

Empathy Fatigue

*Healing the Mind, Body, and Spirit
of Professional Counselors*

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Introduction

To say that we are in the midst of a paradigm shift in the counseling and allied helping professions is clearly an understatement when it comes to dealing with the extraordinarily stressful and traumatic events that have taken place globally. Catastrophic events have accelerated worldwide within the last seven years. In America, the horrific terrorist attacks of Tuesday, September 11, 2001, and Hurricane Katrina, which took place on August 29, 2005, left emotional, physical, spiritual, and environmental scars upon our minds, bodies, and souls. The desolation left in the aftermath has created a sort of historical trauma among Westerners that seems to have prompted a consciousness shift within the counseling field and other helping professions. Fires, floods, drought, and school shootings require our complete attention to the survivors of such events. As professionals, we are constantly in a state of disaster preparedness and mental health disaster response. As a consequence, we are emotionally, socially, physically, spiritually, and vocationally exhausted. I would propose that many of us are experiencing “empathy fatigue.”

Our empathy fatigue has been extended on a global basis. This is evidenced by the cataclysmic event that took place on December 26, 2004, when a tsunami and an earthquake, registering 9.0 off the west coast of Northern Sumatra, injured or claimed the lives of millions of people. How easily we forget about this distressing event affecting countries such as Sri Lanka, India, Indonesia, Malaysia, Thailand, and many others. Where did all the disaster volunteers, angels, and earthly saints that descended upon these countries go? Did they have to retreat to their homes for the sake of their own emotional, physical, and spiritual well-being? Who has taken their place? The ensuing wars in Afghanistan, Iraq, and the Middle East are also constant reminders of how fragile our physical safety, mental health, and overall well-being can be. For many, planet earth does not appear to be a safe place to live in, because of the multitude of critical events.

These scenarios of enormous loss of human life, psychological grief, physical pain, and spiritual suffering are replayed on the nightly news, by quick-release television and Hollywood-style movies, in the print media, and over the Internet. The world has become much smaller through the use of satellite television, video cellular phones, and Internet technology. The disaster scenarios that we view on the global media stage add another dimension of reality. In real time, we can watch tragedies unfold in our own backyard and as they happen globally.

Such extraordinarily stressful and traumatic events affect a wide range of members of the population, who require specialists able to work with children and adolescents, college students, middle-aged and older adults, and others who have been victimized in their past. Interestingly, I have found that clients or consumers of outpatient mental health services do not seem to be as severely affected on a daily basis by world events. This may be because they are already consumed by their internal and external environment of intense personal distress.

New clients and consumers of mental health, rehabilitation, and allied health services, who are secondary survivors of extraordinary stressful and traumatic events, seem to be emerging. These include but are not limited to spouses, children, and family members that have a loved one serving in Iraq and Afghanistan; soldiers who have come home injured; and a new population of survivors of sexual abuse perpetrated by online predators. The fact that some of our political and church leaders, who purportedly are defined by their high moral character and ethical behavior, are among the perpetrators is extremely confusing to children and difficult to discuss with them. Is there anyone we can trust?

Despite the fact that most Americans are far from the epicenter of such critical incidents, many are affected at some level of consciousness. This new, intense level of anxiety and traumatic stress affects those who work in school systems, government social services, hospitals and medical centers, faith-based programs, volunteer and professional rescue organizations, and a host of other organizations and institutions. We seem to be in a constant state of disaster preparedness, emergency response, and disaster relief.

So how do we come out of the darkness and into the light to facilitate emotional, social, physical, psychological, spiritual, and occupational healing strategies that can heal our soul wound experience? The existential question, *Why do bad things happen to good people?* requires a skilled professional who can process and facilitate the meaning of such events and bring people's lives back into balance.

Counselors and other helping professionals are profoundly affected by the individuals, groups, families, and systems they serve. Many have been close to the epicenter of extraordinarily stressful and traumatic events themselves. Understanding this new form of professional fatigue is essential, because for some professionals, the occupation itself can be mentally, physically, and spiritually debilitating. The epidemiological significance of empathy fatigue is far-reaching for professional helpers, organizations, institutions, and the individual clients/consumers we serve.

While medical professionals, police officers, and rescue workers all prepare for physical rescue in the multitude of disaster scenarios, counselors and other mental health professionals are called on to provide mental health rescue. Today, many counselors and other human service professionals are required to have training in the various models of crisis intervention. These include but are not limited to workers associated with the Disaster Mental Health response of the American Red Cross (ARC), critical incident stress debriefing (CISD), critical incident stress management (CISM), the National Organization for Victims' Assistance (NOVA) Group Crisis response, and acute traumatic stress management (ATSM). Crisis response teams are formed by various governmental agencies such as Homeland Security and Environmental Protection, computer and internet security specialists, the commercial airline industry, public school and higher education personnel, private companies, faith-based and charitable organizations, and various other groups and organizations.

The literature in counseling and psychology suggests that many mental health practitioners and other helping professionals are affected by the same persistent or transient physical, mental, and psychological symptoms as their clients; many clients have been at or near the epicenter of critical incidents. We need to be open to the idea that preparing our minds, bodies, and spirits is of paramount importance to meet the intense challenges of the 21st century. This should be a principal concern for practitioners, counselor educators, clinical supervisors, and those in the allied helping professions.

This book was inspired by my own experience of empathy fatigue, an expression I coined around 1998. During March 1998, I worked and lived in Jonesboro, AR, and served on the crisis response team for the Westside Middle School shootings, where four students and one teacher were killed and 15 others were injured by 11- and 13-year-old shooters. Since this time I have been trained in various crisis response models and have provided stress debriefings and group crisis response to persons

employed in state and county government, private companies, day care centers and schools, and to persons in the media, survivors of brutal crimes, and individuals who have been at the epicenter of hurricanes, floods, and tornadoes.

As a counselor educator, researcher, and practitioner I have found that there appears to be an emotional, social, psychological, mental, physical, spiritual, and vocational cost to providing counseling and stress debriefings to individuals who have been at the epicenter of some of the most horrific human-made and natural catastrophic events imaginable. I have observed empathy fatigue in my colleagues for many years. These professionals treat persons with substance abuse, sexual and physical abuse, and mood, anxiety, and stress-related disorders. Some work in career and vocational settings. Others are nurses, allied health professionals, school teachers, and case managers who work with children and adults with mental and physical disabilities. Very few of these individuals deal with mental health crises or disaster response, yet they have acquired what I refer to as acute and/or chronic empathy fatigue. They follow their chosen careers in person-centered environments with an aura of compassion and a good heart. Basically, they are skilled helpers who are empathetic and are required to facilitate attachments with others. As a consequence, empathy fatigue appears to be a natural artifact of working in “high touch” or person-centered environments.

