

RUNNING HEAD: EFFECTIVENESS OF CCFST

Training-as-treatment: Effectiveness of the Certified Compassion Fatigue Specialist Training

J. Eric Gentry

Private Practice, Tampa, Florida

Jennifer Baggerly

University of South Florida

Anna Baranowsky

Traumatology Institute (Canada), Toronto, Canada

Key words: "compassion fatigue", "burnout", "vicarious traumatization", "secondary traumatic stress", "trauma treatment", "mental health professionals", "training as treatment"

Corresponding Author:

Jennifer Baggerly, Ph.D., LMHC-S, RPT-S
University of South Florida
4202 E. Fowler Ave., EDU162
Tampa, FL 33624
(813) 974-6714
fax: (813) 974-5814
baggerly@tempest.coedu.usf.edu

Abstract

Mental health and other service professionals who work with trauma survivors often experience the debilitating effects of compassion fatigue and caregiver stress. Leaders within the field have called for effective, empirically supported interventions for professionals who experience these negative effects. In response to the call, this study examines the treatment effectiveness of the Certified Compassion Fatigue Specialist Training (CCFST) for 83 participating mental health professionals. Results show a statistically and clinically significant decrease in participants' compassion fatigue and burnout symptoms and increase in their compassion satisfaction. A "training-as-treatment" effect of CCFST is introduced, described, and evaluated. Discussion of these findings, application of Gold Standards for quantitative empirical research, clinical implications, limitations, and future directions are provided. CCFST appears to be an effective intervention for ameliorating compassion fatigue symptoms in mental health professionals.

Training-as-treatment: Effectiveness of the Certified Compassion Fatigue Specialist Training

The toll on mental health and other service professionals who work with people in pain is a well-established concept. Professional helpers' emotional, physical, cognitive, behavioral, relational, and spiritual symptoms have been found to be related to working with traumatized and troubled clients (Farber, 1983; Hellman, Morrison, & Abramowitz, 1986; McCann & Pearlman, 1990; Marsh, 1997; Rodolfa, Kraft, & Reiley, 1988; Sexton, 1999). One of the earliest references in the scientific literature regarding the emotional toll of caring comes from Carl G. Jung (1907) who discussed countertransference (i.e., the therapist's conscious and unconscious reactions to the patient in the therapeutic situation). More recent writers (Herman, 1992; Pearlman & Saakvitne, 1995) have suggested that mental health professionals may experience countertransference reactions that imitate the symptoms of their clients, including symptoms of posttraumatic stress disorder (PTSD) (Lindy, 1988; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

A related term, burnout, i.e. "the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, 1976, p. 56), has been used to describe the chronic effects that mental health professionals suffer as a result of interactions with their clients and/or the demands of their workplace (Cherniss, 1980; Farber, 1983; Freudenberger, 1974; Grosch & Olsen, 1994; Maslach & Goldberg, 1998; Sussman, 1992). Research has shown that mental health professionals are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic (McCann & Pearlman, 1990). Gentry and Baranowsky (1998) have expanded this definition to address the particular cognitive and schematic distortions that accompany and exacerbate burnout symptoms. They defined burnout as the chronic condition of perceived demands outweighing perceived resources.

The negative impact of countertransference and burnout are compounded when mental health professionals work with trauma survivors (Danieli, 1982; Figley, 1983, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995). Professionals who listen to reports of trauma, horror, human cruelty, and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients. They may also experience PTSD symptoms similar to their clients, such as intrusive thoughts, nightmares, avoidance and arousal, as well as changes in their relationships to their selves, their families, friends and communities (Figley, 1995; McCann & Pearlman, 1990, Salston, 2000). Several terms for this phenomena have emerged including “vicarious traumatization” (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), “secondary traumatic stress” (Figley, 1995; Stamm, 1995) and “compassion fatigue” (Figley, 1995). According to Figley (2002), compassion fatigue is defined as "a state of tension and preoccupation with the traumatized patients by re-experiencing traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g., anxiety) associated with the patient" (p. 1435). Gentry & Baranowsky (1998) further described compassion fatigue as an interactive, or synergistic, effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted mental health professional.

