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EDITORS IRMO MARINI • MARK A. STEBNICKI

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CHAPTER

From Empathy Fatigue to Empathy Resiliency

Mark A. Stebnicki

In traditional Native American philosophy, it is told that each time you heal someone you give away a piece of yourself. The journey to become a medicine man or woman requires an understanding that the healer at some point in time will become wounded and require healing (Tafoya & Kouris, 2003). Nouwen (1972) refers to this experience as *the wounded healer*, where the helper may detach or withdraw into himself or herself, creating a space for no one else to enter. As in Native American culture as well as others who discuss professional fatigue syndromes, many counseling professionals 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, 2007, 2008, 2012). It is of paramount importance that professional counselors, counselor educators, clinical supervisors, and concerned others recognize this negative shift within the professional counselor's mind, body, and spirit that may signal an empathy fatigue experience. This chapter offers (a) a description of the empathy fatigue construct as it relates to other professional fatigue syndromes, (b) a recently developed tool (Global Assessment of Empathy Fatigue [GAEF]) that may be useful for screening and identifying professionals who may be experiencing empathy fatigue, and (c) resources for self-care of empathy fatigue and building resiliency.

Many counselors spend a tremendous amount of time and energy acting in compassionate and empathic ways searching for the meaning of their clients' mind, body, and spirit that has been lost to trauma, incest, addictions, and other stressors that prompt questions concerning the meaning of their lives. As a consequence, professional counselors become affected by the same persistent or transient physical, emotional, and psychological symptoms as their clients. Thus, empathy fatigue is a type of counselor impairment that affects the whole self: mind, body, and spirit. Identifying counselor impairment or fatigue syndromes requires the use of self-care practices to maintain competent and ethical practice in the counseling profession (Herlihy & Corey, 2015). As Corey and Corey (in press) suggest, helpers feel a great pressure being intimately connected with the welfare of their clients. This type of professional work-related stress has a psychological, physical, and behavioral cost that may result in the symptoms of depression, anxiety, and emotional exhaustion. From the empathy fatigue perspective, there is a cost to one's mind, body, and spiritual growth.

COMPARING EMPATHY FATIGUE WITH COUNSELOR IMPAIRMENTS

Similar observations and measurements of counselor impairment and fatigue syndromes have been noted in the nursing, psychology, counseling, and mental health literature. Compassion fatigue was first introduced in the nursing literature by Joinson (1992) and then expanded by Figley (1995, 2002), Pearlman and Saakvitne (1995), and Stamm (1995), as well as others later on in the psychology literature. Early in its development, compassion fatigue hypothesized that therapists who deal with survivors of extraordinarily stressful and traumatic events are more prone to compassion fatigue or a secondary traumatic stress (STS) type of reaction as a result of feeling

compassion and empathy toward others' pain and suffering. McCann and Pearlman (1989) refer to this experience as "vicarious traumatization," where the therapist becomes deeply emotionally affected by the client's traumatic stories. Consequently, the professional counselor experiences a special type of burnout (Maslach, 1982, 2003), where there is an organizational–environmental impact on the person who feels emotionally and physically exhausted, depleted, and has reached the point of depersonalization with his or her professional colleagues.

More recently, Stamm (2010) notes that more than 500 papers, books, articles, and 130 dissertations have been written on or related to compassion fatigue. Stamm has developed the Professional Quality of Life Scale (ProQOL), which is based on the foundations of the compassion fatigue construct. It is beyond the scope of this chapter to describe the ProQOL; therefore, readers should consult the Resources list for a comprehensive discussion given the breadth of this work by Stamm's.

Empathy Fatigue as the Wounded Spirit

Clearly, the search for personal meaning in one's chronic illness, disability, or traumatic experience is an existential and spiritual pursuit (Stebnicki, 2006). Multiple client stories of extraordinary stressful and traumatic events, as well as exposure to clients with chronic illness and life-threatening disabilities, many times place the professional helper at risk of feeling helpless and hopeless. Many professional helpers search for spiritual and existential meaning within the context of their clients' pain and suffering. Such questions as *How could life and death, joy and suffering, love, self-acceptance, and healing exist all within the same day in the lives of my clients?* can be quite overwhelming and disorienting. So the question becomes who pays attention to, and takes care of, the wounded healer. Nouwen (1972) speaks about this type of counselor fatigue experience from his concept of the wounded healer. He suggests that, paradoxically, we withdraw into ourselves, thus creating a sacred space for no other person to enter. Miller (2003) suggests that from the wounded healer concept, as the counselor brings a compassionate spirit to the counseling relationship, the client's expectation of the counselor is that he or she does not have any psychological, emotional, or spiritual vulnerabilities. Thus, the counselor is seen as a role model for emotional and spiritual wellness by the client who feels wounded.

