Compassion Fatigue Among Chaplains, Clergy, and Other Respondents After September 11th

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The September 11th terrorist attacks reminded us of how vulnerable we are to horrifying events and how widespread the effects can be. It also reminded of us how important faith is in difficult times for most Americans. The *New England Journal of Medicine* reported that 90% of Americans turned to religion as a coping response to the terrorist attacks on September 11th (Schuster et al., 2001). This finding is not surprising, because many Americans report that they turn to their religious faith as a means of coping with a variety of problems that cause psychological trauma (Backus et al., 1995; Smith et al., 2000; Weinrich et al., 1990). Indeed, psychiatrists and psychologists have long recognized the role clergy play as front-line, mental-health workers (Larson et al., 1988; Mannon and Crawford, 1996; Mobley et al., 1985).

The American Red Cross established a collaborative relationship with professional chaplains representing a wide spectrum of the American faith communities in 1998 as part of its responsibilities under the Federal Family Assistance Plan of the Aviation Disaster Family Assistance Act of 1996 (ADFAA). Since then, professional chaplains have responded to all major aviation incidents through American Red Cross, including those on September 11th, 2001.

American Red Cross in New York instituted a shift defusing system for its spiritual care volunteers starting on September 13 as part of its spiritual care standard operating procedure (American Red Cross, 1995). All clergy volunteers were debriefed for 15 to 30 minutes at the end of each of their shifts, either individually or as part of a group. Further, those clergy volunteering at Ground Zero and at the morgue were strongly encouraged and given the opportunity to be formally debriefed by a trained mental-health worker near the formal end of the recovery work (American Red Cross, 1995; McCarroll et al.,1993; Ursano and McCarroll, 1990).

In the United States there are approximately 450,000 trained emergency medical workers; 75,000 emergency nurses (McCammon and Murphy, 1995); 10,000 hospital chaplains (VandeCreek and Burton, 2002); 353,000 community-based clergy (U.S. Department of Labor, 1998); and tens of thousands of volunteers from the Red Cross and other agencies that respond to people in disaster situations. These individuals can experience frequent, repetitive, and cumulative exposure to trauma and high levels of extreme stress. Many front-line health and religious professionals suffer from secondary psychological trauma or compassion fatigue (Figley, 1995, 2002). Hence, it is important that chaplains and others be able to recognize and understand compassion fatigue in themselves (Stamm, 1999, 2002).

The present study was designed to examine compassion fatigue and burnout among clergy and disaster relief workers after September 11th. We hypothesized that this compassion fatigue and burnout would be pronounced in clergy and other relief workers directly exposed to the physical destruction at Ground Zero and/or the emotional and spiritual suffering of working with the families of the individuals who died in the terrorist attacks. Further, we hypothesized that compassion fatigue and burnout would be ameliorated by exposure to the American Red Cross debriefing procedures.

METHODS

Procedure

American Red Cross (ARC) conducted a 1-day conference for clergy and other religious leaders on June 17th, 2002, in New York City, which specifically addressed the impact of September 11th. A total of 650 pencils and copies of a survey instrument were distributed to people who attended the conference at the end of the workshop. Conference attendees were asked to complete the survey and hand it in as they left the session.

The instrument consisted of two parts. The first part collected demographic and related information, including gender, age, religion, educational level, work and home ZIP codes, clinical training, type and location of respondent's disaster-relief work related to September 11th (if any), and the agencies with which they did disaster-relief work. ZIP codes were used to calculate the distance of participants' home and workplace from Ground Zero because residents in the vicinity of Ground Zero have been reported to have increased rates of mental health problems (Galea et al., 2002; Vlahov et al., 2002).

The second part consisted of the Compassion Satisfaction and Fatigue Test, which was originally designed to help differentiate between compassion fatigue, which has also been called secondary traumatic stress, and vicarious traumatization and burnout (Figley, 1995; Stamm, 1993). The current version of the test has three subscales: burnout, compassion fatigue, and compassion satisfaction (Figley, 1995; Stamm, 2002).

Analysis

Participants were classified into four groups for analysis: 1) individuals who did not do disaster-relief work related to the September 11th attack, and three respondent catego-

TABLE 1. Percentage Distribution of Compassion Fatigue and Burnout Scores of All Survey Participants by Risk Level

Risk Level	Compassion Fatigue	Burnout
Extremely High	27.5%	2.5%
High	11.7%	
Moderate	15.4%	18.9%
Low	12.7%	
Very Low	32.8%	78.7%

ries: 2) those who only worked for a disaster-relief agency other than the ARC; 3) those who worked for the ARC and another agency; and 4) those who only worked for the ARC.

