for stretch in clinical/personal learning	Commitment to shared peer-to-peer experience	

Theme 2: Participants Perspectives While Moving Through the Three Phases—Educational/Skills Building, Intentionality/Self-Regulation Training, and Connection/Engagement—of the FFPR Training and FFMe Support Groups

All 10 participants proceeded through the three phases of the study and were eager to share their perspectives following completion of the program. Similar to Theme 1, multiple areas

were common among the members alongside varied individual reactions and responses to what held the most meaning for them. Even though most of the participants expressed an initial interest in gaining additional coping skills to mitigate compassion fatigue and burnout, it appeared the intentional practice of such skills, followed by the weekly connection and engagement in the peer groups, held the greatest impact for their experience and personal care.

Educational/Skills Building. Many participants expressed excitement about skill building and learning new self-regulation and coping means to pass along to clients. Derrick noted his appreciation for gaining specific skills and reported the program as being "a very good fit" for his style of experiential learning. Sophia also described what was useful to her, stating:

> I was excited about the material; it was very informational, and I feel like the skills are really awesome. I feel like the material itself [both the FFPR webinar training and the Tools of Hope] was really useful and something that I could use in my practice.

Others described the exercises as "transformational" and experienced "self-compassion through hearing others' stories." Phyllis described her "healing through listening" experience by stating:

> This may sound like a weird thing to say, but when I was listening to the [FFPR] trainings, and he [Dr. Gentry] shared his own [adverse childhood experiences] score, I think I healed just a little bit from that alone.

Several of the participants reflected on completion of the code of honor and mission statement as holding deep meaning in their study experience. Robin shared her response to both exercises by stating:

> The code of honor and mission statement; those were a little bit harder for me, because I noticed [those exercises] required me to be more vulnerable. So, I just said what I wanted to say, and it was really, really, really transformative!

In contrast, some participants held other reactions. Although they noted initial interest and curiosity to learn about the materials, they soon felt "put off" by particular aspects of the approach. Guided by their commitment to complete the study, however, they were able to find other elements that made the experience worthwhile. For example, one participant (Bobbie) felt challenged with time constraints, and, therefore felt ill-prepared in attending the first session, as they shared:

> I wish I could have been more prepared in the beginning, as I didn't really have time to complete all of the [FFPR] trainings in advance, so I didn't really understand what the expectation was or what was happening [in the peer-to-peer groups] at first. But then I kept listening to peoples' stories and just trying to connect with the things that they were saying; I found that aspect was helpful.

Another participant expressed feeling confused and noted concern for what he perceived as a "lack of congruence" between the goals and techniques of what was being taught in the FFPR training course versus what the expectation was for the FFMe peer-to-peer weekly groups. Laurencio elaborated his concerns regarding "serious clinically diagnostic language often being too loosely used as part of a teaching program," as he explained:

> At first, I was excited to learn about the materials, but then I felt confused and put off by the over-use of several terms in the weekly sharing forums—specifically, words like narcissism, dissociation, and perceived threat. I think such terminology could have been better explained.

Intentionality/Self-Regulation. Many reflected on the personal significance of application of tools learned in all arenas of their life—even beyond the therapeutic space. For example, Derrick informed:

> I was directly applying the learning in a kind of a big situation for myself in life at the time [referring to a relational breakup], which made the use of the materials and tools even more meaningful. Otherwise, it might not have been like that. I might have been sort of reaching for what I needed to self-regulate myself. I probably would have been a little more superficial, but it was really, really substantial for me to be using the skills and tools in that moment.

Others stressed the importance of making the connection between the intentional practice of the self-regulation/calming skills learned the previous week and bringing that experiential change via sharing to the next peer-to-peer group. Rosalina spoke about such heightened awareness by saying:

> I was trying to be more aware—especially during the work week—and then share that [both challenges and successes in attempting to self-regulate], which I thought was helpful, because when you're trying to practice self-regulation, that's exactly what it is—practice!

Connection/Engagement. Although most of the study participants revealed a positive response to the weekly peer-to-peer engagement groups, some noted areas of lacking. Although some members appreciated the anonymity of the sharing with fellow clinicians in a virtual format, others expressed feeling a "disconnect" due to geographical distances. Robin considered the groups to be "life enriching," and expounded:

> The group just reaffirmed the importance of trying something new in general. I thought it was very much worth my time. I got a lot out of it. I felt more present, more engaged, more connected with myself, and more connected with other people. I think overall, in the overarching span of things, it has enriched the quality of my life.

Another participant commented on the importance of having a "felt sense of belonging" without having share-backs and using facial expressions as supportive feedback instead. Paulo detailed his account by stating:

> I think it brought me a sense of . . . first, connection, and second, gratitude. To just be a part of that group; like the whole group was awesome. At first, I didn't feel like I belong, because they were a majority group of therapists, and I'm just a coach. But, the welcoming and the connection between us has been there even if we don't do share-backs with each other. Their facial expressions made it so you could feel that the group is really welcoming and there for each other, even if they don't talk, so I think that's the part that was really amazing for me.

In alignment with the participants that felt a great sense of connection, Natalia appreciated how the group normalized the difficulty of doing human service work. She noted:

> It was helpful to my own learning, in hearing the struggles of other people and how they had trouble in regulating themselves. Just normalizing that experience. That's the tough part. It's not like "misery loves company" or anything like that; it's more of like, "Oh, I don't feel so alone now."

Still others described the pros and cons of global engagement and their experience of sharing such intimate details with "strangers" in a virtual platform and finding challenges with such forums. As Bobbie explained:

> I wonder if maybe in a more local group, if I would have felt a little more connected to some of the people, because being across the country I think there's a lot of benefits to that, but I also feel like we're dealing with different [cultural] vantage points. Politically, especially, stuff kept coming up and we have different viewpoints or different things that

> are happening, so there were some things like that that I just wasn't connecting with people and what they were going through.

Similarly, another member noted both challenges and benefits of sharing with fellow clinicians that were distanced from peers or family members. Micca expounded on the anonymity of the virtual format:

> Talking about the successes was the easy part. But, the failures are typically things that are really, really held deep in, like your core beliefs about yourself, and you know things that you struggle with . . . so, that as harder for me to open up that door and share my failures, because the others in the forum were strangers. But, then again, it was also maybe a little bit easier to share those failures virtually with strangers versus talking to my peers or my family members.

See Table 4 for more information about this theme.

Table 4

Theme 2: Participants Perspectives While Moving Through the Three Phases—Educational/Skills Building, Intentionality/Self-Regulation Training, and Connection/Engagement—of the FFPR Training and FFMe Support Groups

Participant responses	Preliminary codes	Final codes	Subthemes
I was excited about the material; it was very informational and I feel like the skills are really awesome, so I feel like the material itself was really useful and something that I could use in my practice. (Sophia)	Learning and skill building	Useful skills	Educational/ Skills Building
The Code of Honor and Mission Statement; those were little bit harder me, because I noticed they required me to be more vulnerable. So I just said what I wanted to say,	Experience of completion of Code of Honor and Mission Statement	Transformative exercises	

Participant responses	Preliminary codes	Final codes	Subthemes
and it was really, really, really transformative. (Robin)			
Sounds like a weird thing to say, but when I was listening to the [FFPR] trainings and he [Dr. Gentry] shared his ACE score, I think I healed just little bit from that. (Phyllis)	Self-compassion through hearing others' stories	Healing from learning	
I really liked the program. I appreciated learning the very specific skills. I found it a very good fit for me. (Derrick)	Enjoyed the overall program	Appreciated learning the specific skills	
At first I was excited to learn about the materials, but then I felt confused and put off by the over-use of several terms –'perceived threat and dissociation' specifically. I think such terminology could have been better explained. (Laurencio)	Response to specific terms and desire for more thorough explanation	Clarification of terminology	
I was trying to be more aware [during the week] and then share that, which I thought was helpful because when you're trying to practice self- regulation, that's exactly what it is—practice. (Rosalina)	Practicing self-regulation skills learned the previous week	Self-regulation skills practice	Intentionality/ Self-Regulation
I was directly applying the learning to a kind of a big situation for myself in my life, which made the use of the materials and tools even more meaningful. Otherwise, it might not have been like that. I might have been sort of reaching for what I needed to self-regulate myself. I probably would have been a little more superficial, but it was really, really substantial for me to be using the skills and tools. (Derrick)	Personal significance of the application of the tools learned	Use of skills in all arenas of life	
The group just reaffirmed the importance of trying something new in general. I thought it was very much worth my time. I got a lot out of it. I felt more present, more engaged, more connected to myself, and more connected with other people. I think overall, in the	Benefits of peer-to-peer engagement	Life enrichment	Connection/ Engagement

