COMPASSION FATIGUE:

A CRUCIBLE OF TRANSFORMATION[1]

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Abstract

This article explores the history, causes, treatments and prevention of compassion fatigue, the negative effects of helping others, contexualized for application to the trauma recovery efforts from the events of September 11, 2001. The author draws upon experience with development and implementation of the Accelerated Recovery Program for Compassion Fatigue, the Certified Compassion Fatigue Specialist Training, and the provision of treatment and training to hundreds of caregivers suffering from compassion fatigue symptoms. A model for understanding the multiple causes of compassion fatigue is presented, along with distillation of the active ingredients for effective treatment and prevention of its symptoms. Symptoms of compassion fatigue are conceptualized not only as disruptive and deleterious effects of caring for the traumatized, but also as a catalyst for positive change, transformation, maturation, and resiliency in the lives of these caregivers. Specific suggestions for compassion fatigue prevention and resiliency are reviewed.

Introduction

On October 19, 2001 I co-facilitated a Critical Incident Stress Debriefing (CISD; Mitchell, 1995) in New York City for 12 mid-level retail managers who had been working two blocks from the World Trade Center on September 11, 2001. As this group navigated through the CISD and its cognitive-affective-cognitive "schwoop" (Norman, 2001), that hallmark of emergency psychology, one person began to describe the debris falling from the crumbling towers by saying, "in my mind I see chunks of concrete falling from the building but I know it was really people that I saw falling… jumping." As she spoke, I could not help myself from forming my own images of falling debris coalescing into anatomical features. Another participant reported that the worst part of September Eleventh for him was the emergence of recurrent intrusive images and nightmares. However, the intrusions he was experiencing were not of the horrors he saw in lower Manhattan; instead they were of tracer rounds from automatic rifles firing over his and his mother's head when he was a child fleeing Vietnam in 1975. As he described the spontaneous emergence of these memories, brought to consciousness for the first time in 26 years, I began to recall images from some of the thousands of combat trauma narratives I have heard from the hundreds of combat veterans that I have treated. I also began to feel some anxiety for the co-facilitator who was leading this debriefing, as this was his thirtieth straight day of providing trauma relief services in New York City and he was a Vietnam combat veteran.

While participating in this debriefing, I was acutely aware of my powerlessness to prevent the images, thoughts and feelings shared by the participants from finding their way into parallel associations in my own consciousness. Having spent the past five years

studying and treating compassion fatigue, I knew that I was high risk for the development of secondary traumatic stress symptoms. For the next several weeks I experienced recurrent images and accompanying arousal from this and other experiences in New York. It was only after extensive support from colleagues and my work, as a client, with Eye Movement Desensitization & Reprocessing (EMDR, Shapiro, 1995), that I was able to relegate these images and feelings from the encroaching present into the near-distant past.

Thousands of emergency service and mental health professionals have labored heroically to assist survivors of the events of 9/11/01. These service professionals have witnessed events and heard stories of incredible courage and resiliency in the course of providing assistance to the survivors. They have also been exposed to incidents and reports of life-shattering pain, terror, and loss. There is no doubt that there are great rewards associated with providing care and assistance to survivors of trauma; for those of us who have chosen traumatology as a professional path, there is no sweeter experience than witnessing a survivor emerge transformed and fortified from the dark jungle of posttraumatic symptoms. There is also, however, little doubt that serving these survivors exacts a toll that while minimal for some caregivers, can be devastating for others. As Viktor Frankl, one of the twentieth century's greatest traumatologists, simultaneously warns and encourages: "*That which is to give light must endure burning*" (Frankl, 1963, p. 129).

This article explores the potential causes, prevention, and treatments of compassion fatigue (Figley, 1995), the deleterious effects of helping the traumatized, as it relates to the tragedy of September 11, 2001. It is offered with the hope that it may help

some of those dedicated to being of service to survivors in New York and across the nation to continue being givers of light, burning ever more brightly, and never burning out.

Compassion Fatigue

The notion that working with people in pain extracts a significant cost from the caregiver is not new. Although the costs vary and have been lamented from time immemorial, anyone who has sat at the bedside of a seriously ill or recently bereaved loved one knows the toll involved in devoting singular attention to the needs of another suffering person. Only in recent years, however, has there been a substantial effort to examine the effects on the caregiver of bearing witness to the indescribable wounds inflicted by traumatic experiences. The exploration and examination of these effects evolved throughout the last century and comes to us from a wide variety of sources.

One of the first earliest references in the scientific literature regarding this cost of caring comes from Carl G. Jung in *The Psychology of Dementia Praecox* (Jung, 1907*).* In this text, Jung discusses the challenges of *countertransference* — the therapist's conscious and unconscious reactions to the patient in the therapeutic situation — and the particular countertransferential difficulties analysts encounter when working with psychotic patients. He boldly *prescribes* a treatment stance in which the therapist participates in the delusional fantasies and hallucinations *with* the patient. Nevertheless, he warns that this participation in the patient's darkly painful fantasy world of traumatic images has significant deleterious effects for the therapist, especially the neophyte and/or the therapist who has not resolved his/her own developmental and traumatic issues (Sedgewick, 1995).

