Understanding Compassion Fatigue:
Helping Public Health Professionals and Other Front-Line Responders
Combat the Occupational Stressors and Psychological Injuries
of Bioterrorism Defense for a Strengthened Public Health Response

Course Manual

Florida Center for Public Health Preparedness
College of Public Health, University of South Florida

Register for the course online at www.fpcho.usf.edu/courses
in order to receive continuing education credit and a course completion certificate.
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Course Description

Delivery Mode: Distance Learning
Delivery Media: Audio CD-Rom, Internet
Course Length: 1 hour
Course Faculty: J. Eric Gentry, MA, MT, CAC
Target Audience: Persons in public health, healthcare, mental health, and emergency response.

Course Aim: To help public health workers, and other professionals on the front lines of bioterrorism defense, combat the potential adverse psychological effects of performing their functional roles and professional responsibilities in bioterrorism preparedness, response and recovery.

Course Goals:
1. Promote and protect the health and safety of bioterrorism front-line responders by assuring that they are aware of the potentially damaging psychological effects of performing their functional roles in emergency preparedness and bioterrorism response and recovery.
2. Limit the psychological distress and negative health behaviors in bioterrorism front-line responders by helping them to combat these occupational stressors through developing skills for compassion fatigue prevention and resiliency.
3. Sustain the capacity of those who must continue to perform their professional roles in bioterrorism response and recovery, following a terrorism event, for the purpose of promoting an effective public health response.

Relevant Competency for Public Health Professionals:
1. Recognize and treat the psychological impact of a bioterrorism event on public health and healthcare professionals.

Relevant Public Health Essential Services:
ES 2. Diagnose and investigate health problem and health hazards in the community.
ES 3. Inform, educate, and empower people about health issues.
ES 4. Mobilize community partnerships to identify and solve health problems.
ES 7. Link people with needed personal health services and assure the provision of healthcare when otherwise unavailable.
ES 8. Assure a competent public health and personal healthcare work force.

Learning Objectives: At the conclusion of this course, learners will be able to:
1. Define compassion fatigue and related terms.
2. Identify the five phases of compassion fatigue and describe the distinguishing characteristics of each phase.
3. Recognize and assess one’s professional risk for developing compassion fatigue.
4. Identify the causes of compassion fatigue.
5. Identify and describe the signs and symptoms of compassion fatigue.
7. Identify compassion fatigue resources.
Section One

COURSE OVERVIEW
Course Introduction

Welcome to Understanding Compassion Fatigue: Helping Public Health Professionals and Other Front-Line Responders Combat the Occupational Stressors and Psychological Injuries of Bioterrorism Defense for a Strengthened Public Health Response. This course is one of several competency-based, continuing education courses developed by the Florida Center for Public Health Preparedness to improve the capacity of front-line public health workers and other front-line professionals to respond to bioterrorism and other threats to physical and mental health.

The psychological consequences of terrorism are more prevalent and widespread than the physical consequences. Adverse psychological effects encompass a broad range of emotional, behavioral, and cognitive reactions that impact most individuals who are exposed to acts of terrorism.

Numerous studies have indicated the potential occupational risk of psychological distress and subsequent disorder in first responders. Findings from disaster mental health and terrorism literature identify first responders and rescue workers at increased risk for stress and other adverse psychological outcomes, resulting from their repeated primary and secondary exposures to traumatic events.

Recent bioterrorism events, such as the anthrax events in the autumn of 2001, have expanded the traditional categories of first responders to include public health, mental health and healthcare professionals. With this first responder classification, comes the heightened exposure to new levels of job related stress, and the increased occupational risk for psychological distress and injury.

It is crucial to general bioterrorism preparedness, recovery, and response to address, promote, and protect the psychological needs of front-line public health, mental health and healthcare workers.

The aim of this course is to help public health workers, and other professionals on the front lines of bioterrorism defense, combat the potential adverse psychological effects of performing their functional roles and professional responsibilities in bioterrorism response and recovery. As such, the Florida Center for Public Health Preparedness offers this course as a prophylaxis to help these workers protect themselves against the psychological trauma and injury that may result from their functional role in bioterrorism response.

The goals of this course are:
1. Promote and protect the health and safety of bioterrorism front-line responders by assuring that responders are aware of the potentially damaging psychological effects of performing their functional roles in emergency preparedness and bioterrorism response and recovery.
2. Limit the psychological distress and negative health behaviors in bioterrorism front-line responders by helping them to combat these occupational stressors, through developing skills for compassion fatigue prevention and resiliency.
3. Sustain the capacity of those, who must continue to perform their professional roles in bioterrorism response and recovery, following a bioterrorism event, for the purpose of promoting an effective public health response.

This course was designed to meet the following competency for public health professionals:
1. Recognize and treat the psychological impact of a bioterrorism event on public health and healthcare professionals.

This course also addresses the following relevant public health essential services:
ES 2. Diagnose and investigate health problem and health hazards in the community.
ES 3. Inform, educate, and empower people about health issues.
ES 4. Mobilize community partnerships to identify and solve health problems.
ES 7. Link people with needed personal health services and assure the provision of healthcare when otherwise unavailable.
ES 8. Assure a competent public health and personal healthcare work force.

At the completion of this course, learners will be able to:
1. Define compassion fatigue and related terms.
2. Identify the five phases of compassion fatigue and describe the distinguishing characteristics of each phase.
3. Recognize and assess one’s professional risk for developing compassion fatigue.
4. Identify the causes of compassion fatigue.
5. Identify and describe the signs and symptoms of compassion fatigue.
7. Identify compassion fatigue resources.
Course Developers
The course was developed and funded by the Florida Center for Public Health Preparedness for public health, healthcare, mental health, and emergency response professionals.

Course Sponsors
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the University of South Florida College of Medicine and the Florida Center for Public Health Preparedness.

Course Faculty
The contents of this course were designed and delivered by J. Eric Gentry, MA and Nadine D. Mescia, MHS.

Eric Gentry is an international expert on compassion fatigue. He is a licensed mental health counselor, a certified master traumatologist, and the former Co-Director of the International Traumatology Institute at the University of South Florida. He brings to this course, over 20 years of clinical experience and knowledge in mental health and disaster mental health. Mr. Gentry has helped hundreds of caring professionals and first responders resist and recover from compassion fatigue and the other harmful effects associated with trauma-related response and recovery work. He has published several articles, chapters, and manuals in the area of trauma treatment. Mr. Gentry holds a Master's Degree in Counseling and a Certificate of Advanced Study in Psychotraumatology. He is a doctoral candidate at Florida State University in Marriage and Family Therapy.

Nadine Mescia is the Director for Education and Training at the Florida Center for Public Health Preparedness. She has an extensive background in mental health, healthcare, public health, and higher education. Ms. Mescia brings to this course over 18 years of advanced graduate study and practical experience in these fields.
About the Florida Center for Public Health Preparedness

The Florida Center for Public Health Preparedness (FCPHP), located at the University of South Florida College of Public Health, was designated as a Center for Public Health Preparedness (CPHP) by the Centers for Disease Control and Prevention in April 2001. It is one of 23 Centers for Public Health Preparedness currently funded by the Centers for Disease Control and Prevention, through a cooperative agreement with the Association of Schools of Public Health, to ensure that front-line public health workers have the necessary knowledge, skills, and competencies required to effectively respond to bioterrorism, infectious diseases, and other current and emerging health threats.

The FCPHP is dedicated to improving the capacity of front-line public health workers (and other front-line responders) to respond to current, new, and emerging public health threats, including bioterrorism preparedness and infectious disease, in Florida and the nation, by providing workforce development, training, and resources that will contribute to public health workforce and bioterrorism preparedness.

The FCPHP’s two national specialty niches among CPHPs in bioterrorism preparedness training are the psychosocial effects of bioterrorism and leadership during times of crisis.

