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Published approaches to compassion fatigue in psychotherapists typically emphasize clinician self-care strategies. Implicit in the self-care emphasis is the assumption that trauma therapy encounters are inherently fatiguing, and that recovery occurs during the clinician's off-duty time. In contrast, the components for enhancing clinician engagement and reducing trauma (CE-CERT) model addresses the experience of the clinician concurrent with the treatment encounter. The clinical skill components are synthesized from evidence within the psychological treatment and neurophysiology literature relating to the management of difficult emotional states. The 5 proposed components are synthesized into an integrated model for the purpose of positively affecting the experience of clinicians during trauma treatment. We propose that effective use of these evidence informed strategies will allow the clinician to remain emotionally regulated during treatment and, will, therefore, reduce compassion fatigue. The 5 skill categories comprising the components of the CE-CERT model are experiential engagement, managing rumination, intentional narrative, reducing emotional labor, and parasympathetic recovery strategies. These skills are defined and evidence is provided to support their use within the model. The model has immediate application for clinical training and supervision and can be used as a basis for operational definitions for use in effectiveness trials.

Keywords: compassion fatigue, resilience, compassion satisfaction, secondary trauma, supervision

The transformative power of joining in a therapeutic relationship with another has been recognized in the psychotherapy literature for decades. Treatment developers like Carl Rogers (1995) have long noted the importance of therapeutic alliance as an agent of change and the crucial role that *experiencing* (Gendlin, 1962), the process of feeling the meaning of a client's suffering, plays in the therapeutic process. In his classic work, *A Way of Being,* Rogers (1995) wrote,

> When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. . . listening, of this very special kind, is one of the most potent forces for change. (p. 116)

The process of creating such powerful human connections is the cornerstone of good therapeutic work. In fact, across many efficacy and effectiveness studies on traumatic stress treatment, the therapeutic use of self is regarded as an important component of the clinical process, regardless of the approach or method used (Figley & Nelson, 1989; Whipple et al., 2003). Yet, Remen (1996) reminds us that "the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (p. 52).

Though it is axiomatic that empathic engagement is prerequisite to effective treatment, several contemporary authors offer terminology to describe the effect of such experiencing upon the therapist, such as *secondary traumatic stress*, which is a condition that mimics posttraumatic stress disorder (PTSD) and develops through the indirect transmission of traumatic material in a clinical encounter and *compassion fatigue*, which is a nonclinical term to describe the cost of caring for traumatized populations (Figley, 1995; Joinson, 1992). Pearlman and Saakvitne (1995) coined the term *vicarious traumatization* to describe the transformation of therapists' cognitive schemas related to identity, spirituality, and worldview resulting from chronic exposure to clients' trauma stories. These terms are used (sometime interchangeably) throughout the literature to describe the psychological harm associated with enacting the clinical role with traumatized groups.

The prevalence of compassion fatigue (and related conditions) varies across studies and populations, with rates at 8% to 16% in graduate students and social workers working in diverse fields (Adams & Riggs, 2008; Bride, 2007) to over 50% in clinicians treating trauma survivors (Bride, Jones, & MacMaster, 2007; Conrad & Kellar-Guenther, 2006; Hargrave, Scott, & McDowall, 2006). Research on secondary traumatic stress across professions also documents a wide range of secondary traumatic stress severity levels (Elwood, Mott, Lohr, & Galovski, 2011), though unsurprisingly, clinicians whose work focuses on traumatized populations appear to have higher levels of secondary traumatic stress compared with that experienced by other mental health professionals (Birck, 2001; Kadambi, & Truscott, 2008).

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Despite the identified need, interventions designed to specifically address these conditions are limited. Current practice wisdom focuses primarily on self-care strategies to protect the clinician from the deleterious effects of empathic engagement (Figley, 2002; Mathieu, 2012; Pearlman & Saakvitne, 1995; van Dernoot Lipsky, 2009). These approaches imply that efforts such as relaxation, time off, yoga, or recreational activities will counteract the effects of "over engagement." Implicit in this approach is that the provision of trauma treatment is depleting, and that recovery must occur during periods of nonexposure. There is little in the practice literature that specifies how, or if, the empathic encounter should be altered to allow for maximum therapeutic benefit to the client and still offer protection from harm for the therapist.

In contrast to this self-care focus, this article outlines a clinical practice and supervision model that begins with the assumption that client interactions can occur in ways that can be protective against the development of compassion fatigue. This model is predicated on the belief that the level of job distress experienced by therapists providing trauma treatment can be reduced by affecting the emotional state of the clinician during the treatment experience. It is proposed that clinicians who have concrete skills in maintaining their own emotional regulation during trauma treatment will not experience the same level of depletion as those who lack this ability.

Components for Enhancing Clinician Engagement and Reducing Trauma Model

Evidence-based trauma treatments share many components that aim to desensitize a client to provocative stimuli and to reduce emotional dysregulation. Curiously, interventions for compassion fatigue in trauma treatment providers have largely ignored the effectiveness of these approaches in favor of an emphasis on self-care after secondary trauma exposure. The components for enhancing clinician engagement and reducing trauma (CE-CERT) model comprises five elements that are discrete actions or skills that derive from a variety of evidence-informed sources. These five elements are (a) experiential engagement, (b) regulating rumination, (c) intentional narrative, (d) reducing emotional labor, and (e) parasympathetic recovery (see Table 1). The CE-CERT model is atheoretical. Model components were selected for model inclusion because the elements have demonstrated effectiveness for recovery from dysregulated states and are therefore proposed to have utility for therapists for whom trauma work may be dysregulating. The model also provides a substantive framework for clinical supervisors to facilitate compassion satisfaction in the clinicians that they supervise.

