Appendix B

Articles on Compassion Fatigue

Low Impact Disclosure - How to stop sliming each other

by Françoise Mathieu

> *"Helpers who bear witness to many stories of abuse and violence notice that their own beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material."* (Pearlman et al, 1995)

After a difficult session…

Are you sliming your colleagues? Are you being slimed?
Can you still be properly debriefed if you don't give all the graphic details of the trauma story you have just heard from a client? Would you like to have a strategy to gently prevent your colleagues from telling you too much information about their trauma exposure? (For those of you who are slightly grammatically challenged, the "iming" in sliming is pronounced the same way one pronounces slime, not limb (therefore slimeing not slimming). This is not about weight reduction though you may lose a few pounds of other peoples' baggage through this strategy…)

When helpers hear and see difficult things in the course of their work, the most normal reaction in the world is to want to debrief with someone, to alleviate a little bit of the burden that they are carrying. It is healthy to turn to others for support and validation. The problem is that we are often not doing it properly. The problem is also that colleagues don't always ask us for permission before debriefing their stories with us.

Two kinds of debriefing

Many helpers acknowledge that they occasionally share sordid and sometimes graphic tales of the difficult stories they have heard with one another in formal and less formal debriefing situations. Debriefing is an important part of the work that we do: it is a natural and important process in dealing with disturbing material.

There are two kinds of debriefing that take place among helpers: the informal debriefing, which often takes place in a rather ad hoc manner, whether it be in a colleague's office at the end of a long day, in the staff lunchroom, the police cruiser or during the drive home, and the second form of debriefing which is a more formal process, and is normally scheduled ahead of time (peer consultations, supervision, critical incident stress debriefing).

Part of the problem with formal debriefing or pre-booked peer supervision is the lack of immediacy. When I have heard something disturbing during a clinical day, I need to talk about it to someone there and then or at least during the same day. I used to work at an agency where peer consultation took place once a month. Given that I was working as a crisis counsellor, I almost never made use of this time for debriefing (or much of anything else) as my work was very live and immediate. A month was a lifetime for the crises I witnessed. This is one of the main reasons why helpers take part in informal debriefing instead. They grab the closest trusted colleague and unload on them.

A second problem for some of us is the lack of satisfactory supervision. If I came and administered a satisfaction scale right after you leave your supervisor's office, I am sure that you would be able to give me a rating on how satisfying/useful that process was for you. Sadly, the score is often rather low for a variety of reasons (having sufficient time, skill level of the supervisor, the quality of your relationship with them, trust etc).

Are you being Slimed during informal debriefs?

The main problem with informal debriefs is that the listener, the recipient of the traumatic details, rarely has a choice in receiving this information. Therefore, they are being slimed rather than taking part in a debriefing process. Therein lies the problem AND the solution.

Contagion

Sharing graphic details of trauma stories can actually help spread vicarious trauma to other helpers and perpetuate a climate of cynicism and hopelessness in the workplace. Helpers often admit that they don't always think of the secondary trauma they may be unwittingly causing to the recipient of their stories. Some helpers (particularly trauma workers, policy, fire and ambulance workers) tell me this is a "normal" part of their work and that they are desensitized to it.

Four key strategies to slow the progress of slime

In their book *Trauma and the Therapist: Countertransference and Vicarious Traumatization in psychotherapy with incest survivors*, Laurie Pearlman and Karen Saakvitne put forward the concept of "limited disclosure" which can be a strategy to mitigate the contamination effect of helpers informally debriefing one another during the normal course of a day.

I have had the opportunity to present this strategy to hundreds of helping professionals over the past 8 years, and the response has been overwhelmingly positive. Almost all helpers acknowledge that they have, in the past, knowingly

and unknowingly traumatized their colleagues, friends and families with stories that were probably unnecessarily graphic.

Over time, it was renamed Low Impact Disclosure (LID). What does it look like exactly?

Low impact disclosure proposes that we conceptualise our traumatic story as being contained behind a tap. We then decide, via the process described below, how much information we will release and at what pace. Simple as that.

Let's walk through the process of LID. It involves four key steps: self-awareness, fair warning, consent and low impact disclosure.

1) Increased Self Awareness
How do you debrief when you have heard or seen hard things?
Take a survey of a typical work week and note all of the ways in which you formally and informally debrief yourself with your colleagues. Note the amount of detail you provide them with (and they you), and the manner in which this is done: do you do it in a formal way, at a peer supervision meeting, or by the water cooler? What is most helpful to you in dealing with difficult stories?

