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Compassion Fatigue Resilience

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Abstract and Keywords

Drawing on more than 48 years of experience working with compassionate people who were suffering, the authors discuss and illustrate the useful applications of the new Compassion Fatigue Resilience Model. Briefly reviewing the relevant research and theoretical literature, they point to the common findings that human service workers frequently forget about their own workplace comforts and are often unaware of the heavy price they pay in giving service to others. Several case studies illustrate what prompts efforts to build compassion fatigue resilience, and the life improvements that result when these efforts are successful. These improvements not only enhance the quality of human services by the workers; attention to their mental health needs leads to better worker health and morale, and sense of mutual support that extends their careers.

Keywords: compassion, fatigue, compassion fatigue, self-harm, stress, resilience, compassion fatigue resilience, prevention

According to the U.S. Bureau of Labor Statistics (2014), healthcare practitioners and technical fields were approximately 6% of the American work force. Add to this the nearly 2% who are engaged in community and social services. Today across the United States, thousands of human services workers are helping suffering people. This chapter is about their welfare, or more specifically, their compassion satisfaction, compassion fatigue, and the resources needed to be resilient. [1]

The delivery of human services requires a special kind of professional who follows the ethical and treatment standards of their specialty and is able to establish an effective working relationship with the patient (Hersong, Hogland, Monsen, & Havik, 2001; Horvath & Symonds, 1991). Human service workers must be able to gain the trust and support of their patients to help develop a treatment plan and work toward the agreed-upon goals. This process is highly complex and requires adaptation, creativity, and

especially empathy and rapport with the patient (Scilleppi, Teed, & Torres, 2000). A professional who understands the needs and style of the patient will quickly establish good connections with her or him and help the client reach their goals. For nurses focusing on patients' care, Abendroth and Figley (2014) note it is critical to simultaneously focus on their own welfare and boundaries. Otherwise, nurses will migrate toward the welfare of others, despite the boundaries.

Figley (1995a) defines *compassion fatigue* as the formal caregiver's reduced capacity or interest in being empathic or "bearing the suffering of clients," and as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person" (p. 7; see also Figley, 2002a, 2002b). Compassion fatigue (CF) is the manifestation of succumbing to the demands of client care over self-care of those who provide the care of clients as a professional. CF is the fatigue from dispensing compassion, day after day, year after year. Thus, CF is a hazard associated primarily with the clinical setting and with first-responders to trauma.

(p. 388) Professionals are expected to be compassionate and empathic every day. What if they begin to run short of compassion? What if their work becomes toxic to their health or interferes with their professional judgment? We will consider these questions through the lens of the Compassion Fatigue Resilience Model (CFRM). The model is composed of 13 empirically derived variables that together predict who will develop CF and who will be resilient to it, under similar circumstances. After defining relevant terms and concepts and introducing CFRM, we examine fundamental questions that arise within the professional self-care movement and offer some potential solutions. In addressing these questions, we offer an explanation for the mechanism that accounts for how professionals develop and become free of CF by focusing on building their resilience; a habit of self-care and mindfulness through an effective Compassion Stress Management/Resilience plan. Along the way, we will use specific case studies to enrich the phenomenological, or experiential, understanding of CF and the resilience that is its antidote.

Case Study #1: Sasha Wilkinson, MSW

"I think I have compassion fatigue," Sasha [a composite of four people] said in an email. "But I think I am on my way to getting better." She had read my book (Figley, 2002a) on the topic and wanted to focus her doctoral research on this phenomenon. She had met me briefly at a workshop I gave in the 1990s on the topic. As it turned out, Sasha started working as a hospice social worker out of graduate school. She was impressed with the local hospice. She believed that the entire staff did their best to make the final months of her dear grandmother's life as comfortable as possible. During her first weeks, Sasha was providing assistance to the four other social workers and was learning her job. Everyone who worked there seemed very professional and caring. She had a passion for helping

others, and she found that the job fit her well. Even with some shift work, she thrived in the position and steadily improved during the first 10 years.

Death was, she had discovered, “nothing to fear.” Then, two weeks from her tenth anniversary at the hospice, an incident occurred that shocked her and forced her to question her abilities as a helper. I learned over several exchanges and a phone call that, despite her best efforts, the husband of one of her patients admitted to assisting in his wife’s suicide. He was charged with murder. An aging man in his eighties was in jail for murdering his wife.