Participant responses	Preliminary codes	Final codes	Subthemes
overarching span of things, it has enriched the quality of my life. (Robin)			
I think it brought me a sense of first connection, second gratitude. To just be a part of that group; like the whole group was awesome. At first I didn't feel like I belonged, because they were majority a group of therapists and I'm just a coach. But, the welcoming and the connection between us has been there even if we don't do share-backs with each other. Their facial expressions made it so you could feel that the group is really welcoming and there for each other, even if they don't talk, so I think that's the part that was really amazing for me. (Paulo)	Felt sense of belonging without share-backs, using facial expressions as supportive feedback	Felt sense of belonging	
Talking about the successes was the easy part. But, the failures are typically things that are really, really held deep in, like your core beliefs about yourself, and you know things that you struggle with, so that was harder for me to open up that door and share my failures, because the others were strangers. But then again, it was also maybe a little bit easier to share those failures virtually with strangers versus talking to my peers or my family members. (Micca).	Experience of sharing failures virtually with strangers	Benefits of sharing with fellow clinicians distanced from peer or family members; anonymity of virtual format	
I wish I could have been more prepared in the beginning, but I was listening to people's stories and just trying to connect with the things that they were saying; I found that that was helpful. (Bobbie)	Challenges with time constraints	Empathic listening	
I wonder if maybe in a more local group if I would have felt a little more connected to some of the people, because across the country I think there's a lot of benefits to	Pros and cons of global engagement	Commonalities despite geographical distance	

Participant responses	Preliminary codes	Final codes	Subthemes
that, but I also feel like we're dealing with different things. Politically, stuff kept coming up and it we have different viewpoints or different things that are happening, so there was some things like that that I just wasn't connecting with people and what they were going through. (Bobbie)			
Hearing the struggles of other people how they had trouble in regulating themselves. So, just normalizing that experience. That's the tough part. It's not like misery loves company or anything like that; it's more of like, oh, I don't feel so alone now. (Natalia)	Normalizing the difficulty of human service work	Similarities in response to work environment	

Theme 3: Meaning Derived From Participating in the Weekly Peer-to-Peer Engagement

Following the initial learning of the FFPR and FFMe framework and settling in the routine for the weekly peer-to-peer engagement groups, the participants showed an immediate sense of bonding, followed by a profound division of perspectives related to whether feedback should be included as an aspect of the group encounters.

Group Bonding. The 'sense of belonging' was noted among all study participants, as Rosalina articulated:

> With the peer-to-peer group, there was almost a sense of "Ahhh, oh, I get to be with my own people." It's the isolation of the [therapy] office that is difficult for me and feeling like if I had a hard day or I had a difficult client, there's nobody to talk to about it. And, so, going into this peer group, I felt being able to hear other people's experiences was helpful, having that peer-to-peer connection. But, I still felt like I was missing that ability to really get more feedback on how I was feeling.

Other members responded to the space of support and connection through sharing. Robin shared aspects of being part of the weekly groups that were especially significant to her learning process by stating:

> I felt that it was a very intentional space, and I tried to lead with that vulnerability and being genuine rather than rigid and cloistered, and not coming off as inauthentic. She went on to say: inviting some healthy down regulation and just noticing the intentional practice of those topics was super helpful. Some things that helped me a lot is when I could hear language and different speakers talk about the same topics, because it's just *their* vantage point, *their* wisdom, *their* experiences, and it was very helpful for me.

Similarly, several members noted the most helpful aspects of the group were "growing through empathic listening" and witnessing others' struggles. Phyllis described her growth experience in this way:

> Probably the number one most helpful thing to me was hearing that other people struggle and that other professional people have their stuff. In the past, I would have judged myself and others negatively, but after witnessing other peers' disclosures and seeing that no one challenged them, I found it to be really, really helpful to realize we are not alone in our struggles.

Another significant experience that was mentioned repeatedly was the completion, followed by the sharing of the mission statement and personal covenant. Micca described the importance of this exercise for her by stating:

> One of the most meaningful aspects was completing the Covenant and Mission Statement. I found that to be especially helpful because I just don't think about that kind

> of stuff for me. That was really important for my learning and that guided me throughout the entire time of showing up each week for the group.

Feedback. There were a plethora of viewpoints expressed across all 10 participants and all were articulated passionately. Although some members had strong feelings at the outset and held firm throughout the entire 6-week program, others noticed a shift in their experience, and a couple remained neutral in their stance. Micca's reflection was an example of preferring nonfeedback, as they stated:

> Sharing about some things that we were encountering or going through, and hearing you own voice talk about difficult things in the context of strangers was very helpful. I think for me that was all I needed. I just needed that space to share I guess because I don't get a lot of opportunities to do that. I'm just listening to a lot of other people and not really having a single moment to be heard. I don't have a partner to talk to at the end of the day about what's going on, so having that space for me was important.

Upon contemplation that difference in opinion and preference for feedback may have been the result of personality style, participants commented that they felt it had more to do with current clinical context, historical experiences with group processing, and availability of opportunity to share without interruption. Paulo also echoed sentiment for having the no cross-talk/feedback policy, stating:

> I appreciated the policy of having no cross talks and just giving people that free space that they need to vent out . . . no comments whatsoever so that they would feel safe. I know that really resonated and made good sense for me. I like what Stephen Porges always says, "As human beings we fail to witness right; that we just always wanna say our story or comfort people with our words, but some people just really need a space to

> listen and be heard." I liked having a place to vent out where you don't have to appear strong all the time. I think it's important to have a space where you can be vulnerable.

In contrast, some members felt a strong need for an element of feedback and deeper engagement within the group setting. Natalia shared her personal response:

> I think there was only once that [the facilitator] commented on my sharing and it felt dismissive, like I was being ignored in a way. It's something I don't like; it's triggering in a way for me to be ignored . . . that I'm speaking, and I don't get anything back; it's weird.

Several of the participants noted awareness of a 'shift' that took place—initially having both the need for feedback and the desire to provide feedback to others—followed by the recognition they were no longer experiencing such validation needs by the end of the program. Rosalina provided a detailed account of this significant change in her own response to her earlier need for feedback, stating:

> At first, I had wanted feedback, like when you're talking about something in the moment and you're sharing that experience, but it's not like you're in a process group . . . you talk and then somebody say, "Oh well, yeah, I understand how you feel," and you kind of have a little bit of dialogue and people can have this type of peer-to-peer rapport. Instead, not hearing the feedback right away was also very enlightening, because it made me start to ask myself, "Well, why do I care about what other people think or say?" or "Why do I need their feedback in the first place?" If I'm feeling a certain kind of way or I self-regulated through this or I felt this type of way during this event. . . . "What is it about me that needs somebody else to validate or invalidate whether that's an appropriate way to feel?"

Still, others expressed more of a neutral position on requiring feedback. They noted feeling comfortable with the specified policy and format and didn't think to question it. Those in the neutral category reported having an initial expectation for actual processing stressors together; however, once learning the rules of engagement, just accepted there would be no feedback elicited.

Sharing. Many of the participants noted a significant appeal to the weekly sharing of strengths and challenges (related to integration of the Tools of Hope) experienced the prior week, as well as the importance of receiving nonverbal feedback via visual affirmations. All participants described the profound sense of being seen and heard merely by the nodding of heads, hand gestures (shape of heart, thumbs up, etc.), and/or facial expressions (smiling/sad look) that provided ample validation and feelings of support in response to their sharing. See Table 5 for additional information about this theme.

