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Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

EDITED BY
CHARLES R. FIGLEY, Ph.D.

COMPASSION FATIGUE

Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

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COMPASSION FATIGUE

Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

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Editorial Note

This volume is the latest in a series of books that have focused on the immediate and long-term consequences of highly stressful events. The first volume, *Trauma and Its Wake*, published in the Psychosocial Stress Series in 1985, provided the initial historical, theoretical, and empirical grounding and included several treatment chapters. The second volume, *Trauma and Its Wake*, Volume II, published the next year, was even more treatment oriented. Both volumes are credited with advancing the field through the publication of theoretical and clinical innovations, along with a comprehensive review of the emerging literature. In 1988 the third book in the series that focused on trauma and treatment, *Post-traumatic Therapy and Victims of Violence*, edited by Frank Ochberg, was published. The fourth book, published in 1989, was edited by John P. Wilson: *Trauma, Transformation, and Healing: An Integrative Approach to Theory, Research, and Post-traumatic Therapy*. The fifth book, *Treating Stress in Families*, published the same year, was edited by this author.

This volume attempts further to define and clarify the field of psychotraumatology. It, however, is only the latest in a series of books with a similar goal. The present volume follows the earlier, two-volume series, *Trauma and Its Wake* (TAW) (Figley, 1985, 1986). The first volume of that series (Figley, 1985), which was also the first to focus specifically on the concept of post-traumatic stress disorder (PTSD), included chapters on treatment. The second volume (Figley, 1986) was more treatment oriented. Volume III in the TAW series, originally planned for publication in 1988, was superseded by the *Journal of Traumatic Stress*, which featured several of the chapters originally destined for TAW as the initial articles in its premier issue. Now,

after more than six volumes of the journal, more than a decade of experience with the concept of PTSD, and the emergence of a new field of study, it is time for another volume in the TAW tradition that will once again move the field ahead. This time our focus is secondary traumatic stress.

Charles R. Figley, Ph.D.
Series Editor

Table of Contents

Acknowledgments

This project is a product of the efforts of many, many people, in addition to the eight scholars who contributed chapters. First were my students who were sufficiently interested in this topic to sustain my own interest. Several of them—Jeff Todahl, Mike Barnes, Jerry Solomon, David Mackey, Lynn Marzoni, Cindy Lee, and Brian Bride—formed a research team that assisted me in selecting the most promising chapter proposals. Other students served as my editorial assistants at different stages of development, and in the peer review process, a cumbersome and complex task. Kim Shurliff was especially helpful as an enthusiastic and creative assistant who carefully read many of the chapters. To my students, I express my deepest appreciation and the hope that they one day will be involved in further extending this area of the field of psychotraumatology, as have a number of my former students.

Members of the Series Editorial Board reviewed all of the chapters, blind to authorship. Assisting them in this task were a number of scholars who specialize in one or more areas of psychotraumatology and are among the few dozen, worldwide, who are experts on STSD. Other reviewers were Gail Walker, Ann Burgess, Susan Roth, Evelyn Gislin, Joanne E. McIntyre, Zahava Solomon, Frank Ochberg, Arthur Blank, Larry Rapp, Carolyn Kauffman, Denis Donovan, Conner Walters, Sharon Krantz, Jeffery Mitchell, Christine Dunning, Terry Trepper, Mary Jo Barrett, Lisa McCann, Susan Solomon, C. Denning, Christine Courtois, and Matthew J. Friedman.

Staff members at the Florida State University's Marriage and Family Therapy Center deserve special recognition. Because this volume was peer reviewed and each chapter required numerous revisions, correspondence and phone calls were rather overwhelming at times, and Mike Barnes and Jeff Todahl were very cordial and efficient in their contacts with both authors and reviewers. Barb Myers, center manager, deserves special recognition for her work in coordinating her staff, and for her diplomacy in dealing with authors and reviewers. Also at the

center, Kathy Vanlandingham and Michele Smith provided useful support toward the end of the project. Lorrie Guttman did an excellent job as editorial consultant.

No less important are the administrators who have the responsibility of keeping the professors on task and within budget. Dr. Ray Bardill, Dean of the School of Social Work, provided the administrative leadership to ensure that I could focus my energy on this project and encouraged me to get it done. The support of Dr. Penny Ralston, dean of our Interdivisional Program in Marriage and Family, also was vital.

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Together with the thousands of people I have worked with over the two decades of my career, these people have made this book possible. I am very grateful for their contributions.