Vision and Mission

The vision of the FCPHP is a public health workforce superbly prepared to protect and promote the public's health from current and emerging threats. Its mission is to assure that the Florida public health workforce has access to excellent workforce development and training programs and resources necessary to acquire the competencies needed to protect and promote the public's health.

For more information about the Florida Center for Public Health Preparedness and our training programs, please visit our web site at www.fcphp.usf.edu.
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Developer’s Note

The contents of this manual are provided for instructional purposes only. This manual may NOT be used as a substitute, but rather as an adjunct to formal training and supervision. This manual is NOT to be used as a self-help manual, or as a substitute for psychotherapy or professional mental health guidance. Always consult a licensed mental health professional for professional mental health advice.

The contents of this course and instructional materials are solely the responsibility of the Florida Center for Public Health Preparedness and do NOT necessarily represent the official views of the Centers for Disease Control and Prevention, the Association of Schools of Public Health, the University of South Florida, the USF College of Public Health or the USF College of Medicine.

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Section Two

COURSE CONTENT: COMPASSION FATIGUE
Learning Objective #1: Define compassion fatigue and related terms.

What is Compassion Fatigue?

Public health, healthcare, and mental health professionals who render assistance to trauma survivors, first responders, and their families, face a potential consequence of their care giving - that of experiencing trauma or suffering as a direct result of their exposure to people in crisis. Compassion fatigue is the potential cost of such caring. It is caused by the very act of aiding others, and often results in the compromise of the caregiver’s own well-being.

There are many definitions of compassion fatigue. The following definitions represent a select sample.

Compassion Fatigue is:
- The convergence of primary traumatic stress (Figley, 1995), secondary traumatic stress (Stamm, 1995), and cumulative stress/burnout in the lives of helping professionals and other care providers (Gentry, 2001).
- “A state of tension and preoccupation with the client or cumulative trauma of clients as manifested in one or more ways:
  - re-experiencing the traumatic events;
  - avoidance or numbing of the reminders of the traumatic event;
  - persistent arousal; combined with the added effects of cumulative stress (burnout)” (Figley, 1995).
- A physical, emotional, and spiritual fatigue or exhaustion resulting from care giving that causes a decline in the caregiver’s ability to experience joy or to feel and care for others.
- “The emotional residual of the exposure to working with the suffering, particularly those individuals suffering from the consequences of traumatic events” (“What Is Compassion Fatigue: The Stress of Caring Too Much”).
- A form of burnout, a kind of “secondary victimization” that is transmitted by clients or patients to caregivers through empathetic listening (Figley, 1983).
- Secondary Traumatization + Burnout (Figley, 1995).
- Primary traumatic stress +/x the synergistic effect of secondary traumatic stress +/x the synergistic effect of burnout (Gentry & Baranowsky, 1997).

What are some common terms related to compassion fatigue?

- **Vicarious Traumatization** is the transmission of traumatic stress to caregivers through observing and/or listening to the stories of traumatic events experienced by their clients (McCann & Pearlman, 1990).
- **Secondary Traumatic Stress** occurs when an individual is exposed to the extreme events directly experienced by another and then becomes overwhelmed by this secondary exposure to trauma (Figley, 1995).
- **Burnout** is the state of physical, emotional, and mental exhaustion caused by a depletion of the ability to cope with one’s environment, resultant from one’s responses to the on-going demands and stressors of one’s daily life (Maslach, 1982). It occurs when “one’s perceived demands outweigh one’s perceived resources” (Gentry & Baranowsky, 1997).
Learning Objective #2: Identify the five phases of compassion fatigue and describe the distinguishing characteristics of each phase.

What are the phases of compassion fatigue and the characteristics of each phase?

1. **Zealot (Idealistic) Phase**
   In this phase, the caregiver is:
   - motivated by idealism;
   - ready to serve and problem solve;
   - desires to contribute and to make a difference;
   - volunteers to help and assist; and
   - full of energy and enthusiasm.

2. **Irritability Phase**
   In this phase, the caregiver begins to:
   - cut corners;
   - avoid patient/client contact;
   - mock peers, patients, and clients;
   - denigrate own efforts at wellness;
   - lose concentration and focus; and
   - distance oneself from others.

3. **Withdrawal Phase**
   In this phase, the caregiver:
   - loses patience with patients and clients;
   - becomes defensive;
   - neglects self and others;
   - is chronically fatigued;
   - loses hope;
   - views oneself as victim; and
   - isolates oneself.

4. **Zombie Phase**
   In this phase, the caregiver:
   - views others as incompetent or ignorant;
   - loses patience, sense of humor, and zest for life;
   - dislikes others; and
   - becomes easily enraged.

5. **Pathology and Victimization or Maturation and Renewal**
   In this phase, the caregiver can choose pathology and victimization or maturation and renewal. Pathology and victimization result when no action is taken. Maturation and renewal are only possible when the caregiver acknowledges the symptoms of compassion fatigue and takes direct action to overcome it.

   If pathology and victimization, the caregiver becomes overwhelmed, considers leaving or leaves the profession, and/or develops somatic illness.

   If maturation and renewal, the caregiver becomes strong, resilient, and transformed.
Learning Objective #3: Recognize and assess one’s professional risk for developing compassion fatigue.

Why is it important to recognize compassion fatigue?

There are many human costs associated with compassion fatigue. The negative effects of compassion fatigue include:

- diminished job performance;
- increased tardiness and absenteeism;
- declining physical health;
- poor morale;
- low energy;
- stressed personal relationships;
- increased substance abuse;
- depression; and
- irritability.

Who is at risk for developing Compassion Fatigue?

Any person who provides assistance or aid to others is susceptible to developing compassion fatigue. Some caregivers are more resilient than others to the transmission of traumatic stress. However, any caregiver, who repeatedly works with those who are traumatized, is at risk for developing compassion fatigue.

Compassion fatigue is most prevalent among helping professionals, who work with trauma survivors, and the close friends, family, and associates of trauma survivors. Professionals, who are especially vulnerable to compassion fatigue, include emergency service professionals, first responders, counselors, mental health professionals, healthcare professionals, religious professionals, advocate volunteers, disaster relief workers, and human service workers. Of these high-risk groups, healthcare and mental health professionals appear to be at greatest risk for developing compassion fatigue.

Individuals at Increased Risk for Developing Compassion Fatigue:

- Any caregiver or helping professional.
- Professionals who directly experience or witness trauma (primary traumatic stress). For example:
  - Healthcare providers;
  - First responders (Police, Fire, EMS);
  - Emergency, disaster, and armed services
- Professionals or caregivers whose clients or patients experience trauma (secondary traumatic stress):
  - Mental health professionals (therapists, social workers, psychologists, counselors, employee assistance professionals)
  - Teachers
  - Adult and child care workers
  - Protective services workers
  - Insurance adjusters
  - Clergy
How do I assess my risk for developing compassion fatigue?

If you are a member of one of the high-risk groups, and feel, or have ever felt, as though you are losing your sense of self to the clients, patients, or individuals that you serve, then you are at risk for developing compassion fatigue.

There are several self-assessments that you can take to assess your risk. One such primary assessment instrument is the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Pro QOL – R III) by B. Stamm [http://www.isu.edu/~bhstamm/tests/ProQOL.htm](http://www.isu.edu/~bhstamm/tests/ProQOL.htm).
Learning Objective #4: Identify the causes of compassion fatigue.

Compassion fatigue is a residual of care giving. It is the physical, emotional, mental, and spiritual exhaustion in the caregiver caused by the repeated exposure of working with the suffering, particularly those individuals surviving the consequences of traumatic events.

It is transmitted to the caregiver in a variety of ways:

- **Primary Traumatic Stress** results from directly experiencing the trauma.

- **Secondary Traumatic Stress** results from the direct exposure to someone who is traumatized. It occurs through the direct exposure to extreme events directly experienced by another.