Table 1
Components for Enhancing Clinician Experience and Reducing Trauma

Component and action
1. Experiential engagement
a. Conscious intent
b. Noticing and acknowledging feelings
c. Nonreactivity
2. Reducing rumination
a. Noticing/labeling rumination
b. Focused engagement
i. Redirecting thought
ii. Focus on rumination as thought
iii. Nonself-referential, goal-oriented task
c. Social engagement
d. ACES (i.e., action oriented, concrete, experiential, specific)
3. Conscious narrative
a. Antecedent narrative
i. Accepting a "trauma stewardship" role
ii. Self-efficacy in treatment skills
iii. Positive expectancy
1. Treatment as challenging and pleasurable
2. Treatment role as meaningful
3. Focus on dynamics underlying client motivations
4. Low cynicism toward core role
b. Concurrent narrative
i. Problem-solving orientation
ii. Mastery of foundational therapy skills
iii. Belief in effectiveness of treatments
iv. Intentional learning
v. Equanimity
c. Consolidation narrative
i. *Ex post facto* reflection on experience
ii. Articulation of experience
iii. Narrative of evolving competency
iv. Regular reflective supervision
4. Reducing emotional labor
a. Radical empathy
i. Stance of curiosity
ii. Use of behavioral strategies when necessary
iii. Acquiring empathy with intentionality
b. Surfacing therapy interfering behaviors
5. Parasympathetic recovery
a. Practice in your practice
i. Create emotional space (mindful soothing)
ii. Focused activity when agitated
iii. Grounding
b. Balanced supervision
i. Reliably scheduled
ii. Balances craft skills and reflection
iii. Balances craft skills and affect management skills
c. Teaming/social connection
i. Avoiding isolation
ii. Case reviews−shared responsibility
iii. Ad lib peer consultations
d. Standing/movement
e. Strategic vacations
f. Focused engagement
g. Accountability partner

Practice Element 1: Experiential Engagement

Experiential engagement refers to a cluster of skills used by the therapist to establish, balance, and maintain a connection to a client and the client's experience and to acknowledge and experience the feelings that arise as a result of this engagement. Engagement without event processing allows for these emotions to dissipate naturally.

The helping professions maintain a popular wisdom that over engagement or "caring too much" is at the root of compassion fatigue. This view dates back at least to Freudenberger (1974), who first coined the concept of burnout in clinicians and attributed it to over commitment and dedication to a cause. Many published texts and articles related to compassion fatigue refer to the need for therapists to limit their level of empathic engagement (Aarons, Hurlburt, & Horwitz, 2011; Figley, 1995; Pearlman, 1995; Saakvitne, 2002; Udipi, Veach, Kao, & LeRoy, 2008; Williams,

1989). This view of the relationship between empathic engagement and compassion fatigue is so pervasive that it is surprising that little, if any, research supports that association. A reasonable reading of extant research suggests that the field may have inferred a causal pathway from survey data that reveals only that clinicians with high levels of burnout (typically measured with the Maslach Burnout Scale or similar scale) also report that they wish to reduce their level of engagement (Conrad & Kellar-Guenther, 2006; Leiter & Harvie, 1996). It is noteworthy, however, that when highly engaged therapists are asked, they report that empathic engagement is energizing and protective (Harrison & Westwood, 2009; Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Miller, 2007; Sullivan, Skovholt, & Jennings, 2005). Human service workers who experience higher levels of empathy have higher job satisfaction and longer tenure (Miller, Stiff, & Ellis, 1988). Even Maslach (Maslach & Leiter, 2008) has termed engagement the *positive antithesis* of burnout. Research on mindfulness practices has demonstrated that when empathy increases, burnout actually decreases (Sibinga & Wu, 2010). A great deal of the professional burnout, compassion fatigue, and secondary trauma literature cited correlations that are inadvertently viewing treatment work through the lens of workers who are disaffected. Indeed, the opposite of engagement—that is, escape/avoidance—has been known for many years to correlate with, and even predict, burnout in helping professionals (Cushway & Tyler, 1996; Duquette, Kérouac, Sandhu, & Beaudet, 1994; Maslach & Leiter, 2008).

Perhaps the field has misguidedly adopted the view that the solution for compassion fatigue is to limit the level of experiential involvement is due to a failure to make the critical distinction between empathy and countertransference. A therapist who becomes dysregulated and reports intrusive thoughts about a client's traumatic experience may be sensitized because of his or her own trauma history. It is not surprising that workers with a trauma history do appear to have higher rates of secondary traumatic stress in their work (Baird & Kracen, 2006; Nelson-Gardell & Harris, 2003; Sprang, Clark, & Whitt-Woosley, 2007). Countertransference reactions of this type should not be conflated with empathy. The ability to tolerate the feelings evoked by hearing trauma experiences without becoming personally dysregulated is prerequisite to doing trauma treatment. Supporting, supervising, and screening therapists with trauma history are separate subject matters beyond the scope of this article but are crucial, related issues.

It may be counterintuitive, then, that the most important ability therapists must develop to deal with the intensity of trauma work is to engage with the experience fully and to allow it to be experienced through to completion. The logic for making this skill the foundation of the CE-CERT model becomes apparent when we consider that many evidence-based psychotherapies such as dialectical behavior therapy, mindfulness-based cognitive–behavioral therapy (CBT), prolonged exposure therapy, and acceptance and commitment therapy make the concept of experiencing and tolerating distressing feelings—albeit expressed in different terms—a core component of those treatments.

Trauma work is necessarily intense. Experiencing empathy for clients who have experienced trauma will provoke feelings of sadness, anxiety, fear, anger, and frustration in the therapist. It is clarifying to note that experiencing feelings—even intense emotions—may be uncomfortable and at times deeply painful, but it is not harmful, and does not cause compassion fatigue. Direct experience of even powerful feelings is not traumatizing, and the suggestion that this was the root of compassion fatigue has no research support. On the other hand, there is ample evidence that avoiding, or trying to limit those feelings, may be harmful. In fact, it may be that the efforts of the clinician to inhibit the intensity of the feelings generated during trauma treatment, and the energy that this requires, accounts for much of what has been conceptualized as compassion fatigue.