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Introduction

BACKGROUND

Traumatology, or the field of traumatic stress studies, has become a dominant focus of interest in the mental health fields only in the past decade. Yet the origin of the study of human reactions to traumatic events can be traced to the earliest medical writings in Kunus Pyprus, published in 1900 B.C. in Egypt. Many factors account for the recent emergence of this field, including a growing awareness of the long-term consequences of shocking events. Among these consequences are violence toward others, extraordinary depression, dysfunctional behavior, and a plethora of medical maladies associated with emotional stress.

Many identify the publication of the American Psychiatric Association's third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 as a major milestone in the progress of this field of study. The publication provided credibility to various theories and research findings about psychological trauma emerging from the investigation of the long-term effects of war, hostage taking, rape, family abuse, natural disasters, accidents, and, most recently, the death of a loved one.

The DSM-III (APA, 1980) included the diagnosis of post-traumatic stress disorder (PTSD). 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. In the latest revision (APA, 1994), the symptom criteria were modified somewhat, and its popularity with professionals (including lawyers, therapists, emergency professionals, and researchers) working with traumatized people grew, as did the accumulation of empirical research that validated the disorder.

After nearly 12 years of usage, the rubric PTSD is commonly applied to people affected by one of many types of traumatic events. However, a review of the traumatology literature yields the following proposition: 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 direct victims). But, descriptions of what constitutes a traumatic event (i.e., Category A in DSM-III, and DSM-III-R descriptions of PTSD) clearly suggest that simply the knowledge that a loved one has been exposed to a traumatic event can be traumatizing. If this is true, why are there so few reports of such traumatized people?

Perhaps even more important, the burnout and countertransference literature suggests that therapists are vulnerable to experiencing stress as a result of their jobs, yet few studies can identify the active ingredients that are most connected to this job/profession–related stress. It appears that secondary traumatic stress—or, as we prefer, compassion fatigue—is the syndrome that puts most therapists at risk.

OVERVIEW OF THE BOOK

As noted in the series editor's Editorial Note earlier in this volume, this is the latest in a series of books that have focused on the immediate and long-term consequences of highly stressful events. This series began with *Trauma and Its Wake* (Figley, 1985) and provided the initial historical, theoretical, and empirical grounding, and included several treatment chapters.

This is the latest in the series to concentrate on treating traumatic stress, and the third in the *Trauma and Its Wake* series. Here we focus on those who provide the therapy: therapists and crisis and trauma counselors. The purposes of the book, then, are (a) to introduce the concept of compassion fatigue as a natural and disruptive by-product of working with traumatized and troubled clients; (b) to provide a theoretical basis for the assessment and treatment of compassion stress and compassion fatigue: (c) to explain the difference between compassion fatigue and PTSD, burnout, and countertransference; (d) to identify innovative methods for treating compassion fatigue in therapists, and (e) to suggest methods for preventing compassion fatigue.

Here we define compassion stress as the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized person. In this volume the focus is exclusively on professional caregivers, especially therapists, but also Red Cross workers, nurses, doctors, and informed personnel who react in emergencies.

Compassion fatigue is identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD. The following passage is taken from the PTSD description of what constitutes a sufficiently traumatic experience. The italicized sections emphasize that people can be traumatized without actually being physically harmed or threatened with harm.

> The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone: a serious threat to his or her life or physical integrity; serious threat or harm *to his children, spouse, or other close relatives or friends;* sudden destruction of his home or community; or *seeing another person seriously injured or killed in an accident or by physical violence* (APA, 1994).

Thus, there is a fundamental difference between the sequelae or pattern of response, during and following a traumatic event, for people exposed directly to harm (primary stressors) and for those exposed to those in harm's way (secondary stressors). Moreover, not only are therapists and other professionals vulnerable to compassion fatigue (secondary stress disorders), so too are the family and friends of people in harm's way (i.e., "victims") vulnerable to secondary traumatic stress (compassion stress) and stress disorder (compassion fatigue).

PURPOSE

The purpose of this groundbreaking book is fourfold: (a) to discuss the results of a systematic reevaluation of the field in general, and PTSD in particular, after more than a decade of use of the term; (b) to introduce a reconceptualization of trauma, traumatic events, traumatic stress, and traumatic stress disorders that appreciates the varying degrees of impact of traumatic events on individuals and interpersonal relationships or systems depending on the proximity to harm—primary, secondary, and tertiary traumatic stress reactions/disorders; (c) to review the scholarly and clinical literature vis-à-vis this new conceptualization; and (d) to propose new approaches to conceptualizing, researching, and treating traumatic stress built upon this new conceptualization.

