1

Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview

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There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our sense of self to the clients we serve. Therapists who work with rape victims, for example, often develop a general disgust for rapists that extends to all males. Those who have worked with victims of other types of crime often "feel paranoid" about their own safety and seek greater security. Ironically, as will be noted later, the most effective therapists are most vulnerable to this mirroring or contagion effect. Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress.

Mary Cerney (Chapter 7) notes that working with trauma victims can be especially challenging for therapists, since some may feel that they, in the words of English (1976), ". . . have taken over the pathology" of the clients (p. 191). Cerney suggests:

> This affront to the sense of self experienced by therapists of trauma victims can be so overwhelming that despite their best efforts, therapists begin to exhibit the same characteristics as their patients—that is, they experience a change in their interaction with the

world, themselves, and their family. They may begin to have intrusive thoughts, nightmares, and generalized anxiety. They themselves need assistance in coping with their trauma.

The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering itself as well.

Over the past 10 years, I have been studying this phenomenon. Although I now refer to it as compassion fatigue, I first called it a form of burnout, a kind of "secondary victimization" (Figley, 1983a). Since that time, I have spoken with or received correspondence from hundreds of professionals, especially therapists, about their struggles with this kind of stressor. They talk about episodes of sadness and depression, sleeplessness, general anxiety, and other forms of suffering that they eventually link to trauma work.

This chapter and those that follow represent our best efforts to understand, treat, and prevent compassion fatigue. We begin with a discussion of the conceptual development of the concept of trauma and related terms and ways of knowing about them.

Paul Valent (Chapter 2) presents a framework for the next century of investigation of traumatic stress. "Survival strategies" are assigned to each of the eight types of traumatic stressors, and each strategy is considered within the three reaction domains: biological, psychological, and social. This synthesis of decades of research and theoretical work appears to be a very useful framework for categorizing traumatic stress reactions, including secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD) among therapists and others who care for victims.

This chapter proposes a reconfiguration of post-traumatic stress disorder (PTSD) that is consistent with the current, scientifically based views of the disorder, as specified in the revised third edition of the DSM-III (American Psychiatric Association [APA], 1987) and of the new version described in DSM-IV (APA, 1994) and ICD-10. As noted in the introduction to this book, the criteria of a traumatic event in these diagnostic manuals take note of but do not discuss the implications of a person's being confronted with the pain and suffering of others. It will be suggested later that PTS and PTSD retain the same set of symptoms, and thus methods of assessment, but that parallel symptoms and methods of assessment must be developed for STS and STSD. This chapter draws on the research and theoretical literature, primarily presented in the chapters to follow, to support this new configuration.

What follows is an explication of STS and STSD, later called compas-

sion stress/fatigue, because they have received the least attention from traumatology scholars and practitioners. This is followed by an illustrative review of the theoretical and research literature that supports the existence of STS. The last section of the chapter discusses the implications of the proposed reconfiguration for diagnostic nomenclature, research and clinical assessment, and theory development.

CONCEPTUAL CLARITY

The diagnosis of PTSD has been widely utilized in mental health research and practice, and its application has influenced case law and mental health compensation (Figley, 1986; Figley, 1992a, b). In a report of the review of trauma-related articles cited in *Psychological Abstracts,* Blake, Albano, and Keane (1992) identified 1,596 citations between 1970 and 1990. Their findings support the view that the trauma literature has been growing significantly since the advent of the concept of PTSD (APA, 1980). However, most of these papers lack conceptual clarity. They rarely consider contextual and circumstantial factors in the traumatizing experience or adopt the current PTSD nomenclature.

As noted in the introduction to this volume, although the psychotraumatology field has made particularly great progress in the past decade, the syndrome has an extremely long history. A field devoted exclusively to the study and treatment of traumatized people represents the culmination of many factors. One was the greatly increased awareness of the number and variety of traumatic events and their extraordinary impact on large numbers of people. As noted in the introduction, many identify the publication of the American Psychiatric Association's DSM-III in 1980 as a major milestone. It was the first to include the diagnosis of post-traumatic stress disorder.