There is a growing interest in psychology, counseling, and related fields in preventing the professional fatigue syndromes that go by various terms, such as empathy or compassion fatigue, burnout, and counselor impairment. These syndromes will be described throughout this book. In order to facilitate the reader’s understanding of these concepts, Part I of *Empathy Fatigue* provides the reader with a unique in-depth analysis of the construct of empathy fatigue and describes this phenomenon from a mind, body, and spiritual perspective. Part I also discusses the phenomenon of working close to the epicenter of critical incidents and how it impacts the overall wellness of both younger and older helping professionals. The research is clear that cumulative occupational or job stress, even outside the psychology and counseling professions, can lead to higher levels of impaired functioning, including depression, anxiety, and substance abuse disorders. Accordingly, it is important, in order to lessen empathy fatigue, that we make ordinary sense out of the non-ordinary stressful and traumatic events that have taken place in our clients’ lives.

Part II of *Empathy Fatigue* calls for an integral approach to healing the professional’s empathy fatigue. Fundamental to the emotional,

physical, and spiritual well-being of preprofessional and professional counselors are self-care strategies that promote resiliency for the prevention of empathy fatigue. Minimizing or ignoring the personal negative countertransference associated with extraordinary and traumatic stressors has a physical, emotional, spiritual, and psychological cost.

Part III of *Empathy Fatigue* offers guidelines for counselor educators and clinical supervisors, enabling them to identify the emotional, physical, and mental exhaustion that occurs early on in the chosen career. Clinical supervision is critical because of the cumulative and long-term nature of the stress and anxiety that impact the client-counselor relationship and may result in an empathy fatigue reaction. The collective wisdom of indigenous cultures throughout the world has much to offer to 21st-century healers. Thus, this section presents the foundational Eastern and Western philosophies of healing the wounded soul. This section also offers guidelines and activities for an integral approach to paying attention to the mind, body, and spirit while working in “high touch” person-centered environments.

As is described throughout this book, empathy fatigue results from a state of mental, emotional, social, physical, spiritual, and occupational exhaustion that occurs as counselors’ own wounds are continually revisited by their clients’ life stories of chronic illness, disability, trauma, grief, loss, and extraordinarily stressful events. This type of “fatigue reaction” and its consequences are recognized as “counselor impairment” by the American Counseling Association’s Taskforce on Counselor Wellness and Impairment. The American Psychological Association (APA) has also been proactive in self-care practices for “impaired psychologists,” and it established a task force in 1986 to address such issues. The American Medical Association (AMA) recognizes a similar condition called “physician impairment,” defined basically as a physical, mental, and behavioral disorder that hinders the physician’s ability to safely treat patients. The nursing profession for years has called this compassion fatigue. Regardless of the term used, there appears to be a mind, body, and spiritual cost to both the individual and the profession.

The unique approach communicated throughout *Empathy Fatigue* is the emphasis on promoting self-care approaches for the wounded healer. Overall, this book honors the collective wisdom of indigenous cultural practices and philosophical beliefs with regard to healing the healer’s mind, body, and spirit.



PART I

1

A Theoretical Framework for Understanding Empathy Fatigue: Analyzing the Critical Pathways

In traditional Native American teaching, it is said that each time you heal someone you give away a piece of yourself until at some point, you will require healing. The journey to become an Indian doctor, or medicine man/woman, requires an understanding that the healer at some point in time will become wounded and require healing (Tafoya & Kouris, 2003). As in the Native American culture, many professional counselors in the West also encounter a wounded healer type of experience. I refer to this phenomenon as empathy fatigue. It results from a state of psychological, emotional, mental, physical, spiritual, and occupational exhaustion that occurs as the counselors' own wounds are continually revisited by their clients' life stories of chronic illness, disability, trauma, grief, and loss (Stebnicki, 1999, 2000, 2001, 2007a). Similar observations and measurements of professional impairment and fatigue have been noted in the nursing, psychology, counseling, and mental health literature (e.g., as compassion fatigue, secondary traumatic stress, burnout, vicarious traumatization). For example, compassion fatigue, first introduced to the nursing literature by Joinson (1992) and then expanded by Figley (1995), Stamm (1995), and others in psychology, suggests that therapists who deal with survivors of extraordinarily stressful and traumatic events are more prone to a compassion or secondary stress type of reaction as a result of feeling compassion and empathy toward others' pain and suffering. Consequently,

“vicarious traumatization” (McCann & Pearlman, 1989) is experienced by therapists when they become deeply emotionally involved in their client’s traumatic stories.

IMPAIRED PROFESSIONALS: A CONCERN FOR PERSON-CENTERED DISCIPLINES

Professional associations in the person-centered professions have recently expressed a concern to identify and prevent professional fatigue reactions. This is because of the significant negative impact of working with professionals who have acute and chronic mental and physical health conditions that may compromise or even pose harm to the clients/consumers receiving services. These professional fatigue reactions and their consequences have been recognized as “counselor impairment” by the American Counseling Association’s Taskforce on Counselor Wellness and Impairment (American Counseling Association [ACA], 2003). The American Medical Association (American Medical Association [AMA], 2004) recognizes a similar condition, termed “physician impairment” and defined basically as a physical, mental, and behavioral disorder that hinders the physician’s ability to safely treat patients. The American Psychological Association (APA) is also concerned about impaired psychologists and has created the Advisory Committee on Colleague Assistance (ACCA) to address such issues (American Psychological Association [APA], 2007).

The nursing profession is quite familiar with professional impairment and fatigue syndromes, given the intense level of psychological and physical health care that its members provide. The nursing literature has referred to this experience as “compassion fatigue.” In fact, the American Nurses Association (ANA, 2007) has addressed this concern in its code of ethics and has provided resources designed to reduce the effects of professional fatigue syndromes, much as many other professional associations have done. Regardless of the definition used in the counseling, psychology, and medical fields, the mental, emotional, social, physical, spiritual, and occupational cost of professional fatigue syndromes is enormous to the profession and to consumers of services.

The Dalai Lama (1999) has observed that those in the caring professions, such as counselors, do in fact experience a fatigue reaction. His Holiness proposes that counselors are sometimes exhausted by their duties because of constant exposure to the suffering of others, which

can induce feelings of helplessness and despair. During a presentation, the Dalai Lama (see Berger, 2006) stated that “empathy is really what we are describing when we talk about compassion fatigue and . . . it is the simple compassion a person experiences when they want to see another person free from suffering” (p. 1).