Sasha had worked with the couple for three weeks and thought she knew them and their needs. The patient was dying of terminal cancer, and hospice was providing the care that would make the wife’s natural death more comfortable for her and, in turn, her family. But over and over, the husband, a physician, complained that she was hardly ever awake; that he was gradually losing his wife due to “over-medication.” The wife explicitly asked her husband to help her end her life, a mercy killing. He did.

Sasha was devastated by the news. Talking it over with other staff was not helpful. She sensed that they may have somehow blamed her for not knowing what was going on and stopping it. This was despite the fact that she’d had less contact with the couple than others who had counseled the couple. Sasha’s sleep was not as restful. She avoided friends out of a concern that they would ask her why she was upset. She did not want to relive the event. Sasha was able to get a similar job in the next city. She believed a fresh start would help. She had become overly cautious about client risks, especially suicide. She found that she was more reactive and less sure of herself in working with colleagues as well as with her patients. This continued for three years.

Sasha rarely missed work, but it was not as satisfying as it once was. There was distance between her and other staff members, until she attended a stress management workshop. She found that having the ability to effectively manage her stress through a simple breathing exercise and practicing yoga made her more willing to face her fears and eventually talk with her minister. Gradually she began to appreciate working with dying patients again and not fearing client suicides. She then became interested in talking with others about her own experiences and was able to transform her experiences from something to fear into lessons she had learned and could share with others.

Sasha’s traumatic experiences as a human service provider are not unusual. Physician-assisted suicide is most common among cancer patients (Vann der Mass, van der Wal, & Haverkate, et al., 1996). Nor was her particular workplace environment exceptionally stressful, but the “compassion stress,” the demand to act compassionately in the face of loss, like any other stress, comes with the job; and too much pain might end her career. We will now identify and define some important concepts and variables useful in explaining Sasha’s experiences.

(p. 389) # Definitions

Compassion

As defined by Goetz, Keltner and Simon-Thomas (2010), *compassion* is the "sensitivity to the pain or suffering of another, coupled with a deep desire to alleviate that suffering." It is safe to say that compassion is a requirement for all human service providers. The ability of these providers to understand and help those in need depends on their compassion, empathic abilities, and performance (Figley, 2002b). This means that they are acutely sensitive to the pain and suffering of their clients. This painful information and the connected emotions will remain with these providers beyond their face-to-face meetings with clients. Practitioner compassion combines this sensitivity to the clients' suffering with the passionate focus on helping to alleviate the suffering.

A factor that makes practitioner compassion unique is that this dedication to the sensitivity to the pain or suffering of others often springs from deeply held values and a commitment to the highest standards of professional and ethical practice. To be compassionate is to be effective in assessing and helping the suffering. For example, the physician ethic of "First, do no harm" implies that workers care for themselves to ensure quality, ethical services: that is, the concept of "First, do no *self harm*" (Figley, Huggard, & Rees, 2013).

Stress

The term *stress* was originally defined as (Selye, 1936) as "the non-specific response of the body to any demand for change." Selye was able to determine that there were endless demands for change (stressors), but that laboratory animals, despite being subjected to many types of demands (e.g., noxious physical and emotional stimuli such as blaring noises or lights or temperature changes) all exhibited the same physiological reactions: persistent stress could cause medical and emotional breakdowns. He helped shift the focus from pathogens as being solely accountable for disease to include environmental factors such as stressors. Post-traumatic stress disorder (PTSD), for example, as stipulated by the most recent *Diagnostic and Statistical Manual of Mental Disorders Version 5* (DSM-5; APA, 2013) diagnostic criteria for PTSD include:

1. A history of exposure to a traumatic event that meets specific stipulations
2. Symptoms from each of four symptom clusters—intrusion symptom cluster
3. Avoidance symptom cluster
4. Negative alterations in cognitions and mood
5. Alterations in arousal and reactivity symptoms

6. Duration of symptoms
7. Assessment of functioning
8. Only symptoms not attributable to a co-occurring substance abuse or co-occurring medical condition

There is also a delayed expression of symptoms and dissociative subtype of PTSD. Secondary traumatic stress (STS) and traumatic stress are examples of stress. Traumatic stress is the demand to act that is experienced by those in harm's way. STS is the demand to act to understand and help those in harm's way; indirect exposure to trauma through experiencing compassion and empathy for the suffering.

