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Compassion fatigue

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Compassion Fatigue

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ABSTRACT. This paper addresses the issue of compassion fatigue as a symptom of the stress and strain induced upon individuals working with the field of social services. The purpose of this paper is to make individuals aware of the issue of compassion fatigue and its' implications upon workers in this field and related helping fields. Among the literature presented, job-burnout, countertransference, secondary traumatic stress disorder and vicarious traumatization are defined as issues relating to and synonymous with compassion fatigue. It has been found, through the literature and research available, that individuals working within the helping field can prevent the occurrence of such issues with appropriate self-care methods and by simply being aware of the symptoms involved with these issues.

Compassion Fatigue

Compassion Fatigue is a fairly recent phenomenon that has caught the attention of many researchers. This condition, which is also known as Secondary Traumatic Stress Disorder and Vicarious Traumatization, is seen across many occupations. However, for the purpose of this paper I will be focusing on the helping profession of social services.

In the field of social services, individuals work to help better the lives of others. According to Kemberg, (as cited in Fox, 2003) "all helping responses in psychotherapy must include: the capacity to empathize with what the patient cannot tolerate within himself as well as intuitive awareness of the patient's central emotional experience" (Fox, 2003, p. 49). Empathy is crucial in helping the trauma victims. However, a social worker who is empathetic is also opening himself/herself up to the dangers of feeling the same intense emotional strain that the trauma victim feels. Empathy allows the victim to feel as if they have entered a safe haven in their time with you, the social worker (Dane, 2002). Figley (1999) has stated "Helpers discover early in their careers that traumatized people are relieved by a caring professional who understands and respects their pain, engenders hope in recovering from it, goes about the task with confidence, and quickly succeeds" (p. 3). However, researchers have found that this field has a cost to helping others for many people--Compassion Fatigue. Gentry, Baranowsky, and Dunning (2002) define Compassion Fatigue as "a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways:

Re-experiencing the traumatic events,

Avoidance/numbing of reminders of the traumatic event,

Persistent arousal

Combined with the added effects of cumulative stress (bumout)"(p. 125). These symptoms mirror the three common symptoms of Post-Traumatic Stress Disorder, intrusion, avoidance, and hyper-vigilance. Compassion Fatigue has symptoms related to burnout, as well. However, Compassion Fatigue has symptoms that are unique to it.

There are three categories of symptoms of Compassion Fatigue that need to be examined and understood. Gentry, Baranowsky, and Dunning describe these symptom categories to include: "1) intrusive thoughts, images and sensations, 2) avoidance of people, places, things and experiences which elicit memories of the traumatic experience, and 3) negative arousal in the forms of hyper-vigilance, sleep disturbances, irritability, and anxiety" (2002, p. 125). According to Gentry, Baranowsky, and Dunning, within these categories the following symptoms can be experienced: "Depression, loss of hope, dread of working with certain individuals, difficulty separating work from personal life, decreased feelings of work competence, lowered functioning in non-professional situations, diminished sense of purpose/enjoyment with career, and lowered frustration tolerance (increased outbursts of anger or rage)" (2002, p. 126). Anyone or combination of these symptoms is a warning indicator that the individual may be experiencing Compassion Fatigue. Chrestman (1999) found, in all, these symptoms create a state of physical, emotional, cognitive, and spiritual instability for the individuals, families or groups experiencing Compassion Fatigue. These professionals listen to stories of trauma, pain, suffering and fear, from their clients. As a result, some of the professionals begin to experience similar trauma in their own lives. Essentially, these professionals' work has carried over into the rest of their life (Figley, 1995). For example, a therapist who listens to a client's rape story may develop disgust for rapists which are then generalized to all men. This therapist would be experiencing Compassion Fatigue. Interestingly, it has been found that the "best" therapists are most at risk for Compassion Fatigue. This is due to their high ability to be empathetic (Figley, 1995).

Vicarious Traumatization occurs over time. It is not specific to one client or trauma story, but it occurs as a result of many clients and therapeutic relationships. The effects of vicarious traumatization are unique to each therapist, depending on the therapist's personality, resources and defensive mechanisms. Many aspects of the therapist's life are affected by vicarious traumatization, including but not limited to:

psychological needs, beliefs about oneself and others, interpersonal relationships, and physical presence within the world. Vicarious traumatization affects the therapist's ability to live fully, love, work to one's potential and enjoy life through play (Pearlman & Saakvitne, 1995).