Counseling is a “high touch profession” (Naisbitt, 1984), in which there are multiple potential hazards that can exacerbate one’s personal and professional difficulties (Skovholt, Grier, & Hanson, 2001). Members of the high touch community of professionals should be aware that “constant empathy, interpersonal sensitivity, and one-way caring . . . can take tremendous effort, and the relationship with the client, while perhaps collaborative, is not reciprocal” (Skovholt et al., 2001, p. 170). Thus, life for professional counselors can be extremely difficult at times because they must have a high level of critical awareness of their client’s thoughts, feelings, and experiences. Additionally, evaluating client success is sometimes a problematic process because outcomes are not immediately apparent. Such evaluation involves a complex interplay in the client-counselor working relationship. Thus, it is incumbent upon the professional to develop realistic expectations of client success and balance clients’ psychological, social, emotional, physical, spiritual, and occupational well-being against the professional’s ability to remain in his or her chosen profession.

EMPATHY FATIGUE: A CONSEQUENCE OF MULTIPLE CLIENT STORIES

Clearly, counselor empathy is essential within the healing process. It sometimes requires the professional helper to respond to and even experience vicariously the client’s pain and suffering. However, after attending, listening, and responding to multiple client stories with intense emotional themes, professional helpers may experience an empathy fatigue reaction. Despite the professional helper’s best efforts to reduce the level of intensity of the client’s emotional pain and suffering, an empathy fatigue experience may emerge. It may be experienced by many well-intentioned helping professionals as an ambiguous sense of loss, grief, or stress, and helpers may react to their own intense level of emotions. Accordingly, when clients express feelings of pain, confusion, shock, trauma, distress, or other significant emotions, these can sometimes be transferred or projected onto the professional helpers’ psyches. For

counselors, having an understanding and awareness of their own empathy fatigue buttons can help them gain closure with regard to their own, maybe confusing, emotions. From a content analysis of well over 100 studies on professional counselor impairments such as burnout and compassion fatigue (Jones, 2007), the following conclusions were reached concerning the characteristics of professionals who are affected by counselor fatigue syndromes:

- Professional counselors who primarily engage in crisis counseling for a living tend to burn out at much higher levels than those that have just a general mental health caseload (involving, e.g., anxiety and mood disorders, substance abuse, marriage counseling).
- Race, gender, and professional certification and licensure (e.g., LPC, CRC, Licensed Clinical Social Worker [LCSW]) are not correlated with level of burnout. Most professional helpers are affected by professional fatigue syndromes regardless of the counseling specialty.
- Higher client/consumer satisfaction is positively correlated with lower counselor burnout. Counselors who have established a stronger rapport with their clients/consumers also have a stronger working alliance.
- When counselors reported higher levels of ego development and a sense of personal accomplishment, lower levels of burnout were noted.
- Counselor supervision was found to be a key element in counselor satisfaction and lower levels of professional impairment. In other words, when counselors reported that they received good supervision and had a positive supervision experience, they felt supported and their level of burnout was significantly less than for those that did not receive supervision or feel supported in their work environment.

KEY CONCEPTUAL AND THEORETICAL TENETS OF EMPATHY FATIGUE

There is a constellation of professional fatigue reactions. The labels that are given to the various fatigue syndromes (e.g., burnout, compassion fatigue, secondary traumatic stress, vicarious traumatization) vary depending upon the researcher and the discipline. Despite the perceived

theoretical and conceptual differences that will be described later, those who approach their work empathically with their client/consumer appear to be profoundly affected by their client's story of loss, grief, daily stress, anxiety, depression, and traumatic stress. This should be of paramount concern for professional counselors, counselor educators, and supervisors so that they may identify and prevent empathy fatigue reactions. Such a life's work requires that we prepare our mind, body, and spirit to grow and develop in ways that help us to become more resilient in working with individuals at intense levels of interpersonal functioning.

Most counselors trained in counselor education programs in the West have been trained in the foundational person-centered skills of empathy as a therapeutic strategy to communicate understanding and respect and establish client rapport, so that they may advance toward a therapeutic working alliance and use more complex counseling theories and strategies. Thus, person-centered approaches, such as client-focused empathy, as well as many other counseling theories and strategies, have typically been integrated into the foundational training of counselors. Despite the fact that most professional counselors describe their philosophy, theory, and approach to counseling as eclectic, the nature of the counseling relationship requires a below-the-surface level of intense and compassionate listening. This requires the counselor to be deeply empathically involved with clients' critical life stories.

Depending on their developmental level of experience and other personality attributes, counselors may be at low, moderate, or high risk for empathy fatigue. This of course is related to multiple characteristics and variables relating to the individual. Despite the varied characteristics and professional identities of counselors, a majority of individuals chose their profession because of its humanistic nature. Thus, many counselors may have a natural intuitive ability to be compassionate and empathic. As a result of the cumulative effects of empathic and compassionate attending, listening, and responding, counselors many times will experience parallel emotions that are almost as deep as their clients' intense feelings of loss, grief, pain, trauma, or suffering. These feelings can be triggered by a counselor's perception of stress and they range along a continuum of empathic stress from minimal to very intense levels.

The client's disclosure of intense personal emotions can result in some degree of countertransference or secondary traumatic stress (STS) for the counselor (see Figley, 1995). However, this may or may not be experienced as a rapid onset or acute reaction of empathy fatigue, because individuals do not turn on their physiological and emotional stress

responses in exactly the same manner. It is suspected that professional helpers who do not engage in crisis response or facilitate stress debriefing groups may also experience empathy fatigue due to both the cumulative and the intense nature of their work setting, as well as the types of clients, consumers, or patients they serve.

