Title: Burning Up: The Negative Effects of Caregiving

Abstract: This course engages the reader in an introduction to compassion fatigue--or the negative effects associated with helping professions. This course explores the signs, symptoms, causes, and "cures" for compassion fatigue. The author draws upon his experience in developing and implementing both the Accelerated Recovery Program for Compassion Fatigue and the Certified Compassion Fatigue Specialist Training to present material that has been utilized in the treatment and training of thousands of professional caregivers. This course provides the reader with some "hands-on" principles and activities to lower their levels of stress, burnout, and compassion fatigue associated with their work.

This course co-provided by AKH Consultant and St. Petersburg College. AKH Inc. is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center (ANCC) Commission on Accreditation.

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Contact Hours: 2

Contact Hours will be awarded to: ANCC, Nurses, Physical Therapist, Physical Therapist Asst, Occupational Therapist, Occupational Therapist Asst, Respiratory Therapy, Respiratory Therapy Assistant, Addiction Professional, Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, ALF Administrators

Objectives: After you study the information presented here, you will be able to:

1. Outline the potential negative effects (e.g., compassion fatigue) associated with providing care for seriously ill, troubled, and/or traumatized individuals.
2. Describe the symptoms of compassion fatigue and other negative effects of caregiving in their lives and in the lives of their co-workers.
3. Identify the causes of caregiver stress and recognize high-risk situations.
4. Express an understanding of the ingredients involved in treatment and resiliency for compassion fatigue.
5. Prepare a protocol for self-assessment and self-help for compassion fatigue.

Course Number: 252

Take this Test

Compassion Fatigue

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 someone who is seriously ill or a recently bereaved loved one knows the toll involved in devoting singular attention to the needs of another suffering person. In recent years, however, there has been a substantial effort to examine the effects on the caregiver when helping those who are ill, injured, and traumatized. 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 earliest references in the scientific literature regarding this cost of caring comes from Carl G. Jung in *The Psychology of Dementia Praecox*.[37] In this text, Jung discusses the challenges of countertransference--the helper's conscious and unconscious reactions to the patient in the therapeutic situation--and the particular countertransferential difficulties helpers encounter when working with severely ill or troubled patients. Jung boldly *prescribes* a treatment stance in which the therapist participates in the patient's delusional fantasies and hallucinations *with* the patient. Nevertheless, he warns that this participation in the patient's darkly painful world of traumatic images and injuries has significant deleterious effects for the helper; especially the neophyte and/or the therapist who has not resolved his/her own developmental and traumatic issues.[55]

The study of countertransference produced the first writings in the field of caregiving that systematically explored the effects of helping upon the helper.[8,34,38,39,49,66] Recent texts have suggested that therapists sometimes experience countertransference reactions that imitate the symptoms of their clients.[35,49] For instance, when working with survivors of traumatic experiences, authors have reported countertransference phenomena that mimic the symptoms of posttraumatic stress disorder (PTSD).[39,49,66]

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[22,43] 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"[43], has been used to describe the chronic effects that workers suffer as a result of interactions with their clients and/or the demands of their workplace.[7,10,22,33,45,63] Research has shown that helpers are particularly vulnerable to burnout because of personal isolation, ambiguous successes and the emotional drain of remaining empathetic.[40] Moreover, burnout not only is psychologically debilitating to caregivers, but also impairs the caregiver's capacity to deliver competent health services.[10] 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."[57] 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).[1,46] Since that time, research into posttraumatic stress has grown at an exponential rate[13,66] and the field of traumatology has been established with two of it's own journals, several professional organizations, and a unique professional identity.[3,12,32]

As caregivers are increasingly called upon to assist survivors of violent crime, natural disasters, childhood abuse, torture, acts of genocide, political persecution, war, and now terrorism[56], discussion regarding the reactions of helpers to working with trauma survivors has recently emerged in the traumatology literature.[8,11,13,40,49,62] 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.[13,40,52] Therefore, they may themselves come to need assistance to cope with the effects of listening to others' traumatic experiences or to working with those who suffer severe illness and injury.[13,25,49,53]

While the empirical literature has been slow to develop in this area, there is an emerging body of scientific publications that attempt to identify and define the traumatization of helpers through their efforts of helping. Pearlman and Saakvitne[49], Figley[13], and Stamm[62] all authored and/or edited texts that explored this phenomenon among helping professionals during the same pivotal year. The terms "vicarious traumatization"[40,49], "secondary traumatic stress"[12,62] and "compassion fatigue"[13] have all become cornerstones in the vernacular of describing the deleterious effects that helpers suffer when working with trauma survivors.

