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COMMENTARY

Compassion Fatigue and Secondary Traumatization: A Second Look

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The recent special issue (September 2007) of Clinical Social Work Journal on "Compassion Fatigue" highlights the important topic of the social worker's subjective response to the stressors that are inevitably encountered in social work practice. Brian Bride, Charles Figley and their colleagues have provided an important service to our profession by highlighting these issues in a series of articles, books and research studies over the past 20 years. While social workers focus daily on caring for others, issues of self-care are too often neglected. The constructs of "compassion fatigue" and "secondary traumatization" have played an important role in raising awareness of these self-care issues throughout the social work profession: in direct practice, administration and academia.

At the same time, our colleagues in the "compassion fatigue" realm have taken a largely ahistorical approach in their scholarly pursuits, specifically neglecting a large body of literature on countertransference which greatly enhances our appreciation of the self-care issues involved in social work practice. For example, in a recent NASW article, Brian Bride suggests that "secondary traumatization" is conceptualized as distinct from "pronounced countertransference" (Stoesen 2007, p. 4). In this recent special issue of CSWJ, countertransference is barely mentioned, although it is frequently discussed in this journal's pages.

Reviewing Figley's extensive writings, it appears that he uses an outdated and limited definition of countertransference which suggest that the social worker's past life experiences trigger an emotional reaction to current work experiences. According to Figley (2002), countertransference is "an emotional reaction to a client by the therapist—irrespective of empathy, the trauma, or suffering. It is defined as the process of seeing oneself in the client, of over identifying with the client, or of meeting needs through the client (Corey 1991). In contrast to compas/sion fatigue, countertransference is chronic attachment associated with family of origin relationships and has much less to do with empathy toward the client that causes trauma" (pp. 1433–1434).

Although Figley acknowledges that the concept of countertransference has emerged from "psychodynamic therapy," his sole reference (to Corey's book) is to the counseling literature. In my limited review of Figley's writings, I could not find a single reference to the voluminous psychoanalytic or clinical social work literature on countertransference.

Figley's differentiation of countertransference and compassion fatigue is illustrated by a clinical vignette in an article written for psychotherapists (Figley 2002). He reports on a client, Jane, a young graduate student in counseling psychology who "was not responding well to an assigned client" and was making "clinical errors" which were "associated more with how the client's story was upsetting her." The client was a female college student who was having adjustment problems in separating from her family. Jane's supervisors noticed that "her client felt guilty about leaving her mother; that the client had been over-functioning while the mother had developed a considerable dependency that needed addressing." Jane often shifted the focus of therapy to other issues. In therapy, "Jane wanted to talk about and face these clinical errors... and, reluctantly, her mother's chronic illness. We quickly moved to Jane's feelings of guilt about her own mother's condition...'' (p. 1434).

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Most psychoanalytic psychotherapists would immediately recognize these issues as examples of countertransference phenomena, although they might approach the situation from different theoretical and clinical perspectives. But Figley explicitly argues that countertransference is not involved here: "Jane is experiencing secondary traumatic stress reaction called *compassion fatigue* associated with both her mother and her client" (p. 1435). Later he states that Jane had "the characteristic pattern of compassion fatigue in contrast to burnout and countertransference" (p. 1436). Figley argued that Jane's response was not countertransference because "it had more do do with Jane's exposure to a traumatic event involving her mother than to attachment issues" (p. 1436).

If the reader is confused here, it is because the analysis itself is confusing. In one point in this article, Figley argues that countertransference is defined by attachment issues with family of origin. But when discussing Jane's issues, the "traumatic event involving her mother" becomes the rationale for describing her clinical errors as evidence of compassion fatigue. And given the focus in the recent Clinical Social Work Journal issue on such populations as military veterans, disaster survivors and HIV/AIDS patients, expanding the scope of the compassion fatigue construct to encompass treatment of guilt-ridden college students suggests an almost total lack of specificity in this construct.

The differentiation that Bride, Figley and their colleagues attempt to make between compassion fatigue and countertransference seems driven more by intellectual prejudice than intellectual pursuit. While they address the important question of how the interpersonal field of the helping relationship impacts the internal life of the social worker or psychotherapist, they seem uninterested in any exploration or consideration of the psychoanalytic literature on this topic.

Contemporary psychoanalytic thought encompasses much more than countertransference phenomena; it reflects larger interactional currents reflected by interpersonal, relational, intersubjective and object relations perspectives. In all of these perspectives, the impact of the reciprocal interactions between client and helper on the subjective reactions of both parties are carefully examined. Given the developments in psychoanalytic thought and practice in the past half century, it is would be surprising if a psychoanalytically trained clinician today ignored the subjective impact of the current therapeutic situation and focused only on historical antecedents.

