

Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care¹

▼
Charles R. Figley

School of Social Work, Traumatology Institute
Florida State University, Tallahassee

Psychotherapists who work with the chronic illness tend to disregard their own self-care needs when focusing on the needs of clients. The article discusses the concept of *compassion fatigue*, a form of caregiver burnout among psychotherapists and contrasts it with simple burnout and countertransference. It includes a multi-factor model of compassion fatigue that emphasizes the costs of caring, empathy, and emotional investment in helping the suffering. The model suggests that psychotherapists that limiting compassion stress, dealing with traumatic memories, and more effectively managing case loads are effective ways of avoiding compassion fatigue. The model also suggests that, to limit compassion stress, psychotherapists with chronic illness need to development methods for both enhancing satisfaction and learning to separate from the work emotionally and physically in order to feel renewed. A case study illustrates how to help someone with compassion fatigue. © 2002 Wiley Periodicals, Inc. J Clin Psychol/In Session 58: 1433-1441, 2002.

Keywords: compassion fatigue; burnout; self-care for psychotherapists; countertransference

Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care

There is a cost to caring for those with chronic illness just as there is a realization that these clients will never fully recover. As psychotherapists, we learn to be on the one hand objective and analytical in our professional role as helper. We must put our personal feelings aside and objectively evaluate our clients and administer the best treatments

Correspondence concerning this article should be addressed to: Charles R. Figley, Ph.D., Professor, School of Social Work and Director of the Traumatology Institute at Florida State University, 1303 Broome St., Tallahassee, FL 32301; telephone: (850) 656-7158; e-mail: cfigley@mailr.fsu.edu.

¹This essay is dedicated to all those psychotherapists who have worked with clients over many sessions who were diagnosed with some kind of chronic problem and it left a lasting impression on the psychologist. Also, this is dedicated to those psychotherapists who either have a chronic illness or live with or love someone with one.

according to best practice guidelines. But on the other hand we cannot avoid our compassion and empathy. They provide the tools required in the art of human service. To see the world as our clients see it enable us to calibrate our services to fit them and to adjust our services to fit how they are responding.

Case Illustration

"My professors think I need therapy . . . maybe they are right." This statement greeted me as I checked my voice mail Monday morning in April. It turned out to be a counseling psychology Ph.D. student from a smaller university in the region. According to two of her clinical supervisors she was not responding well to an assigned client. Although Jane (not her real name) had five years of experience as a licensed mental health counselor, she was missing important aspects of the client's story. When Jane finally faced the fact that she was failing in a profession she loved, she began to recognize that her clinical errors were associated more with how the client's story was upsetting her than her abilities as a psychotherapist.

Jane's client was a young, female college student who was away from home for the first time and sought Jane's help with adjusting to the changes. Only after more than a half dozen sessions did Jane's supervisors notice and mention to her that her client felt guilty about leaving her mother; that the client had been over-functioning while the mother had developed a considerable dependency that needed addressing. Jane most often shifted the focus of therapy to other issues. Jane wanted to talk about and face these clinical errors, her resentment toward the faculty members who challenge her, and, reluctantly, her mother's chronic illness. We quickly moved to Jane's feelings of guilt about her own mother's condition and her inability to or ambivalence toward addressing her dysfunctional relationship with her mother.

We will return to Jane shortly after introducing some terms and a conceptual model. These are what I drew upon in treating Jane.

Compassion Fatigue

The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others.

I first studied the consequences of helping the traumatized in 1971 (Figley, 2002b). It was the first interview I conducted with a Vietnam War veteran named "Doc." He served as a corpsman, a nurse attached to a Marine Corps unit between 1969-1970. His memories of the war were dominated by guilt and regrets associated with not saving or not helping or not doing enough for his patients. These burdensome memories were associated with lots of psychological problems that would later be diagnosed as war-related Post-Traumatic Stress Disorder (PTSD).

We were both in Washington, D.C., on a mission. We were both there as members of the Vietnam Veterans Against the War in an effort to convince Congress to stop the war. I found that I was far more effective as a researcher than as a war protestor. Although my research expanded from combat veterans (Figley, 1978) to others exposed to distress in the line of duty to civilians and victims who experienced a wide variety of calamities, I never forgot Doc.

