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COMPASSION FATIGUE IN MARRIAGE AND FAMILY THERAPY: IMPLICATIONS FOR THERAPISTS AND CLIENTS

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Given that marriage and family therapists are exposed to a wide range of circumstances that leave them uniquely vulnerable to experiencing compassion fatigue, it is important to examine the stresses and hazards they face and what those consequences mean for both themselves and clients. It is essential that they identify how compassion fatigue negatively affects the therapeutic relationship and overall treatment outcome as well as that of the personal life of the family therapist. The marriage and family therapist is responsible and ethically obligated to identify and implement ways in which he or she can prevent and remedy compassion fatigue.

COMPASSION FATIGUE IN MARRIAGE AND FAMILY THERAPY

Diana has been a marriage and family therapist for over 20 years. She began her profession in a mental health clinic and worked there 14 years. For the last 6 years Diana has worked alone as a private practitioner; her typical work day is 10 hr. About a year ago Diana was divorced from her husband and gained legal custody of her 15-year-old daughter. Over the last year, Diana has suffered from regular headaches and some back pain. In only 6 months, she has lost 30 pounds and has become increasingly irritable and angry. Diana is feeling exhausted and sleeping fewer hours at night. During therapy she is not in contact with her patients and is unable to empathize. She has become isolated at work and complains of feeling overwhelmed. Recently, she has become less tolerant with clients and has little empathy for couples engaged in struggles similar to those of her own family.

DEFINING COMPASSION FATIGUE

Like many in the field of marriage and family therapy, Diana appears to be exhibiting the warnings signs and effects of compassion fatigue. Compassion fatigue is a form of burnout, often experienced by those who work as caregivers in their own families and/or the human service sector. The term has also synonymously been used to describe secondary traumatic stress (Salston & Figley, 2003). Figley (1995) was the first to develop the concept after noticing the unique work conditions and experiences of those working with traumatized individuals in the mental health profession and others who assumed the role of caregiver (e.g., families, medical personnel, etc.). Figley (1998) also described that compassion fatigue manifests after professionals are exposed to secondary trauma, an experience of stress and anguish directly related to the demands of caring for someone who is suffering or has suffered from a traumatic event/stress. Chronic physical and emotional exhaustion, depersonalization, feelings of inequity, irritability, headaches, and weight loss are a few of the many symptoms of compassion fatigue. Other symptoms of compassion fatigue may include negative feelings toward work, life, and others outside the therapeutic relationship. Therapists who suffer from fatigue can also experience

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self-contempt, feelings of low job satisfaction, and psychosomatic problems (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000).

The experience of compassion fatigue does not necessarily exist in isolation. It may be a precursor or symptom of other stressors, including burnout (Dutton & Rubinstein, 1995; Stamm, 1995), work-family interface conflict, and/or issues related to self of the therapist. Compassion fatigue has delineable and common traits to these forms of stressors experienced by therapists. Therapists use the terms *compassion fatigue* and *burnout* interchangeably when describing their work-related stressors; however, as opposed to compassion fatigue, literature shows that there is no standard definition for burnout (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000). In contrast to burnout, compassion fatigue has a more rapid onset of symptoms (Figley, 2002a). Another disparity between burnout and compassion fatigue is that compassion fatigue stems from secondary exposure to trauma or suffering experienced by the client (Figley, 2002b). Common symptoms of burnout and compassion fatigue include but are not limited to sleep difficulties, irritability, emotional exhaustion, emotional withdrawal, and cognitive disturbances. Also, experiencing either stressor may lead to poor work performance, but as opposed to compassion fatigue, which is highly treatable, burnout may require a change in occupation or job (Figley, 2002b).