McCann and Pearlman have identified (as cited in Pearlman and Saakvitne, 1995) seven "fundamental psychological needs" of therapists who work closely with trauma clients, trauma-safety, dependency/trust, power, esteem, intimacy, independence, and frame of reference. Perhaps the most impacting transformation for the trauma therapist is his frame of reference: his identity, worldview and spirituality. These aspects of one's life provide the therapist with the lens through which he is able to think systematically about his viewpoints, experiences and interpretations regarding the world. Once one's frame of reference changes, the original perception about one's world is lost. When an aspect of one's identity is changed, alienation from oneself occurs, resulting in feelings of isolation from oneself and others (Pearlman & Saakvitne, 1995). Redefinition of one's beliefs, identity and self-worth must occur at this point. Trauma therapists may question what it means to be a trauma therapist and why they are in this demanding, stressful line of work. These therapists may feel isolated when socializing in public situations, due to the sheer nature of their work--individuals these therapists socialize with typically do not share the same type of traumatic career experiences with which they could share and relate. The important issue for trauma therapists is to develop a personal identity aside from one's professional identity. Otherwise the therapist's professional identity will carry over into his personal life causing a barrier to form in his interpersonal relationships. Preoccupation in one's clients' distress, trauma and grief interferes with one's ability to fully engage in one's personal life experiences (Pearlman & Saakvitne, 1995). A few other general warning signs of Vicarious Traumatization include: "decreased sense of energy, no time for one's self, increased disconnection from loved ones, social withdrawal, increased sensitivity to violence, threat or fear, or the opposite,

decreased sensitivity, cynicism, generalized despair and hopelessness" (Dane, 2002, p. 8-9).

Countertransference is known as one of the responses one has to the trauma. These include but are not limited to: the responses the therapist has to the client, the responses the therapist has toward others and the responses the therapist has generated from his/her own experiences. Countertransference frequently occurs when therapists begin working with individuals who are hurting. It is a common result to the client/therapist relationship. The conscious and unconscious reactions that the therapist has to the "helping situation" are a result of the clients' realities as well as the therapists' own realities. When the reactions are unconscious, they are a result of internal responses. The therapist may either over-identify with their clients, their personal views, or seeing the issue for what it really is (due to the interference of their "own internal responses") or the therapist may under-identify by responding to the client unempathetically. When the therapist is aware ofhislher reactions to trauma and the client, he/she may still respond unconstructively by abstaining from appropriate interventions due to a fear of releasing powerful feelings on the client or by causing the client to experience "re-traumatization" because of a guided recollection of the traumatic memory. One's awareness ofhislher own issues and conflicts can serve as either an obstacle of one's work or as an aid in the understanding of the feelings and difficulties associated with trauma. The client's well-being should be considered at all times. Therefore, therapists' own personal history must be carefully organized to ensure a professional manner is given to the client.. "The better we can handle our own anxiety as others express strong emotion, the less likely will we be caught in the negative effects of countertransference" (Fox, 2003, p. 50).

Secondary Traumatic Stress Disorder can be defined 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, 1995, p. 7). Secondary Traumatic Stress Disorder (STSD) is almost identical to Primary Traumatic Stress Disorder (PTSD) in its symptoms. The only difference between the two disorders is that PTSD symptoms are associated with the sufferer directly, and STSD symptoms are associated with the knowledge of a traumatizing event of a significant other (Figley, 1995).

Some researchers have viewed problems with job stress as burnout. Therapists who work with victims of trauma are bound to confront issues of:

a.) "Emotional exhaustion resulting from intense transactions

b.) A profound sense of an inability to help acutely distressed clients

c.) cynicism arising from a lack of observable progress with difficult situations

d.) isolation accompanying the absence of social support" (Fox, 2003, p. 50).

"A cycle occurs where these factors interact with each other to precipitate distress and consequent isolation; these reactions, in turn, exacerbate the negative consequences that are produced in us in the first place" (Fox, 2003, p. 50). According to Figley (1999), burnout can be defined as "a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (p. 15). The most dedicated and determined social workers are most vulnerable to the effects of burnout. The factors associated with social workers becoming stressed and feeling the effects of burnout are: "the isolation of work, level of caseload, lack of professional support/supervision, professional experience, and client population" (Dane, 2002, p. 5). The most popular measure used to assess burnout is the Maslach Burnout Inventory (MBI), developed by Maslach and Jackson (as cited in Stamm, 1999). This measure assesses three aspects: emotional exhaustion, depersonalization, and reduced personal achievement. A more recent version is the Burnout Measure which assesses: physical exhaustion, emotional exhaustion, and mental exhaustion. This measure was developed