Compassion Fatigue Intervention Needed

Due to the experience of compassion fatigue, helping professionals may themselves need assistance to cope with the effects of helping others resolve their traumatic experiences (Figley, 1995, 2000; Gentry, 2002, Gentry, Baranowsky & Dunning, 1997, 2002; Pearlman & Saakvitne, 1995; Saakvitne, 1996). This need for service professionals to receive compassion fatigue

intervention should be viewed as normal, rather than a deficit or weakness within professionals.

Pearlman and Saakvitne (1995) state:

As teachers and supervisors, we have a responsibility to educate our students and supervisees [and practicing clinicians] about vicarious traumatization [compassion fatigue]. We must help them to understand that this is an inevitable part of the work, that it is a natural response. We must validate the difficulty of the work and encourage discussion of its effects ... thus normalizing and ameliorating these effects (pp. 171-172).

In order to ensure mental health professionals receive effective treatment for compassion fatigue, empirically validated research studies of appropriate interventions are needed. Accordingly, the pioneers of compassion fatigue, vicarious traumatization and secondary traumatic stress, have challenged the scientific and clinical traumatology community to develop and provide empirical validation for effective treatment and prevention strategies for this debilitating condition (Pearlman & Saakvitne, 1995; Cerney, 1995; Figley, 1995; Harris, 1995; Pearlman, 1995; Stamm, 1995).

Accelerated Recovery Program. In an effort to respond to this call for compassion fatigue interventions, the Accelerated Recovery Program (ARP) (Gentry & Baranowsky, 1998; Gentry, Baranowsky & Dunning, 1997, 2002) was developed to address the symptoms of secondary traumatic stress and burnout, or compassion fatigue, in caregivers. The first use of ARP, a five-session manualized and copyrighted protocol, provided compassion fatigue treatment to ten professional helpers who delivered on-going assistance to survivors of the 1995 Murrah Building bombing in Oklahoma City. These caregivers included chaplains (n = 5), psychologists (n = 3), emergency services personnel (n = 1) and a doctoral level medical psychotherapist (n = 1). Each of these professionals received between 15 to 21 hours of treatment via the ARP. Gentry &

Baranowsky (1999, November) reported that the ARP's results showed a significant difference between the participants' pretest and posttest mean scores on the compassion fatigue, compassion satisfaction and burnout subscales of the Compassion Satisfaction/Fatigue Self-Test (Figley, 1995; Figley & Stamm, 1996; Stamm, 1995).

Certified Compassion Fatigue Specialist Training. In direct response to the success of the ARP, the Certified Compassion Fatigue Specialist Training (CCFST) was developed and manualized to provide helping professionals with comprehensive training in interventions for other caregivers suffering the effects of compassion fatigue (Gentry & Baranowsky, 1998). While the CCFST was designed to teach skilled implementation of the ARP, it also offered a thorough exploration of the theoretical and empirical development and current conceptualizations of compassion fatigue, countertransference, posttraumatic stress disorder, secondary traumatic stress, vicarious traumatization and burnout. In an effort to ensure that participants were thoroughly skilled in the interventions of the ARP, experiential exercises were developed for each of the interventions in the five-session ARP. Since the ARP had demonstrated effectiveness with ameliorating compassion fatigue symptoms (Gentry & Baranowsky, 1999, November), it was hypothesized that the CCFST would also reduce these symptoms with the participants of the training.

Purpose of Study

The purpose of this study was to determine the treatment effectiveness of the CCFST in decreasing compassion fatigue and burnout symptoms and increasing compassion satisfaction of mental health professionals participating in the training. The first hypothesis was that pretest posttest mean differences of seven participants in a revised 17-hour version of CCFST would not be significantly different from pretest posttest mean differences of 76 participants in the original

20-hour version of the CCFST. The second hypothesis was that when all 83 participants' (seven from the 17-hour version and 76 from the 20-hour version) scores were combined, there would be a statistically significant decrease in their pretest and posttest scores on compassion fatigue and burnout subscales and an increase on a compassion satisfaction subscale, as measured by the *Compassion Satisfaction/Fatigue Self-Test (CSFST)* (Figley, 1995; Figley & Stamm, 1996).

Methods

This research study utilized a pretest-posttest design to investigate the effectiveness of the CCFST on decreasing participants' compassion fatigue and burnout and increasing their compassion satisfaction.