With the publication of DSM-III, for the first time the common symptoms experienced by a wide variety of traumatized persons were viewed as a psychiatric disorder; one that could be accurately diagnosed and treated. Although a revision of DSM-III modified the symptom criteria somewhat (APA, 1987), the popularity of the concept among professionals working with traumatized people (including lawyers, therapists, emergency professionals, and researchers) grew, as did the accumulation of empirical research that validated the disorder.

After well over a decade of use, the term PTSD is more commonly applied to people traumatized by one of many types of traumatic events. Yet a review of the traumatology literature yields the following: Nearly

all of the hundreds of reports focusing on traumatized people exclude those who were traumatized indirectly or secondarily and focus on those who were directly traumatized (i.e., the "victims"). But descriptions of what constitutes a traumatic event (i.e., Category [criterion] A in the DSM-III and DSM-III-R descriptions of PTSD) clearly indicate that mere knowledge of another's traumatic experiences can be traumatizing.

People are traumatized either directly or indirectly. The following excerpt is taken from the PTSD description in DSM-IV (APA, 1994) of what constitutes a sufficiently traumatic experience.

> The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves threatened death, actual or threatened serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or *learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates* (Criterion A1). Italics added; [p. 424]

The italicized phrases emphasize that people can be traumatized without actually being physically harmed or threatened with harm. That is, they can be traumatized simply by learning about the traumatic event. Later it is noted:

> Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. [p. 424]

This material has led to a conceptual conundrum in the field, although few have identified it. For example, I have pointed out (Figley, 1976; 1982; 1983a,b) that the number of "victims" of violent crime, accidents, and other traumatic events is grossly underestimated because only those directly in harm's way are counted, excluding family and friends of the victims. In a presentation (1982) and subsequent publications (1983b; 1985a,b; 1989), I noted a phenomenon I called "secondary catastrophic stress reactions," meaning that the empathic induction of a family member's experiences results in considerable emotional upset.

Parallel phenomena exist: fathers, especially in more primitive societies, appear to exhibit symptoms of pregnancy out of sympathy for those of their wives (i.e., *couvade*; see Hunter & Macalpine, 1963); a psychiatric illness can appear to be shared by the patient's spouse (folie à deux; Andur & Ginsberg, 1942; Gralnick, 1939). Other parallels have been reported in the medical and social science literatures, including copathy (Launglin, 1970); identification (Brill, 1920; Freud, 1959); sympathy (Veith, 1965); and hyperarousal, "mass hysteria," or psychogenic illness, which appears to sweep through groups of people, including children (see Colligan & Murphy, 1979). An emotional arousal appears to be associated with an empathic and sympathetic reaction. Also, in the process of dispensing this care, the support becomes exhausted. As noted elsewhere (Figley, 1983b):

> Sometimes . . . we become emotionally drained by [caring so much]; we are adversely affected by our efforts. Indeed, simply being a member of a family and caring deeply about its members makes us emotionally vulnerable to the catastrophes which impact them. We, too, become "victims," because of our emotional connection with the victimized family member. [p. 12]

In a later treatise (Figley, 1985), I commented that families and other interpersonal networks (e.g., friendships, work groups, clubs, and the client–therapist relationship) are powerful systems for promoting recovery following traumatic experiences. At the same time, these same systems and their members can be "traumatized by concern." We can classify this trauma as follows: (1) simultaneous trauma takes place when all members of the system are directly affected at the same time, such as by a natural disaster; (2) vicarious trauma happens when a single member is affected out of contact with the other members (e.g., in war, coal mine accidents, hostage situations, distant disasters); (3) intrafamilial trauma or abuse takes place when a member causes emotional injury to another member; and (4) chiasmal or secondary trauma strikes when the traumatic stress appears to "infect" the entire system after first appearing in only one member. This last phenomenon most closely parallels what we are now calling STS and STSD.