Table 5

Theme 3: Meaning Derived From Participating in the Weekly Peer-to-Peer Engagement Groups

Participant responses	Preliminary codes	Final codes	Subthemes
With the peer-to-peer group, there was almost a sense of 'Ah, oh, I get to be with my own people.' It's the isolation of the office that is difficult for me and feeling like if I had a hard day or I had a difficult client there's nobody to talk to about it. And so going into this peer group, I felt being able to hear other people's experiences was helpful, having that peer-to-peer connection. But I still felt like I was missing that ability to really get more feedback on how I was feeling. (Rosalina)	Reduction of feelings of isolation	Connection	Group Bonding

Participant responses	Preliminary codes	Final codes	Subthemes
I felt that it was a very intentional space and I tried to lead with that vulnerability and being genuine rather than like rigid and cloistered, and not coming off as inauthentic. (Robin)	Connection through sharing	Support	
Inviting some healthy down regulation and just noticing the intentional practice of those topics was super helpful. Some things that helped me a lot is when I could hear different language and different speakers talk about the same topic because it's just their vantage point, their wisdom, their experiences, and it was very helpful to me. (Robin)			
Probably the number one most helpful thing to me was hearing that other people struggle and that other professional people have their stuff. In the past, I would have judged myself and others negatively, but after witnessing other peers' disclosures and seeing that no one challenged them, I found it to be really, really helpful to realize we are no alone in our struggles. (Phyllis)	Growth through witnessing others' struggles	Empathy	
I wasn't sure what to expect, but I thought we were going to bond between people a little bit more and talk to each other. It was something I missed, I have to say. It felt it felt weird to not to be able to react and to say something to someone when they were sharing something painful. (Natalia)	Desire for group bonding	Group Engagement	
I can see the benefit of like a support group or something like that, but I feel like even in support groups, people have a format for giving feedback in an appropriate format, where they're not giving advice maybe, or they maybe give suggestions about the skills and	Withholding feedback after participant sharing	Responses to sharing	Feedback

Participant responses	Preliminary codes	Final codes	Subthemes
tools in the program. I think the facilitator was pretty good about doing that part. (Sophia)			
At first I had wanted feedback, like when you're talking about something in the moment and you are sharing that experience, but it's not like you're in a process group . . . you talk and then somebody says, 'Oh well, yeah, I understand how you feel,' and you kind of have a little bit of dialogue and people can have this type of peer-to-peer rapport. Instead, not hearing the feedback right away was also very enlightening, because it made me start to ask myself, well, why do I care about what other people think or say or why do I need their feedback in the first place? If I'm feeling a certain kind of way or I self-regulated through this or I felt this type of way during this event … what is it about me that needs somebody else to validate or invalidate whether that's an appropriate way to feel? (Rosalina)	Awareness of initial desire for feedback	Shift in awareness related to feedback	
If you say your stuff and people are quiet and then there's no feedback, you wonder if that has any real meaning. But, I guess that's how it was built, so I'm sure that it has very good benefits for some people. I am just a very curious person, so I found myself wondering why the people who dropped out dropped out? (Phyllis)	Curiosity about participants that left the group	Benefits of nonfeedback	
Sharing about some things that that we were encountering or going through, and hearing your own voice talk about difficult things in the context of strangers was very helpful. I think for me that was all that I needed. I just needed that space to share I guess because I don't get a	Benefits of having space to share and be heard	Preference for nonfeedback	

Participant responses	Preliminary codes	Final codes	Subthemes
lot of opportunities to do that. I'm listening to a lot of other people and not really having a single moment to be heard. You know, I don't have a partner to talk to at the end of the day about what's going on, so having that space for me was important. (Micca)			
One of the most meaningful aspects was completing the Covenant and Mission Statement. I found that to be especially helpful, because I just don't think about that kind of stuff for me. That was really important and that guided me throughout the entire time of showing up for the group. (Micca)	Significance of Covenant and Mission Statement	Completion of Mission Statement	
I appreciated the policy of having no cross talks and just giving people that free space that they need to vent out … no comments whatsoever so that they would feel safe. I know that really resonated and made good sense for me. I like what Stephen Porges always says, is that 'as human beings we fail to witness right; that we just always wanna say our story or comfort people with our words, but some people just really need a space to listen and be heard.' I liked having a place to vent out where you don't have to appear strong all the time. I think it's important to have a space where you can be vulnerable. (Paulo)	Appreciated having no cross-talk and/or feedback	No Crosstalk Policy	
In some ways I was comfortable with that format [of not having feedback following sharing]. It makes sense so I didn't question it, I just went along with it. (Derrick)	Neutral response to not have feedback after individual sharing	Nonpreference for Feedback	
I think there was only once that [Jenny] commented on my sharing and it felt sometimes like I felt ignored in a way. Yeah, and it's something I don't like, like it's	Desire for feedback; felt ignored when no response given	Desire for Feedback	

Participant responses	Preliminary codes	Final codes	Subthemes
triggering in a way for me to be ignored. That I'm speaking, and I don't get anything back, it's weird. (Natalia)			
The strengths and weaknesses or the 'what you did well and what you feel like you could have worked on,' I thought that was helpful for me to reflect on my own, because I go100 mph and I don't stop to reflect as much as I wish I would or as much as I used to. (Bobbie)	Importance of self-reflection	Sharing Successes and Failures	Sharing
No, that didn't bother me at all because [Jenny] did give a little bit of feedback. There were nods and there was understanding that was offered, and so you know if it was over the phone, it might have felt different, but I could see everybody, and so I could see their feedback. (Bobbie)	Nods and facial expressions as feedback	Visual Affirmations	
I could see the benefit of the peer-to-peer sharing format, but I had hoped for actual engagement and opportunity to process stressors together. In this setting, no feedback was elicited. (Laurencio)	Desire for group engagement and consultation	Group Processing	

Theme 4: Tools Gained for Sustained Work With Populations Processing Traumatic Life Events

Upon integration of learning and daily practice of the Tools of Hope self-regulation coping skills, all 10 participants shared a positive response and reported reduction in somatic response to stress. Although many of the participants had prior knowledge of the brain–body connection, linking ventral vagal activation to physiological response patterns, none had been previously acquainted with the terms such as "interoceptive body scanning; also referred to as the 'Wet Noodle'" (i.e., having an acute awareness of how we are feeling, followed with an

exercise of successive intentional tightening and releasing of each muscle group) or "neuroception" (i.e., an unconscious response to both safety or perceived threat) related to the process of stress reduction and intentional calming.

Tools of Hope. Most of the participants noted their impetus for joining the study was to acquire new coping techniques (e.g., peripheral vision exercise, pelvic floor relaxation, diaphragmatic breathing, wet noodle) and all left satisfied with receiving not only several new practical skills (to be used both personally and shared with clients). Additionally, they also expressed appreciation for the academic explanation and information evidence-based research to support such claims. Sophia noted this aspect in her response:

> I really enjoyed the science and the learning aspect about the nervous system. I feel like it wasn't just a standard trauma course, and we learned about when cortisol levels and the [underlying mechanisms] of the fight or fight response. It felt really useful and meaningful, and I've been able to use that learning and integrate it into my practice.

Techniques and Practice. Other clinicians noted the benefits of not only using the techniques in the therapeutic space (i.e., invoking the peripheral vision technique or pelvic floor relaxation) during moments when feeling triggered in response to a client's trauma narrative, but also using social engagement as a practice forum in everyday life. Several of the members encouraged the varied use of self-regulation tools throughout the day. For example, Paulo described alternating multiple techniques as needed, stating "using a little bit of everything we have learned each day, but the pelvic floor exercise is used when I am really, really stressed, and I'm about to cross that line. I would say that is my primary response to stress." Similarly, many of the participants spoke of becoming more focused and aware of body response to nervous system activation and learning to incorporate the methods at the moment of noticing. One

participant shared her use of the techniques in a very practical way, during a recent interview. Phyllis detailed the following event:

> It is helpful for me to use the tools throughout the day. I find myself noticing tension in my body, and I like using the wet noodle and just letting go of all the tension. I have also been stoked about the pelvic floor exercise, and it really helped me get through a job interview recently; where I would have normally choked (I sense that people can sense my tense energy, pick up on it, and get turned off). But, this time, I want you to know that I was actually offered the job!

Lastly, all participants reported feeling empowered in their learning about new techniques, eagerness in practicing the exercises in both clinical and personal arenas, and enjoyment in later sharing to group at the close of the week. Micca articulated this multifaceted learning by stating:

> I became more focused in on my body responses—what was activating me and then really taking into account some of the methods to relax the body and pick up on what was going on. I noticed myself paying more attention to that, and I really liked just being able to look back on the week and see where I had grown in my practice, then share with the group.

See Table 6 for more information about this theme.