Participants

The 83 participants for this study were recruited through the International Traumatology Institute's marketing and advertising efforts, which included mailings of over 5000 brochures, radio and periodical advertisement as well as dissemination through the Institute's web site. A convenience sample was used. There was no control group and no randomization of training participants. All participants were mental health professionals, i.e., Master's level social workers, counselors, or psychologists. Seven participants completed the 17-hour CCFST and 76 completed the 20-hour CCFST.

Although demographic data were not collected on the 76 participants in the 20-hour CCFST, the seven participants in the CCFST were all females with a mean age of 45.7 years. These participants held either Master's or Doctorate degrees and had significant experience ($m = 17$ years) with helping survivors of trauma.

Procedures

Approval for this study was obtained from the Human Subjects Committee at Florida State University.

Training Intervention. The CCFST (Gentry & Baranowsky, 1998) is a "manualized" protocol that provides helping professionals with comprehensive training in interventions for other caregivers suffering the effects of compassion fatigue. The curriculum of the CCFST provides detailed step-by-step didactic and experiential training to implement the five-session Accelerated Recovery Program (ARP). It also offers a thorough exploration of the theoretical and empirical development and current conceptualizations of compassion fatigue, countertransference, posttraumatic stress disorder, secondary traumatic stress, vicarious traumatization and burnout. After successfully completing the training, participants were certified as Compassion Fatigue Specialists by the Florida State University's Traumatology Institute. (Although this program is no longer at Florida State University, training information can be obtained through Corporate Crisis Management at www.CorporateCrisis.net and the Traumatology Institute (Canada) at www.psychink.com).

The original CCFST was offered in 20 hours but was later revised to 17 hours through the following changes: (a) participants completed informed consents, pre-training instruments, and the mission statement exercise prior to training, (b) a dyadic exercise of sharing a chronological narrative of their professional experiences with a partner was shortened by one-half hour, and (c) the self-supervision exercise was shortened by one-half hour. The 17-hour CCFST program was delivered over two consecutive days. The content for the first day was as follows: (a) compassion fatigue history, etiology, and phenomenology, (b) crucible of transformation (guided imagery exercise), (c) Accelerated Recovery Program overview, (d) session I (assessment), (e) mission

statement (small group exercise), (f) telling the story (dyadic exercise), and (g) discussion, closure, and homework. The content for the second day was as follows: (a) session III (anxiety management and resolution of secondary traumatic stress), (b) graphic time line (selection of targets/self-assessment of anxiety), (c) anxiety management, (d) Thought Field Therapy, (e) desensitization and reprocessing of secondary traumatic stress using Neuro Linguistic Programming anchoring technique, (f) debriefing (large group), (g) Session IV (self-supervision), (h) audio-dialogue for self-supervision (coercion vs. guidance), (i) PATHWAYS, and (j) discussion, closure, and post-test.

The CCFST was delivered six different times to a total of 83 participants (N = 83). The instructor for four of the trainings was the first author (Gentry), who is a Licensed Mental Health Counselor, a doctoral candidate, a Master Traumatologist, and has over 20 years of clinical experience. The third author (Baranowsky), who holds a doctorate in clinical psychology and is a Registered Traumatologist, provided instruction at one of the trainings. One training was co-facilitated by both Gentry and Baranowsky.

Instruments

Compassion Satisfaction/Fatigue Self-Test (CSFST) (Figley, 1995; Figley & Stamm, 1996). This 66-item scale, originally developed by Figley (1995), is comprised of three subscales, i.e., compassion fatigue, compassion satisfaction, and burnout. The instrument utilizes the following 6-point Likert scale: (0) Never; (1) Rarely; (2) A few times; (3) Somewhat often; (4) Often; and (5) Very often. An example of a question item from this scale is “I am happy.”

Based on a sample of 142 respondents, Figley and Stamm (1996) reported *CSFST*'s psychometric properties are alphas ranging from .96 to .86 on two subscales of this instrument, (i.e., compassion fatigue and burnout) and a structural reliability coefficient (Tuckers) of .91. In

1997, this instrument was revised to include a subscale for compassion satisfaction (Rudolph, Stamm & Stamm, 1997, November). While these authors have not reported alpha for this subscale, the reliability coefficient (alpha) for this subscale with the 76 participants of previous CCFST trainings is .85. The alpha for the burnout subscale is .93, while the alpha for the compassion fatigue subscale is .90 for the sample of previous participants. Although no validity data is available for any of the subscales of this instrument, many of the 16 items for burnout are drawn from the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1982), which consistently obtains alphas of above .90.

