1. What Is Compassion Fatigue?

When Judith Herman, author of the highly acclaimed book *Trauma and Recovery,* spoke at a conference on child sexual abuse in 1998, she described the volunteers who staffed the health stations during Vietnam peace marches. The volunteers thought they were there to help if someone got injured, but when the marchers started getting tear-gassed and coming to the health stations, the health workers got doses of tear gas as well.

Like these volunteers, advocates get doses of the trauma while helping trauma survivors heal. This work, however, is not without substantial meaning and reward. McCann and Pearlman (1990) point out that, by engaging empathetically with survivors to help them resolve the aftermath of violence and trauma, advocates open themselves to deep transformation that encompasses personal growth, a deeper connection with individuals and the human experience, and a greater awareness of and appreciation for all aspects of life.

Some people have a tremendous capacity for empathy because of their own past victimization. Survivors often become particularly sensitive to the fears and concerns of victims, the inadequacies of victim services, or the magnitude of victim needs, all of which may contribute to a desire to become involved in victim services.

Survivors of sexual assault may have had a positive experience with the system and now want to offer other victims the same compassionate care. Alternatively, they may have had a very disappointing experience and want to prevent others from having the same experience.

Every victimization and recovery is different. Experience may or may not give a survivor greater empathy for other victims. Each survivor reacts differently; advocates cannot expect someone else to react as they did or to have the same needs and concerns. Survivors may have continuing unresolved issues such as anger, depression, fear, and difficulty trusting others. It will be very hard to help others deal with issues that they have not resolved.

The darker side of this work, however, includes changes that are similar to those experienced by survivors. Compassion fatigue is defined as the enduring negative psychological consequence of caregivers' exposure to the traumatic experiences of victims in their care (Schauben and Frazier 1995).

There are various subtleties of compassion fatigue in current literature. Mary Jo Barrett, director of training and consultation at the Center for Contextual Change, lectures widely on compassion fatigue. She differentiates between compassion fatigue, burnout, secondary posttraumatic stress, and vicarious traumatization. Understanding each of these better prepares advocates to identify and cope with the issues.

According to Barrett, all individuals have energy in five different compartments: intellectual, physical, emotional, spiritual, and sexual. When your work depletes these energy reserves, especially your emotional and spiritual energies, the result is compassion fatigue. Advocates working with sexual violence issues are likely to be depleted of sexual energy as well.

Visualize yourself as a goblet of energy that gets depleted drop by drop. Clients rely on advocates' energy for their healing; however, if advocates neglect their own needs too long and do not replenish their goblets, they run dry. With emotional and spiritual energy reservoirs drained, advocates no longer have the vital energy to offer their clients or themselves, and they begin to suffer from compassion fatigue.

Burnout

Burnout is the depletion of physical and intellectual energy that happens when you are overworked, stressed, and involved in demanding situations over a long period of time. As a result, you may feel tired, rundown, overwhelmed, and irritable.

Burnout also has been associated with a reduced sense of personal accomplishment and with discouragement as an employee (Maslach and Jackson 1981).

Burnout can happen concurrently with the emotional, spiritual, and sexual energy depletion indicative of compassion fatigue. This occurs in mental health workers who have unmanageably large caseloads, for instance. Individuals also may experience burnout in other professions, such as technical or business fields; however, they generally do not have their emotional and spiritual energy challenged or used up.

Although these individuals may become tired, drained, and unmotivated, they are not inclined to begin wondering if people are basically good or evil, or if the world is safe, both of which may happen to those repeatedly exposed to violence.

Secondary Posttraumatic Stress (SPTS)

SPTS is a specific form of compassion fatigue that occurs when we get symptoms of posttraumatic stress disorder (PTSD), including sleep disturbances, nightmares, intrusive thoughts, flashbacks of clients' stories, exaggerated startle response, irritability, withdrawal from others, feelings of increased vulnerability, and emotional reactions such as fear and anxiety.