Table 6

Theme 4: Tools Gained for Sustained Work With Populations Processing Traumatic Life Events

Participant responses	Preliminary codes	Final codes	Subthemes
The tools of hope, and the videos that went along with those two that I could send out to clients; those are really awesome. The little YouTube	Helpful tools	Tools	Tools of Hope

Participant responses	Preliminary codes	Final codes	Subthemes
ones that are just like each skill. I use those a bunch with clients where I've sent them out to practice. (Sophia)			
I really enjoyed like the science and the learning about the nervous system. I feel like it wasn't just a standard trauma course and we learned about when cortisol levels and fight or flight response. It felt really useful and meaningful, and I've been able to use that learning and integrate it into my practice. (Sophia).	Integration of learning related to science and nervous system	Useful learning	
Sometimes the topics covered were based on things might trigger memories within our own selves, our own developments, our own experiences. It was helpful to use the self-regulation tools in those moments and say, 'Is my getting upset gonna be helpful or harmful?' (Rosalina)	Practicing self-regulation tools in vivo	Intentional self-regulation	
I thought one very helpful exercise was when we did the touch memory, and we talked about ventral vagal activation and using something (like a stress ball) in therapy with patients. It's amazing when you can take something that you can squish, and, when you were noticing the activation under excessive thoughts, squeeze and then let go when you were ready. It's a really great teaching tool for patients when I'm educating on polyvagal theory. (Robin)	Ventral vagal activation	Self-calming techniques	Techniques and Practice
The one that I really loved in the beginning was the engaging pelvic floor with peripheral vision. That one was a big one for me, but over time I really learned the harness, especially with the group from the interoceptive body scanning and the wet noodle. I think that one became my favorite and kind of eclipsed the pelvic floor,	Using the peripheral vision, pelvic floor relaxation, and interoceptive body scanning and wet noodle	Self-regulation exercises	

Participant responses	Preliminary codes	Final codes	Subthemes
and I have really honed that skill by using it frequently throughout the day. (Robin)	for self-regulation		
It was helpful for me to use the tools throughout the day; I find myself noticing my body throughout the day, kind of noticing tension somewhere and I like using the wet noodle and just letting go of all the tension.. And then the whole pelvic floor thing; I was kind of stoked about this tool, and I shared it in the group. That tool really helped me get through a job interview recently; where I would have normally choked in in a job interview (I sense that people can sense my tense energy, pick up on it, and get turned off). But, this time, I want you to know that I was actually offered the job! (Phyllis)	Using Tools of Hope in everyday life situations	Practical use of Tools of Hope	
I became more focused in on my body responses—what was activating me and then really taking into account some of the methods to relax the body and pick up on you know what was going on. I noticed myself paying more attention to that, and I really liked just being able to look back on the week and see where I had grown in my practice, then share with the group. (Micca)	Increased somatic awareness of need for relaxation	Using learned tools to reduce activation	
I find my muscles clench like all the time, so I just release it, and it really helped me with my mood. That way I can handle stuff without the constant pressure. So, I use a little bit of everything each day, but the pelvic floor exercises when I'm really, really stressed and I'm about to cross that line. I do the pelvic floor extra; I would say that is the primary response to stress. (Paulo)	Varied use of self-regulation tools throughout the day	Alternating self-regulating tools	

Participant responses	Preliminary codes	Final codes	Subthemes
I enjoyed learning about the 'wet noodle, the interoceptive body scan, and how to relax the pelvic floor. Relaxing the pelvic floor was the one I found to be most helpful. In fact, I went on a walk one day and practiced it, and every time I kind of brought my awareness back to it, I realized that I was tense and flexing my pelvic floor, and I didn't know how often I did that, and so all week that week I challenged myself every time I thought of it to check in. (Bobbie)	Practicing self-regulation techniques	Intentional practice	
I appreciated the idea of relaxing the muscle tension as a direct means for self-regulation. And I liked the focus on social engagement as one of the main forums for practicing self-regulation in a group setting. (Derrick)	Importance of muscle tension for self-regulation	Social engagement as practice forum	

Theme 5: Elements of the FFPR and FFMe Sessions That May Inform Future Virtual Support Groups

Upon completion of the 6-week program, all 10 participants had an abundance of viewpoints to share. Although many of the responses focused on pragmatic elements (e.g., consideration of group size, preference for time of day, and specifics of in-vivo virtual learning) others were more broadly homed in on the power of the group communication dynamic.

Dialogue and Interaction. For example, one aspect that stood out most vividly was the desire to "have more space for 'nonstructured' sharing and a specified time allotted for open-ended, flexible dialogue." Although all the members noted an understanding and appreciation for staying within the guidelines during the bulk of the FFPR and FFMe framework, they were also sensitive to the human need for the natural flow of group conversation at some point in the

overall process. In fact, several participants noted having an increased awareness specific to such need and began to long for the structured sharing times to end more quickly, making ample time leftover at the end of session organic discussion. Sophia summarized her perspective in this way:

> I really liked connecting with other professionals and talking about the material, especially when there were no rules and it was just like this open forum where everybody could talk. I liked it when we got to have this open engagement. It only happened a couple of times when we finished early. I started to really look forward to the end of the group, because I was like, wait, maybe we'll have time left over to actually enjoy this.

Self-Reflection. Although most of the participants desired some level of open dialogue, they also recognized the purpose of efficient use of the limited time for each participant's sharing and valued a multitude of other program elements. For example, several participants self-reflected on the depth of meaning simultaneously gained in both their professional and personal lives. Robin described the impact and importance of having an intentional daily practice of care, stating:

> I'm noticing my perceptual maturation—the shift that I'm going through is it's not just learning a modality of therapy; rather, it's a way of living and I'm actively embracing that 'cause I see it and I sense it. I know it's enriching my life. I'm reflecting and realizing this is actually an intentional daily living practice.

Benefits of Program. The notion of "broad spectrum learning" was common among all participants. Given the somewhat limited one-dimensional vantage point of virtual interaction, all 10 members responded with a sense of appreciation for being able to connect with others they would not have otherwise met. Despite geographic distance, clinical variation, and diverse cultural backgrounds, the participants were astonished to realize their common ground in both

negative symptom experiences, as well as ease and ability to gain (or rather preempt) symptom management. Micca explored this realization by stating:

> I've actually brought some of the language of the FFPR modality and things I've learned to other therapists that are at my agency and clients we are helping to trauma process. So, this experience has been meaningful both personally and professionally!

See Table 7 for more information about this theme.

Table 7

Theme 5: Elements of the FFPR and FFMe Sessions That May Inform Future Virtual Support Groups

Participant responses	Preliminary codes	Final codes	Subthemes
I like connecting with other professionals and talking about the material, when there were 'no rules' and it was just like this open forum where everybody could like talk. I liked it when we got to really have this open engagement, and it only happened a couple of times when we finished early. I started to really look forward to the end of the group because I was like, wait, maybe we'll have time left to actually enjoy this. (Sophia)	Desire for open engagement time	Open dialogue	Dialogue
And some days we were done early or also gave a little bit of time at the end to go over some stuff or having open-sharing. It was kind of nice to step outside of the structured focus and sharing; I think it just added another layer humanness to the connection. (Micca)	Appreciation for open-sharing at the close of group	Space for open/ nonstructured sharing	
I thought that [Jenny] was great and just her open-ended kind of flexible format that she offered towards the	Importance of open-ended and flexible format	Flexible Format	

Participant responses	Preliminary codes	Final codes	Subthemes
end, whenever there was time left for open discussion. (Bobbie)	with leftover time		
I felt was helpful for my understanding of the power of having peer support and when you're working in an organization or an environment that has that available—whether it's having a peer group once a week or whether it's being able to talk to somebody who can understand and validate how you feel. I feel it can be very powerful for your mental health and I think during these 6 weeks of peer-to-peer meetings, I started to realize how that affected me. I really did find peace being with peers like myself and hearing their success and fails and looking forward to some of that interaction each week. (Rosalina)	Power of peer-to-peer engagement	Experience of group interaction	Interaction
I'm noticing my perceptual maturation—the shift that I'm going through is it's not just learning a modality of therapy; rather, it's a way of living and I'm actively embracing that 'cause I see it and I sense it I know it's enriching my life. I'm reflecting and realizing this is actually an intentional daily living practice. (Robin)	Depth of meaning for practice in life	Importance of intentional daily practice	Self-reflection
There was one group session where the sharing ended early, and there were only a few members that stayed on.	Smaller group preference	Consideration of group size	Group size
It was my favorite session, because I do so much better in smaller groups, and it felt real and intimate, and actually kind of fun! I really enjoyed the smaller group dynamic. (Phyllis)			
I've actually brought some of the language of the FFPR modality and things that I've learned to the other	Use of modality both personally	Broad spectrum use of learning	Benefits of program

Participant responses	Preliminary codes	Final codes	Subthemes
therapists that are my agency and clients we are helping to trauma process, so this experience has been meaningful both personally and professionally! (Micca)	and professionally		

Field Notes and Behavioral Observation

All 10 posttreatment interviews took place remotely, due to both COVID-19 and geographical distance. Each participant was contacted via email with a request for a follow-up session within three days after the final peer-to-peer group meeting. They responded quickly, and 6 of the 10 were scheduled within a 2-week period. The remaining four were completed by month-end. Each of the participants displayed a high level of comfort with meeting virtually, and awareness of the societal shift in such online interactions was a common theme of discussion at the outset of each postinterview. Many shared how the benefits of online meetings, trainings, and therapy sessions had impacted their lives in a positive way, to the point they had moved to full-time telehealth work as a result freeing space in their workday that would have previously been spent on commute time or nonproductive office interactions. It was apparent each participant was at ease, as the interviews had a natural flow and authenticity experienced similarly in face-to-face interactions.