Not unlike compassion fatigue, self of therapist stressors can impede the therapeutic process and cause harm to clients (Patterson, Williams, Grauf-Grounds, & Chamow, 1998; Satir, Banmen, Gerber, & Gomori, 1991). Nonetheless, compassion fatigue differs from issues related to self of the therapist. Self of the therapist refers to a therapist's personal self-awareness, and issues are related to experiences that stem from a therapist's personal life, perhaps dating back to issues that originate in his or her family of origin (Satir et al., 1991). In contrast to compassion fatigue, self of the therapist issues do not stem from a client's experience or excessive exercise of passion and empathy. However, unresolved issues that are not nurtured prior to the therapeutic relationship can be a catalyst for the inappropriately or exhausting exercise of compassion and empathy. On the other hand, therapists who monitor the sense of self in relation to their clients are still vulnerable to experiencing compassion fatigue. The development of self of the therapist requires therapists to be "fully present for the clients" (Lum, 2002, p. 182). As a consequence of becoming completely available, therapists may become so involved in the clients' experience and suffering that they develop compassion fatigue.

Moreover, compassion fatigue can be differentiated from stress that stems from work-family interface. Work-family interface refers to the mutual dependence between the domains of work and family (Edwards & Rothbard, 2000; Noor, 2004). Stressors related to work-family interface manifest when either work demands become difficult to exercise independent of family demands or vice versa (Greenhaus & Beutell, 1985) and do not demand the exercise of compassion or empathy. In contrast, compassion fatigue is not related to interrole demands and is exclusive to caregivers. On the other hand, caregivers may be more vulnerable to experiencing stressors related to work-family interface due to the additional emotional demands required of the caregiver role (Gordon & Perrone, 2004). Not unlike compassion fatigue, work-family interface conflict can have negative implications on overall psychological well-being and can be remedied by the increased practice of balancing work and family.

WORK SETTINGS

Perceiving work settings positively or negatively may also contribute to the experience of a marriage and family therapist (MFT). Marriage and family therapists perceive less autonomy than psychologists and social work practitioners and are more likely to be seeking a change in work setting than any other clinical practitioner group (Trudeau, Russell, Mora, & Schmitz, 2001). One reason for the change in work setting may be that family therapists regularly adopt a continuum of complicated and sensitive situations that require them to exercise emotional

flexibility. Marriage and family therapists who work in rigid and micromanaged settings lack the freedom to be flexible in their role as therapists. For many MFTs such restrictions may play a role in their decision to shift work settings.

Half of all family therapists work in private practice (Northey, 2002). Marriage and family therapists who work in private sectors are known to have a stronger sense of job autonomy and report a higher level of overall job satisfaction (Trudeau et al., 2001). They fare better than their MFT colleagues in the public sector, experiencing a lesser degree of emotional exhaustion and depersonalization and more feelings of personal accomplishment (Ackerly, Burnell, Holder, & Kurdek, 1988). Demerouti et al. (2000) determined that there was a significant correlation between a therapist's work conditions and his or her experience of emotional exhaustion and depersonalization.

Additionally, 25% of family therapists work in institutional and organizational settings (Northey, 2002). Those working in institutional and organizational settings face a higher risk of compassion fatigue (Farber, 1990; Rosenberg & Pace, 2006). Family therapists who work for community organizations, agencies, and hospitals face a sizeable number of organizational constraints as a result of the hierarchical work environment. Often, these institutions subject therapists to increased policies, higher expectations, large caseloads smaller salaries, additional paperwork (Rosenberg & Pace, 2006; Rupert & Morgan, 2005), conflicts with coworkers and tighter deadlines (Ross, Altmaier, & Russell, 1989). Family therapists who have high work demands and limited resources, as the situation above describes, are more likely to experience fatigue (Demerouti et al., 2000). Gender differences also exist between men and women working in agency settings. Female therapists working in agency settings are at a greater risk of developing symptoms of compassion fatigue than men working in agency settings (Rupert & Morgan, 2005). This may be due to compound factors related to perceived family responsibilities and salary differences. Supervisor support, collegial relationships, personal time off, and the number of hours worked per week are all factors that contribute to compassion fatigue among family therapists.

INTERPERSONAL INFLUENCES

Clients can present a wide array of individual and relational problems that require an MFT to participate in sessions that range from mild to extremely critical. Therapists may have clients who exhibit severe problems or they may choose to specialize in an area of therapy that introduces them to severe problems during every session. Events that occurred less regularly, such as clients threatening the therapist physically, clients committing suicide, and concern for his or her family's safety when working with a dangerous client, were rated as being most stressful (Ross et al., 1989). Therapists working with chronic clients who suffer from severe depression and child abuse are also at a higher risk for experiencing fatigue compared with others working in the mental health profession (Rosenberg & Pace, 2006).