In 1980, when the Diagnostic and Statistical Manual of Mental Disorders was published, it contained for the first time the diagnosis of PTSD. Included in the description of the diagnosis was the provision that one could be traumatized both by being in harms way and by bearing the distress of others who are. This does not only include the family and close friends of the suffering but also professionals involved in helping the suffering. This includes those suffering from chronic illness.

In the first example, Jane is experiencing secondary traumatic stress reaction called *compassion fatigue* associated with both her mother and her client. Jane must effectively face and deal with it before she can effectively help her client.

Secondary Traumatic Stress is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1993)" (Figley, 1995b, p. 7). STSD is a syndrome with symptoms nearly identical to PTSD, except that exposure to knowledge about the traumatizing event experienced by the significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person in harms way. Specifically, compassion fatigue is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others.

Prevalence of STS and STSD

A recent study (Meldrum, King, and Spooner, 2002) in Australia found 27 percent of professionals who work with the traumatized experienced extreme distress from this work. In all, 54.8 percent were distressed at the time of the study and 35.1 percent were very or extremely emotionally drained. In another study 17.7 percent had STSD and 18 percent were just below cut off for the diagnosis. In a study of rural mental health professionals, the prevalence rate was 24.1 percent for STSD and 21.4 percent sub-clinical.

In a study of Oklahoma City trauma workers (Wee & Myers, 2002), 64.7 percent exhibited some degree of severity for posttraumatic stress disorder, as measured by the Frederick Reaction Index (Fredrick, 1987). Among the findings were that 44.1 percent of counselors exhibited "caseness" (scores at or above the 90th percentile for non-patient norms on the SCL-90-R Global Severity Index score or two dimensional T scores greater than or equal to 63). Most (73.5 percent) of counselors were rated as being at moderate risk (23.5 percent), high risk (29.4 percent), or extremely high risk (20.6 percent) for compassion fatigue, as measured by the Compassion Fatigue Self Test for Psychotherapists (Figley, 1995). Also most (76.5 percent) of counselors were rated as being at moderate risk (35.3 percent), high risk (26.5 percent), or extremely high risk (14.7 percent) for burnout, using the same Compassion Fatigue Self Test. Similarly, in a study (Myers & Zunin, 1994) of Northridge Earthquake mental health workers, 60.5 percent met criteria for PTSD.

Forms of Secondary Stress?

Some would argue that both Doc and Jane suffer from countertransference. Countertransference is from psychodynamic therapy and an emotional reaction to a client by the therapist—irrespective of empathy, the trauma, or suffering. It is defined as the process of seeing oneself in the client, of over identifying with the client, or of meeting needs through the client (Corey, 1991). In contrast to compassion fatigue, countertransference

is chronic attachment associated with family of origin relationships and has much less to do with empathy toward the client that causes trauma. In the case of Jane it had more to do with Jane's exposure to a traumatic event involving her mother than to attachment issues.

In contrast to compassion fatigue, simple burnout is "... a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9) rather than the specific exposure to the trauma and suffering of a specific client. Neither Jane nor Doc reported characteristic symptoms of burnout. These symptoms go far beyond the symptoms of traumatic stress reactions.²

However, both Jane and Doc had the characteristic pattern of compassion fatigue, in contrast to burnout and countertransference (Figley, 2002a): Compassion fatigue and countertransference have a faster onset of symptoms. Compassion fatigue and standard burnout have a faster recovery from symptoms. Compassion fatigue, in contrast to both burnout and countertransference, is associated with a sense of helplessness and confusion; there is a greater sense of isolation from supporters. The symptoms disconnected from real causes and are triggered by other experiences. Burnout may require changing jobs or careers. However, compassion fatigue is highly treatable once workers recognize it and act accordingly.

Etiological Model

Since the publication of the first book on compassion fatigue (Figley, 1995) there has been an emergence of newfound appreciation for the costs of caring, and the relationship between the role of empathy and previous traumatic experiences. A model first introduced in 1995 and revised subsequently offers a way for those most susceptible to compassion fatigue to prevent and mitigate it quickly.

This model is based on the assumption that empathy and emotional energy are the driving force in effective working with the suffering in general, establishing and maintaining an effectively therapeutic alliance, and delivering effective services including an empathic response (Figley, 1995; Figley, 2002a). However, being compassionate and empathic involves costs in addition to the energy required to provide these services. Following are the eleven variables that, together, form a causal model that predicts compassion fatigue. Herein lies both an appreciation for what causes compassion fatigue and what is required to prevent and treat it.