2) Fair Warning
Before you tell anyone around you a difficult story, you must give them fair warning. This is the key difference between formal debriefs and ad hoc ones: If I am your supervisor, and I know that you are coming to tell me a traumatic story, I will be prepared to hear this information (for more on this read Babette Rothschild's newest book *Help for the Helper*, where she explores the concept of trauma exposure and helper preparedness)

3) Consent
Once you have given warning, you need to ask for consent. This can be as simple as saying: "I need to debrief something with you, is this a good time?" or "I heard something really hard today, and I could really use a debrief, could I talk to you about it?" The listener then has a chance to decline, or to qualify what they are able/ready to hear. For example, if you are my work colleague I may say to you: "I have 15 minutes and I can hear some of your story, but would you be able to tell me what happened without any of the gory details?" or "Is this about children (or whatever your trigger is)? If it's about children then I'm probably the wrong person to talk to, but otherwise I'm fine to hear it."

4) Low Impact Disclosure
Now that you have received consent from your colleague, you can decide how much of the tap to turn on. Imagine that you are telling a story starting with the outer circle of the story (i.e. the least traumatic information) and you are slowly moving in toward the core (the very traumatic information) at a gradual pace. You

may, in the end, need to tell the graphic details, or you may not, depending on how disturbing the story has been for you.

Questions to ask yourself before you share graphic details:

Is this conversation a:
Debriefing?
Case consultation?
Fireside chat?
Work lunch?
Parking lot chat?
Children's soccer game (don't laugh, it's been done)
Xmas party?
Pillow talk?
Other…

Is the listener:
Aware that you are about to share graphic details?
Able to control the flow of what you are about to share with them?

If it is a case consultation or a debriefing:
Has the listener been informed that it is a debriefing, or are you sitting in their office chatting about your day? Have you given them fair warning?

How much detail is enough? How much is too much?

If this is a staff meeting or a case conference, is sharing the graphic details necessary to the discussion? Sometimes it is, often it is not. E.g.: discussing a child being removed from the home, you may need to say "The child suffered severe neglect and some physical abuse at the hands of his mother" and that may be enough, or you may in certain instances need to give more detail for the purpose of the clinical discussion. Don't assume you need to disclose all the details right away.

Final words: I would recommend applying this approach to all conversations we have. In social settings, even if it's a work dinner or something with all trauma workers, think to yourself; is this too much trauma information to share?

Some additional suggestions:
Experiment with Low Impact Disclosure (LID) and see whether you can still feel properly debriefed without giving all the gory details. You may find that at times you do need to disclose all the details, which is an important process in staying healthy as helpers, and at other times you may find that you did not need this.

Have an educational session followed by conversation at your workplace about this concept.

Low Impact Disclosure is a simple and easy CF protection strategy. It aims to sensitize helpers to the impact that sharing graphic details can have on themselves and their colleagues.

What to expect:
Not everyone will receive this well (like any boundary setting that we do).
All those of you who are social workers, psychologists and mental health counsellors, return to your Family Therapy 101 course. Remember what Minuchin and his friends said about family systems? That systems like status quo (even if it is dysfunctional) and that most systems are highly resistant to change even if this change is for the better in the long term. The same applies to this new boundary setting strategy. Expect some resistance among your coworkers, but don't give up.

Originally posted on www.compassionfatiguesolutions.com

Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers

By Françoise Mathieu, M.Ed., CCC., Compassion Fatigue Specialist

Dr Charles Figley, world renowned trauma expert and pioneer researcher in the field of helper burnout has called compassion fatigue a "disorder that affects those who do their work well" (1995) It is characterized by deep emotional and physical exhaustion, symptoms resembling depression and PTSD and by a shift in the helper's sense of hope and optimism about the future and the value of their work. The level of compassion fatigue a helper experiences can ebb and flow from one day to the next, and even very healthy helpers with optimal life/work balance and self care strategies can experience a higher than normal level of compassion fatigue when they are overloaded, are working with a lot of traumatic content, or find their case load suddenly heavy with clients who are all chronically in crisis.

Compassion fatigue can strike the most caring and dedicated nurses, social workers, physicians and personal support workers alike. These changes can affect both their personal and professional lives with symptoms such as difficulty concentrating, intrusive imagery, loss of hope, exhaustion and irritability. It can also lead to profound shifts in the way helpers view the world and their loved ones. Additionally, helpers may become dispirited and increasingly cynical at work, they may make clinical errors, violate client boundaries, lose a respectful stance towards their clients and contribute to a toxic work environment.

It has been shown that, when we are suffering from compassion fatigue, we work more rather than less. What suffers is our health, our relationship with others, our personal lives and eventually our clients.