by Pines and Aronson (as cited in Stamm, 1999). Figley (1999) states that burnout is a gradual process that worsens over time. It happens as a person is repeatedly exposed to job stress. The person loses "a void of achievement and erosion of idealism" (p. 16). Figley asserted burnout to be characterized along five dimensions: physical symptoms, emotional symptoms, behavioral symptoms, work-related symptoms, and interpersonal symptoms. However, the research suggests that the most important factors associated with burnout are the factors of the client's problems: chronicity, (frequency of feelings), perception of the situation, and development over time. Two variables that should be considered by the therapist are: the degree of social support one has and factors relating to one's personal life. Satisfying activities in one's life coupled with a trustworthy support system help to diminish the stress associated with one's job (Fox, 2003). Figley (1999) found Secondary Traumatic Stress Disorder (STSD) to differ from burnout in that STSD can occur suddenly, not gradually. In addition, STSD is characterized by a feeling of helplessness, a feeling of isolation from one's support system, and often the symptoms are "disconnected from real causes." Interestingly, STSD has a faster recovery rate than burnout..

STSD provides the most recent and precise descriptions of what researchers have observed for hundreds of years. However, compassion fatigue is used interchangeably with STSD to describe this "disorder" among professionals of the caring profession. Compassion Fatigue is characterized by a feeling of profound sympathy, accompanied with a powerful desire to help soothe the suffering and eliminate its' causes (Figley, 1995). These terms will be used interchangeably throughout this paper.

So why are some professionals affected by compassion fatigue while others are not? Munroe, Shay, Fisher, Makary, Rapperport, and Zimering (1995) found two factors that seem to relate to the vulnerability of compassion fatigue among professionals--empathy and exposure. Empathy is necessary for therapists to understand the victim's condition and in order to devise a treatment plan. However, empathy is the

single most important factor to the initiation of trauma from the primary (client) to the secondary (therapist) victim. Consequently, in the process of empathizing and understanding the victim's traumatization, the therapist may be traumatized himself/herself Along with the therapist empathizing with the client's trauma, the therapist may over empathize with the client through personal experience. Therapists are humans. They have life experiences and traumatic events in their own lives. A client may have a traumatic event that mimics the therapist's experience, causing the therapist to re-experience the traumatic event. It is important for therapists to resolve issues of trauma in their own lives in order to avoid this re-living of painful experiences. According to Williams and Sommer (1999), it is not uncommon for therapists to work with individuals experiencing similar problems to those they have experienced themselves. "The therapist is a witness to his clients' traumas, through their vivid descriptions of traumatic events, reports of intentional cruelty and sadistic abuse, and experiences of reliving terror, grief, and yearning. He is both a witness to and a participant in traumatic reenactments within and outside of the therapy relationship" (Pearlman & Saakvitne, 1995, p. 279). As a consequence to this exposure, therapists' mind frames change over time. Vicarious traumatization, or Compassion Fatigue, affects the therapist's response to his clients' emotional exposure and his conscious and unconscious defense mechanisms against the exposure (Pearlman & Saakvitne, 1995). Williams and Sommer (1999) state that the likelihood of Compassion Fatigue affecting an individual heightens as the exposure is closer to the individual. For example, a close family member experiencing Compassion Fatigue will have a negative impact on those in his immediate environment.

Chrestman (1999) conducted a recent study where questionnaires were given to therapists who belonged to the following groups: the International Society for Traumatic Stress Studies (lSTSS), the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D), and the American Association of Marital and Family

Therapists (AAMFT). The questionnaires were made to establish: personal and professional history, psychological symptoms. cognitive schematas, coping behaviors and behavior changes. The results of this study indicated that therapists' exposure to trauma was correlated with an increase in: sleep disturbance. dissociation. intrusion and avoidance. This study also revealed that an increased income and additional job training decreased these symptoms. An increased caseload of trauma clients increased these symptoms. Therefore. an increase in symptoms seems to be related to the amount of time spent as a therapist, especially with trauma clients.

Chrestman's research has some implications for therapists dealing with trauma victims. First. in order for therapists to minimize their chances of secondary traumatic stress disorder having a negative impact on their lives. it is suggested that therapists practice self-care. It is especially important that the therapists receive increased supervision and support. Second. this study's data suggests that occasional participation in training programs may help to alleviate the stress for trauma therapists. This training provides new skills to use in therapy. an increased professional and social support system to help decrease feelings of isolation and a referral network to help decrease the therapist's sense of exhausting responsibility. Third. it is important for a trauma therapist to have a variety of caseload clients. A trauma therapist's caseload ideally should include some non-traumatic cases. Finally, trauma therapists' lifestyles should contain minimal stress. It is important to eliminate the general stresses from a trauma therapist's life (Chrestman. 1999).

