Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization

THE COMPASSION FATIGUE WORKBOOK

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Routledge
Taylor & Francis Group
New York London

Chapter 5

Low-Impact Debriefing: How to Stop Sliming Each Other

> 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.
>
> **—Karen Saakvitne and Laurie Anne Pearlman**
> *Transforming the Pain,* p. 49

In this chapter, you are invited to:

- Read the following article and discuss it with your supervision group and/or work colleagues
- See whether there are ways for you to use Low-Impact Debriefing in your personal and professional life

After a Difficult Session ...

Are you debriefing *all over* your colleagues? Do your colleagues share graphic details of their days with you?

Can you still properly debrief 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?

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. One problem is that we are often not doing it properly. Another problem is that colleagues don't always ask us for permission before debriefing their stories with us.[1]

RESPECTING PATIENT AND CLIENT CONFIDENTIALITY

In some helping professions, patients and clients must sign a consent form indicating whether you have permission to discuss their clinical issues or any content of their file before you discuss their particular case with anyone else. Clients can also clearly specify with whom you are allowed to discuss their case. Respecting client confidentiality is paramount. Even if you have consent, make sure that you are not releasing identifying information unnecessarily. If you live in a small community, it can sometimes be very easy for your colleagues to identify the client you are speaking of. Ask yourself: "how much information do I need to share in order to debrief? Is it really necessary to mention the client's name in this instance, or his occupation?" Taking these extra steps will protect your clients' paramount right to privacy and confidentiality.

Two Kinds of Debriefing

Many helpers acknowledge that they occasionally share sordid and sometimes graphic details 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 occur among helpers: (1) 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, in the police cruiser, or during the drive home; and (2) the debriefing that is a more formal process and is normally scheduled ahead of time and referred to as peer consultations, supervision, or critical incident stress debriefing.

Part of the problem with formal debriefing or scheduled peer supervision is the lack of immediacy. When a helper has heard something disturbing during a clinical day, they usually need to talk about it to someone then and there or at least during the same day. I used to work at an agency where peer supervision took place once a month. Given that I was working as a crisis counselor, I almost never made use of this time for debriefing (or much of anything else) because 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 administered a satisfaction scale right after you left your supervisor's office, I am sure that you would be able to give me a rating on how useful that process was for you. Sadly, for many helpers, the score they would give their supervisor is often rather low for a variety of reasons (having insufficient 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 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 the recipient of their stories. Some helpers (particularly trauma workers, police, and fire and ambulance workers) tell me this is a "normal" part of their work and that they are desensitized to it, but the data on vicarious trauma (VT) show otherwise.

Four Key Strategies to Avoid Retraumatizing Our Colleagues and Loved Ones

In their book *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy With Incest Survivors*, Laurie Anne Pearlman and Karen Saakvitne put forward the concept of "limited disclosure," which is a strategy to mitigate the contamination of helpers informally debriefing one another during the normal course of a day.[2]

I have had the opportunity to present this strategy to hundreds of helping professionals over the past decade, 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, we started referring to the strategy of limited disclosure as low-impact disclosure (LID) or low-impact debriefing. What exactly does LID look like?

Think of the traumatic stories you hear in your work as being contained behind a tap. I invite you to decide, via the process described below, how much information you will release and at what pace.

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

Increased Self Awareness

How do you debrief when you have heard or seen hard things?

Take a survey of a typical workweek and note all of the ways in which you formally and informally debrief with your colleagues. Note the amount of detail you provide them with (and the amount of detail they share with 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?

Fair Warning

Before you tell anyone 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 and it will be less traumatic for me to hear.[3] If I am casually chatting with a colleague about their weekend plans and you barge in and tell us graphic details of a sexual abuse story you just heard, we will be more negatively impacted by the details. In fact, we use fair warning in everyday life: If you had to call your sister and tell her that your uncle has passed away, you would likely start the phone call with "I have some bad news" or "You'd better sit down." This allows the listener to brace themselves to hear the story.