Despite the subjective self-reporting nature of empathy fatigue and the painstaking, ongoing efforts required in scale development to measure such fatigue syndromes, at the end of the counselor's day, the physical, emotional, psychological, and spiritual costs of working with clients/consumers at intense interpersonal levels is quite evident to self and others. At a minimum, the professional helper's stress level has increased significantly. This should be a major concern for the counseling profession, because it is well documented by stress researchers that the physiological and psychological costs of acute and cumulative stress can have adverse consequences on the mind, body, and spirit of the individual. Accordingly, the key conceptual and theoretical tenets of empathy fatigue (EF) are as follows:

- EF is viewed as an impairment that can occur developmentally early in one's professional career due to an interaction of variables that include but are not limited to (a) personality traits; (b) general coping resources; (c) counselor age and developmental factors; (d) opportunities to build resiliency; (e) organizational and other environmental supports; and (f) the interrelationship between the individual's mind, body, and spiritual development.
- EF many times goes unrecognized or ignored by the individual and the individual's professional environment. This is because the EF reaction for many counselors is thought to be (a) an unconscious process, (b) an expected or anticipated emotion after dealing with clients who have extraordinary stressful and traumatic issues, and (c) a professional obligation of the therapist. Consequently, many counselors do not verbally communicate their experience of empathy fatigue to their colleagues. Doing so may signal that they are impaired professionals. This could potentially jeopardize their standing in their professional setting.
- Counselors who are significantly impaired are not practicing as competent and ethical professionals. Impaired professionals may not be providing services in the best interests of their clients/consumers. The inability to control or cope with personal stress, adversity, psychological dysfunction, and/or excessive maladaptive

emotional reactions interferes with the client/consumer's welfare. Accordingly, the various codes of ethics in counseling and psychology address specific ethical standards related to counselor impairment. These standards have the explicit intention of consumer protection. However, there is much work to be done to clearly define "counselor impairment." Outside of the obvious impairments (e.g., the counselor has a drug or alcohol relapse or a mental health disorder resurfaces), impaired counselor behaviors may be open to interpretation based on the counseling setting, client population, and many other factors. The questions become (a) how do we measure counselor impairment? and (b) at what point in the therapeutic relationship does the counselor become impaired or constitute a risk to the client/consumers? Because counselor impairment syndromes many times may be invisible and range on a continuum from "no impairment" to "significantly impaired," there appears to be some ambiguity with regard to the construct of compassion or empathy fatigue and counselor burnout. Despite the fact that there are real ethical dilemmas in clinical settings, the disciplines of counseling and psychology have struggled to address issues related to impaired professionals.

- EF has both acute onset and cumulative emotional, physical, and spiritual reactions that are unique to each individual. Accordingly, an EF reaction does not follow a predictable linear path from healthy to unhealthy functioning. Rather, there are degrees of professional impairment and competency, and evaluating such behaviors can be problematic. Also EF does not exclusively follow the pattern of job burnout or countertransference. There are multiple intervening variables that are unaccounted for. Many professionals are affected by EF and they tend to move back and forth along a continuum of feeling from "affected very little" to "affected significantly" by this experience.
- The unhealthy symptoms and unethical behaviors of counselors experiencing EF can often be recognized by others in the professional environment; whereas the professionals themselves may not recognize the acute or cumulative symptoms. Eventually, professionals experience daily reminders that their minds, bodies, and spirits are out of balance and that their mental health and well-being has been compromised. Accordingly, different forms of supervision (i.e., group, individual, peer) are critical to the counselor's mental, physical, and spiritual well-being. Thus, clinical

supervision can serve impaired professionals in a supportive and facilitative manner, as opposed to a punitive role. A fully functioning professional is required to facilitate competent and ethical therapeutic interactions.

- It is not necessarily the nature of the client's stress, trauma, loss, or grief issues that creates a sense of EF among professional counselors. Rather, it is the counselor's perception of a particular client and critical incident that determines the response. This depends on multiple interacting variables. Thus, counselors have their own emotional (empathy fatigue) buttons that can trigger this experience.

CRITICAL PATHWAYS TO EMPATHY FATIGUE

Based on a comprehensive review of material on professional fatigue syndromes and counselor impairment, the following analysis of critical pathways is provided to the reader. Accordingly, in analyzing the critical pathways that result in the phenomenon of empathy fatigue, these are the present author's contentions:

- 1 Most counselors trained in counselor education programs in the West have acquired the foundational person-centered skills of empathy to establish client rapport and develop a therapeutic working alliance. Those professionals that facilitate therapy with a high level of empathy are more significantly affected by EF.
- 2 Despite the fact that most professional counselors describe their philosophy, theory, and approach as eclectic, the nature of the counseling relationship requires a below-the-surface person-centered level of intense and compassionate listening, requiring counselors to be deeply empathically involved with their clients' critical life stories.
- 3 As a result of empathic and compassionate relationships, counselors many times will have parallel emotions that are nearly as intense as their clients' feelings of loss, grief, pain, trauma, or suffering, and these feelings range along a continuum from "affected very little" to "affected significantly."
- 4 Depending on their developmental level of experience, work setting, and empathic states and traits, counselors may be at low, moderate, or high risk of empathy fatigue.

- 5 Clients' intense emotional issues have acute, chronic, and delayed onsets for counselors, resulting in a fatigue reaction of the professional's mind, body, and spirit.
- 6 The counselor's experience of empathy fatigue is very similar to a stress response, which is a complex, cumulative interaction of the person's mind, body, spirit, and environment. The EF response may or may not be related to serving clients who have been through extraordinarily stressful and traumatic events. The significantly impaired phase of EF, which may last weeks, months, or years, results in a total professional burnout in which the individual is emotionally, psychologically, physically, spiritually, and occupationally depleted. As a result of this experience of depletion, the professional will actively avoid exposure to the aversive triggers of EF.

SUMMARY OF CRITICAL PATHWAYS

Overall, it is hypothesized that the cumulative effects of multiple client sessions throughout the week may lead to a deterioration of the counselor's resiliency or coping abilities for dealing with client caseloads that range along a continuum from "daily hassles" and stress to extraordinarily stressful and traumatic issues. Although it is recognized that the client's traumatic story can negatively impact counselor emotions immediately, the acute nature of extraordinarily stressful and traumatic events many times turns into a chronic and persistent mental and physical health condition for the client. Accordingly, the professional who is a highly compassionate individual and facilitates therapeutic interactions in a highly empathic manner is at high risk for experiencing the parallel mental, physical, and spiritual exhaustion related to the client's experiences.

According to this hypothesis, professional counselors who experience empathy fatigue appear to have a diminished capacity to listen and respond empathically to their client's stories, which may or may not contain various themes of acute or traumatic stress. There appear to be multiple variables interacting with the counselor's experience of empathy fatigue. For example, some professionals find it difficult to work with children and adolescents with life-threatening chronic illnesses and disabilities. Conversely, other counselors may thrive in such therapeutic interactions within the pediatric rehabilitation setting.