The level of enthusiasm for sharing their experiences, insights, and critiques was striking to witness, and it was evident via their narratives that the study interactions held meaning for each clinician in unique ways. Eight of the 10 participants presented for the final interviews dressed in semiprofessional attire, and most joined from their respective office spaces. The interviews took an average of 60 minutes or less, and none lacked for either volume or depth of knowledge to share. All 10 showed eagerness to provide reflections and were not hesitant in their

transparency around both positive and negative vantage points. Several displayed a degree of tearful emotion when describing the benefits they had experienced from taking part in the peer-to-peer groups. In fact, a couple of the study members were so impacted by the learning and forward-facing work, they decided to continue on with the formal FFMe program and expressed interest in completion of the FFPR Coaching and Consulting Certification. Each of the participants expressed gratitude for the opportunity to take part in the study and appreciation for future virtual formats to sustain and support clinicians in sustainment of their professional work and personal mental health care.

Chapter 4

Discussion

Forward-facing me (FFMe) peer-to-peer virtual support groups have emerged as a powerful force in responding to the call for both the digital world of promoting psychological health and well-being for mental care providers, as well as leading the new frontier with formation of essential support groups and professional networking (Morie et al., 2012; Suresh et al., 2021; Wu et al., 2020). Despite the fact that the framework of the FFMe program was already in process of being created to expand engagement from an in-person to an online format, it was the collective exhaustion experienced by the medical and mental healthcare workers and exacerbated by the COVID-19 global pandemic that illuminated the necessity for a collective and interactive supportive virtual space (APA, 2021; Murthy, 2022; Sexton et al., 2022). At the outset of this research project, there were no other found online peer-to-peer support group studies of comparison available, making this one of the very first qualitative treatment studies to offer a glimpse of the participants' lived experience of completing the FFMe 6-week program. As a result, this study sought to not only address the current gap in the availability of online clinician-focused support groups emphasizing the efficacy of meeting in a virtual in-vivo setting, but also to contribute to the body of rapidly growing knowledge as to what constitutes best practices for safe, flexible, and effective web-based engagement platforms.

Because the FFMe groups in this study came to fruition during the inception of social distancing and other safety measures mandated during the COVID-19 global pandemic, it evident that many aspects of societal interaction—personal, social, academic and professional—have since blossomed in their use of virtual forums for communication (Golz et al., 2022). Individuals have formed virtual communities and benefited from each other's shared experiences

during this time of reduced access to mental health services. Given the exponential burden placed on the helping professions during the unprecedented time of global and economic crisis, many looked to virtual support groups to play a significant role in providing such mechanisms for adaptive coping (Gonzalez et al., 2020). Interestingly, although there have been many online support-focused groups created during this time, the FFMe has remained uniquely multifaceted in its psycho-education and skills building approach, making this study a significant offering to the much-needed knowledge base for future peer-to-peer platforms. In that light, the reader is encouraged to consider the participants' experience in the context of the timeframe associated with this study.

Relationship Between Current Findings and Previous and Recent Literature

Importance of Virtual Support Options for Frontline Mental Health Providers

Ample research has pointed to both the underlying causation of compassion fatigue, as well as the importance of preemptively addressing the negative symptoms in hopes of mitigating the potential for burnout. As mentioned at the outset of this study, although early studies focused on *who* is affected (i.e., primarily medical and mental health workers) and *what* (i.e., the experience now known as vicarious traumatization and toxic stress), and later researchers honed in on *why* it occurs (i.e., essentially breakdown of the biological stress cycle and need for self-regulation), current theorists have been in consensus that supportive online programs are paramount to countering such debilitation—especially during critical global events, such as the COVID-19 global pandemic (Cordero, 2022; David, 2016; Gentry, 2021; Murthy, 2022; Porges, 2004; Van der Kolk, 2015).

Many have stressed digital chat rooms and video conferences played a crucial role in sharing information, collaboration and promoting the common good, and increasing awareness

of public health during the COVID-19 global pandemic (Corderi, 2022). Others have recognized the enormous emotional stress placed on frontline workers and called for innovative virtual support systems to help counter debilitating symptoms and sustain continued work in the field (Viswanathan, 2020). The role of online peer support communities has become so prevalent clients and clinicians alike have reported a significant in increase in both accessing and preference for mental health support via online means (Merchant et al., 2022). Interest in accessing services were broadly related to increasing coping mechanisms and skills, enabling overall well-being, and connection to peer support. Many have looked to support groups to fill a critical void in the healthcare system and alleviate the psychological burden of caregiving, and researchers recognize that the essence of a support group in fostering psychological well-being lies in the earliest teachings of Yalom's therapeutic factors. Although the shared experience may now take place in a peer-led, asynchronous and online forum, many of Yalom's 11 primary therapeutic factors (e.g., instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behaviors, interpersonal learning, group cohesiveness, catharsis, existential factors) have remained as critical components for the group experience (Diefenbeck et al., 2014).

Despite earlier researchers providing caution and contending that social media platforms may exacerbate negative mental health problems (Pantic, 2014), more recent findings have stressed the development of online mutual aid groups born out of the need for emotional connection and supportive conversation both during and in the aftermath of the pandemic. One study focused on practitioners in Italy illuminated the reciprocal supportive dynamics that helped social workers stay resilient through online groups that offered supervision and mutual support

based on experiential learning processes (Cabiati, 2021). The helping professionals looked to the online forum as an opportunity to both give and receive help mutually.

Similarly, the participants in the FFMe study reported being called on to face multifaceted challenges and concerns for patients and themselves, and desiring access to new platforms for much needed discussion. Despite the fact that all of the members reported experiencing typical signs and negative symptomatology of compassion fatigue and secondary trauma (e.g., emotional dysregulation, numbing, insomnia, physical complaints) as a result of their work with clients and patients struggling with traumatic histories prior to the COVID-19 global pandemic, each of the participants voiced a noticeable increased response in distress as they navigated the "new normal" of providing mental health care. In fact, the most prominent response in the preinterviews to the inquiry related to motivation for participation in this study resoundingly pointed to not only the need for symptom relief, additional psychoeducation, coping tools acquisition, and peer connection/consultation, but also, more importantly, the ability to have access to such benefits via the means of a supportive and safe virtual space. Each of the participants expressed curiosity and desire to increase their level of professional and personal resilience as their primary reasoning for joining the study and were excited to test the parameters of a new virtual approach.

Pros and Cons of Global Online Support Platforms

Although computer technology has altered the traditional ways in which health care workers might have previously sought to handle workplace stress, experts recognize both the benefits and drawbacks of such distanced interaction. While all can recognize the advantages (e.g., increase to access, adjunct to counseling, therapeutic factors, specialization, connection with peers) beyond the geographic barriers, there is the simultaneous acknowledgment of

potential challenges (i.e., differing levels of professional development, privacy, limited feedback, and ethical and legal concerns) that come into play (Gary & Remolino, 2000). Despite the previous hesitation toward virtual collaboration as being an "authentic" form of connection, recent studies have demonstrated social interaction is crucial for maintaining health and well-being, and, whether in-person or online, such interplay improves emotional regulation and a sense of belonging and purpose and decreases negative emotional experiences, such as loneliness and isolation (Sahi et al., 2021).

With so many social interactions and programs transitioning to online formats, it is easy to focus on the positive aspects of virtual engagement; however, additional studies are now recognizing the new conundrum of "Zoom Fatigue"—a condition resulting from the high use of videoconferencing that skyrocketed during the social distancing and quarantine guidelines (Fauville et al., 2021). With substantial portions of both personal and professional interactions now spent staring at the computer screen, attempts to understand and ameliorate the effects of this phenomenon are now underway (Nesher & Wehrt, 2022). Interestingly, researchers have found group belongingness has remained the primary protective factor against videoconferencing fatigue, and such implications will be valuable to healthcare workers still entrenched in the new terrain of remote work (Bennett et al., 2021). Not surprisingly, there are numerous guidelines and recommendations now available to help counter the psychological consequences of prolonged Zooming, Googling, and videoconferencing (Ramachandran, 2021).