Richard Kishur, a master's student studying under the author's direction, reanalyzed a large data set of a study of New York City crime victims and their supporters (family members, neighbors, friends). Utilizing metaphorically the transmission of genetic material or "crossing over" that takes place between like pairs of chromosomes during meiotic cell division, Kishur (1984) coined the term "chiasmal effect." To

him, this term best accounted for why there was such a strong correlation between the quality and quantity of the symptoms of crime victims and that of the supporters of these victims.

> It is clear that a pattern of effects emerges in both victim and supporter. The crime victims as well as their supporters suffer from the crime episode long after the initial crisis has passed. Symptoms of depression, social isolation, disruptions of daily routine, and suspicion or feelings of persecution affect the lives of these persons. [p. 65]

Even in the absence of precise, conceptual tools, however, the literature is replete with implicit and explicit descriptions of this phenomenon. Some of the most cogent examples are reports by traumatized people who complain that family and friends discourage them from talking about their traumatic experiences after a few weeks because it is so distressing to the supporters (Figley, 1989).

I previously (Figley, 1989) expressed my dismay about seeing so many colleagues and friends abandon clinical work or research with traumatized people because of their inability to deal with the pain of others. "The same kind of psychosocial mechanisms within families that make trauma 'contagious,' that create a context for family members to infect one another with their traumatic material, operate between traumatized clients and the therapist" (p. 144). Those who are most vulnerable to this contagion are those who "begin to view themselves as saviors, or at least as rescuers" (pp. 144–145).

In summary, there has been widespread, although sporadic, attention in the medical, social science, family therapy, and psychological literature to the phenomenon we now refer to as compassion stress/fatigue or secondary traumatic stress/disorder. At the same time, in spite of the clear identification of this phenomenon as a form of traumatization in all three versions of the DSM, nearly all of the attention has been directed to people in harm's way, and little to those who care for and worry about them.

Why are there so few reports of these traumatized people? Perhaps it is because the psychotraumatology field is so young, although the focus of interest stretches back through the ages. Beaton and Murphy (Chapter 3) note that perhaps the field is in a "pre-paradigm state," as defined by Kuhn (1962, 1970). Kuhn, in his classic treatise on theory development, reasoned that paradigms follow the evolution of knowledge, and, in turn, influence the development of new knowledge. Knowledge about experiencing, reexperiencing, and reacting to traumatic material evolves

in "fits and starts." Prevailing paradigms are viewed, suddenly, as anomalies when new information and paradigm shifts occur. This certainly applies to the prevailing, limiting view of PTSD and the need to recognize that the process of attending to the traumatic experiences and expressions may be traumatic itself.

The concept of PTSD, developed through both scholarly synthesis and the politics of mental health professions (see Scott, 1993), was introduced in DSM-III (APA, 1980) as the latest in a series of terms to describe the harmful biopsychosocial effects of emotionally traumatic events. This concept has brought order to a growing area of research that is now a field of study (Figley, 1988a, b, c; Figley, 1992a, b). After more than a decade of application of the concept and two revisions of the DSM, it is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress.

Why STSD?

It has been confirmed by a wide variety of sources (e.g., Ochberg, 1988; Wilson & Raphael, 1993) that the most important and frequently used remedies for people suffering from traumatic and post-traumatic stress are personal rather than clinical or medical. These personal remedies include the naturally occurring social support of family, friends, and acquaintances, and of professionals who care (see Figley, 1988a, b, c; Flannery, 1992; Solomon, 1989). Yet little has been written about the "cost of caring" (Figley, 1975, 1978, 1982, 1985b, 1986, 1989, 1993b, in press; Figley & Sprenkle). It is important to know how these supporters become upset or traumatized as a result of their exposure to victims. By understanding this process, we not only can prevent additional, subsequent traumatic stress among supporters, but we can also increase the quality of care for victims by helping their supporters.

Scholars and clinicians require a conceptualization that accurately describes the indices of traumatic stress for both those in harm's way and those who care for them and become impaired in the process. Alternate theoretical explanations for the transmission of trauma that results in this impairment are discussed in the latter part of this chapter.

Definition of Secondary Traumatic Stress and Stress Disorder

We can define STS as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1993a).