DEALING WITH TRAUMA AND GRIEF

Many family therapists who choose to specialize in death, grief, and bereavement may be vulnerable to experiencing symptoms of fatigue. Conversations about the death of a loved one or listening to someone talk about his or her own impending death can make one uncomfortable, helpless, hopeless, and upset. Such feelings also hold true for family therapists who choose to specialize in trauma counseling. Gamble (2002) stated:

> When the grief therapy is one's chosen area, it is not at all unusual to be preoccupied with or haunted by the pain clients may be experiencing, thus placing great strain on the emotional and spiritual resources of the professional. (p. 472)

Moreover, when the focus of the family therapy is about a dying child or the death of a child, the therapist may experience an even greater sense of anxiety.

A large number of MFTs also specialize in trauma therapy and are exposed to situations that require a heightened sense of empathy and commitment. Often, family therapists who work with traumatized patients and their families are more susceptible to fatigue for a number of reasons. Those who enter the field to work with trauma patients may do so to help those suffering from experiences similar to their own. They may also work with trauma victims in order to remedy an unresolved trauma from their own past. "There is always the risk that a trauma worker will generalize his or her experiences as a way of coping to the victim and over promote those methods" (Miller, 1998, p. 138). Many MFTs working with trauma patients will also work with traumatized children. These reasons, along with others, illustrate why therapists may grow to lose objectivity, overidentify with patients, and become depressed (Miller, 1998).

CLINICAL IMPLICATIONS OF COMPASSION FATIGUE

Emotional Exhaustion

Being an MFT can prove to be emotionally exigent and sometimes physically exhausting after prolonged periods of dealing with other people's families. Long hours, gradual results, high expectations, and exposure to sensitive information leave many MFTs feeling emotionally depleted. After a long day or evening of giving to others who exhibit and explore pain and anger, and controlling their own emotions to better help clients, therapists are often left exhausted (Coleman & Kaplan, 1987).

Loss of Empathy

There are a number of clinical implications associated with compassion fatigue among MFTs; especially important are the implications that compassion fatigue has on the therapeutic relationship. A therapist faced with feelings of compassion fatigue may find him- or herself in jeopardy of developing a weak or ineffective therapeutic relationship. Joining with clients in the practice of marriage and family therapy is undeniably critical in strengthening the therapeutic relationship. However, joining becomes difficult for family therapists who experience emotional exhaustion, which is known to be the primary product of compassion fatigue. Creating an empathic connection with couples and families can be difficult without the existence of clear and effective emotional boundaries. An emotionally exhausted therapist is one who most likely will find it difficult to create any genuine empathic relationships, which may prevent the therapist from making any genuine contributions to his or her clients' treatment and outcome.

Establishing and maintaining appropriate empathic connections can often prove challenging but is nevertheless essential in the development of beneficial services. Often, clients seek such compassion in order to compensate for feelings of loneliness. Clients who fear judgment in the therapeutic process may also find comfort in gaining empathy from the therapist. Moreover, MFTs find themselves developing an array of empathic attachments with each member of the client's party, knowing that each empathic relationship may have implications for how other relationships within the therapeutic setting operate. Having to identify with individual family members can often be a difficult and trying task for a therapist, but will be even more trying for one suffering from fatigue. When an MFT experiences fatigue, empathy becomes more complicated and difficult to balance. The therapist may relate strongly to one member and not to another. These emotional dynamics affect the connections within the clinical session and can be positive or negative contributors to treatment (Patterson et al., 1998).