- **Empathic Transmission** results from directly listening to the narrative of clients and patients who are trauma survivors.

- **Anxiety Transmission** results from directly experiencing the anxiety of others.
Learning Objective #5: Identify and describe the signs and symptoms of compassion fatigue.

How do I know if I am, or someone I know is, suffering from compassion fatigue?

If you feel as if you are losing, or as if you have lost, your sense of self to the clients, patients, or individuals that you serve, and are experiencing any of the warning signs or symptoms of compassion fatigue that are listed below, then you may be experiencing compassion fatigue.

What are the Signs and Symptoms of Compassion Fatigue?

Fortunately, there are many warning signs of compassion fatigue. These warning signs are early signals that you may be vulnerable to developing compassion fatigue. Signs may progress to symptoms if prevention and resiliency skills are not practiced.

Compassion Fatigue Warning Signs:

- Increased substance use or abuse
- Change in eating habits
- Anger
- Blaming
- Anxiety
- Chronic tardiness
- Increased absenteeism
- Depression
- Diminished sense of self and personal accomplishment
- Extreme fatigue
- Frequent headaches
- Gastrointestinal upset
- Unrealistic self-expectations
- Hopelessness
- Hypertension
- Inability to maintain balance of empathy and objectivity
- Increased irritability
- Diminished feelings of happiness and joy
- Lowered self-esteem
- Sleep disturbances
- Workaholism
Compassion Fatigue Symptoms:

There are many symptoms of compassion fatigue. All of the symptoms fall into one of the five major categories of traumatic stress symptoms. Experiencing any of these symptoms may be signaling the presence of compassion fatigue.

1. Arousal
   a. Increased negative arousal
   b. Hyper-vigilance
   c. Increased irritability and lowered frustration tolerance as exhibited by anger or rage
   d. Difficulty concentrating
   e. Sleep disturbances
   f. Exaggerated startle response

2. Intrusion
   a. Recurring thoughts or images
   b. Images of clients’ traumas
   c. Nightmares

3. Avoidance
   a. Avoiding thoughts, feelings, conversations or places associated with the trauma
   b. Silencing and/or minimizing clients’ stories
   c. Diminished capacity for intimacy
   d. Lack of interest or participation in meaningful or enjoyable activities

4. Depressive
   a. Depression or extreme sadness
   b. Dread of working with certain clients
   c. Ineffective or self-destructive self-soothing behaviors (i.e. substance abuse, over or under eating)
   d. Feelings of therapeutic impotence or lack of skill with certain clients
   e. Diminished sense of purpose and/or enjoyment of career
   f. Reduced ego functioning (time, volition, identity, language, cognitive)
   g. Lowered functioning in non-professional situations
   h. Loss of hope
   i. Lack of energy or enthusiasm

5. Dissociative
   a. Difficulty separating work and personal life
   b. Increased transference/counter-transference issues with certain clients
   c. Perceptive/assumptive world disturbances (ex. Sees the world in terms of victims and perpetrators.)

Although there are many effective therapeutic strategies for overcoming compassion fatigue, preventing compassion fatigue is best. As with most conditions, it is much better to prevent compassion fatigue from occurring, than it is to recover from its damaging effects.

How do you prevent and/or develop resiliency to Compassion Fatigue?

One of the best ways to prevent compassion fatigue is to regularly practice good emotional and physical health maintenance. Practicing fundamental self-care and self-management skills, while maintaining a balanced life, are all good ways to prevent compassion fatigue.

Compassion Fatigue Prevention and Resiliency Skills and Strategies:

1. **Practice Self-Care**
   - Live a healthy, satisfying, and well-balanced life.
   - Eat sensibly.
   - Exercise regularly.
   - Rest and relax.
   - Make time for fun and recreation.
   - Reserve time for yourself.
   - Develop/attend to your spiritual and creative self.
   - Be kind to yourself.
   - Spend time in nature.
   - Allow for alone time.
   - Adhere to a commitment for regularly scheduled time-off from work.
   - Develop an artistic or sporting discipline or hobby.

2. **Be Self-Managed**
   - Self-regulate anxiety and emotions.
   - Develop relaxation, anxiety, and stress management skills.
   - Practice positive self-talk.
   - Maintain a positive mental attitude.
   - Alter/modify your perceptions.
   - Be realistic.
   - Renounce perfectionism.
   - Let go of idealism.
   - Develop a non-reactivity to emotions.
   - Maintain non-reactivity to others’ reactivity of your emotions.
3. Develop Awareness
   • Become more informed about compassion fatigue.
   • Participate in ongoing professional development training.
   • Take self-assessment inventories. (Ex: Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Pro QOL – R III), Trauma Recovery Scale, Index of Clinical Stress).

4. Connect with Others
   • Establish/maintain connection with others.
   • Seek/receive support from peers, family, and friends.
   • Teach your friends, family, and peers how to support you.
   • Join or establish a peer support or study group.
   • Join a traumatic stress support or study group.
   • Engage in meaningful conversation on a regular basis.
   • Take a class.
   • Participate in social activities.
   • Provide volunteer service to others.

5. Seek Professional Assistance
   Seek short-term professional assistance to resolve secondary traumatic stress. A brief treatment with some of the accelerated trauma techniques delivered by a qualified professional may rapidly resolve secondary traumatic stress symptoms.

6. Participate in Education and Training
   • Develop new skills and fund of knowledge.
   • Embrace personal development.
   • Participate in professional workforce development activities.
   • Attend workshops and conferences.
   • Be a life-long learner.

7. Self-Supervision
   • Examine/assess/monitor your care giving motivations.
   • Practice supportive self-supervision.
   • Restructure your cognitions.
   • Be positive.
   • Alter your perceptions and self-talk.

8. Intentionality
   • Be intentional vs. reactive to others and situations.
   • De-triangulate. Prevent the transmission of anxiety and negativity.
   • View problems and challenges as developmental opportunities.

9. Maintain a Non-Anxious Presence
   • Keep your muscles relaxed and unclenched.
   • Practice stress reduction and stress/anxiety management techniques, such as guided visualizations, meditation, yoga, and deep breathing.
10. Be Balanced
   • Lead a balanced life.
   • Maintain balance between your personal and professional life.

11. Practice Self-Validated Care Giving
   • Know that your best is all you can do.
   • Assume an internal locus of control.
   • Reward comes from within and not from others.
   • Practice positive self-talk.

How do you recover from compassion fatigue?

Although resiliency and prevention strategies are very effective, sometimes compassion fatigue cannot be prevented. Fortunately, compassion fatigue is very responsive to treatment. It is important to recognize, however, that the healing process takes time.

Acknowledging and accepting the symptoms of compassion fatigue and seeking help to overcome them are the essential first steps to recovery. In addition to practicing the strategies for preventing compassion fatigue, there are many strategies one can employ to mitigate and treat the effects of compassion fatigue. The strategies for recovery are very similar to those of prevention.

Strategies to Overcome Compassion Fatigue:

1. Acceptance
   • Acknowledge the symptoms of compassion fatigue.
   • Associate symptoms with work-related experiences.
   • Recognize the need for assistance.

2. Intentionality
   • Address symptoms.
   • Understand the meaning of symptoms.
   • Resolve internal conflict.

3. Connection/Support/Therapeutic Alliance
   • Join a traumatic stress peer support or study group.
   • Allow yourself to receive support from peers, family, and friends.
   • Teach others how to help you.
   • Engage in meaningful conversation on a regular basis.