The study of countertransference produced the first writings in the field of psychotherapy that systematically explored the effects of psychotherapy upon the therapist (Haley, 1974; Danieli, 1982; Lindy, 1988; Wilson & Lindy, 1994; Karakashian, 1994; Pearlman & Saakvitne, 1995). Recent texts have suggested that therapists sometimes experience countertransference reactions that imitate the symptoms of their clients (Herman, 1992; Pearlman & Saakvitne, 1995). For instance, when working with survivors of traumatic experiences, authors have reported countertransference phenomena that mimic the symptoms of posttraumatic stress disorder (PTSD; Lindy, 1988; Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995).

Business and industry, with their progressive focus upon productivity in the last half of the twentieth century, have provided us with the concept of burnout (Fruedenberger, 1974; Maslach, 1976) to describe the deleterious effects the environmental demands of the workplace have on the worker. Burnout, or "the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, 1976, p. 56), has been used to describe the chronic effects that psychotherapists suffer as a result of interactions with their clients and/or the demands of their workplace (Freudenberger, 1974; Cherniss, 1980; Farber, 1983; Sussman, 1992; Grosch & Olsen, 1995; Maslach & Goldberg, 1998). Research has shown that therapists are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic (McCann & Pearlman, 1990). Moreover, burnout not only is psychologically debilitating to therapists, but also impairs the therapist's capacity to deliver competent mental health services (Farber, 1983). The literature on burnout, with its twenty-five year history, thoroughly describes the

phenomena and prescribes preventive and treatment interventions for helping professionals.

The study of the effects of trauma has also promoted a better understanding of the negative effects of helping. Psychological reactions to trauma have been described over the past one hundred and fifty years by various names such as “shell shock”, “combat neurosis”, “railroad spine”, and “combat fatigue” (Shalev, Bonne, & Eth, 1996). However, not until 1980 was the latest designation for these reactions, posttraumatic stress disorder (PTSD), formally recognized as an anxiety disorder in the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III, American Psychiatric Association, 1980; Matsakis, 1994). Since that time, research into posttraumatic stress has grown at an exponential rate (Figley, 1995; Wilson & Lindy, 1994) and the field of traumatology has been established with two of it’s own journals, several professional organizations, and unique professional identity (Figley, 1988; Bloom, 1999; Gold & Faust, 2001).

As therapists are increasingly called upon to assist survivors of violent crime, natural disasters, childhood abuse, torture, acts of genocide, political persecution, war, and now terrorism (Sexton, 1999), discussion regarding the reactions of therapists and other helpers to working with trauma survivors has recently emerged in the traumatology literature (Figley, 1983, 1995; Danieli, 1988; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995). Professionals who listen to reports of trauma, horror, human cruelty and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients. They may also experience PTSD symptoms similar to their clients’, such as intrusive thoughts, nightmares, avoidance and arousal, as well as changes in their relationships to their

selves, their families, friends and communities (Figley, 1995; McCann & Pearlman, 1990, Salston, 1999). Therefore, they may themselves come to need assistance to cope with the effects of listening to others' traumatic experiences (Figley, 1995; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Gentry, Baranowsky & Dunning,1997, in press).

While the empirical literature has been slow to develop in this area, there is an emerging body of scientific publications that attempts to identify and define the traumatization of helpers through their efforts of helping. Pearlman and Saakvitne (1995), Figley (1995), and Stamm (1995) all authored and/or edited texts that explored this phenomenon among helping professionals during the same pivotal year. The terms "vicarious traumatization" (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), "secondary traumatic stress" (Figley, 1987; Stamm, 1995) and "compassion fatigue" (Figley, 1995) have all become cornerstones in the vernacular of describing the deleterious effects that helpers suffer when working with trauma survivors.

Vicarious traumatization (McCann & Pearlman, 1990) refers to the transmission of traumatic stress through observation and/or hearing others' stories of traumatic events and the resultant shift/distortions that occur in the caregiver's perceptual and meaning systems. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and becomes overwhelmed by this secondary exposure to trauma (Figley & Kleber, 1995). Several theories have been offered but none has been able to conclusively demonstrate the mechanism that accounts for the transmission of traumatic stress from one individual to another. It has been hypothesized that the caregiver's level of empathy with the traumatized individual plays a significant role in

this transmission (Figley ,1995) and some budding empirical data to support this hypothesis (Salston, 2000).

Figley (1995) also proposes that the combined effects of the caregiver's continuous visualizing of clients' traumatic images added to the effects of burnout can create a condition progressively debilitating the caregiver that he has called "compassion stress." This construct holds that exposure to clients' stories of traumatization can produce a form of posttraumatic stress disorder in which Criterion A, or "the event" criterion, is met through listening to, instead of the *in vivo* experiencing of, a traumatic event. The symptoms of compassion fatigue, divided into categories of intrusive, avoidance, and arousal symptoms, are summarized in Table I.

