

COMPASSION FATIGUE RESILIENCY – A NEW ATTITUDE

Compassion Fatigue Treatment & Resiliency – Programs with Legs: The ARP, CFST & CF Resiliency Training

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We must be willing to fail and to appreciate the truth that often
'Life is not a problem to be solved, but a mystery to be lived' Peck, 1978

Yesterday I spent several hours walking through the fluffy snow with my dog. It was a well deserved break from a demanding schedule. A few hours to decompress in quiet, engaged in an activity that I know works to relax my body and soothe my mind. But at the end of the walk, I was not entirely settled. Knowing this, reminds me of the very delicate balance we all live. I pride myself in knowing the edge of my strain and when it begins to feel like stress and what I can do to accommodate to the load. But what happens when we tip over in a world shattered by trauma or where too many things have gone wrong too quickly and we cannot regain our balance fast enough. In those times the demands are so acute that finding calm is not an easy goal (Baranowsky & Lauer, 2012). Even the best of us strain at the edges when our internal resources simply do not provide enough balm to deal with the last client who we did not help enough, or the emotional weight of a story with too many painful edges or familiar pain.

We have journeyed a long way since 1997 when we first developed the Accelerated Recovery Program for Compassion Fatigue (Gentry, Baranowsky & Dunning, 2002). The ARP was inspired by Figley's (1995) pivotal release of "Compassion Fatigue as Secondary Traumatic Stress Disorder". At that early stage of research and reflection on this new construct, helpers in every profession rallied around the idea that there could be an emotional cost to care giving work. It spoke loudly to those who struggled with the gravitas of caring for those who were seriously injured, emotionally scarred or devastated by illness or loss.

Compassion Fatigue, Secondary Traumatic Stress, Burnout, Vicarious Traumatization are all terms that help us appreciate the deep impact of working with people who have faced terrible things (Najjar et al. 2009; Devilly, Wright, & Varker, 2009). Compassion Fatigue is an experience of secondary wounding in caring for trauma survivors that leaves the helper feeling as if they faced the injury on a personal level. Emergency responders, mental health practitioners, family practitioners, lawyers, journalists, librarians, veterinarians, nurses, red cross volunteers and every hero who stands beside a man, woman, child or animal who has faced tragedy and trauma personally can experience Compassion Fatigue (Rank, Zaparanick & Gentry, 2009; Meadors, et.al., 2009).

Compassion Fatigue can leave the sufferer feeling depleted, embarrassed, confused, angry, withdrawn, anxious and depressed along with so many other emotions (Showalter, 2010). In fact, in the early development of the ARP, we recognized that the symptoms of Compassion Fatigue were remarkably similar to Post-Traumatic

Stress (American Psychiatric Association, 2000; Friedman, et. al., 2011). This led us to search for interventions within the trauma care field that were demonstrated as efficacious in the literature. Approaches that seemed fruitful were selected for trial within the ARP (Dietrich, et. al., 2000). Early outcome among mental health professionals who worked with trauma survivors was encouraging (Gentry, 2000; Baggerly, Gentry & Baranowsky, 2004).

Since our early work in 1997, we have taught 1000's of clinicians to offer the ARP (Compassion Fatigue Specialist/Therapist Training) to others and worked directly with many more individuals through their Compassion Fatigue recovery (Gentry, Baranowsky & Dunning, 1997; 1999; 2002). On the heels of this successful application of treatment we developed the Certified Compassion Fatigue Specialist Training (CFST) in 1998-99 (Gentry & Baranowsky, 2011; Baranowsky & Gentry 2011a, 2011b) to teach other health professionals to utilize the ARP in their practice. This training was well received and well attended for several years. As we increasingly received reports about how valuable and useful the training had been to the *participants*—not just their clients—we began to ask ourselves: Is the CFST training an effective *treatment* for the symptoms of Compassion Fatigue? With a scientific curiosity, we began collecting data to evaluate this *training-as-treatment* phenomenon and answer this question.

We indeed found that the CFST was an effective treatment for the symptoms of Compassion Fatigue both immediately after the training and at follow-up (Gentry, 2000; Baggerly, Gentry & Baranowsky, 2004). Enthused with these findings and subsequent publications, we noticed that not only were people who had participated in our training reporting relief from their Compassion Fatigue symptoms, they were also remaining symptom free and resilient months and years following the training. By 2001, we were just beginning to notice the prevention and resiliency effects, or the trickle effect resulting from our trainings when the events of September 11th occurred. This spurred on efforts that continue today.

The reality of this work is the recognition of the ongoing trickle. From the early work of Dr. Figley, through to the development of the ARP in 1997 these efforts continue to have a positive rippling effect throughout the helping field and beyond. The work continues to spread through individual, group and community interventions as well as on demand E-Learning programs (<http://www.ticlearn.com>) and in CD or MP3 Self-Guided Compassion Fatigue Resiliency approach (Baranowsky & Gentry, 2010). We have both worked with individuals who have confessed a belief they could never return to their work because of emotional and physical depletion. Yet these same people went on to recover and continue to make meaningful contributions in their communities and beyond. What we now know is that there is something different among those who truly recover. They take on the mantle of self-care and self-compassion that allows them to build reserves through good daily practices and to replenish when they feel the edges of their own strain before they arrive at the breaking point. They have learned that this approach is a necessity and not a luxury item (Gentry, 2001; Mathieu, 2012a, 2012b).

The reference to a “Program with Legs” is really all about the journey we have taken over the years of training clinicians in this approach and the power of the “train the trainer” workshops. Every time we offer the program it continues to pay forward to those in need, to spin off creative endeavors and to inspire self-care everyday in small and large ways. It is simply not enough to have a walk in the woods today. Instead good daily practices are a necessity bringing the reality of our human frailties into our work so that we see with deep accuracy and self-compassion the need for self-care and conscious caring for those around us and for the everyday hero's who care for others. It is about how we walk in our lives every day and how this allows us to

remain strong resilient and able to continue with our work (Mathieu, 2012a, 2012b).

The final section of this chapter focuses on the importance of daily resiliency practices and the need for prevention as a means of ensuring a long, happy and healthy work life balance. This section goes the journey from a pivotal experience; Disease as the absence of effective antibodies; as well as the development and provision of Compassion Fatigue Resiliency training. It is within the resiliency/prevention training that Compassion Fatigue care truly takes on a new life. Here we focus on Self-Regulation, Intentionality, Perceptual Maturation, Connection and Support, as well as Self-Care and Revitalization as key components for long-term well-being within the care providing fields and beyond.

The primary focus of the ARP program was always the facilitation of a recovery process for compassion fatigued helpers. Although there will always be a place for programs to help caregivers overwhelmed by their care giving role, this work has now progressed forward to include necessary prevention and resiliency models (Killian, 2008; Lauvrud, Nonstad & Palmstierna, 2009; Tosone, Bettmann, Minami & Jaspersen, 2010). In doing so we hope that there will be more focus on resiliency within organizations, among individuals and throughout professional training schools.

COMPASSION FATIGUE PRIMER

Compassion Fatigue (CF) (Figley, 1989, 1995) is the convergence of primary of traumatic stress, secondary traumatic stress (Landry, 1999; Stamm, 1995, 1997, 2005) and cumulative stress/burnout (Maslach, 1982) in the lives of helping professionals and other care providers. Secondary Trauma occurs when one is exposed to extreme events directly experienced by another. Burnout is a state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's everyday environment (Figley & Kleber, 1995; Friedman, 2000; Baranowsky & Gentry, 2011a, 2011b). When helping others precipitates a compromise in our own well-being we are suffering from Compassion Fatigue. "By understanding . . . Compassion Fatigue, [as] the natural, predictable, treatable, and preventable consequences of [caregiving] we can keep these caring professionals at work and satisfied with it" (Figley, 1995).