This interactional approach to countertransference phenomena was pioneered 60 years ago by Winnicott (1978) in his classic 1947 paper "Hate in the Countertranference." Moving beyond a classical psychoanalytic view of countertransference as suggestive of therapist psychopathology, Winnicott explored the impact of psychotherapeutic intervention on the therapist with both neurotic analysands and hospitalized psychotic patients. Also, reflecting his social work and pediatric experiences, he expanded his exploration of the subjective experience of caregiving to include the more banal experiences of caring for foster children with behavior problems and even ordinary infants. In his discussion of the emotional responses of foster parents and mothers, Winnicott never linked these responses to the psychopathology of the caregiver; he only focused on the here-and-now of the caregiving situation.

Even earlier, Clare Winnicott, D.W. Winnicott's wife, acknowledged the stress of caregiving in her wartime work with evacuated children. As a social worker supporting group homes with evacuated children with special needs, she reported that the "staff living in the hostels were taking the full impact of the children's confusion and despair.... They were demanding to be told *what to do* and were desperate for help in the form of instructions" (Kanter 2004, p. 124). Consultation was provided to address these feelings of "compassion fatigue" without ever suggesting that these responses resulted from the caregivers' childhood experiences.

Examining these issues from the perspective of contemporary social work practice, Brandell (2004) defines countertransference as "the broad range of subjective reactions, whether conscious or unconscious, educed from the therapist in the context of ongoing therapeutic interaction with a client. These reactions may consist of fantasies, thoughts, attitudes, affects, counterreactions, counterresistances, behavior, and behavioral enactments. Although specific countertransference reactions may involve displacements of affective or ideational phenomena from historically important relationships of the therapist, this is neither a universal feature nor a requirement" (p. 105).

similar perspective is expressed throughout the clinical social work literature. Edwards and Sanville's (1996) edited volume "Fostering Healing and Growth: A Psychoanalytic Social Work Approach" has chapters which explore countertransference responses with domestic violence survivors and perpetrators, anorexic young women, HIV-infected patients, and substance abusers. And a search of the titles and abstracts of the Clinical Social Work Journal immediately identified 80 articles which focus on these issues with a wide array of client populations.

Including this literature in a discussion of compassion fatigue would greatly enhance the understanding of self-care issues in social work practice. The constructs of "compassion fatigue" and "secondary traumatization" encompass, as evidenced both by the articles in the September 2007 special issue of this journal and by the aforementioned case of Jane, an enormous array of clinical

phenomena in helping relationships. Applying the diagnosis of "compassion fatigue" to a distressed social worker is akin to applying the diagnosis of "fatigue" to a medically ill patient. The symptom is identified, but there is, essentially, no differential diagnosis. And the "treatment" for "compassion fatigue" is as non-specific as the "treatment" for "fatigue".

Perhaps we might return to the medical diagnosis of "neurasthenia" which preoccupied physicians in the second half of the 19th century. The patient was tired and lacked energy. Visits to spa resorts were often recommended where patients would bathe in mineral waters and engage in relaxing pursuits.

Such interventions are also helpful for social workers experiencing "compassion fatigue." A recent article on secondary traumatic stress (STS) in NASW News suggested that social workers can prevent STS by "getting enough sleep and exercise and eating well. Getting social support and asking for help are also important" (Stoesen 2007, p. 4). In the same article, Brian Bride is quoted as recommending "maintaining a balance, stress management, exercise, spending time with family and friends, and on an individual level getting pleasure and relaxation. Making sure to take vacation and personal time" (p. 4). Even D.W. Winnicott made a similar recommendation in a 1943 talk to social workers (D.W. Winnicott 1943, unpublished manuscript): "The social worker's main function... is to bear emotional burdens... This bearing of burdens is a heavy job. That is why the psychiatric social worker has to be told to go away and take a proper holiday lest she become a case herself."

But while these interventions to reduce the stress and fatigue experience of social workers are undeniably helpful, they fail to explore and address the many differential causes of such responses. This is where the neglect of the relevant psychoanalytic literature exacts a heavy price. As suggested earlier, many clinical social workers and psychoanalytic therapists have explored these issues for decades, identifying diverse etiological pathways which result in these global syndromes of worker distress. And these pathways, as might be expected, suggest an array of both preventive and ameliorative strategies for addressing compassion fatigue which go beyond the aforementioned generic nostrums.

Figley (1995) has defined *secondary traumatic stress* as "the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). While straightforward, this definition has some implicit difficulties.