Depersonalization

Another behavioral consequence of compassion fatigue is depersonalization. Depersonalization refers to a process whereby the therapist develops a disparaging attitude toward the client

or views the client as less than human. The authors of a national study that assessed incidents of compassion fatigue concluded that more than one third of the respondents experienced high levels of depersonalization (Ackerly et al., 1988). The depersonalization of a client by the family therapist can have severe implications on the client's standard of care. When depersonalization takes place, the family therapist may have difficultly examining a client's subjective experience, thoughts, and feelings without bias. As a result, a family therapist may find it difficult to effectively use certain relational therapy techniques (i.e., reflective listening, reflective or circular questioning, and reframing). ''Because therapeutic services should be beneficial, family therapists have an obligation to maintain competence and to stay abreast of new developments in the field, which includes understanding the dynamics of diverse client life conditions and situations'' (Woody & Woody, 2001, p. 16). An MFT who depersonalizes his or her clients is also in danger of incorrectly interpreting information that is disclosed by the couple or family. The family therapist may assess the presented problems from a theoretical position without being sensitive to the client's thoughts or feelings about the problem.

Depersonalization that stems from fatigue may lead family therapists to provide advice that is not necessarily appropriate or beneficial to a specific client. A family therapist who objectifies his or her client may present advice or information that does not cater to the client's situation or desired outcome. Depersonalizing a couple or family may also inhibit a family therapist from completing an open-minded and thorough assessment of the different relationships that exist in each case. As a result, it is imperative that MFTs take the time to carefully produce service goals that meet the individual needs of clients and their situations. Depersonalization may also lead family therapists to work at a pace that is not practical or sensitive to the client and his or her situation. An expedited therapeutic pace may inadvertently cause clients to make connections between things they learned in therapy and their outside lives that are ineffective and sometimes harmful.

Family therapists who depersonalize their clients usually have disparaging thoughts and feelings toward their clients, which results in a reduced quality of service. Creating and following through with service goals that are in the best interest of the client may prove to be difficult if the family therapist views the client in a negative manner. Maslach (1982) suggests that fatigue is a negative internal psychological experience involving feelings, attitudes, motives, and expectations. The family therapist's negative perception may lead him or her to develop little motivation toward providing the client with high-quality services. A reduced level of motivation on the part of the family therapist may, in turn, slow down the pace of therapy and reduce the client's level of motivation.

In addition, depersonalization may affect the type of influence strategies that a therapist uses with his or her client. Research has shown that depersonalization and feelings of ineffectiveness and worthlessness that accompany emotional compassion fatigue may lead therapists to choose maladaptive strategies (McCarthy & Frieze, 1999). Such choices in therapeutic technique can have a negative and harmful impact on the client. Therapists play an interactive role in the therapeutic process; therefore, their behaviors may bring about certain unwanted events such as resistance or termination of therapy (Omer, 1991).

Loss of Respect

The therapeutic relationship exists in many shapes and forms, but there are some things that must always remain constant. Certain feelings must be reciprocated at all times to ensure effective communication and outcomes. One such feeling is respect. Unfortunately, fatigue may manifest itself in a loss of empathy, respect, and positive feelings for clients (Skorupa & Agresti, 1993). Respect refers to consideration and deference in the therapeutic relationship. The client's decision to maintain a therapeutic relationship may be one way in which the client shows his or her respect toward a therapist. However, respect is usually harder to develop and maintain for family therapists. Often, it is more difficult to show respect for clients they see as

troubled, inappropriate, and dangerous. Nonetheless, certain forms of respect are critical in maintaining the therapeutic relationship. In order to achieve positive change and outcomes, the MFT must not only show the client that he or she respects the client's uniqueness, but the therapist should also understand and respect the client's desire to maintain homeostasis. The therapist must learn to respect the therapeutic goals set by the client. "A key area of stickiness comes from a mismatch between the therapist's goal and the family's goals" (Patterson et al., 1998, p. 196). The therapist's focus on his or her therapeutic goals and theoretical perspective may lead the client to feel as though his or her thoughts and feelings are being discounted, and as a result he or she may feel disrespected by the therapist. Common factors of therapy include empathy, warmth, and respect; they are key ingredients to any successful and rewarding relationship (Strupp, 1996).

