

Compassion Fatigue

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COMPASSION FATIGUE

- Term first used in a nursing magazine by Johnson in 1992 to describe nurses worn down by daily hospital emergencies.
- Figley defines as: “A state of tension and preoccupation with the individual or cumulative trauma of one’s clients as manifested in one or more ways:
 - 1 Re-experiencing traumatic events
 - 2 Avoidance/numbing of reminders and
 - 3 Persistent arousal”

C. Figley, 1994

HELPERS IN DISASTERS

- Many well trained workers including Firemen, Police, Emergency Medical and Red Cross personnel
- All systems overwhelmed by magnitude of the disasters
- Many others volunteered, longing to do something to help. Some could handle the situation and some could not.

UNTRAINED HELPERS

- Some rise brilliantly to the occasion, needing only support and discussion of issues as they come up.
- Others may not cope with hardship conditions but can be redeployed to less arduous but important tasks.
- Others have to be sent home. Ideally they should have been screened out.

STRESSORS ASSOCIATED WITH DISASTER WORK

- Exposure to unpredictable physical danger
- Encounter with violent death and human remains.
- Encounter with suffering of others
- Negative perceptions of disaster and assistance being offered
- Long hours, erratic work schedules, extreme fatigue.
- Cross cultural differences between workers and community

STRESSORS ASSOCIATED WITH DISASTER WORK - 2

- Lack of adequate housing
- Communication breakdowns
- Low funding/allocation of resources
- Over-identification with victims
- Injury of self or close associate
- Pre-existing stress or traumatization
- Low level of training or preparedness
- Self-expectations
- Low level of social support

STRESS REACTIONS

- Difficulty communicating thoughts, remembering instructions or maintaining balance
- Irritable and argumentative
- Difficulty making decisions
- Limited attention span
- Unnecessary risk-taking
- Tremors/headaches/nausea/flu-like symptoms

STRESS REACTIONS - 2

- Difficulty concentrating
- Loss of objectivity
- Unable to engage in problem-solving
- Unable to relax when off duty
- Refusal to follow orders eg to leave the scene
- Increased use of drugs/alcohol

SELF HELP STRATEGIES

- Limit on-duty work hours to 12 hours/day
- Work rotations from high to lower stress functions
- Drink plenty of water and eat healthy snacks
- Take frequent brief breaks
- Talk about your emotions to process experiences
- Stay in touch with family and friends
- Participate in memorials and rituals
- Pair up with a responder to monitor one another's stress

CONSULTATION

- Work with the incident commander emphasizing normal reactions to abnormal conditions
- Information gathering by speaking with “key informants” at break and observing environment
- Discuss proposed interventions with incident commander
- Implement and assess effects

INTERVENTIONS

- Pragmatic suggestions re: shifts etc
- Defusing: “Shmooze” with workers drawing them out, checking for stress reactions
- Teach relaxation techniques
- Debriefing: More formal group or individual interventions based on ideas of Jeffrey Mitchell (1983). No longer used exactly as originally described because workers can be retraumatized by listening to traumatic stories and each person’s coping mechanisms with overwhelming experiences needs to be respected

DEBRIEFING

- Individually or in small groups
- Debriefing is an opportunity to talk about personal impressions of the recent experience and learn about stress reactions and stress management strategies
- Ask about major positive and negative experiences, educate, normalize, reassure, bolster positive coping mechanisms, enquire about negative ones such as excess drinking (if appropriate), discuss re-entry to normal life and possible delayed reactions.

BURNOUT

“A state of extreme dissatisfaction with one’s clinical work, characterized by:

- 1) Excessive distancing from survivors
- 2) Impaired competence
- 3) Low energy
- 4) Increased irritability
- 5) Other signs of impairment and depression resulting from individual, social, work environment and societal factors”

C.Figley, 1994

SURVIVAL STRATEGIES

- Rescuing (Caretaking)
- Attaching
- Asserting (Goal Achievement)
- Adapting (Goal Surrender)
- Fighting
- Fleeing
- Competing
- Cooperating

Compassion fatigue results from problems in rescuing/caretaking and burnout results from problems with asserting/goal achievement

Paul Valent 2002

SILENCING RESPONSE

A major indicator of compassion fatigue

- Changing the subject
- Avoiding the topic
- Providing pat answers
- Minimizing client distress
- Suggesting the client “get over it”
- Boredom
- Angry or sarcastic with clients
- Using humour to change or minimize the subject
- Faking interest or listening
- Fearing what the client has to say
- Fearing that you will not be able to help
- Blaming clients for their experiences
- Not believing clients
- Feeling numb and avoidant
- Difficulty paying attention
- Being reminded of one’s own traumatic experiences

HUMOUR

- May increase physical wellbeing
- Can reduce tension and reframe events
 - Some evidence that people with high sense of humour handle stress better
 - “Things can’t be that bad if I can still laugh”
 - Can be insensitive

May help communication

“Crying does not seem to help us do it better whereas laughing does”

Generally restricted to situations outside range of public hearing

Gallows humour – “offers a way of being sane in insane places”

HUMOUR - 2

- Can be a sign of distress especially excessive use, may indicate denial
- Can be an avoidance technique
- Loss of humour may indicate serious distress
- May need permission to express humour
- Mahatma Gandhi said, "If I had no sense of humour I would long ago have committed suicide".