Fatigue

Defined for our purposes as a noun, *fatigue* means weariness from bodily or mental exertion. It is a state of being exhausted with the ability to recover and spring back. In the context of the field of physiology, *fatigue* means a temporary diminution of the irritability or functioning of organs, tissues, or cells after excessive exertion or stimulation (Dictionary.com).

Compassion Fatigue (CF)

CF is caused by an unchecked buildup of compassion (secondary traumatic) stress. This buildup of secondary stress resulting from day after day of feeling cumulative stressors from delivering human services to suffering clients. This buildup of the emotional residue of energy from exposure to client suffering takes a toll of the practitioner. Moreover, the toll increases with more stressors from the memories of past trauma, the overexposure to the suffering, and life's unexpected stressors.

Resilience

Resilience is defined for our purposes as the ability of a human service worker to spring back into their old selves following a work-related incident or any highly stressful event or setback. Resilience is the indicator of numerous human resources that, together, enable the worker to overcome challenges, including the emotional upset from providing direct client services. How well a worker bounces back from being attacked by a patient, for example, or having to give heartbreaking news (p. 390) to a family member of a client, is an indication of the worker's resilience. The popularity of the concept of resilience was influenced by the thinking of George Bonanno (2004). He asserts that, as a field of study, psychology has underestimated the human capacity to thrive even after extremely aversive events. He calls for a paradigm shift from a deficit model of psychopathology and

viewing clients by their diagnosis; a shift to a more neutral or positive approaches that focus on health, wellness, rehabilitation, and resilience.

Most recently, Hobfoll, Stevens, and Zalta (2015) suggested that the concept of resilience is critical to understanding the entire stress reduction and management process. Bonanno, Romero, and Klein (2015) delineated several key elements emerging from the literature that would guide stress resilience research. These include, for example, not only quantifying resilience at the individual level of functioning, but quantifying stress at the familial and community levels. This has been attempted in the context of disaster capacity and functioning markers (Ferrira & Figley, 2015).

Compassion Fatigue Resilience

More specific to the current discussion, *compassion fatigue resilience* is the spectrum of resources available to the human service worker, varying from very low resilience to very high resilience. High resilience would include optimization and self-nurturance through *self-care, detachment, sense of satisfaction,* and *social support*, which are considered the resilience or "protective" factors. This form of resilience offers adaptation and coping as well as resistance to STS. As a result, the trauma-exposed person can develop into a confident, caring, competent, and efficient worker and social being. CF resilience is reached when one's *compassion core* (empathy for client, self, and colleagues) is honed and built (Harrison & Westwood, 2009). It results in an exquisite form of empathy that is protective and invigorating. Thus, the focus is on the protective factors such as self-compassion that increase CF resilience.

This focus on quantifying resilience is consistent with our CFRM. Though the model focuses on the individual, it takes into account the systemic and community implications by calculating individual vulnerability to the distress experienced by human service providers that may lead to poor performance, and the overall resilience of the community the providers serve.

The Compassion Fatigue Model

The CFRM is a potentially useful theoretical tool for predicting who will become vulnerable to burnout, CF, and vicarious trauma. CFRM applies to all human service workers, a category that includes social workers, psychologists, nurses, and physicians; all provide human services in direct contact with the clients to help improve their lives (Woodside & McClam, 2011). The model represents the current understanding of the primary risk factors for developing CF. At the same time, the model is a road map for helping those helping the traumatized, for it links risk factors with associated protective factors that practitioners can cultivate to increase their CF resilience. The CFRM presented here improves upon earlier versions (Figley, 1995), a reflection of increased

experimental research and theoretical contemplation. The original CF model was developed to account for the variance in CF and revised later to focus on treatment (Figley, 2002a).

Figure 28.1 (Figley & Ludnick, in press, 2016) explains both the causes and the antidotes for CF. The diagram suggests that the variables that are more amenable to lowering and managing STS are the four boxes encased in dotted lines that offset the impact of CF (self-care, detachment, sense of satisfaction, and social support). In contrast, four variables add to elevations in STS and a lower CFR score. Empathic response requires the practitioner to experience empathy and compassion for the client under the practitioner's care.