Data Analysis

For the first hypothesis, a paired sample *t*-test was utilized to compare the 17-hour CCFST participants' (n=7) pretest and posttest *CSFST* mean scores with the 20-hour CCFST participants' (n=76) scores. If a paired sample *t*-test showed no significant difference between the 17-hour participants and 20-hour participants' scores, then the participants' scores would be combined to obtain a larger sample size for the subsequent analysis. For the second hypothesis, a paired sample *t*-test was utilized to determine if there was a significant difference between the combined participants' (n=83) pretest and posttest mean scores on the three subscales of the *CSFST*. A Bonferroni correction (alpha divided number of tests from the same pool of data) was computed for alpha (.05) to account for family-wise error associated with multiple measures from the same population.

Results

Comparison of 17-hour vs. 20-hour CCFST

As shown in Table 1, when the 17-hour CCFST participants' pretest and posttest *CSFST* mean scores were compared to the 20-hour CCFST participants' scores, none of the pairs of

change scores reached statistically significant differences. This finding indicates there was no statistically significant difference between the results of the 17-hour training and the 20-hour training. Moreover, the negative scores for the *t*-test on compassion fatigue and burnout subscales indicate that the participants of the 17-hour training obtained greater benefit, in terms of score reduction, than did the participants of the previous 20-hour trainings. The compassion satisfaction factor, however, is reverse-scored, with higher scores reflecting an increase in the potential for satisfaction in one's work. Therefore the negative *t*-test score indicates that participants of the 17-hour training did not fare as well as the participants of the 20-hour training. However, this difference does not reach statistical significance when comparing the two groups compassion satisfaction change scores.

Combined CCFST

As shown in Table 2, the combination of the 17-hour and 20-hour CCFST participants' mean scores (N=83) resulted in a significant reduction in compassion fatigue and burnout subscale scores and an elevation of compassion satisfaction scores. Specifically, *t* tests indicate significant decreases in participants' subscale scores of Compassion Fatigue ($t = 8.71, p > .05$) and of Burn Out ($t = 6.93, p > .05$). The reverse scoring of the Compassion Satisfaction subscale is depicted by the predictable negative value ($t = -11.86, p > .05$), which reveals a significant increase in Compassion Satisfaction.

To account for the inflated family-wise error that occurs as a result of using the same data set to test the significance of three separate differences, a Bonferroni correction (a moderately conservative method) was applied to the alpha level required for the differences to reach significance. This correction is obtained by dividing the pre-set alpha level (.05) by the number

of repeated tests with the same data set (3). This resets the alpha level required for significance to .0167. The results of these t-tests are still far below this level and, therefore, retain significance.

Discussion

Comparison of 17-hour and 20-hour CCFST

For hypothesis one, not only did the *t*-tests fail to find any significant differences between the two-day, 17-hour and the three-day, 20-hour training, the former demonstrated mildly superior performance for ameliorating symptoms of compassion fatigue and burnout. The performance of the 17-hour version coupled with the resource-saving utility of offering the CCFST in two days, instead of three, have led to the decision to retain this 17-hour format for all future offerings of the CCFST. This process of intervention research, in which the data collected is utilized to refine the intervention, follows the prescription of Rothman and Thomas (1994) for developing and maintaining effective empirically validated intervention programs.

Combined CCFST Effectiveness

The combined results of the CCFST suggest the protocol provides an effective intervention, in the form of training-as-treatment, (i.e., reduction of compassion fatigue symptoms in training participants). In reviewing the mean scores of pre-training and post-training subscales, the mean of the pre-training group (35.80) reflects a score that is interpreted as “high risk” for compassion fatigue. The post-training mean of the compassion fatigue score is 28.84, or “low risk.” Thus, in addition to statistical significance, the CCFST has also demonstrated clinical significance for the reduction of compassion fatigue symptoms. CCFST enabled participants to not only receive skills in reducing compassion fatigue in others, but more importantly, the training-as-treatment effect enabled them to reduce compassion fatigue in themselves.

Effectiveness Based on Gold Standards

As shown in Table 3, we applied the “Gold Standards” (Foa & Meadows, 1997) criteria for evaluating the PTSD treatment outcome research to this CCFST study and found mixed results. To better assist our review of the study relative to the Gold Standards, we developed a six-point scale (0-5) to quantify these results. The scores of the scale are defined as follows:

5 – Exemplary. Studies receiving a score of five (5) will have met or exceeded each of the criteria for evaluation in the particular category. These studies are considered “ideal” for scientific inquiry in this category.