In alignment with both the benefits and challenges stressed in the aforementioned research, all of the participants in this study reported paralleled grapplings. For example, even though they found meaning in the weekly engagement groups related to feelings of connection, group bonding, empathy, and peer support, there was also report of profound desire for increased

feedback, interactive sharing, and verbal affirmation that was sensed as being absent, due to time constraints, program format, and one-dimensional context of meeting in an online forum. Additionally, although some expressed a sense of freedom and anonymity in meeting in a nontraditional interactive space, others shared feelings of frustration caused by an absence of visual, auditory, or interpersonal cues that would have been apparent in an in-person setting. Thus, the common experience of the participants in this study seemed to reflect that even though online support groups provided an alternative vehicle to make connections with peer clinicians during times of distress, they may also encounter unexpected challenges within such delivery that may not fulfill the desire for a sense of emotional community in a cybercommunity platform.

Limitations

Despite it being evident the increased speed of computer applications and technological advances have allowed synchronous group interactions and in-vivo interactions, there remains a significant amount of drawbacks to online communication that must be considered as global programs continue to be created. Differing stages of professional development, host competency, language and cultural barriers, and limited feedback were only a few of the cautions noted in the research (Gary & Remolino, 2000). Gary and Remolino (2000) noted even though membership and accountability to the group may be highly recommended, the fluctuation in members logging on or off during the sessions, as well as within a certain timeframe, may drastically reduce the efficacy of the sought-after therapeutic support as well as group cohesion. Additionally, crisis management, privacy, and ethical and legal considerations were highlighted as significant considerations in other virtual focused studies (Gary & Remolino, 2000; Kuntze et al., 2002; Prescott et al., 2020). Despite steps being taken to maintain confidentiality and anonymity of

members in an effort to protect information shared within the online context, members must have awareness and consider the risk of breaching such agreements outside the virtual walls.

In line with the above-mentioned concerns, participants in this study shared similar viewpoints. For example, given most clinicians were at a master's level of education or higher, there was some mention that the host should be at least at the similar level of qualification. Although all were at differing stages of professional development, there seemed to be consensus that providing mental care to traumatized populations resulted in the common need for support. Interestingly, however, the most substantial differing in perspectives was related to the aspect of limited feedback. Although many of the participants were outspoken about the necessity to include space for feedback in the program, others were adamantly opposed, stating appreciation for the protected safe space to share without receiving bias and judgment often inherent in such responses. Still others more neutral in their response, recognized the benefits in either direction—they preferred a balance of structured weekly reporting of successes and challenges, alongside enjoying the open-ended, flexible sharing space reserved at the end of each meeting. Additionally, although ethical, privacy, legal, and crisis management considerations are an important aspect of virtual interactions and often are found as primary factors, there was only one report of a minor incident (i.e., one person in the session became dysregulated and tangential, then abruptly left the meeting) observed during this study that brought concern to one participant. And, because the person involved was a nonstudy participant and addressed professionally and with care by the FFMe host, the reporting participant stated experiencing no distress as a result—only empathy and curiosity when the person of interest did not return to future meetings.

Lastly, even though many recognize the potential communication challenges when engaging in a global format of care, with all participants of this study speaking English as their primary language, this issue did not seem to be apparent. There was, however, an aspect of cultural diversity that came to the surface with some members sharing openly about religious and political viewpoints that may not have been shared by all members, which challenged some to consider difference in the context of geographic location, as well as to remain open-minded to varying points of view.

Future Directions/Recommendations

With such terms as metaverse and the future of social engagement in healthcare resting on some level of virtual reality (Marr, 2022; Shreejit, 2022), it is apparent continued consideration for best practices of virtual peer-to-peer support groups may be a worthwhile focus of both research and mental health care. Although many broadly associate the term metaverse with "cyberspace," wherein there is an augmented reality that combines aspects of both digital and physical spaces (for example in virtual reality video games), it is important to recognize the recent shift and comfort level in how we interact with technology on a daily basis (Ravenscraft, 2022). Although some organizations such as the American Psychological Association (APA, 2021) and National Alliance on Mental Health (NAMI) have begun to provide guidelines for optimal use of social media, as well as tips and steps for online gatherings (Smith, 2021), much of the current research has pointed to the combination of online and offline support groups in community mental health settings as the best form of care (Strand et al., 2020). Even though there are multiple website searches available (e.g., PsychCentral, Medical News Today, or NAMI) that provide a generalized framework for how to navigate the maze of support groups available (Litner, 2021; NAMI, 2022; Wade, 2021) it is imperative that further research is

required to explore both the effectiveness and potential adverse consequences of internet support groups (Griffiths, 2017). Additionally, with the influx of online support groups moving to a global forum, researchers have expressed an urgent need for an independent and international quality control body to review individual support groups and offer best practices for practitioners (Brodey, 2021; Eysenbach et al., 2004; Suresh, 2021).

Despite there being broad and diverse literature available to inform how best to facilitate healthcare support groups in an in-person format (Cranley et al., 2017), it will be useful to extend such practices to the considerations of mental health supportive care via a virtual forum. Having completed the 6-week FFMe peer-to-peer support group program, all 10 participants had much to offer for recommendations of future online support forums. Although none of the participants stated concerns related to time of day, length of the 90-minute sessions, or number in the 12-person groups, all had much to share about the experiential meaning of their process.

Most of the participants noted the outstanding benefits of the broad-spectrum learning. In addition to gaining the specific *Tools of Hope* coping techniques and self-regulation skills from the forward-facing professional resilience (FFPR) treatment modality, they appreciated the usefulness of the practices to increase emotional regulation in both personal and professional situations. All participants expressed having the addition of psycho-education and learning as an adjunct to the peer-to-peer sharing model as imperative to a more holistic support group experience.

Another common remark was the consideration for open versus structured sharing time, and the consensus of the participants leaned toward having a flexible sharing format, where additional time might be allotted for feedback or general discussion of topics. The participants

noted a great desire to have some opportunity for open dialogue, balanced with weekly sharing of successes and challenges.

Additional highlights that were of importance to the group was the importance of intentional daily practice of the Tools of Hope self-regulation skills. Most of the participants self-reflected that such daily practice resulted in an unexpected depth of meaning for their overall life experience. Lastly, the power of peer-to-peer interactions that led to continued communication and further interest in the FFPR and FFMe programs was the common theme expressed as holding the takeaway benefits of taking part in the study.

Clinical Implications

The ethical imperative for medical and mental health providers to practice proactive self-compassion, self-care, and work–life balance has not only emerged in the recent psychological literature as gaining recognition to counter the debilitating caregiving risks of toxic stress, compassion fatigue, and burnout, but has also been magnified in the wake of the collective trauma of the COVID-19 global pandemic (Abramson, 2021). The "Trauma Trifecta"—impacting three of the major areas that contribute to well-being—physical health and safety, social and emotional wellness, and our basic needs, became a heightened concern for both client and clinician alike (Weingarten et al., 2020; Wilson, 2021). Rather than the previous recommendation for clinicians to take part in self-care workshops or to find time to destress, new guidance emerged that prioritized safe and supportive virtual spaces for clinicians to interact and engage (APA, 2021). As a result, online and web-based support groups forums were created to counter the debilitating effects of prolonged working conditions with distressed clients by providing a mutual space for connection, sharing, and resilience building. In this way, meeting in

cyberspace has become one aspect of the "new normal" and many have found solace and connection, albeit in a very *distance* way.

Conclusion

FFMe virtual peer-to-peer engagement groups are now one of many supportive online forums that have sprung up in navigating new ways for connection and belonging in our global community. Learning captured from the lived experience of the 10 participants who took part in the 6-week program has illuminated both areas of strengths as well as ideas for future adjustments to the format. Despite there being a variety of online support groups to address multiple topics, FFMe has continued to stand alone in its unique framework of providing training as treatment—evidenced-based FFPR and Tools of Hope psychoeducation and skills building—followed by 6-weeks of virtual interactive meetings. Knowledge gained from this study will be instrumental for both furthering improvements to the current FFMe groups, as well as development of similar virtual peer support models that may be created in the future.

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Appendix A

Invitation to Participate

Hello,

My name is Leticia Holleman, and I am a doctoral student in the PsyD Counseling Psychology Program at Northwest University. I will be conducting a study to explore the experience of mental health care clinicians as they engage in a virtual peer-to-peer support program focused on professional resilience. Your participation in the study will help to provide further insight as to what constitutes best practices for safe, flexible, and effective virtual engagement platforms, which may likely become more common as a future means of mental health clinician connection and support. I welcome your participation in this study!