According to the model, a practitioner with high CF resilience has the ability to withstand considerable distress of others; whereas the practitioner with low CF resilience experiences symptoms of distress and distraction associated with CF and has difficulty witnessing another's suffering.

Considered from left to right, the model starts with the importance of the empathic response, as noted earlier. To generate the proper empathic responses requires the human service provider to be willing and able to work directly with the suffering clients with sufficient empathic ability and concern.

This model accounts for how and when compassion stress leads to CF, and the role of resilience simply follows the model. Specifically, the four variables that together account for the quantity of compassion stress—(1) empathic response-related stress; (2) trauma memory–related stress, (3) overexposure to trauma-related stress, and (4) stressful life events–related stress—are modulated and potentially counterbalanced by the seven CF *protective* factors. (p. 391) The challenge, then, is to apply the right empathic response for the appropriate client at the right time. This combination of skill and empathy represents the art (rather than the science) of counseling and helping others (Figley, 1989). Each of the four sectors and 11 variables will be considered in more detail later.

Click to view larger

Figure 28.1 The Compassion Fatigue Resilience Model.

Exposure to Suffering

The exposure factor is to the degree to which the workers interact directly with suffering clients who seek their services (Figley, 1995). Karademas (2009) noted that exposure to suffering is the first pathway to *compassion stress*. Those who avoid or minimize trauma caseloads reduce their risk (protective factor). Those who work with people who are suffering experience impaired cognitions directly and through decrease in positive mood. It seems that an "in vivo" exposure to human suffering activates a cognitive and emotional reaction, which affects evaluations about self and personal well-being (Karademas, 2009). The case example provides an example of how human service workers can develop tunnel vision, ignoring all else but their job in dealing with suffering, sometimes even forgetting to breathe.

Empathic Concern

In this context of what accounts for effective interpersonal response toward suffering clients, *empathic concern* (Davis, 1983) is defined as the worker's explicit, high level of compassion and interest in helping clients meet their goals as needed. Schroeder, Dovidio, Sibicky, Matthews, and Allen (1988) found in an experiment with subjects exposed to strangers in distress (not clients) that concern about another person's distress rather than about one's own emotional state can be the primary motivation for helping. Empathy is the primary mechanism of appropriate response to suffering, both as a person and as a professional.

Because of this innate and universal importance, empathy is therefore a very significant pathway to STS. Specifically, without empathy generally and one's empathic concern specifically, no secondary stress would be generated, because there is insufficient emotional resonance or connection between humans.

Empathic Ability

Empathic ability refers to a person's ability and proclivity to recognize suffering in others (Batson, 1990; Figley, 2002c); to adapt to and understand another person's position, emotions, needs, and pain, which enables service providers to enact just the right empathic response required. Empathy and empathic concern have the ability to both protect and harm (Salston & Figley, 2003). Empathic (p. 392) ability or accuracy is fully engaging with the client through understanding the client's pain and suffering. These accurate, raw data are critical for accurately assessing and determining the best

treatment plan to enable the client to recover and to recognize when recovery happens (Figley, 2002c).

Those who work with the traumatized recognize that being a healer is a huge responsibility. Empathic ability enables the healer to effectively read emotions of the traumatized client and anticipate and respond to their special sensitivities, such as being susceptible to re-traumatization, and thus to avoid doing harm by the very treatment designed to undo harm (e.g., iatrogenic impacts) (Boscarino et al., 2004). Attending to the special needs of the traumatized in delivering all types of services is consistent with trauma-informed care (Hopper, Bassuk, & Olivet, 2010) that is emerging nationally and internationally in all aspects of human services, with special attention to empathy-centered service-delivery goals.

Empathic Response

The *empathic response* by a caregiver to a client is a response that is informed by the caregiver's empathic ability when exposed to the suffering at a high level of concern for the client. It is a caring response that is the precisely correct response to the client to effectively help the suffering client. The empathic response requires establishing and maintaining the trust and sense of safety of the suffering client, and it is the key ingredient in all effective human services. A meta-analysis (Greenberg et al., 2003) found a statistically and clinically significant relationship between empathy and positive therapeutic outcomes.