4. Resolution of Traumatic Stress
   • Seek professional assistance. A brief treatment with some of the accelerated trauma techniques delivered by a qualified professional may rapidly resolve secondary traumatic stress symptoms.
     o Traumatic Incident Resolution (TIR)
     o Cognitive Behavior Therapy (CBT)
     o Systematic Desensitization (SD)
     o Visual-Kinesthetic Dissociation Neurolinguistic Reprocessing (V/KD-NLP)
     o Eye Movement Desensitization and Reprocessing (EMDR)
5. Self-Care
   - Engage in aerobic exercise regularly.
   - Pursue a creative interest, hobby, or sport.
   - Eat a well-balanced diet.
   - Get plenty of rest.
   - Practice anxiety and stress management techniques.
   - Establish and maintain balance and boundaries between your personal and professional lives.

6. Self-Management
   - Develop anxiety reduction and self-regulatory skills.
   - Practice relaxation and deep breathing exercises.
   - Adopt positive self-talk and cognitive restructuring.
   - Maintain a positive attitude.
Learning Objective #7: Identify compassion fatigue resources.

There are many resources for understanding, preventing, and overcoming compassion fatigue. The following is a list of recommended readings, Internet web sites, assessments, videotapes, and organizations.

RESOURCES:

Self-Tests

- Measures of Traumatic Stress and Secondary Traumatic Stress
  http://www.isu.edu/~bhstamm/tests.htm

- Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales – Revision III (Pro QOL – R III)
  http://www.isu.edu/~bhstamm/tests/ProQOL.htm

Videotapes

- Compassion Fatigue: The Stress of Caring Too Much
  http://www.ace-network.com/mentalhealthvideos.htm

Resource Sites

- Veterans’ Affairs
  http://www.vaonline.org/care.html

- Canadian Mental Health Association
  http://www.cmha.ca

- Psychology Self-Help Resources - Internet
  http://www.psywww.com/resource/selfhelp.htm

- Crisis Intervention: Stress Management and Self Care
  http://www.css.edu/users/dswenson/web/MED-CI/ci-selfcare.html

- Firefighter Ministries, Inc. Emotional Health Programs
  http://www.theultimatefirehouse.com/emotional_issues1.htm

- Compassion Fatigue: An Introduction
  http://mailer.fsu.edu/~cfigley/CFintro.html
On-line Articles

- Accelerated Recovery Program for Compassion Fatigue
  (http://www.employeefamilyassistance.torontopolice.on.ca/baranowsky1.html)

- Overcoming Compassion Fatigue
  (http://www.aafp.org/fpm/20000400/39over.html)

- Compassion Fatigue: An Introduction
  (http://mailer.fsu.edu/~cfigley/CFintro.html)

- Near Ground Zero: Compassion Fatigue in the Aftermath of September 11
  (www.fsu.edu/~trauma/NearGroundZero.doc)

- Counseling Counselors: 9/11’s Vicarious Victims
  (http://www.counseling.org/site/News2?page=NewsArticle&id=7512&JservSessionIdr011=p8aiknoes2.app13b)

- Surviving Trauma Treatment
  (http://www.apa.org/journals/figley.html)

- Empowering Healthcare Providers: The Care Giving Personality
  (http://www.healerwarrior.com/caregiving_personality.htm)

- Empowering Healthcare Providers: The Personal Cost of Caring
  (http://www.healerwarrior.com/personal_cost.htm)

- What is Compassion Fatigue?
  (http://www.ace-network.com/cfspotlight.htm#cfmenu)
Suggested Readings


Section Four

RESOURCES
References


http://www.fema.gov/


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Article Written by J. Eric Gentry and Adopted from Bioterrorism Trauma Intervention Specialist Training

Bioterrorism preparedness training would not be complete without preparing front-line responders to prevent and mitigate the possible deleterious effects of bioterrorism response and recovery work upon these workers. This section is provided so that participants of this course can understand the risks and potential effects of this work. Additionally, this manual, the audio CD-Rom, and the exercises during the course are designed to help the learner develop the requisite skills, knowledge, and attitudes to maximize resiliency and prevent and mitigate compassion fatigue. Effective treatment strategies for the symptoms of compassion fatigue are also offered.

Overview

The notion that working with people in pain extracts a significant cost from the caregiver is not new. Although the costs vary and have been lamented from time immemorial, anyone who has sat at the bedside of a seriously ill or recently bereaved loved one knows the toll involved in devoting singular attention to the needs of another suffering person. Only in recent years, however, has there been a substantial effort to examine the effects on the caregiver of bearing witness to the indescribable wounds inflicted by traumatic experiences. The exploration and examination of these effects evolved throughout the last century and comes to us from a wide variety of sources.

One of the first earliest references in the scientific literature regarding this cost of caring comes from Carl G. Jung in *The Psychology of Dementia Praecox* (Jung, 1907). In this text, Jung discusses the challenges of countertransference — the therapist’s conscious and unconscious reactions to the patient in the therapeutic situation — and the particular countertransferential difficulties analysts encounter when working with psychotic patients. He boldly *prescribes* a treatment stance in which the therapist participates in the delusional fantasies and hallucinations *with* the patient. Nevertheless, he warns that this participation in the patient’s darkly painful fantasy world of traumatic images has significant deleterious effects for the therapist; especially the neophyte and/or the therapist who has not resolved his/her own developmental and traumatic issues.

The study of countertransference produced the first writings in the field of psychotherapy that systematically explored the effects of psychotherapy upon the therapist (Haley, 1974; Danieli, 1982; Lindy, 1988; Wilson & Lindy, 1994; Karakashian, 1994; Pearlman & Saakvitne, 1995). Recent texts have suggested that therapists sometimes experience countertransference reactions that imitate the symptoms of their clients (Herman, 1992; Pearlman & Saakvitne, 1995). For instance, when working with survivors of traumatic experiences, authors have reported countertransference phenomena that mimic the symptoms of posttraumatic stress disorder (PTSD; Lindy, 1988; Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995).

Business and industry, with their progressive focus upon productivity in the last half of the twentieth century, have provided us with the concept of burnout (Maslach, 1976) to describe the deleterious effects the environmental demands of the workplace have on the worker. Burnout, or “the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (Maslach, 1976, p. 56), has been used to describe the chronic effects that psychotherapists suffer as a result of interactions with their
clients and/or the demands of their workplace (Cherniss, 1980; Farber, 1983; Sussman, 1992; Grosch & Olsen, 1994; Maslach & Goldberg, 1998).

Research has shown that therapists are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic (McCann & Pearlman, 1990). Moreover, burnout not only is psychologically debilitating to therapists, but also impairs the therapist’s capacity to deliver competent mental health services (Farber, 1983). The literature on burnout, with its twenty-five year history, thoroughly describes the phenomena and prescribes preventive and treatment interventions for helping professionals.

The study of the effects of trauma has also promoted a better understanding of the negative effects of helping. Psychological reactions to trauma have been described over the past one hundred and fifty years by various names such as “shell shock,” “combat neurosis,” “railroad spine,” and “combat fatigue” (Shalev, Bonne, & Eth, 1996). However, not until 1980 was the latest designation for these reactions, posttraumatic stress disorder (PTSD), formally recognized as an anxiety disorder in the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III, American Psychiatric Association, 1980; Matsakis, 1994). Since that time, research into posttraumatic stress has grown at an exponential rate (Figley, 1995; Wilson & Lindy, 1994) and the field of traumatology has been established with two of its own journals, several professional organizations, and unique professional identity (Figley, 1988; Bloom, 2000; Gold & Faust, 2001).

As therapists are increasingly called upon to assist survivors of violent crime, natural disasters, childhood abuse, torture, acts of genocide, political persecution, war, and now terrorism (Sexton, 1999), discussion regarding the reactions of therapists and other helpers to working with trauma survivors has recently emerged in the traumatology literature (Figley, 1983, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995). Professionals who listen to reports of trauma, horror, human cruelty and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients. They may also experience PTSD symptoms similar to their clients’ such as intrusive thoughts, nightmares, avoidance and arousal, as well as changes in their relationships to their selves, their families, friends and communities (Figley, 1995; McCann & Pearlman, 1990, Salston, 2000). Therefore, they may themselves come to need assistance to cope with the effects of listening to others’ traumatic experiences (Figley, 1995; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Gentry, Baranowsky & Dunning, 1997, in press).