Spirituality is a natural part of being human (Assagioli, 1965; Jung, 1973; Worthington, 1988). In many cultures, one of the most significant and meaningful questions relate to where we came from before birth and where we will transcend at the time of our death (Pedersen, 2000), a deep spiritual and existential question. Accordingly, professional counselors have an ethical obligation to explore the spiritual identity of their clients' lives (Association of Spiritual, Ethical, and Religious Values in Counseling [ASERVIC], 2014; Pargament & Zinnbauer, 2000; Shafranske & Malony, 1996). Indeed, spirituality plays a prominent role in the lives of individuals from many different cultural and ethnic backgrounds. Spiritual connectedness is a cultural attribute and can be a form of social support that empowers individuals with chronic illnesses and disabilities to cope with their environment (Harley, Stebnicki, & Rollins, 2000). Thus, to work effectively with the client's spiritual identity and worldview, it has been suggested throughout the literature that counselor educators and supervisors need to intentionally prompt their supervisee to inquire about the client's spiritual health (Bishop, Avila-Juarbe, & Thumme, 2003; Cashwell & Young, 2004; Polanski, 2003; Stebnicki, 2006).

Overall, a major departure from the construct of empathy fatigue with other fatigue syndromes is the spiritual aspect. Facilitating empathic approaches in the counseling relationship requires that we help our clients unfold the layers of their stress, grief, loss, or traumatic experiences by searching through their emotional scrapbooks. The search for personal meaning and purpose of our client's pain and suffering may contribute to our own spiritual fatigue experience. If counselors are mindful of this experience, and view this as an opportunity for nurturing personal growth and development, then they may create opportunities for resiliency so that they can replenish their wounded spirits.

A NEW LOOK AT COUNSELOR IMPAIRMENT AND FATIGUE SYNDROMES

One of the most troubling aspects of counselor impairment and fatigue syndromes is that counselor educators, supervisors, and professional counseling associations have been slow to prepare counselor supervisees for cultivating self-care approaches. We do a good job of preparing competent and ethical practitioners for diagnosing and treating a variety of mental health conditions and addressing other counseling-related issues. However, the role and function of professional counselors have expanded significantly in the past 10 years. Today, many counselors provide mental health and disaster relief services to those involved in a multitude of extraordinary stressful and traumatic events (e.g., hurricanes, fires, floods, school shootings, workplace violence, exposure to

combat). Consequently, providing the mental health rescue to those at the epicenter of critical incidents profoundly affects the mind, body, and spirit of professional counselors.

Maintaining personal and professional wellness in one's career goes beyond acquiring continuing educational credits at conferences and workshops. Rather, some counselors will require a transformative personal experience to continue in their chosen profession. There appears to be some promise for addressing issues in counselor impairment and fatigue syndromes that have drawn the interest of some state and national professional counseling associations. For example, the American Counseling Association (ACA) Taskforce on Counselor Wellness and Impairment was formed in 2003 to recognize the importance of self-care approaches to increase counselor wellness (ACA, 2014). The ACA website (www.counseling.org) provides a variety of stress and compassion fatigue self-reporting instruments for the identification and prevention of counselor impairment and fatigue syndromes. It also offers resources for building capacity for occupational and career wellness.

EMPATHY: A NATURAL WAY OF BEING FOR PROFESSIONAL COUNSELORS

Throughout the history of the helping professions, the most fundamental approach to helping others has been rooted in compassion and empathy. In fact, empathy has a rich history of being at the core of most humanistic theoretical orientations within counselor education and training programs. Accordingly, possessing the skills of empathy is a prerequisite for becoming a competent helper and is a person-centered approach that practitioners can facilitate to increase interpersonal effectiveness and enhance client outcomes (Corey & Corey, in press; Egan, 1998; Ivey & Ivey, 1999; Truax & Carkhuff, 1967). The richness of using the skills of basic- and advanced-level empathy can build a strong client–counselor relationship. If facilitated competently by the therapist, empathy can (a) help increase client self-awareness; (b) be a motivation for personal growth and change; and (c) cultivate new ways of thinking, feeling, and acting to achieve optimal levels of mind, body, and spiritual wellness.

Rogers (1980) talked passionately about empathy and empathic listening as a "way of being" with a client. However, there is an emotional and physical cost to entering the private perceptual world of the client because the counselor may be a "sponge" for his or her client's emotional and physical pain. The conscious and unconscious absorption of the client's emotional, physical, spiritual, and existential issues is a natural artifact of helping others at intense levels of service. This is because many counselors are in "high touch" professions and are at the epicenter of their client's life stories. Many client stories contain themes of extraordinary stressful and traumatic events, pain and suffering, and result in client transference and negative countertransference of toxic energy during the session. Accordingly, there is a shadow side to facilitating empathic approaches with clients during counseling interactions. If the experience of empathy fatigue is not recognized by self and others, then it can potentially lead to a deterioration of the counselor's resiliency or coping abilities.