Along with therapists exposure to trauma. therapists' relationships with others impacts the effects that vicarious traumatization has on the therapist.. According to Marmaras, Siegel and Reich (2003), attachment styles effect therapists relationships with others and the effects that vicarious traumatization has on the therapist.. According to Bowlby. (as cited in Marmaras et al., 2003) attachment is defined as "the foundation on which personality is built" (p. 83). Hazan and Shaver explain (as cited in Marmaras et

al., 2003) as children, individuals incorporate the experiences that they had with their caregivers into their personality, which provides internal working models that one uses for one's relationships with self and others. The four styles of attachment are: secure, preoccupied, fearful-avoidant, and dismissive. Secure attachment styles promote healthy relationships, positive feelings of self-worth and an ability to cope with trauma. In turn these therapists are able to develop productive coping strategies to help them deal with and minimize stressors. Preoccupied attachment is a style of attachment where individuals seek contact with others before a separation, but after the separation the individual either resists or rejects contact with the person. Therapists displaying this attachment style may initially show interest in their client, yet over time they may distance themselves from the client and even turn to reject their client. Fearful-avoidant attachment style is an attachment where individuals are distressed by the separation from others and hesitant to rejoin with the person once separation has seized. Therapists displaying this attachment style may begin the therapy not fully cognitively present and then when a situation of distress separation occurs they are slow to return to full functioning. Dismissive attachment style is an attachment style where individuals display qualities from both fearful-avoidant and preoccupied attachment styles. These therapists may contradict their actions from session-to-session with their clients (Baron & Kalsher,2002). Dozier, Cue, and Barnett studied (as cited in Marmaras et al., 2003) how attachment styles are correlated with therapists' ability to intervene intensely and effectively with their clients and are correlated with the ability to cope with vicarious traumatization. Studies have indicated that therapists with secure attachment styles are better able to be attentive and responsive to their clients. Insecure therapists were found to have been more "distressed" by their trauma work and to have intervened with their clients in a less attentive and responsive manner.

Marmaras, Siegel and Reich (2003) conducted a study in which attachment styles were compared to cognitive schemas in trauma therapists. Three hundred seventy-five

female, trauma therapists filled out a Relationship Questionnaire in order to measure their attachment styles. The questionnaire consisted of paragraphs describing the four attachment styles with regards to close relationships. The participants rated themselves along each of the four attachment styles. The researchers hypothesized and the study confirmed that there is a "significant relationship" between attachment styles and disrupted cognitive schemas. Bartholomew and Horowitz's study found (as cited in Marmaras et al., 2003) that therapists with a fearful-avoidant or a preoccupied attachment style reported more disrupted cognitive schemas than therapists with a dismissive attachment style. Therapists with a secure attachment style reported minimal cognitive disruptions, which may be due to secure therapists' comfortable feelings regarding intimate relationships and intense emotions. Dozier, Cue and Barnett's study revealed (as cited in Marmaras et al., 2003) individual differences in attachment styles due to therapists' view of self and others. The female trauma therapists who viewed themselves negatively reported more feelings of avoidance and intrusion. These therapists experienced heightened emotional arousal.. Therapists with a fearful-avoidant, preoccupied, or dismissive attachment style were more likely to experience these feelings as a result of their inability to accurately evaluate the therapeutic relationship with their clients.

Yassen (1995) describes how in order to prevent secondary traumatic stress disorder from occurring, one must first recognize that the disorder exists. Also, prevention is best occurred with a lifestyle that promotes dealing with various levels of stress impact.. Having a variety of skills and strategies helps an individual to cope with an unexpected traumatic event.. Prevention occurs along three different dimensions: primary, secondary, and tertiary. Primary prevention focuses on the social causes of a problem by eliminating the causes. Secondary prevention involves personal and environmental planning. This prevention prepares an individual for coping with secondary traumatic stress disorder. Tertiary prevention is a form of crisis intervention

for individuals and communities. This prevention helps individuals after the secondary traumatic stress disorder has occurred.

Prevention of mental health problems requires an understanding of the disease as well as an understanding of the social implications of primary, secondary and tertiary prevention. Psychologist James Kelly empathizes (as cited in Figley, 1995) the difference between individuals and their social settings. Kelly's ecological approach is based on three assumptions:

> "1. Physical, social and psychological environments affect personal behavior.
>
> 2. Personal adaptations to environmental conditions facilitate growth and development. .
>
> 3. Community health is determined by energy flow and the cycling of resources" (as cited in Figley, 1995, p. 181).