As someone who works with victims of sexual violence, you are susceptible to SPTS because you are repeatedly exposed to traumatic events and you accumulate traumatic memories which affect your physiological reactions and view of the world. Just as PTSD is a normal reaction to an abnormal event, SPTS is a normal reaction to the stressful and sometimes traumatizing work with survivors (Rosenbloom, Pratt, and Pearlman 1995).

Advocates and trauma therapists are especially at risk, as are people who are close to the survivor. If you begin to experience these symptoms but do not understand why, the symptoms begin to consume all of your energy. You may see fear where there is no fear, feel crazy or unlike yourself. SPTS is cumulative; symptoms increase over time. Therefore, self-care is important to prevent SPTS from impairing your work and life.

Vicarious Traumatization (VT)

In contrast to the cumulative nature of compassion fatigue, burnout, and SPTS, vicarious traumatization can emerge suddenly. It happens when you are actually traumatized during your job; for example, you have a traumatic reaction upon hearing a survivor's account of the assault that is particularly painful to you, or you witness violence or its immediate aftermath.

2. Effects of Compassion Fatigue

Compassion fatigue disrupts your frame of reference (identity, worldview, and spirituality), self-capacities (eating, sleeping, exercising, hobbies, and relationships with friends and partners), and ego resources (the ability to self-monitor) as outlined on the following pages (McCann and Pearlman 1990).

Disruptions in Frame of Reference

Compassion fatigue can shake the foundation of your basic identity. As a result of working with trauma survivors, you will likely experience disruptions in your sense of who you are as a woman/man, activist, partner, caregiver, and mother/father, or how you customarily characterize yourself (Pearlman 1995).

Such disruptions occur when your identity becomes too aligned with your work. You may find yourself putting in too many hours, taking more calls than you can handle, and believing that your work is a mission that takes priority over all of your other needs.

Compassion fatigue also can disrupt your worldview, including your moral principles and life philosophy (Pearlman 1995). Repeated exposure to violence and suffering can cause you to question your beliefs about the world and its inhabitants, whether random acts of violence are inevitable, or if justice exists.

You may begin to feel unsafe and vulnerable, checking the backseat of your car or feeling unusually afraid at home. Spirituality, defined here as your sense of meaning and hope, appreciation of a larger humanity, and sense of connection with a higher power, may be challenged by your work with trauma survivors (Pearlman 1995).

You may struggle to maintain your faith and trust, belief in a higher power, and sense of cosmic meaning and goodness.

Another type of disruption reported by trauma workers is the intrusion of sexually traumatic images while engaging in sexual activity (Maltz 1992). This is a distressing example of how images from your professional life can blur into the intimacies of your private life. One way to deal with this intrusion is to explain the cause of your distress to your partner (without revealing any details that would betray confidentiality) and focus on processing your own feelings and need to reconnect (Pearlman 1995).

Disruptions in Self-Capacities

Engaging empathically with client after client can be draining, and one response is to shut down emotionally (Pearlman 1995). As a result, you may tend to refuse social engagements or activities as a way of storing up energy to cope with the demands of your job. You may find yourself answering your phone less or making excuses to stay home. This coping mechanism is particularly maladaptive because you limit your life while simultaneously severing yourself from some of the most effective ways to restore your energy. Connection is an antidote to violence and helps caregivers maintain the optimism and hope that clients rely on for their own healing.

You also may notice disruptions in self-care habits. Your eating habits may steadily worsen, and your consumption of caffeine, alcohol, or nicotine increase. Sleep disturbances are common, as are changes in sexual appetite. Compassion fatigue may affect your overall motivation, and you may see the hobbies you once enjoyed become a thing of the past.

Disruptions in Ego Resources

Ego resources refer to being able to effectively meet your psychological needs and manage interpersonal relationships. These resources include self-examination, intelligence, willpower, sense of humor, empathy, and the ability to set and keep boundaries, all of which can be affected by working with issues of sexual violence (Pearlman 1995). Regarding your overall functioning, these disruptions are arguably the most insidious. When your ability to step back and assess your choices and behaviors becomes impaired, it is difficult to even recognize that you have a problem or no longer feel fulfilled and balanced.