According to Figley (2002), Compassion Fatigue is:

A state of tension and preoccupation with ... traumatized patients [characterized] by re-experiencing traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g., anxiety) associated with the patient (p. 3).

The symptoms of Compassion Fatigue can mimic, to a lesser degree, those of the traumatized people we are working with (Bourassa & Clements, 2010). Vicarious traumatization (Clemens, 1999; McCann & Pearlman, 1990) is a related term that also depicts the phenomena of trauma transmission resulting from secondary trauma exposure and/or "bearing witness" to the stories of traumatic events. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and is overwhelmed by this secondary exposure to trauma (Figley, 1995) hypothesized that the caregiver's empathy level with the traumatized individual plays a significant role in this transmission. The Baranowsky and Gentry model includes the conceptualization of primary traumatic stress as a latent vulnerability to Compassion Fatigue or Secondary Traumatic Stress (STS) (Baranowsky & Gentry, 2011a, 2011b; Bonanno, Brewin, Kaniasty & LaGreca, 2010;

Gentry & Baranowsky, 2011; Rosenheck & Nathan, 1985; Solomon, 1990; Solomon, Kotler, & Mikulincer, 1988). Mathieu (2012b) briefly outlines research problems linked with a glut of terminology used to describe the impact of caring for trauma survivors. Based on a recent literature review, Mathieu (2012b) described Compassion Fatigue lifetime occurrence rates among helping professions to range between 40% to 85% lifetime.

Burnout, or cumulative stress, is the state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's environment resulting from our responses to the on-going demand characteristics (stress) of our daily lives (Maslach, 1982). Baker (2012) explains that "prolonged exposure to a stressful and demanding environment is structurally conducive to burnout". High levels of cumulative stress in the lives of caregivers negatively affects resiliency consequently leaving them more susceptible to Compassion Fatigue. The Silencing Response (Baranowsky, 2002; 2012; Danieli, 1984, 1996) is an inability to attend to the stories or experiences of others and instead to redirect to material that is less distressing for the professional. This occurs when another's experiences and stories are overwhelming, beyond our scope of comprehension and desire to know, or simply spiraling past our sense of competency. The point at which we may notice our ability to listen becoming compromised is the point at which the silencing response has weakened our efficacy.

Secondary traumatization and burnout, the two components of Compassion Fatigue, affect most every caregiver at some point in his or her professional cycle leaving them too challenged to reach out for help a difficult position for many care providers to be in (Mathieu, 2012b). Fear of judgement, reprisal, or ridicule; fear of exposing oneself; illusions of omnipotence and difficulty trusting other professionals seem to contribute to the silencing response and often prevent us from reaching out for the help we need.

Figley (1996) defined 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 (burnout)." (p. 11)

Those familiar with the diagnostic criterion for PTSD (to be upgraded shortly in the May 2013 release of the DSM-V) will see the clear link between PTSD and CF (American Psychiatric Association, 2000; Friedman, et. al., 2011). The primary categories are described as: 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 hypervigilance, sleep disturbances, irritability and anxiety. These symptoms combine to form a state of physical, emotional, cognitive and spiritual volatility in traumatized individuals, families and groups (Janet, 1889; van der Kolk, 1996) and are hypothesized to encompass the primary Compassion Fatigue symptomatology (Killian, 2008; Showalter, 2010). Burnout further compromises one's resistance to CF and undermines tolerance to trauma exposure. Persons who work closely with traumatized groups and individuals are vulnerable to the contagion of this volatility. Although some caregivers appear to be more resilient than others any caregiver who continually works with traumatized individuals is vulnerable to feeling overwhelmed at some point in his or her professional life.

Since the release in 1995 of Figley's pivotal book on Compassion Fatigue 100's of articles and research papers

have been published. In fact, 1,034 items appeared in a comprehensive bibliography compiled by Stamm (2010) on Compassion Fatigue and related terms with a surprising 250,000 accurate hits on Google. The research in this area and the results suggests that Compassion Fatigue is a very real concern and one that may result in diminished capacity to function at work, home, and within personal relationships. Much of the early research on Compassion Fatigue focused on psychotherapy as emotional contagion passed from client to clinician, other professionals, community members, family, friends and co-workers are impacted (Baranowsky, 2012; Baranowsky, 2002; Baranowsky et al., 1998; Bloom, 1997; Danieli, 1985, 1996; Mathieu, 2012). Professionals other than therapists, psychologists, and psychiatrists who also vulnerable to the effects of Compassion Fatigue include physicians, nurses, other physical healthcare professionals, police, legal council, clergy, emergency service responders, CISD members, journalists, trauma researches and other individuals or materials related to extremely disturbing events.

Other target symptoms of Compassion Fatigue include:

- Increased negative arousal
- Intrusive thoughts/images of anothers' critical experiences (or caregiver's own historical traumas)
- Difficulty seperating work from personal life
- Lowered frustration to tolerance. Increased outburts of anger or rage.
- Dread of working with certain individuals
- Depression
- Perceprive/"assuptive world" disturbances (i.e., seeing the world in terms of victims and perpetrators coupled with a decrease in subjective sense of safety)
- Ineffective and/or self-destructive self-soothing behaviors
- Hypervigilance
- Decreased feelings of work competence
- Diminished sense of purpose/enjoyment with career
- Reduced ego-functioning (time, identity, volition)
- Lowered functioning in nonprofessional situations
- Loss of hope

These symptoms constitute an interconnecting weave of responses or behaviors that warn us of Compassion Fatigue. They may appear singly or in combination with other symptoms. Any of these symptoms could signal the presence of Compassion Fatigue.

Stamm's (2005) Professional Quality of Life Scale (ProQOL) was based on an original Compassion Fatigue Scale developed by Figley (1996). The ProQOL does an excellent job of capturing the core features of Compassion Fatigue; Compassion Satisfaction and Burnout. Her scale construction and psychometrics are well thought out and demonstrate the features of a reliable instrument. At this time the ProQOL is the most utilized scale for capturing Compassion Fatigue in research studies as well as in clinics and programs. We have now adopted the use of the ProQOL within the ARP program. The manual is available online at <http://www.compassionfatigue.org/pages/ProQOLManualOct05.pdf>.

15 YEAR OVERVIEW

More than 15 years have passed since we met with our first Compassion Fatigue clients and held our first CFST

group. We have worked with a variety of organizations (i.e., 911 Officers; Nurses; Physicians; Emergency Departments; Addiction Centers; Rape Crisis Centers; Women's Shelter's; Police Department, etc.) and with various helping professionals. Over this time, we have collected a qualitative overview of key Compassion Fatigue Risk Factors.

Those most vulnerable to developing Compassion Fatigue:

- Highly dedicated individuals – the best & the brightest are at risk! (Baranowsky & Schmidt, in press; Killian, 2008; Meyers & Fine, 2003).
- Individuals expect positive feedback & work outcome. Those most at risk will work to achieve results even if it results in a risk to personal health (Shanafelt, et. al., 2012).
- High demand for personal competence. Some helpers will continue to demand the highest level of attainment even if they are already depleted (Figley, 2002a).
- Low Self-Compassion drives speed to accomplish more – Those with low self-compassion are more vulnerable to depression, anxiety and symptoms of PTSD (Thompson & Waltz, 2008; Neff, 2009).
- Tolerates exhaustion for results. Of 7,288 physicians who completed a burnout assessment, 45.8% reported at least 1 symptom of burnout. While those in frontline role (i.e., emergency, family and general internal medicine practices) were more vulnerable to burnout than workers from other fields (Shanafelt, et.al., 2012).
- Personal trauma/loss history results in increased vulnerability to symptoms (Chaverri, 2011; Baird & Kracen, 2006).
- Large & complex caseload or work demands. Overwhelmed with job demands and showing signs of burnout, workers were found to be at greater risk of compassion fatigue (Killian, 2008).
- Lack of comprehensive trauma training & CF Training (Mathieu, 2012a).
- Identifying with victims, relating to their personal stories and igniting mirror neurons or the engine of empathy (Wilson & Thomas, 2004; Gallese, 2001; Morrison, Lloyd, DiPellegrino & Roberts, 2004).
- Working in an unsupportive workplace (Van der Ploeg & Kleber, 2003; Gibbons, Murphy & Joseph, 2011) found that social workers (N=62) scored higher on job satisfaction and lower on burnout when they felt valued in their professional roles, suggesting that support in the workplace is a protective factor.
- Poorly established or unavailable social network or personal support (Killian, 2008; Mathieu, 2012a). One study found that social workers (N=154) demonstrated lower levels of secondary traumatic stress symptoms in environments with greater support from coworkers, supervisors and work teams (Choi, 2011).