Yassen stresses individual adaptation, personal coping, as an important factor in prevention. However, this trait alone will not prevent secondary traumatic stress disorder from occurring. Community resources and values play an important role in the prevention of the disease. Therefore, the ecological approach to prevention stresses that both personal and environmental components be considered and used (as cited in Figley, 1995).

Yassen (1995) states that the personal component of the ecological approach of prevention combines knowledge, strategies and techniques. The prevention approach addresses the following areas of our personal lives: physical, psychological, cognitive, interpersonal, behavioral, and spiritual.. The physical component refers to maintaining good health for our bodies. The most important aspect to a healthy body is physical exercise. Research has shown for years that exercise is an important part of stress reduction. For many people it is difficult to exercise with their busy schedules. It is suggested that individuals choose an exercise that fits their own lifestyle. For example, a

student may exercise by walking to class and taking the stairs up to her classroom instead of taking the bus or riding up the elevator. Yassen says another important aspect to a healthy body is adequate sleep. Sleep deprivation causes impaired cognitive and neurological functioning and irritability. A final important aspect to a healthy body is eating well-balanced meals. It is important to eat nutritious food and to eat it properly. Eating too quickly does not allow the body to digest properly. Not eating enough food causes the body to turn to the fat cells, which are the body's source of protection and insulation. Appetite can be affected by stress. People overeat, undereat and replace food with feelings in times of stress. It is important to be aware of one's eating habits.

Yassen also discusses the psychological component of individual prevention as having several aspects to it. First, life balance is important to stress reduction. This includes having a variety of activities to attend to at a calm pace. Life balance refers to dividing one's time among work-related activities, pleasurable interests and hobbies, social interests, and personal time. Second, relaxation is important to stress reduction. Relaxation should occur at regular times in the form of: down time on a daily basis, fun activities weekly and vacations yearly. It is sometimes difficult for individuals working with trauma to relax, but it is important to realize that there will always be work to be done--take the time. Third, contact with nature is an important aspect of stress reduction. This allows us to view the world as a whole. Also, it gives us a sense of our place within the world and society at large. Fourth, creative expression is an important aspect of reducing stress and preventing secondary traumatic stress disorder. By this we mean that one needs to learn to use hislher mind in a way that allows for expansion of ideas and experiences. This will help one to handle stress more appropriately. For example, one may enjoy photography and take pictures as a way to escape his/her work and reduce the stress in hislher life. Fifth, meditation and spiritual practice is crucial to reducing the stress one has in hislher life. Meditation helps to heal the body both physically through exercises like Yoga and emotionally through taking time out of the day for one to reflect..

Yassen describes the social and interpersonal component of individual prevention as having a few different aspects to it. First, social support systems help individuals to prevent secondary traumatic stress disorder by providing outside feedback for the individual to rely on and network with. Trauma results from the attachment styles one has with others. Therefore, it is important for individuals' support systems to understand the dynamics of trauma. One may need to educate his/her support system with his/her needs and experiences in order for the support system to be available to him/her. Regular time should be scheduled for loved ones. It is crucial to maintain healthy relationships with those whom one cares about. This time may seem like a burden, but it will help reduce the feelings of stress. Second, recognizing and seeking help when it is needed is a very important aspect to preventing the long-term effects of secondary traumatic stress disorder. "Establishing a plan of help includes developing the attitude that getting help is a sign of personal strength, identifying specific people in one's personal and professional life who are viewed as helpful, and becoming familiar with professional resources should one choose to use them" (Yassen, p. 189). Yassen describes third and finally, "social activism" allow individuals to sustain a feeling of hope and purpose for engaging in trauma work. Also, this provides individuals with a feeling of engaging in a "shared mission" with their co-workers, which helps to eliminate feelings of isolation that can result from secondary traumatic stress disorder. Social activism can serve as a release for feelings of powerlessness by openly expressing views, beliefs and ideals with the public regarding trauma work.