What is being asserted is that there is a fundamental difference between the sequelae or pattern of response during and following a traumatic event, for people exposed to primary stressors and for those exposed to secondary stressors. Therefore, STSD is a syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress. Table 1 depicts and contrasts the symptoms of PTSD with those of STSD.

TABLE 1
Suggested Distinctions Between the Diagnostic Criteria for Primary and Secondary Traumatic Stress Disorder

Primary	Secondary
A. Stressor:	**A. Stressor:**
Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:	Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:
1. Serious threat to self	1. Serious threat to traumatized person (TP)
2. Sudden destruction of one's environs	2. Sudden destruction of TP's environs
B. Reexperiencing Trauma Event	**B. Reexperiencing Trauma Event**
1. Recollections of event	1. Recollections of event/TP
2. Dreams of event	2. Dreams of event/TP
3. Sudden reexperiencing of event	3. Sudden reexperiencing of event/TP
4. Distress of reminders of event	4. Reminders of TP/event distressing
C. Avoidance/Numbing of Reminders	**C. Avoidance/Numbing of Reminders of Event**
1. Efforts to avoid thoughts/feelings	1. Efforts to avoid thoughts/feelings
2. Efforts to avoid activities/situations	2. Efforts to avoid activities/situations
3. Psychogenic amnesia	3. Psychogenic amnesia
4. Diminished interest in activities	4. Diminished interest in activities
5. Detachment/estrangements from others	5. Detachment/estrangements from others
6. Diminished affect	6. Diminished affect
7. Sense of foreshortened future	7. Sense of foreshortened future
D. Persistent Arousal	**D. Persistent Arousal**
Difficulty falling/staying asleep	Difficulty falling/staying asleep
2. Irritability or outbursts of anger	2. Irritability or outbursts of anger
3. Difficulty concentrating	3. Difficulty concentrating
4. Hypervigilance for self	4. Hypervigilance for TP
5. Exaggerated startle response	5. Exaggerated startle response
6. Physiologic reactivity to cues	6. Physiologic reactivity to cues

(Symptoms under one month duration are considered normal, acute, crisis-related reactions. Those not manifesting symptoms until six months or more following the event are delayed PTSD or STSD.)

At the same time, we suggest that PTSD should stand for primary traumatic stress disorder, rather than post-traumatic stress disorder, since every stress reactions is "post" by definition.

Contrasts Between STS and Other Concepts

The STS phenomenon has been called different names over the years. We suggest that compassion stress and compassion fatigue are appropriate substitutes. Most often these names are associated with the "cost of caring" (Figley, 1982) for others in emotional pain.

Among the few dozen references in this general area, this phenomenon is called secondary victimization (Figley, 1982, 1983b, 1985a, 1989), "co-victimization" (Hartsough & Myers, 1985), and secondary survivor (Remer & Elliot, 1988a, 1988b). McCann & Pearlman (1989) suggest that "vicarious traumatization" is an accumulation of memories of clients' traumatic material that affects and is affected by the therapist's perspective of the world. They propose a team-oriented approach to both preventing and treating this special kind of stress.

Miller, Stiff, and Ellis (1988) coined the term *emotional contagion* to describe an affective process in which "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions" (p. 254). Other terms that appear to overlap with STS or STSD include rape-related family crisis (Erickson, 1989; White & Rollins, 1981); "proximity" effects on female partners of war veterans (Verbosky & Ryan, 1988); generational effects of trauma (Danieli, 1985; McCubbin, Dahl, Lester, & Ross, 1977); the need for family "detoxification" from war-related traumatic stress (Rosenheck & Thomson, 1986); and the "savior syndrome" (NiCathy, Merriam, & Coffman, 1984). But "countertransference" and "burnout" are most frequently cited, and will be discussed separately in more detail in the following.

Countertransference and Secondary Stress

Countertransference is connected with psychodynamic therapy and often appears to be an emotional reaction to a client by the therapist. Although there are many definitions, countertransference in the context of psychotherapy is the distortion on the part of the therapist resulting from the therapist's life experiences and associated with her or his unconscious, neurotic reaction to the client's transference (Freud, 1959). Most recently, Corey (1991) defined countertransference as the process of seeing oneself in the client, of overidentifying with the client, or of

meeting needs through the client.