Growing Inequity

Compassion fatigue among MFTs also manifests from feelings of inequity in the therapeutic relationship. Consistent with previous interpretations, inequitable exchange relationships are associated with higher levels of stress; these, in turn, are related to fatigue (Taris, Peeters, Le Blanc, Schreurs, & Schaufeli, 2001). Marriage and family therapists and other mental health professionals provide information, insight, encouragement, and support; in return they expect clients to reciprocate gratitude and a certain degree of effort. Given the multifaceted nature of couple and family relationships, MFTs may find themselves perceiving their therapeutic relationships as inequitable more often than other mental health professionals. Building strong therapeutic relationships when working with couples and families takes more time and effort as does the manifestation of change and positive outcomes (i.e., gratitude, appreciation, and/or problem resolution; Taris et al., 2001). As suggested by Minuchin and Fishman (1981), building a relationship with families and married couples requires more patience and effort, especially in the initial phase of therapy. Fortunately, feelings of inequity among marriage and family therapists may be monitored and remedied. A promising intervention program aimed at the cognitive restoration of equity perception was designed to reduce feelings of inequity resulting from a discrepancy between goals and expectations (Van Dierendonck, Schaufeli, & Buunk, 2001).

Compassion fatigue among MFTs may also lead to interface issues. Interface issues (e.g., countertransference) are experienced when a family therapist brings his or her own personal issues into the therapeutic arena. Fatigued family therapists who suffer from emotional exhaustion may end up assuming a role or implementing a technique that may be harmful to the goals of the client in the therapeutic relationship. A family therapist may engage in negative interface issues by being excessively critical of the client or emotionally rejecting the client (Marcus & Buffington-Vollum, 2005). Additionally, the therapist may find him- or herself focusing more on his or her own best interests rather than those of the client. When an MFT's sense of self and functioning in relationships is impaired, he or she may use excessive or obsessive approaches to heal developmental wounds or disown personal deficits. These can include turning to clients for esteem, support, power, or love (Woody & Woody, 2001). It is also important that a family therapist not be overly concerned with the idea of interface issues while in a session. An increased effort in managing self-awareness has been linked with the countertherapeutic result of reduced therapist interpersonal involvement (Fauth & Williams, 2005).

Ethical, Clinical, and Legal Implications

When the best interest of the client is not exercised throughout the therapeutic process, it results in an unethical and substandard level of care. In the Code of Ethics of the American Association for Marriage and Family Therapy (American Association for Marriage and Family Therapy, 2001), Subprinciple 3.3 states that it is required that "marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may

impair work performance or clinical judgment.'' Therapists play an interactive role in the therapeutic process; therefore, their own behaviors may bring about certain unwanted events such as emotional resistance or discontinuation of therapy (Omer, 1991). Often, interface issues can be avoided with self-monitoring and the establishment of stable emotional boundaries; however, that can prove to be difficult if the marriage and family therapist suffers from compassion fatigue.

Another ethical implication of compassion fatigue may include incomplete or inaccurate documentation. According to Subprinciple 3.6 of the *AAMFT Code of Ethics* (2001), ''marriage and family therapists must maintain accurate and adequate clinical and financial records.'' Compliance with such a provision can prove difficult if a marriage and family therapist becomes unable to make clear, focused assessments of the client due to compassion fatigue. The therapist's train of thought, expectations, level of motivation, and feelings toward the client are all psychological implications of compassion fatigue that can transgress into the client's case file. A therapist who depersonalizes his or her clients may also find him- or herself recording information that paints a distorted, biased, or overly disturbed view of the client's situation. Such documentation may be harmful and at best ineffective in producing positive outcomes for the client. Furthermore, a therapist may produce documentation that inaccurately depicts a client's progress and outcome, which in turn could have negative implications if the client were to review his or her own records or if those records were to be used in court. Considering that MFTs meet with minors and adults involved in custody matters, it is important that documentation be objective, well thought out, and in the best interest of the client.

Along with the clinical and ethical implications of compassion fatigue also reside serious legal implications. Negative feelings toward a therapist may lead the client to feel as though he or she received a reduced standard of care or were injured emotionally or mentally by the therapist. Providing adequate service to clients is a necessity in therapy. The *AAMFT Code of Ethics* (2001) states that MFTs must maintain high standards of professional competence and integrity. Therapists who show no competence and/or integrity may thus find themselves in a malpractice suit. Subprinciple 3.2 of the *AAMFT Code of Ethics* (2001) requires that MFTs ''maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.'' These professional standards should be adhered to in order to avoid malpractice claims. In addition to a standard level of care claim, fatigued family therapists may find themselves held liable if clients harm themselves or others. The therapist should be aware of and educated about the serious legal implications associated with compassion fatigue.