Vicarious traumatization[40] 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.[14] Several theories have been offered, but none have 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[13], and there is some budding empirical data to support this hypothesis.[52]

Figley[13] 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 to the caregiver that he has called "compassion stress." This theory 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 *in vivo* experiencing of, a traumatic event. The symptoms of compassion fatigue, divided into categories of intrusive, avoidance, and arousal symptoms, are summarized below.

Compassion Fatigue Symptoms

Intrusive Symptoms:

- Thoughts and images associated with client's traumatic experiences
- Obsessive and compulsive desire to help certain clients
- Client/work issues encroaching upon personal time
- Inability to "let go" of work-related matters
- Perception of survivors as fragile and needing the assistance of the caregiver ("savior")
- Thoughts and feelings of inadequacy as a caregiver
- Sense of entitlement or special-ness
- Perception of the world in terms of victims and perpetrators
- Personal activities interrupted by work-related issues

Avoidance Symptoms:

- Silencing Response (avoiding hearing/witnessing client's traumatic material)
- Loss of enjoyment in activities/cessation of self-care activities
- Loss of energy
- Loss of hope/sense of dread working with certain clients
- Loss of sense of competence/potency
- Isolation
- Secretive self-medication/addiction (alcohol, drugs, work, sex, food, spending, etc.)

- Relational dysfunction

Arousal Symptoms:

- Increased anxiety
- Impulsivity/reactivity
- Increased perception of demand/threat (in both job and environment)
- Increased frustration/anger
- Sleep disturbance
- Difficulty concentrating
- Change in weight/appetite
- Somatic symptoms

As a result of our work with hundreds of caregivers suffering the effects of compassion fatigue, we have augmented Figley's[13] 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.[42,51] 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.[23] There may have been no symptoms associated with these events, or the symptoms related to them may have remained sub-clinical and without overtly manifest symptoms. However, we have observed that as these caregivers begin to encounter the traumatic material presented by patients, 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.

The Gentry / Baranowsky (1997) Model of Compassion Fatigue

PRIMARY TRAUMATIC STRESS

+/x (synergistic effect)

SECONDARY TRAUMATIC STRESS

+/x (synergistic effect)

BURNOUT

COMPASSION FATIGUE

Treatment & Prevention: Active Ingredients

It has been demonstrated that the potential to develop negative symptoms associated with work in

providing health services to trauma survivors (especially the symptoms of secondary traumatic stress) increases as our exposure to their traumatic material increases.[40,52] 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[25] or in the Compassion Fatigue Specialist[27,28,29] training groups, we have identified some enduring principles, techniques, and ingredients that seem to consistently lead to these positive treatment outcomes and enhanced resiliency.

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 caregiving.

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 a progressive loss in their sense of connection and community. Many caregivers become increasingly isolated 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 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 Accelerated Recovery Program (ARP), during which the facilitator works intentionally to develop a strong relationship with the caregiver suffering compassion fatigue symptoms. In the Certified Compassion Fatigue Specialist Training (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 caregiving 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 is 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 caregiving 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 she/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.[2] 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, 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[20] 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 more important than 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 how the caregiver is affected by working beyond levels of competency or by providing services while impaired with stress symptoms (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 in the care provider.

Sometimes training in the area of treating trauma, especially experiential training such as Eye Movement Desensitization and Reprocessing[61] (EMDR) or Traumatic Incident Reduction[21] (TIR), 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 of 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.[5,50]

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 (akin to the protection of wearing a seatbelt while driving an automobile), the caregiver can now practice with the assurance that they are maximizing resiliency toward, and prevention of, the symptoms of compassion fatigue.

It should be noted that those care providers responding on-site to a crisis situation, such as those caused by the events of September 11th, 2001, 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 the 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.[17,64,65] We have found that a creation of a time-line narrative of a caregiving 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 caregiving--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 lead 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[60,61] as the method-of-choice for this work. In the CCFST, we utilize a hybridized version of a Neuro-Linguistic Programming Anchoring Technique (Baranowsky & Gentry, 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[21], the anamnesis procedure from the Trauma Recovery Institute (TRI) Method[64], or many of the techniques from Cognitive-Behavioral Therapy.[16,19] 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 9/11 attacks[48], we learned that at least one Certified Compassion Fatigue Specialist was available to provide daily debriefing services for every ten (10) responders. The Incident Commander 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 hometown. With the intense demands of critical incident work and the paramount importance of worker safety, attempts at desensitization and reprocessing of a 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 health care 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"[36] 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, she/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"[4], which 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.