<Insert **Table I** about here>

As a result of our work with hundreds of caregivers suffering the effects of compassion fatigue, we have augmented Figley's (1995) definition to include pre-existing and/or concomitant primary posttraumatic stress and its symptoms. Many caregivers, especially those providing on-site services, will have had first-hand exposure to the traumatic event(s) to which they are responding (Pole et al., 2001; Marmar et al., 1999). For many, these symptoms of PTSD will have a delayed onset and not become manifest until some time later. We have also found that many caregivers enter the service field with a host of traumatic experiences in their developmental past (Gentry, 1999). There may have been no symptoms associated with these events, or the symptoms related to them may have remained sub-clinical. However, we have observed that as

these caregivers begin to encounter the traumatic material presented by clients, many of them begin to develop clinical PTSD symptoms associated with their previously "benign" historical experiences. In our efforts to treatment compassion fatigue, we have concluded that it is often necessary to successfully address and resolve primary traumatic stress before addressing any issues of secondary traumatic stress and/or burnout. Additionally, we have discerned an interactive, or synergistic, effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted caregiver. Experiencing symptoms from any one of these three sources appears to diminish resiliency and lower thresholds for the adverse impact of the other two. This seems to lead to a rapid onset of severe symptoms that can become extremely debilitating to the caregiver within a very short period of time.

<Insert **Table II** about here>

Accelerated Recovery Program for Compassion Fatigue

In 1997, two Green Cross Scholars and one doctoral student under the direction and supervision of Charles Figley at Florida State University developed the Accelerated Recovery Program for Compassion Fatigue (Gentry, Baranowsky & Dunning, 1997, in press; Gentry & Baranowsky, 1998, 1999, 1999a, 1999b). This five-session manualized and copyrighted protocol[2] was designed to address the symptoms of secondary traumatic stress and burnout, or compassion fatigue, in caregivers. Phase one clinical trials with this protocol was completed with the developers and seven volunteers from various

[2] Treatment Manual for Accelerated Recovery from Compassion Fatigue (Gentry & Baranowsky, 1998) is available from Psych InK Resources, 45 Sheppard Ave., Suite 202, Toronto, Ontario, Canada, M2N 5W9.

disciplines and backgrounds who had experience working with trauma survivors.[3] The qualitative data obtained from these initial volunteers were utilized to create the final version of the protocol. Each of these participants reported clinically significant lessening of compassion fatigue symptoms with one exception. [4]

The Accelerated Recovery Program (ARP) was presented in the fall of 1997 at the International Society for Traumatic Stress Studies (ISTSS) in Montreal, Canada. In attendance at this presentation was an official with the Federal Bureau of Investigation who requested that the developers provide training to his staff, and, subsequent to this training, the Accelerated Recovery Program was adopted for use in this agency (McNally, 1998, personal communication). As a result of contacts made through the FBI, twelve professional helpers who have provided on-going assistance to the survivors of the bombing of the Murrah Building in Oklahoma City requested treatment for their compassion fatigue symptoms through the Traumatology Institute at Florida State University. The ARP provided statistically and clinically significant successful treatment for each of these professionals (Gentry, 2000). Subsequent presentations on the ARP at ISTSS meetings in 1998, 1999, and the development of the Certified Compassion Fatigue Specialist Training (CCFST) have lead to the successful treatment of hundreds of caregivers with compassion fatigue symptoms through the Accelerated Recovery Program all over the world.

Certified Compassion Fatigue Specialist Training: Training-as-Treatment

In late 1998, Gentry and Baranowsky, two of the developers of the Accelerated

[3] These trials were completed with volunteers who were Marriage & Family Therapists, a trauma therapist from South Africa, and a volunteer who had been providing relief work in Sarajevo.

[4] This participant uncovered a primary traumatic experience for which she was previously amnestic. She left the country before her primary or secondary trauma could be successfully addressed and resolved.

Recovery Program, were approached by the Traumatology Institute at Florida State University to create a training program for helping professionals interested in developing expertise in treating compassion fatigue. Through initial consultations, it was decided that the training would be designed around the ARP Model and that the participants would receive training on the implementation of the five sessions of this protocol. In addition, the training was designed to provide the participants with an in-depth understanding of the etiology, phenomenology and treatment/prevention of compassion fatigue, including secondary traumatic stress and burnout. The participants of this training would be certified by Florida State University's Traumatology Institute as Compassion Fatigue Specialists and authorized to implement the Accelerated Recovery Program for other caregivers suffering from compassion fatigue symptoms.

In their design of the program, the developers decided that the participants should receive first-hand experiential training for each of the interventions used in the Accelerated Recovery Program. With this in mind, the 17-hour training was developed and manualized (Gentry & Baranowsky, 1998; 1999a) with a focus upon the experiential components of the ARP. This phase in development of the Certified Compassion Fatigue Specialist Training (CCFST) was the first conceptualization of the "*training-as-treatment*" (Gentry, 2000) model for addressing the participants' symptoms of compassion fatigue. The rationale was that since the interventions of the ARP were effective working with individuals, the interventions would also be effective with these symptoms, albeit to a lesser degree, with the participants of the training.

It was then decided that the collection of baseline and outcome data would be conducted from the first training that was implemented in January of 1999. Baseline and

post-training scores from compassion fatigue, compassion satisfaction and burnout subscales of the Compassion Satisfaction/Fatigue Self-Test (Figley, 1995; Figley & Stamm, 1996) were collected. Data were analyzed for 166 participants who successfully completed the CCFS Training between January 1999 and January 2001 (Gentry, 2000). The protocol demonstrated clinically and statically significant results ($p < .001$) when pre-training and post-training scores on the compassion fatigue, compassion satisfaction and burnout subscales of the Compassion Satisfaction/Fatigue Self-Test (Figley & Stamm, 1996) were compared.