4 – Excellent. Studies receiving a score of four (4) in a particular category will have met most, if not all, of the above criteria for evaluation. At least one area of possible improvement will be identified to receive this score.

3 – Good to adequate. Studies receiving a score of three (3) will meet minimum requirements for scientific rigor without exceeding them. One or more areas of possible improvement, which would significantly enhance the quality of the study, will be identified for studies receiving this score. Additionally, the categories that receive a score of (3) may have failed to meet one or more important criteria in a category while successfully fulfilling others.

2 – Fair to poor. Studies receiving a score of two (2) in a particular category will have failed to meet criteria of one or more significant evaluative measures. A study receiving this score, in any category, fails to meet scientific rigor and its results should be viewed very cautiously.

1 – Inadequate. Studies receiving a score of one (1) are seriously flawed in that category. This score, in any category, renders the results of the study nearly meaningless. Any study in this review receiving a score of one (1) will be removed from the review.

0 – Unknown/Not reported. Studies receiving a score of zero (0) in any category have failed to explicitly address the evaluation criteria deemed necessary to provide an adequate assessment in this category. This omission may have been intentional or unintentional by the author(s). While this score represents an omission of important information and/or data to be included in the study, the authors are unable to make any inferences as to cause or impact.

In the first category, which evaluates the study's use of clear and parsimonious operational definitions and concepts, we scored this study as 4.5, between excellent and exemplary. The CCFST manual used in this study carefully and explicitly synthesized the essential components of compassion fatigue in a simple, straightforward manner.

On the use of reliable and valid measures, we scored this study as a 4.0 because the *CSFST* (Figley, 1995; Figley & Stamm, 1996) exhibited reliability alpha coefficients between .86 and .96. For this study, the compassion fatigue subscale had an alpha of .93, burnout had an alpha of .96 and compassion satisfaction had a reliability coefficient of .84. This reliability is in the good to excellent range. The *CSFST* is the only known instrument that measures both compassion fatigue and compassion satisfaction, so no validity data is available. Comparisons of the *CSFST* burnout subscale with existing measures for burnout, such as the Maslach Burnout Inventory (MBI, Maslach, 1982) have not been published. If such validity data were available and a measure for primary traumatization was added, then this study would have received a score of 5.0.

For replicability, we scored this study at a perfect 5.0 because CCFST provides a complete step-by-step Trainer's Manual. However, in the design and methodology category, we scored this study as a 3.5. This study's two-phase design, which allows for its use of aggregate data from previous trainings, is a unique and effective design. However, this study did lack a control and comparison group. The lack of a control group for comparison is offset somewhat by the stability of the results obtained in different locations with different participants and facilitators. Although the dependence upon *t*-tests to test multiple pairs of mean differences can threaten internal validity, these analyses were most appropriate for this study and probable family-wise error was addressed with statistical corrections to the alpha level.

Generalizability provided the greatest challenge to this study. The major limitations of this study in this category are (a) a lack of random sampling or assignment, (b) a lack of control and comparison groups, and (c) a lack of demographic data for 76 of the participants. In defense of these shortcomings, one should consider that intervention outcome research in a naturalistic setting does not lend itself to the use of randomization and control groups. In addition, collection of demographic data is planned for future research. Never the less, we scored this study as a 1.0, or inadequate, for generalizability.

In the results category, we scored this study as 4.5 because significant differences in participants' pretest and posttest mean scores on all three *CSFST* subscales were found, thereby demonstrating effectiveness with the sample population. The results were presented in a cogent fashion with helpful tables and charts. In the final category, the discussion section, we scored this study as a 4.5. In addition to interpretation and elaboration of the results, this study also provides a comprehensive analysis of the limitations as well as implications for future training, clinical practice and research (see below). Additionally, after an exhaustive review of the literature, this

study emerges as the only known research to offer empirical data supporting an effective treatment methodology for the symptoms of compassion fatigue. Overall, we scored this study with a mean evaluative score of 3.86, or near excellent.