Scores on the subscales were analyzed separately by Analysis of Covariance ANCOVA in a gender X group design using age, distance of regular workplace from Ground Zero, and days of September 11th volunteer work. It was decided to use work ZIP code as a covariate instead of home ZIP code because nearly a third of the participants worked in Manhattan and were likely to have been at work on September 11th. Trend analysis was conducted as part of the ANCOVA for the three respondent groups by coding respondents according to the amount of work they did with the ARC, with the respondent categories 1, 2, and 3, coded as −1, 0, and 1, respectively. Subsequent statistical tests were performed to compare clergy and other types of participants and to examine the effects of workplace distance from Ground Zero on each of the 3 subscales.

RESULTS

Of the 650 questionnaires that were distributed, 437 were returned, for a return rate of 67.2%. Thirty-four of these were discarded because they were incomplete, reducing the sample to 403 (62.0%). While clergy constituted 62.8% of the conference attendees, they represented 78.5% of survey participants ($N = 317$), including 220 congregational clergy and 97 chaplains who worked in health care settings. The rest of the sample consisted of relatively small numbers of mental health practitioners, seminary students, executives of mental health and disaster relief agencies, and others who provide direct relief services. The percentage of males and females were, respectively, 53.4% and 46.6% at the conference, and 50.4% and 49.6% in the sample.

Table 1 gives the percentage distribution of participants' scores for compassion fatigue and burnout in terms of risk levels. The results indicated that participants were at a significant risk for compassion fatigue. Potential for compassion satisfaction scores ranged from low to high and had a roughly normal distribution.

Table 2 presents the means for the measures by volunteer category. Analysis of Covariance revealed that individuals who volunteered to work with ARC (respondent categories 2 and 3) had significantly lower compassion fatigue scores ($p < 0.05$) and marginally lower ($p < 0.06$) burnout scores than other groups, controlling for age; sex; distance of regular workplace from Ground Zero; and days worked at Ground Zero, the morgues, the family assistance centers, etc. A significant inverse trend was found among respondents between the amount of work they did with the ARC (respondent categories 1, 2, and 3) and their compassion fatigue and burnout scores ($p < .05$). Age was the only covariate found to have any significant effect, and it was inversely related to burnout ($p < 0.05$). Potential for compassion satisfaction did not differ appreciably across groups, ranging from a mean low of 80.4 for September 11th nonrespondents to a mean high of 82.0 for respondents who only worked with ARC. The mean score for the entire sample was 80.9. No significant differences were found between clergy respondents and other respondents.

DISCUSSION

The results indicate that a large group of respondents were at a high risk for compassion fatigue. With the exception of age, which was inversely related to burnout, factors such as religion, workplace proximity to Ground Zero, and length of time volunteering with a relief agency had no effect on the dependent variables. The only variable we analyzed that had a

TABLE 2. Mean Compassion Fatigue Scores and Burnout and Their Associated Risk Levels by Volunteer Category

Volunteer Category	Compassion Fatigue		Burnout	
	Mean	Level	Mean	Level
Non-Respondents	33.0	Moderate	28.8	Extremely Low
Respondents				
1. Non-ARC Volunteer	36.4	High	31.0	Moderate
2. ARC and Other Agencies	31.1	Moderate	27.9	Extremely Low
3. ARC Only	30.2	Low	26.8	Extremely Low
Total Sample	32.5	Moderate	28.5	Extremely Low

statistically significant effect on compassion fatigue was whether a participant had volunteered with ARC or some other relief agency after September 11th. Respondents who volunteered only with ARC had the lowest risk of compassion fatigue, even lower than nonrespondents. By comparison, those who volunteered with relief agencies other than ARC had the highest levels. A linear trend was found in the sense that respondents who worked with other agencies as well as ARC had intermediate levels of compassion fatigue, between that of ARC and non-ARC respondents. The same trend was found when the data from only the clergy were analyzed.

The September 11, 2001 terrorist attacks in New York directly affected more than 400,000 people working and living in lower Manhattan on that day and more than one million family members. Since the attack, leaders of faith communities (*e.g.*, priests, rabbis, imams, ministers, sisters, chaplains) have served as frontline mental health workers within their communities and with disaster relief agencies to help others who were affected by it. However, helping others has a risk. Caring professionals, such as clergy, may experience the emotional and/or spiritual distress of those with whom they work. It is thought that compassion fatigue is a natural, predictable, treatable, and preventable consequence of working with suffering people (Figley, 1996).