Singer and Luborsky (1977), not bound by the limits of psychoanalysis, suggest that countertransference extends far beyond the context of psychotherapy. They include all of a therapist's conscious and unconscious feelings about or attitudes toward a client, and believe that these feelings and attitudes may be useful in treatment.

In the recent book *Beyond Transference: When the Therapist's Real Life Intrudes* (Gold & Nemiah, 1993), contributors recount how personal events in the lives of therapists affect the quality and characteristics of therapy. The most compelling part of the book, however, focuses on how clients, not the personal life experiences of the therapist, are stressful and difficult to handle. Countertransference was once viewed simply as the therapist's conscious and unconscious response to the patient's transference, especially if the transference connected with the therapist's past experiences. Johansen (1993) suggests that a more contemporary perception of countertransference views it as all of the emotional reactions of the therapist toward the patient—regardless of their sources. These sources include, for example, the life stressors—past or present—experienced by the therapist. But they also include the traumata expressed by the client and absorbed by the therapist. This, unfortunately, is rarely discussed in the literature, and is the major focus of this book.

A recent study (Hayes, Gelso, Van Wagoner, & Diemer, 1991) found that five therapist qualities appear to help therapists, in varying degrees, to manage countertransference effectively. These are anxiety management, conceptualization of skills, empathic ability, self-insight, and self-integration. The study surveyed 33 expert therapists regarding the importance of five factors, subdivided into 50 personal characteristics, which composed their five-item, Likert-response-type Countertransference Factors Inventory (CFI). Although all five were found to be important, expert therapists rated self-integration and self-insight as the most significant factors in managing countertransference.

In a follow-up study, Van Wagoner, Gelso, Hayes, and Diemer (1991) surveyed 93 experienced counseling professionals using the CFI to rate the factors for either therapists in general or excellent therapists in particular. Excellent therapists, in contrast to therapists generally, were viewed by the sample as (1) having more insight into and explanation for their feelings; (2) having greater capacity for empathy for and understanding of the client's emotional experience; (3) being more able to differentiate between the needs of self and client; (4) being less anxious with clients; and (5) being more adept at conceptualizing "client dynamics" in both the client's current and past contexts (p. 418).

One could argue, then, that STS includes, but is not limited to, what these researchers and other professionals view as countertransference. It is assumed that countertransference happens only within the context of psychotherapy, it is a reaction by the therapist to the transference actions on the part of the client, and it is a negative consequence of therapy and should be prevented or eliminated. However, STS, or event STSD, is a natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first's traumatic experiences. These effects are not necessarily a problem but, more, a natural by-product of caring for traumatized people.

Burnout and Secondary Stress

Some view the problems faced by workers with job stress simply as burnout (Maslach & Jackson, 1984; cf. Pines, 1993). A 1993 literature search of *Psychological Abstracts* located more than 1,100 relevant articles and 100 books since the term was coined by Freudenberger (1974) and carefully explicated by Maslach (1976). According to Pines and Aronson (1988), burnout is "a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations" (p. 9). The most widely utilized measure of burnout is the Maslach Burnout Inventory (MBI), developed by Maslach and Jackson (1981). It measures three aspects: emotional exhaustion (e.g., "I feel emotionally drained by my work"); depersonalization (e.g., "I worry that the job is hardening me emotionally"); and reduced personal accomplishment (e.g., "I feel I'm positively influencing other people's lives through my work"). More recently, Pines and Aronson (1988) developed the Burnout Measure (BM), which measures physical exhaustion (e.g., feeling tired or rundown); emotional exhaustion (e.g., feeling depressed, hopeless); and mental exhaustion (e.g., feeling disillusionment, resentment toward people). Emotional exhaustion appears to be the key factor the two measures of burnout have in common. Burnout has been defined variously as a collection of symptoms associated with emotional exhaustion.