Assessing your own level of Compassion Fatigue

If would you like to assess your current level of Compassion Fatigue, visit Beth Stamm's website: www.isu.edu/~bhstamm/tests.htm. Dr Stamm and Charles Figley have developed a self-test called the Proquol (professional quality of life) that can be accessed via this site. They not only look at Compassion Fatigue, they also assess helpers' level of *compassion satisfaction* which is "about the pleasure you derive from being able to do your work well." (Stamm, 1999) I have affectionately nicknamed this test "the thingy" as I find the name ProQuol rather unwieldy. If you are interested in obtaining a free self scoring excel version of this test, email our autoresponder: thingy@aweber.com and you will instantly receive the excel version, which is far easier to use than the original version.

Developing an Early Warning System for Yourself

I believe that compassion fatigue is a normal consequence of working in the helping field. The best strategy to address compassion fatigue is to develop excellent self care strategies, as well as an early warning system that lets you know that you are moving into the caution zone of Compassion Fatigue.

For the past 7 years, I have been training and assisting helpers in developing a better understanding of this complex occupational hazard. Here is a sample of my favourite self care strategies to transform compassion fatigue into compassion satisfaction.

Top 12 Self-Care Tips for Helpers

1.Take Stock-What's on your plate?

You can't aim to make changes and improvements without truly knowing where the problem areas are. Start by taking a nonjudgmental inventory of where things are at in your life. Make a list of all the demands on your time and energy (Work, Family, Home, Health, Volunteering, other). Try to make this list as detailed as you can. E.g.: Under the Work category, list the main stressors you see (number of clients, or, amount of paperwork, or difficult boss, etc).

Once you have the list, take a look at it. What stands out? What factors are contributing to making your plate too full? Life situations or things you have taken on? What would you like to change most? If you are comfortable sharing this with a trusted friend or colleague, have a brainstorming discussion with them on strategies and new ideas. A counsellor or coach can also help you with this exercise. If you would like to read more on this, we highly recommend reading Cheryl Richardson's excellent book "**Take time for your life**" (1998).

2. Start a Self-Care Idea Collection

This can be fun. You can do it with friends and at work.
With friends: Over a glass of wine or a cappucino, interview three friends on their favourite self-care strategies. Start making a list even if they are not ideas that you would do/are able to afford at the moment. Something new might emerge that you had not yet thought of.

At work: If you are doing this at work, you could even start a contest for the best self care idea of the week or have a "self care board" where people post their favourite ideas. You could have a "5 minutes of self care" at each staff meeting, where someone is in charge of bringing a new self care idea each week.

Once you have a really nice long list, pick three ideas that jump out at you. Make a commitment to implementing these in your life within the next month. Ask a friend/colleague if they would commit to supporting you (and you them) in maintaining your self care goals. This could mean that they go to the gym with you every Thursday, or that they email you at lunch to remind you to get out of your office. This is a wonderful way to stay on track and to validate your own experiences by sharing them.

3. Find time for yourself every day – Rebalance your workload

Do you work straight through lunch? Do you spend weekends running errands and catching up on your week without ever having 20 minutes to sit on the couch and do nothing? Can you think of simple ways to take mini breaks during a work day? This could simply be that you bring your favourite coffee cup to work, and have a ritual at lunch where you close your door (if you have a door) and listen to 10 minutes of your favourite music. A friend of mine has a nap on her yoga mat at work during her lunch break. What would work for you?

Not everyone has control over their caseload, but many of us do, providing we see all the clients that need to be seen. Would there be a way for you to rejig your load so that you don't see the most challenging clients all in a row?

Make sure you do one nourishing activity each day. This could be having a 30 minute bath with no one bothering you, going out to a movie, or it could simply mean taking 10 minutes during a quiet time to sit and relax. Don't wait until all the dishes are done and the counter is clean to take time off. Take it when you can, and make the most of it. Even small changes can make a difference in a busy helper's life.

4. Delegate - learn to ask for help at home and at work

Here is a home-based example: Have you ever taught a 4 year old how to make a sandwich? How long would it take you to make the same sandwich? Yes, you would likely make it in far less time and cause far less mess in the kitchen, but at the end of the day, that four year old will grow into a helpful 10 year old, and one day, you won't have to supervise the sandwich making anymore. Are there things that you are willing to let go of and let others do their own way? Don't expect others to read your mind: consider holding a regular family meeting to review the workload and discuss new options. Think of this: If you became ill and were in hospital for the next two weeks, who would look after things on the home front?

5. Have a transition from work to home

Do you have a transition time between work and home? Do you have a 20 minute walk home through a beautiful park or are you stuck in traffic for two hours? Do you walk in the door to kids fighting and hanging from the curtains or

do you walk into a peaceful house? Do you have a transition process when you get home? Do you change clothes?