Our findings suggest that a substantial proportion of clergy and others in the tri-state New York area are at significant risk for compassion fatigue. The mean risk for compassion fatigue and burnout (Table 2) for the entire sample was higher than that of the validation sample of the test (compassion fatigue $M = 28.8$, Low Risk; Burnout $M = 24.2$, Extremely Low, Stamm, 1999). And the mean compassion satisfaction rating of our sample was lower than that of the validation group ($M = 92.1$, Good Stamm, 1999).

This may be the tip of the proverbial iceberg. The small group of mental health workers who were surveyed had an even higher risk for compassion fatigue than clergy but the sample size was small. No research has yet been published on the effects either upon the uniformed personnel responding to the September 11th terrorist attacks or upon the tens of thousands of construction workers and other personnel who worked for 8 months at Ground Zero recovering body parts.

There has been much discussion in the literature about the effectiveness of debriefings and defusing for those directly exposed to critical incidents or those working with families, friends, and relief workers who are directly affected by a critical incident (Harris, 2002). The present findings suggest that these procedures may be useful in ameliorating burnout and compassion fatigue.

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REFERENCES

American Red Cross (1995) *Disaster Mental Health Services I—Participant Workbook*. Washington DC: American Red Cross.

Backus CJ, Backus W, Page DI (1995) Spirituality of EMTs: a study of the spiritual nature of EMS workers and its effects on perceived happiness and prayers for patients. *Prehospital Disaster Med*. 10:168–173.

Figley CR (ed.) (1995) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who Treat the Traumatized*. New York: Brunner/Mazel.

Figley CR (1996) Compassion fatigue: toward a new understanding of the costs of caring. In BH Stamm (Ed.), *Secondary Traumatic Stress: Self care Issues for Clinicians, Researcher, & Educators* (p. 4). Lutherville, MD: Sidran Press.

Figley CR, Ed. (2002) *Treating Compassion Fatigue*. NY: Brunner-Rutledge.

Galea S, Ahern J, Resnick H, Kilpatrick D, Bucuvalas M, Gold J, Vlahov D (2002) Psychological sequelae of the September 11 terrorist attacks in New York. *N Engl J Med*. 346:982–987.

Harris MB (2002) Mental health of trauma-exposed firefighters and critical incident stress debriefing. *J Loss Trauma*. 7:223–238.

Larson DB, Hohmann AA, Kessler LG, Meador KG, Boyd JH, McSherry E (1998) The couch and the cloth: the need for linkage. *Hosp Comm Psychiatry*. 39:1064–1069.

Mannon JD, Crawford RL (1996) Clergy confidence to counsel and their willingness to refer to mental health professionals. *Fam Therapy*. 23:212–231.

McCarroll JE, Ursano RJ, Fullerton CS, Lundy A (1993) Traumatic stress of a wartime mortuary: anticipation of exposure to mass death. *J Ment Nerv Dis*. 181:545–551.

Mobley MF, Katz EK, Elkins RL (1985) Academic psychiatry and clergy: an analysis of ministerial referrals. *Hosp Community Psychiatry*. 36:79–80.

Schuster MA, Stein BD, Jaycox LH, Collins RL, Marshall GN, Elliott MN, Zhou AJ, Kanouse DE, Morrison JL, Berry SH (2001) A national survey of stress reactions after the September 11, 2001, terrorist attacks. *N Engl J Med*. 345(20):1507–1512.

Smith BW, Pargament KI, Brant C, Oliver JM (2000) Noah revisited: religious coping by church members and the impact of the 1993 Midwest flood. *J Community Psychol*. 28:169–186.

Stamm BH, ed. (1999) *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*, 2nd edition. Lutherville, MD: Sidran Press.

Stamm BH (2002) Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test. In CR Figley (Ed.), *Treating Compassion Fatigue* (p. 112). New York: Brunner-Rutledge.

Stamm BH, Varra ME, Eds. (1993) *Instrumentation in the Field of Traumatic Stress*. Chicago: Research and Methodology Interest Group, International Society for Traumatic Stress Studies.

Ursano RJ, McCarroll JE (1990) The nature of traumatic stress: handling dead bodies. *J Nerv Ment Dis.*. 178:396–398.

Vlahov D, Galea S, Resnick H, Ahern J. , Boscarino JA, Bucuvalas M, Gold J, Kilpatrick D (2002) Increased use of cigarettes, alcohol, and marijuana among Manhattan, New York residents after the September 11th terrorist attacks. *J Epidemiology*. 155:988–997.

Weinrich S, Hardin SB, Johnson M (1990) Nurses response to hurricane Hugo: victims' disaster stress. *Arch Psychiatr Nurs*. 4:195–205.