Rogers (1980) appeared to have an understanding of counselor fatigue syndromes. He observed a significant need for therapists to rebalance their minds, bodies, and spirits after spending countless hours in psychotherapy sessions. As I have observed, counselors who work in a variety of professional practices experience professional fatigue. This includes professionals who work with clients who have experienced loss of a loved one (i.e., grief, divorce, extramarital affairs); trauma (combat, intimate-partner sexual abuse, and violence); substance abuse (i.e., family, legal, career issues); career development issues (i.e., company downsizing, work-related job stress, career transitions); chronic health conditions (i.e., cancer, HIV/AIDS); and generalized anxiety, depression, as well as other general stress conditions.

This chapter author hypothesizes that empathy fatigue may be different from other types of counselor impairment and fatigue syndromes. This is primarily because empathy fatigue (a) is viewed as a counselor impairment that can occur early on in one's career due to an interaction of variables that include, but are not limited to, personality traits, general coping resources, age and developmental-related factors, opportunities to build resiliency, organizational and other environmental supports, and the interrelationship among the person's mind, body, and spiritual development; (b) many times goes unrecognized by the individual and the professional counseling setting or environment because of its subtle characteristics; (c) may be experienced as both an acute and cumulative type of emotional, physical, and spiritual stressor that does not follow a predictable linear path to total burnout or fatigue; (d) is a highly individualized experience for most individuals, because the counselor's perception toward the client's story and life events differs depending on the issues presented during session; and (e) is a dynamic construct where the search for personal meaning in one's chronic illness, disability, traumatic experience, pain, and suffering is an existential and spiritual pursuit (Stebnicki, 2006).

In view of this hypothesis, professional counselors who experience empathy fatigue appear to have a diminished capacity to listen and respond empathically to their client's stories that contain various themes of acute and cumulative psychosocial stress, not necessarily stories of acute and posttraumatic stress. Client stories that have themes such as addictions, physical or sexual abuse, and psychological trauma can adversely affect the mind, body, and spirit of the counselor. Remembering emotions related to such painful or traumatic events and recreating an internal "emotional scrapbook" can be extremely painful and difficult for clients as well as counselors. This is especially relevant for new professional counselors who have not had the opportunity to cultivate self-care strategies for professional wellness.

Carl Jung appeared to have an understanding of counselor fatigue syndromes as he observed the need for therapists to rebalance their mind, body, and spirit after spending countless hours in psychotherapy sessions with their clients. Jung was inspired by the belief that humans are spiritual beings, not just biological, instinctual, or behavioral organisms. He explored manifestations of the soul and the process of transforming the mind, body, and spirit into a greater awareness of the self to increase one's purpose in life. In Jung's view, regaining psychic equilibrium, soul searching, and self-discovery appear to be paramount in maintaining one's therapeutic practice.

New studies on the mind–body connection report that the shared emotions and physiological arousal experienced between client and therapist can contribute to our knowledge of how empathic connections are developed during counseling sessions. For example, Marci, Ham, Moran, and Orr (2007) looked at 20 client–therapist pairs, with the client being treated for mood and anxiety disorders. The researchers specifically focused on the therapeutic relationships that were formed during psychotherapy sessions. They then took measures of the physiological reactions of both client and therapist and the client's perceived level of empathy as expressed by the therapist. They found that when high positive emotions and empathy were experienced by the client and therapist, then similar physiological responses were experienced as measured by electrical skin conductance recordings, heart rate, voice dynamics, and body movement.

It appears that a much stronger working alliance or social–emotional attachment is formed in therapy than once perceived. Because an empathetic connection forms between client and therapist, there appears to be a potential for some degree of emotional and physical exhaustion experienced by intense, cumulative, and regular therapeutic interactions.

Emotions and the Brain: The Neuroscience of Empathy Fatigue

In the study of emotions and the brain, it is hypothesized that there are discrete, basic, and universal emotions that persons react to on a mind, body, and spiritual dimension (Bar-On & Parker, 2000; Barone, Hutchings, Kimmel, Traub, Cooper, & Marshal, 2005; Mayne & Bonanno, 2001). Advances in neuroimaging have provided scientific tools to measure the emotional and physiological experiences of empathic therapeutic interactions, showing a significant positive correlation between developing strong empathic ties and interactions and enhanced client and patient outcomes (Riess, 2010). Despite the fact that many individuals express universal emotions (e.g., anger, love, happiness, sadness) with varying levels of experience and intensity, Mayne and Ramsey (2001) indicate that this only constitutes a measure of personal experience and a self-report of emotional expression. From a purely dynamic physiological state, emotions involve different body systems and are measured much differently by neuroscientists than experimental psychologists. This is important to understand because our individual perception of critical events will determine how our parasympathetic and sympathetic nervous systems are activated during times of an actual or anticipated stressful event. After prolonged periods of physiological stress, such as those seen by professionals who work with the traumatized, it is evident that chronic activation of the stress response has both a physiological and emotional cost. Consequently, professionals who work at such intense levels of service may experience anxiety and depressive disorders and may account for some aspects of the emotional and physical fatigue experienced by those who report counselor fatigue syndromes such as empathy fatigue.