In light of these key conceptual tenets, professional helpers who experience empathy fatigue are at risk for acquiring feelings of stress, grief, loss, detachment, anxiety, and/or depression, which culminate in professional burnout. They often feel that their therapeutic interactions with a client have very little meaning and purpose in their client's overall life. Thus, in summary:

- The cumulative effects of multiple client/consumer sessions throughout the week may lead to a deterioration of the counselor's resiliency or coping abilities.
- Empathy fatigue is a highly individualized process because not all counselors have the same caseloads, work in the same settings, or respond to work-related stress in the same manner.
- Empathy fatigue has both acute and delayed onset reactions that range along a continuum from dealing with clients/consumers who report daily hassles and stress to dealing with those who have experienced extraordinarily stressful and traumatic events.
- Counselors are at the epicenter of their client/consumer stories, they are captive to the client/consumer's toxic emotions, negative vibrations, disharmony, and blocked flows of energy, which occur moment-to-moment within the sessions.
- Counselors are bound ethically to act in beneficent ways: (a) to assist their clients/consumers to reach optimal levels of functioning; (b) to be present throughout the session and respond empathically; (c) when appropriate, to challenge their client/consumer's pattern of dysfunctional thinking, feeling, and behaving; and (d) to act in many other intentional ways to cultivate a holistic plan of optimal functioning.
- The communication (verbal and nonverbal) that is exchanged between clients and counselors during therapeutic interactions becomes integrated through the counselor's thoughts and emotions, which become associated with a physiological reaction. Consequently, some specific or universal meaning is construed regarding the counselor's felt sense of self and what the counselor is experiencing during client interactions. Bringing meaning to this relationship may be an existential or spiritual pursuit for some counselors. Accordingly, clinical supervision early in one's career and ongoing peer supervision are critical for maintaining personal growth, for development as a counselor, and for the protection of clients/consumers from impaired professionals.

CONCLUDING REMARKS

As professional counselors engage in therapeutic interactions, this may predispose them to an empathy fatigue reaction that ranges along a continuum from low or moderate to high. There are also multiple other risk factors, as identified in Stebnicki's (2000) Empathy Fatigue Risk-Factor Functional Assessment, which will be discussed in chapter 10 in part III. Multiple client stories can result in the depletion of the professional counselor's empathic energies, resulting in empathy fatigue.

2 Comparing and Contrasting Professional Fatigue Syndromes

Understanding the epidemiology of the helping professions' new anxiety and traumatic stress-related condition requires a shift in thinking about professional fatigue syndromes in general. First, we should be open to the idea that such fatigue conditions do in fact exist among different helping professionals. Since counselors may experience some type of professional fatigue or counselor impairment, they may distance themselves from friends, family, and colleagues. At times, counselors may feel that they have experienced something more than just a "bad day at the office" and that no one can possibly understand the extraordinary stress and secondary trauma they have been exposed to. Accordingly, I make some important distinctions between empathy fatigue (EF) and other fatigue syndromes in a revision of my previous position on the topic (see Stebnicki, 2000, 2007a). I theorize as follows:

- 1 EF, as opposed to other fatigue syndromes (e.g., compassion fatigue, burnout, vicarious traumatization) is experienced by professional counselors who primarily use person-centered and empathy-focused interactions to build rapport with their clients so they can achieve a therapeutic working alliance.
- 2 EF has acute, cumulative, and delayed onset reactions that are associated with client stories that may or may not be trauma

related. Thus, EF results from the cumulative effects of multiple client sessions that contain themes ranging from daily hassles, stress, anxiety, depression, and addictions to other unhealthy and negative emotions.

- 3 The cumulative affects of multiple client sessions throughout the week may lead to a deterioration of the counselor's resiliency or coping abilities for dealing with client caseloads that range along a continuum from daily hassles and stress to extraordinarily stressful and traumatic issues.
- 4 The professional counselor who facilitates therapy using higher levels of empathy (as measured by valid and reliable empathy scales) will be more affected by empathy fatigue than counselors who exhibit lower levels of empathic concern.

Overall, empathy fatigue results from a state of psychological, emotional, mental, physical, spiritual, and occupational exhaustion that occurs as counselors' own wounds are continually revisited by their client's life stories of chronic illness, disability, trauma, grief, and loss.

The labels that are given to the phenomenon of the professional fatigue syndromes (e.g., compassion fatigue, burnout, secondary traumatic stress, vicarious traumatization) vary depending upon the researcher and the discipline. Despite the conceptual differences, there appears to be one critical factor common to the different helping professions and disciplines. Primarily, the helping professionals who approach their work empathically with their client/consumer appear to be profoundly affected by their client's story of loss, grief, daily stress, anxiety, depression, and traumatic stress. Such a life's work requires that we prepare our mind, body, and spirit to grow and develop in ways that help us to become more resilient in working at such intense levels of interpersonal functioning.

Regardless of the constructs described by researchers with regard to the various fatigue syndromes, the constellation of professional fatigue experiences may be best described anecdotally by various counseling professionals. For professionals as for clients and consumers of mental health services, having a diagnostic category can create fear and anxiety or it can be liberating. There may be some solace in knowing that others in the counseling profession experience similar types of physical, emotional, and spiritual fatigue. At a minimum, it would be beneficial for professional counselors, counselor supervisors, and counselor educators to identify and prevent such professional fatigue syndromes. Thus,

the following distinctions are made between empathy fatigue and other types of counselor impairment and fatigue syndromes.

COUNTERTRANSFERENCE

Countertransference was first discussed within psychoanalytic theory and has been discussed in the general counseling literature for many decades. Freud first described this concept in 1910 as a reflection of the counselor's unresolved internal conflicts that encompasses thoughts, feelings, and emotions that are related directly to specific client issues. Thus, to manage classical (Freudian) countertransference, the therapist must possess healthy emotions, while maintaining a balance of counselor empathy so as not to overidentify with the client's unhealthy emotions (Salston & Figley, 2003). Rogers (1961) suggests that as a result of "negative countertransference," counselors may exhibit reduced feelings of warmth, acceptance, respect, or positive regard for their clients. Emotionally intense relationships can easily blur the boundaries between the therapist's personal conflicts and those of the client, which may eventually hinder the client's capacity to change and work through her or his extraordinarily stressful and traumatic issues.

Professional helpers who work with persons who have life-threatening chronic illnesses and disabilities are especially vulnerable to the effects of countertransference. Rando (1984) discusses this concept as it relates to caregivers of persons that have bereavement or death and dying issues. She states that dying persons touch us personally in at least three ways. They may (a) make us painfully aware of our own losses, (b) contribute to our apprehension regarding our own potential and feared losses, or (c) arouse existential anxiety in our personal death awareness. Thus, professional helpers must take care of their unfinished business, which may relate to feelings of grief, separation by death, and loss.