The research provides two-pronged evidence for the importance of experiential engagement: the harmful effects of experiential avoidance and the benefits of a willingness to experience distressful feelings and skillfully respond to that emotion. Hayes, a principal developer of acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 2011), cites a sizable list of research supporting the idea that willingness to experience difficult feelings that accompany many disorders is a mediating variable for distress and that doing so may reduce the symptoms of panic disorder (Levitt, Brown, Orsillo, & Barlow, 2004), anxiety (Eifert & Heffner, 2003), posttraumatic stress (Marx & Sloan, 2005), and depression (Hayes et al., 2011).

Skill 1: Intentionality. Experiential engagement is, in short, acknowledging and fully allowing feelings that arise from doing trauma therapy. The first aspect of experiential engagement is conscious intent. Professionals must answer the question, as Spence (cited in van Dernoot Lipsky, 2009) said, "What are you going to do with the pain of this work?" The only career-sustaining answer to that question must be conscious acceptance of all of the feelings that accompany trauma work. As the preceding evidence suggests, it may be hazardous to try to avoid or down-regulate these feelings because the affective cycle is not allowed to come to completion. Thus, the first step toward experiential engagement is to form the conscious intent to let those feelings be naturally metabolized—not to be endlessly regenerated by ruminative thoughts, but to allow them to be experienced in their primary form, and then released.

Skill 2: Conscious acknowledgment of experience. The second aspect of engagement is simple acknowledgment of feelings. When examined, this guidance may run counter to what may be patterned behavior for some therapists. Some may have an acquired practice of not directly experiencing emotions, in the attempt to always offer unconditional positive regard, to always appear to be in control, and to always seem up to the challenge of the work. In such cases, some relearning is necessary to fully attend to the viscera, the breath, the body, the state of mind. A clinician must learn to be attuned to changes in their own mood states and periodically ask reflectively, "What am I feeling?" The act of acknowledging and labeling feelings is, in itself, transformative. There is a qualitative difference in experiencing feelings consciously versus being embedded in those feelings. Noticing and observing reduces reactiveness to the emotions transforms the experience from a reaction to the stimuli into a conscious response. Reflective supervision—an often recommended strategy for dealing with compassion fatigue—has this acknowledgment of the emotional experience of the clinician at the heart of the model.

Skill 3: Nonreactivity. The skill of experiential engagement requires confidence in the neurobiological fact that whenever feelings—even intense ones—are simply noticed and allowed, the energy of the emotion and associated physiological responses will arise, strengthen, and then fade. The psychoanalytic metaphor of

emotions being metabolized is useful, and may have a physiological basis in fact. It is important that the emotional process that was initiated by exposure to a provocative event during trauma treatment be allowed to follow the natural course to completion. As Levine (1997) has suggested, in humans, trauma may occur as a result of the initiation of the instinctual cycle that is not allowed to finish. This is precisely why the goal of experiential engagement is to acknowledge and experience the emotions directly, but also to allow the feelings to fade as new experiences arise. In the absence of event processing, primary emotional experiences are metabolized quickly (Verduyn, Van Mechelen, & Tuerlinckx, 2011). As human beings, however, our neocortex allows us to conjure the memory of the event, and to initiate the process of emotional experiencing over and over again without limit. It is for this reason that the second skill targets the ruminative process. Without this ability, the therapist will be understandably disinclined to fully engage the primary experience if that event can reproduce itself ad infinitum. Thus, there is a transactional relationship between the first skill, experiential engagement, and the second skill, reducing rumination.

Practice Element 2: Regulating Rumination

Regulating rumination involves reducing the cognitive reproduction of distressing experiences through active control of the cognitive processes away from a wandering state to a focused, goal-directed activity. Some therapists are strongly affected by exposure to the trauma exposure of their clients because images and thoughts of the described trauma may follow them for a long time after the clinical session. Clinicians often receive the advice in training and supervision that they should learn to "leave work at work." However, at least for some clinicians, this may be a skill that must be acquired, and one they are likely to have never been taught.

If the experience is decoupled from cognitive event processing, the clinician will be able to return to a homeostatic state relatively quickly. Clinicians, especially those who work with deeply provocative material during the clinical session, may struggle to return to baseline, as images and descriptions of scenarios may replay well after the session. It is this process—and the physical and emotional dysregulation that results from this process—that prevents clinicians from "leaving work at work."

Rumination involves the mental process of reimagining past events and projecting future concerns and behaviors—often in the form of worry or dread. After an evocative clinical session, the therapist is likely to begin to ruminate when he or she is not immediately engaged in a focused task and allows his or her mind to wander. This inactive, mind-wandering state has been described neurologically as the default mode network, a set of neural regions that activate during off-task periods (Christoff, Gordon, Smallwood, Smith, & Schooler, 2009; Mason et al., 2007). The significance of the default mode network is that it is more active during rumination (Kross, Davidson, Weber, & Ochsner, 2009) and has been linked to poor emotional regulation (Abler, Hofer, & Viviani, 2008) and negative mood states (Berman et al., 2011).

In an effort to recalibrate the internal state because of the arousal produced during a workday filled with secondary exposure to trauma, therapists may attempt to reduce stimulation by minimizing socialization and physical activity. This stimulus-reducing effort will result in considerable mind wandering because he or she has avoided activities that provide significant external stimulation. This lack of engagement, in turn, will allow cognition to move into the default mode. This means that the clinician will continue to replay the events of the day. As he or she does so, the physiological kindling produced by these now imaginal events will result in increased arousal. The increased arousal will produce more rumination in a self-perpetuating, closed dynamic loop.