ORGANIZATIONAL STRUCTURE AND CONTENT

Each chapter, written by a specialist in the field, follows a similar, basic outline. The primary questions addressed throughout the book are as follows:

1. What are compassion stress and compassion fatigue?
2. What are the unintended, and often unexpected, deleterious effects of providing help to traumatized people?
3. What are some examples of cases in which individuals were traumatized by helping, and how were they traumatized?
4. What are the characteristics of the traumatized helper (e.g., race, gender, ethnicity, age, interpersonal competence, experience with psychological trauma) that account for the development, sustenance, preventability, and treatability of secondary traumatization?
5. Is there a way, theoretically, to account for all these factors?
6. What are the characteristics of an effective program to prevent compassion stress and its unwanted consequences?
7. What are the characteristics of an effective treatment program to ameliorate compassion stress and its unwanted consequences?

Each chapter underwent peer review by the Series Editorial Board and other traumatologists knowledgeable about STSD/compassion fatigue.

CHAPTER CONTENT

In Chapter 1, "Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview," Charles R. Figley reviews the traumatology literature and suggests that what is missing is a conceptual accounting of how and why people not directly at risk in traumatic situations nevertheless can become traumatized—that knowing and especially treating someone who is traumatized is the systemic connector that links the traumatic feelings and emotions of the primary to the secondary "victims." The purpose of this chapter is fivefold: (a) to introduce the designation compassion fatigue to describe the result of working with traumatized people; (b) to provide a rationale for the stress-producing potential of these secondary traumatic stressors, which is equal to or greater than that of more conventional, direct traumatic stressors; (c) to discuss the advantages of separating out secondary stress reactions (compassion stress) and stress disorders (compassion fatigue) in the DSM from direct stress reactions and stress disorders; (d) to describe a theoretical model that accounts for and predicts the emergence of compassion stress and compassion fatigue among professionals working with traumatized people; and (e) to explicate the principles associated with accurate diagnosis, assessment, research, treatment, and prevention of compassion fatigue.

Chapter 2, "Survival Strategies: A Framework For Understanding Secondary Traumatic Stress and Coping in Helpers," by Paul Valent, a psychiatrist with extensive experience in emergency mental health services, presents a new framework. This model helps to categorize and conceptualize traumatic stress reactions as a *context* for understanding the nature and role of survival strategies. This view is helpful in understanding STSD, especially for psychotherapists and other professional helpers. He notes that whereas PTSD describes the reliving and avoidance of traumatic stress responses, there is a need for a framework for the great variety of such responses, some of which may even be contradictory (such as courage and fear). Valent suggests that the variety of traumatic stress responses corresponds to the variety of survival strategies that have evolved to deal with different traumatic situations. He presents eight survival strategies, which are described in their biological, psychological, and social aspects: rescue, attachment, assertiveness, adaptation, fight, flight, competition, and cooperation. According to Valent, survival strategies have other clinical applications, such as classifying emotions and tracing responses back to their original traumatic contexts. Secondary traumatic stress (STS) responses may be elicited in helpers through identifying with and complementing victim survivor strategies. Moreover, he suggests that STSD may develop if the identifications are too intense, the complementing survival strategies are inappropriate, or helpers cannot execute their own survival strategies adaptively.

Chapter 3, "Working with People in Crisis: Research Implications," by Randal D. Beaton and Shirley A. Murphy, includes as "crisis workers" the front-line, first responders such as firefighters, law enforcement personnel, and rescue workers, for whom exposure to occupational trauma is frequent and repetitive. Crisis workers also include persons with jobs in which they may be physically removed from the trauma incident scene, such as 911 dispatchers and emergency room nurses, but who are nonetheless exposed to traumatic stress and "absorb" it. Beaton and Murphy assert that crisis workers, by the nature of their duties and responsibilities, are at risk of experiencing secondary trauma stress (i.e., stress reactions that arise from being exposed to a traumatizing event or from assisting or wanting to assist a traumatized person). This important chapter reviews the unintended and deleterious effects on crisis workers that arise as a result of their providing help. These include negative consequences, relationship problems, and substance abuse. Various hypothetical and empirical similarities and differences between PTSD and compassion fatigue are enumerated and discussed. The contributions of individual, occupational, social, and community contextual variables to secondary traumatization are considered on the basis of the available research.