We fully expect that this list of risk factors will develop further over time and encompass more fully the research in the field. What the list does help us with is recognizing the areas where the original ARP was on track and areas for further improvement in the Train the Trainer model as well as the Compassion Fatigue Resiliency Training programs subsequently developed.

WHO IT AFFECTS?

We now understand empathy to be a “Biopsychosocial” phenomenon which engages our best skills in reaching out to help others but also leaves us potentially vulnerable and overtaxed when exposed to the strain experienced directly by those we help. The remarkable work in the field of Mirror Neurons makes a striking connection between our ability to look into the eyes of another experiencing emotional or physical pain and the personal pain we may experience as a result. Two noteworthy “Youtube” videos explain both the unexpected discovery of mirror neurons and the early conclusions made by researchers (<http://bit.ly/RYdpCp>; <http://bit.ly/P5BdY1>). Although controversy remains within this area of research it certainly leaves us with a plausible explanation for the depth of feeling one may experience when bearing witness to another’s pain. So basically, anyone with a functioning capacity for empathy who engages with another person who has experienced emotional, physical distress or injury is vulnerable to Compassion Fatigue.

We believe that empathy is a primary tool that creates the platform for engagement between helpers and those they assist. Over time, working in continuously emotionally charged situations, this empathy can become overtaxed and exhausted even when the professional is diligently maintaining self-care skills.

There are two main groups of people that are typically impacted by Compassion Fatigue: 1) those who aid in a professional capacity; and 2) family and friends of those in need. Compassion Fatigue may occur in a wide range of persons involved in providing aid to others (Jay, 1991). We have found that it is most prevalent among professionals and personal family members, friends, and associates of trauma survivors (Beaton & Murphy, 1995; Baranowsky & Gentry, 2011a, 2011b; Gentry & Baranowsky, 2011; Mathieu, 2012). Therapists, psychologists, social workers, disaster relief workers, 911 operators, journalists/reporters, lawyers, nurses, doctors, emergency care professionals, police, help-line attendants, crisis shelter workers, among others, are all susceptible to Compassion Fatigue (Friedman, 2000; Killian, 2008).

THE ARP – CFST & BEYOND

Gentry, Baranowsky and Dunning (1997) developed the Accelerated Program for Compassion Fatigue (ARP) while visiting Florida State University (FSU) on a Green Cross Scholar's Project under the direction of Dr. Charles Figley. The ARP is a five (5)-session model for the treatment of the deleterious effects helpers experience as a result of their care giving work (Baranowsky & Gentry, 2011a, 2011b; Gentry & Baranowsky, 2011). Since its inception in 1997, thousands of caregivers have successfully resolved their symptoms of Compassion Fatigue and have re-created their professional and personal lives to remain resilient to these effects. The program has continued to evolve since it began with revisions to the core training and through rapid resiliency programs offered daily at numerous organizations, clinics, hospitals, training centers and in the individual lives of helpers everywhere.

Early 1997, the development team began preliminary trials with the ARP. Although the ARP was first developed as a standardized individual treatment model, offering the program as a “train the trainer” model allowed for the work to spread quickly throughout communities throughout North America. There are 1000’s of trained Compassion Fatigue Specialist/Therapists using the ARP model in most States and Provinces throughout the U.S. and Canada and now beyond. By the spring of 1999, the authors were contacted by

caregivers in Oklahoma City requesting that we create both a one-day and a three-day group model of the ARP. We were, at first, skeptical that we could condense this rich material into a group model. This led to brief Resiliency training as well as Retreat/Workshop programs.

All ARP models were designed to address prevention and treatment of Compassion Fatigue for a broad range of professionals of all types. The ARP was designed to be powerfully introspective and interactive. Its purpose was to provide participants with the raw materials to begin to develop resiliency and prevention skills from Compassion Fatigue. 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.

The ARP was designed to assist those working in high-stress/high-demand careers. However, it was never meant to be a panacea or “cure-all” but rather a step along the way of ongoing commitment to self-care, resiliency and increased self-compassion. We recognize the complexities of individuals working within helping fields and understand that this may be just a first step in a journey to gain the foundation for a long and healthy engagement in work/life and all it has to offer. We hope helpers will be able to find this work of use as a step toward their own well-being.

PRIMARY ARP PROGRAM ELEMENTS

The ARP was originally developed as a brief (five session) treatment program designed to assist professionals in reducing the intensity, frequency and duration of symptoms associated with Compassion Fatigue. Whether the program is presented to individuals, trainers, or in small to large group formats, all elements are covered. Treatment sessions are standardized and directed toward the completion of all major objectives.

Program goals include:

- Symptom identification
- Recognize Compassion Fatigue trigger
- 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
- Implement supportive aftercare plan-utilizing the PATHWAYS self-care program

ARP COMPONENTS

The ARP follows a standardized component treatment model that covers the following elements:

1. *Therapeutic Alliance* - This is especially important in a model that offers care for professionals who generally view themselves as care providers and hence are resistant to seek help for themselves. The

developers asked themselves, what does it mean for a care provider to leave his or her identification of caregiver to seek out care? It became a central tenet of the program that each individual who completed the ARP would be treated with great respect and an understanding of the unique challenge of a professional asking for help.

2. *Assessment – Quantitative* - The ARP utilizes a Compassion Fatigue Evaluation profile, a carefully constructed assessment package that allows us to consider many of the aspects of Compassion Fatigue, silencing, primary trauma exposure, emotional disturbance, and stressors that may be impacting on the professional's life functioning. Some of these are in the experimental stages and are used to determine change over time as opposed to diagnosis (Baranowsky & Gentry, 2011a, 2011b; Gentry & Baranowsky, 2011). The ARP Evaluation package is available for free download at <http://psychink.com/free-information/compassion-fatigue-tests/>

Assessment – Qualitative – The qualitative assessment portion of the work consists of a participant interview recognizing the importance of non-pathological, collaborative, strength-based approaches with helpers.