Skill 1: Acknowledgment. As with experiential engagement, the first step in decreasing rumination is for clinicians to acknowledge when it is occurring. Clinicians may misinterpret repetitive ruminations for "problem solving," but in fact, the ruminative process takes them further away from problem resolution. Indeed, self-focused rumination has been shown to reduce problem-solving ability (Lyubomirsky & Nolen-Hoeksema, 1995). Because the problem never gets solved, the rumination can perpetuate itself without end, and as the mental images are reproduced, physiological and emotional dysregulation is rekindled and the clinician may feel as if they are still in the primary experience. On recognizing that they are not problem solving but are repeating a provocative scenario endlessly, the clinician must acknowledge that he or she is ruminating. Once the ruminative process is consciously identified and is attended to, the degree of psychic disorder produced by unattended experience is reduced. Research on depression treatment using behavioral activation has demonstrated the effectiveness of attending to the immediate experience in reducing rumination (Cuijpers, Van Straten, & Warmerdam, 2007).

Skill 2: Focused engagement. Once clinicians acknowledge rumination, the skills they should use to manage that rumination will be contingent on their level of competency at consciously controlling emotional arousal and the degree of dysregulation. For low levels of arousal during which the clinician is physiologically regulated, simply noticing the rumination and gently redirecting conscious thought as one would in a meditation may sufficiently reroute thinking into ordered and productive cognition. Or, if their agitation level is elevated but their skill level is also high, they may be successful in making the ruminative process itself an object of focused meditation. By focusing directly on the process of rumination, they are directing cognition into the present—neurologically, the task-positive network—and away from the mind-wandering default mode network. Indeed, multiple studies have shown that meditation has this effect; that is, it reduces activity in the default mode network, as cognition becomes more focused (Brewer et al., 2011; Lutz et al., 2014). Focusing upon the ruminative process has been shown to reduce rumination (Broderick, 2005; Deyo, Wilson, Ong, & Koopman, 2009; Jain et al., 2007). This is, however, a difficult skill to practice when levels of autonomic arousal are high. Without considerable skill, the meditation could become a continued rumination.

Meditation is not the only way to transition out of the cycle of the repetitive thinking process. Ruminations serve what has been termed a survival-salient role of remembering the past and planning the future (Sheline et al., 2009). These survival-salient thoughts will be the objects of the ruminations as well: reexperiencing the events of the day, and worrying about what to do in the future. Any cognitive or physical activity that takes us into nonself-referential, goal-oriented tasks will activate the task positive network and move us out of our ruminations and will interrupt the cascade of increasing dysregulation and recurring negative

thoughts. This may include exercise or other physical activities, favored hobbies (if those activities require focus), meditation, or yoga. Studies consistently found that people are in the most pleasant affective states when their cognitive focus is on what they are doing and that they are unhappiest during mentally inactive states (Killingsworth & Gilbert, 2010).

Skill 3: Social engagement. Isolation is an ineffective strategy during rumination because the cognitive looping is a closed system when the clinician is alone. Moving out of the thinking and into the social realm can have an immediate effect in disrupting the rumination cycle. Merely engaging another person in a conversation may immediately end the ruminative process. This engagement may involve telling an account of the events that are the object of the rumination—the importance of constructing a narrative is discussed as the next skill—or it may be a conversation removed from this subject material entirely. Key here is to intentionally choose to engage at least one other person and redirect the energy into the interpersonal and away from cogitating about the events that energize the rumination, and disrupting the cascading link between physiological arousal and cognitive rumination.

Skill 4: Action-oriented, concrete, experiential, and specific (ACES). An additional skill that may help reduce intractable ruminations is to consciously transition from the abstract and evocative cognitions of the rumination into concrete, specific, and action-focused thinking. This strategy is a therapeutic approach used in rumination-focused CBT (Watkins et al., 2011) to make thoughts action-oriented, concrete, experiential, and specific. The content of ruminations involves a focus on what we are feeling, and is usually a passive reexperiencing of disquieting events. Ruminations often focus on judgments about the events or people involved and the negative aspect of what happened, or what we should have done, or what was so distressful about what someone else did. By focusing on ACES, our thoughts change materially into a specific action oriented plan that helps quiet these thoughts by moving our cognitive processing into the task positive mode.

For some clinicians there is little difficulty metabolizing the events of the clinical day and transitioning into the nonwork part of the day. For others, this is a skill that must be approached with intentionality to assure that trauma work does not intrude into personal time. The willingness to fully engage trauma work requires that professionals learn how to let the experience be finished when it is finished.

Practice Element 3: Conscious Narrative

Conscious narrative describes having both opportunity and ability to coherently describe a difficult or traumatic experience or memory throughout the therapeutic encounter in a manner that promotes assimilation of the narrative and calming of dysregulated states. The construction of a trauma narrative is a component of many treatments (Cohen, Mannarino, & Deblinger, 2006; Neuner et al., 2008; Schauer, Neuner, & Elbert, 2005; Tuval-Mashiach et al., 2004; Watkins et al., 2011; Wigren, 1994). There are many reasons that the narrative is important in trauma treatment, including evidence that exposure occurs during the retelling experience that reduces anxiety (Foa, 1997; Schauer et al., 2005) and that developed narratives create coherence in memory (Gwozdziewycz & Mehl-Madrona, 2013). Overarching these explanations is evidence that linguistically representing an emotional experience reduces limbic system arousal (Adenauer et al., 2011; Hariri, Bookheimer, & Mazziotta, 2000).