Also, the empathic response is the key pathway for experiencing compassion stress and, with time, CF. Human beings are strongly motivated to be connected to others (Batson, 1990). Empathic response is the quality of responding, of making an effort to meet a client with empathy, insight, and caring (Figley, 1995c). The empathic response is informed by empathic concern and empathic ability. When providing an empathic response, the worker is projected into the distressed client's position, even experiencing their fear or suffering. Over time, constant empathic responses can have a numbing effect on workers and elicit compassion stress (Figley, 1995c).

Compassion Stress

Compassion stress is the demand to be compassionate as perceived by the human service worker. The level and chronicity (how long it is sustained without relief) of stress is directly associated with the level of CF resilience. The risk factors increase stress and lower CF resilience, and the protective factors reduce the stress and increase resilience. These risk factors are noted later.

Traumatic Memories (Risk Factor)

The concept of *traumatic memories* is defined here as memories of past traumatic events that remain linked to triggers (reminders) and often lead to a cascade of negative images and accompanying unwanted emotions. These are markers, symptoms that are critical to an accurate assessment or diagnosis and the subsequent treatment plan. Traumatic memories of practitioners are no different from those of (their) clients. Our traumatic memories—both as clients and as practitioners—have an impact on our functioning. Traumatic memories are the person's own trauma recollections that could take the form of the practitioner's personal trauma history or traumatic memories from previous client dealings (Figley, 2002c). These memories have the potential to be reactivated and to cause further distress, anxiety, or depression.

Prolonged Exposure to Suffering

A sense of *prolonged exposure* in this context means "an ongoing sense of responsibility for the care of the sufferer and the suffering, over a protracted period of time … associated with a lack of relief from the burden of responsibility, and the inability to reduce the compassion stress" (Figley, 2011, p. 253). This constant exposure and repeated empathic engagement leave behind harmful cumulative emotional energy that includes self-doubt about one's competence as a practitioner, and other doubts and stress reactions. If left unchecked, this cumulative emotional pain and negative energy can wreak havoc with the affected person, be they client or caregiver (Radey & Figley, 2007).

Other Life Demands

This term refers to the stressors from outside work that sometime invade one's work life, such as changing jobs, moving, and other changes of schedule and status, including divorce and the death of a child or spouse (Holmes & Rahe, 1967). These are life situations that demand attention and can temporarily disrupt functioning (Figley, 2002a). Unexpected changes in routine/schedule and managing demanding responsibilities—such as financial difficulties, changes in social status, (p. 393) illness, and added obligations—could add strain. Certain life changes, however, in combination with the other variables in the model, affect compassion stress (Figley, 1995) and subsequently CF. To the over-extended person, an unexpected minor event can seem catastrophic and insurmountable, whereas it would hardly cause a stir in a prospering individual.

Self-Care

Self-care is defined as the successful thoughts and actions that result in improving or maintaining one's good physical and mental health, and a general sense of personal comfort. Alternatively, Gantz (1990, p. 2), noted a panel of 15 experts in self-care were unable to reach consensus on a definition but were able to agree on four characteristics of self-care. Among other things, these characteristic included self-care: (a) being

situation- and culture-specific; (b) having the capacity to act and to make choices; (c) being influenced by knowledge, skills, values, motivation, locus of control, and efficacy; and, (d) focusing on aspects of healthcare under individual control (as opposed to social policy and legislation). For human service providers, the optimum self-care program would enhance overall resilience because of the overlap of characteristics associated with resilience and self-care (Barnett, Baker, Elman, & Schoener, 2007). Both are ways of defining the readiness of a person to adapt to any situation and cope with any new stressor.

To be more effective, human service providers must balance work stress and self-care (Figley, 2002a). While attending to heavy client caseloads, they frequently fail to perform the basics of self-care, which include, for example, (1) effectively monitoring nutrition and drink; (2) managing to experience good sleep and rest; (3) maintaining access to social support; (4) regularly experiencing a sense of joy in life; and (5) regularly engaging in some form of physical exercise. Effective self-care enhances resilience generally and CF resilience in particular, as argued in this chapter. Moreover, self-care is associated with post-traumatic growth (Tedeshi & Calhoun, 1996). It is not surprising that Kulkarni, Bell, Hartman, and Herman-Smith (2013) found that greater time invested in self-care was unequivocally associated with lower levels of stress. They concluded that commitment to self-care held a lot of protective potential against STS. Similarly, Newsome, Waldo, and Gruszka (2012) found that poor self-care can lead to poor performance and difficulty adapting to setbacks.