Implications for Mental Health Professionals: Training-as-Treatment

The CCFST is particularly valuable because while it trains participants to treat others with compassion fatigue, it simultaneously provides treatment to those participants who are suffering with compassion fatigue symptoms themselves. This treatment by-product of the CCFST is extremely helpful in reaching those professionals suffering from the symptoms of compassion fatigue who may be hesitant about seeking treatment for themselves. These professionals may be anxious about the possible stigmatization or negative perceptions of other professionals and/or potential clients that may occur if they seek help to address and resolve their own compassion fatigue symptoms. These individuals will, however, eagerly participate in a training program that provides the opportunity for both professional and monetary growth. CCFST offers personal growth and healing for the mental health professional without the threat of exposure or stigmatization.

In an effort to extend this training-as-treatment model to other mental health professionals suffering from compassion fatigue, a website (<http://lists.fsu.edu/mailman/listinfo/compassionfatigue>) was developed to provide up-to-date information on trainings, publications, and a virtual community to allow helping professionals from all over the world to share their experiences of hardship and recovery from compassion fatigue. Additionally, Gentry and Baranowsky (1999) enhanced the training-as-treatment model even further by designing a one-day “Compassion Fatigue Prevention & Resiliency Training” that synthesizes the preventative and resiliency factors from the CCFST for presentation to large

groups. Completion of this training makes participants eligible to receive the “Certified Compassion Fatigue Educator” designation through the Academy of Traumatology.

Limitations

While this study provides reasonably strong evidence for the effectiveness of the CCFST with the sample population, it has some significant limitations. The first limitation is that it does not have a randomized control or comparison group. Because the CCFST is a naturalistic, for-profit professional training program, it does not lend itself to random sampling or assignment procedures. Consequently, the results of this study cannot be generalized to the entire population of mental health professionals. The second limitation is the lack of demographic data on 76 of the participants. These data would have allowed for further analysis such as predictive factors in compassion fatigue and resiliency.

The third limitation is the utilization of a single, self-report measure with three subscales. Some potential problems inherent to self-report measures are (a) respondents wanting to provide socially desirable responses in order to appear healthy, (b) subjects’ reactions to experimenter’s expectations, and (c) dependency upon the accuracy of the subject’s perceptions (Brigham, 1986). The use of only one measurement instrument could be seen as constrictive and potentially invalid. In defense of this strategy, it must be noted that the Compassion Satisfaction/Fatigue Self-Test (Figley, 1995; Figley & Stamm, 1996) is the only existing instrument that measures the symptoms of compassion fatigue.

Future Directions

In order to overcome the limitations of this study, continued analysis of the effectiveness of the CCFST should occur by building of a large sample aggregate, collecting demographic data, and implementing quasi-experimental conditions, such as multiple baseline or wait-list

control groups. In order to generalize future results, researchers should randomly place a large sample of participants in CCFST, comparable training workshops, and control groups to determine if treatment effect was due entirely to the CCFST or other intervening variables. Future researchers should also add instruments to measure primary traumatic stress, such as the Impact of Event Scale - Revised (IES-R; Weiss & Marmar, 1997), and to measure burnout, such as the Maslach Burnout Inventory (MBI; Maslach, 1982). Participant interviews that attempt to distill the active ingredients of the CCFST's effectiveness should also be included in future evaluations. Finally, since the primary goal of the CCFST is to train helping professionals to become "compassion fatigue specialists" who provide skilled application of the ARP to other helping professionals, future research should also measure the effectiveness of ARP in reducing the compassion fatigue of individuals receiving the treatment.

Research on the effectiveness of CCFST with graduate students in training may also be appropriate. Many authors of compassion fatigue-related research and popular literature (Pearlman & Saakvitne, 1995; Figley, 1995; Stamm, 1995; Schauben & Frazier, 1994) have called for the addition of information about compassion fatigue prevention strategies to graduate training programs. Since CCFST is a manualized protocol with didactic and experiential capsules, it may easily be incorporated into classroom curricula.

Conclusion

The training-as-treatment intervention, powerfully applied through the CCFST, seems poised to provide an excellent delivery system for educating mental health professionals about compassion fatigue and for developing the resiliency needed to assess, prevent, and resolve symptoms that they may suffer anytime during their professional trajectory. This training also provides the participants with the skills needed to provide an evidence-based effective treatment

for the symptoms of compassion fatigue for other service professionals. Empirical research has already established that all caregiving professionals who work with traumatized populations are at-risk for the deleterious effects of compassion fatigue, including secondary traumatic stress/vicarious traumatization and burnout symptoms (Deutsch, 1984; Farber, 1983; Follette, Polusny, & Milbeck, 1994; Pearlman & Mc Ian, 1995; Schauben and Frazier, 1995). The CCFST is a comprehensive, concise, and systematic method for providing professionals with the skills and knowledge necessary to remain resilient to these deleterious effects while offering them certification to treat the symptoms suffered by others or themselves.