3. *Anxiety Management* – Each participant is exposed to a variety of anxiety reduction tools to assist with the management of stress and lowering of negative arousal. Many cutting edge approaches commonly utilized in the field of traumatic stress have been incorporated into this component of the training (Baranowsky & Lauer, 2012; Ehlers, et.al., 2010).
4. *Narrative* - The power of story and the restorative quality of personal self-awareness clearly aids in rebuilding professional and personal life quality. As with trauma survivors, so with those with Compassion Fatigue or secondarily wounded, the story becomes a component of the journey back to wellness (Dietrich et al., 2000; Herman, 1992; Mathieu, 2012; Baranowsky & Schmidt, in press).
5. *Exposure/Resolution of Secondary Traumatic Stress (STS)* - Using "exposure" methods in the treatment of anxiety disorders and PTSD in particular is common (Baranowsky & Lauer, 2012; Rothschild, 2000; Rosenbloom & Williams, 1999). Hence, it was believed that exposure methods could also be the hallmark of efficacious treatment for Compassion Fatigue. Although there are many new techniques in which we achieve exposure/resolution (Baranowsky & Lauer, 2012; Dietrich et al., 2000; Ehlers, et.al., 2010) most are based on the early work of Wolpe (1969) *The Practice of Behavior Therapy*.
6. *Cognitive Restructuring (Self-care and Integration)* - What we say to ourselves creates an internal environment in which we may flourish or flounder. If we have been through a difficult experience we may believe from that moment on that "we live in a dangerous world." This belief may persist even when we are with people we love in a safe physical environment. In this case we feel we are NOT SAFE even when we are. What we say to ourselves may make all the difference in breaking down negative beliefs. Getting a reality check helps but, *even better*, challenging the internal dialogue may help to shift our automatic thoughts and beliefs to one of a more honest and harmonious inner world. We use "letter from the 'Great Supervisor'" and Video-Dialogue with "critical self" to accomplish this in our program. This work has been greatly enhanced by newly emerging work on Self-Compassion (Thompson & Waltz, 2008; Neff, 2009). Early research suggests that those with a greater degree of self-compassion are less vulnerable to depression, anxiety and PTSD.

7. *PATHWAYS- Self-directed Resiliency and Aftercare Plan* - The PATHWAYS is an integral component of the ARP and constitutes an aftercare element that reinfuses the individual's life with a sense of personal commitment to wellness and responsibility for making this happen throughout the program and into the future. In the final section of this article we focus more closely on resiliency models and our current efforts in this work. Primary skills in the aftercare ARP model included: Resiliency Skills; Self-Management and Self-Care; Connection with Other; Skills Acquisition; and Resolution of Primary and/or Secondary Traumatic Stress.

DISCUSSION AND TREATMENT RESPONSIVENESS

The good news is that in preliminary testing, compassion fatigue appeared to be very responsive to ARP treatment (Gentry, Baranowsky & Dunning, 1997; Gentry & Baranowsky, 1999; Gentry, 2000; Gentry, Baggerly & Baranowsky, 2004). When helping professionals make the crucial first step of reaching out to ask for help, they are already well on their way to recovery. Many helping professionals who have successfully resolved their symptoms of Compassion Fatigue credit this reaching out as one of the most important personal and professional moves of their career. Not only do these professionals report a marked reduction in Compassion Fatigue symptoms, they also state that they feel more empowered, more energetic, and enlivened with a strong sense of self-worth.

This program addresses the symptoms of Compassion Fatigue and identifies primary trauma where relevant. All participants are informed that primary trauma may need to be addressed first before commencing with the ARP protocol (Gallo, 1997). The program attempts to deal holistically with Compassion Fatigue and underlying unresolved trauma using the essential elements of this program.

Group models are most suitable for larger organizations, such as hospitals, police departments, social work agencies and other related work. For example, training clinicians through employee assistance programs to aid hospital staff is an excellent means to maintain high functioning and reduce employee turnover. Training materials for clinicians interested in treating Compassion Fatigue in themselves and others are also available (Baranowsky & Gentry, 2011a, 2011b; Gentry, 2012; Gentry & Baranowsky, 2011). Training is also available in an online learning platform that is on demand and can be completed by licensed mental health professionals at <http://www.ticlearn.com> (Course TI-207).

NEXT STEPS - PURPOSEFUL PREVENTION & RESILIENCY

Having spent time in New York City (fall/winter 2001 and spring/summer 2002) working with first responders and care providers who were assisting survivors of the terrorist attacks of September 11, 2001 formed the foundation of this “purposeful prevention & resiliency” work. Providing the ARP to many of the Project Heartland care professionals from the Oklahoma City bombing and seeing the deteriorating effect that Compassion Fatigue had upon the lives of many of these heroes—three, four and five years after the bombing — I was keen to explore this idea of resiliency. A “911” Operators project, run through the Traumatology Institute put the ARP to the test with 100’s of operators facing the impact of daily exposure to significant

trauma. Feedback was impressive as they harnessed resiliency skills to help them face their work. During the time in NYC, scores of volunteer and professional care providers were interviewed (i.e., first responders, law enforcement, mental health professionals, medical professionals, clergy/chaplains, and volunteers) to capture what it was that was helping them to tolerate this stamina-sapping and soul-draining work. During this time ideas around preventing rather than treating CF began to deeply coalesce.

Stumbling over an esoteric definition of disease — that likely came from the Center for Disease Control and Prevention website — led to a changed perspective. This definition stated: *Disease is the absence of effective antibodies, not the presence of a toxic environment.* Reflection about this truism was exciting. It cracked wide open a new door of possibilities. The definition was meant to reference physiological diseases like (i.e., Swine Flu, H1N1). Common knowledge informs us that it is the H1N1 virus that causes swine flu; however, when you look at this disease through the lens of the previous definition you can interpret that it is not the virus that causes the disease. Instead, it is the failure of the individual's immune system to prevent the viral replication of H1N1. Most of us have probably had this virus in our bodies at one point or another, yet very few of us have swine flu. That is because our immune system has done an adequate job of neutralizing the effect of the virus. When you think about the way that the Center for Disease Control and Prevention (CDCP) addresses epidemic diseases, do they fumigate the air attempting to exterminate all the infectious microbes? No, they help bolster the individual's resiliency and immunity to the pathogens through inoculations (i.e., flu shots) as the primary means of preventing the spread of disease.

This perceptual shift was exciting and galvanized further reflection on this paradigm as treatment for my individuals with "mental diseases." *What does a psychological/spiritual antibody look like ... and how can we help inoculate individuals with this capacity for health?* Our thinking about mental health changed forever with this insight. Armed with this new conceptualization, we have moved further and further away from an allopathic understanding of mental health and towards a more developmental, skills-acquisition approach to treating helpers. These days we help people acquire the "antibodies" necessary to remain healthy and happy, even while they live and work in potentially "toxic" environments.

It did not take long until this insight was fully transferred into our work with Compassion Fatigue. Since we were already witnessing the successful results we were achieving within the CCFST ARP model, we began to seriously consider that maybe what was working with ameliorating these symptoms among professional care providers might also work towards *preventing* Compassion Fatigue. This was the beginning of the work towards developing Compassion Fatigue Prevention & Resiliency. These are generally brief programs ranging between one-hour to one-day long. A brief CF Resiliency and Recovery program is also available in an on demand E-Learning format (<http://bit.ly/ZMw64J>) through the Traumatology Institute.

In 2000, we developed the one-day Compassion Fatigue Prevention & Resiliency Workshop (Gentry, 2000) and began offering this training to healthcare professional's world-wide in class and online (<http://bit.ly/ZMw64J>) in over 30 countries. The training identified and promulgated five (5) professional resiliency skills or "antibodies". These initial skills/antibodies consisted of: (1) self-regulation; (2) intentionality; (3) self-validation; (4) connection; and (5) self-care. The one-day training has been administered over 500 times to over 250K care professionals globally during the past decade. The qualitative and quantitative data has demonstrated its effectiveness at helping professional and volunteer care providers mature their resiliency and practice in this demanding field with lessened negative effects (Gentry, Baggerly & Baranowsky, 2004; Rank,

Zapparanick & Gentry, 2009; Flarity, Gentry & Mesnikoff, in press). We refined these resiliency skills in 2008 and changed “self-validation” to “perceptual maturation;” “connection” to “connection & support;” and “self-care” to “self-care & revitalization.” These skills/antibodies have been utilized to develop programs that target preventing Compassion Fatigue in large healthcare systems throughout North America.