Kabat-Zinn (1990; see Berger, 2006) indicates that empathy fatigue can be scientifically measured in the brain because there are specific neurological pathways to empathetic responses. The complexities of studying how emotions affect our mind, body, and spirit require studying such problems from a multidisciplinary perspective that includes the fields of psychology, neurology, immunology, and biology. The discipline of psychoneuroimmunology (PNI) has provided a model by which researchers can study emotions and the brain. The task of PNI researchers is a difficult one because as Sapolsky (1998) suggests, our emotions, particularly the stress response, have their own unique physiological arousal patterns of magnitude, frequency, and intensity. This is so, in part, because people differ in how they turn on their stress mechanism and other emotional responses in the brain. As Sapolsky (1998) notes, if we are constantly trying to mobilize energy,

we never have the opportunity to store it; therefore, we can use this source of energy for calm and relaxed states of consciousness. Accordingly, there is a physical and emotional cost to persistent sympathetic arousal because of the heavy secretion of glucocorticoids released in the body that are markers for depression and anxiety disorders.

Brothers (1989) points to the brain's amygdala–cortical pathway as part of the key neural circuitry that underlies the emotions associated with the empathy response. The amygdala appears to be the specific structure of the brain that orchestrates the most intense electrical activation when reading, interpreting, or trying to understand the emotions of others. Over time, the counselor's inability to express a healthy and facilitative emotional response (such as empathy) based on the client's expression of feelings such as stress, grief, or trauma appears to have a biopsychosocial–spiritual cost to the counselor. In other words, the chronic and cumulative activation of the emotional brain and habitual repression of emotions can compromise our immune system, which increases our resistance to infections, chronic illness, and diseases (Pert, Dreher, & Ruff, 2005; Sapolsky, 1998; Weil, 1995).

Although we have no control over our autonomic nervous system, we do have some degree of control over our voluntary nervous system, such as that observed during a biofeedback session. Thus, becoming attuned to things we do have control over in life is central to the care we can provide for ourselves and our clients.

RISK FACTORS IN EMPATHY FATIGUE

Stebnicki (2000) offers a functional risk-factor assessment for empathy fatigue that may assist professional counselors, counselor educators, and supervisors to identify and recognize risk factors. The items in this particular functional assessment were developed from a meta-analysis of similar counselor impairments and fatigue conditions as noted in the literature (e.g., burnout, compassion fatigue, STS, depression, substance abuse, other mental health conditions). In the current development of an empathy fatigue measure, consideration will be given to content items that address the spiritual dimension. There is a constellation of areas to consider within the experience of empathy fatigue that includes, but is not limited to, the professional's:

1. *Current and preexisting personality traits and states*: type A personality traits, unrealistic or high expectations by the person, need for recognition, and pattern of cynicism
2. *History of emotional or psychiatric problems*: underlying mental health issues or behaviors that may interfere with the counselor's competency, direct or indirect exposure to critical incidents, lethality issues, or harm to self and others
3. *Maladaptive coping behaviors*: patterns of alcohol or substance abuse, increased use of tobacco, caffeine, and food
4. *Age- and experience-related factors*: younger professionals new to counseling versus older professionals' coping abilities, experience in working with different types of clients/consumers, and experience in crisis response
5. *Organizational and system dynamics at the counselor's place of work*: an organization or system is insensitive to or unappreciative of the emotional needs of counselor, organization, or system's openness to trying new approaches
6. *Specific job duties of counselor in which the counselor is employed*: direct service versus supervisory, caseload size, work overly demanding and time-consuming
7. *Unique sociocultural attributes*: values, beliefs, and cultural identities that may be different from that of the organization/employer
8. *Response to handling past critical and other stressful life events*: level of exposure to trauma or STS and counselor's ability to cope and identification of any counselor isolation, detachment, or dissociative issues
9. *Level of support and resources*: individual, group, or family support, ability to seek out assistance
10. *Spirituality*: counselor questioning the meaning and purpose of life, occupation, spiritual, and/or religious beliefs; anger toward God or religious affiliation; any spiritual emergencies

Generally, there are multiple risk factors in empathy fatigue that complicate one's competence and ethics, impair one's personal and professional relationships, and hinder one's capacity for personal coping and resiliency. Thus, consideration must be given to assessing empathy fatigue from a holistic perspective. Developing domains before scale items is essential in the scale development process. Other analysis and statistical procedures will also assist the researcher in the design process. The following domains are suggested to measure the construct of empathy fatigue.