Despite the broad usage of the trauma narrative concept in treatment, there has been little use of this construct in proposed models of intervention for compassion fatigue in helpers. There are qualitative differences in the narratives of child abuse survivors or persons with PTSD who have good versus impaired functioning as adults (Alvarez-Conrad, Zoellner, & Foa, 2001; Klein & Janoff-Bulman, 1996; O'Kearney & Perrott, 2006). Extrapolating from this finding, it is credible that there are qualitative differences in the narratives of treatment professionals who have high levels of compassion satisfaction and those who are experiencing distress in their work. Numerous studies have demonstrated that disorganized, unassimilated narratives about traumatic events lead to PTSD (Gwozdziewycz & Mehl-Madrona, 2013). Likewise, intense and unarticulated experiences are likely to lead to deleterious effects in the clinician.

Intense levels of affect demand the verbalization of a coherent narrative to activate the soothing circuits of the prefrontal cortex to calm the dysregulated limbic system (Adenauer et al., 2011; Hariri et al., 2000). When an individual has an intense experience, there is a desire to describe it verbally. Linguistic accounting provides meaning, coherence, and predictability to what happened. Most professionals accept this as fact in their clinical care of clients, but it is equally true for the professional after becoming emotionally agitated by a clinical encounter.

The third practice element, conscious narrative, directs that the clinician transform the incipient and unarticulated memories, reactions, and conclusions about their clinical work into a narrative that is consciously directed, consciously articulated, and that promotes compassion satisfaction. As with all of the practice elements, intentionality is central to the skill. Conscious direction of the narrative is protective against what will otherwise be a reactive and incoherent experience of the arousing events.

Consciously directing the narrative of the professional's work necessitates that a representation is made at three intervals: before the clinical experience, concurrent with the experience, and also after the experience. The antecedent and concurrent narrative can be viewed as cognitive strategies that the therapist employs that help to prime a positive experience. Certain narrative elements during these intervals make it more likely that the therapist will maintain emotional regulation. The consolidation narrative most closely parallels the kind of narrative work done in treatment. This narrative entails an *ex post facto* process of making the events coherent and extracting value and meaning from the experience.

Skill 1: Antecedent narrative. Consciously directing the antecedent narrative requires that professionals examine the ideas they currently maintain about their role in the community, their experience of doing treatment, their relationships to their clients, and their self-judgments about their level of confidence in their professional role. van Dernoot Lipsky (2009) proposed the concept of "trauma stewardship" and described the role treatment professionals play in being steward of a community's trauma. This may be a helpful narrative element for therapists—to define themselves in roles as skilled caretakers of the trauma for the community. This role suggests that they possess skills to hold this trauma that other community members do not. This narrative can only be supported, of course, if the therapist believes that they have mastered these skills—or that they are acquiring those skills with intentionality.

The narrative of trauma stewardship also implies that this will be intense but important work, a helpful mental set to have as the clinician enters the psychotherapy encounter.

It is important that the therapist examine the level of cynicism that they have about the core task of helping the clients in their care. Cynicism may have developed because of conclusions the clinician has reached about poorly administered programs, underfunding, staff conflict, productivity requirements, or other frustrations. But clinicians must conscientiously return to an undivided belief in the core purpose of this work: to assist the clients that are before them. If they allow themselves to become cynical about that essential task, compassion satisfaction is impossible. And, because there are so many distractions from this core task during the workday, intentionality is required to return frequently to why they are doing this work.

Skill 2: Concurrent narrative. During a complex or difficult clinical encounter, the clinician's satisfaction with the experience will be largely determined by the narrative that they maintain about their own therapeutic skill level. Resilience is supported by maintaining a stance of problem solving as opposed to emotional reactivity (Campbell-Sills, Cohan, & Stein, 2006; Walsh, 2003). Therefore, key narrative elements that support the therapist's experience are the belief that they have the capacity to manage the difficult situations that they encounter; and that these situations are skills challenges, as opposed to an inherently aversive aspects of the job. The clinician must believe that their efforts have the potential to influence the outcome, and that they are growing in their skillfulness as therapists. Importantly, this must include a belief that they are growing in skillfulness at attending to their own emotional responses to the work.

Clinicians who use evidence-based practices report lower levels of compassion fatigue (Sprang et al., 2007) and stay in their jobs longer (Aarons et al., 2011; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). Satisfaction with clinical work improves when therapists believe that they have effective tools. This fact also explains why distress levels are highest in young and less seasoned clinicians (Ackerley, Burnell, Holder, & Kurdek, 1988; Craig & Sprang, 2010; Tobin & Carson, 1994), as these therapists are less likely to feel that they have mastered therapeutic skills. As with any element of the therapist's narrative, this self-narrative of possessing skills that are sufficient to the challenge before them must be a rational belief, not merely empty self-talk. And when there is, objectively, a skills deficit, the therapist must nurture a narrative that the circumstance is a skills challenge and that they can acquire the skill via experience, formal learning, and supervision. Job mastery and job enjoyment correlate highly (Janssen & Van Yperen, 2004).

A rewarding aspect of being a trauma therapist is that one will never exhaust the learning and mastery one can acquire. Before a therapist has a critical level of perceived competence, however, the complexity of the work and the seeming limitlessness of what one must learn can be daunting. For inexperienced therapists it is especially imperative that their narrative be constructed in a way that emphasizes intentionality toward learning. The therapist's account should include the fact that most client situations that cause job distress can be alleviated with experience. The apprentice therapist must be coached to define the specific skills that are needed, and to resist concluding that the work is simply too difficult.

Although the amount of knowledge that a therapist could acquire over a career is boundless, there is also a level at which the professional has acquired a core competence. At the point at which the therapist has mastered the basics of therapeutic relationship and change approaches, managing the clinical session begins to require significantly less effort.