A more contemporary perspective on countertransference as discussed in the traumatology literature delineates the unique attributes of therapists who often experience countertransference reactions from hearing clients' stories that contain extremely violent and graphic themes. Hence, classical countertransference takes on a new meaning today, especially in trauma counseling (Baranowsky, 2002; Danieli, 1996; Salston & Figley, 2003). In traumatic-specific-transference (TST; Wilson, 2001) and countertransference, there is an unconscious absorption

of the trauma survivor's story by the professional counselor. As a result, the client's traumatic story involves a type of symbolic or parallel experience for the counselor. Since empathy is a helpful form of intense listening that should be facilitated by the trauma counselor (Jackson, 1992), the helper unconsciously makes him- or herself available to the absorption of the client's traumatic story (Figley, 2002b). In dealing with the challenging aspects of either classical or trauma-specific countertransference, the therapist must possess a healthy personality and character structure in order to manage the anxiety associated with clients who have issues of traumatic stress (Hayes, Gelso, Van Wagoner, & Diemer, 1991).

There is however a "shadow side" to frequent empathy with others. For instance, counselors who are unaware of their own unresolved personal issues tend to experience increased levels of countertransference, which may manifest as empathy fatigue reactions. Thus, an empathy fatigue reaction may be much like the experience of countertransference, where the counselor has intense feelings of being overwhelmed by listening to multiple client stories of loss, grief, stress, or trauma. Many therapists who communicate deep levels of empathy will occasionally experience an overidentification with their clients' issues (Gelso & Hayes, 1998). Consequently, after repeated client stories of stress and trauma, professionals may dissociate and distance themselves from their clients' overwhelming feelings of loss, grief, and helplessness.

Managing the natural response of countertransference requires more than just awareness, knowledge of the topic, or the acquisition of a specific set of skills to manage this unconscious process. It is suspected that this process is a function of a unique blend of personality characteristics and other counselor attributes (Hayes et al., 1991). It requires some deeper level of insight to integrate the client's traumatic experience into the counselor's own personal and existential understanding of life.

THE EXPERIENCE OF PROFESSIONAL BURNOUT

The literature on burnout is quite extensive. There are well over 1,100 articles and over 100 books on this topic in the Psychological Abstracts database alone (Figley, 1995). Burnout, a word first coined by Freudenberg (1974), has been described as a state of physical, emotional, and mental exhaustion in which individuals who are "burned out" have

negative feelings about themselves, the other professionals with whom they work, and the clients whom they serve (Maslach, 1982, 2003; Pines & Aronson, 1988). The theoretical aspects of burnout were first discussed by psychologists in the occupational stress literature as it related to human service and mental health professionals. Burnout is considered a specific type of job stress that results from prolonged social and interpersonal interactions between the helper and the recipient (Maslach, 2003). Without the appropriate level of organizational support and internal hardiness, the human service professional is at risk for acquiring this unique type of psychological strain.

The hallmark of the burnout syndrome is a negative shift in the way professionals view people they serve (Maslach, 1982, 2003). As a consequence, professional helpers may respond to their clients with less compassion, genuineness, or unconditional positive regard. There tends to be a progressive loss of physical energy, a loss of the sense of idealism about their job, and a dearth of feelings of personal accomplishment. Pines and Aronson (1988) identified three basic characteristics within the role and function of the professional helper that may contribute to the experience of burnout: (a) the work they perform is emotionally draining, (b) they are characteristically sensitive to the people they serve, and (c) they typically facilitate a person-centered orientation.

One of the most widely used measures of workplace burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981, 1986). Jenkins and Baird (2002) assert that the MBI is the most widely accepted and best validated measure of burnout. The MBI is multidimensional and contains three subscales that have been identified during the scale development process. These three factors include emotional exhaustion (EE; feelings of being emotionally overextended), depersonalization (DP; an impersonal response style to clients), and reduced personal accomplishment (PA; the loss of feelings of competence and success resulting from job stress).

Maslach (2003) recently revisited some of her earlier theoretical constructs about the phenomenon of burnout. She found strong support for first assessing and measuring the situational sources of job-related stress and the interpersonal stressors or demands that are placed on the professional. Traditionally, researchers on burnout tended to overanalyze the personality characteristics and other attributes of the individual concerned. However, this may only be a small piece of the puzzle. Maslach (2003) suggests that when there has been no immediate change in the individual's work environment, then the person concerned tends to view

him- or herself as the cause of the occupational stress. As a consequence, the individual internalizes this belief into her or his cognitive schema (e.g., there must be something wrong with me, I am too incompetent to handle this type of work, I should be able to handle my caseload). Historically, researchers have identified job-related stress and the interpersonal demands of the work environment as explanations for burnout. Thus, personality characteristics were the early rationale used to explain the experience of burnout.

Despite the fact that personality continues to be a factor in assessing and predicting the severity and degree of burnout, Maslach (2003) suggests that the phenomenon of burnout varies widely in terms of the types or groups of individuals that are most affected. For instance, there are sociocultural, career development, and other issues that need to be addressed in regard to interpreting the individual's experience of burnout.

There appear to be some similarities between empathy fatigue and burnout. First, it is recognized that burnout is a cumulative condition that results in physical, emotional, and mental exhaustion. As a consequence, people who are considered burned out become overly involved emotionally in their work, overextend themselves by juggling too many projects all at once, and feel overwhelmed by the emotional demands imposed by other people in their work environment. The experience of empathy fatigue, I believe, is also cumulative in nature. The professional counselor is required to be actively engaged empathically with the client/consumer's issues. In other words, to establish a therapeutic relationship with others and to achieve a working alliance, the counselor should be genuine, possess unconditional positive regard for the other person, exhibit an intense posture of verbal and nonverbal attending and listening, and respond to the client's emotional experience. Consequently, counselors can become overwhelmed by their client/consumer's emotional life story as they are called upon to assist in problem-solving a variety of life issues in a solution-focused manner. Given the multiple client issues and professional demands, it is not surprising that the emotional exhaustion observed in burnout plays a central role in the experience of empathy fatigue.