Consent

After you have given warning to the listener, 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 and 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, I'm probably the wrong person to talk to; but otherwise I'm fine to hear it."

Limited Disclosure

Now that you have received consent from your colleague, you can decide how much of the tap to turn on. I suggest imagining that you are telling the story starting on the outer circle of the story (i.e., the least traumatic information) and 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 catch-up?
- Children's soccer game (Sadly, I have seen this.)
- Christmas 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?

Are you participating in a staff meeting or a case conference? Is sharing the graphic details necessary to the discussion? Sometimes it is, but often it is not. For example, when 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.

I would recommend applying this approach to all conversations you have. Ask yourself: Is this too much trauma information to share?

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

SOME ADDITIONAL SUGGESTIONS

- Experiment with low-impact debriefing 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 information; this is often an important process in staying healthy as helpers. At other times, however, you may find that you did not need to disclose all the details.
- Organize an educational session followed by a discussion at your workplace about the concept of low-impact debriefing.

***MAKING IT PERSONAL* HOMEWORK**

Consider bringing this chapter on low-impact debriefing to work and discussing it with your colleagues. Failing that, discuss it with your peer support group. How might low-impact debriefing be received in your respective places of work? Could you identify two or three colleagues who might be willing to adopt LID?

If you wish to provide your colleagues with more information, you can download and print copies of an article that outlines the steps to LID by visiting my Web site: http://compassionfatigue.ca/category/resources/articles-to-download/

What to Expect

Like any other boundary-setting, not everyone will welcome this strategy. All those of you who are social workers, psychologists, and mental health counselors, return to your Family Therapy 101 course. Remember what Minuchin and his friends said about family systems? That systems like status quo 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 strategy. Expect some resistance among your co-workers, but don't give up.

Endnotes

1. Mathieu, F. (2008). Adapted from a post on my blog http://compassionfatigue.ca/low-impact-debriefing-how-to-stop-sliming-each-other/
2. Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
3. Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton.

Chapter 6

Warning Signs of Compassion Fatigue and Vicarious Trauma

> When you're in the red zone of compassion fatigue, a bath ain't gonna cut it!
>
> **—Robin Cameron**
> *(Personal communication, 2003)*

In this chapter, you are invited to:

- Gain a clearer understanding of your own warning signs of compassion fatigue (CF) and vicarious trauma (VT)
- Develop an early detection system for your warning signs
- Identify your "red zone" of CF and VT

I was recently at the drugstore with my 10-year-old son.[1] I was paying for my purchase when an elderly man approached the counter. He appeared to be in his late 80s and had deep red bags under his eyes. He looked, in a word, absolutely terrible. With a shaking hand, he took a photo out of his pocket and showed it to us and to the women behind the cash register. "This is my wife," he said. "She died 2 days ago; we were married for 58 years. She was the love of my life. Now I can't sleep and the doctor wants me to take these pills." We all fell silent for a minute, and then I had a little chat with him. He told me his children all lived out of town and that he was completely alone. When I left the store with my son in tow, I felt regret that I did not do more. My head was already buzzing with all the community resources I know about, how to link him with the right ones, how we should have taken him out for tea, and more. I was dying to case manage this man into getting support right on the spot, but I also had to go home and cook dinner and take care of my family.

This is the constant challenge we face as helpers. Pain and suffering is all around us; it's not just at work. Where do you draw the line? Do you take every elderly widower out for tea? Do you tell every person with a funny-looking mole to go get it checked out? Do you rescue every kitten you see? So what we do is try our best to figure out boundaries. Sometimes we overcorrect and we become like Fort Knox, not letting a single person inside our walls. Sometimes we go too far in the other direction and become ambulance chasers, fostering too many pets and baking for every little old lady on our street.