- *Individual traits*: current and preexisting personality traits, any history of emotional or psychiatric problems, maladaptive coping behaviors
- *Family*: level of support and resources, family history of poor coping abilities, lack of clear expectations and rules for occupation or career

- *Sociocultural*: worldview, personal cultural identity, choice of occupation, family and extended family members, coping resources, age, gender, race, ethnicity, disability
- *Developmental level*: experience level of counselor: practicum, internship, postgraduate, or expert
- *Occupational setting*: organizational and system dynamics, setting where professional is employed, specific job duties, responsibilities, and position within the organization
- *Physical attributes*: medical–physical status, chronic illness, disability, health status, nutritional intakes, and lifestyle factors related to health
- *Cognitive behavioral*: dysfunctional thought patterns, ability to motivate oneself, flexibility in problem-solving tasks
- *Religious–spiritual*: connection to higher power, God, spirit helpers, and patterns of religious practices in terms of rituals and ceremonies

GLOBAL ASSESSMENT OF FUNCTIONING IN THE THEORETICAL MEASUREMENT OF EMPATHY FATIGUE

The GAEF rating scale is a theoretical measure of the holistic experience of empathy fatigue (Table 82.1). The GAEF is categorized according to five different levels of functioning. Level V indicates the highest level and Level I the lowest level of the hypothetical construct of empathy fatigue. It is hypothesized that professional helpers may experience and project this felt-sense of empathy fatigue in seven distinct content areas that are contained within each of the five levels: (a) cognitively, (b) behaviorally, (c) spiritually, (d) process/counseling skills, (e) emotionally, (f) physically, and (g) occupationally. Table 82.1 delineates each of these areas that may be observed by self and others in the professional helper's environment. The theoretical constructs involved in measuring this type of counselor impairment are currently being researched. As the GAEF is in its theoretical stage of development, the construct of empathy fatigue is differentiated theoretically from other counselor impairment and fatigue syndromes. There is no empirical evidence as yet to report, however.

The intent and purpose of the GAEF in its early stage of development are to provide a means of viewing the overall level of functioning as the professional helper experiences empathy fatigue. The content contained within each of the five levels of functioning is based on a comprehensive review of the counselor impairment and fatigue literature in counseling, psychology, and mental health, as well as biopsychosocial research in the fields of nursing and medicine (see Stebnicki, 2008). The GAEF rating scale was also guided by the present author's clinical experiences.

Counselor impairments appear to involve a constellation of states, traits, behaviors, and other factors that encompass the person's experience of working with clients who have a diversity of issues ranging from daily hassles and life adjustment issues to extraordinary stressful and traumatic events. It is difficult to determine universal traits or states of counselor impairment because each professional experiences and perceives his or her clients' general levels of stress differently. It is much like the difficulties in studying stressful life events. Overall, it is hypothesized that there are both conscious and unconscious factors that relate to the professional counselor's experience of stress and fatigue. Furthermore, the frequency, intensity, level of intrusion, and avoidance of critical issues are considered to be both acute and cumulative in nature. Thus, some counselors may perceive more relevance of certain characteristics within each of the content areas in the GAEF than other areas. The theoretical continuum ranging from Level V (most impaired) to Level I (least impaired), it is hoped, can provide an anchor or benchmark for the optimal level of functioning for professional helpers within each of the content domains.

Use of Different Raters

The GAEF should be used to rate the professional helper's current level of functioning. Because individual behaviors, states, and traits are often dependent on the environment in which they are observed, observations should be documented based on multiple raters as listed subsequently. A time sampling method should be used because the individual may differ in his or her experience of empathy fatigue with regard to events that take place at different times throughout the day (e.g., mornings, afternoons, evenings, weekends, before client sessions, after client sessions, and every other day). Persons considering rating themselves and/or others using the GAEF should be open to, and understand, the limitations and bias that are found in other subjective ratings of experiences such as mood, affect, personality, stress, attitude, motivation, level of satisfaction, and job burnout, as well as measures of spiritual well-being.

- *Self-ratings by the professional*: The individual himself or herself may use the GAEF as a self-report measure.
- *Ratings by the professional's colleagues*: The professional may request the involvement of his or her clinical supervisor, peer mentor, or another professional to rate his or her observations independently on the GAEF measure.