Empathic Ability is the aptitude of the psychotherapist for noticing the pain of others. The model suggests that without empathy there will be little if any compassion stress and no compassion fatigue. However, without empathy there will be little if any empathic response to the suffering clients. Thus, the ability to empathize is a keystone both to helping others and being vulnerable to the costs of caring.

Empathic Concern is the motivation to respond to people in need. The ability to be empathic is insufficient unless there is motivation to help others who require the services of a concerned psychotherapist. With sufficient concern, the empathic psychotherapist

² Burnout symptoms are categorized as Physical Symptoms (e.g., physical exhaustion, Sleeping difficulties, and Somatic problems); Emotional Symptoms (e.g., irritability, anxiety, depression, guilt, and a sense of helplessness); Behavioral Symptoms (e.g., Aggression, Callousness, Pessimism, Defensiveness, Cynicism, Avoidance of clients, Substance abuse); Work-Related Symptoms (e.g., Quitting the job, Poor work performance, Absenteeism, Tardiness, Constantly seeking avoidance of work, and Risk-taking); and; Interpersonal Symptoms (e.g., Perfunctory communication, Inability to concentrate, Social withdrawal, Lack of a sense of humor, Dehumanization, and Poor patient interactions)

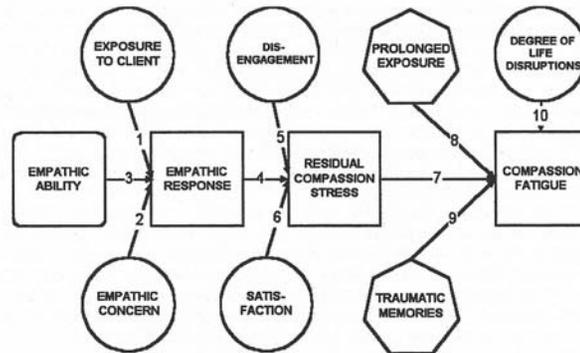


Figure 1. Compassion Stress and Fatigue Model (Figley, 1995, 1997).

draws upon her or his talent, training, and knowledge to deliver the highest quality of services possible to those who seek it.

Exposure to the Client is experiencing the emotional energy of the suffering of clients through direct exposure. One of the reasons why those in direct practice of human services become supervisors, administrators, or teachers in mental health professions is due directly to the costs of direct exposure to clients. Some make the shift for direct practice because of additional pay, improved working conditions, and higher status. However, the costs of direct exposure to the suffering of others is high and it is impossible to know how many have chosen to abandon direct practice because the price was too high for them.

Empathic Response is the extent to which the psychotherapist makes an effort to reduce the suffering of the sufferer through empathic understanding. This insight into feelings, thoughts, and behaviors of the client is achieved by projecting one's self into the perspective of the client. In doing so, the psychotherapist might experience the hurt, fear, anger, or other emotions experienced by the client. Therein lie both the benefits and the costs of such a powerful therapeutic response. The benefits are immediately obvious to every graduate student who practices her or his new skills with another. The costs are rarely discussed and must be experienced to elicit efforts on the part of the psychotherapist to guard against or mitigate the effects on the self.

Compassion Stress is the residue of emotional energy from the empathic response to the client and is the on-going demand for action to relieve the suffering of a client. Like any stress, with sufficient intensity it can have a negative impact on the human immune system and the quality of life in general. Together with other factors it can contribute to compassion fatigue unless the psychotherapist acts to control compassion stress. There appear to be two major sets of coping actions that can do this.

Sense of Achievement is one factor that lowers or prevents compassion stress and is the extent to which the psychotherapist is satisfied with his or her efforts to help the client. A psychotherapist with a sense of achievement regarding the delivery of services

to the client demands a conscious, rational effort to recognize where the psychotherapist's responsibilities end and the client's responsibilities begin.

Disengagement is the other factor that lowers or prevents compassion stress. It is the extent to which the psychotherapist can distance himself or herself from the ongoing misery of the client between sessions in which services are being delivered. A psychotherapist's ability to disengage the client also demands a conscious, rational effort to recognize that she or he must "let go" of the thoughts, feelings, and sensations associated with the sessions with the client in order to live their own life. Disengagement is the recognition on the part of the psychotherapist for importance of self-care and to carry out a deliberate program of self-care.

