An image of one page of a document, as well as some previously extracted raw textual content, is provided. The content seems to be an excerpt from a publication discussing the experience of compassion fatigue among emergency service and mental health professionals in the context of the events of 9/11. The text describes a Critical Incident Stress Debriefing (CISD) session and the emotional reactions of the participants, including the experience of secondary traumatic stress. The author, J. Eric Gentry, PhD (cand), MT, CAC, reflects on his own reactions and the importance of support and treatment for those who have been involved in such traumatic events.
posttraumatic symptoms. There is also, however, little doubt that serving these survivors exacts a toll that while minimal for some caregivers, can be devastating for others. As Viktor Frankl, one of the twentieth century’s greatest traumatologists, simultaneously warns and encourages: “That which is to give light must endure burning” (Frankl, 1963, p. 129).

This article explores the potential causes, prevention, and treatments of compassion fatigue (Figley, 1995), the deleterious effects of helping the traumatized, as it relates to the tragedy of September 11, 2001. It is offered with the hope that it may help some of those dedicated to being of service to survivors in New York and across the nation to continue being givers of light, burning ever more brightly, and never burning out.

**Compassion Fatigue**

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

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

The study of countertransference produced the first writings in the field of psychotherapy that systematically explored the effects of psychotherapy upon the therapist (Haley, 1974; Danieli, 1982; Lindy, 1988; Wilson & Lindy, 1994; Karakashian, 1994; Pearlman & Saakvitne, 1995). Recent texts have suggested that therapists sometimes experience countertransference reactions that imitate the symptoms of their clients (Herman, 1992; Pearlman & Saakvitne, 1995). For instance, when working with survivors of traumatic experiences, authors have reported countertransference phenomena that mimic the symptoms of posttraumatic stress disorder (PTSD; Lindy, 1988; Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995). Business and industry, with their progressive focus upon productivity in the last half of the twentieth century, have provided us with the concept of burnout (Fruedenberger, 1974; Maslach, 1976) to describe the deleterious effects the
environmental demands of the workplace have on the worker. Burnout, or “the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (Maslach, 1976, p. 56), has been used to describe the chronic effects that psychotherapists suffer as a result of interactions with their clients and/or the demands of their workplace (Freudenberger, 1974; Cherniss, 1980; Farber, 1983; Sussman, 1992; Grosch & Olsen, 1995; Maslach & Goldberg, 1998). Research has shown that therapists are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic (McCann & Pearlman, 1990). Moreover, burnout not only is psychologically debilitating to therapists, but also impairs the therapist’s capacity to deliver competent mental health services (Farber, 1983). The literature on burnout, with its twenty-five year history, thoroughly describes the phenomena and prescribes preventive and treatment interventions for helping professionals.

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

As therapists are increasingly called upon to assist survivors of violent crime, natural disasters, childhood abuse, torture, acts of genocide, political persecution, war, and now terrorism (Sexton, 1999), discussion regarding the reactions of therapists and other helpers to working with trauma survivors has recently emerged in the traumatology literature (Figley, 1983, 1995; Danieli, 1988; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995). Professionals who listen to reports of trauma, horror, human cruelty and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients. They may also experience PTSD symptoms similar to their clients’, such as intrusive thoughts, nightmares, avoidance and arousal, as well as changes in their relationships to their selves, their families, friends and communities (Figley, 1995; McCann & Pearlman, 1990, Salston, 1999). Therefore, they may themselves come to need assistance to cope with the effects of listening to others’ traumatic experiences (Figley, 1995; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Gentry, Baranowsky & Dunning, 1997, in press).

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

Vicarious traumatization (McCann & Pearlman, 1990) refers to the transmission of traumatic stress through observation and/or hearing others’ stories of traumatic events and the resultant shift/distortions that occur in the caregiver’s perceptual and meaning systems. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and becomes overwhelmed by this secondary exposure to trauma (Figley & Kleber, 1995). Several theories have been offered but none has been able to conclusively demonstrate the mechanism that accounts for the transmission of traumatic stress from one individual to another. It has been hypothesized that the caregiver’s level of empathy with the traumatized individual plays a significant role in this transmission (Figley, 1995) and some budding empirical data to support this hypothesis (Salston, 2000).

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

As a result of our work with hundreds of caregivers suffering the effects of compassion fatigue, we have augmented Figley’s (1995) definition to include pre-existing and/or concomitant primary posttraumatic stress and its symptoms. Many caregivers, especially those providing on-site services, will have had first-hand exposure to the traumatic event(s) to which they are responding (Pole et al., 2001; Marmar et al., 1999). For many, these symptoms of PTSD will have a delayed onset and not become manifest until some time later. We have also found that many caregivers enter the service field with a host of traumatic experiences in their developmental past (Gentry, 1999). There may have been no symptoms associated with these events, or the symptoms related to them may have remained sub-clinical. However, we have observed that as these caregivers begin to encounter the traumatic material presented by clients, many of them begin to develop clinical PTSD symptoms associated with their previously “benign” historical experiences. In our efforts to treatment compassion fatigue, we have concluded that it is often necessary to successfully address and resolve primary traumatic stress before addressing any issues of secondary traumatic stress and/or burnout. Additionally, we have discerned an interactive, or synergistic, effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted caregiver. Experiencing symptoms from any one of these three sources appears to diminish resiliency and lower thresholds for the adverse impact of the other two. This seems to lead to a rapid onset of severe
symptoms that can become extremely debilitating to the caregiver within a very short period of time.

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