We need to gain a better understanding of our own warning signs along the continuum of compassion fatigue. Using traffic lights as an analogy, the green zone is where you are when you are at your very best (I sometimes joke that you are only in the green zone when you've been in the field for 2 weeks or when you have just returned from a 5-month yoga retreat in Tahiti). The yellow zone is where most of us live most of the time. We have warning signs emerging but we often ignore them. The red zone is the danger zone. The far end of the red zone finds us on stress leave, clinically depressed or totally withdrawn from others and wracked with anxiety.

We will all visit the less extreme end of the red zone several times in our career—it is a normal consequence of doing a good job.

What suffers first is our emotional and physical health, our family and friends, our colleagues, and eventually our clients. They pay the price as we become less compassionate and irritable, and may make clinical errors.

Learning to recognize your own symptoms of compassion fatigue and vicarious trauma has a twofold purpose: First, it can serve as an important check-in process if you have been feeling unhappy and dissatisfied but did not have the words to explain what was happening to you; and second, it can allow you to develop a warning system for yourself. Developing this warning system allows you to track your levels of emotional and physical depletion. It also offers you tools and strategies that you can implement right away. Let me give you an example:

Say that you were to learn to identify your compassion fatigue symptoms on a scale of 1 to 10 (10 being the worst you have ever felt about your work/compassion, and 1 being the best you have ever felt). Then, you learn to identify what an 8 or a 9 looks like *for you*. For example, "When I'm getting up to an 8, I notice it because I don't return phone calls, I think about calling in sick a lot, and I can't watch any violence on TV," or "I know that I'm moving toward 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 your level of compassion fatigue is creeping up to the red zone is the most effective way to implement strategies immediately before things get worse.

But look back to what also emerges in this process: you are starting to identify the solutions to your depletion.

If I know that I am getting close to an 8, I may not take on new clients with a trauma history, I may take a day off a week, or I may return to seek my own therapist.

Back to my story about the elderly man in the drugstore—I would not have always had this warm compassionate reaction to this man. In fact, my reaction is actually a sign for me that I am well out of the red zone of compassion fatigue (for the time being!). You see, there have been times where I have felt so depleted by all my work demands and difficult stories that I would have hardened myself to this old man's story and not talked to him at all. Have you ever noticed that in yourself, or thought, am I the only hard, crusty person out there? Conversely, for some of you, being in the red zone would mean you would have jumped into rescuing this man and neglected your family's needs for the evening.

Research shows that compassion fatigue hits hardest among those of us who are the most caring.[2] As helpers, we have a homing device for need and pain in others and we have this from childhood onward (for many reasons: family of origin issues, birth order, heredity, etc.) So often for helping professionals the main challenge in their personal life is setting limits and not being a helper or rescuer to everyone around. But eventually, compassion fatigue makes us detach from others: often our colleagues, family, and friends suffer far before our clients and patients. Although I am not proud of it, I know that I always seem to save the best for work and give the remaining crumbs to my loved ones. In my clinical work, I feel present, warm, and loving toward my clients, even with the most challenging soldier who has never wanted to come to counseling and hates being there. But when I am in the red zone, I avoid my neighbors, ducking into my house as quickly as possible to avoid a chat, feeling slightly guilty and irritated at the same time.

Each of us will have different warning signs. The key to developing an early intervention plan is to get better acquainted with your own warning signs.

Your Symptoms

To develop your warning scale, you need to develop an understanding and an increased awareness of your own symptoms of compassion fatigue and vicarious trauma. CF and VT will manifest themselves differently in each of us. In *Transforming the Pain,* Saakvitne and Pearlman have suggested that we look at symptoms on three levels: physical, behavioral, and psychological. Here is a list of warning signs based on a review of the literature to date.[3] I suggest that you begin by reading through the signs and symptoms below and circle those that feel true to you. Remember, this is not a diagnostic test but rather a process whereby we begin to understand our own physical and psychological reactions to the work that we do.