In conclusion, the CCFST provides the education called for by the leaders of this field (Pearlman & Saakvitne, 1995; Cerney, 1995; Figley, 1995; Harris, 1995; Pearlman, 1995; Stamm, 1995) and also offers a training-as-treatment protocol with powerful interventions to successfully mitigate the symptoms of compassion fatigue in the participants. In addition to the personal benefits that participants receive from the CCFST, they also emerge as knowledgeable and skilled experts certified in the treatment of the symptoms of compassion fatigue in others.

References

- Cerney, M. S. (1995). Treating the “heroic treaters”. In C. R. Figley (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, (pp. 131-148). New York: Brunner/ Mazel.
- Cherniss, C. (1980). *Professional burnout in human service organizations*. New York: Praeger.
- Danieli, Y. (1982). Psychotherapists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology*, 1(1), 23-46.
- Deutsch, C. J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research & Practice*, 15, 833-845.
- Farber, B. A. (1983). Introduction: A critical perspective on burnout. In B. A. Farber (Ed.) *Stress and burnout in the human service professions* (pp. 1-20). New York: Pergamon Press.
- Figley, C. R. (1983). Catastrophe: An overview of family reactions. In C. R. Figley and H. I. McCubbin (Eds.), *Stress and the family, volume II: Coping with catastrophe*. New York: Brunel/Mazel.
- Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Bruner/Mazel: New York.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *JCLP/In Session: Psychotherapy in Practice*, 58 (11), 1433-1441.
- Figley, C.R. & Stamm, B.H. (1996). Psychometric Review of Compassion Fatigue Self Test. In B.H. Stamm (Ed), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press. 127-130.
- Foa, E. B. & Meadows, E.A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology*, 48, 449-480.

- Folette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to sexual abuse survivors. *Professional Psychology: Research and Practice, 25*,(3), 275-282.
- Freudenberger, H. (1974). Staff burn-out. *Journal of Social Issues, 30*, 159-165.
- Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice, 1* (3), 37-61.
- Gentry, J. E. & Baranowsky, A., (1998). *Treatment manual for the Accelerated Recovery Program: Set II*. Toronto: Psych Ink Resources.
- Gentry, J. E. & Baranowsky, A. (1999). Compassion satisfaction manual: 1-Day group workshop, Set III-B. Toronto: Psych Ink Resources.
- Gentry, J. E. & Baranowsky, A. (1999, November). *Accelerated recovery program for Compassion Fatigue*. Pre-conference workshop presented at the 15th Annual meeting of the International Society for Traumatic Stress Studies, Miami, FL.
- Gentry, J. E., Baranowsky, A., & Dunning, K. (1997, November). *Accelerated recovery program for Compassion Fatigue*. Paper presented at the meeting of the International Society for Traumatic Stress Studies, Montreal, QB, CAN.
- Gentry, J. E., Baranowsky, A., & Dunning, K. (2002). The accelerated recovery program for compassion fatigue. In C. R. Figley (Ed.), *Compassion fatigue II: Treating compassion fatigue*. New York: Brunner/Mazel.
- Grosch, W.N., & Olsen, D.C. (1994). Therapist burnout: A self psychology and systems perspective. In W.N. Grosch and D.C. Olsen (Eds.), *When helping starts to hurt: A new look at burnout among psychotherapists*. New York: W.W. Norton. 439-454.