Often it is difficult for therapists to admit that they are fatigued. Some do not admit to being fatigued because they do not recognize their own symptoms; others do not want to appear weak or inadequate to their peers. Similarly, colleagues find it difficult to report a fatigued counterpart: partially because they would rather not challenge the professionalism of their colleague and also because they do not feel comfortable interfering in their colleagues' work or life. Skorina (1982) suggested that psychology has developed an aura of invulnerability that fosters high expectations for personal efficacy, equates personal difficulties with incompetence, and leads to an unwillingness to seek help from colleagues. Thus, the practice of not reporting fatigued colleagues also has to do with feelings of grandiosity in the profession, which can also lead therapists to suffer from compassion fatigue and result in resistance to seek help.

SEPARATION OF PERSONAL LIFE FROM PROFESSIONAL ROLE

Thinking systemically, it can be stated that along with the influence of the client's problems to his or her family life, the therapist's own family problems can also influence the treatment. A family therapist can have high expectations about how a client's family should function. If the family does not share the same goals as the therapist, it may leave both the family and the therapist feeling stressed and disconnected. On the other side, a family therapist's own family

can also be affected by the problems that are experienced by his or her clients. Figley (1993) suggested that a therapist's support network is vulnerable to compassion fatigue. Marriage and family therapists seem to have more personal marital difficulties than those in any other mental health discipline (Deacon, Kirkpatrick, Wetchler, & Niedner, 1999). This circular interaction can lead to disintegration of the therapist's job and family life (Wetchler, Flores, & Piercy, 1988). A marriage and family therapist experiencing symptoms of fatigue may begin to associate with his or her family in the same way he or she associates with clients. A therapist suffering from fatigue may also attempt to become a therapist to his or her own family, which in turn can lead him or her to feel more fatigued. Marriage and family therapists suffering from fatigue may find themselves isolated from family or friends as a result of depression and emotional exhaustion. Marriage and family therapists must maintain concrete boundaries between personal and professional life in order to maintain a sense of emotional control, resilience, and clarity.

MFT Training Program Impact on Personal Life

The often rigorous and time-consuming requirements of marriage and family therapy graduate programs can leave an MFT trainee with family demands in danger of experiencing an early onset of compassion fatigue. MFT programs around the country continue to receive a growing number of admissions applications each year, many of whose applicants are married. Further, married MFT trainees now represent a significant number of those in their field. In a study carried out by Sori, Wetchler, Ray, and Niedner (1996), married trainees ranked their number one complaint and stressor in their marriage as the lack of time they had to spend with their spouse or family. Survey results revealed that it was difficult for trainees to manage jobs, internships, and course requirements in addition to personal relationships. Often, the spouse in the relationship bears the emotional and financial cost of the trainee's program responsibilities. Sori et al. (1996) reported that it is difficult for the spouse to assume the additional familial responsibilities that are unattended to by the busy trainee. Sometimes the spouse may feel as though he or she must abandon, at least temporarily, personal goals, leisure activities, and time alone. Many spouses are also left feeling isolated from the trainee, especially in the first year of the program (Sori et al., 1996). Furthermore, many trainees reported feeling guilty for not being emotionally involved and/or physically present for their children's upbringing. Trainee-parents with preadolescent children who are more dependent and considerably attached to their parents may experience even stronger feelings of guilt for not being regularly present during important periods of time in their children's development. Upon entering a program and continuing throughout professional training, trainees can experience a lifestyle that is imbalanced and consuming as a result of demanding and frantic scheduling (Valenta & Marotta, 2005). With the difficult demands of family and graduate program requirements, MFTs may enter the field experiencing symptoms of fatigue before they ever enter the job market.