The Crucible of Transformation

Our initial intent in developing the ARP was to simply gather a collection of powerful techniques and experiences that would rapidly ameliorate the suffering from symptoms of compassion fatigue in the lives of caregivers, so that they would be able to return to their lives and their work refreshed and renewed. However, as we embarked upon yoking ourselves with the formidable task of sitting across from our peers who were suffering with these symptoms, many of whom were demoralized, hopeless, and desperate, we began to understand that recovery from compassion fatigue required significant changes in the foundational beliefs and lifestyles of the caregiver. As we navigated through the five sessions of the ARP with these suffering professionals, we found that most underwent a significant transformation in the way in which they perceived their work and, ultimately, themselves.

Drawing from the work of David Schnarch[59], who works with enmeshed couples to develop self-validated intimacy and achieve sexual potentials in their marriages, we began to see that many caregivers exhibited a similar form of enmeshment with their *careers*. We found that many of those suffering with compassion fatigue symptoms maintained an other-validated stance in their caregiving work--they were compelled to gain approval and feelings of worth from their clients, supervisors, and peers. In beginning to explore the developmental histories of many of the caregivers with whom we have worked, we found that many carried unresolved attachment and developmental issues into their adult lives and careers. For the caregiver who operates from an other-validated stance, clients, supervisors, and peers all represent potential threats when approval is withheld. These perceptions of danger and threat by the caregiver, which are enhanced by secondary traumatic stress contracted in work with trauma survivors, often lead to increased anxiety, feelings of victimization, and a sense of overwhelming powerlessness. As the caregiver is able to evolve toward a more self-validated stance and become more grounded in the non-anxious present, these symptoms begin to permanently dissipate. Pearlman and Saakvitne[49] urge therapists to "find self-worth that is not based on their professional achievements. It is essential to develop and nurture spiritual lives outside our work." While we have found no existing empirical data in this ripe area of study, from a treatment perspective we began to see how the symptoms of compassion fatigue make sense in the lives of many professional caregivers, urging them towards maturation.

Instead of viewing the symptoms of compassion fatigue as a pathological condition that requires some external treatment agent or techniques for resolution, we began to see these symptoms as indicators of the need for the professional caregiver to continue his/her development into matured caregiving and self-care styles and practices. From this perspective the symptoms of compassion fatigue can be interpreted as *messages* from what is right, good, and strong within us, rather than indicators of shameful weaknesses, defects, or sickness.

Through our continued working with caregivers suffering the effects of secondary traumatic stress and burnout, we have been able to distill two primary principles of treatment and prevention that lead to a rapid resolution of symptoms and sustained resilience from future symptoms. These two important principles, which have become the underlying goals for our work in the area of compassion fatigue, are: 1) the development and maintenance of intentionality, through a non-anxious presence, in both personal and professional spheres of life, and 2) the development and maintenance of self-validation, especially

self-validated caregiving. We have found, in our own practices and with the caregivers that we have treated, that when these principles are followed, not only do negative symptoms diminish, but quality of life is also significantly enhanced and refreshed as new perspectives and horizons begin to open.

Suggestions for Compassion Fatigue Prevention and Resiliency

If you or someone you know is experiencing symptoms of compassion fatigue, the following suggestions may be helpful. Please check with your family physician to assure that there are no physical illnesses associated with these symptoms first.

- **Become more informed.** Read Figley[13], Stamm[62] and/or Pearlman & Saakvitne[49] to learn more about the phenomena of compassion fatigue, vicarious traumatization, and secondary traumatic stress. One book that is especially helpful is *Transforming The Pain: A Workbook on Vicarious Traumatization* by Saakvitne and Perlman.[53]

- **Join a Traumatic Stress Study Group.** A weekly, bi-weekly or monthly meeting of trauma practitioners can become an excellent sanctuary in which the caregiver can both share (therefore diluting) traumatic stories as well as receive support. Check with the International Society for Traumatic Stress (www.istss.org) for a group that may meet in your area, or start one of your own. There are several on-line support resources also. You can find some of these resources through the excellent David Baldwin's Trauma Pages (www.trauma-pages.com) in the "Resources" section.

- **Begin an exercise program today** (see your physician first). Exercise is one of the most important ingredients to effectively manage stress and anxiety and keeps us buoyant and energized while working with heinous trauma.