Helpers have told us that one of their best strategies involved a transition ritual of some kind: putting on cozy clothes when getting home and mindfully putting their work clothes “away” as in putting the day away as well, having a 10 minute quiet period to shift gears, going for a run. One workshop participant said that she had been really missing going bird watching, but that her current life with young children did not allow for this. She then told us that her new strategy would be the following: From now on, when she got home from work, instead of going into the house straight away, she would stay outside for an extra 10 minutes outside, watching her birdfeeders. Do you have a transition ritual?

6. Learn to say no (or yes) more often

Helpers are often attracted to the field because they are naturally giving to others, they may also have been raised in a family where they were expected to be the strong supportive one, the parental child etc.

Are you the person who ends up on all the committees at work? Are you on work-related boards? Do you volunteer in the helping field as well as work in it? Are you the crisis/support line to your friends and family? It can be draining to be the source of all help for all people. As helpers, we know that learning to say no is fraught with self esteem and other personal issues and triggers. Do you think you are good at setting limits? If not, this is something that needs exploring, perhaps with a counsellor. Can you think of one thing you could do to say no a bit more often?

Conversely, maybe you have stopped saying yes to all requests, because you are feeling so depleted and burned down, feel resentful and taken for granted. Have you stopped saying yes to friends, to new opportunities?

Take a moment to reflect on this question and see where you fit best: Do you need to learn to say no or yes more often?

7. Assess your Trauma Inputs

Do you work with clients who have experienced trauma? Do you read about, see photos of, and are generally exposed to difficult stories and images at your work? Take a *trauma input survey* of a typical day in your life. Starting at home, what does your day begin with? Watching morning news on tv? Listening to the radio or reading the paper? Note how many disturbing images, difficult stories, actual images of dead or maimed people you come across.

Now look at your work. Not counting direct client work, how many difficult stories do you hear, whether it be in a case conference, around the water cooler debriefing a colleague or reading files?

Now look at your return trip home. Do you listen to the news on the radio? Do you watch tv at night? What do you watch? If you have a spouse who is also in the helping field, do you talk shop and debrief each other?

It is important to recognize the amount of trauma information that we unconsciously absorb during the course of a day. Many helpers whom we meet say that they are unable to watch much of anything on television anymore, other than perhaps the cooking channel. Others say the reverse, that they are so desensitized that they will watch very violent movies and shows and feel numb when others around them are clearly disturbed by it.

In a nutshell, there is a lot of extra trauma input outside of client work that we do not necessarily need to absorb or to hear about. We can create a “trauma filter” to protect ourselves from this extraneous material.

8. Learn more about Compassion Fatigue and Vicarious Trauma

Compassion Fatigue (CF) and Vicarious Trauma (VT) are serious, profound changes that happen when helpers do their best work. Learn more about CF and VT, including ways to recognise the signs and symptoms and strategies to address the problem. Consider attending a workshop or read more on the topic. Visit our website for more information: www.compassionfatigue.ca or email us: whp@cogeco.ca

9. Consider Joining a Supervision/Peer Support Group

Not all places of work offer the opportunity for peer support. You can organise such a group on your own (whether it be face to face meetings or via email or phone). This can be as small as a group of three colleagues who meet once a month or once a week to debrief and offer support to one another.

10. Attend Workshops/Professional Training Regularly

Helpers with severe compassion fatigue often speak of feeling de-skilled and incompetent. Researchers in the field of CF and VT have identified that attending regular professional training is one of the best ways for helpers to stay renewed and healthy. There are of course several benefits to this: connecting with peers, taking time off work, and building on your clinical skills. Identify an area of expertise that you want to hone. If you are not able to travel to workshops, consider taking online courses.

11. Consider working part time (at this type of job)

Managers often cringe when we say this in our workshops, but studies have shown that one of the best protective factors against Compassion Fatigue is to work part time or at least, to see clients on a part time basis and to have other duties the rest of the time. There are some excellent books on this topic, such as ***Your money or your life*** by Joe Dominguez and Marsha Sinetar's ***Do what you love and the money will follow.***

12. Exercise

We tell our clients how important physical exercise is. Do you do it on a regular basis? Can you think of three small ways to increase your physical activity? One busy counselling service hired a yoga instructor to come once a week to their office and everyone chipped in their 10$ and did yoga together at lunch. Another agency said that they had created a walking club, and that a group of helpers walk outside for 30 minutes three times a week. The key to actually increasing physical exercise is to be realistic in the goals we set out for ourselves. If you don't exercise at all, aiming to walk around the block twice a week is a realistic goal, running a 10km run in two weeks is not.

Conclusion: "Dig where the ground is soft" *Chinese proverb*

When I was training in couples counseling with Dr Les Greenberg, he always used to say "when you are working with couples, dig where the ground is soft. Work with the client who seems most ready to change, not with the client who seems most closed and defensive." Instead of picking your trickiest area, pick the issue that you can most easily visualise improving on. (e.g. "making a commitment to going for a walk every lunch time vs. getting rid of my difficult supervisor").