While the empirical literature has been slow to develop in this area, there is an emerging body of scientific publications that attempts to identify and define the traumatization of helpers through their efforts of helping. Pearlman and Saakvitne (1995), Figley (1995), and Stamm (1995) all authored and/or edited texts that explored this phenomenon among helping professionals during the same pivotal year. The terms “vicarious traumatization” (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), “secondary traumatic stress” (Figley, 1988; Stamm, 1995) and “compassion fatigue” (Figley, 1995) have all become cornerstones in the vernacular of describing the deleterious effects that helpers suffer when working with trauma survivors.

Vicarious traumatization (McCann & Pearlman, 1990) refers to the transmission of traumatic stress through observation and/or hearing others’ stories of traumatic events and the resultant shift/distortions that occur in the caregiver’s perceptual and meaning
systems. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and becomes overwhelmed by this secondary exposure to trauma (Figley & Kleber, 1995). Several theories have been offered but none has been able to conclusively demonstrate the mechanism that accounts for the transmission of traumatic stress from one individual to another. It has been hypothesized that the caregiver’s level of empathy with the traumatized individual plays a significant role in this transmission (Figley, 1995), and there is budding empirical data to support this hypothesis (Salston, 2000).

Figley (1995) also proposes that the combined effects of the caregiver’s continuous visualizing of clients’ traumatic images added to the effects of burnout can create a condition progressively debilitating the caregiver that he has called “compassion stress.” This construct holds that exposure to clients’ stories of traumatization can produce a form of posttraumatic stress disorder in which Criterion A, or “the event” criterion, is met through listening to, instead of the \textit{in vivo} experiencing of, a traumatic event. The symptoms of compassion fatigue, divided into categories of intrusive, avoidance, and arousal symptoms, are summarized in Table I.

\section*{Table I: Compassion Fatigue Symptoms}

<table>
<thead>
<tr>
<th>Intrusive Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thoughts and images associated with client’s traumatic experiences</td>
</tr>
<tr>
<td>• Obsessive and compulsive desire to help certain clients</td>
</tr>
<tr>
<td>• Client/work issues encroaching upon personal time</td>
</tr>
<tr>
<td>• Inability to “let go” of work-related matters</td>
</tr>
<tr>
<td>• Perception of survivors as fragile and needing the assistance of caregiver (“savior”)</td>
</tr>
<tr>
<td>• Thoughts and feelings of inadequacy as a caregiver</td>
</tr>
<tr>
<td>• Sense of entitlement or special-ness</td>
</tr>
<tr>
<td>• Perception of the world in terms of victims and perpetrators</td>
</tr>
<tr>
<td>• Personal activities interrupted by work-related issues</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Avoidance Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Silencing Response (avoiding hearing/witnessing client’s traumatic material)</td>
</tr>
<tr>
<td>• Loss of enjoyment in activities/cessation of self-care activities</td>
</tr>
<tr>
<td>• Loss of energy</td>
</tr>
<tr>
<td>• Loss of hope/sense of dread working with certain clients</td>
</tr>
<tr>
<td>• Loss of sense of competence/potency</td>
</tr>
<tr>
<td>• Isolation</td>
</tr>
<tr>
<td>• Secrecive self-medication/addiction (alcohol, drugs, work, sex, food, spending, etc.)</td>
</tr>
<tr>
<td>• Relational dysfunction</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Arousal Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased anxiety</td>
</tr>
<tr>
<td>• Impulsivity/reactivity</td>
</tr>
<tr>
<td>• Increased perception of demand/threat (in both job and environment)</td>
</tr>
<tr>
<td>• Increased frustration/anger</td>
</tr>
<tr>
<td>• Sleep disturbance</td>
</tr>
<tr>
<td>• Difficulty concentrating</td>
</tr>
<tr>
<td>• Change in weight/appetite</td>
</tr>
<tr>
<td>• Somatic symptoms</td>
</tr>
</tbody>
</table>
As a result of work with hundreds of caregivers suffering the effects of compassion fatigue, we have augmented Figley’s (1995) definition to include pre-existing and/or concomitant primary posttraumatic stress and its symptoms. Many caregivers, especially those providing on-site services, will have had first-hand exposure to the traumatic event(s) to which they are responding (Pole et al., 2001; Marmar et al., 1999). For many, these symptoms of PTSD will have a delayed onset and not become manifest until some time later. We have also found that many caregivers enter the service field with a host of traumatic experiences in their developmental past (Gentry, 1999). There may have been no symptoms associated with these events, or the symptoms related to them may have remained sub-clinical. However, we have observed that as these caregivers begin to encounter the traumatic material presented by clients, many of them begin to develop clinical PTSD symptoms associated with their previously “benign” historical experiences.

In our efforts to treat compassion fatigue, we have concluded that it is often necessary to successfully address and resolve primary traumatic stress before addressing any issues of secondary traumatic stress and/or burnout. Additionally, we have discerned an interactive, or synergistic, effect among primary traumatic stress, secondary traumatic stress, and burnout symptoms in the life of an afflicted caregiver. Experiencing symptoms from any one of these three sources appears to diminish resiliency and lower thresholds for the adverse impact of the other two. This seems to lead to a rapid onset of severe symptoms that can become extremely debilitating to the caregiver within a very short period of time.

Table II: Compassion Fatigue Model

<table>
<thead>
<tr>
<th>The Gentry/Baranowsky (1997) Model of Compassion Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY TRAUMATIC STRESS</td>
</tr>
<tr>
<td>+/-x (synergistic effect)</td>
</tr>
<tr>
<td>SECONDARY TRAUMATIC STRESS</td>
</tr>
<tr>
<td>+/-x (synergistic effect)</td>
</tr>
<tr>
<td>BURNOUT</td>
</tr>
<tr>
<td>COMPASSION FATIGUE</td>
</tr>
</tbody>
</table>
Understanding Compassion Fatigue: Helping Public Health Professionals and Other Front-Line Responders Combat Occupational Stressors and Psychological Injuries of Bioterrorism Defense for a Strengthened Public Health Response

Treatment & Prevention: Active Ingredients

It has been demonstrated that the potential to develop negative symptoms associated with our work in providing services to trauma survivors, especially the symptoms of secondary traumatic stress, increases as our exposure to their traumatic material increases (McCann & Pearlman, 1990; Salston, 2000). We believe that no one who chooses to work with trauma survivors is immune to the potential deleterious effects of this work. However, in our work with providing effective treatment to hundreds of caregivers with compassion fatigue symptoms, either individually through the Accelerated Recovery Program for Compassion Fatigue (Gentry, Baranowsky, & Dunning, 2002) or in the Compassion Fatigue Specialist Training (Gentry & Baranowsky, 1998; Gentry, 2002) groups, we have identified some enduring principles, techniques, and ingredients that seem to consistently lead to positive treatment outcomes and enhanced resiliency for caregivers working with troubled and traumatized populations.

**Intentionality**. Initiation of effective resolution of compassion fatigue symptoms requires specific recognition and acceptance of the symptoms and their causes by the caregiver, along with a decision to address and resolve these symptoms. Many caregivers who experience symptoms of compassion fatigue will attempt to ignore their distress until a threshold of discomfort is reached. For many caregivers this may mean that they are unable to perform their jobs as well as they once did or as well as they would like due to the symptoms they are experiencing. For others, it may entail the progressive debilitation associated with somatic symptoms or the embarrassment and pain associated with secretive self-destructive comfort-seeking behaviors. Whatever the impetus, we have found that successful amelioration of compassion fatigue symptoms requires that the caregiver intentionally acknowledge and address, rather than avoid, these symptoms and their causes. Additionally, we have found the use of goal-setting and the development of a personal/professional mission statement to be invaluable in moving away from the reactivity associated with the victimization of compassion fatigue and toward the resiliency and intentionality of mature care giving.