1. Burnout is a process (rather than a fixed condition) that begins gradually and becomes progressively worse (Cherniss, 1980; Maslach, 1976, 1982).
2. The process includes (a) gradual exposure to job strain (Courage & Williams, 1986), (b) erosion of idealism (Freudenberger, 1986; Pines, Aronson, & Kafry, 1981), and (c) a void of achievement (Pines & Maslach, 1980).

3. There is an accumulation of intensive contact with clients (Maslach & Jackson, 1981).

In a comprehensive review of the empirical research on the symptoms of burnout, Kahill (1988) identified five categories of symptoms.

1. Physical symptoms (fatigue and physical depletion/exhaustion, sleep difficulties, specific somatic problems such as headaches, gastrointestinal disturbances, colds, and flu).
2. Emotional symptoms (e.g., irritability, anxiety, depression, guilt, sense of helplessness).
3. Behavioral symptoms (e.g., aggression, callousness, pessimism, defensiveness, cynicism, substance abuse).
4. Work-related symptoms (e.g., quitting the job, poor work performance, absenteeism, tardiness, misuse of work breaks, thefts).
5. Interpersonal symptoms (e.g., perfunctory communication with, inability to concentrate/focus on, withdrawal from clients/coworkers, and then dehumanizing, intellectualizing clients).

In addition to depersonalization, burnout has been associated with a reduced sense of personal accomplishment and discouragement as an employee (see Maslach & Jackson, 1981). From a review of the research literature, it appears that the most salient factors associated with the symptoms of burnout include client problems—chronicity, acuity, complexity—that are perceived to be beyond the capacity of the service provider (Freudenberger, 1974, 1975; Maslach, 1976, 1982; Maslach & Jackson, 1981). Moreover, Karger (1981) and Barr (1984) note that service providers are caught in a struggle between promoting the well-being of their clients and trying to cope with the policies and structures in the human service delivery system that tend to stifle empowerment and well-being.

In contrast to burnout, which emerges gradually and is a result of emotional exhaustion, STS (compassion stress) can emerge suddenly with little warning. In addition to a more rapid onset of symptoms, with STS, in contrast to burnout, there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate. The Self Test for Psychotherapists was designed to help therapists differentiate between burnout and STS. This measure (see pp. 13–14) is discussed elsewhere (Figley, 1993a) in some detail.

*Compassion Fatigue Self Test for Psychotherapists**

Name _____ *Institution* _____ *Date*_____
Please describe yourself: ___*Male*___*Female;* _____ *years as practitioner. Consider each of the following characteristic about you and your current situation. Write in the number for the best response. Use one of the following answers:*

1=Rarely/Never 2=At Times 3=Not Sure 4=Often 5=Very Often

Answer all items, even if not applicable. Then read the instructions to get your score.

Items About You:

1. __ *I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.*
2. __ *I find myself avoiding certain activities or situations beause they remind me of a frightening experience.*
3. __ *I have gaps in my memory about frightening events.*
4. __ *I feel estranged from others.*
5. __ *I have difficulty falling or staying asleep.*
6. __ *I have outbursts of anger or irritability with little provocation.*
7. __ *I startle easily.*
8. __ *While working with a victim I thought about violence against the perpetrator.*
9. __ *I am a sensitive person.*
10. __ *I have had flashbacks connected to my clients.*
11. __ *I have had first-hand experience with traumatic events in my adult life.*
12. __ *I have had first-hand experience with traumatic evevts in my childhood.*
13. __ *I have thought that I need to "work through" a traumatic experience in my life.*
14. __ *I have thought that I need more close friends.*
15. __ *I have thought that there is no one to talk with about highly stressful experiences.*
16. __ *I have concluded that I work too hard for my own good.*
17. __ *I am frightened of things a client has said or done to me.*
18. __ *I experience troubling dreams similar to those of a client of mine.*
19. __ *I have experienced intrusive thoughts of sessions with especially difficult clients.*
20. __ *I have suddenly and involuntarily recalled a frightening experience while working with a client.*
21. __ *I am preoccupied with more than one client.*
22. __ *I am losing sleep over a client's traumatic experiences.*
23. __ *I have thought thatI might have been "infected" by the traumatic stress of my clients.*
24. __ *I remind myself to be less concerned about the well-being of my clients.*
25. __ *I have felt trapped by my work as a therapist.*
26. __ *I have felt a sense of hopelessness associated with working with clients.*
27. __ *I have felt "on edge" about various things and I attribute this to working with certain clients.*