Detachment

Viewed from the perspective of a human service worker, having *detachment* means being able to take a mental and physical break from the work—especially the most troubling and difficult parts. Because it serves as a resource for the worker in modulating the level of work stress for maximum performance, we support the early view of Figley (1985) that detachment is a protective factor. Sonnentag and Fritz (2014) and colleagues have found that recovery from work, a form of purposeful detachment (from work during off-hours) is important in lowering job stress. Not everyone shares the same ability and motivation to detach, but it is often included in a comprehensive self-care plan.

Research on the role of professional disengagement from traumatic materials had been quite sparse until recently (cf. Sonnentag, Arbeus, Mahn, & Fritz, 2014). Recent evidence was found that those suffering from PTSD often have difficulty disengaging from the trauma memories (cf. Aupperle, Melrose, Stein, & Paulus, 2011). The practitioner also has difficulty disengaging from trauma memories. This inability to disengage from traumatic materials often hinders the individual from attending to aspects such as family, friends, positive emotions, and pleasurable activities, which in turn perpetuates the emotional numbness and depressive symptoms so often seen in the aftermath of trauma exposure.

Social Support

The concept and variables of social support have been studied for a generation. In 1985, more than 30 years ago, Kessler, Price, and Wortman published “Social factors in psychopathology: Stress, social support, and coping processes” for the *Annual Review of Psychology* for that year. They cited the pioneering work of Dohrenwend and Dohrenwend (1974), who started the interest in social support in the context of coping with stress.

Social support is among five protective factors that enhance compassion stress resilience and lower CF (Figley, 2002b). Some have argued that social support represents the essence of being human. Hirsch (1980) suggested that social support was the perceived support one receives if, in times of need, you seek out and succeed in acquiring emotional support, advice, tangible aid, companionship, and encouragement and was the basis of the frequently used Purdue Social Support Scale (Figley, 1989). Eriksson, Vande Kemp, Gorsuch, Hoke, and Foy (p. 394) (2001) found social support to significantly determine psychological adjustment in international relief personnel after trauma exposure or hearing about traumatic events. Social support acted as a buffer, especially in the workers with high levels of trauma exposure. Lerias and Byrne (2003) asserted that social support is a crucial factor in bolstering one’s ability to deal with trauma exposure.

Compassion Satisfaction

The term *compassion satisfaction* emerged from the work of Beth Stamm (2009). She found that practitioner scores on their ProQOL Survey (measure of CF) indicated that, among others, compassion satisfaction was a protective factor associated with lower levels of STS that leads to CF. Stamm originally defined compassion satisfaction as the pleasure you derive from being able to do your work well. These pleasant thoughts are associated with hope and a sense of accomplishment. In the first case study presented here, Sasha derived thrilling satisfaction from most of her clients, including her first clients in her clinical placement in graduate school. Much of her satisfaction was derived from her believing in the worth and abilities of her clients enabled by her care. This was why she felt so baffled and guilty after the assisted suicide event; that she had somehow failed in her duties. Next, we introduce you to Chaplain Bob Gomez, our second case study whose experience is quite different from Sasha’s.

Case Study #2: Bob Gomez, MS, CPC

Bob Gomez joined the U.S. Army as a captain in 2002 after he completed his master’s degree in religious studies. He learned to be an Army chaplain on the job. He had finished his undergraduate degree and went immediately into his master’s of science program in chaplaincy with no practice experience, other than a brief internship. He was not

concerned: His focus was on God's guidance. Bob was soon promoted to major and responsible for supervising five Army chaplains in his Army battalion at Ft. Hood. Then they were deployed to Iraq. His sense of inadequacy increased as he worked with the chaplains who were older and more experienced than he. He found out that his education was inadequate and interpreted his professional failures as his failing God.