Yassen cites the final component of the individual prevention of secondary traumatic stress disorder as professional. This component has many aspects to it. First and foremost, one must establish a sense of balance with his/her trauma work, other kinds of work, and life in general. It is important to plan how many hours per week one will spend engaged in work. Along with balancing the hours engaged in work is "pacing." This refers to how one's work is affecting oneself. Pacing should occur daily

and may include taking breaks from his/her work, taking time to eat and taking vacations from work.. A second significant aspect is establishing boundaries and limits. Setting boundaries is crucial to self-care. Self-care involves caring for oneself in order to be able to maintain the empathetic and caring relationship with others that is so crucial to the social service career field. Boundaries include: time management, professional boundaries as a therapist and personal boundaries for oneself.. Time management includes: being on time for appointments with clients and co-workers, staying within the time limits established for given appointments and allowing our own personal time for our life outside of work.. Professional boundaries as a therapist refer to the process of establishing a professional relationship as therapist and client.. It is vital that the client understand the nature of the relationship (Yassen, 1995).

Trauma creates a sense of unknown fear for clients. Therapy should steer away from continuing to add to that unknown fear. The therapist, on the other hand, should be aware of the helpless feelings that the client holds. This sense of dependence, rage, and hopelessness may be displayed against the therapist.. It is crucial that the therapist not take these negative feelings personally. Using one's support system could help remove some of the stress involved with this trauma work.. Personal boundaries include one's role as a therapist.. As a therapist one must decide to what extent he/she will become personally involved in the therapy. Will one disclose personal information to clients? When and how much information is appropriate to disclose? These issues should be determined before the therapy sessions begin. A third significant aspect to the professional component of individual prevention is the evaluation of one's healing. This aspect is unique in that it involves therapists who have been trauma victims themselves. These therapists need to sustain consistent and constant self-care. These therapists provide a wealth of knowledge to the field and their work.. However, it is both difficult and important for them to maintain recovery status with their own trauma issues. Healing from traumatic events is a lifelong process for survivors. These therapists should

learn to recognize their limits with doing trauma work and take the appropriate actions when personal issues are brought to the surface. This way their personal experiences are not interfering with their work. A final significant aspect to the professional component of individual prevention of secondary traumatic stress disorder is job commitment. It is important for individuals to consider their job satisfaction regularly. Job commitment and satisfaction can be a hard quality to have in trauma work, but without the commitment and satisfaction to one's work the job is done ineffectively. If one does not care about his/her job, then how can one care for his/her clients? Compassion and empathy for clients in trauma work is the key to success. If clients do not feel that they are cared for and understood they will not trust you (the therapist) and have an open relationship with you (the therapist) (Figley, 1995).

Yassen states that another form of secondary traumatic stress disorder prevention is the environmental intervention. Environmental prevention involves secondary and tertiary prevention activities. A major part of one's environment is his/her social setting. An individual's social setting may give information that is prejudiced, misleading, or simply incorrect. Trauma victims are often surrounded with misinformation, since they have been victimized. Some prevention activities included in one's social setting are: educational interventions to change individuals' attitudes and provide accurate information; using the legal system to enforce one's rights in trauma situations; the mass media for purposes of publicity; coalition building; and social activism to plan actions in order for attention to be given to a problem. Another part of one's environment is his/her work setting. Assessment of one's work environment can help influence job satisfaction, self-care practices and the prevention of secondary traumatic stress disorder. The work environment has implicit and explicit values and understandings of what is expected of its' workers. It is beneficial for the workers to know these about their job--it allows easier self-care to be done. Some other important aspects that one should clarify with regards to his/her work environment are: "tasks: job descriptions, philosophy, realistic

expectations, task variety, adequacy of supervision, in-service and career opportunities, training and orientation that prepare the employee for the job, job security, job overload and pay, managerial: lines of authority, accessibility of leaders who are open to feedback, role models, accountability, ability to motivate/build morale, interpersonal: personnel guidelines, respect for differences, value of social support/mutual aid, trust among staff and sensitivity to the needs of individuals" (Yassen, 1995, p. 201). Kelly discusses (as cited in Figley, 1995) that implementing ideas for prevention into actual prevention plans can be difficult. The most important guideline for prevention is being willing to honestly give change the time that it needs for long-range plans. Plans should be able to be easily adapted to environmental and resource changes, as well.

When the prevention of Compassion Fatigue does not occur for whatever reason, there are some treatment approaches that can be implemented for the individual(s) suffering from Compassion Fatigue. Gentry, Baranowsky, and Dunning discuss one treatment option for Compassion Fatigue which is called the Accelerated Recovery Program (ARP). This program is a five-session model aimed at treating the effects that Compassion Fatigue has on the lives of professionals who deal with trauma in their work. This program was designed to help the prevention and treatment of Compassion Fatigue (CF). "Its purpose was to provide participants with the raw materials to begin to develop resiliency and prevention skills from CF. In addition, the program offers an opportunity to review personal and work history to the present and assist in the process of movement toward a more intentional and less reactive professional and personal life" (Gentry et al., 2002, p. 128). Gentry et al. describe how this program is intended to assist individuals in highly stressful, demanding careers. ARP has proven to be successful over the years. However, some individuals may wish to pursue further training programs in order to alleviate the symptoms of Compassion Fatigue and further learn resiliency skills. ARP has the following goals: "symptom identification, recognize compassion fatigue triggers, identify and utilize resources, review personal and professional history to the present day,