Participation in this research will involve the initial viewing of the Forward-Facing® professional Resilience (FFPR) training model, followed by six weekly sessions in the Forward Facing® Me (FFMe) follow-up engagement group – providing the virtual in-vivo space combined with Tools of Hope self-regulation coping skills for transforming suffering into meaningful growth and healing. The aim of the study will be to gather participants' perspectives as they move through the three phases – education/skills building, intentionality/self-regulation training, and connection/engagement – of the FFPR training and FFMe support groups.

In order to qualify for participation, you must be an adult age 18 years or older. Completion of this study typically takes approximately 6 weeks and is strictly anonymous. Your responses will be treated confidentially and will not be linked to any identifying information about you. If you agree to participate in this study, you will complete a verbal questionnaire regarding: demographic information (i.e., age, gender, ethnicity, years worked in the mental health profession, etc.), as well as an oral interview answering questions about your experience of participating in a virtual support group, consisting of 12 other people.

- Participation in this study is completely voluntary. You may choose to withdraw your participation at any point.
- To partake you must have access to an electronic device allowing for Zoom meeting, internet connection, and agree to have your interview audio recorded.
- A pre-screening phone interview will determine if you meet the criteria of this study.

If you have any questions about the study you are welcome to contact the Chair of the Northwest University Institutional Review Board, Professor Cheri Goit.

If this sounds like a study you would be interested in contributing to or if there are any questions regarding the study, please contact the principal researcher, Leticia Holleman.

Thank you very much for your time and consideration!
Leticia

Appendix B

Consent

Forward-Facing Virtual Support Groups Study

Northwest University

Welcome to Forward-Facing Virtual Support Groups, a research study that explores the experience of mental health care clinicians as they engage in a virtual peer-to-peer support program focused on professional resilience. This study is being conducted by Leticia Holleman/Psy.D. student at Northwest University.

To qualify for participation, you must be an adult age 18 or older. Completion of this study typically takes approximately 6 weeks, and is strictly anonymous. Your responses will be treated confidentially and will not be linked to any identifying information about you. If you agree to participate in this study, you will complete a verbal questionnaire regarding: demographic information (i.e., age, sex, ethnicity, years worked in the mental health profession, etc.), as well as an oral interview, answering questions about your experience of participating in a virtual support group, consisting of 12 other people. All recorded data collection will be kept confidential and password encrypted on Northwest University Microsoft 365 Office System and safely stored on a password encrypted OneDrive cloud-based storage service. All electronic data information will be deleted by August 1, 2022; there will be no paper forms included in this study.

To ensure protection of personal information and identity, all participants will be asked to do the following when joining the virtual meetings: create a Zoom display name (different from actual name), wait in the Zoom waiting room until host starts the meeting, and choose a different background and Zoom profile picture. Additionally, participants will be encouraged to avoid posting messages in the Zoom chat that may include identifiable information.

The Northwest University Institutional Review Board has approved the study. No deception is involved, and participation in this study poses minimal risk to participants, although some participants may experience emotional distress when answering questions that trigger uncomfortable memories. If content of this questionnaire causes you significant distress, please contact the National Alliance of Mental Illness (NAMI) HelpLine at (800) 950-6264, the Crisis Text Line (741741), or contact your local counseling agency (search https://www.psychologytoday.com/us). Participation in this study is voluntary, and you may elect to discontinue from the study at any time and for any reason. You may print this consent form for your records. By submitting the survey, you are giving permission to use your responses in this research study.

The results from this study will be used for dissertation and may be presented within a variety of psychological forums (formal and informal).

If you have any questions about this study, please contact the principal researcher, Leticia Holleman. If you have further questions, please contact my faculty advisor, Dr. Kim Lampson. You may also contact the Chair of the Northwest University IRB, Professor Cheri Goit.

Before beginning the survey, please read this consent form in full. If you understand all information contained in this form and agree to freely participate in this study, please click the “I Agree” button. You may exit the survey at any time.

Thank you for considering participation in this study.
Leticia Holleman, PsyD Student
College of Social and Behavioral Sciences

Appendix C

Demographic Questionnaire

*Please note: This is a verbal questionnaire, and participants will be given the option of "prefer not to answer" for all of the following questions.

1) What is your age?

2) What is your gender?

___Cisgender Male
___Cisgender Female
___Transgender Male
___Transgender Female
___Prefer Not to Answer

3) What is your race/ethnicity?

Ethnically of Hispanic/Latino origin
White/European American
Black/African American
Asian
American Indian/Alaska Native
Native Hawaiian/Pacific Islander
Aboriginal
Other: _____

4) How many years have you worked in the field of mental health?

0-5_____ 6-10_____ 11-15_____ over 15_____

5) What is your educational degree?

6) What is your identified profession?

7) What is the therapeutic theory or framework that guides your work?

8) The estimated percentage of my caseload that involves trauma: _____

9) Have you ever received any trauma-specific training? Yes _____ No _____

10) The quality of my clinical supervision is: poor_____ adequate_____ excellent_____

11) I view myself as having social supports. Yes_____ No_____

12) I have received personal therapy. Yes_____ No_____

    The quality of that therapy is/was: poor_____ adequate_____ excellent_____

13) Do you use self-care practices? Yes_____ No_____

Appendix D

SemiStructured Interview Protocol

*Please note: This is a questionnaire will be given orally, and participants will be given the option of "prefer not to answer" for all of the following questions.

- Background Questions
  - Tell me a little about your background.
    - How long have you been in the helping profession?
    - What is your role? What type of clients do you work with?
    - What made you decide to go into your field?
    - What do you find enjoyable and satisfying about your work?
    - What do you find challenging and stressful about your work?

- Inquiry and Experiences
  - One aspect of this study is about the effects of clients' traumatic experiences on clinicians in the helping professions and ways to reduce the negative symptoms that may result. The peer-to-peer support group intervention will use psychoeducation as a means to help better understand the origin, causes, symptoms, and possible ways to mitigate such indications.
  - Can you describe for me what compassion fatigue means to you? Have you ever experienced negative signs (i.e., exhaustion, mood changes, or insomnia) as a result from working closely with others in crisis?
    - What forms of self-care have you found helpful to cope with such stress?
    - What challenges have you encountered in seeking options for self-care?
    - Are there supportive online resources provided by your worksite? If made available, would you be interested in attending? What are some reasons you may be hesitant?

- Reasons for Participation
  - What enticed you to take part in this study?
  - Which topics have been most helpful since the initial completion of the web-based *Forward-Facing® Professional Resilience* training?
  - What aspects of the *Forward-Facing® Me* support groups have been most helpful?
  - Do you find the *Tools of Hope* to be helpful in your self-regulation and grounding practices throughout your workweek?

- Post-Intervention
  - What was the most challenging aspect of both learning and taking part in this study?
  - What was most helpful about the Forward-Facing peer-to-peer support group experience?

Appendix E

Definition of Terms

Term	Definition
Mental health professional	Persons who work directly with clients in the field of mental health. This encompasses professions and roles in mental health beyond therapists, including, but not limited to case managers, life coaches, skills trainers, residential workers, and caregivers.
Mental health clinicians	Both novice and licensed psychotherapists in the mental health field having direct care of clients. This includes Clinical Psychology doctoral students, Mental Health Counselors, Marriage and Family Therapists, Clinical Social Workers, psychologists, and psychiatrists.
Peer-to-peer learning model	A reciprocal learning space where clinicians learn from and with each other in both formal and informal ways.
Virtual (in-vivo) support group	Alternative online vehicle (via Zoom platform) of support for mental health clinicians to process both challenges of distress and successes of self-regulation by linking people with similar issues. Participants meet with both video camera and sound on during the session.
Tools of Hope	Psycho-educational and skills building practice, to include: self-regulation, perceptual maturation, connection and support, and self-care and revitalization.
Interoception	The individuals' awareness of subtle sensory, body-based feelings related to related to physiological reactions to stressful events, accompanied by appropriate regulation strategies that temper and influence the emotional response.
Neuroception	The individuals' capacity to evaluate relative neurobiological mechanisms involved in perception of danger and safety in one's environment.
Trauma	Experiences that include adverse life events, including, but not limited to: emotional, physical, and sexual abuse, terrorism, war, sudden loss, natural disasters, school and community violence, global economic crisis, and pandemics.
Compassion fatigue	Condition that effects therapists who work with traumatized clients and is characterized by symptoms similar to post traumatic stress disorder.
Vicarious trauma	Condition in which therapists working with traumatized clients experience a negative shift in their thoughts, beliefs, sense of safety, and worldview.
Moral distress	The inability of the clinician to act according to his or her core values and perceived obligations due to internal and

Term	Definition
	external constraints of the context (often a medical or mental health setting) in which they are providing care. It is characterized by the "rightness" or "wrongness" of decisions, treatments or procedures, while feeling powerless to change situations they perceive as morally wrong.
Burnout	Condition effecting helping professionals in which they are physically and emotionally exhausted after long term exposure to their work.
Toxic stress	Debilitating effects that may be triggered when caring for traumatized clients – resulting from prolonged activation of the stress response system in the absence of supportive and protective relationships.
Compassion satisfaction	Sense of fulfillment derived from helping others in therapy
Professional resilience	Helping professionals ability to return to a stable emotional place after being exposed to trauma in their work.
Post traumatic growth	Increased appreciation for life in general, more meaningful relationships, an increased sense of personal strength, changed life priorities, and a richer existential or spiritual life that follows surviving traumatic events.