- Harris, C. J. (1995). Sensory-based therapy for crisis counselors. In C. R. Figley (Ed.). *Compassion Fatigue* (pp. 101-114). New York: Brunner/ Mazel.
- Hellman, I. D., Morrison, T. L., & Abramowitz, S. L. (1986). *The stresses of psychotherapeutic work: A replication and extension. Journal of Clinical Psychology, 42*, (1), 197-205.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Jung, C.G. (1907) The psychology of dementia praecox. Read, M. Fordham, G. Adler and W. McGuire (eds.), *The Collected Works of C.G. Jung, H. Vol. 3*. Bollingen Series XX, Princeton: Princeton University Press.
- Lindy, J. D. (1988). *Vietnam: A casebook*. New York: Brunner/Mazel.
- Marsh, D. (1997). Serious mental illness: Ethical issues in working with families. In D.T. Marsh & R.T. Magee (Eds.), *Ethical and legal issues in professional practice with families. Wiley series in couples and family dynamics and treatment*. New York: John Wiley & Sons, Inc. 217-237.
- Maslach, C. (1976). Burnout. *Human Behavior, 5*, 16-22.
- Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. S. Paine (Ed.) *Job stress and burnout: Research, theory and intervention perspectives* (pp. 29-40). Beverly Hills, CA: Sage Publications.
- Maslach, C. & Jackson, S. (1982). *The measurement of experienced burnout. Journal of Occupational Behavior, 2*(2), 99-113
- Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology, 7*, 63-74.

- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, (1), 131-149.
- Pearlman, L.A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press. 51-64.
- Pearlman, L. A. & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research & Practice, 26*, 558-565.
- Pearlman, L. A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
- Rodolfa, E. R., Kraft, W. A., & Reilley, R. R. (1988). Stressors of professionals and trainees at APA-approved counseling and VA medical center internship sites. *Professional Psychology: Research and Practice, 19*, 43-49.
- Rothman, J. & Thomas, E. (1994). An integrative perspective on intervention research. In J. Rothman & E. Thomas (Eds.), *Intervention research: Design and development for human service* (pp. 3-24). Binghamton, NY: Hawthorne Press.
- Rudolph, J.M., Stamm, B.H. & Stamm, H.E. (1997, November). *Compassion fatigue: A concern for mental health policy, providers and administration*. Poster at the 13th Annual Meeting of the International Society for Traumatic Stress Studies, Montreal, CA.
- Saakvitne, K.W. (1996). *Transforming the pain: A workbook on vicarious traumatization*. Norton: New York.

- Salston, M.G. (2000). *Secondary traumatic stress: A study exploring empathy and the exposure to the traumatic material of survivors of community violence*. A defended dissertation. Florida State University.
- Schauben, L. J. & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49-64.
- Sexton, L. (1999). Vicarious traumatization of counselors and effects on their workplaces. *British Journal of Guidance and Counseling, 27*, 393-303.
- Stamm, B.H. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran.
- Sussman, M. (1992). *A curious calling: Unconscious motivations for practicing psychotherapy*. New Jersey: Jason Aronson Inc.
- Weiss, D. & Marmar, C. (1997). The Impact of Event Scale-Revised. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399-411). New York: Guildford.
- Wilson, J. & Lindy, J. (1994). *Countertransference in the treatment of PTSD*. The Guilford Press: New York.

Table 1.

Difference between 17-hour and 20-hour CCFST Training

	Mean Difference	Standard Deviation	t	Sig.
Compassion Fatigue (20 hr) vs. Compassion Fatigue (17 hr)	-3.14	7.99	-1.04	.338
Burnout (20 hr) vs. Burnout (17 hr)	-1.29	9.91	-.34	.743
Compassion Satisfaction (20 hr) vs. Compassion Satisfaction (17 hr)	-5.29	8.77	-1.60	.162

Table 2.

Combined 17 hour and 20 hour CCFST Pre- and Post-Test Scores.

	Pre Test Mean (SD)	Post Test Mean (SD)	t	Sig.
<i>Combined 17hr & 20 hr</i>				
<i>CCFST (N=83)</i>				
Compassion Fatigue	35.80 (13.29)	28.84 (11.92)	8.71	p> .05
Burnout	33.87 (11.90)	29.56 (10.33)	6.93	p> .05
Compassion Satisfaction	93.81 (11.54)	103.85 (9.48)	-11.86	p> .05

Table 3.

Gold Standards for Quantitative Empirical Research: CCFST

Author, Date, and Study	Gentry, Baggerly, & Baranowsky (2004). Training-as-treatment: Effectiveness of the Certified Compassion Fatigue Specialist Training.
Definitions	4.5
Reliable and Valid Measures	4.0
Replicability	5.0
Design and Methodology	3.5
Generalizability	1.0
Results	4.5
Discussion	4.5
Σ	27
\bar{M}	3.86