As it turned out, Chaplain Bob was not very adept at reading people. He was far more comfortable with books than with people. He struggled in his clinical chaplaincy internship. He had difficulty accurately summarizing the feelings and positions of his clients because he lacked empathic ability, as noted by his supervisors. "Bob was more of a thinker than a talker," one observed. However, his day to day work required little therapeutic skill until their battalion began to be struck by Iraqi insurgents, which required additional troops. This placed considerable pressure on the chaplains, and for a short time, it forced Chaplain Bob to provide chaplain services to the men in his unit. All three of these (soldier) clients were experiencing a fear response from different stressors for different reasons that were puzzling to Bob. In the evenings, Bob obsessed over the situations of the clients he had seen that day. He was unable to sleep soundly. The next day he was tired and wary of another day of new clients and their spiritual and clinical challenges. There was no one particular soldier that led Bob to experience compassion stress and it was no one symptom. It was, as he explained it, "a numb feeling"; a sense of hopelessness in being able to help, and an inability to answer the call for help effectively.

Applying the CFRM to Bob's case, he was not interested in working in direct practice because he was not sure how to help; nor did he want to make the effort. As a result, he found himself caring much less. He justified this shift by saying he was not much of a "people person." Because Bob did not engage clients by being either empathic or especially compassionate in a feeling kind of way, he was not vulnerable to compassion stress that would lead to CF. He was initially numb and he put aside his feelings and those of his clients and supervisee chaplains.

Bob was different than Sasha in other ways. His social support was good enough. His compassion satisfaction was near zero, but he was not disappointed, nor did he expect that compassion would bring him satisfaction in the first place. Bob was a master at depersonalization and compartmentalization. His stress level was at the moderate level most of the day because he knew how to isolate himself from others and their needs. He tried to appear compassionate. He derived little satisfaction from delivery of human services because of some bad experiences in his clinical training. His clients had reported dissatisfaction with his lack of compassion to his supervisor but with no suggestions for improvement. He did not have CF, because he seldom turned on his compassion. It came on from time to time, accompanied with bouts of uncertainty and stress.

(p. 395) The Compassion Fatigue Resilience Model in Action

Mindful of the differences evident in the cases of Sasha and Bob, we now more closely examine the CFRM's 12 variables associated with CF resilience in light of their case studies. In the case of Sasha the social worker, she has always had empathic ability: It was one of the reasons she knew she was a good social worker. Although she had some bad days, she looked forward to going to work every day to face suffering and sad patients and their families, and she had the requisite empathic concern. Her empathy enabled her to hear what patients and family members said to her and to formulate almost effortlessly the right empathic responses through her kind and caring ways.

The empathic response directly affects the level of compassion stress because the worker is expected to take in information about the patient and their family that is disturbing. Thus Sasha's exposure to human suffering activated a cognitive and emotional reaction, which affected her evaluations about herself and her personal well-being.

Compassion stress can be exacerbated or diminished by other variables, in addition to the empathic response, including prolonged exposure to suffering, other life demands, and traumatic memories. In Sasha's case, she took insufficient breaks during the day and often skipped lunch or ate with colleagues who would talk about work, removing the rest that might have mitigated her high stress. She tended to take short vacations and experienced considerable life demands other than work. Personal matters taxed Sasha further. In contrast, Chaplain Bob had few distractions in Iraq. He had his "room," a portion of a tent, his assignments, and a considerable amount of free time.

According to the model, the opposite of risk factors are four protective factors that reduce the compassion stress and enhance resilience: *self-care, detachment, compassion satisfaction,* and *social support*. Sasha was fortunate in knowing about and practicing self-care. She learned how to develop and maintain a self-care plan that included good nutrition, a reasonable and sustainable exercise program, and a wide variety of interests and activities that were relaxing and that helped her avoid thinking about work. She learned in her initial years as a social worker to compartmentalize and detach from work as needed to provide the breaks from the grind and to become revitalized, especially after work hours. Sasha drew great satisfaction from working with the dying and their families, and she won numerous awards from her employer and field as well as dozens of letters of appreciation from surviving family members. Finally, Sasha had considerable social support both at work and at home and turned to her trusted others for encouragement, companionship, advice, and inspiration.

Toward a Mechanism Accounting for Compassion Stress and Resilience

Human service delivery of an empathic response requires workers to think deeply about their clients; to reach the right decision about how best to approach, help, and complete work with each new patient. There is considerable guidance available from employee training, supervision, and peer coaching to enable a worker to adhere to standards of practice in the assessment, treatment, and recording of data for each patient. There is little or no guidance in self-care and thriving the human services demands. In order to perform important human services, the worker must have the ability to empathize and be compassionate in thought and behavior toward the customers and their families. Thus, poor empathic responses are bad for customers and their families. At the same time, what may account for poor empathic responses may also be protective against high compassion stress and fatigue.