Clinician's feelings of mastery are important, but it is also true that some client circumstances are insurmountable. A rationally supportable narrative must contain the opposing idea that sometimes, despite the best and most skillful efforts, success is not possible. A healthy narrative is one that balances a sincere belief in the effectiveness of the therapist's skills and a rational realization that these skills are not limitless. The therapist must be able to maintain equanimity in the face of circumstances they cannot change without giving into feelings of impotence.

Skill 3: Consolidation narrative. Traumatic stress symptoms, which can be indirectly transmitted from client to clinician, can derail the construction of an adaptive, conscious narrative. Numbing, detachment, avoidance, and hyperarousal are common responses to trauma exposure when the intensity of the experience feels overwhelming and unmanageable. It is in the reflection about a clinical experience that the meaning of the event becomes evident, adaptation is activated, and learning coalesces into a coherent whole. The first essential component of the consolidation narrative is that there is such a period of reflection. Ideally, this reflection will be in the form of supervision or peer case reviews, but this is not feasible for every trauma case. Reflective supervision has been recommended by many leaders in the field to reduce compassion fatigue in clinicians who are exposed to trauma material (Gibbs, 2001; Sprang, Craig, & Clark, 2011; Tomlin & Hadadian, 2007). Even when not done formally in supervision, clinicians still should take time for reflective narrative building after trauma interventions. They should allow themselves to take stock of how they were affected by the work. They should note whether they were physically agitated and how they were emotionally affected. Consolidation occurs when the emotional and physical arousal subsides as the clinician moves into articulation of the narrative. This requires that the experience be noticed and put into words. A narrative that merely conjures the traumatic story serves only to revivify the experience, increasing autonomic arousal. A coherent narrative must extend to resolution in order to serve a soothing function. Therefore, what is most important is not the graphic retelling of the client's trauma story, rather it is that clinicians have a coherent expression of what happened and what it means to them.

Evocative material from the clinical experience should be consciously woven into the therapists' advancing narrative about their competency. Ideally, this narrative will include a description of how their skills are expanding and how they are becoming more effective in certain ways. The narrative should develop from frequent opportunities to consider the deeper meaning of the work, that is how the experiences have affected them and their worldview, what conclusions they have made about their role in attending to trauma, and what personal meaning they make from this vocation.

These narrative tasks are facilitated greatly by a regular supervision process focused on reflection about the effect of the work on the therapist. Skillful supervisors will help guide the development of the narrative of the therapist by inviting reflection and in

assisting in reframing content toward career sustaining narrative elements. The practice of fully engaging in reflective supervision demands a cognitive shift from the autonomous practitioner perspective that permeates many psychotherapy settings and requires the clinician to allow an "other" into the therapeutic experience.

Practice Element 4: Reducing Emotional Labor

Reducing emotional labor describes the development of an awareness of and reconciliation of differences between expressed and experienced emotions and enhancing the skills needed to decrease the perceived burden associated with doing clinical work with clients who have experienced traumatic events. To reduce the amount of emotional effort that trauma work requires, the therapist must develop mindfulness of the sources of emotional suppression and false affective expression and intentionally nurture skills for easing this effort.

Therapists who thrive in this work do so for the simplest of reasons: They enjoy doing therapy (Clark, 2009; Melamed, Szor, & Bernstein, 2001; Miller, 2007). This simple fact may be overlooked if the therapist focuses exclusively on the aversive aspects of trauma work. Even the most intense trauma work can contribute to compassion satisfaction if the therapist is open to the intensity of the task, possesses skills to manage it, and is able to make meaning of the experience.

Emotional labor, a term coined by Hochschild (1983) and used predominately in the organizational development literature, refers to the "act of expressing organizationally desired emotions during service transactions" (Morris & Feldman, 1996, p. 987). Significant from this literature is the replicated finding that emotion work can have beneficial or deleterious effects on the worker, but dissonance between expressed emotions and experienced emotions produces negative effects (Zapf, 2002). The compassion fatigue literature may fail to make this distinction between empathy and empathy strain caused by the "surface acting" to appear empathic. Easing this type of effort requires the achievement of improved alignment between genuine and expressed emotions.

In the CE-CERT model, it is proposed that therapists do not experience compassion fatigue because of too much experiential engagement, but, rather, they experience it because they do not fully engage and metabolize the full emotional experience. Thus, the source of emotional labor that depletes the therapist is often caused by suppression of frustration or anger because of client therapy-interfering behaviors, evocation of one's own history (especially if it involves trauma), feelings of being overwhelmed by the intensity of the client's experience, or feelings of helplessness. It takes considerable energy when experiencing such emotions to communicate, both verbally and nonverbally, a message of confidence and caring concern. Over time, such dissonance is depleting. When therapists notice and acknowledge genuine—as opposed to the organizationally desired—feelings, they are in much better stead to act consciously and skillfully as therapists. To reduce the amount of effort such emotional labor requires, the therapist must develop a sense of ease in two key skill domains: enhancing genuine empathy and identifying and working with difficult feelings about clients openly.

In the CE-CERT model, empathy is considered to be a skill domain and not merely an emotional experience or a virtue. As with each of the models' practice elements, the first step in acquiring this skill involves intentionality: establishing a conscious intent toward what might be termed radical empathy. The goal of radical empathy is to experience genuine empathy—not surface-acted empathy, which requires emotional labor for all clients, even those clients who the clinician may believe are engaging in unacceptable behavior or exhibiting low motivation. Radical empathy is more feasible if the therapist has confidence that he or she does not need the client to assist in the maintenance of emotional regulation. To be sure, radical empathy may require surface acting at times, but the goal is to develop clinical skills at achieving genuine empathy with less effort.