COMPASSION FATIGUE

Compassion fatigue (CF) is an evolving construct within the field of traumatology and is inextricably linked to both posttraumatic stress disorder (PTSD) and secondary traumatic stress (STS), which will be discussed

below. The terms CF, compassion stress (CS), and STS are used synonymously because there tends to be a parallel experience between CF, CS, STS, and PTSD (Salston & Figley, 2003). The term CF was first discussed in the literature as it related to the burnout that nurses experience when working in high stress situations with those who are traumatized (see Joinson, 1992). Charles Figley (1995, 2002b) has written extensively on this topic. He suggests that professionals who work with others in crisis can also be traumatized by being exposed to the client's intense story of traumatic experience. The primary difference is that the client (known as the primary survivor) is the individual exposed to the traumatic event. However, there is a "cost to caring" in Figley's model, as the professional helper (referred to as a secondary survivor) can acquire a reaction very similar to that of the client's posttraumatic stress experience. Figley (1995) suggests that "those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress" (p. 1) or compassion fatigue.

The research in CF was first developed through hundreds of case studies of therapists who have worked with those who have been traumatized by some critical life event. Anecdotally, these therapists have described a unique kind of stressor through which they have acquired symptoms of frequent sadness, depression, sleeplessness, generalized anxiety, and other forms of emotional pain and suffering that are directly related to their trauma counseling practice. Many professionals tend to avoid these CF symptoms, resulting in a diminished capacity for empathy and compassion for others that they serve. CF not only affects the professional helper but also the helper's family, friends, and colleagues, who may also become secondary survivors of the critical incident. Consequently, there appears to be a "contagion effect" transmitted to the professional's support system (Figley, 1993).

The experience of CF is thought to transcend the cumulative, emotional, mental, and physical exhaustion that is typically associated with organizational burnout. This is because CF is considered to be more acute in nature while burnout is cumulative in its effects. Additionally, burnout has been described as more of a general psychological stressor associated with working with difficult clients having complex issues (Trippany, White Kress, & Allen Wilcoxon, 2004).

More recently, Figley (2002b) has suggested that CF is just one form of burnout. Not all agree, however. Other researchers (Jenkins & Baird, 2002; Schauben & Frazier, 1995) have suggested that burnout is more related to the "chronic tedium of the workplace" rather than to exposure

to clients who have been traumatized. Accordingly, the construct of empathy fatigue (EF) is both the same as and different from burnout or CF. Similarities to EF include the physical energy depletion and emotional exhaustion factors that are observed in burnout and CF. However, it is hypothesized within the theoretical constructs of EF that some preprofessional personality characteristics may predispose the individual to the depletion of the mind, body, and spiritual energy needed to pursue a career in the counseling profession. Additionally it is hypothesized that professional counselors who report having the experience of EF do not necessarily work with clients/consumers who have traumatic issues. Rather, these professionals deal with persons who are trying to cope with daily hassles (e.g., school or relationship issues), significant life stressors (e.g., divorce or legal issues), and life-adjustment issues (e.g., loss of a job, geographic relocation).

SECONDARY TRAUMATIC STRESS

Professionals working with clients/consumers who are closest to the epicenter of a critical incident are indeed secondary survivors of the traumatic event. For many professional helpers, the physical, psychological, emotional, and psychosocial symptoms are very real and tend to mirror the symptoms of the traumatized person (primary survivor). Figley (1993, 1995) and his colleagues have done extensive research in this area and refer to this phenomenon as secondary traumatic stress (STS). Figley suggests that the symptoms of STS are nearly identical to those of PTSD. The experience of STS is acquired by the helper as a natural consequence of knowing about a traumatizing event. This exposure results in a special type of compassion stress that professionals experience because they are compelled to help the traumatized individual(s).

Figley (1995) has advocated for the inclusion of STS as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], *DSM-IV-TR*, 2000). He further contends that PTSD should be renamed “Primary PTSD,” because the same set of symptoms appears in those who are caregivers for the traumatized. Accordingly, professional helpers who are deeply involved with traumatized individuals tend to acquire an experience parallel to that of primary survivors, many of whom are diagnosed with acute stress disorder and then PTSD (30 days later if the symptoms persist). In Figley’s model, the term “secondary traumatic stress disorder” (STSD)

is used to characterize this experience. The only difference between PTSD and STSD is that the client experiences the traumatizing event at first hand while the professional helper experiences it through therapeutic interactions with the traumatized client. Figley believes that it is the unconscious attunement to the absorption of the traumatized victim's stresses and traumas that leads to this type of trauma-specific countertransference experience.

More recently, Figley (2002b) has delineated more clearly his conceptualization of PTSD and STSD:

Compassion fatigue is a more user-friendly term for secondary traumatic stress disorder, which is nearly identical to PTSD, except that it applies to those emotionally affected by the trauma of another (usually a client or family member). Compassion fatigue is related to the cognitive schema of the therapist (social and interpersonal perceptions or morale). (p. 3)

COMPARING AND CONTRASTING EMPATHY WITH COMPASSION FATIGUE

Despite the fact that Figley recognizes empathy as a major resource for trauma workers (Figley 2002a), I would like to make a basic distinction between empathy and compassion fatigue. I contend that empathy fatigue is a condition acquired by those professionals who first and foremost are perceived by self and/or others as facilitating therapeutic interactions in an empathic manner. Second, these professionals may or may not be exposed to clients that have extraordinary stressful or traumatic issues to deal with. Rather, empathy fatigue can be acquired by professionals who approach their work empathically and deal with a variety of clients/consumers who have been exposed to everything from daily hassles (e.g., school, work, relationship problems) and life adjustments (e.g., divorce, job loss, major grief) to traumatic stress-related issues (e.g., exposure to death, rape, homicide).

Professionals who have obtained their graduate-level training in nationally accredited counselor training programs (i.e., Council for Accreditation of Counseling and Related Educational Programs [CACREP] and Council on Rehabilitation Education [CORE]-accredited counselor training programs) may be more at risk for empathy fatigue because the concept and practice of empathy is inherent in various parts of the curriculum. This is the point at which supervisees typically first

acquire the basic and advanced skills of attending, listening, paraphrasing, questioning, summarizing, and responding empathically to their clients' stories. These stories may or may not contain themes of extraordinarily stressful and traumatic events; especially during the supervisees' first clinical experiences (i.e., practicum and internship). Accordingly, counselors who approach their work compassionately use the skills of empathy as a tool or resource to establish a client rapport and build the therapeutic working alliance. More importantly, this is where many preprofessionals begin to recognize that their empathy fatigue buttons are being pushed. Depending upon the competence of the supervisee's clinical supervisor, the supervisee may or may not understand this as a countertransference experience.