Single-Parent Households

Like Diana, a greater number of women are assuming the responsibility of being the primary or sole caregiver in the home. With divorce rates at 38% (National Center for Health Statistics, 2005) and 33% of children being raised in single-parent homes, 4 out of 5 of which are run by women (Childs Trends Databank, 2005), an increasing amount of responsibility is being placed upon mothers. This leaves women, who represent 55% of all family therapists (Doherty & Simmons, 1996), more susceptible to experiencing compassion fatigue, especially if they lack the family, social, and financial resources needed to assist them in raising their children. For the single-parent family therapists, the constant struggle to maintain structure in the household and meet financial responsibilities while also meeting the needs of clients increases the odds of experiencing fatigue. Conventional tasks adopted by mothers, such as housekeeping, nurturing, and child sitting, require female family therapists to work at a pace

outside of work similar to that being demonstrated in a 40-hr work week. Working at such a continuous pace can lead to emotional exhaustion, which is often accompanied by depression, anxiety, and physical ailments. Moreover, single, female family therapists are faced with challenges and family life cycle transitions in their personal life that, to some degree or another, resemble those of their clients. Many clients of MFTs present custody issues and divorce dilemmas. Such cases and clientele require that MFTs be able to separate the client's problems from their own problems. A family therapist who overlooks important differences that exist between his or her personal life and that of his or her clients risks losing creditability (Catherall & Pinsof, 1987).

Personality Factors

The degree of compassion fatigue among family therapists is known to be correlated with personality factors. Therapists who are characteristically nonflexible in their routines and in their tendencies to set clear boundaries seem vulnerable to disagreements with their clients (Hellman, Morrison, & Abramowitz, 1987). However, therapists who maintain personal boundaries seem less vulnerable to such stress-triggering client situations. Therapists' attributions are also an important consideration. How a problem is perceived directly relates to the personality of the therapist and his or her understanding of the systems and the need to keep clear boundaries within those systems. Not internalizing or overidentifying with clients' problems can prove beneficial to the therapist. Given that humans are bio-psychosocial beings, efforts to consider all of these factors at the same time are challenging, but nonetheless important to both the personal and professional life of an MFT.

Linley and Joseph (2007) found that therapists who by nature had a greater sense of coherence (i.e., perceive things with greater lucidness and rationality) were protected against compassion fatigue and reported greater overall well-being, including compassion satisfaction.

The term *compassion satisfaction* is associated with the positive changes that stem from the therapeutic relationship. Compassion satisfaction refers to a sense of satisfaction that comes from caring or helping an individual(s) (Collins & Long, 2003; Stamm, 2002). Several studies have discussed the development and role of compassion satisfaction in various therapeutic settings (i.e., Collins & Long, 2003; Schauben & Frazier, 1995; Tedeschi & Calhoun, 2004). Collins and Long (2003) found a negative correlation between compassion satisfaction and compassion fatigue, indicating that compassion satisfaction may act as a defense mechanism against compassion fatigue. Stamm (2002) also found that compassion satisfaction fueled people's will to continue their work in the face of harm or distress. In order for therapists to provide genuine compassion and experience compassion satisfaction, they must exercise self-care (Kraus, 2005).

Substantial literature attests to therapists' positive evolutionary journey (Framo, 1975; Linley & Joseph, 2004, 2007; Napier & Whitaker, 1978). In the face of trauma and extreme stress that manifest within the therapeutic setting lies an opportunity to make personal gains. The growth potential associated with the passion and empathy exercised in therapy can strengthen the therapist's personal and professional resolve. Being witness to clients' strength and growth can motivate therapists and make positive changes in their own lives (Tedeschi & Calhoun, 2004). Radeke and Mahoney (2000) compared therapists against research psychologists and found that therapists reported feeling more prudent and experienced regarding life than research psychologists. Schauben and Frazier (1995) found that therapists valued being witness to the resilience and growth of their traumatized clients.