Resiliency Skills/Antibodies

We have found these combination of skills, when taught to groups of professional care providers, to be significantly correlated with lessened Compassion Fatigue, greater job satisfaction, better quality of life and lessened anxiety (Gentry, 2012; Potter, Berger, Clarke, Deshields, & Chen, in press; Bonanno, Brewin, Kaniasty & LaGreca, 2010):

Self-Regulation

We have found this resiliency skill to be the most important of the five antibodies. In the one-day workshop, we dedicate a significant portion of the day’s training to understanding this important concept and then developing the skills for successful self-regulation with the participants.

Self-regulation is simply the ability to intentionally control the activity and lessen the energy of their Autonomic Nervous System while engaged in the activities of daily living. It is the consistent movement away from overstimulation of Sympathetic Nervous System (SNS) dominance toward the relaxed comfort of Parasympathetic Nervous System (PNS).

When an individual perceives a threat—real or imagined—the Sympathetic Nervous System activates. As long as this person stays in the context of this perceived threat then the Sympathetic Nervous System acquires and maintains dominance of the Autonomic Nervous System. According to Sapolsky (1999), when the SNS is dominant, it is busy infusing the body with energy (e.g., elevated heart rate, increased respiration rate, decreased respiration volume, acuity of senses, release of catalytic hormones/enzymes, and chronic muscle tension). Simultaneously, while in this state of SNS dominance we progressively lose neocortical functioning (e.g., judgment, reasoning, decision-making, relational skills, impulse control, fine motor skills, etc). Additionally, it produces in the individual a felt-sense of distress and s/he becomes increasingly compelled to seek relief from this state of heightened arousal (Brodal, 2010) usually in the form of compulsive and/or impulsive behaviors (i.e., fight or flight).

It is in this state of a chronically dominant SNS that we are generating the symptoms and negative effects associated with Compassion Fatigue. We have traditionally referred to this build up of energy associated with SNS dominance as “stress”. However, the use of the concept of “stress” is usually not helpful in resolving the negative effects and can often exacerbate them instead—as it targets outside factors as the cause of our “stress” and, therefore creating an external locus of control. For example, when a care professional says, “I have a stressful job”, they believe that the factors associated with their work are causing their distress AND that these factors must change before they can be happy, healthy, and comfortable in their work. They are potentially limited by this perspective of outside cause of stress and left with a feeling that nothing that they could do personally would ever change the organization, a toxic co-worker, a fearful event, unless something outside of themselves changed. They can learn to change their perspective and felt experience by intentionally

practicing new internal language such as, “I recognize that, I am constantly perceiving threat in my workplace, yet, I am not in real danger in the moment. Let me practice relaxing my body while I encounter these perceived threats”. In this way, an individual can move away from SNS dominance towards an internalized locus of control. This is a very important way of taking ownership and regaining true personal power that is long-lasting and transformative. This leads to a feeling of being comfortable, less agitated, more intelligent and no longer generating symptoms.

Self-regulation is as simple as relaxing one’s muscles while encountering the myriad of perceived threats that emerge throughout each workday. It is physiologically difficult to activate and sustain SNS dominance (i.e., “stress”) while maintaining relaxed muscles in one’s body (Baranowsky, Gentry & Schultz, 2011). Sounds simple, right? The techniques are simple, but the discipline to practice this skill is not always easy. Most professional care providers who have successfully developed this capacity report that they needed to arrive at enough suffering from the stress associated with their work before they were amply motivated to begin the process of learning to recognize the tight muscles in their body and then releasing this tension. It takes a lot of concentration to begin to redirect our focus away from the 10,000 external happening during a day of professional care giving toward the state of our physical selves—the muscles in our bodies. However, when we do that—when we develop this “body-fullness”—we shift from an external locus of control where we are victims of our environment to one that is internal. From this position of strength, awareness and control we become resilient, flexible, and comfortable—no matter what is going on around us.

Intentionality

The second of the five resiliency skills we have called intentionality. The definition of this resiliency skill is split into two related concepts: deliberateness and integrity. Both of these concepts play an important role in understanding and practicing intentionality.

Think about the people you know who are suffering from stress at work—those you would call “burnt out”. How reactive, impulsive and compulsive are they? How much do they complain? How much do they “pop off”? How snarky are they? How frequently do you see them act in ways that are self-defeating and destructive (i.e., overeating, argumentative)? “Frequently,” is the usual response to these questions.

One of the consequences of being “stressed out” is reactivity—compulsive and/or impulsive behavior (Porges, 1992; Mezzacappa, et. al., 1996). When the energy in one’s body, brought about by sustained SNS dominance, overwhelms the neo-cortex’s ability to manage this energy then the individual will often “act out,” frequently in violation of their own integrity (Gentry, Baranowsky & Shultz, 2011). These reactive behaviors may be understood as a regressive expression of an attempt to neutralize the perceived threat (i.e., fight) or to get away from the perceived threat (i.e., flight). The greater the intensity of felt stress, the more likely and more frequently the individual engages in reactive thinking and behaviors. Professionals in this state frequently find themselves involuntarily attempting to manipulate the environment, which is often beyond their control, in an attempt to lessen the perceived threats. Or they will engage this same energy in compulsive attempts to avoid those activities, people or objects that they perceive as threatening (i.e., stressful). This overstimulation and subsequent reactive behavior is resolved when the professional simply relaxes his/her body as perceived threats are encountered throughout the workday. This simple practice is all that is required to (a) eradicate

stress and (b) shift from reactive to intentional behavior (Staples & Gordon, 2005). Once again this is simple, but not easy.

The opposite of reactive is intentional. We help professional caregivers to become deliberate where they have previously been compulsive or impulsive. We help them to migrate away from the reactivity associated with a “stressful” environment towards the intentionality associated with resiliency and maturation. How do we do this? We teach professionals that the pathway to intentional living is not one of willfulness and brute force but, instead, one of elegance and relaxation. The reason we engage in reactivity is to discharge and seek relief from the overwhelming amount of anxious or uncomfortable energy with which the SNS has charged our bodies. As we begin to practice self-regulation in the context of these “triggers” that we perceive as threat, then we move toward allowing Parasympathetic Nervous System (PNS) to dominate our Autonomous Nervous System functioning. In this state, we are comfortable inside of our bodies, have maximal neocortical functioning and are able to “decide” how we want to handle whatever present situation we encounter (Jha, Krompinger & Baime, 2007). This is the deliberate part of intentionality.

The integrity part of this resiliency skill involves first becoming aware of our intention. You cannot be intentional unless you are first aware of what it is that you intend and that means turning intention into clear, explicit language. So, we help participants of our trainings to craft their intention into words. We have called this putting language to an intention a “covenant” or personal mission statement. This statement is an articulation of the care professional’s over-arching life-mission but also his/her intention while at work each day. We also help them to identify the personal principles that guide their behavior and call this a Code of Honor. Once a professional has articulated these intentions, we then show them how they can maintain fidelity to these principles—no matter the eternal/external demands—while engaging in the routine activities of a work day.

In this way the professional matures into a person who is going to work with a purpose. Their success and worth begins to be less defined by the capricious evaluations of others (i.e., patients, administrators, colleagues, or significant other) and progressively is measured by their ability to maintain adherence to their own purpose and principles while in their workplace context.

We have watched this simple process revitalize crusty and cynical veterans of a workplace, as they begin to reconnect to the mission and purpose that originally propelled them into the professional helping arena. They find that they are able to concentrate more acutely upon that which they have control over---themselves and their own behavior, while they relinquish that which is beyond their control—the demands of their environment and judgment of others.

Perceptual Maturation

This resiliency skill is more cognitive than behavioral and involves maturing both the perceptions of ourselves toward resiliency and the perceptions of our workplace to render them less toxic. This resiliency skill can prove more challenging to those with more concrete thinking styles but even the most hardened and cynical professional can benefit from evolving their perceptions.