TABLE 82.1

GLOBAL ASSESSMENT OF EMPATHY FATIGUE RATING SCALE (GAEF)					
Content Area	**Level V**	**Level IV**	**Level III**	**Level II**	**Level I**
Cognitive	• Diminished concentration • Preoccupied • Disorganized thoughts • Detachment from client	• Diminished concentration • Preoccupied • Slightly disorganized thoughts • Detachment • Possible irrational thinking	• Exhibit some diminished concentration • Somewhat preoccupied • Thought organization is loose • Fair focus on the therapeutic process • Quiet attending of counselor to internal thoughts and feelings • Having an "off day"	• Slight problems in concentration • Occasionally preoccupied • Need to continually refocus • Good focus on therapeutic process • Some response to internal thoughts and feelings • Thoughts of hopefulness • Physical signs of being restless or impatient, but controls behavior • Eye contact good • Occasionally strained vocal quality and pace of speech	• Slight problems in concentration and thought organization • More preoccupied than usual • Responding to internal thoughts and feelings more than usual, but therapeutic process good
Behavioral	• Impatience • Irritability • Aggression	• Impatient • Irritable • Competitive	• Exhibit signs of restlessness or impatience • Slightly inattentive eye contact • Slightly strained vocal tone and pace of speech		• Exhibit physical signs of restlessness or impatience, but control behavior • Eye contact good • Vocal quality and pace of speech good, but sometimes strained
	• Cynical with client • Hypervigilance • Poor eye contact • Strained, erratic, or slow- or fast-paced speech	• Very cautious • Eye contact fair • Somewhat strained, erratic, or slow- or fast-paced speech • Somewhat cynical with clients			
Spiritual	• Detached from spiritual support • Lack meaning and purpose in faith or spiritual beliefs	• Lack some meaning and purpose with regard to faith or spiritual beliefs • Some detachment of spiritual support	• Confusion regarding meaning and purpose with regard to faith or spiritual beliefs • Separation from spiritual support	• Sense of awareness of refocusing on meaning and purpose with regard to faith or spiritual beliefs	• Sense of connectedness to faith restored after self-reassurance

(continued)

TABLE 82.1

GLOBAL ASSESSMENT OF EMPATHY FATIGUE RATING SCALE (GAEF) *(CONTINUED)*					
Content Area	**Level V**	**Level IV**	**Level III**	**Level II**	**Level I**
	• Communication of these deficits	• Communication of lack of meaning and purpose spiritually		• Attempts to remain connected spiritually • Makes attempts to become reconnected to spiritual support	• Attempts to become reconnected to spiritual support
Process skills	• Lack of rapport with client • Strained working alliance	• Rapport difficult to establish • No working alliance	• Longer time to establish rapport • Working alliance achieved more slowly	• Working alliance takes longer to achieve but remains stable • Empathic response more genuine, deeper, and more frequent	• Rapport takes slightly longer to establish • Working alliance takes somewhat longer to achieve, but work with client remains intact and stable
	• Nonexistent attending and listening • No genuine empathetic responses • Resistant • Apprehensive • Hypersensitive • High degree of countertransference • Lack of open-ended questioning • Lack of solution-focused probes • Diminished use of brainstorming techniques • Basic information gathering sessions vs. processing client story • Misses opportunities to integrate client content, experience, and affect	• Poor attending and listening • Gather information in session vs. processing client story • Superficial empathic responses • Some degree of countertransference • Little use of open-ended questioning • Little use of solution-focused probes • Little use of brainstorming techniques with clients • Somewhat resistant or apprehensive during session • Show little nonverbal interest during testing	• Listening and attending to clients fair to good • Empathetic responses more genuine • Session involves gathering basic information • Some missed opportunities in therapeutic interactions • Responses have only basic empathy • Somewhat resistant or apprehensive • Little nonverbal interest during the session • Some degree of countertransference • Little use of open-ended questioning • Little use of solution-focused probes • Little use of brainstorming techniques	• Session goes beyond data gathering • Nonverbal incongruences in session • Avoids dealing with countertransference • Uses some open-ended questioning, solution-focused probes, or brainstorming techniques • Rapport takes longer to establish, but eventually is good • Working alliance takes longer to achieve • Ongoing therapeutic work with client remains intact and stable • Attending and listening are good	• Attending and listening are appropriate • Integration of client content, experience, and affect better • Few missed therapeutic opportunities • Empathic responses somewhat deeper • Somewhat hesitant to explore new areas of client support and resources • Some nonverbal incongruences • Increased interest in understanding countertransference • Open-ended questioning, solution-focused probes, and brainstorming techniques used