**Connection**. One of the ways trauma seems to affect us all, caregivers included, is to leave us with a sense of disconnected isolation. A common thread we have found with sufferers of compassion fatigue symptoms has been the progressive loss in their sense of connection and community. Many caregivers become increasingly isolatory as their symptoms intensify. Fear of being perceived as weak, impaired, or incompetent by peers and clients, along with time constraints and loss of interest, have all been cited by

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<table>
<thead>
<tr>
<th>Etiology</th>
<th>Burnout/Compassion Stress</th>
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</thead>
<tbody>
<tr>
<td>1. Primary Traumatic Stress</td>
<td>1. Perceived demand &gt; resources</td>
</tr>
<tr>
<td>2. Secondary Traumatic Stress</td>
<td>2. Perceived demand = threat</td>
</tr>
<tr>
<td>3. Empathy transmission</td>
<td>3. Mundane work</td>
</tr>
<tr>
<td>5. Digital/Holographic traumatic event</td>
<td>5. Unresolved grief</td>
</tr>
<tr>
<td></td>
<td>6. Resentment/conflict</td>
</tr>
<tr>
<td></td>
<td>7. Anxiety</td>
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</tbody>
</table>
caregivers suffering from compassion fatigue as reasons for diminished intimate and collegial connection. The development and maintenance of healthy relationships, which the caregiver uses for both support and to share/dilute the images and stories associated with secondary traumatic stress, may become a powerful mitigating factor in resolving and preventing compassion fatigue symptoms. Often the bridge for this connection is established in the peer-to-peer offering of the ARP, during which the facilitator works intentionally to develop a strong relationship with the caregiver suffering compassion fatigue symptoms. In the CCFST, we facilitate exercises specifically designed to dismantle interpersonal barriers and enhance self-disclosure. It seems that it is through these relational connections that the caregivers suffering compassion fatigue are able to gain insight and understanding that their symptoms are not an indication of some pathological weakness or disease, but are instead natural consequences of providing care for traumatized individuals. In addition, with the enhanced self-acceptance attained through self-disclosure with and by empathetic and understanding peers, caregivers are able to begin to see their symptoms as indicators of the developmental changes needed in both their self-care and care giving practices. We have seen that a warm, supportive environment in which caregivers are able to discuss intrusive traumatic material, difficult clients, symptoms, fears, shame, and secrets with peers to be one of the most critical ingredients in the resolution and continued prevention of compassion fatigue.

**Anxiety Management/Self-Soothing.** It is our belief that providing care-giving services while experiencing intense anxiety is one of the primary means by which compassion fatigue symptoms are contracted and exacerbated. Alternately stated, to the degree that a caregiver is able to remain non-anxious (relaxed pelvic floor muscles), we believe, s/he will maintain resistance to the development of symptoms of compassion fatigue. The ability to self-regulate and soothe anxiety and stress is thought to be a hallmark of maturity. The mastery of these skills comes only with years of practice. However, if we fail to develop the capacity for self-regulation, if we are unable to internally attenuate our own levels of arousal, then we are susceptible to perceiving as threats those people, objects, and situations to which we respond with anxiety — believing that benign people, objects and situations are dangerous. As one very insightful and astute psychologist who was a participant in the CCFST stated: “Maybe the symptoms of compassion fatigue are a good thing, they force us to become stronger.” It does seem to be true that those caregivers with well-developed self-regulation skills who do not resort to self-destructive and addictive comfort-seeking behaviors are unlikely to suffer symptoms of compassion fatigue.

In both the ARP and the CCFST, we work rigorously with participant caregivers to help them develop self-management plans that will assist them in achieving and maintaining an *in vivo* non-anxious presence. This non-anxious presence extends far beyond a calm outward appearance. Instead, it entails the ability to maintain a level of relaxed mindfulness and comfort in one’s own body. This ability to remain non-anxious when confronted with the pain, horror, loss, and powerlessness associated with the traumatic experiences in the lives of clients, of having the capacity to calmly “bear witness,” remains a key ingredient in the resolution and prevention of compassion fatigue symptoms.
Self-Care. Closely associated with self-management is the concept of self-care, or the ability to refill and refuel oneself in healthy ways. It is quite common for caregivers to find themselves anxious during and after working with severely traumatized individuals. Instead of developing a system of healthy practices for resolving this anxiety — such as sharing with colleagues, exercise, meditation, nutrition, and spirituality — many caregivers find themselves redoubling their work efforts. Frequently this constricting cycle of working harder in an attempt to feel better creates a distorted sense of entitlement that can lead to a breach of personal and professional boundaries. We have worked with many caregivers who have reported falling prey to compulsive behaviors such as overeating, overspending, or alcohol/drug abuse in an effort to soothe the anxiety they feel from the perceived demands of their work. Others with whom we have worked have self-consciously admitted to breaching professional boundaries and ethics when at the low point in this cycle, distortedly believing that they “deserve” this “special” treatment or reward.

Meta-analyses of psychotherapy outcomes consistently point toward the quality of the relationship between therapist and client as the single most important ingredient in positive outcomes (Bergin & Garfield, 1994). The integrity and quality of this relationship is contingent upon the therapist’s maintenance of his/her instrument, the “self of the therapist.” When caregivers fail to maintain a life that is rich with meaning and gratification outside the professional arena, then they often look to work as the sole source of these commodities. In this scenario, caregivers interact with their clients from a stance of depletion and need. It is completely understandable that this orientation would produce symptoms in caregivers. Conversely, professionals who responsibly pursue and acquire this sense of aliveness outside the closed system of their professional role are able to engage in work with traumatized individuals while sharing their own fullness, meaning, and joy. The cycle of depletion by our work and intentionally refilling ourselves in our lives outside of work, often on a daily basis, may have been what Frankl meant when he challenged us to “endure burning.”

One of the most important aspects of this category of self-care that we have found in our work with caregivers has been the development and maintenance of a regular exercise regimen. No other single behavior seems to be as important as regular aerobic and anaerobic activity. In addition to exercise, good nutrition, artistic expression/discipline (e.g., piano lessons and composition, dance classes and choreography, structural planning and building), meditation/mindfulness, outdoor recreation, and spirituality all seem to be important ingredients to a good self-care plan.

We have found a few caregivers with compassion fatigue symptoms that seemed to be at least partially caused by working beyond their level of skill. Working with traumatized individuals, families, and communities is a highly skilled activity that demands many years of training in many different areas before one gains a sense of mastery. Trying to shortcut this process by prematurely working with trauma survivors without adequate training and supervision can very easily overwhelm even seasoned clinicians, much less neophytes. While empirical research has not yet addressed the effects of working beyond levels of competency or of providing services while impaired with stress symptoms has upon the care provider, especially in contexts of mass casualties like we have witnessed in New York City, we believe that these factors contribute significantly to the frequency, duration and intensity of compassion fatigue symptoms.
Sometimes training in the area of treating trauma, especially experiential trainings such as EMDR (Shapiro, 1995) or TIR (French & Harris, 1998), can have a powerful ameliorative effect upon compassion fatigue, bringing a sense of empowerment to a caregiver who was previously overwhelmed. The caveat here is that there exists some danger that an overwhelmed therapist who has been recently trained in one of these powerful techniques may emerge from the training with an inflated sense skill and potency. Newly empowered, this therapist may be tempted to practice even further beyond their level of competence and skill. This scenario highlights the importance of good professional supervision during the developmental phases of a traumatologist’s career. In addition, many therapists working with trauma survivors have found it helpful to receive periodic “check ups” with a trusted professional or peer supervisor. This is especially true during and immediately following deployment in a disaster or critical incident situation. These professional and peer supervisory relationships can serve as excellent opportunities to share, and therefore dilute the effects, of the artifacts of secondary traumatic stress that may have been collected while in service to trauma survivors. Professional supervision is also reported to have an overall ameliorative effect upon compassion fatigue symptoms (Pearlman, 1995; Catherall, 1995).