When empathy for the client is not naturally occurring, the first strategy is to move into a stance of curiosity. Positive expectancies about the clinical session can be increased by balancing the focus on the prosaic and repetitive elements of the work and expanding attention to the rich dynamics that underlie client motivation. Empathy for the client may be enhanced when the therapist becomes curious about the ways in which the client responds to his or her distress through behaviors that the therapist experiences as aversive, rather than labeling those behaviors pejoratively. Even angry and resistant responses reflect the pain the client may be experiencing. Possessing a more elegant understanding of the treatment relationship beyond simple calculations of problems and responses can greatly enhance the richness of the clinical encounter and lead to better clinical decision making.

When empathy is absent, the therapist to can also use a behavioral strategy that facilitates autonomic regulation and enhances its development. One example of such a strategy is to move into conscious diaphragmatic breathing with imagery of breathing in the agitating emotion on inhalation and to breathe out calmness and empathy on the exhalation. This paired response of parasympathetic effect of calm breath combined with the imagery and intent toward empathy can supplant the increasing agitation that accompanies anger or judgment and facilitates the development of genuine empathy. Therapists need to possess a set of such behavioral strategies that keep them grounded so they can return to empathy.

Once the therapist has formed a conscious intent toward radical empathy, it is important for him or her to adopt an attitude of intentional learning toward the empathic response. When genuine empathy does not naturally emerge, the therapist should begin noticing when he or she is expending emotional labor to act as if he or she is empathic and what other, more genuine emotions, are being suppressed. The intentional learning stance is one of commitment to acquiring more insight about the circumstances under which empathy and lack of empathy occur and the skills that will help create more empathy toward difficult clients. Without this commitment, it is easy to attribute the presence or absence of empathy to the client's deservedness. When such a conclusion is made, the therapist will continue to expend emotional labor toward faking displays of empathy and suppression of authentic feelings, both of which deplete the energy and job enjoyment of the therapist.

A final skill domain to ease emotional labor is the acquisition of specific skills for bringing heretofore suppressed feelings of anger or resentment into the treatment process. Emotional labor is reduced when the therapist can communicate authentically rather than acting and when feelings no longer are suppressed by the therapist and can be worked with therapeutically in a manifest

way. Obviously, it is not advisable for therapists to express all feelings to the client as they are experienced. With skill, however, these feelings can be surfaced in the treatment process in ways that will aid the client. Emotional labor is reduced when the therapist can skillfully use the self rather than restrain the self (Edwards & Bess, 1998). An example of surfacing difficult feelings is for the therapist to disclose openly to the client that they are beginning to feel depleted with the course of treatment and to express their desire to stay energized for the client. Then, the client can be engaged in new strategies to revitalize the process in ways that will be more effective for the client, and the therapist will no longer be expending emotional labor to suppress feelings of frustration.

Practice Element 5: Parasympathetic Recovery

Parasympathetic recovery refers to the real-time activation of strategies to monitor internal states and to intentionally produce a state of physical, psychological, and emotional regulation. The objective of this skill domain is for the therapist to become fully attuned to their internal state during times of sympathetic arousal and to acquire a repertoire of proactive actions to facilitate parasympathetic recovery early in the arousal cycle and continuously throughout the day.

Contemporary practice wisdom regarding the best way to respond to compassion fatigue emphasizes the importance of professional self-care (Mathieu, 2012; Shapiro, Brown, & Biegel, 2007; van Dernoot Lipsky, 2009). Indeed, strategies such as meditation, mindfulness, exercise, and yoga have been found to be effective self-regulatory methods for reducing stress and promoting a sense of well-being in a variety of conditions (Hamer, Taylor & Steptoe, 2006; Tang et al., 2007).

Rather than separating self-care from the activities of the workday, however, the CE-CERT model places caring for one's own well-being integrally into the clinician's daily treatment tasks continuously throughout the day. Self-regulation and clinical work are viewed as a continuous process of transitory episodes of emotional arousal and emotional calm. It is not helpful for clinicians to define hard boundaries between work as inherently dysregulating and evenings as inherently restorative, as neither assumption reflects reality. Therefore, in this model self-regulation activities are integrated into the workday as well as during leisure time, and the actions serve not as avoidance strategies, but rather to restore and consolidate traumatic exposure to help clinicians engage the work more comfortably and more completely throughout the day.

Once again, intentionality is the first step toward this practice element. Attending to the professional self with deliberateness is a significant tool for creating change in others. A routine of self-directed care provides a structure and process for resetting dysregulated internal states. Self-care is ultimately a manifestation of good self-awareness and an undertaking of professional development and maintenance. The very act of caring for oneself is a declaration of independence from the comingling of traumatic material and the subsequent distress that occurs between a client and clinician during trauma therapy.

Practice within your practice. Fortney, Luchterhand, Zakletskaia, Zgierska, and Rakel (2013) demonstrated that an abbreviated mindfulness intervention for physicians could be effective in reducing stress, depression, anxiety, and emotional exhaustion, depersonalization, and personal accomplishment as measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996). In addition to brief 10- to 20-min daily mindfulness practices, these researchers emphasized exercises that were integrated into the physician's work routines. One notable example from the Fortney et al. (2013) study was the suggestion that before entering an examination room, physicians do a brief mindfulness exercise in which they notice their two feet beneath them and follow one breath through mindfully. Also fully consistent with the CE-CERT model is the researcher's emphasis on "practice within your practice," with such examples of pausing to be fully present with their patients before making recommendations. Brief pausing exercises and mindfully engaging with clients are examples of practicing within the clinician's practice that can be applied to the trauma treatment context. Whether or not therapists use specific mindfulness approaches, the operational concept is that therapists engage in practices that facilitate a calm, regulated state throughout the day. Additionally, the goal is to become better at noticing when their internal state is becoming dysregulated so that they can consciously employ actions to move them back into homeostasis.