As we begin to understand and appreciate that almost all the negative effects from our work and our workplaces comes from an overactive Sympathetic Nervous System we begin to become empowered to change. What is it that causes our Sympathetic Nervous System to activate and remain dominant? It is always one singular thing: *perceived* threat. Ask yourself, compared to how often we feel threatened, how often are we in the context of real encroaching danger while working a shift? Answer: Infrequently. As we can evolve this simple perception—that “we are very rarely in real acute danger, so relax”—we significantly reduce the stressful nature of our work.

This was well illustrated by an Emergency Department physician who was a participant at a recent resiliency workshop conducted in St. Louis. In order to maintain coverage for all the shifts, the physicians were split into two groups and two workshops were offered on two consecutive days. This particular physician had come to the first day’s training and then worked an overnight shift following the workshop. On the second day during one of the morning breaks this doctor was in the hallway outside the training room and when we exited he asked to speak to us. He related to us that he had just finished his shift and was compelled to come speak to us before he went home to sleep. He said he worked his shift the previous night and kept asking himself, “Are you in danger? No, I am not.” He said it was the first time in 15 years of emergency medicine that he left the Emergency Department, “not stressed out”. Simply by changing his perception of the workplace, he changed his reaction to the workplace.

It is not the workplace that causes the negative effects; it is the *perception* of the workplace (i.e., perceived threat). It is usually very difficult, costly and beyond our control to change the negative aspects of our workplace. However, we *do* have the ability to easily change these perceptions.

We have identified several perceptions that we have found to help enhance resiliency and lessen the negative effects of our work. A few of these are:

- Eschew obsession with outcomes ... they are, to a large degree, beyond your control. Instead focus upon that which you do have control over—your intentional actions.
- Lots of perceived threat ... very little real danger. So relax your body.
- Relinquish entitlement. Your work as a professional care provider does not entitle you to any special dispensations. All you get from your decision to practice emergency medicine (or any other helping role) is the opportunity to fulfill your personal mission.
- Nothing is demanded of you at your work. You always have the final choice. And although this may seem absurd, many who have gone through this training have found this perceptual change to be extremely liberating and have reported personal symptom reduction.
- Your workplace is always going to demand more from you than you can give and never be satisfied with what you do accomplish. This is not a dangerous situation, just typical. So Relax. You were never going to live up to the all encompassing expectations of the “fully charged” workplace.

These perceptual shifts do not graft overnight and we have seen that professionals often wait to begin the process of maturing their workplace perceptions until they have suffered enough pain from their current ones. When enough pain has been experienced we find ourselves open-minded enough to entertain some of these new—and less painful--ways of perceiving our work, our workplace and ourselves.

Connection & Support

Feeling supported, heard and cared about by colleagues is a crucial skill to maintain resiliency and to combat Compassion Fatigue (Tosone, Bettmann, Minami & Jaspersen, 2010). There are several reasons why this skill is so crucial.

First, as you have probably already read, Secondary Traumatic Stress—witnessing other’s trauma and suffering—can take an enormous toll on the emotional and physical health of the care professional and their family. Having chosen a career as a helping professional, it is nearly a forgone and empirically demonstrated inevitability that we are likely to experience some of these negative effects throughout our careers. These effects can be as subtle as the gradual increase of perceived threat in our lives to severe (i.e., relation dysfunction; forced/voluntary job loss; mental/physical health problems).

One effective treatment for Secondary Traumatic Stress is sharing narratives of painful and difficult work experiences with another person—ideally a colleague and NOT a family member (less you traumatize them)—while maintaining a relaxed body. As we are able share these experiences it allows us to put these experiences behind us and ameliorate the stressful effects. Nothing else has demonstrated such effectiveness for lessening these effects except talking about it with another person while in a relaxed state (Baranowsky, Gentry, Schultz, 2011).

Over the past decade, our work as professional care providers has become increasingly demanding and isolating. When professionals perceive that they are supported by their colleagues, friends and community they exhibit less work related symptoms (Choi, 2011; Gibbons, Murphy & Joseph, 2011; Van der Ploeg & Kleber, 2003). Intentionally building a community around us from which we can draw support and strength is a crucial element of resiliency.

Most professionals do not understand that part of maturing as a care provider is accepting the responsibility of developing, training and maintaining this support network. Most of us have an unconscious expectation that others will spontaneously provide us with this support or we feel victimized that we do not have these connections, and therefore do nothing to develop this important aspect of resiliency. During our workshops we offer suggestions for how to recruit, train, maintain and utilize this network of support.

Self-Care & Revitalization

That which is to give light must endure burning (Victor Frankl)

This quote by Viktor Frankl has become the *sine qua non*, the essence, of our work with resiliency. It contains two important concepts. First, we reflect on “the burning”. In this, Viktor is telling us that for those of us who have chosen to be “givers of light” we must accept the experience of “burning”. It is inevitable that we are going to experience pain from our work of fixing the broken, healing the sick, comforting the lost and witnessing the dying. And to endure this, we must become stronger, to mature and become resilient enough that we are not diminished by the witnessing and absorption of this pain. That has been discussed in the previous pages.

The second part of this quote, however, has to do with “re-fueling”. If we are going to burn then we need to be burning fuel and not burning ourselves. We, ourselves, do not burn very brightly for very long until we are all burned out. Therefore, we need to develop a systematic discipline of refueling ourselves—physically, emotionally, psychologically, spiritually, relationally and professionally.

There are a plethora of ways in which we can achieve this refueling and revitalization. For some it is more physical while for others it is more ethereal. It is our responsibility to (a) learn and (b) regularly practice what works for us to sustain our energy, buoyancy and hope.

We have found some things that work well for most people and represent the essential components of good self-care. These are:

- Regular (3x/week) aerobic activity
- Healthy diet
- Good sleep hygiene
- Regular social activities
- Creative activity or hobbies
- Spiritual practices
- Professional enrichment

In addition to these suggestions, it is the responsibility of each and every professional in the health care field to find and implement a program of self-care and revitalization that works for them.

CONCLUSIONS

A single event can awaken within us a stranger totally unknown to us.
To live is to be slowly born Antoine de Saint Exupery

The ARP combines several brief treatment protocols, a comprehensive assessment package, and a self-administered self-care plan (PATHWAYS). This constellation of treatment/training strategies, distilled into program components and goals seems to have combined to provide an effective means for resolution of Compassion Fatigue symptoms.

In the development of this program, we began meeting with individuals, then in a small group format to “train-the-trainer” in the CCFST Compassion Fatigue Specialist/Therapist program, and finally into CF Resiliency programs to both large and small groups. We hope that these program continue to open the window of hope to Compassion Fatigued professionals and those who have set their sights on remaining resilient while managing the early warning signs of strain whenever and wherever they appear.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (DSM-IV-TR). Washington, DC: Author.
- Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, 19(2), 181-188.
- Baker, T.E. (2012). Burnout. In C.R. Figley (Ed.), *Encyclopedia of Trauma: An Interdisciplinary Guide*, (pp. 69-72). Los Angeles: Sage Publications
- Baranowsky, A. B. (2002). The silencing response in clinical practice: On the road to dialogue. In C. R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 155-170). New York: Brunner-Routledge.
- Baranowsky, A. B. & Gentry, J. E. (2010). *Compassion Fatigue: A Self-Guided Resiliency & Recovery Series* [Audio Recording CD/MP3]. Available <http://www.cdbaby.com/cd/drannabbaranowskydrjeric>
- Baranowsky, A. B., & Gentry, J. E. (2011a). *Compassion Satisfaction Manual*. Toronto, Ontario, Canada: Psych Ink Resources. Available FTP: <http://www.psychink.com>
- Baranowsky, A. B., & Gentry, J. E. (2011b). *Workbook/Journal for a Compassion Fatigue Specialist*. Toronto, Ontario, Canada: Psych Ink Resources. Available FTP: <http://www.psychink.com>
- Baranowsky, A. B., Gentry, J. E. & Schultz, F. (2011). *Trauma Practice: Tools for Stabilization & Recovery* (2nd Ed). Cambridge, MA: Hogrefe
- Baranowsky, A. B. & Lauer, T. (2012). *What is PTSD? 3 Steps for Healing Trauma*. Toronto, Ontario: Traumatology Institute.
- Baranowsky, A. B. & Schmidt, D. (in press). Medical Doctor Vulnerability to Compassion Fatigue. In C.R. Figley, P. Huggard & C. Rees (Eds.) *First Do No Self Harm: Understanding and Promoting Physician Stress Resilience*. New York: Oxford Press
- Baranowsky, A. B. (2012). Silencing Response. In C.R. Figley (Ed.), *Encyclopedia of Trauma: An Interdisciplinary Guide* (pp. 627-630). Los Angeles: Sage Publications.
- Baranowsky, A. B., Young, M., Johnson-Douglas, S., Williams-Keeler, L., & McCarrey, M. (1998). PTSD Transmission: A review of Secondary Traumatization in Holocaust survivor families. *Canadian Psychology*, 39, 247-256.
- Beaton, R. D., & Murphy, S. A. (1995). Working with people in crisis: Research implication. In C. F. Figley (Ed.), *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 51-81). New York: Brunner/Mazel.