Every caregiver’s self-care needs are different. Some will need to remain vigilant in the monitoring and execution of their self-care plan, while others will, seemingly, be able to maintain resiliency with minimal effort. However, we strongly urge the caregiver who specializes in working with trauma and trauma survivors to develop a comprehensive self-care plan that addresses and meets the caregiver’s individual needs for each of the areas discussed in this article. With this self-care plan in place, the caregiver can now practice with the assurance that they are maximizing resiliency toward and prevention of the symptoms of compassion fatigue that is akin to the protection of wearing a seatbelt while driving an automobile.

It should be noted that those care providers responding on-site to crisis situation, such as those caused by the events of September 11, may be limited in their ability to employ habitual self-care activities. They may not have access to gymnasiums or exercise facilities, nutritious food and water may be scarce for a period of time, and it is doubtful that care providers deployed in situations of mass destruction will have access to their traditional support network. While most trauma responders are a hardy and resilient breed, we simply cannot sustain the rigors of this depleting and intensive work without intentional concern for our own health and welfare. Making best use of available resources to establish respite and sanctuary for ourselves, even in the most abject of circumstances, can have an enormous effect in minimizing our symptoms and maximizing our sustained effectiveness. Many responders have reported acts of kindness as simple as the gift of a bottle of water, a pat on the back, or an opportunity to share a meal with another responder as having a powerfully positive impact upon their morale and energy during these difficult times.

**Narrative.** Many researchers and writers have identified the creation of a chronological verbal and/or graphic narrative as an important ingredient in the healing of traumatic stress, especially intrusive symptoms (Tinnin, 1994; van der Kolk, 1996; Foa et al., 1999). We have found that a creation of a time-line narrative of a care giving career that identifies the experiences and the clients from which the caregiver developed primary and secondary traumatic stress is invaluable in the resolution of compassion fatigue symptoms, especially those associated with secondary traumatic stress. In the ARP, we instruct the participant/caregiver to “tell your story…from the beginning — the first
experiences in your life that led you toward care giving — to the present.” We use a video camera to record this narrative and ask the caregiver to watch it later that same day, taking care to identify the experiences that have led to any primary and secondary traumatic stress (intrusive symptoms) by constructing a graphic time-line. In the CCFST, we utilize dyads in which two participants each take a one-hour block of time to verbalize their narrative while the other practices non-anxious “bearing witness” of this narrative.

Desensitization and Reprocessing. With the narrative completed and the identification of historical experiences that are encroaching upon present-day consciousness and functioning in the form of primary and secondary traumatic stress, the caregiver is now ready to resolve these memories. In the ARP, we have utilized Eye Movement Dissociation and Reprocessing (Shapiro, 1989, 1995) as the method-of-choice for this work. In the CCFST, we utilize a hybridized version of a Neuro-Linguistic Programming Anchoring Technique (Gentry & Baranowsky, 1998). Any method that simultaneously employs exposure and relaxation (i.e., reciprocal inhibition) is appropriate for this important cornerstone of treatment. We have had success utilizing Traumatic Incident Reduction (French & Harris, 1999), the anamnesis procedure from the Trauma Recovery Institute (TRI) Method (Tinnin, 1994), or many of the techniques from Cognitive-Behavioral Therapy (Foia & Meadows, 1997; Follette, Ruzek, & Abueg, 1998). With the successful desensitization and reprocessing of the caregiver’s primary and secondary traumatic stress, and the cessation of intrusive symptoms, often comes a concomitant sense of rebirth, joy, and transformation. This important step and ingredient in the treatment of compassion fatigue should not be minimized or overlooked.

In our work with the responders of the Oklahoma City bombing, none reported experiencing intrusive symptoms of secondary and/or primary traumatic stress until several days, weeks, months, and sometimes years after their work at the site. From personal communication with an Incident Commander for a team of mental health responders who worked with over 2700 victims in New York City the first month after the attacks (Norman, 2001), he indicated that at least one Certified Compassion Fatigue Specialist was available to provide daily debriefing services for every ten (10) responders. He further indicated that if a responder began to report symptoms or show signs of significant traumatic stress they were provided with acute stabilization services by the team and arrangements were made for transportation back home with a referral to a mental health practitioner in the worker’s home town. With the intense demands of critical incident work and the paramount importance of worker safety, attempts of desensitization and reprocessing care provider’s primary and secondary traumatic stress while on-site seems counterproductive as it draws from the often already depleted resources of the intervention team. For this reason, it is recommended that the worker engage in resolving the effects of accumulated traumatic memories only after safely returning to the existing resources and support offered by their family, friends, churches/synagogues, and healthcare professionals in their hometown.

Self-Supervision. This aspect of treatment is focused upon the correction of distorted and coercive cognitive styles. Distorted thinking may be developmental (i.e., existent prior to a caregiver’s career), or may have been developed in response to primary and secondary traumatic stress later in life. Whatever the cause, we have found that once a caregiver contracts the negative symptoms of compassion fatigue, these symptoms will not fully resolve until distorted beliefs about self and the world are in the process of correction. This is especially true for the ways in which we supervise and motivate ourselves. Caregivers recovering from the symptoms of compassion fatigue will need to
soften their critical and coercive self-talk and shift their motivational styles toward more self-accepting and affirming language and tone if they wish to resolve their compassion fatigue symptoms. For many this is a difficult, tedious, and painstaking breaking-of-bad-habits process that can take years to complete. In the ARP and the CCFST, we have employed an elegant and powerful technique called “video-dialogue” (Holmes & Tinnin, 1995) that accelerates this process significantly. This technique, adapted for use with the ARP, challenges the participant to write a letter to themselves from the perspective of the “Great Supervisor,” lavishing upon themselves all the praise, support, and validation that they wish from others. They are then requested to read this letter into the eye of the camera. While watching back the videotape of this letter, the caregiver is asked to “pay attention to any negative or critical thought that thwarts your acceptance of this praise.” Then, s/he is instructed to give these critical and negative thoughts a “voice,” as these negative thoughts are articulated into the video camera, directed at the caregiver. This back-and-forth argument between the “self” and the “critical voice” of the caregiver continues on videotape until both “sides” begin to see the utility in both perspectives. With this completed, polarities relax, self-criticism softens, and integration is facilitated.

While this technique is powerfully evocative and can rapidly transform self-critical thinking styles, the Cognitive Therapy “triple column technique” (Burns, 1980), that helps identify particular cognitive distortions and challenges a client to rewrite these negative thoughts into ones that are more adaptive and satisfying will also work well for this task. Additionally, as caregivers suffering from compassion fatigue symptoms develop some mastery in resolving these internal polarities with themselves, they are challenged to identify and resolve polarities with significant others. Individuals traumatized from either primary or secondary sources who are able to “un-freeze” themselves from their polarities, resentments, conflicts, and cut-offs will be rewarded with less anxiety, a heightened sense of comfort inside their own skin, and a greater sense of freedom from the past to pursue their mission of the present and future.