First, many, if not most, social work interactions are not a response to a "traumatizing event." More often, client difficulties are chronic in nature: alcoholism and substance abuse, severe mental illness, poverty, racism, homelessness, chronic mental illness, aging and so on. Reducing all stress to traumatic origins oversimplifies most human suffering.

Second, while exposure to client suffering (or any human suffering) is inherently stressful, it is how this suffering is experienced and responded to by the social worker that impacts whether the stress is bearable, and even growth-enhancing, or whether it is corrosive and even destructive.

Reflecting on my professional practice, I have identified five factors that impact how exposure to client suffering affects social workers.

1. The most obvious factor is social worker competence. Simply, does the social worker have the skills and training to accomplish his or her professional objectives? It is hardly surprising that the topic of "compassion fatigue" has emerged as the quality of practice faculty and field supervision in social work training has diminished, as agency supervision has too often become an administrative function, and as in-service training and consultation has been slashed. Too many social workers lack the skills to do their jobs. Worse, many of these same social workers are unaware of their lack of competence; they simply flounder in the workplace without a template for professional development. Without these professional skills, feelings of helplessness flourish.

Some have suggested the need for more training in "compassion fatigue" and "secondary traumatization"; I advocate more training in basic clinical skills.

The animus in social work education and in agency practice toward psychodynamic concepts has played a role here. Too many social workers have difficulty identifying and addressing negative transferences; they plunge ahead as if a collaborative relationship exists, only to discover that their clients are "non-compliant." Similarly, there is often little acknowledgment of client ambivalence; workers encourage clients to achieve their goals by a given target date, unaware that many are torn by a hidden agenda of conflicting aspirations. A social worker may work diligently toward helping a client achieve *independence*, ignoring the powerful riptide of dependent yearnings. When one swims against strong currents, *fatigue* is the inevitable result.

2. A lack of realistic professional expectations is frequently a common reason for worker distress. This may have multiple causes. Some social workers have an unrealistic wish to rescue all their clients and become distressed at the discrepancy between their professional aspirations and actual outcomes. In baseball, a batter who gets on base 30% of the time is an All-Star. And improving a batting average from .250 (25%) to .300 (30%) is a tremendous

accomplishment. But a social worker with a similar batting average is a disappointment.

Yet if internal pressures to achieve success with all clients are not in play, then external pressures often play a role. Many agencies adopt a practice model and ethos that implies "no client will be left behind." Research findings will be touted that suggest that a given practice model will transform the lives of most, if not all, clients with a given difficulty. Yet the data, carefully examined, almost always yields a quite different picture.

For example, the ACT (assertive community treatment) model for severe mental illness has been replicated throughout the nation. One purported outcome of this model has been a substantial impact on employment and research findings found a statistically significant increase in days worked (Stein and Test 1978). Yet a naturalistic study of the same client sample reported that not a single client who remained in the program was employed on an ongoing basis (Estroff 1981). The experimental group merely lasted a few weeks longer before losing their jobs.

Furthermore, although many social work interventions are long-term, most empirical studies are short-term. Hogarty et al.'s (1997a, b; Hogarty 2002) impressive research on a "personal therapy" model with schizophrenic clients is perhaps the only social work intervention I know of where the intervention and data collection continued for 3 years. What one learned is that the experimental intervention had no significant impact in year one, a modest impact in year two and a dramatic impact in year three. Without competent supervision or consultation, many social workers would become overwhelmed with "compassion fatigue" in year one, unaware that they were establishing a foundation for future progress.

3. Yet another cause of "compassion fatigue" is cumulative countertransference responses from a caseload of clients with similar difficulties. Social workers in a hospice may find themselves struggling with cumulative feelings of grief, guilt, and helplessness. Social workers in a correctional setting may struggle with feelings of rage and narcissistic injury while dealing with a sociopathic clientele.

The capacity of the social worker to effectively contain these affects is often greatly affected by temperament and prior life experience. A social worker who grew up in a noisy household may find it easier to work with a caseload of acting out adolescents. Alternatively, a worker who grew up with an alcoholic parents may find it difficult to contain his or her rage and disappointment when substance abusing clients "fall off the wagon."

While some of these issues can be worked through in supervision or even personal psychotherapy, I've found that social workers need to find a client population and agency setting which suits their temperament and defensive structure. A worker who becomes easily over-stimulated will likely find the environment of a busy hospital overwhelming, but may thrive working with the developmentally disabled. Similarly, a worker who is uncomfortable with anger or rage may do best avoiding acting out clients, but may do best with clients who respond best to a gentle approach. Compassion fatigue is minimized when social workers have the self-awareness, perhaps with the support of a sympathetic mentor, to find a practice setting that compliments their personal qualities and limitations.