- Beavan, V., & Stephens, C. (1999). The characteristics of the traumatic events experienced by nurses on the accident and emergency ward. *Nursing Praxis in New Zealand, 14*(1), 12-21.
- Bloom, S. (1997) *Creating sanctuary: Toward an evolution of sane societies*. New York & London: Routledge.
- Bonanno, G. A., Brewin, C. R., Kaniasty, K. Z., & LaGreca, A. M. (2010). Weighing the costs of disaster: Consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest, 11*(1), 1-49.
- Bourassa, D. B., & Clements, J. (2010). Supporting ourselves: Groupwork interventions for Compassion Fatigue. *Groupwork, 20*(2), 7-23.
- Brodal, P. (2010). *The Central Nervous System: Structure and Function* (4th Ed.). New York: Oxford University Press.
- Callahan, R. J. (1994, September). The five-minute phobia cure: A reproducible experiment in psychology based upon the language of negative emotions. Paper represented at the International Association for New Science, Fort Collins, CO.
- Chaverri, J. (2011). The effects of personal trauma history and working with clients with similar trauma on well-being among mental health counselors (Doctoral dissertation). University of Texas, Arlington, Texas.
- Choi, G-Y. (2011). Organizational Impacts on the Secondary Traumatic Stress of Social Workers assisting Family Violence or Sexual Assault Survivors. *Administration in Social Work, 35*(3), 225-242.
- Clemens, L. A. (1999). *Secondary Traumatic Stress in rape crisis counselors: A descriptive study* (Master's Theses). California State University, Fresno, California.
- Craig, C. D., & Sprang, G. (2010). Compassion Satisfaction, Compassion Fatigue, and Burnout in a national sample of trauma treatment therapists. *Anxiety, Stress and Coping, 23*(3), 319-339.
- Danieli, Y. (1984). Psychotherapists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology, 1*(1), 23-42.
- Danieli, Y. (1985). The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors and their children. In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of Post-Traumatic Stress Disorder* (pp. 295-313). New York: Brunner/Mazel.
- Danieli, Y. (1996). Who takes care of the caretaker?: The emotional consequences of working with children traumatized by war and communal violence. In R. J. Apfel & B. Simon (Eds.), *Minefields in their hearts: The mental health of children in war and communal violence* (pp. 189-205). New Haven, CT: Yale University Press.
- Deville, G. J., Wright, R., & Varker, T. (2009). Vicarious Trauma, Secondary Traumatic Stress or simply Burnout?: Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry, 43*(4), 373-385.

Dietrich, A. M., Baranowsky, A. B., Devich-Navarro, M., Gentry, E., Harris, D. J., & Figley, C. R. (2000). A review of alternative approaches to the treatment of post traumatic sequelae. *Traumatology*, 6, 251-271.

Ehlers, A., Bisson, J., Clark, D. M., Creamer, M. C., Pilling, S., Richards, D., Schnurr, P.P., Turner, S. & Yule, W. (2010). Do all psychological treatments really work the same in Posttraumatic Stress Disorder? *Clinical Psychology Review*, 30(2), 269-276.

Figley, C.R. (1989). *Helping traumatized families*. San Francisco: Jossey-Bass.

Figley, C. R. (1995). Compassion Fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.

Figley, C. R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, 58(11), 1433-1441.

Figley, C.R. (2002). Introduction. In C. R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 1-14). New York: Brunner/Rutledge.

Figley, C. R., & Kleber, R. J. (1995). Beyond the "victim": Secondary Traumatic Stress. In R. J. Kleber, C. R. Figley & V. P. R. Gersons (Eds.), *Beyond trauma: Cultural and societal dynamics* (pp 75-98). New York: Plenum.

Flarity, K., Gentry, J.E., & Mesnikoff, N. (In press) Compassion fatigue resiliency in emergency nurses. *Advanced Emergency Nursing Journal*.

Friedman, M. J. (2000). PTSD diagnosis and treatment for mental health clinicians. In M. Scott & J. Palmer (Eds.), *Trauma and Post-Traumatic Stress Disorder* (pp. 1-14). New York: Cassell.

Gallese, V. (2001). The "Shared Manifold" hypothesis: from Mirror Neurons to empathy. *Journal of Consciousness Studies*, 8, 33-50.

Gallo, F. P. (1997, March). Reflections on active ingredients in efficient treatments of PTSD, Part I. *International Electronic Journal of Innovations in the Study of the Traumatization Process and Methods for Reducing or Eliminating Related Human Suffering*. [On-line serial] Available: *Traumatology Forum- Green Cross Forum*.

Gentry, J. E. (2002). Compassion Fatigue: A crucible of transformation. *Journal of Trauma Practice*, 1(3), 37-61.

Gentry, J. E. (2012). Final report of the Emergency Medicine Resiliency Project. Presented to the Board of Directors of California Emergency Physicians, Emeryville, CA.

Gentry, J.E., Baggerly, J. & Baranowsky, A.B. (2004). Training-as-Treatment: Effectiveness of the Certified Compassion Fatigue Specialist Training. *International Journal of Emergency Mental Health*, 6 (3), 147-155.

Gentry, J. E., & Baranowsky, A. B. (2011). *Treatment manual for accelerated recovery from Compassion Fatigue*.

Toronto, Ontario, Canada: Psych Ink Resources.

Gentry, E., Baranowsky, A. B., & Dunning, T. (1997, November). Compassion Fatigue: Accelerated Recovery Program (ARP) for helping professionals. Paper presented at the meeting of the International Society for Traumatic Stress Studies on Linking Trauma Studies to the Universe of Science and Practice, Montreal, Quebec, Canada.

Gentry, J. E., Baranowsky, A. B., & Dunning, K. (2002). ARP: The Accelerated Recovery Program (ARP) for Compassion Fatigue. In C. R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 123-138). New York: Brunner/Routledge.

Gentry, J. E., & Schmidt, I. M. (1996). Safety reconnaissance for trauma survivors. Paper presented at the Sixth Annual Conference for Treating Traumatic Stress and Dissociation, Morgantown, WV.

Gibbons, S., Murphy, D. & Joseph, S. (2011). Countertransference and positive growth in social workers. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community* 25(1), 17-30.

Herman, J. L. (1992). *Trauma and Recovery*. New York: Basic Books.

Holmes, D. & Tinnin, L. (1995). On hearing voices: Video-dialogue technique. MDTV, West Virginia University closed-circuit telemedicine training.