Treatment & Prevention: Active Ingredients

It has been demonstrated that the potential to develop negative symptoms associated with our work in providing services to trauma survivors, especially the symptoms of secondary traumatic stress, increases as our exposure to their traumatic material increases (McCann & Pearlman, 1990; Salston, 2000),. We believe that no one who chooses to work with trauma survivors is immune to the potential deleterious effects of this work. However, in our work with providing effective treatment to hundreds of caregivers with compassion fatigue symptoms, either individually through the ARP or in CCFS training groups, we have identified some enduring principles, techniques, and ingredients that seem to consistently lead to these positive treatment outcomes and enhanced resiliency.

Intentionality. Initiation of effective resolution of compassion fatigue symptoms requires specific recognition and acceptance of the symptoms and their causes by the caregiver, along with a decision to address and resolve these symptoms. Many caregivers who

experience symptoms of compassion fatigue will attempt to ignore their distress until a threshold of discomfort is reached. For many caregivers this may mean that they are unable to perform their jobs as well as they once did or as well as they would like due to the symptoms they are experiencing. For others, it may entail the progressive debilitation associated with somatic symptoms or the embarrassment and pain associated with secretive self-destructive comfort-seeking behaviors. Whatever the impetus, we have found that successful amelioration of compassion fatigue symptoms requires that the caregiver intentionally acknowledge and address, rather than avoid, these symptoms and their causes. Additionally, we have found the use of goal-setting and the development of a personal/professional mission statement to be invaluable in moving away from the reactivity associated with the victimization of compassion fatigue and toward the resiliency and intentionality of mature caregiving.

Connection. One of the ways trauma seems to affect us all, caregivers included, is to leave us with a sense of disconnected isolation. A common thread we have found with sufferers of compassion fatigue symptoms has been the progressive loss in their sense of connection and community. Many caregivers become increasingly isolatory as their symptoms intensify. Fear of being perceived as weak, impaired, or incompetent by peers and clients, along with time constraints and loss of interest, have all been cited by caregivers suffering from compassion fatigue as reasons for diminished intimate and collegial connection. The development and maintenance of healthy relationships, which the caregiver uses for both support and to share/dilute the images and stories associated with secondary traumatic stress, may become a powerful mitigating factor in resolving

and preventing compassion fatigue symptoms. Often the bridge for this connection is established in the peer-to-peer offering of the ARP, during which the facilitator works intentionally to develop a strong relationship with the caregiver suffering compassion fatigue symptoms. In the CCFST, we facilitate exercises specifically designed to dismantle interpersonal barriers and enhance self-disclosure. It seems that it is through these relational connections that the caregivers suffering compassion fatigue are able to gain insight and understanding that their symptoms are not an indication of some pathological weakness or disease, but are instead natural consequences of providing care for traumatized individuals. In addition, with the enhanced self-acceptance attained through self-disclosure with and by empathetic and understanding peers, caregivers are able to begin to see their symptoms as indicators of the developmental changes needed in both their self-care and caregiving practices. We have seen that a warm, supportive environment in which caregivers are able to discuss intrusive traumatic material, difficult clients, symptoms, fears, shame, and secrets with peers to be one of the most critical ingredients in the resolution and continued prevention of compassion fatigue.

Anxiety Management/Self-soothing. It is our belief that providing caregiving services while experiencing intense anxiety is one of the primary means by which compassion fatigue symptoms are contracted and exacerbated. Alternately stated, to the degree that a caregiver is able to remain non-anxious (relaxed pelvic floor muscles), we believe, s/he will maintain resistance to the development of symptoms of compassion fatigue. The ability to self-regulate and soothe anxiety and stress is thought to be a hallmark of maturity. The mastery of these skills comes only with years of practice. However, if we

fail to develop the capacity for self-regulation, if we are unable to internally attenuate our own levels of arousal, then we are susceptible to perceiving as threats those people, objects, and situations to which we respond with anxiety — believing that benign people, objects and situations are dangerous. As one very insightful and astute psychologist who was a participant in the CCFST stated: "Maybe the symptoms of compassion fatigue are a good thing, they force us to become stronger." It does seem to be true that those caregivers with well-developed self-regulation skills who do not resort to self-destructive and addictive comfort-seeking behaviors are unlikely to suffer symptoms of compassion fatigue.

In both the ARP and the CCFST, we work rigorously with participant caregivers to help them develop self-management plans that will assist them in achieving and maintaining an *in vivo* non-anxious presence. This non-anxious presence extends far beyond a calm outward appearance. Instead, it entails the ability to maintain a level of relaxed mindfulness and comfort in one's own body. This ability to remain non-anxious when confronted with the pain, horror, loss, and powerlessness associated with the traumatic experiences in the lives of clients, of having the capacity to calmly "bear witness," remains a key ingredient in the resolution and prevention of compassion fatigue symptoms.