In Chapter 4, "Working with People with PTSD: Research Implications," Mary Ann Dutton and Francine L. Rubinstein review the relevant research literature to build a profile of the compassion fatigue of trauma workers' reactions. Of special concern are the professionals (mostly therapists) exposed to traumatic events through contact with survivors of trauma as well as with the perpetrators of traumatic events on others. Further, this chapter presents a theoretical framework that includes a discussion of traumatic events to which the trauma worker is exposed, the trauma worker's post-traumatic stress reaction, coping strategies for responding to the traumatic situation and to the psychological sequelae, and the personal and environmental mediators of trauma workers' secondary post-traumatic stress (PTS) reactions. Dutton and Rubinstein note several important implications for assessment, intervention, and prevention.

Most of the other chapters focus on methods of treatment and prevention with therapists and others working with traumatized people. All follow a common outline that first notes the importance of the focus of the chapter and estimates the number of persons affected (e.g., family members of people traumatized), then reviews the literature on effective ways in which these people have been helped, and then provides a detailed description of one or more suggested approaches to intervention (including assessment, establishment of a therapeutic alliance, agreement on goals and objectives, and a description of the treatment program/plan). The final section covers helpful suggestions to professionals working with similar clients.

Chapter 5, "Sensory-Based Therapy for Crisis Counselors," by Chrys J. Harris, identifies various assessment and treatment paradigms appropriate for helping crisis workers who suffer from STS/STSD. According to the author, crisis workers include immediate responders (firefighters and law enforcement personnel); later responders (medical, paramedic, and ambulance personnel); unexpected responders (passersby, others in the event); emergency room personnel; body recovery, identification, and burial personnel; crisis intervenors (clergy, medical, and mental health professionals); voluntary personnel (Red Cross, Salvation Army, and shelter/caregivers); remote responders (equipment maintenance personnel); and emergency support personnel (dispatchers). Harris presents a model for understanding the etiology of STS, followed by a brief discussion of ethnic and cultural issues. He introduces his "sensory-based therapy" as a promising approach. After a discussion of assessment characteristics, two treatment paradigms are presented: one preventative and the other ameliorative. Toward the end of the chapter, Harris argues for utilizing a sensory-based therapy in two ways: as a

preventive intervention and in combination with more traditional PTS therapy to ameliorate compassion fatigue.

Chapter 6, "Debriefing and Treating Emergency Workers," by Susan L. McCammon and E. Jackson Allison, Jr., emphasizes the importance of promoting trauma resolution and healthy coping strategies in emergency workers. Strategies that can be implemented before, during, and after a traumatic event are summarized. Pretrauma interventions include the use of a stress audit, training regarding stress and its management, and policy development.

During a traumatic event, interventions include orientation to the trauma site, on-scene support, demobilization, and debriefing. Common elements among the several debriefing models described include the structuring of opportunities to review the events of the traumatic situation and to ventilate feelings, the learning of skills for integrating and mastering the event, and obtaining assistance in identifying, enlisting, and accepting help from one's support system. Post-trauma activities include individual follow-up sessions, the use of experimental procedures such as eye movement desensitization and reprocessing, and attention to anniversaries of traumatic events. A decade of anecdotal reports testifies to the effectiveness of debriefing and provides helpful insights into working with emergency responders. Currently, research efforts are under way to assess systematically the impact of debriefing. Future research should address the mediating effect of emergency workers' coping behaviors and cognitions.

Chapter 7, "Treating the 'Heroic Treaters,' " by Mary S. Cerney, focuses on treaters who work with psychologically and physically traumatized patients. Cerney notes that these therapists are especially vulnerable to STS and STSD, as the assault on their sense of personal integrity and belief in humanity can be so shattering that it places them in a special group of traumatized individuals who are similar in many ways to the individuals they treat, although each trauma victim, whether patient or therapist, is different. The author assesses the reactions of therapists who experience compassion stress and compassion fatigue, including issues of transference, countertransference, projective identification, and identification. She also describes factors that influence the experience and consequences of compassion stress/fatigue, preventive measures to minimize or prevent its occurrence, and ways to help the therapist who has suffered compassion fatigue.