If compassion stress is permitted to build, despite the psychotherapist's effort at disengagement and a sense of work satisfaction, the psychotherapist is at a greater risk of compassion fatigue. Three other factors play a role in increasing compassion fatigue.

Prolonged Exposure is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time. The longer the period of time between breaks—the better—at least a day of appointments and as much as a week's vacation. These breaks are specifically viewed as such; a respite from being compassionate and empathic toward clients; a break from being a professional service provider.

Traumatic Recollections are memories that trigger the symptoms of PTSD and associated reactions, such as depression and anxiety. These memories may be from the psychotherapist's experiences with other, rather demanding or threatening clients or clients who were especially sad or suffering. These memories are events that, when recalled, cause an emotional reaction. These memories can be provoked by certain types of clients and client experiences that have a connection to the traumatic events experienced by the therapist.

Life Disruption is the unexpected changes in schedule, routine, and managing life responsibilities that demand attention (e.g., illness, changes in life style, social status, or professional or personal responsibilities). Normally such disruptions would cause a certain but tolerable level of distress. However, when combined with the other seven factors, these disruptions can increase the chances of the therapist developing compassion fatigue.

Managing and Treating Compassion Fatigue

Just as this model of compassion fatigue can help to predict its onset, the model can also help in preventing and mitigating this fatigue. With Doc or Jane or any psychotherapist who works with the suffering, there are five implications derived from this model to do so.

First, if it is clear that the therapist has compassion fatigue, providing a comprehensive overview of compassion fatigue for educational purposes is vital. A copy of this article could be the first step. The therapist can find more on the Web, at the library, and in professional journals, such as *Professional Psychology*.

Second, it is important to desensitize the therapist to traumatic stressors. In doing so, she or he has greater ability to face and work through the various issues associated with causing and retaining the traumatic stress reactions. The methods for desensitization psychotherapists are no different than those for other traumatized clients. There should be a good match between the preferences of the therapist-client and the desensitization method utilized by the treating therapist. The method should minimize the degree of discomfort and should maximize the exposure to the stimuli which most accounts for the distressing reactions. The result of such methods, of course, should substantially decrease or eliminate the unwanted emotional reactivity linked to the traumatic stressor(s). In Jane's case,

it was female clients' disclosures about their mothers, particularly a sense of responsibility, or a fear for safety. In Doc's case it was any reminders of the war and especially war casualties.

The third issue is associated with exposure dosage. There is considerable evidence that the primary active ingredient in effective desensitization is exposure (Figley, 2002b). Utilizing the right therapeutic dosage of exposure is challenging. One effective method is to combine exposure with relaxation, thereby activating the reciprocal inhibiting reflex. A number of treatment methods are effective primarily because of this reflex (Figley, 2002b).

A fourth issue in treating compassion fatigue is assessing and enhancing social support. Psychotherapists gradually view themselves as others view them: someone who is an expert at helping others cope with life's challenges. They seem to forget that they are human beings as well. A physician sometimes gets sick and needs another physician's services, for example. Often the therapist has a rather limited social support system composed of colleagues and only a few intimate relationships. It is vital to increase the therapist's support system in both numbers and variety of relationships so that she or he is viewed apart from the therapist persona. Moreover, some relationships may be a source of strain and stress. These toxic relationships are an additional demand and should be addressed (Figley, 1997).

Mitigating Jane's Compassion Fatigue

In returning to Jane's case, we quickly moved in the initial interview to Jane's feelings of guilt about her mother's condition and her inability to address her ambivalence toward confronting her dysfunctional relationship with her mother.

After the first session, Jane completed a battery of tests including the Purdue Social Support Scale (Burge & Figley, 1987; Figley, 1989), the Compassion Fatigue Self Test (Figley, 1995; Stamm & Figley, 1999; Stamm, 2002), and a measure of PTSD. She also completed a structured clinical interview to determine her current relationship with her mother and the degree of systemic enmeshment. Her results confirmed our (Jane and the treating team's) assessment that she was suffering from compassion fatigue, a restricted social support network, and from considerable traumatic stress. But rather than being the classic struggle between mother and daughter, it became obvious that there was some secret she had not disclosed yet. This secret was the fact that her mother was attacked by a dog and nearly killed.