- **Teach your friends and peers how to support you.** Don't rely upon random remarks from friends and colleagues to be helpful. Instead, let them know what is most helpful for you during times of stress and pain. You may choose to offer the same to them in a reciprocally supportive arrangement. Periodic or regular professional supervision may also be helpful, especially during a rough time.

- **Develop your spirituality.** This is different than going to church, although church may be part of your spirituality. Spirituality is your ability to find comfort, support, and meaning from a power greater than yourself. We have found this quality necessary for the development of self-soothing capacity. Meditation, Tai Chi, church/synagogue, Native American rituals, journaling, and workshops are all examples of possible ways in which to enhance one's spirituality.

- **Bring your life into balance.** Remember that your best is ALWAYS good enough. You can only do what you can do so when you leave the office after 8 hours of work…leave the office! Perseverating on clients and their situations is not helpful to them, you, or your family. You can most help your clients by refueling and refilling yourself while not at the office. Live your life fully!

- **Develop an artistic or sporting discipline.** Take lessons and practice as well as play and create. These are integrative and filling experiences. It is paradoxical that when we feel drained that we need to take action instead of sinking into the sedentary "couch potato." Taking action will be rewarded with a greater sense of refreshment and renewal, while activity avoidance will leave us even more vulnerable to the effect of stress the next day.

- **Be kind to yourself.** If you work with traumatized individuals, families, and/or communities, your life is hard enough already. You do not need to make it more difficult by coercive and critical self-talk. In order to become and remain an effective traumatologist, your first responsibility is keeping your instrument in top working condition. Your instrument is YOU, and it needs caring for.

- **Seek short-term treatment.** A brief treatment with some of the accelerated trauma techniques (i.e., EMDR) can rapidly resolve secondary traumatic stress symptoms. If you would like assistance in finding a Certified Compassion Fatigue Specialist in your area, please contact the International Traumatology Institute at (813) 974-1191.

Conclusion

There is little doubt that the extensive efforts that caregivers devote to assisting those affected by illness and traumatic events are, more often than not, heroic. For the first time in the history of our planet, we are beginning to accumulate sufficient knowledge, skills, and resources to facilitate recovery and healing from terrible illnesses and traumatic events such as the attacks of September 11th, 2001. This is not to say that we will not all have painful losses to accommodate or indelible psychological scars--but we do recover. It is a humbling experience to participate, on any level, in this healing.

From our experience with the health professionals, emergency service workers, and professional caregivers who have served the survivors of the Murrah building bombing in Oklahoma City since 1995, we also know that there will be casualties in this effort. Many kind and good-hearted service professionals, caregivers, friends and family members who have witnessed the pain, grief, and terror in their service to survivors will themselves end up wrestling with encroaching intrusive images, thoughts, and feelings from these interactions in the weeks, months, and years ahead.

Compassion fatigue is an area of study that is in its infancy. Therefore, very little empirical research has yet been published in this important area. However, the empirical research that does exist and the stories of hundreds of suffering caregivers provides us with evidence that compassion fatigue, and its painful symptoms, are a very real phenomenon.[6,9,18,54,58] These symptoms carry with them the potential to disrupt, dissolve, and destroy careers, families, and even lives (many of us grieve the loss of at least one colleague who has committed suicide), and should be treated with great respect. Often, it seems, those who suffer most from compassion fatigue are those individuals who are highly motivated to bring about change and healing in the lives of the suffering. It is especially painful to witness the progressive debilitation of these loving caregivers, who are often our very close friends. Without a doubt, many hundreds, if not thousands, of health professionals, caregivers, and emergency service workers provide hour after hour of intensive and life-altering service to those affected by illness, injury, and trauma. Finding the ways and means to both thoroughly study these effects and, maybe more importantly, provide rapidly effective and empirically validated treatment for these suffering heroes, will become a crucial task toward our nation's healing.

The good news is that the symptoms of compassion fatigue appear to be very responsive to being treated and rapidly ameliorated.[27,49] While substantially more research in this area will be required before we can offer definitive statements about the nature of treatment, prevention and resiliency with compassion fatigue, some principles and techniques discussed here offer a foundation for helping caregivers resolve their current symptoms and prevent future occurrences. Moreover, we have witnessed that for numerous caregivers, the symptoms of compassion fatigue becoming a powerful catalyst for change. With skilled intervention and determination, care providers with compassion fatigue can undergo a profound transformation--leaving them more empowered and resilient than they were previously, and therefore better equipped to act as and remain "givers of light."

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