Limit Contact with Traumatic Event and Survivors. This final strategy for preventing compassion fatigue encourages workers to minimize their contact with traumatic stress and traumatic events. Both survivors and the events that victimize them have a gravity toward which we all are drawn. You are probably taking this course because you are drawn to trauma or helping survivors. Something about these situations and the people affected by them calls out for our participation. It is common lure in crisis situations to find caregivers who have spent many days on the scene providing services to survivors. Many may see this selfless sacrifice as heroic. However, with the more we learn about the way the body’s brain and physiology function during times of high anxiety, there is a good chance that these people who over-expose themselves to traumatic experiences and working with survivors are not only putting themselves at risk for the deleterious effects described above, they are also probably working with diminished physical, cognitive, and motor functioning. An overwhelmed caregiver is minimally effective, at best.
Compassion Fatigue Resiliency Worksheet
Worksheet developed by J. Eric Gentry and adopted from Bioterrorism Trauma Intervention Specialist Training course developed by the Florida Center for Public Health Preparedness

1. Non-anxious Presence. Identify two things that you can do to help you develop and maintain a non-anxious presence.
   a. ____________________________________________
   b. ____________________________________________

2. Self-validated Care giving. Identify one thing that you can do to move you away from being dependent upon affirmation from others toward self-validation.
   a. ____________________________________________

3. Connection With Others. Identify two people with whom you can develop a support network for diluting traumatic stress (remember it is your responsibility to teach your friends what you need).
   a. ____________________________________________
   b. ____________________________________________

4. De-polarizing/de-triangulation. Trauma always produces polarities in systems. Your commitment toward remaining connected with all members of your community and systems will empower you as a “ground” to the energy of traumatic stress and will result in your own enhanced resiliency. Identify one person with whom you are polarized and the way in which you can begin to “thaw” the tension between you.
   a. ____________________________________________

5. Self-Care. Identify three things that you will do to enhance your sense of fullness and satisfaction (read “resiliency”) outside your work. Including aerobic exercise as one of these will greatly enhance your resiliency.
   a. ____________________________________________
   b. ____________________________________________
   c. ____________________________________________

6. Skills Building. Sometimes compassion fatigue and burnout are brought on by the caregiver practicing beyond their level of competency and great relief can come from developing new skills. Identify one area in which you can build skills that will provide you with a greater sense of mastery and empowerment
   a. ____________________________________________

Because I care about myself and preventing the deleterious effects of working with traumatized and suffering individuals, families, and communities I will complete the above before ________________.

_________________________________________ Signature
_________________________________________ Witness
Emotional Health Issues for Disaster Workers
(Source: the American Red Cross)

As disaster workers seek to meet the needs of victims and communities following any type of disaster, they are surrounded by and exposed to disorganization, confusion, scenes of destruction, and the tears and the pain of victims.

Disaster workers have the potential to become "secondary victims," as they work long, hard hours under poor conditions. In some cases, physical dangers exist for responders. Worker accommodations may be poor when they are near or within the affected area, or may require an hour or more of travel when located outside the affected area. Personal support systems are left at home, and new supports must be formed while on the operation and while time is scarce. Supervisory styles are different from person to person, administrative organization and regulation often must change with little warning, adding additional stressors as workers try to satisfy the needs of the clients and of the organization.

Most disaster workers are dedicated individuals who also tend to be perfectionists. Because of this, they are at risk of pushing themselves too hard and of not being satisfied with what they have accomplished. With so much yet to do, they often fail to take credit for the amount of work completed and the effort contributed to the operation.

Frustration is common, and our usual sense of humor is often stretched beyond limits. Workers become exhausted, and anger comes easily to the surface. The anger of others -- workers, victims, and media -- becomes difficult to deal with, and may be seen as a personal attack on the worker rather than as a normal response to exhaustion. Survivor guilt may emerge as workers see the losses of others when they have suffered none themselves.

COPING: Remember that you are giving those victimized by the disaster a gift of yourself -- your time and your caring -- a gift you could not give if you were also a victim.

This may be your first experience with scenes of great destruction or high levels of injury and death. These are realities we don't often face, and methods of coping with these are not developed overnight. In each of us, there is an unconscious fear that a victim could be you or a loved one. You need to understand and
appreciate the intensity of your emotions, and talk about your feelings to others.

Although we may function in superhuman ways during a disaster operation, the stress associated with our jobs takes its toll. We get tired . . . and confused . . . and hurt . . . and scared. It is critical both for ourselves and those we try to help that we understand the effects of stress and make every effort to deal with it.

Stress-relieving activities are not as difficult or time consuming as we may think. A 15-minute walk during a lunch or coffee break; talking to a co-worker, supervisor, or mental health worker; going out to dinner or a movie; or just learning and using deep breathing exercises can significantly reduce stress.

During the operation, it's important to eat nutritional foods, avoid drinking large amounts of caffeine and alcohol, get some exercise whenever possible, and get as much sleep as you can. That way you'll be better able to continue meeting the challenges of your job.

Your supervisors will be attempting to juggle schedules so that you can have some time off to yourself to sleep, read, or just sit in the sunshine. If you feel that you need this time off before you're scheduled for it, just ask. If you need a change of assignment or setting, just ask. And, hard as it may be to turn over your duties to someone else, when it is time for your shift to be over, leave and take time to recharge.
Emotional Health Issues for Families of Disaster Workers
(Source: the American Red Cross)

Someone very important to you and your family has just left on a disaster assignment. It is natural for you to be worried about the experiences and possible hardships he or she may face on assignment. Please be assured that the safety and well-being of your family member is as important to us as it is to you.

DEALING WITH STRESS

Your family member has probably given you all the information available at the time of assignment. It may seem very scanty to you. That's because in the beginning stages of any operation we don't really know very much about where the need is the greatest and where we will require the particular skills your family member has to share. We often don't know what accommodations are available in the affected area, or even whether phone service has been restored.

For the disaster staff member, the beginning of any operation is a process of reporting as quickly as possible to a headquarters (which may change location as additional damage reports come in), to perform a function that may be changed as the needs of the operation change. The staff member may be reassigned once or many times to different towns during the assignment. It is a time of great confusion and considerable frustration, as we begin to meet the needs of disaster victims and affected communities. But one thing we can guarantee is that this is an opportunity unlike any other for disaster workers to find the satisfaction that accompanies helping others and stretching their own limits and potential.

We know that you will keep in touch with your family member as often as possible, and continue to make him or her feel like a part of the family at home. Friendships are formed quickly on disaster assignments, and workers look out for the welfare of each other as if they had been lifelong friends. But even with this sense of camaraderie, it is not the same as news and expressions of caring from home.

Should an emergency arise, the Disaster Services department at your local Red Cross chapter can contact the operation. We can provide work numbers for your family member, pass messages, or facilitate a compassionate release from the operation and provide travel home.

Disaster workers usually work long hours with little time off. They are constantly exposed to scenes of destruction and the strong emotions of victims. The pace on an operation is accelerated so that the most assistance can be provided to the largest number of people in the shortest possible time so their recovery will not be extended and they can begin to resume a more normal life.
RETURNING HOME
(Source: the American Red Cross)

When your family member returns home, he or she may need a little additional time to adjust to the "normal" pace of everyday life, and may require a few days' rest before picking up the total load of responsibilities carried prior to leaving. It will be important for your family member to be able to talk to you about what happened on the operation and the emotions that accompanied the work. He or she may be proud, frustrated, angry, sad, tearful, and happy all at the same time. It will take a little time for these conflicting emotions to sort themselves out.

He or she may seem preoccupied with the disaster experience, and may not seem to share your excitement, disappointment, or frustration about events at home. Please be assured that what has happened during the absence is as important as it always was; your family member has just been through an experience that tends to overshadow everyday events and put them in a different perspective when viewed against the enormity of the disaster.

All disaster workers return home with a conscious or an unconscious need to reassure themselves of the safety of their environment. And all workers feel they left something undone on the disaster operation. It is important that you greet your family member with the love and understanding that made you the type of family he or she could feel comfortable leaving in order to help others.

Disaster workers, even when they have served in a location that's not far from home, may have some difficulty readjusting to home life. This can create some conflicts and misunderstandings when they return. By sharing this information with you, we hope that the family reunion will be as joyful as you and your family wishes it to be.

If you wish to talk to someone about your family member's assignment, please feel free to call your local Red Cross chapter's Disaster Services department at any time of the day or night.