Self-care. Closely associated with self-management is the concept of self-care, or the ability to refill and refuel oneself in healthy ways. It is quite common for caregivers to find themselves anxious during and after working with severely traumatized individuals. Instead of developing a system of healthy practices for resolving this anxiety — such as

sharing with colleagues, exercise, meditation, nutrition, and spirituality — many caregivers find themselves redoubling their work efforts. Frequently this constricting cycle of working harder in an attempt to feel better creates a distorted sense of entitlement that can lead to a breach of personal and professional boundaries. We have worked with many caregivers who have reported falling prey to compulsive behaviors such as overeating, overspending, or alcohol/drug abuse in an effort to soothe the anxiety they feel from the perceived demands of their work. Others with whom we have worked have self-consciously admitted to breaching professional boundaries and ethics when at the low point in this cycle, distortedly believing that they "deserve" this "special" treatment or reward.

Meta-analyses of psychotherapy outcomes consistently point toward the quality of the relationship between therapist and client as the single most important ingredient in positive outcomes (Bergin & Garfield, 1994). The integrity and quality of this relationship is contingent upon the therapist's maintenance of his/her instrument, the "self of the therapist." When caregivers fail to maintain a life that is rich with meaning and gratification outside the professional arena, then they often look to work as the sole source of these commodities. In this scenario, caregivers interact with their clients from a stance of depletion and need. It is completely understandable that this orientation would produce symptoms in caregivers. Conversely, professionals who responsibly pursue and acquire this sense of aliveness outside the closed system of their professional role are able to engage in work with traumatized individuals while sharing their own fullness, meaning, and joy. The cycle of depletion by our work and intentionally refilling

ourselves in our lives outside of work, often on a daily basis, may have been what Frankl meant when he challenged us to "endure burning."

One of the most important aspects of this category of self-care that we have found in our work with caregivers has been the development and maintenance of a regular exercise regimen. No other single behavior seems to be as important than regular aerobic and anaerobic activity. In addition to exercise, good nutrition, artistic expression/discipline (e.g., piano lessons and composition, dance classes and choreography, structural planning and building), meditation/mindfulness, outdoor recreation, and spirituality all seem to be important ingredients to a good self-care plan.

We have found a few caregivers with compassion fatigue symptoms that seemed to be at least partially caused by working beyond their level of skill. Working with traumatized individuals, families, and communities is a highly skilled activity that demands many years of training in many different areas before one gains a sense of mastery. Trying to shortcut this process by prematurely working with trauma survivors without adequate training and supervision can very easily overwhelm even seasoned clinicians, much less neophytes. While empirical research has not yet addressed the effects of working beyond levels of competency or of providing services while impaired with stress symptoms has upon the care provider, especially in contexts of mass casualties like we have witnessed in New York City, we believe that these factors contribute significantly to the frequency, duration and intensity of compassion fatigue symptoms.

Sometimes training in the area of treating trauma, especially experiential trainings such as EMDR (Shapiro, 1995) or TIR (French & Harris, 1998), can have a powerful

ameliorative effect upon compassion fatigue, bringing a sense of empowerment to a caregiver who was previously overwhelmed. The caveat here is that there exists some danger that an overwhelmed therapist who has been recently trained in one of these powerful techniques may emerge from the training with an inflated sense skill and potency. Newly empowered, this therapist may be tempted to practice even further beyond their level of competence and skill. This scenario highlights the importance of good professional supervision during the developmental phases of a traumatologist's career. In addition, many therapists working with trauma survivors have found it helpful to receive periodic "check ups" with a trusted professional or peer supervisor. This is especially true during an immediately following deployment in a disaster or critical incident situation. These professional and peer supervisory relationships can serve as excellent opportunities to share, and therefore dilute the effects, of the artifacts of secondary traumatic stress that may have been collected while in service to trauma survivors. Professional supervision is also reported to have an overall ameliorative effect upon compassion fatigue symptoms (Pearlman, 1995; Catherall, 1995).

Every caregiver's self-care needs are different. Some will need to remain vigilant in the monitoring and execution of their self-care plan, while others will, seemingly, be able to maintain resiliency with minimal effort. However, we strongly urge the caregiver who specializes working with trauma and trauma survivors to develop a comprehensive self-care plan that addresses and meets the caregiver's individual needs for each of the areas discussed in this article. With this self-care plan in place, the caregiver can now practice with the assurance that they are maximizing resiliency toward and prevention of

the symptoms of compassion fatigue that is akin to the protection of wearing a seatbelt while driving an automobile.

It should be noted that those care providers responding on-site to crisis situation, such as those caused by the events of September 11, may be limited in their ability to employ habitual self-care activities. They may not have access to gymnasiums or exercise facilities, nutritious food and water may be scarce for a period of time, and it is doubtful that care providers deployed in situations of mass destruction will have access to their traditional support network. While most trauma responders are a hardy and resilient breed, we simply cannot sustain the rigors of this depleting and intensive work without intentional concern for our own health and welfare. Making best use of available resources to establish respite and sanctuary for ourselves, even in the most abject of circumstances, can have an enormous effect in minimizing our symptoms and maximizing our sustained effectiveness. Many responders have reported acts of kindness as simple as the gift of a bottle of water, a pat on the back, or an opportunity to share a meal with another responder as having a powerfully positive impact upon their morale and energy during these difficult times.