master arousal reduction methods, learn grounding and containment skills, contract for life enhancement, resolve impediments to efficacy, initiate conflict resolution, and implement supportive aftercare plan--untilizing the PA TRW AYS self-care program" (p. 129). The ARP, discussed by Gentry et al. (2002), covers the following components in the treatment and prevention of Compassion Fatigue: "Therapeutic Alliance, Assessment Quantitative and Qualitative, Anxiety Management, Narrative, ExposurelResolution of Secondary Traumatic Stress, Cognitive Restructuring (Self-care and 'Integration), and PA TRW AYS--Self-directed Resiliency and Aftercare Plan" (p. 129).

They state that the first component of the program, Therapeutic Alliance, refers to the understanding that care professionals often abandon their own identity with the idea that it is their responsibility to simply care for others. The goal of this program with regard to this component is to offer the care professional the respect and understanding that their career, as a care professional, is demanding. The second component of the program, Assessment Quantitative and Qualitative, refers to a Compassion Fatigue profile produced to help determine all of the underlying factors affecting the care professionals'life. For example, the care professional may be experiencing primary trauma exposure, emotional disturbance and other stressors all of which are causing the Compassion Fatigue symptoms. This component was designed to help the care professionals recognize the importance of different collective approaches that may be used in their career. The third component of the program, Anxiety Management, encompasses the participants of the program being exposed to various "anxiety reduction tools" to help teach the individuals how to keep negative arousal and stress low. The fourth component of the program, Narrative, refers to individuals sharing their stories and becoming self-aware of their strengths and weaknesses. This component helps aid the participants in restoring their personal and professional lives. The fifth component of the program, ExposurelResolution of Secondary Traumatic Stress, refers to the common belief that exposure to the traumatizing information or event will help elicit coping

methods for dealing with the stress and help the care professional return to optimal functioning. The sixth component of the program, Cognitive Restructuring (Self-care and Integration), involves restoring dysfunctional cognitive beliefs. Individuals experience and process traumatic events differently. For example, care professionals who are experiencing Compassion Fatigue more than likely have experienced a traumatic event and processed it as being a dangerous situation. This in tum carried over into other aspects of their life, such as their personal life with their family members. Therefore, the individual now views their entire life as being dangerous, when perhaps their personal life with family members represents a safe environment and aspect to their life. This program uses challenging and critical cognitive reality checks to help the participants observe their cognitive distortions. In the end it is the goal of the program to assist the individuals in shifting their rigid cognitive distortions to more honest, accurate depictions of the reality. The final component of the program, PATHW AYS·-Self·directed Resiliency and Aftercare Plan, is the core to this program. PATRW AYS provide the participants with an aftercare plan that constitutes restoring the individuals' lives to one of commitment to wellness and responsibility to oneself.

PATHW AYS represent the self-care, aftercare, prevention part of the ARP, described by Gentry, Baranowsky, and Dunning. The following five areas aid the individuals in preventing Compassion Fatigue to interfere with their lives: "1) Resiliency Skills, 2) Self-management and Self-care, 3) Connection with Others, 4) Skills Acquisition, and 5) Conflict Resolution" (p. 131). First, Resiliency Skills pertains to individuals' ability to develop and maintain the capacity to relieve stress in the absence of anxiety and continue to care for oneself This concept presents the challenge for individuals to intentionally act rather than impulsively act. Second,, Self-management and Self-care bestows the individuals with the following questions to consider: "...what leads them to feel overextended in their work or personal lives? , What boundaries need to be implemented or reinforced", and What self-care or self-soothing skills need to be