Continued

28. __ *I have wished that I could avoid working with some therapy clients.*
29. __ *I have been in danger working with therapy clients.*
30. __ *I have felt that my clients dislike me personally.*

Items About Being a Psychotherapist and Your Work Environment:

31. __ *I have felt weak, tired, rundown as a result of my work as a therapist.*
32. __ *I have felt depressed as a result of my work as a therapist.*
33. __ *I am unsuccessfut at separating work from personal life.*
34. __ *I feel little compassion toward most of my co-workers.*
35. __ *I feel I am working more for the money than for personal fulfillment.*
36. __ *I find it difficult separating my personal life from my work life.*
37. __ *I have a sense of worthlessness/disillusionment/resentment associated with my work.*
38. __ *I have thoughts that I am a "failure" as a psychotherapist.*
39. __ *I have thoughts that I am not succeeding at achieving my life goals.*
40. __ *I have to deal with bureaucratic, unimportant tasks in my work life.*

** Note, this instrument is under development. Please contact Dr. Charles R. Figley, Psychosocial Stress Research Program, Florida State University, MFT Center (F86E) (Phone: 904-644-1588; Fax, 904-644-4804) [11/93]*

Scoring Instructions: (a) Be certain you responded to all items. (b) Circle the following 23 items: 1–8, 10–13, 17–26, and 29. (c) Add the numbers you wrote next to the items. (d) Note your risk of Compassion Fatigue: 26 or less = Extremely low risk; 27 to 30 = Low risk; 31 to 35 = Moderate risk; 36 to 40 = High risk; 41 or more = Extremely high risk.

Then, (e) Add the numbers you write next to the items not circled. (f) Note your risk of burnout: 17–36 or less = Extremely low risk; 37–50 = Moderate risk; 51–75 = High risk; 76–85 = Extremely high risk.

Scores for this instrument emerged using a sample of 142 pschotherapy practitioners attending workshops on the topic during 1992 and 1993. Psychometric properties of the scale are reported by Stamm and Vara (1993). Alpha reliability scores ranged from 94 to 86; structural analysis yielded at least one stable factor which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. Structural Reliability (stability) of this factor, as indicated by Tucker's Coefficient of Congruence (cc), is .91.

Why Compassion Stress and Compassion Fatigue?

Thus although STS and STSD are the latest and most exact descriptions of what has been observed and labeled over hundreds of years, the most friendly term for this phenomenon, and one that will be used here, is compassion fatigue (Joinson, 1992). Webster's Encyclopedic Unabridged Dictionary of the English Language (1989) defines compassion as "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a

strong desire to alleviate the pain or remove its cause" (p. 299). Its antonyms include "mercilessness" and "indifference." My very informal research leads to the finding that the terms compassion stress and compassion fatigue are favored by nurses (Joinson first used the term in print, in 1992, in discussing burnout among nurses), emergency workers, and other professionals who experience STS and STSD in the line of duty. Therefore, the terms can be used interchangeably by those who feel uncomfortable with STS and STSD. Such discomfort might arise from a concern that such labels are derogatory. Feeling the stress, and even the fatigue, of compassion in the line of duty as a nurse or therapist better describes the causes and manifestations of their duty-related experiences.

Who Is Vulnerable to Compassion Fatigue?

In the epilogue to this book, two models are presented to account for how and why some people develop compassion fatigue while others do not. At the heart of the theory are the concepts of empathy and exposure. If we are not empathic or exposed to the traumatized, there should be little concern for compassion fatigue. Throughout this book, authors discuss the special vulnerabilities of professionals—especially therapists—who work with traumatized people on a regular basis. These "trauma workers" are more susceptible to compassion fatigue.