Narrative. Many researchers and writers have identified the creation of a chronological verbal and/or graphic narrative as an important ingredient in the healing of traumatic stress, especially intrusive symptoms (Tinnin, 1994; van der Kolk, 1996; Foa et al., 1999). We have found that a creation of a time-line narrative of a caregiving career that identifies the experiences and the clients from which the caregiver developed primary and secondary traumatic stress is invaluable in the resolution of compassion fatigue

symptoms, especially those associated with secondary traumatic stress. In the ARP, we instruct the participant/caregiver to "tell your story…from the beginning — the first experiences in your life that led you toward caregiving — to the present." We use a video camera to record this narrative and ask the caregiver to watch it later that same day, taking care to identify the experiences that have let to any primary and secondary traumatic stress (intrusive symptoms) by constructing a graphic time-line. In the CCFST, we utilize dyads in which two participants each take a one-hour block of time to verbalize their narrative while the other practices non-anxious "bearing witness" of this narrative.

Desensitization and Reprocessing. With the narrative completed and the identification of historical experiences that are encroaching upon present-day consciousness and functioning in the form of primary and secondary traumatic stress, the caregiver is now ready to resolve these memories. In the ARP, we have utilized Eye Movement Dissociation and Reprocessing (Shapiro, 1989, 1995) as the method-of-choice for this work. In the CCFST, we utilize a hybridized version of a Neuro-Linguistic Programming Anchoring Technique (Baranowsky & Gentry, 1998). Any method that simultaneously employs exposure and relaxation (i.e., reciprocal inhibition) is appropriate for this important cornerstone of treatment. We have had success utilizing Traumatic Incident Reduction (French & Harris, 2000), the anamnesis procedure from the Trauma Recovery Institute (TRI) Method (Tinnin, 1994), or many of the techniques from Cognitive-Behavioral Therapy (Foa & Meadows, 1997; Follette, Ruzek, & Abueg, 1998; Rothbaum, Meadows, Resick, & Foy, 2000). With the successful desensitization and reprocessing of the caregiver's primary and secondary traumatic stress, and the cessation of intrusive

symptoms, often comes a concomitant sense of rebirth, joy, and transformation. This important step and ingredient in the treatment of compassion fatigue should not be minimized or overlooked.

In our work with the responders of the Oklahoma City bombing, none reported experiencing intrusive symptoms of secondary and/or primary traumatic stress until several days, weeks, months, and sometimes years after their work at the site. From personal communication with an Incident Commander for a team of mental health responders who worked with over 2700 victims in New York City the first month after the attacks (Norman, 2002), he indicated that at least one Certified Compassion Fatigue Specialist was available to provide daily debriefing services for every ten (10) responders. He further indicated that if a responder began to report symptoms or show signs of significant traumatic stress they were provided with acute stabilization services by the team and arrangements were made for transportation back home with a referral to a mental health practitioner in the worker's home town. With the intense demands of critical incident work and the paramount importance of worker safety, attempts of desensitization and reprocessing care provider's primary and secondary traumatic stress while on-site seems counterproductive as it draws from the often already depleted resources of the intervention team. For this reason, it is recommended that the worker engage in resolving the effects of accumulated traumatic memories only after safely returning to the existing resources and support offered by their family, friends, churches/synagogues, and health care professionals in their hometown.

Self-supervision. This aspect of treatment is focused upon the correction of distorted and coercive cognitive styles. Distorted thinking may be developmental (i.e., existent prior to a caregiver's career), or may have been developed in response to primary and secondary traumatic stress later in life. Whatever the cause, we have found that once a caregiver contracts the negative symptoms of compassion fatigue, these symptoms will not fully resolve until distorted beliefs about self and the world are in the process of correction. This is especially true for the ways in which we supervise and motivate ourselves. Caregivers recovering from the symptoms of compassion fatigue will need to soften their critical and coercive self-talk and shift their motivational styles toward more self-accepting and affirming language and tone if they wish to resolve their compassion fatigue symptoms. For many this is a difficult, tedious, and painstaking breaking-of-bad-habits process than can take years to complete. In the ARP and the CCFST, we have employed an elegant and powerful technique called "video-dialogue" (Holmes & Tinnin, 1996) that accelerates this process significantly. This technique, adapted for use with the ARP, challenges the participant to write a letter to themselves from the perspective of the "Great Supervisor," lavishing upon themselves all the praise, support, and validation that they wish from others. They are then requested to read this letter into the eye of the camera. While watching back the videotape of this letter, the caregiver is asked to "pay attention to any negative or critical thought that thwarts your acceptance of this praise." Then, s/he is instructed to give these critical and negative thoughts a "voice," as these negative thoughts are articulated into the video camera, directed at the caregiver. This back-and-forth argument between the "self" and the "critical voice" of the caregiver

continues on videotape until both "sides" begin to see the utility in both perspectives. With this completed, polarities relax, self-criticism softens, and integration is facilitated.

While this technique is powerfully evocative and can rapidly transform self-critical thinking styles, the Cognitive Therapy "triple column technique" (Burns, 1980), that helps identify particular cognitive distortions and challenges a client to rewrite these negative thoughts into ones that are more adaptive and satisfying will also work well for this task. Additionally, as caregivers suffering from compassion fatigue symptoms develop some mastery in resolving these internal polarities with themselves, they are challenged to identify and resolve polarities with significant others. Individuals traumatized from either primary or secondary sources who are able to "un-freeze" themselves from their polarities, resentments, conflicts, and cut-offs will be rewarded with less anxiety, a heightened sense of comfort inside their own skin, and a greater sense of freedom from the past to pursue their mission of the present and future.