ACCELERATED RECOVERY PROGRAM

- Developed by Gentry, Baranowsky and Dunning (1997)
 - 5 individual sessions, later developed group model
- Components:
 - Therapeutic Alliance
 - Assessment – Quantitative
 - Anxiety Management – CBT techniques
 - Narrative – the story is a component of the journey back to wellness
 - Exposure/Resolution of Secondary Traumatic Stress – based on the work of Wolpe
 - Cognitive Restructuring (Self-care and Integration) – What we say to ourselves creates an internal environment in which we may flourish or flounder
 - PATHWAYS – Self-directed Resiliency and Aftercare Plan – reinfuses individual's life with sense of commitment to wellness

PATHWAYS – Aftercare Resilience Model

- Resilience Skills – Non-anxious Presence and Self-validated Caregiving: move from reactivity towards intentionality
- Self-management and Self-care: Review one's major causes of stress and ways to self soothe
- Connection with Others: Develop a personal therapeutic community
- Skills Acquisition: Master the skills we need with extra supervision etc.
- Conflict Resolution:
 - Internal: We may know what we need but be unable to implement it during a busy day
 - External: Resolution of Primary Traumatic Stress: We must resolve our own past trauma

Preparation Before Helping In a Crisis

1. Form a team of helpers with a recognized leader, clearly defined responsibilities and an approach tailored to the needs of the situation. Include a discussion of readiness for the range of emotions likely to be encountered and give permission for workers to ask to be removed from direct contact when they are beginning to feel overwhelmed.
2. Review what is known about the event before the team enters the scene. What has happened? Who was involved? What is the extent of the damage?

Preparation Before Helping In a Crisis (cont.)

3. When working with victims, pacing is important. Individuals should recognize how many cases they can handle and limit themselves to that number. Becoming victims themselves will drain the resources of the trauma team.

After the Intervention is Over

1. Helpers will have strong emotional reactions to what they have heard or seen. Feelings of vicarious or secondary victimization are to be expected. This is normal.
2. Helpers often experience a change in the way they view the world. Assumptions about reality will be challenged. Each worker should become aware of areas of their own vulnerability and avoid assignment to these areas. For example, if a helper or someone close to him/her has been raped, it may be too difficult for them to work with rape victims.

After the Intervention is Over (cont.)

3. Professional isolation is a hazard to helpers. Seeking out a colleague for support and processing is crucial.
4. When debriefing after a crisis, it is essential for the group leader to have had training and experience working with the effects of secondary victimization.

Debriefing (cont.)

Debriefing can be done one-on-one or in small groups. If the small group format is used, workers can be paired and leader(s) can circulate among the pairs. Expect a debriefing to last 2 or more hours depending on the extent of the exposure.

There are three stages when working with debriefing.

Stage One: The Victims

- a) The helper is asked to discuss briefly each of the victims with whom he/she worked. What happened to each of them? What kind of symptoms did they show? How is the trauma response likely to progress over time?

- b) Who are the individuals who will have an impact on the victim? Does the individual have any support system? After the crisis, how did others treat the victim? Scapegoated? Isolated? Praised?

Stage One: The Victims (cont.)

(c) If it was a group of victims, what norms does the group have about appropriate responses to crisis? What is acceptable behavior? How much cohesiveness does the group have? Is self-disclosure allowed?

Stage Two: The Professional Behavior of the Helper

- a) What did she/he do? What was productive? What would she/he do differently now?
- b) What was his/her role on the team? Leader/Follower? Supporter of others? Isolate? Does the parallel in any way the role of victims of the traumatic incident?
- c) What were the dynamics of the team? Was communication good? Was leadership available?

Stage Three: How the Trauma Affected the Helper

- a) What were the helper's feelings, thoughts and behaviors? How do these parallel those of the victims?
- b) Were there any issues between the members of the team? Are there unexpressed feelings or reactions that need to be cleared up between team members?
- c) Are there parallels between the team members and the victims? Are there differences from the team's pre-crisis functioning?

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