developed, implemented, reinstated, or reorganized?" (p. 131). These questions challenge the participants of the program to honestly observe their lives both professionally and personally in order to determine changes that need to be created. Third, Connection with Others pertains to the care professionals' ability to reach out to others for help when needed. Professionals in the "caring" field need to build and establish a network of individuals to which they are able to depend on, a "therapeutic community." This network can provide support, nurturance, and understanding that will help prevent feelings of isolation and ultimately--Compassion Fatigue. Fourth, Skills Acquisition refers to the skills professionals have acquired and use in their career. Adequate training and supervision serve as a "buffer" against Compassion Fatigue. If these skills are missing, professionals are likely to feel inadequate and possess low self-esteem, which can actually increase their chance of becoming burned out and developing Compassion Fatigue. Finally, Conflict Resolution is crucial to preventing the internal conflicts that result in Compassion Fatigue. Some professionals know that they are struggling with internal conflicts related to their career~ they even know strategies to which they should be implementing in order to prevent further conflicts, yet it is a difficult process to resolve. By not resolving their conflicts these professionals are stuck in a cycle of past defeats and are wasting precious resources that could be used in their present daily lives. Many professionals have external conflicts, as well. Care professionals are human. They have past experiences and traumatic situations that have happened in their lives. These past traumatic situations are known as the care professionals "primary trauma," as it was the first experience that they came to encounter. These professionals may have this primary trauma "re-triggered" by a similar case/situation that occurs in their career with a client.

According to Dane (2002), an event is considered to be a trauma if the event: is unexpected, overpowers the person's ability to adapt and disturbs the person's cognitive

abilities. Trauma can be either chronic, ongoing, or situational, pertaining to a certain event or situation. Traumas can also be intentional or unplanned.

When traumatic events are re-experienced, the rush of stress hormones causes: the heart to race, senses to be alerted, muscles to become ready for a fight or flight response and feelings of terror and grief overwhelm the therapist. There are many situations or items that can cause a previous traumatic event to become re-triggered. For example, a particular smell or sound may give the therapist a "flashback" of the trauma. This "flashback" could occur through a conscious or unconscious link, while communicating with one's client (Fox, 2003). Figley states (as cited in Fox, 2003) that in order for these care professionals to be most productive it is critical that they resolve these past traumatic conflicts. Otherwise these external conflicts will interfere with their professional career. According to Fox (2003), therapists are at risk for experiencing the same "emotional (fear, depression, numbness, irritability), physical (dizziness, fatigue, headaches, jitteriness), behavioral (withdrawal, outbursts, inability to rest, avoidance), and cognitive (confusion, hyper-vigilance, preoccupation, memory problems) reactions as their clients do" (p. 45).

Memories of traumatic events are easily accessed and re-triggered due to the effects that these events have on the brain. Stress hormones, such as cortisol and adrenaline, are released when strong emotions are experienced. These hormones' presence in the brain produces long lasting memories. The brain regions affected by traumatic events are the areas of memory in the brain. Trauma disrupts the brain's ability to concentrate, distinguish between stimuli and the short-term memory. Professionals have suggested that the effects of traumatic events on the brain and the central nervous system may be able to be reproduced without actually being exposed to the trauma. This suggests that trauma may alter the structure and functions of the brain (Fox, 2003).

In the helping profession of Social Work it is important to understand the risks of helping sufferers. However, simply knowing about various problems such as

Compassion Fatigue, Secondary Traumatic Stress Disorder and Burnout is not enough. In order to prevent such problems from interfering with one's professional career and personal life it is crucial for helpers to understand how and why Compassion Fatigue happens to individuals. The Trauma Transmission Model offers an explanation that addresses these questions. First of all, clinicians believe that in order for helping professionals to work with sufferers they must first be able to relate to the sufferer and hislher trauma. This is done by listening to the trauma story and visualizing it mentally. The professional attempts to understand the trauma by asking: "What happened? Why did it happen? Why did I act as I did then? Why have I acted as I have since? If it happens again, will I be able to cope?" (Figley, 1995, p. 249). This exposure to the trauma causes the professional to experience intense emotions similar to those experienced by the sufferer. This model describes how Compassion Stress, or Compassion Fatigue, has six interrelating variables. The first is empathetic ability. Empathetic ability is the ability to notice pain in others. The second variable is the individual's susceptibility to emotional empathy, or emotional "contagion." This refers to the individual's ability to feel what the sufferer is feeling due to hislher exposure to the sufferer's trauma story. The third variable is empathetic response. Empathetic response is the ability for the professional to identify with the sufferer. The fourth variable is empathetic concern, which is the motivation for the professional to act and help the sufferer. Empathetic ability and emotional contagion both represent the professional's willingness to help the sufferer. The fifth variable is sense of achievement, which refers to the extent that the professional is satisfied with the results of the helping process. Sense of achievement also involves the professional's ability to disengage himself from the suffering of the client.. "Those who experience very little compassion stress and yet are exposed to enormous emotional contagion and have considerable empathetic ability and empathetic concern find a sense of satisfaction in their empathetic response because they believe that they relieved suffering and thus have a sense of achievement or because

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