The Crucible of Transformation

Our initial intent in developing the ARP was to simply gather a collection of powerful techniques and experiences that would rapidly ameliorate the suffering from symptoms of compassion fatigue in the lives of caregivers so that they would be able to return to their lives and their work refreshed and renewed. However, as we embarked upon yoking ourselves with the formidable task of sitting across from our peers who were suffering with these symptoms, many of whom were demoralized, hopeless, and desperate, we began to understand that recovery from compassion fatigue required significant changes in the foundational beliefs and lifestyles of the caregiver. As we navigated through the five sessions of the ARP with these suffering professionals we

found that most underwent a significant transformation in the way in which they perceived their work and, ultimately, themselves.

Drawing from the work of David Schnarch (1991), who works with enmeshed couples to develop self-validated intimacy and achieve sexual potentials in their marriages, we began to see that many caregivers exhibited a similar form of enmeshment with their *careers*. We found that many of those suffering with compassion fatigue symptoms maintained an other-validated stance in their caregiving work — they were compelled to gain approval and feelings of worth from their clients, supervisors, and peers. In beginning to explore the developmental histories of many of the caregivers with whom we have worked, we found that many carried into their adult lives, and careers, unresolved attachment and developmental issues. For the caregiver who operates from an other-validated stance, clients, supervisors, and peers all represent potential threats when approval is withheld. These perceptions of danger and threat by the caregiver, which are enhanced by secondary traumatic stress contracted in work with trauma survivors, often lead to increased anxiety, feelings of victimization, and a sense of overwhelming powerlessness. As the caregiver is able to evolve toward a more self-validated stance and become more grounded in the non-anxious present, these symptoms begin to permanently dissipate. Pearlman and Saakvitne (1995) urge therapists to "find self-worth that is not based on their professional achievements. It is essential to develop and nurture spiritual lives outside our work" (p. 396). While we have found no existing empirical data in this ripe area of study, from a treatment perspective we began to see how the symptoms of compassion fatigue make sense in the lives of many professional caregivers, urging them towards maturation.

Instead of viewing the symptoms of compassion fatigue as a pathological condition that requires some external treatment agent or techniques for resolution, we began to see these symptoms as indicators of the need for the professional caregiver to continue his/her development into matured caregiving and self-care styles and practices. From this perspective the symptoms of compassion fatigue can be interpreted as *messages* from what is right, good, and strong within us, rather than indicators of shameful weaknesses, defects, or sickness.

Through our continued working with caregivers suffering the effects of secondary traumatic stress and burnout, we have been able to distill two primary principles of treatment and prevention that lead to a rapid resolution of symptoms and sustained resilience from future symptoms. These two important principles, which have become the underlying goals for our work in the area of compassion fatigue, are: (1) the development and maintenance of intentionality, through a non-anxious presence, in both personal and professional spheres of life, and (2) the development and maintenance of self-validation, especially self-validated caregiving. We have found, in our own practices and with the caregivers that we have treated, that when these principles are followed not only do negative symptoms diminish, but also quality of life is significantly enhanced and refreshed as new perspectives and horizons begin to open.

<Insert **Table III** about here>

Conclusion

There is little doubt that the extensive efforts being devoted to assisting those affected by the events of September 11, 2001 will have far-reaching influence on the healing of survivors in New York, the people of our nation, and the people of the world. For the first time in the history of our planet, we are beginning to accumulate sufficient knowledge, skills, and resources to facilitate recovery and healing from events such as these. This is not to say that we will not all have painful losses to accommodate or indelible psychological scars — but we will recover. It is a humbling experience to participate, on any level, in this healing.

From our experience with the emergency service workers and professional caregivers who served the survivors of the Murrah building bombing on Oklahoma City since 1995, we also know that there will be casualties in this effort. Many kind and good-hearted emergency service professionals, caregivers, friends, and family members who have witnessed the pain, grief, and terror in their service to survivors will themselves end up wrestling with encroaching intrusive images, thoughts, and feelings from these interaction in the weeks, months, and years ahead.

Compassion fatigue is an area of study that is in its infancy. Therefore, very little empirical research has yet been published in this important area. However, the empirical research that does exist and the stories of hundreds of suffering caregivers provides us with evidence that compassion fatigue, and its painful symptoms, are a very real phenomenon (Deutch, 1984; Pearlman & McCann, 1990; Follette et al 1994; Schauben & Frazier, 1995; Cerney , 1995; Salston, 2000). These symptoms carry with them the potential to disrupt, dissolve, and destroy careers, families, and even lives (many of us grieve the loss of at least one colleague who has committed suicide) and should be treated

with great respect. Often, it seems, those who suffer most from compassion fatigue are those individuals who are highly motivated to bring about change and healing in the lives of the suffering. It is especially painful to witness the progressive debilitation of these loving caregivers, who are often our very close friends. Without a doubt, many hundreds, if not thousands, of caregivers and emergency service workers providing hour after hour of intensive and life-altering service to those affected by the events of September Eleventh will experience deleterious effects themselves from this heroic work. Finding the ways and means to both thoroughly study these effects and, maybe more importantly, provide rapidly effective and empirically validated treatment for these suffering heroes, will become a crucial task toward the completion of our nation's healing.