You may not notice it right away, but making one small change to your daily routine can have tremendous results in the long term. Imagine if you started walking up two flights a stairs per day instead of using the elevator, what might happen after three months?

For more information on Compassion Fatigue Workshops and resources:
Contact Françoise Mathieu at: compfatigue@gmail.com
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Françoise Mathieu is a Certified Mental Health Counsellor and Compassion Fatigue Specialist. She works individually with clients in private practice and offers workshops and consultation to agencies on topics related to compassion fatigue, wellness and self care. She and a colleague created Cameron & Mathieu

Consulting in 2001 (now called Compassion Fatigue Solutions inc.) to provide workshops to helpers with a focus on personal and professional renewal.

CF Solutions inc. offers practical, skill-based workshops on various topics related to compassion fatigue, burnout and stress management. For more information and resources, contact Françoise Mathieu: (613) 547-3247; compfatigue@gmail.com or visit our website: www.compassionfatigue.ca.

Recommended books on Compassion Fatigue and Vicarious Trauma:

Mathieu, F., (2012) The Compassion Fatigue Workbook. New York: Routledge.

Figley, C.R. (Ed.). (1995) Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.

McCann, I.L.; & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3: 131 - 149.

Stamm, B.H. (Ed.). (1999). Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators, 2nd Edition. Lutherville, MD: Sidran Press.

Recommended Self-Care books for Helpers:

Borysenko, J. (2003) Inner peace for busy people: 52 simple strategies for transforming your life.

Fanning, P. & Mitchener, H. (2001) The 50 best ways to simplify your life

Jeffers, S. (1987) Feel the fear and do it anyway.

O'Hanlon, B. (1999) Do one thing different: 10 simple ways to change your life.

Posen, D. (2003) Little book of stress relief.

Richardson, C. (1998) Take time for your life.

SARK, (2004) Making your creative dreams real: a plan for procrastinators, perfectionists, busy people, avoiders, and people who would rather sleep all day.

Weiss , L. (2004) Therapist's Guide to Self-care.

Running on Empty:
Compassion Fatigue in Health Professionals

By Françoise Mathieu, M.Ed., CCC. Compassion Fatigue Specialist

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> "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (Remen, 1996)

What is compassion fatigue?

Our primary task as helping professionals is first and foremost to meet the physical and/or emotional needs of our clients and patients. This can be an immensely rewarding experience, and the daily contact with patients is what keeps many of us working in this field. It is a Calling, a highly specialized type of work that is unlike any other profession. However, this highly specialised rewarding profession can also look like this: Increasingly stressful work environments, heavy case loads and dwindling resources, cynicism and negativity from co-workers, low job satisfaction and, for some, the risk of being physically assaulted by patients.

Compassion Fatigue has been described as the "cost of caring" for others in emotional and physical pain. (Figley, 1982) It is characterized by deep physical and emotional exhaustion and a pronounced change in the helper's ability to feel empathy for their patients, their loved ones and their co-workers. It is marked by increased cynicism at work, a loss of enjoyment of our career, and eventually can transform into depression, secondary traumatic stress and stress-related illnesses. The most insidious aspect of compassion fatigue is that it attacks the very core of what brought us into this work: our empathy and compassion for others.

Who does it affect?

Compassion fatigue is an occupational hazard, which means that almost everyone who cares about their patients/clients will eventually develop a certain amount of it, to varying degrees of severity. Statistics Canada recently published their first ever National Survey of the Work and Health of Nurses (2005) which found that "close to one-fifth of nurses reported that their mental health had made their workload difficult to handle during the previous month." In the year before the survey, over 50% of nurses had taken time off work because of a physical illness, and 10% had been away for mental health reasons. Eight out of ten

nurses accessed their EAP (employee assistance program) which is over twice as high as EAP use by the total employed population. In addition, nurses reported on the job violence and were found “more likely to experience on the job violence than all other professions.” (ONA, 2006) A study of Cancer Care Workers in Ontario carried out in 2000 also found high levels of burnout and stress among oncology workers and discovered that a significant number of them were considering leaving the field: 50% of physicians and 1/3 of other cancer care professionals had high levels of emotional exhaustion and low levels of personal accomplishment. (Grunfeld 2000) Similar findings have been found among other helping professionals such as child protection workers, law enforcement, counselors and prison guards. (Figley, 2006)

Signs and Symptoms of Compassion Fatigue

Each individual will have their own warning signs that indicate that they are moving into the danger zone of compassion fatigue. These will include some of the following:

Exhaustion
Reduced ability to feel sympathy and empathy
Anger and irritability
Increased use of alcohol and drugs
Dread of working with certain clients/patients
Diminished sense of enjoyment of career
Disruption to worldview, Heightened anxiety or irrational fears
Intrusive imagery or dissociation
Hypersensitivity or Insensitivity to emotional material
Difficulty separating work life from personal life
Absenteeism – missing work, taking many sick days
Impaired ability to make decisions and care for clients/patients
Problems with intimacy and in personal relationships

Drs Figley and Stamm have developed a Compassion Fatigue self-test called the ProQuol that can be taken online to assess one’s own level of CF. It is considered the most effective screening tool to date: www.isu.edu/~bhstamm/tests.htm. You can also access a very easy self-scoring excel version of it by emailing me at: thingy@aweber.com. I affectionately renamed the ProQuol “thingy” as I found the original name rather unwieldy.

Learning to recognise one’s own symptoms of compassion fatigue has a two-fold purpose: firstly, it can serve as an important “check-in” process for a helper who has been feeling unhappy and dissatisfied, but did not have the words to explain what was happening to them, and secondly, it can allow them to develop a warning system for themselves.

Say, for example, that a helper was to learn to identify their compassion fatigue symptoms on a scale of 1 to 10 (10 being the worst they have ever felt about their work/compassion and 1 being the best they have ever felt) and they learned to identify what an 8 or a 9 looks like for them (i.e.: " when I'm getting up to an 8, I notice it because I don't return phone calls, think about calling in sick a lot and can't watch any violence on tv" or "I know that I'm moving towards a 7 when I turn down my best friend's invitation to go out for dinner because I'm too drained to talk to someone else, and when I stop exercising." Being able to recognize that one's level of compassion fatigue is creeping up to the red zone is the most effective way to implement strategies immediately before things get worse.

Contributing Factors

As a Compassion Fatigue Specialist, I offer training, counselling and consultation to helpers across the country. During these workshops, I have heard the stories of hundreds of resilient therapists, nurses, midwives, personal support workers, correctional workers, ministers, physicians, psychologists, social workers and students in these professions. What we have discovered through these conversations is that compassion fatigue exists on a continuum, meaning that at various times in our careers, we may be more immune to its damaging effects and at other times feel very beaten down by it. Within an agency, there will be, at any one time, helpers who are feeling well and fulfilled in their work, a majority of people feeling some symptoms and a few people feeling like there is no other answer available to them but to leave the profession. Many factors contribute to this continuum: personal circumstances and the helper's work situation.

Current life circumstance

The helper's current life circumstance, their history, coping style and personality style all affect how compassion fatigue works its way through. In addition to working in a challenging profession, most helpers have other life stressors to deal with. Many are in the "sandwich generation" meaning that they take care of both young children and aging parents. Helpers are not immune to pain in their own lives and in fact some studies show that they are more vulnerable to life changes such as divorce and difficulties such as addictions than people who do less stressful work.

Working conditions

Helpers participating in compassion fatigue sessions will often say "I don't have any problems with my clients/patients, in fact, I love my client work, it's everything around it at work that is grinding me down." It is clear that clients and their stories are not always the main source of stress for helpers -it's also the paperwork, the new computerized time tracking system they have to learn, and, let's not forget, the 10th "restructuring/merging with the agency next door/new executive director/best practice remodel that an agency is going through for the 4th time in 10 years. Moreover, helpers often do work that other people don't want to hear about, or spend their time caring for people who are not valued or understood in our society, (for example, individuals who are homeless, abused,

incarcerated or chronically ill). The working environment is often stressful and fraught with workplace negativity as a result of individual compassion fatigue and unhappiness.

What can be done to prevent Compassion Fatigue?

Compassion Fatigue is a treatable problem providing we recognise the signs and symptoms early and that the level of intervention is appropriate to the level of compassion fatigue present in the helper. There are strategies and solutions both at the personal and at the organizational level.

Organizational Strategies
There are many simple and effective strategies that helpers can implement to protect themselves from compassion fatigue. First, by openly discussing and recognizing compassion fatigue in the workplace, helpers can normalise this problem for one another. They can also work towards developing a supportive work environment that will encourage proper debriefing, regular breaks, mental health days, peer support, assessing and changing workloads, improved access to further professional development and regular check-in times where staff can safely discuss the impact of the work on their personal and professional lives. Research has shown that working part time, or only seeing clients or patients part time and doing other activities the rest of the workday can be a very effective method to prevent compassion fatigue.

Personal
Improved self-care is the cornerstone of compassion fatigue prevention. This may seem obvious, but most helpers tend to put their needs last and feel guilty for taking extra time out of their busy schedules to exercise, meditate or have a massage. On the personal front, helpers need to carefully and honestly assess their life situation: Is there a balance between nourishing and depleting activities in their lives? Do they have access to regular exercise, non-work interests, personal debriefing? Are they caregivers to everyone or have they shut down and cannot give any more when they go home? Are they relying on alcohol, food, gambling, shopping to de-stress? Helpers must recognise that theirs is highly specialised work and their home lives must reflect this.