In Figley's (2002b) conceptualization of CF, he suggests that "empathy is the vehicle whereby helpers make themselves open to absorption of traumatic information" (p. 20). Again, I contend that empathy fatigue can be acquired by professionals who work in areas other than trauma counseling. Both acting in a compassionate manner and using the skills of empathy appear to predispose the therapist to the absorption of the client's stressors. If a counselor is acting compassionately and using the skills of empathy on a daily/weekly basis, then the counselor may become fatigued by the cumulative effects of multiple client stories that may or may not contain themes of extraordinarily stressful and traumatic events. Thus, for some counselors, empathy fatigue is a cumulative process, while others may experience it more rapidly as in CF.

I also contend that counselors who facilitate therapeutic interactions in a highly empathic and intuitive state may experience empathy fatigue more easily. Likewise, persons who are perceived by themselves and others as highly empathic may be more prone to an empathy fatigue reaction. Thus, empathy may be a personality state or trait of some professional counselors, and some may be more affected because empathy is part of their personality structure.

It is possible that many counselors have personalities that overidentify with their client's issues, resulting in a negative form of countertransference. Consequently, professionals who do not have the awareness and capacity to monitor this maladaptive response or do not receive competent clinical supervision may be repeating the pattern of having their empathy fatigue buttons pushed. These professionals may experience empathy fatigue on a daily/weekly basis and thus it becomes a more deeply rooted trait or state in their cognitions, schemas, emotional brain, physiology, and spirit.

Overall, CF is viewed as more acute in nature, resulting from the experience of counselors who deal mostly with clients who have traumatic stress issues. On the other hand, EF results from dealing with clients who have a variety of nontraumatic issues. The cumulative effects interact with the counselor's mind, body, and spirit, and professionals who exhibit higher levels of empathy during therapeutic interactions tend to be more predisposed to this particular fatigue experience. This process may begin with a personality structure characterized as possessing high levels of both compassion and empathy. However, having to be empathically available to clients/consumers on a daily/weekly basis has an emotional, physical, and spiritual cost. The theoretical framework for empathy fatigue will be discussed in greater detail at various points in this book in order to provide better clarity.

VICARIOUS TRAUMATIZATION

The term vicarious traumatization (VT; McCann & Pearlman, 1989, 1990a, 1990b; Pearlman & Saakvitne, 1995) has been used widely to describe professional counselors' complex traumatic reactions resulting from cumulative exposure to primary survivors' traumatic events. Vicarious victimization (McCann & Pearlman, 1990b) and contact victimization (Courtois, 1988) have been used in the literature to describe similar reactions. However, VT is a unique concept because it presumes a developmental and constructivist model of personality in which meaning and relationship are integral to the human experience (Pearlman & Saakvitne, 1995). The developmental and constructivist model is an interpersonal theory that explains the impact of trauma on the counselor's psychological development, adaptation, and identity. As a result of this traumatic exposure, there appear to be profound changes in the cognitive schemas of the counselor's identity, memory, and belief system. It is this intense empathic engagement with the client's traumatic issues that appears to transform the therapist's inner psychic experience and results in the experience of VT. The psychological symptoms are reported to include depression, despair, cynicism; alienation from friends, colleagues, and family; premature job changes; and a multitude of other psychological and physical symptoms that are similar to those of the primary trauma survivor (Pearlman & Saakvitne, 1995).

The differences between VT and the other fatigue syndromes previously mentioned are not always clear in the literature (Figley, 1995;

Trippany et al., 2004). For example, VT is not always associated with the counselor's reaction to her or his own past traumatic experiences. The experience of VT appears to be mostly associated with the counselor's here-and-now experience when counseling the traumatized. It appears there may be some overlap with STS, since the VT experience can be emotionally, interpersonally, and physically debilitating to the professional helper. Overall, within the framework of recognizing, assessing, and treating professional fatigue syndromes such as VT, we see a profound personal cost to the therapist who is empathically engaged in counseling those who have been traumatized.

LOADING

The literature addressing the phenomenon of loading is sparse. Eisner (1995), who describes this experience, states that loading occurs when the professional takes on another person's psychic pain. Eisner's discussion of this phenomenon is not limited to the therapist's shared pain, which may result in a tremendous energy drain. Rather, this experience has been observed when two individuals are emotionally tied to one another (e.g., spouses, family, friends). Further, loading can be experienced where each takes on the "load" of the other's stressful, traumatic, or critical life-changing event. Loading can occur when the "ill person" appears to transmit or project his or her pain, suffering, and negative moods to the other person, who may or may not be a professional helper. Loading is particularly familiar to those in the helping professions who work with persons experiencing issues of loss, grief, death, and dying.

CONCLUDING STATEMENT

The overall effect of listening to multiple client stories of stress, anxiety, depression, trauma, grief, and loss appears to a depletion of the counselor's interpersonal effectiveness, creating an experience of mental, physical, cognitive, and spiritual fatigue. Depending upon the counselor's work setting and the type of clients served, this experience can have both acute and cumulative consequences.

A point that is of paramount importance to the construct of EF is that this experience may be either a chronic or an acute negative reaction in a variety of counseling interactions. Consideration should be given to

the possibility that an EF reaction for some professionals is a “counselor trait” as opposed to a “counselor state.” Hence, the cumulative effects of the professional counselor’s EF experience may lead to a chronic and persistent mental health condition that may, in fact, manifest as a chronic malaise or transient condition that parallels that of the client. As the counselor’s dysthymic mood lingers, it may go unrecognized by self and/or others. Overall, each professional will react to different levels of fatigue. In the case of EF, this reaction ranges along a continuum from low or moderate to high levels of fatigue.

There are various assessment instruments that measure counselor impairment and professional fatigue. However, some researchers have viewed self-report measures of counselor impairment and professional fatigue as subjective and artificial in nature. Self-report instruments tend to qualitatively measure the individual’s unique experience of specific feelings and emotions. Additionally, this type of measurement relies on the personal, subjective experience of the professional counselor who qualitatively assesses the client’s sense of personal distress, anxiety, or depression.

Regardless of how the different professional fatigue syndromes are measured, at the end of the day, the professional will require self-care strategies to continue in the chosen profession as a competent and ethical counselor. The counselor’s cumulative exposure to multiple client stories, regardless of the degree of intensity, seems to interact with the counselor’s mind, body, and spirit, resulting in a type of loss or detachment from the self. As we will see in chapter 4, the meaning of empathy changes depending upon who is observing such a trait or state.