Janet, P. (1889). *L'Automatisme psychologique*. Paris: Felix Alcan. Reprint: Societe Pierre Janet, Paris, 1973.

Janoff-Bullman, R. (1992). *Shattered assumptions: Toward a new psychology of trauma*. New York: Free Press.

Jay, J. (1991). Terrible knowledge. *Family Therapy Networker*, 15, 18-29.

Jha, A.P., Krompinger, J. & Baime, M.J. (2007). Mindfulness training modifies subsystems of attention. *Cognitive Affective and Behavioral Neuroscience*. 7(2):109-119

Kabat-Zinn, J. (1990) *Full catastrophe living*. New York: Delta Books.

Killian, K. D. (2008). Helping till it hurts?: A multimethod study of Compassion Fatigue, Burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, 14(2), 32-44.

Landry, L. P. (1999), *Secondary traumatic stress disorder in the therapists from the Oklahoma City bombing* (Doctoral Thesis). University of North Texas, Denton, Texas.

Larsen, D., & Stamm, B. H. (2008). Professional quality of life and trauma therapists. In S. A. Joseph, & A. Linley (Eds.), *Trauma, recovery and growth: Positive psychological perspectives on posttraumatic stress* (pp. 275-296.). Hoboken, NJ: Wiley Press.

Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post traumatic stress symptoms and their relationship to

professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: A cross-sectional study. *Health and Quality of Life Outcomes*, 7(31).

Mathieu, F. (2012a). *The Compassion Fatigue workbook: Creative tools for transforming Compassion Fatigue and Vicarious Traumatization*. New York: Routledge.

Mathieu, F. (2012b). Compassion Fatigue. In C.R. Figley (Ed.), *Encyclopedia of Trauma: An Interdisciplinary Guide* (pp. 136-139). Los Angeles: Sage Publications

Maslach, C. (1982). *Burnout- The cost of caring*. Englewood Cliffs, NJ: Spectrum.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1)131-149.

Meadors, P., Lamson, A. L. S., Swanson, M., White, M., & Sira, N. (2009). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, Burnout and Secondary Traumatic Stress. *Omega*, 60(2), 103-128.

Meyers M. & Fine, C. (2003). Suicide in Physicians: Toward Prevention. *Medscape General Medicine: Psychiatry & Mental Health*, 5(4) [On-line], Available: <http://222.medscape.com/viewarticle/462619>.

Mezzacappa, E., Tremblay R.E., Kindlon, D., Saul, J. P., Arseneault, L., Pihl, R. O. & Earls, F. (1996). Relationship of aggression and anxiety to autonomic regulation of heart rate variability in adolescent males. *Annals of the New York Academy of Sciences*. 794, 376-379.

Morrison, I., Lloyd, D., Di Pellegrino, G., Roberts, N. (2004). Vicarious responses to pain in anterior cingulate cortex: Is empathy a multisensory issue? *Cognitive, Affective, & Behavioral Neuroscience* 4(2): 270–278.

Neff, K. D. (2009). Self-Compassion. In M. R. Leary & R. H. Hoyle (Eds.). *Handbook of Individual Differences in Social Behavior* (pp. 561-573). New York: Guilford Press.

Najjar, N., Davis, L. W., Beck-Coon, K., Carney Doebbeling, C. Compassion Fatigue: A Review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology*. 2009 March; 14(2) 267-277.

Ochberg, F. M. (1993). Gift from within. Posttraumatic therapy. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 773-783). New York: Plenum.

Pearlman, L. A., & Maclan, P. S. (1995). Vicarious traumatization: An empirical study of effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558-565.

Porges, SW. (1992) Autonomic regulation and attention. In B.A. Campbell, O.H. Hayne, & R. Richardson (Eds.), *Attention and information processing in infants and adults* (pp. 201-223). Hillsdale, NJ: Lawrence Erlbaum Associates.

Potter P, Berger, J, Clarke M, Deshields T, & Chen L, (in press) Evaluation of a Compassion Fatigue Resiliency Program for Oncology Nurses, *Oncology Nursing Forum*.

Rando, T. A. (1996). On treating those bereaved by sudden, unanticipated death. In *Session: Psychotherapy in*

Practice, 2(4), 59-71.

Rank, M. G., Zapanick, T. L., & Gentry, J. E. (2009). Nonhuman-animal care Compassion Fatigue: Training as treatment. *Best Practices in Mental Health*, 5(2), 40-61.

Rosenbloom D., & Williams M. G. (1999). *Life after trauma: A workbook for healing*. New York: Guilford.

Rosenheck, R., & Nathan. P. (1985). Secondary Traumatization in children of Vietnam veterans. *Hospital and Community Psychiatry*, 5, 538-539.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: Norton.

Sapolsky, R. (1999). Stress and Your Shrinking Brain. *Discover*, 20(3), 113-122.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Norton.

Showalter, S. E. (2010). Compassion fatigue: What is it? Why does it matter?: Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects. *American Journal of Hospice and Palliative Medicine*, 27(4), 239-242.

Solomon, Z. (1990). Does the war end when the shooting stops? The psychological toll of war. *Journal of Applied Social Psychology*, 20, 1733-1745.

Solomon, Z., Kotler, M., & Mikulincer, M. (1988). Combat-related Posttraumatic Stress Disorder among second-generation Holocaust survivors: Preliminary findings. *American Journal of Psychiatry*, 7, 865-868,

Stamm, B. H. (Ed). (1995). *Secondary Traumatic Stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.

Stamm, B. H. (1997). Work-related Secondary Traumatic Stress. *PTSD Research Quarterly*, 8(2), 1-6.

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 107-119). New York: Brunner/Rutledge.

Stamm, B. H. (2005). *The ProQOL Manual. The Professional Quality of Life Scale: Compassion Satisfaction, Burnout & Compassion Fatigue/Secondary Trauma Scales*. Idaho: Sidran Press. Available <http://www.compassionfatigue.org/pages/ProQOLManualOct05.pdf> & http://www.proqol.org/uploads/ProQOL_5_English.pdf

Stamm, B. H. (28 November, 2010). Comprehensive Bibliography of the Effect of Caring For Those Who Have Experienced Extremely Stressful Events and Suffering. Retrieved from http://www.proqol.org/uploads/costs_of_caring_bib_11-2010.pdf

Staples, J.K., & Gordon, J.S.. (2005). Effectiveness of a mind body skills training program for healthcare professionals. *Alternative Therapy for Health and Medicine*. 11(4):36-41

Shanafelt, T.D., Boone, S., Tan, L., Dyrbye, L., Sotile, W., Satele, D., West, C., Sloan, J., & Oreskovich, M.R. (2012). Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population. *Archives of Internal Medicine*, 172(18), 1377-1385.

Tinnin, L. (1994). Time-limited trauma therapy for dissociative disorders. Bruceton Mills, WV: Gargoyle Press.

Thompson, B. L., & Waltz, J. (2008). Self-Compassion and PTSD symptom severity. *Journal of Traumatic Stress*, 21(6), 556-558.

Tosone, C., Bettmann, J. E., Minami, T., & Jaspersen, R. A. (2010). New York City social workers after 9/11: Their attachment, resiliency, and compassion fatigue. *International Journal of Emergency Mental Health*, 12(2), 103-116.

van der Kolk, B. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society*. New York: Guildford.

Van der Ploeg, E & Kleber, R. J. (2003 June). Acute and chronic job stressors among ambulance personnel: Predictors of health symptoms. *Occupational and Environmental Medicine*, 60(Supplemental), i40-i46.

Williams, M. B., & Sommer, J. F. (1994). *Handbook of post-traumatic therapy*. Westport, CT: Greenwood Press.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*. New York: Brunner-Routledge.