4. Some clients elicit ubiquitous countertransference responses which tend to affect most social workers in a similar manner. For example, a chronically suicidal client can elicit intense feelings of helplessness among workers throughout an agency. A particularly unkempt client can elicit disgust and revulsion in most workers. Or an orphaned child whose parents were murdered can evoke rescue fantasies in many staff.

In such situations, supervision or consultation can greatly help the worker in containing these affects and finding a mode of effective intervention. Often such situations occur with clients who have an unconscious motive to reenact prior experiences. The suicidal client may want to reenact a scenario where a rescuer's efforts are ultimately foiled or a situation where only extreme expressions of distress attracted parental sympathy. Or the unkempt client may be reenacting a scenario of rebellion in response to controlling parents. Understanding the role that the worker is expected to play in these scenarios can greatly increase one's capacity for empathy and minimize a sense of fatigue.

5. Finally, some clients elicit idiosyncratic countertransference responses which have a unique impact of specific workers. Most of us have had experiences with specific clients who just know how to "push our buttons." We may find ourselves impotently trying to control a "manipulative" client or futilely attempting to rescue the "damsel in distress."

Sometimes, this involves participation in a re-enactment which requires a unique participant; the "casting call" required a specific sort of performer—and the worker finds him or herself in a "role of a lifetime." A worker in this sort of interaction will likely find him or herself ruminating about the client and often talking compulsively about the situation with colleagues. Again there is a sense of being swept away by a powerful riptide of unconscious forces. A skilled supervisor or consultant often can help extricate the social worker from such situations with minimal damage to the client or worker. And, in other instances, such support can help the clinician work through the situation with the client, enabling both to grow from the experience.

I reflect here on Rose, a client I treated who suffered from a severe borderline personality disorder with chronic

suicidality. This highly intelligent woman was capable of great insight as well as dramatic acting-out. In one instance, she survived a severe overdose by the timely visit of an acquaintance who discovered her in a comatose state and called 911.

Several months later, another acquaintance rushed breathlessly into my office and told me I needed to go immediately to Rose's apartment, just blocks from the agency. I rushed to the apartment and found blood oozing from several dozen minor cuts on one arm. Rose begged me to take her to the emergency room, but I refused and insisted that she go to the hospital with her acquaintance.

The next morning I discussed the situation with an experienced supervisor, expressing my helplessness and frustration in treating Rose. He helped me recognize that I was also angry at Rose; her acting-out repeatedly disrupted the therapeutic relationship and my anxiety regarding her survival interfered with my empathic capacity. I visited Rose in the hospital and directly expressed my anger with her. She was shocked at my reaction, but it helped her realize that there were two people in our relationship. In later sessions, we explored the meaning of her suicidal behavior. This incident was the last suicidal gesture and hospitalization and Rose continued to achieve a substantial recovery.

In other situations, there are no unconscious motives when the client "pushes our buttons." The social worker's responses reflect his or own prior life experiences, temperamental inclinations or defensive structure. Sometimes, working through these feelings in supervision can be a growth experience for the clinician. In other situations, transferring the client to another worker is the best option.

Conclusion

The constructs of compassion fatigue and secondary traumatization point us in an important direction, raising our awareness of the stress and burdens implicit in social work practice. Yet the lack of etiological specificity offer little guidance for ameliorating these conditions beyond the generic nostrums of rest, relaxation and support. A more careful examination of these phenomena reveals very different pathways of causation: inadequate professional training, unrealistic expectations, and an array of countertransferences responses. Preventing or ameliorating compassion fatigue involves addressing the root causes, not just providing palliative care to the overt symptoms.

Over time, we learn that we cannot resolve all conflicts, resolve all situations or assist all clients. Returning to the baseball metaphor, we learn that we are suited to play some positions more than others and we put our talents to use where we will be of most use and derive the greatest satisfaction. This reflects Figley and Bride's concept of "compassion satisfaction," an antidote to compassion fatigue. This concept was eloquently articulated by Clare Winnicott in her 1964 paper "Development Toward Self-Awareness"

"To sum up, what are the positive gains to be had from doing a job as difficult as social work? I hope that I have already suggested some of them, but perhaps the most important thing is that it gives us an opportunity for personal growth which is beyond what we could achieve in our own private lives because it enables us to share the experiences of others and to add these to the sum total of what we are. This is both a privilege and a responsibility, and it is also exciting, because we are always in a position to gain ever new experiences. In other words, there is no final examination for social work" (Kanter 2004, p. 234).

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