Appendix F

Code Book

Theme 1: Clinicians' Lived Experience of Working With Distressed Clients

Subtheme: Effects of working with traumatized populations

- Code: Complex Caseloads
    - Code Definition: Participants reference challenging aspects of working with clients with multi-layered diagnoses.
- Code: Mood Dysregulation
    - Code Definition: Feelings of exhaustion, shift in mood, and level of engagement with clients.
- Code: Self-Doubt in Career Focus
    - Code Definition: Awareness of inner questioning whether current clinical role or mental health field was the right choice for them.

Subtheme: Search for Sustainment

- Code: Desire to Expand Clinical/Personal Learning
    - Code Definition: Commitment to shared peer-to-peer experience
- Code: Need for Recovery
    - Code Definition: Using personal leave for extra rest and relaxation
- Code: Need for Stress Relief
    - Code Definition: Overwhelm in managing multiple clinical roles
- Code: Toll of Authenticity
    - Code Definition: Importance of being authentic with clients and awareness of fine line between healthy disclosure and personal exposure

- Code: Relief
    - Code Definition: Work-life imbalance and juggling multiple life demands.

Subtheme: Motivation for Peer-to-Peer Groups

- Code: Desire for Symptom Alleviation
    - Code Definition: Feelings of imposter syndrome and secondary trauma response.
- Code: Need for Connection/Collaboration
    - Code Definition: Awareness of pros/cons of telehealth work, emotional distancing from clients, and desire for connection with professional peers.

Theme 2: Participants Perspectives While Moving Through the Three Phases – Educational/Skills Building, Intentionality/Self-Regulation Training, and Connection/Engagement – of the FFPR Training and FFMe Support Groups

Subtheme: Educational/Skills Building

- Code: Gaining Useful Coping Exercises
    - Code Definition: Learning coping techniques to help mitigate compassion fatigue and interrupt cycle of burnout.
- Code: Transformative Exercises
    - Code Definition: Experience of completion of Code of Honor and Mission Statement.
- Code: Healing Through Listening
    - Code Definition: Self-compassion through hearing others' stories and experiences.
- Code: Gaining Specific Skills
    - Code Definition: Enjoyment of overall program and appreciation for learning new skills.

- Code: Clarification of Terminology
    - Code Definition: Response to learning new application of clinical terms and desire to understand more about the implication of such use.

Subtheme: Intentionality/Self-Regulation Training

- Code: Self-Regulation Skills Practice
    - Code Definition: Practicing self-regulation skills learned during the week.
- Code: Broad Application of Tools
    - Code Definition: Personal significance of using self-regulation skills in all arenas of life.

Subtheme: Connection/Engagement

- Code: Life Enrichment
    - Code Definition: Benefits of peer-to-peer engagement.
- Code: Felt Sense of Belonging
    - Code Definition: Format did not require sharebacks; instead, used facial expressions as supportive feedback.
- Code: Anonymity of Virtual Forum
    - Code Definition: Benefits of sharing with fellow clinicians distanced from peers or family members. Experienced ease of sharing failures virtually with strangers versus familiarity of peers.
- Code: Empathic Listening
    - Code Definition: Found it was helpful to connect with others through hearing peoples' stories.
- Code: Commonalities Despite Geographic Distance

    - Code Definition: Pros and cons of global engagement.

- Code: Similarities in Response to Work Challenges
    - Code Definition: Normalizing the difficult in human service work.

Theme 3: Meaning Derived From Participating in the Weekly Peer-to-Peer Engagement Groups

Subtheme: Group Bonding

- Code: Connection
    - Code Definition: Reduction of feelings of isolation.
- Code: Support
    - Code Definition: Connection through sharing in a vulnerable space.
- Code: Empathy
    - Code Definition: Growth through witnessing others' struggles.
- Code: Engagement
    - Code Definition: Expressed desire for open forum discussion and group processing.

Subtheme: Feedback

- Code: Responses to Sharing
    - Code Definition: Difficulty from withholding feedback after participant sharing.
- Code: Shift in Awareness
    - Code Definition: Awareness of initial desire for feedback, followed by curiosity around such need for validation.
- Code: No Cross-Talk Rule
    - Code Definition: Appreciation for having no cross-talk and/or feedback; need for place to vent without response,

- Code: Benefits of Non-Feedback
    - Code Definition: Acceptance of meaning held for participants to share without feedback; recognition of benefit in just being heard.
- Code: Preference for Non-Feedback
    - Code Definition: Value of having non-judgmental space to share work/life challenges.
- Code: Desire for Feedback
    - Code Definition: Felt ignored when no response given.
- Code: Neutral Stance on Feedback
    - Code Definition: High comfort level with current format of non-feedback following sharing.

Subtheme: Sharing

- Code: Completion of Covenant and Mission Statement
    - Code Definition: Significance of reading Covenant and Mission Statement to entire group.
- Code: Sharing Successes and Failures
    - Code Definition: Importance of sharing weekly strengths and weaknesses to peers.
- Code: Non-verbal Affirmations
    - Code Definition: Nods and facial expressions as important visual feedback.

<u>Theme 4: Tools Gained for Sustained Work With Serving Traumatized Populations</u>

Subtheme: Tools of Hope

- Code: Tools

    - Code Definition: Helpful tools to use in everyday life.
- Code: Useful Learning
    - Code Definition: Integration of learning related to science and nervous system.
- Code: Intentional Self-regulation
    - Practicing self-regulation both in real life and “in-vivo” virtual forum.

Subtheme: Techniques and Practice

- Code: Self-calming Techniques
    - Code Definition: Gaining learning aspects related to ventral vagal activation.
- Code: Self-regulation Exercises
    - Code Definition: Using the peripheral vision, pelvic floor relaxation, and interoceptive body scanning and “wet noodle” for self-regulation and calming.
- Code: Practical Use of Tools of Hope
    - Code Definition: Importance of practicing self-regulation tools throughout the workday and in everyday life situations.
- Code: Using Learned Tools for Activation Reduction
    - Code Definition: Increased somatic awareness of need for relaxation and calming
- Code: Alternating Self-regulating Tools
    - Code Definition: Varied use of self-regulation tools throughout the day.
- Code: Intentional Practice
    - Code Definition: Increased awareness and practicing self-regulation techniques until it becomes an automatic response to stress.
- Code: Social Engagement as Practice Forum

    - Code Definition: Importance of relaxing muscle tension as means of self-regulation.

Theme 5: Elements of the FFPR and FFMe Sessions That May Inform Future Virtual Support Groups

Subtheme: Dialogue

- Code: Open Dialogue
    - Code Definition: Importance of dialogue and desire for open engagement time.
- Code: Sharing Space
    - Code Definition: Appreciation for greater space of open-sharing at the close of group time (completion of individual weekly sharing).
- Code: Flexible Format
    - Code Definition: Importance of open-ended and flexible format with leftover time in weekly sessions.

Subtheme: Interaction

- Code: Experience of Group Interaction
    - Code Definition: Power of peer-to-peer engagement.

Subtheme: Self-Reflection

- Code: Importance of Intentional Daily Practice
    - Code Definition: Depth of meaning for practicing tools in everyday life.

Subtheme: Group Size

- Code: Consideration of Group Size
    - Code Definition: Smaller group preference.

Subtheme: Benefits of Program

- Code: Broad Spectrum Use of Learning
    - Code Definition: Use of modality both personally and professionally.