Three factors that account for poor empathic responses are the worker's (1) low empathic ability (negates any negative impact of formulating and delivering a useful empathic response); (2) avoidance of the traumatized (and thus not being exposed to the emotionality and suffering); and (3) lack of interest in serving the traumatized (and therefore not applying empathy toward the traumatized).

On the other hand, these same indicators can serve as protective factors against high compassion stress and fatigue. After all, there is little or no emotional incentive to become upset about clients if the healthcare worker does not empathically engage with them. Bob is a good example of such a worker. As his clinical skills emerged from additional training and experience, he began to recognize that client criticism in the past was more hurtful than he had admitted. His sense of burnout and ambivalence about working with the suffering eventually went away.

To survive as a social worker, Sasha needed the protective factors suggested in the model in Figure 28.1: social support, self-care, detachment, and compassion satisfaction. Bob, however, expended little energy regarding his empathy because it amounted to such a small part of his persona. He was better (p. 396) than Sasha at self-care. He had an excellent ability to detach in part to provide better self-care. He derived little satisfaction from delivery of human services because of some bad experiences (feedback from clients). This may be why he had never sought out direct practice experiences. He learned early in his graduate education and training that being empathic with people did not come easily to him and was not appreciated by the client when delivered.

Prevention of Compassion Fatigue

The first step in lowering compassion stress and, thus, preventing CF is to recognize the signs and symptoms of CF. Workers need to be mindful of the presence of numbing, startle response, intrusive thoughts, nightmares, insomnia, anxiety, and avoidance of situations (citation?). Conscientious monitoring of both the worker's work environment and personal life needs to be implemented to address the buildup and continuation of CF (Bride & Figley, 2009).

The next step is to develop a plan for lowering or eliminating the symptoms. As noted in the model, the lower the compassion stress levels, the lower the prospects of developing CF. Moreover, human service workers who have experienced the consequences of compassion stress may take some degree of comfort from the fact that this form of stress is not an indication of some pathological weakness or disease or personal failing. Rather, the symptoms are a call for action by leadership and workers, and a natural consequence of providing care for traumatized individuals.

Preventing CF means increasing the worker's resilience. Increasing their resilience means, among other things, attending to the variables that can increase resilience, consistent with the description of the mechanism of CF resilience. Resilience to CF and other work-related, unwanted distress markers demands a combination of skills, aspirational mantras, level of compassion satisfaction, and CFR, along with post-traumatic growth (Tedeshi, & Calhoun, 1996) and self compassion (Neff, 2003), as noted elsewhere in this volume. It is the combination of capabilities that enables the compassionate to also be extremely competent and effective at what they do in working with the traumatized. Designing programs that facilitate the development of CF resilience in all those who work with the traumatized enables trauma workers to thrive in the face of emotionally toxic stressors.

Compassion stress is preventable, highly responsive to treatment, and oftentimes needs very little effort to be ameliorated (Figley & Figley, 2001; Figley, 2011). The CFRM suggests that compassion stress can be effectively monitored and lowered to prevent CF by boosting the known protective factors and reducing the risk factors, and therefore, elevating resilience. No study has specifically tested this assertion. There is, however, considerable research on the positive impact of social support, across a spectrum of measures, for enhancing the sense of well-being and life satisfaction and personal comfort (cf. Hirsch & Barton, 2011). The studies that helped build and verify this model helped pave the way to understanding resilience, and especially CF resilience. The first step, however, in testing and being guided by the model in any community not yet studied, is to calibrate the measures of variables to fit the culture.

This chapter is about compassion for the compassionate. In hearing the story of Sasha and Bob, you might wonder about them and the quality of care they dispense. They represent tens of thousands of workers in the U.S. and many more throughout the world. They represent real people engaging in the emotions of dozens of people, sometimes

many more than that, per week. Through their efforts and sense of purpose and ethics, they are dispensing kindness and compassion. And we are all the better for it.

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Notes:

(1.) We explain these terms more fully in the Definitions section.

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