During the next session we shared the results with Jane, discussed the treatment options, and agreed upon a treatment plan. The plan entailed increasing her self-soothing and stress management skills (e.g., workbooks, video training), enhancing the number and variety of social supporters (e.g., through volunteer work and involvement in extracurricular activities), and utilizing cognitive-behavioral therapy that minimized exposure and clinical time that would result in desensitization (i.e., reduction or elimination of traumatic stress). She selected the Eye Movement Desensitization and Reprocessing (EMDR) as the method for addressing the secondary traumatic stress associated with her own experiences that were affecting her effectiveness as a professional. EMDR procedures call for the client to select a "target memory" that represents the worst and most stressful aspect of the trauma. She selected the dog attack as the initial experience. As an indicator of success, we would use the same case material she used in class (the young, female college student adjusting to being away and feeling guilty about leaving her mother).

For the next five sessions, using EMDR, Jane worked through the dog attack, the first signs of her mother's chronic illness, Jane's sacrifices, feelings of resentment toward

her mother, and the embarrassments she felt—particularly during her teenage years—having to take care of her mother.

By the final session Jane's symptoms subsided (desensitization). She shifted from self-blame and self-hatred to a more realistic view of herself and her mother. Discussions about the clinical cases she found challenging were now interesting but rather routine. Jane recognized that she still has work to do. She still is reactive around her mother and knows that patience and practice are necessary to be fully differentiated from her mother emotionally and, as a result, it will be easier to love and appreciate her. Her test scores showed significant reductions in symptom prevalence and intensity, confirming what we could see ourselves. At our request she checks in with us periodically. After more than a year she is thriving in both her own practice and her personal life.

How We Help Our Fellow Therapists?

There are things that we can do to help our colleagues who work with clients with chronic illnesses. The first is to speak openly about our own struggles with compassion stress and compassion fatigue. The conspiracy of silence among the profession about this compassion fatigue is no different than the silence about family violence, racism, and sexual harassment in the past. Today there are videotapes, books, and articles on the topic. Of special note have been the series of articles published in *Professional Psychology* in the last several years. Have these handy and available to our colleagues who are interested or should be. The first step is completing the Self Test for Psychotherapists that is available free on the Internet at www.greencross.org/selftest4psychotherapists.pdf. The test will provide a rough estimate of the respondent's level of satisfaction with their work as a psychotherapist, their risk of burnout, and their risk of compassion fatigue. Hopefully, the results will motivate the psychotherapists to take action to correct any concerns and enhance satisfaction for their work.

Stress management and self-soothing techniques are critical for surviving modern work—no matter the focus of the work. In Jane's case and with other psychotherapists experiencing compassion fatigue burnout, it is vital to be able to gain mastery of distress. This is true during sessions when working directly with clients or outside the session in the privacy of one's office, automobile, or home.

The psychotherapist also needs ways to desensitize from distressing memories; memories that invoke traumatic stress symptoms and are the hallmark of compassion fatigue. Most often, the psychotherapist needs the services of another to effectively treat this through some type of desensitization program.

Summary

It is vital that today's psychotherapist continue to work with empathy and compassion. Yet, there is a cost to this work that is obvious to any one practitioner working with the suffering. As the evidence mounts proving the negative consequences of a lack of self-care and the presence of compassion fatigue, so will the ethical imperative for the suffering practitioner to do something, or something will be done for them. We cannot afford to not attend to the mistakes, misjudgments, and blatant clinical errors of psychotherapists who suffer from compassion fatigue. It is, therefore, up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise we will lose clients and compassionate psychotherapists.