Chapter 8, "Constructivist Self Development Approach to Treating Therapists with Secondary Traumatic Stress Disorders," by Laurie Anne Pearlman and Karen W. Saakvitne, like the previous chapter, focuses on

trauma therapists, with special emphasis on those who treat adult survivors of childhood sexual abuse. Pearlman and Saakvitne have observed that these therapists find that their inner experiences of "self" and "other" transform in ways that parallel the experience of the trauma survivor. This transformation, which the authors deem "vicarious traumatization," involves changes in the therapist's frame of reference. This is a special manifestation of STSD that includes modifications in one's identity and world view, self capacities, ego resources, psychological needs and cognitive schema, and sensory experiences that are part of the authors' constructivist self development (CSD) theory. Based on CSD theory, the authors suggest that treatment of STSD—especially vicarious traumatization in therapists—must focus on three realms: personal, professional, and organizational. They discuss specific strategies for each realm to counteract the negative effects of trauma work on the therapists. The strategies emphasize the necessity for balance; the use of external resources; self-atonement; connection; and the need to foster one's sense of meaning, interdependence, and hope.

The final three chapters focus on prevention, and also follow a common outline. Unlike the treatment chapters, more emphasis is placed on psychoeducation, preparedness, and planning. Moreover, unlike the previous chapter, in which mental health professionals exclusively design and implement a treatment program, prevention is the business of many more professionals. Policy makers, administrators, educators, emergency workers, disaster preparedness workers, and community safety specialists are all responsible for some aspect of preventing compassion fatigue.

In Chapter 9, "Preventing Secondary Traumatic Stress Disorder," Janet Yassen offers a framework for prevention of compassion stress that includes an appreciation of the primary, secondary, and tertiary dimensions of prevention. In the final section of the chapter, Yassen presents practical guidelines for preventing STS, based on an ecological model. This model assumes that prevention can be most successful if it incorporates both the individual and the environmental factors. Individual strategies address the physical, social, and psychological aspects as of STS, as well as its professional components. Environment interventions include social, societal, and work-setting strategies.

Chapter 10, "Preventing Compassion Fatigue: A Team Treatment Model," by James F. Munroe, Jonathan Shay, Lisa Fisher, Christine Makary, Kathryn Rapperport, and Rose Zimering, suggests that isomorphic characteristics of compassion fatigue and PTSD, and the intensity and duration of exposure by clients, is predictive of responses. The authors assert that no therapists are immune to these effects. The chapter deals with the thorny ethical questions in traumatology: the duty to

inform, educate, and act in connection with compassion fatigue among colleague therapists. This team of authors suggests that therapists working alone may be unable to identify their own responses. A team approach is described that prevents secondary trauma and enhances client treatment by actively modeling appropriate coping strategies. Recognizing the effects of secondary trauma, the authors argue, gives therapists not only a means of prevention for themselves, but also a window of understanding and an opportunity to intervene actively with their clients. They offer several examples of client patterns and team responses, and outline several specific practices for therapists.

In the final chapter, Chapter 11, "Preventing Institutional Traumatic Stress Disorder," by Don Catherall, institutions are the central point of interest, especially those that are vulnerable to acts of violence or other sources of traumatic stress. The author argues that well-prepared institutions establish ongoing mechanisms to deal with PTSD and compassion fatigue among their workers, including therapists. He maintains that the first step is to evaluate the degree of exposure and assign responsibility for prevention activities before incidents actually occur. The institution must then work to establish an atmosphere that acknowledges the normality of reactions to compassion stress and facilitates the processing of exposure to secondary stressors. This healthy atmosphere, according to Catherall, is similar to that in families that cope functionally with primary trauma (i.e., they identify the stressor as a problem for the entire group, and not just the affected individual) and that approach the problem in an open, supportive, nonblaming fashion. In addition, Catherall notes that institutions must attend to aspects of the institutional environment that affect the workers' abilities to function as a closely knit group. These elements include the hierarchical structure of most institutions, the impersonal and disempowering atmosphere of many bureaucracies, and the influence of the institutional mission. Finally, Catherall points out that institutions must attend to the dynamics of the group and ensure that affected workers are not viewed as having something wrong *with* them, but, rather, as having had something happen *to* them.

In the Epilogue we bring together the major axioms from the literature and recommendations noted throughout the book. We also provide models for understanding and predicting compassion stress and compassion fatigue. Last, the editor introduces the next volume in the series. That book will focus on the secondary effects of trauma on family members and friends struggling to recover from a traumatic event.

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Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview

CHARLES R. FIGLEY

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: Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:	**A. Stressor:** 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 unsuccessful 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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3 3. Working with People in Crisis: Research Implications

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