This special vulnerability is attributable to a number of reasons, most associated with the fact that trauma workers are always surrounded by the extreme intensity of trauma-inducing factors. As a result, no matter how hard they try to resist it, trauma workers are drawn into this intensity. Beyond this natural by-product of therapeutic engagement, there appear to be four additional reasons why trauma workers are especially vulnerable to compassion fatigue.

1. *Empathy is a major resource for trauma workers to help the traumatized.* Empathy is important in assessing the problem and formulating a treatment approach, because the perspectives of the clients—including the victim's family members—must be considered. Yet as noted earlier and throughout this volume (see Harris, Chapter 5) from research on STS and STSD we know that empathy is a key factor in the induction of traumatic material from the primary to the secondary victim. Thus the process of empathizing with a traumatized person helps us to understand the person's experience of being traumatized, but, in the process, we may be traumatized as well.

2. *Most trauma workers have experienced some traumatic event in their lives.* Because trauma specialists focus on the context of a wide variety of traumatic events, it is inevitable that they will work with traumatized people who experienced events that were similar to those experienced by the trauma worker. There is a danger of the trauma worker's overgeneralizing his or her experiences and methods of coping to the victim and overpromoting those methods. For example, a crime-related traumatization may be very different from that of the trauma worker, but the counselor may assume that they are similar and so listen less carefully. Also, the counselor may suggest what worked well for him or her but would be ineffective—or, at worst, inappropriate—for the victim.
3. Unresolved trauma of the worker will be activated by reports of similar trauma in clients. Trauma workers who are survivors of previous traumatic events may harbor unresolved traumatic conflicts. These issues may be provoked as a result of the traumatic experiences of a client. In this volume, the chapters by Cerney, by Yassen, and by others confirm the power of past traumatic experiences on current functioning.
4. Children's trauma is also provocative for therapists. Police officers, firefighters, emergency medical technicians, and other emergency workers report that they are most vulnerable to compassion fatigue when dealing with the pain of children (see Beaton & Murphy, Chapter 3). And because children so often are either the focus of trauma counseling or are important players, trauma workers are more likely than are other practitioners to be exposed to childhood trauma.

IMPLICATIONS FOR TRAINING AND EDUCATING THE NEXT GENERATION OF PROFESSIONALS

The chapters to follow more fully explicate the role of trauma in the lives of professionals. They review in detail the scholarly and practice literature to identify what we know and have known about compassion fatigue (i.e., STSD). Each of the contributors suggests his or her own theories, concepts, and methods of assessment and treatment. Few discuss the implications for trauma worker education, however.

As an educator, as well as a researcher and practitioner, this author is concerned about the next generation of trauma workers. Although we need to know a great deal more about compassion fatigue—who gets it

when, and under what circumstances; how it can be treated and prevented—we know much already. We know enough to realize that compassion fatigue is an occupational hazard of caring service providers—be they family, friends, or family counselors.

Recognizing this, we as practicing professionals have a special obligation to our students and trainees to prepare them for these hazards. A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision in practica.

We can use the relatively protected environment of our educational centers and the clients who seek help there as a place for discussing these issues. Some fundamental principles for preventing compassion fatigue might be useful. In addition, training programs could (1) institute policies that require processing all clinical material that appears to be upsetting to either the individual worker or another team member (including a supervisor); and (2) recognize that upsetting clinical material is and should be discussed confidentially with confidants (spouse/partner), following prescribed ethical procedures, and that the confidant could, in turn, become upset; and (3) experiment with various methods for avoiding compassion fatigue while, at the same time, not sacrificing clinical effectiveness.

We must do all that we can to insure that trauma workers are prepared. As noted later in the book, we have a "duty to inform" them about the hazards of this work. But, at the same time, to emphasize that this work is most rewarding: to see people suffering from the shock of highly stressful events be transformed immediately from sadness, depression, and desperation to hope, joy, and a renewed sense of purpose and meaning of life. This transformation is equally possible for professionals who recognize that they themselves are suffering from compassion fatigue. We hope that the chapters to follow will help facilitate this transformation both in those in harm's way and in the professionals they go to for help.

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