PREVENTATIVE MEASURES

The work of a family therapist is one that is emotionally, mentally, and physically challenging; however, there are antidotes and preventative measures that can reduce the symptoms that lead to compassion fatigue. Self-care is an indispensable defense mechanism and remedy

(Figley, 2002a, 2002b). Self-awareness and self-monitoring are essential for recognizing when changes in behavior or work life are needed (Kramen-Kahn & Hansen, 1998). Therapists should monitor their sleep patterns, physical and emotional reactivity, and physical activities. Common signs of compassion fatigue include (a) trouble sleeping, (b) amplified or exaggerated physical reflex, (c) increased emotional reactivity (i.e., irritability, anxiety), (d) hypervigilance, and (e) diminished interest in regular activities (Figley, 1995). The authors of this article recommend that MFTs pay close attention to their emotional reactivity both inside and outside of therapeutic relationships. A therapist who has trouble detaching thoughts and feelings related to his or her clients suffering from their own personal lives may be experiencing warning symptoms of compassion fatigue. The authors also recommend a number of measures that may be used to prevent or reduce fatigue, including reducing caseloads (Skorupa & Agresti, 1993), cultivating formal supervisory relationships and informal mentor relationships (Kramen-Kahn & Hansen, 1998), maintaining consistent levels of supervision, taking regular vacations, and participating in educational retreats. Sustaining a balance between one's personal and professional life is essential. MFTs need assistance in restoring and maintaining that balance. Seeking personal therapy for problems related to work and family difficulties can substantially reduce the onset and symptoms of fatigue. In a study completed by Deacon et al. (1999), 68.9% of AAMFT Clinician Members who had participated in personal therapy reported their experience as very successful, with 95% of the respondents reporting at least some success in therapy.

In addition, supervisors are obligated to recognize and act when MFTs fail to notice or admit to symptoms of compassion fatigue. Therapists may appear distracted or emotionally reactive in supervision. Using professional discretion, supervisors are encouraged to inquire into the therapist's personal life. Reports of sleep disturbance or interpersonal challenges within the therapist's personal life should be further investigated. Supervisors are also encouraged to monitor the extent of time in which the therapist is exposed to suffering. Prolonged exposure to suffering can leave the therapist more vulnerable to experiencing compassion fatigue (Figley, 2002a, 2002b). Furthermore, supervisors should use their discretion in deciding whether or not a therapist is struggling to maintain an appropriate level of care and empathy for his or her clients.

SPENDING TIME IN LEISURE ACTIVITIES CAN ALSO BE A SOURCE OF RELAXATION AND RENEWAL

Monitoring physical health, making time for spiritual practices, taking part in meditation, and journaling are important ways in which family therapists can maintain emotional stability (Becvar, 2003). Yoga is another method MFTs can use to promote self-care. A regimen of yoga is an affordable method used by therapists to enhance self-awareness, patterns of cognition, and a lifestyle that is beneficial to their self-growth and professional goals (Valenta & Marotta, 2005).

Developing external support is also critical for MFTs. Maintaining healthy and open communication with family and friends allows therapists great emotional escapes from their professional responsibilities. Being with friends also allows therapists to escape daily expectations of family and clients (Odell & Campbell, 1988). Laughter and fun, whether with friends or family, also proves to be an effective method in preventing fatigue (Becvar, 2003). Engaging in lighthearted conversation, watching comedy entertainment, practicing religion, and participating in noncompetitive activities or hobbies may also reduce stress and increase happiness. The overall idea is to avoid stress, increase relaxation, and be part of a world that does not mirror that of the therapeutic setting.

CONCLUSION

Marriage and family therapists work with clients who present with a continuum of problems and suffering. In order to provide clients with relief and resolution, it is required that

therapists constantly show compassion and empathy, two feelings that may leave them vulnerable to stress and fatigue. The job of an MFT can reduce emotional stability, lead to poor therapeutic skills, personal family challenges, and much more. Ethical and legal implications arise when an MFT experiencing fatigue continues to provide therapeutic services that are not of benefit to a client. A number of job-related factors are correlated to an MFT's experience of fatigue including work setting, therapeutic specialization, and personal lifestyle. It is the MFT's responsibility and obligation to ensure that he or she takes whatever measures possible in efforts to reduce and/or eliminate fatigue. Fortunately, there are a number of preventative measures and solutions that MFTs can exercise, all of which provide them the opportunity to gain greater emotional stability and continued fulfillment in the field.

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