Costs of Compassion Fatigue

The consequences of compassion fatigue are pervasive and real. Those who suffer from it find it increasingly difficult to attend to survivors with an empathetic, hopeful, and compassionate response. Once affected, advocates may dread going to work and taking calls, become irritable, and appear to shut down or distance themselves when interacting with survivors. In the worst circumstances, compassion fatigue can result in caregivers changing roles from the caregiver to the victim.

Both caregivers and supervisors must be aware of this possibility and recognize early symptoms, such as feeling used or unappreciated by the system or the survivors they serve.

It is important to remember the rewards of advocacy even when considering its possible drawbacks. In a study of both sexual assault counselors and those who work with a wide variety of populations, Schauben and Frazier (1995) found that counselors' disruption in their belief about the safety of the world and the goodness of others, PTSD symptoms, and self-reported compassion fatigue were associated with the percentage of sexual assault survivors in an individual's caseload.

Yet, working with a higher percentage of rape survivors was not correlated with job burnout or the negative effects associated with depression. They concluded this was likely because many caregivers also reported the work's positive aspects which they found rewarding, including being able to help people in crisis move toward recovery. In this light, McCann and Pearlman (1990) suggest that you can remain connected to survivors and protect yourself emotionally by remaining conscious of the broader context. For example, while survivors are telling their accounts of sexual violence, keep remembering that they have survived, are now connected to caring people and helpful resources, and that healing can and does happen.

Compassion fatigue and its variations, the terms of which are often used interchangeably in the literature, pose a problem to caregivers, yet our profession has only recently begun to talk about it. We still work in a culture where it is largely unacceptable to talk about feeling exhausted or overwhelmed or not connecting with clients.

However, if you are good at advocacy work, it is very difficult not to get compassion fatigue; it is an occupational hazard. The only way to avoid it is to not care, which is hardly an option. The only way to continue caring is to pay attention to how you are being affected by your work, prioritize your own self-care, and do whatever you need to do to keep refilling your goblet again and again.

3. Maintaining Healthy Boundaries

It is essential that advocates maintain healthy boundaries with the survivors with whom they work. This means being willing and able to set limits on what advocates will do for victims and when advocates will be available. Being a good advocate does not mean doing anything asked at any time; rather, it requires being able to distinguish between appropriate and inappropriate client requests. There are times when it is perfectly legitimate not to meet the requests of the victim and to put our own needs ahead of those of the victims.

4. Strategies for Self-Care

Caregivers generally know what to do to help themselves feel healthy, but they are often too tired to do it. Once advocates understand compassion fatigue, however, they must recognize that taking care of themselves is both their right and their responsibility and they must commit to replenishing themselves. Advocate supervisors also must support their staff in doing the things that staff need to do to keep themselves healthy. Supervisors need to set a good example by making self-care a priority in their own lives as well.

The alternative is to continue doing advocacy at an impaired level or leaving the field entirely, neither of which serves survivors or advocates. Advocates should figure out what depletes them, then automatically do something to replenish that energy. Effective self-care means raising their awareness of how well they are/are not eating, sleeping, exercising, socializing, enjoying life, spending time with family, and participating in the hobbies and activities they love, then taking measures to make their own needs a priority.

As much as it is normal for a rape survivor to experience symptoms of distress because of the assault, so it is for the advocate. It does not mean you are doing anything wrong, or that you are unfit for this work. It means you need to recognize the impact and take measures to take care of yourself, reducing your distress by whatever means you can reasonably achieve.

It is crucial that advocates have a supervisor for their clinical work with whom they meet regularly to discuss cases. The frequency of these meetings will depend upon the amount of time the advocates work, the number of cases they see and their level of experience. Supervision once a month is probably the minimum for maintaining consistency. Less experienced advocates/counselors should schedule more frequent meetings.

When meeting with a supervisor, advocates will want to discuss:

- Difficult, new, or unusual cases.
- Cases involving vicarious trauma.
- Cases with boundary issues.
- Cases in which they meet with the victim more than once a week, or 12 total sessions.

The activity provides the opportunity to explore self-care planning.