Developing a Compassion Fatigue Prevention Toolkit for yourself

In our workshops, we encourage helpers to design a prevention toolkit that will reflect their own reality and that will integrate their life circumstances and work challenges. This is a very individual process – your self-care strategies may not work for your neighbour and vice versa. Here are some key questions to ask yourself to start the process:

What would go in that toolkit?

What are my warning signs – on a scale of 1 to 10, what is a 4 for me, what is a 9?
Schedule a regular check in, every week – how am I doing?
What things do I have control over?
What things do I not have control over?
What stress relief strategies do I enjoy? (taking a bath, sleeping well or going for a massage)

What stress reduction strategies work for me? Stress reduction means cutting back on things in our lives that are stressful (switching to part time work, changing jobs, rejigging your caseload, etc.)
What stress resiliency strategies can I use? Stress resiliency are relaxation methods that we develop and practice regularly, such as meditation, yoga or breathing exercises.

What if those strategies aren't enough?

Compassion Fatigue can lead to very serious problems such as depression, anxiety and suicidal thoughts. When this happens you deserve to have help. Talk to your physician about options such as counselling. In addition to the strategies described above, there are effective treatment modalities available to helpers with more severe compassion fatigue. Compassion fatigue counselling needs to focus on a combination of screening for and treating depression and secondary traumatic stress as well as developing an early detection system to prevent relapse. The focus is also on assessing work/life balance and developing strategies to deal with difficult case loads and repeated exposure to traumatic material. We recommend reading Charles Figley, Beth Stamm and Saakvitne's books for more information on this. When looking for a counsellor, be sure to ask them if they are familiar with treating compassion fatigue.

What if I think that someone close to me is suffering from cf?

A helpful strategy is right in the name, have compassion! No one likes to feel blamed, unfortunately one negative effect of the work that has been done in this area is that some helpers have felt blamed for their compassion fatigue. They have received a strong message from their workplace, "if you feel burnt out, it means you are not taking good enough care of yourself". This can further silence people in pain and ignores a key contributing factor that most individual helpers have no or little control over (caseloads etc). Be kind and supportive and start small, it can be hard to hear that something you have been trying to hide is obvious to others. Talking about the effects of the work can be helpful and a good entry point.

Conclusion

Developing compassion fatigue is a gradual, cumulative process and so is healing from its effects. A few people can be fully restored by taking a holiday or

going for a massage but most of us need to make life changes and put our own health and wellness at the top of the priority list.

The Author
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Recommended Self-Care books for Helpers:

Borysenko, J. (2003) Inner peace for busy people: 52 simple strategies for transforming your life.

Fanning, P. & Mitchener, H. (2001) The 50 best ways to simplify your life

Jeffers, S. (1987) Feel the fear and do it anyway.

O'Hanlon, B. (1999) Do one thing different: 10 simple ways to change your life.

Posen, D. (2003) Little book of stress relief.

Richardson, C. (1998) Take time for your life.

SARK, (2004) Making your creative dreams real: a plan for procrastinators, perfectionists, busy people, avoiders, and people who would rather sleep all day.

Mindfulness-Based Stress Reduction: An Important Tool in Mitigating Compassion Fatigue in Helpers

By Françoise Mathieu, September 2009

Mindfulness-Based Stress Reduction (MBSR) is a holistic mind/body approach developed by Jon Kabat-Zinn at the University of Massachusetts Medical Center in 1979. MBSR is "[...] based on the central concept of mindfulness, defined as being fully present to one's experience without judgment or resistance". (Cohen-Katz et al, 2005) The MBSR program recommends using meditation, yoga, relaxation training as well as strategies to incorporate these practices into every day life.

Research on the effectiveness of MBSR is highly conclusive: over 25 year of studies clearly demonstrate that MBSR is helpful in reducing emotional distress and managing severe physical pain. In fact, MBSR has been used successfully with patients suffering from chronic pain, depression, sleep disorders, cancer-related pain and high blood pressure. (Cohen-Katz et al, 2005) Based at Toronto's CAMH, Zindel Segal has developed a mindfulness-based cognitive therapy program for treating depression that has shown to be highly effective.