The good news is that the symptoms of compassion fatigue appear to be very responsive to being treated and rapidly ameliorated (Pearlman & Saakvitne, 1995; Gentry & Baranowsky, 1999). While substantially more research in this area will be required before we can offer definitive statements about the nature of treatment, prevention and resiliency with compassion fatigue, some principles and techniques discussed here offer a foundation for helping caregivers resolve their current symptoms and prevent future occurrences. Moreover, we have witnessed that for numerous caregivers the symptoms of compassion fatigue becoming a powerful catalyst for change. With skilled intervention and determination, care providers with compassion fatigue can undergo a profound transformation leaving them more empowered and resilient than they were previously, and therefore better equipped to act as "givers of light."

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Table I: Compassion Fatigue Symptoms

Intrusive Symptoms
• Thoughts and images associated with client's traumatic experiences • Obsessive and compulsive desire to help certain clients • Client/work issues encroaching upon personal time • Inability to "let go" of work-related matters • Perception of survivors as fragile and needing the assistance of caregiver ("savior") • Thoughts and feelings of inadequacy as a caregiver • Sense of entitlement or special-ness • Perception of the world in terms of victims and perpetrators • Personal activities interrupted by work-related issues
Avoidance Symptoms
• Silencing Response (avoiding hearing/witnessing client's traumatic material) • Loss of enjoyment in activities/cessation of self care activities • Loss of energy • Loss of hope/sense of dread working with certain clients • Loss of sense of competence/potency • Isolation • Secretive self-medication/addiction (alcohol, drugs, work, sex, food, spending, etc) • Relational dysfunction
Arousal Symptoms
• Increased anxiety • Impulsivity/reactivity • Increased perception of demand/threat (in both job and environment) • Increased frustration/anger • Sleep disturbance • Difficulty concentrating • Change in weight/appetite • Somatic symptoms

Table II: Compassion Fatigue Model

The Gentry/Baranowsky (1997) Model of Compassion Fatigue

PRIMARY TRAUMATIC STRESS

+/x (synergistic effect)

SECONDARY TRAUMATIC STRESS

+/x (synergistic effect)

BURNOUT

COMPASSION FATIGUE

Table III: Suggestions for Compassion Fatigue Prevention and Resiliency

If you or someone you know is experiencing symptoms of compassion fatigue, the following suggestions may be helpful. Please check with your family physician to assure that there are no physical illnesses associated with these symptoms first.

- Become more informed. Read Figley (1995), Stamm (1995) and/or Pearlman & Saakvitne (1995) to learn more about the phenomena of compassion fatigue, vicarious traumatization, and secondary traumatic stress. One book that is especially helpful is Transforming The Pain: A Workbook on Vicarious Traumatization by Saakvitne and Perlman (1996).
- Join a Traumatic Stress Study Group. A weekly, bi-weekly or monthly meeting of trauma practitioners can become an excellent sanctuary in which the caregiver can both share (therefore diluting) traumatic stories as well as receive support. Check with the ISTSS (www.istss.org) for a group that may meet in your area or start one of your own. There are several on-line support resources also. You can find some of these resources through the excellent David Balwin's Trauma Pages (http://www.trauma-pages.com) in the "Resources" section.
- Begin an exercise program today (see your physician first). Exercise is one of the most important ingredients to effectively manage stress and anxiety and keeps us buoyant and energized while working with heinous trauma.
- Teach your friends and peers how to support you. Don't rely upon random remarks from friends and colleagues to be helpful. Instead, let them know what is most helpful for you during times of stress and pain. You may choose to offer the same to them in a reciprocally supportive arrangement. Periodic or regular professional supervision may also be helpful, especially during a rough time.
- Develop your spirituality. This is different than going to church, although church may be part of your spirituality. Spirituality is your ability to find comfort, support,

and meaning from a power greater than yourself. We have found this quality necessary for the development of self-soothing capacity. Meditation, Tai Chi, church/synagogue, Native American rituals, journaling, and workshops are all examples of possible ways in which to enhance one's spirituality.

- Bring your life into balance. Remember that your best is ALWAYS good enough. You can only do what you can do so when you leave the office (after 8 hours of work)…leave the office! Perseverating on clients and their situations is not helpful to them, you, or your family. You can most help your clients by refueling and refilling yourself while not at the office. Live your life fully!
- Develop an artistic or sporting discipline. Take lessons and practice as well as play and create. These are integrative and filling experiences. It is paradoxical that when we feel drained that we need to take action instead of sinking into the sedentary "couch potato." Taking action will be rewarded with a greater sense of refreshment and renewal, while activity avoidance will leave us even more vulnerable to the effect of stress the next day.
- Be kind to yourself. If you work with traumatized individuals, families, and/or communities, your life is hard enough already. You do not need to make it more difficult by coercive and critical self-talk. In order to become and remain an effective traumatologist your first responsibility is keeping your instrument in top working condition. Your instrument is YOU, and it needs cared for.
- Seek short-term treatment. A brief treatment with some of the accelerated trauma techniques (i.e., EMDR) can rapidly resolve secondary traumatic stress symptoms. If you would like assistance in finding a Certified Compassion Fatigue Specialist in your area, please contact the International Traumatology Institute at (813) 974-1191.