Balanced supervision. Recognizing the importance of supervision is an important component of self-care within clinical practice. Supervision is essential in supporting reflection about one's practice, facilitating narrative coherence for challenging cases, and communicating support to the therapist. In this managed care era, clinical supervision as an unreimbursed activity may be difficult to support. But it is critically important that clinicians who are treating a significant number of clients with trauma have access to clinical supervision that is reliably scheduled and that deliberately addresses the need for the clinician to reflect upon the experience of providing trauma treatment. Balanced supervision will, in addition to providing supervision on the craft skills necessary to trauma treatment, also include an opportunity for reflection and narrative accounting of intense experience. The supervision should also offer support in the development of affect management skills such as those used in this model as a specialized form of knowledge necessary to trauma work.

Professional teaming and social connection. Trauma workers consistently rate administrative and organizational factors as significant factors in the development of compassion fatigue. Chief among these risk factors is professional and personal isolation (Birck, 2001; Boscarino, Figley, & Adams, 2004; Bride & Figley, 2009; Bride et al., 2007; Collins & Long, 2003; Elwood et al., 2011; Kadambi & Truscott, 2008; Killian, 2008; Slattery & Goodman, 2009). Avoiding professional isolation is both a personal and organizational responsibility. Willingness to seek supervision and assertiveness in insisting on regular opportunities to engage in reflective supervision is an important clinician responsibility. Case review in team meetings provides an opportunity to articulate the narrative of the case, to share the responsibility even further among the team, and increase feelings of comradery. Equally important is an organizational culture that allows for informal, brief peer consultations that allow every team member to feel they will not be isolated in managing a difficult case.

Standing and frequent movement. Recent medical research suggests that there may be significant adverse metabolic and health effects from prolonged sitting and that this effect persists even in people who actively exercise each day. The research also suggests that standing or frequent but brief walking can mediate this effect

(Dunstan et al., 2012; Katzmarzyk, Church, Craig, & Bouchard, 2009; Owen, Bauman, & Brown, 2009). Because clinical work requires sustained periods of sitting during treatment, clinicians should strategize how to increase time spent standing and walking during the day. This can include standing when returning phone calls or when doing service documentation, scheduling to allow 5-min walks between clients, and brief exercise during any cancellation period before beginning other tasks.

Strategic vacations. There is considerable evidence across occupations that workers who take vacations have lower levels of job stress and better health (Etzion, 2003; Gump & Matthews, 2000; Westman & Etzion, 2001). Frequency of vacations correlates with reduced stress and improved job satisfaction (de Bloom, Geurts, & Kompier, 2012). Duration of vacations, however, has not consistently been shown to correlate with the duration of the effect. Most of the evidence suggested that frequent vacations of shorter duration may be preferable to longer but less frequent vacations (Etzion, 2003.) The positive effects of vacations fade quickly, with any positive impact having dissipated in 3 weeks (Westman & Eden, 1997.) Synthesizing the available evidence leads to a conclusion that frequent vacations, even if brief, do have a positive effect on worker morale and even physical health. Because the effect is short lived, however, this evidence also makes clear that vacations cannot be a stand-alone solution to job stress: We must also develop strategies for making our work pleasant and meaningful.

Minimum of 20 min per day of focused engagement. When our work is challenging or emotionally provocative, we experience the well-established fight or flight response. Because this response might have occurred multiple times during the day at various degrees of intensity, one cycle of the fight or flight response may not resolve fully before another event results in renewed activation of the sympathetic response. It is important, therefore, that at some point each day, clinicians allow the parasympathetic nervous system to fully resolve the fight or flight excitation that the body has been in and return fully to a homeostatic state. The goal is to have at least 20 min each day in which we are at complete mental alignment, when our attention is completely focused on the activity in which we are engaged. For purposes of returning to homeostasis, any activity that creates this sense of mental alignment and that is sustained for at least 20 min a day can be effective.

Accountability partner. The Socratic dictum to "know thyself" and the biblical command "Physician, heal thyself" (Luke 4:23) could be interpreted to imply that dealing with compassion fatigue is a solitary challenge. But peer partnerships may offer a less isolating way to deal with the effects of working with persons who have experienced trauma. Contrasting with formal personal psychotherapeutic processes that are sometimes recommended to treat clinicians who are suffering the effects of countertransference, peer partnerships are more collegial and accessible and have been identified as effective and cost-efficient self-care strategies (Solomon, 2004). An accountability partner is a colleague who collaborates with the clinician to set and achieve self-care goals, functions as a source of support and encouragement, and keeps self-monitoring and self-directed care a practice standard. Participation in such an arrangement is voluntary and open-ended: measurable goals are set between partners, and the strategies used are selected on the basis of the perception of benefit. This type of peer involvement may be especially important when attempting to combat compassion fatigue. For example, in Bober and Rehger's (2006) investigation of the utility of self-care strategies for trauma counselors, they noted a disconnect between the professional perception that self-care is useful, and the time spent engaging in such activities. Accountability-focused partnerships may be a conduit for translating intent into action, a missing ingredient in many self-help programs.

Discussion

Concrete, discrete skills for mitigating compassion fatigue are needed to support therapists doing trauma work. It is invalidating to the experience of clinicians working in the trauma field to suggest that simple self-soothing strategies such as taking a warm bath in the evening will resolve high levels of emotional dysregulation. Therapists would not offer their clients such trivial advice for taking care of their emotional distress.

The CE-CERT model is a skill-based approach that can be used in training, supervision, and clinical practice. The model is a component based approach, and as such, these elements have not been researched as an articulated whole prior to this publication. Although some of the components of the model are conceptual, all of the concepts can be reduced to defined and actionable skills. The next challenge in the development of this model is to operationally define fidelity indicators for each of the practice components. Such definitions would allow for empirical testing of the effectiveness of the model for reducing symptoms of compassion fatigue. Demonstrating effectiveness of the model would lay the groundwork for filling a significant gap in the field of trauma treatment: a defined and evidence-informed model for reducing compassion fatigue.

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