Emotional	• Diminished affective state • Moodiness • Sadness • Tearfulness • Negative • Pessimistic • Clear high and low emotions • Depleted • Exhausted	• Somewhat diminished affective state • Moodiness • Slight mood swings • Moderate level of sadness • Emotionally fatigued • Exhausted • Negative • Pessimistic	• Affective state fair • Slight moodiness • Dysthymic • Appears emotionally tired • Negative • Pessimistic	• Affective state good • Sense of dysthymic mood • Slightly emotionally tired • Feeling negative or pessimistic	• Affective state could be better • Sense of a slightly "down" mood • Somewhat emotionally tired • Slightly negative • Pessimistic, but initiates self-correction
Physical	• Shallow breathing • Sweating • Fatigue • Discomfort while sitting	• Shallow breathing • Slight sweating • Fatigue • Facial grimacing	• Exhibit tiredness • Sighs of frustration with breath • Facial grimacing • Lack of appetite	• Exhibits slight tiredness but takes steps to avoid fatigue • Occasional signs of frustration • Uses internal dialogue to relax • Some discomfort while sitting	• Slight tiredness • Takes steps to avoid fatigue • Occasional sighs of frustration • Uses internal dialogue to relax
	• Dizziness • Nausea • Disturbance in visual acuity • Facial grimace of pain • Muscle tremors or twitches • Severe headache	• Feelings of wooziness • Lack of appetite due to upset stomach • Occasional muscle tremors or twitches • Moderate degree of headache • Disturbance in visual acuity	• Occasional muscle twitches • Slight sense of headache • Dry eyes	• Appetite and eating habits somewhat irregular • Muscles slightly tense • Needs constant reminder to rebalance physical wellness	• Appetite and eating habits somewhat irregular • Muscles feel slightly tense • Constant reminder to rebalance wellness
Occupational	• Missing at least one day of work per week • Cancelling sessions • Not showing up for sessions • Avoids meetings • Avoids colleagues at work • Leaves work early every day • Sick or cynical sense of humor • Poor coping skills • Shows little resiliency • Difficulty separating professional and personal life	• Missing 2–3 days of work per month • Rescheduling client appointments • Avoids meetings • Avoids colleagues at work • Leaves work early on average • Consistently cuts sessions short • Exhibits cynical sense of humor • Difficulties separating professional and personal life • Struggling • Exhibiting decreased coping abilities and resiliency	• Missing 1–2 days of work per month • Some avoidance of starting session on time • Hope for client "no shows" • Cuts session shorter than usual • Makes excuses to try and leave meetings and work early • Superficial contact with colleagues at work • Exhibits inappropriate sense of humor • Some difficulties separating professional and personal life • Some difficulties with coping abilities and resiliency	• May feel the need to take off 2 days of work per month • Has thoughts of client "no shows" • Occasionally makes excuses for leaving meetings early • Minimal contact with colleagues at work • Has difficulties transitioning to social self • Some difficulties separating professional and personal life • Better coping abilities and resiliencies	• May feel the need to take off 2 days of work per month • Thoughts of client "no shows" • Conducts sessions on time and for usual duration • Will make excuses for leaving meetings early • Contact with colleagues less than usual • Exhibits usual sense of humor • Difficulties transitioning to social self • Some difficulties separating • Better coping skills and resiliency

- *Ratings by clients/consumers*: Ratings may be carried out according to a well-designed scheme within the work environment that uses interrater agreement by the therapist's client/consumer and/or a triad of raters (i.e., client, therapist, and independent observer).
- *Ratings by independent observers outside the work environment*: The therapist may request ratings by close professional colleagues.
- *Ratings by another objective individual*: The professional may request ratings by others (i.e., personal therapists) who are closely committed to the professional's personal goals of self-care and personal growth.

As the rater(s) view the GAEF rating scale shown in Table 82.1, they should rate the level of empathy fatigue experienced primarily within the past 2 weeks. Although the professional helper may not relate with all characteristics within each level, the therapist should choose the attributes that he or she identifies with more so than not. Furthermore, the rater(s) may consider using the GAEF levels (V, IV, III, II, and I) for each of the seven content areas and deriving a rating (i.e., Level V in Cognitive Behavioral; Level III in Spiritual, Physical).

CULTIVATING COUNSELOR RESILIENCY

A consistent finding in resiliency psychology research suggests that persons' attitudes and beliefs play a key role in the degree of resiliency that is exhibited or expressed. Resilient professionals almost always appear to possess a higher degree of internal locus of control, and are inwardly directed, self-motivated, and thrive despite adverse conditions. Anecdotal evidence from professional helpers who have bounced back from adversity in their lives, such as substance addiction, divorce, loss of a loved one, career transition, or traumatic stress, have chosen to live in an optimal state of mental and physical well-being. They have incorporated the following principles, some of which are universal, in cultivating a resilient mind, body, and spirit:

Making a choice. Professional helpers make a thinking, feeling, and behavioral choice on a daily basis when they must deal with client adversity. At the end of the day, counselors can choose to vent with their colleagues (and be a good listener for others) and not take home all their clients' stories of adversity. If they take on this stress (consciously or unconsciously), this may already be added to their own wounded soul. Thus, the alternative would be to choose more healthy thoughts and emotions. The act of choosing a healthier outlook basically is a choice to take responsibility for one's own thoughts and emotions. There will always be a professional responsibility of helping another person in a compassionate and empathic way. However, resilient professionals know how to manage client adversity throughout their work, home, social, and interpersonal lives. Thus, not moving forward into one's own program of personal wellness would be self-defeating. The alternative would inevitably be bleak by constantly ruminating over the client's adversity at the end of the day. Thus, making a choice to change one's stream of thoughts and emotions about a client's adversity can be very empowering for some therapists. Negative and destructive thought patterns must be replaced with a plan of personal self-care and wellness. This must be reinforced and supported by colleagues and others in the counselor's environment to be successful. Accordingly, professional counselors need to create opportunities to help cultivate personal wellness and self-care approaches.