MBSR and Compassion Fatigue

Researchers recently turned their attention to the interaction between MBSR and compassion fatigue (CF), to see whether MBSR would help reduce CF symptoms among helpers. One study of clinical nurses found that MBSR helped significantly reduce symptoms of CF, as well as helping the subjects be calmer and more grounded during their rounds and interactions with patients and colleagues. (Cohen-Katz et al, 2005) Another study investigated the effects of teaching mindfulness-based stress reduction to graduate students in counseling psychology. The study found that participants in the MBSR program "reported significant declines in stress, negative affect, rumination, state and trait anxiety, and significant increases in positive affect and self-compassion." (Shapiro, 2007)

The Full MBSR Program

"The MBSR is taught as an 8-week program that meets approximately 2.5 hours a week and includes a 6-hour daylong retreat between the 6th and 7th weeks. Participants are asked to practice the mindfulness techniques 6 days a week as "homework" and given audiotapes to facilitate this. Group sessions include a combination of formal didactic instruction on topics such as communication skills, stress reactivity, and self-compassion and experiential exercises to help participants integrate these concepts. The program is described in detail in Kabat-Zinn's textbook "Full Catastrophe Living: Using the Wisdom of Your Body

and Mind to Face Stress, Pain and Illness." (Cohen-Katz et al, 2005)

As you are reading this, you may be thinking: "I don't have time to take part in a 2.5 hour, 8 week program!" Nor do you have to - let's extract the main features of MBSR and see how you might integrate them in your own life routines.

Incorporating MBSR into Your Life

The key strategies of MBSR mirror the best compassion fatigue reduction techniques described in my book The Compassion Fatigue Workbook: developing self-awareness, self-regulation (how to cope when events are overwhelming and/or stressful) and how to balance the competing demands in our lives. (Shapiro, 2007)

In the Shapiro study with counseling students, five mindfulness practices were taught, adapted from Kabat-Zinn's program:

1) Sitting meditation: This is the cornerstone of MBSR - To develop, over time, a sitting meditation that is done daily, if possible. It involves the "concentration of attention to the sensations of breathing, while remaining open to other sensory events, and to physical sensations, thoughts and emotions."

2) Body scan: A very effective exercise from the field of relaxation training and stress reduction. The full version of the body scan encourages you to focus on each part of your body one after the other, to identify where you are holding tension. This process is normally done lying down, in a quiet room. If time does not allow you to do the full scan, you can also carry out a modified version of the body scan:

Sitting in a quiet, peaceful room, close your eyes and focus on your breathing. Notice what is happening in your body: Working your way down from the top of your head, notice how your jaw, neck and shoulders are feeling at this moment. Remember to keep breathing and, if your mind wanders, gently bring it back. If that is all the time you have, take three, slow deep breaths through your nose and gently open your eyes. If you have more time, work your way down your body, noticing how your shoulders, arms, stomach, calves and toes feel right now.

Where to find the full body scan exercise:

Web: Through Google, I was able to find several audio and scripted body scan exercises in a matter of seconds.

CD: Creating Inner Calm by Mark Berber (only available at Indigo/Chapters, not Amazon)

Books: The Anxiety and Phobia Workbook by Edmund J. Bourne (2000)

3) Hatha Yoga consists of "stretches and postures designed to enhance mindful awareness of the body and to balance and strengthen the musculoskeletal system." (Shapiro, 2007)

4) Guided loving-kindness meditation: A meditation practice which focuses on developing loving acceptance towards oneself and others. You can find examples of loving-kindness meditation on the web.

5) Informal practices: Exploring ways to bring mindfulness into our everyday life (while waiting in line at the grocery story, stuck in traffic, dealing with a challenging patient, etc.)

Want to know more? Where to start?

You can learn more about MBSR on your own or by taking a course or attending a workshop.

On your own

Audio Cds:
Kabat-Zinn has produced a collection of mindfulness meditation CDs that can be purchased on his website and on amazon/indigo. Your local library may also have them. Kabat-Zinn's site also has a useful FAQ which describes the different CDs and guides you on which one to buy. He also has an informative blog and resources.

Books:
Kabat-Zinn, J. (1990) *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.*
Kabat-Zinn, J. (1995) *Wherever you go, there you are: Mindfulness Meditation in Everyday Life*.
Segal, Z. et al (2002) *Mindfulness-Based Cognitive Therapy for Depression.*

Video:
If you can get your hands on it, a good introduction to MBSR is offered in Bill Moyers' 1993 PBS Special "*Healing and the Mind*" featuring Kabat-Zinn in the Stress Reduction Clinic.

Courses/Workshops:
Many mid to large sized cities offer MBSR programs several times a year. Contact your local meditation/yoga centers to see if one is being offered in your community.

Final thoughts

If you are new to meditation practice, the most important thing to remember is that you cannot fail at meditation. There will be times where you can meditate with ease, and other times where your mind will be racing and you will have great difficulty focusing on being mindful. (You may also fall asleep). All of those are part of the process of mindfulness practice. Try not to judge your meditations. Simply try to refocus on your breath and on the meditation itself. It takes time and practice but it could literally save your life.

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