Select References/Recommended Readings

- Burge, S., & Figley, C.R. (1987). The social support scale: Development and initial estimates of reliability and validity. *Victimology*, 121(1), 14-22 (Available in Figley, 1989, pp. 156-158).
- Corey, G.F. (1991). *Theory and practice of counseling psychotherapy*. Belmont, CA: Brooks Cole.
- Figley, C.R. (Ed.) (1978). *Stress disorders among Vietnam Veterans: Theory, research, and treatment*. New York: Brunner/Mazel.
- Figley, C.R. (1982). Traumatization and comfort: Close relationships may be hazardous to your health. Keynote presentation at a conference, "Families and Close Relationships: Individuals in Social Interaction," Texas Tech University, Lubbock, Texas.
- Figley, C.R. (1989). *Helping traumatized families*. San Francisco: Jossey-Bass.
- Figley, C.R. (February 1993). Compassion stress and the family therapist. *Family Therapy News*, pp. 1-8.
- Figley, C.R. (Ed.) (1995a). *Compassion fatigue: Secondary traumatic stress*. New York: Brunner/Mazel.
- Figley, C.R. (1995b). Compassion fatigue as secondary traumatic stress disorder: An overview. In Figley, C.R. (Ed.), *Compassion fatigue*. New York: Brunner/Mazel.
- Figley, C.R. (1997). *Burnout in families: The systemic costs of caring*. Boca Raton: CRC Press.
- Figley, C.R. (1998). *The traumatology of grieving*. Philadelphia: Brunner/Mazel.
- Figley, C.R. (2002a). *Treating compassion fatigue*. NY: Brunner/Rutledge.
- Figley, C.R. (2002b). *Brief treatments for the traumatized*. Westport, CT: Greenwood.
- Forstner, A. (1980). Stress: the psychological scarring of air crash rescue personnel. *Firehouse*, 7, 50-62.
- Frederick, C.J. (1987). Psychic trauma in victims of crime and terrorism. In G.R. Vandenbos & B.K. Bryant (Eds.), *Cataclysms, crises and catastrophes: Psychology in action master lecture series*. Washington, D.C.: American Psychological Association.
- Kleber, R., Figley, C.R., & Gersons, B. (Eds.) (1995). *Beyond trauma: Cultural and societal dynamics*. New York: Plenum Press.
- Meldrum, L., King, R., & Spooner, D. (2002). Compassion fatigue in community mental health case managers. In C.R. Figley (Ed.) *Treating Compassion Fatigue*. NY: Brunner/Rutledge.
- Myers, D., & Zunin, L.M. (1994). *Stress management program after action report: 1994 Northridge earthquake*. Pasadena, CA: Federal Emergency Management Agency and California Governor's Office of Emergency Services.
- Pines, A. & Aronson, E. (1988). *Career burnout: Causes and cures*. New York: The Free Press.
- Stamm, B., & Figley, C.R. (1999). *Compassion fatigue self test for psychotherapists*, revised. Available on the Web at <http://www.isu.edu/~bhstamm/rural-care.htm> and discussed in Stamm (in press).
- Stamm, B. (2002). *Measuring compassion fatigue in psychotherapists*. In C.R. Figley (Ed.), *Treating Compassion Fatigue*. NY: Brunner/Rutledge.
- Wee, D., & Myers, D. (1997). Disaster mental health: Impact on workers. In K. Johnson, *Trauma in the lives of children*. Hunter House Press: Alameda, California.
- Wee, D., & Myers, D. (2002). Response of mental health workers following disaster: The Oklahoma City bombing. In C.R. Figley (Ed.), *Treating compassion fatigue*. New York: Brunner/Rutledge.

Journal of Clinical Psychology IN SESSION

PSYCHOTHERAPY IN PRACTICE

▼
Volume 58 • Number 11 • November 2002

CHRONIC ILLNESS

CONTENTS

- Bent but Not Broken: An Introduction to the Issue on Chronic Illness • *Jackson P. Rainer* 1347
- Ambiguous Loss from Chronic Physical Illness: Clinical Interventions with Individuals, Couples, and Families • *Pauline Boss and Barbara A. Couden* 1351
- Mind's Response to the Body's Betrayal: Gestalt/Existential Therapy for Clients with Chronic or Life-Threatening Illnesses • *Suzanne A. Imes, Pauline Rose Clance, Andra T. Gailis, and Ellen Atkeson* 1361
- Chronic Illness as a Family Process: A Social-Developmental Approach to Promoting Resilience • *Ester R. Shapiro* 1375
- Chronic Pain: Psychological Approaches for the Front-Line Clinician • *John G. Arena* 1385
- Beyond a Sense of Safety: A Psychologist's Tale of Serious Chronic Illness • *Robert N. Solland* 1397
- Pushing Through Solid Rock: Words of Wisdom for Clinicians from Four Patients with Life-Threatening Conditions • *Robert Zucker* 1411
- Caregiving at the End of Life • *Jackson P. Rainer and Patti Ellis McMurry* 1421
- Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care • *Charles R. Figley* 1433
- Inside Every Chronic Patient Is an Acute Patient Wondering What Happened • *F. Marcus Brown, III* 1443

This Journal is Online.

WILEY
InterScience®
www.interscience.wiley.com

Volume 58, Number 11, was mailed the week of October 21, 2002.