Positive thinking. The power of positive thinking is about believing in yourself, having faith in your abilities, and having a high level of confidence that you can effect a positive outcome with your clients. As counselors struggle with their own as well as their clients' issues, it is easier for therapists to see the barriers and obstacles to living from a positive frame of reference. The counselor may have many negative recurring thoughts about the client's life in general. However, this can turn into a self-fulfilling prophecy. Professional counselors need to practice positive redirection in their thinking so that it can become a routine and intentional way of living.

Taking self-responsibility. Shifting blame to others does not provide an opportunity for the therapist to develop resiliency behaviors (e.g., "My clients drive me crazy sometimes by really pushing my buttons; if they think that they have problems, they should have seen the client from my previous session"). Metaphorically, "when you point a finger at someone else, there are four fingers pointing back at you." Taking responsibility is a challenge for many counselors, even though we advocate the same with our clients. Many professionals were never taught how to do this. For example, some clients may be in denial of their son's or daughter's substance abuse behaviors and may enable the adolescent. The consequences of the adolescent's bad choices may be hindered by the therapist who has taken on all the emotional responsibility, or perhaps by identifying with the adolescent's parent. Taking self-responsibility is learned behavior that can generalize to other areas of the therapist's life. We all need to learn how to model self-responsibility and give up some control to the client. Allowing our clients to take safe risks and fail can

be very therapeutic at times. It can build resiliency and promote healthy choices. Meanwhile, we may learn how our clients can live without our assistance. Overall, we should be internally responsible for our own thoughts, emotions, and actions and learn how to build resiliency traits.

Self-motivation. Resilient individuals find their own unique style of internal motivation from school, work, and home, socially, emotionally, and in other ways. Persons who have bounced back and pulled through adverse critical incidents demonstrate to others that they know how to achieve optimal and realistic control in their lives. These types of professional helpers tend to have an increased level of emotional, physical, and spiritual well-being. They are persistent with the tasks they take on and have an innate sense for knowing how to achieve their life goals. Many professionals have had the opportunity to observe healthy role models in their environment. They were fortunate to have a colleague, clinical supervisor, life coach, teacher, religious or spiritual leader, or others who have cared about them to help them overcome the more difficult challenges in their lives.

CONCLUSION

The experience of empathy fatigue is both similar and different from other types of counselor impairment or professional fatigue syndromes. Thus, 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. Professional counselors who interact with clients who experience daily hassles and stressful life events may be at the same risk level as those professionals who assist those who are traumatized.

As the professional counselor engages in therapeutic interactions, this may predispose the counselor to experience an empathy fatigue reaction that ranges on a continuum of low, moderate, and high. However, there are multiple risk factors that should be considered as identified in the GAEF. Consequently, the cumulative effects of multiple client stories can result in the depletion of the professional counselor's empathic energies, resulting in empathy fatigue. Developing a clearer understanding of the risk factors associated with empathy fatigue is pivotal in developing self-care strategies for the professional counselor.

RESOURCES

Al Siebert Resiliency Center: http://resiliencycenter.com. Dr. Siebert (1934–2009) has been a resiliency researcher, trainer, and practitioner for well over 35 years. The resiliency center has, over the years, developed a culture of resiliency, as opposed to "managing ones' stress," which is counter to the resiliency philosophy. The center has a plethora of resources and research articles on resiliency.

American Counseling Association's (ACA) Taskforce on Counselor Wellness and Impairment: http://www.counseling.org/wellness_taskforce/tf_resources.htm. The ACA is the largest professional counseling association in North America. This is a very comprehensive source for counselor self-care. There are multiple assessment and screening tools for professional counselors that include wellness, professional quality of life, traumatic stress, and a variety of other assessments.

Gift From Within: http://www.giftfromwithin.org. Gift is an international not-for-profit organization for survivors of traumatic stress. This particular organization is dedicated to PTSD survivors and advocates multiple supports from family, friends, and peers. Educational materials, list of retreats, workshops, and online support are offered.

Green Cross Foundation and Green Cross Academy of Traumatology: http://www.greencross.org. Green Cross is a professional organization of traumatologists founded by Dr. Charles Figley and colleagues, who have developed the foundational research and educational materials related to compassion fatigue.

Mark Lerner Associates, Inc.: http://www.marklernerassociates.com. Dr. Lerner is a clinical psychologist and traumatic stress consultant with an international reputation in organizations and individuals who have experienced extraordinary stressful and traumatic events in their lives. Dr. Lerner offers consultations, workshops, and educational and training materials for individuals and organizations to thrive and survive after traumatic events.

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