Physical Signs of Compassion Fatigue

- **Physical exhaustion.** Feeling exhausted when you start your day, dragging your feet, coming back to work after a weekend off, and still feeling physically drained. Lipsky calls it, "feeling fatigued in every cell of your being."[4] It's also

important to make the distinction between feeling tired and feeling depleted. I know that one of the ways for me to know that I'm struggling with depletion is that I lose my sense of humor at home and I turn into a drill sergeant. When I'm simply tired, I may need to slow things down at home, but I am still a person I like. Sometimes we are exhausted both emotionally and physically by the work.

- **Insomnia or hypersomnia.** Difficulty falling asleep, early morning awakening, or oversleeping.
- **Headaches and migraines.**
- **Increased susceptibility to illness.** Getting sick more often.
- **Somatization and hypochondria.** *Somatization* refers to the process whereby we translate emotional stress into physical symptoms. Examples are tension headaches, low back pain, gastrointestinal symptoms, stress-induced nausea, unexplained fainting spells, and so forth. The ailments are very real, but the root cause is largely related to emotions and stress. Someone I know has an upset stomach every time she is anxious or stressed. She used to think it was food poisoning but finally had to come to the conclusion that not all restaurants in our fine city could possibly have tainted food.

  Think about which part of your body tells you that you are overloaded. What do you normally do when you get that migraine, eye twitch, or heartburn? Most of us take a pill, ignore it, and keep going. However, eventually, the body keeps the score (to borrow an expression from Bessel van der Kolk). In his book *When the Body Says No: The Cost of Hidden Stress,* Gabor Maté writes about the connection between chronic stress, repressed emotions, and physical illness and states: "Our immune system does not exist in isolation from daily experience."[5] He cites numerous stunning examples of ways in which the immune system is depleted by chronic stress.

  Hypochondriasis refers to a form of anxiety and hypervigilance about potential physical ailments that we may have (or about the health of our loved ones). When it is severe, hypochondria can become a debilitating anxiety disorder. Mild versions of hypochondria can happen to many of us who work in the health care field. If you work in cancer care, particularly at the diagnostic end, you may find yourself overworried about every bump and bruise on your child or yourself, or you may think that everyone with a headache has a brain tumor. The media and the Internet can fuel the flames of hypochondria. Many people who live in Ontario say that they had some mild phantom symptoms of listeria during the summer of 2008 following a large-scale recall of tainted meat due to contamination.

Again, any of these symptoms do not, on their own, constitute a serious problem. The goal here is for you to begin to notice your own susceptibilities and how the work that you do may be contributing to these vulnerabilities.

Behavioral Signs and Symptoms

- **Increased use of alcohol and drugs.** There is evidence that many of us are relying on alcohol, marijuana, or over-the-counter sedatives to unwind after a hard day. Have you seen the size of wine glasses these days? Some of them are bigger than my fishbowl. So the "one glass after work" you are having is possibly half a bottle of wine. Even if you are not addicted to drugs or alcohol, if you are relying on a drink or other substance every night to unwind, then you are likely self-medicating your stress away.

  The difficulty with increased reliance on drugs and alcohol is also that there may be a lot of shame associated with it, and it is not something that we necessarily feel we can disclose to anyone. Is the child protection worker going to tell his supervisor that he smokes a big fat joint every night when he gets home to unwind? Is the nurse going to tell her colleagues that she takes a few Percocets here and there from her mother's medicine cabinet?
- **Other addictions** (shopping, workaholism, compulsive overeating).
- **Absenteeism** (missing work).
- **Anger and irritability.** Anger and irritability are considered two of the key symptoms of compassion fatigue. This can come out as expressed or felt anger toward colleagues, family members, clients, chronic crisis clients, and others. You may find yourself irritated with minor events at work: hearing laughter in the lunch room, announcements at staff meetings, the phone ringing. You may feel annoyed and even angry when hearing a client talk about how they did not complete the homework you had assigned to them. You may yell at your own children for not taking out the garbage. The list goes on and on, and it does not add up to a series of behaviors that make you feel good about yourself as a helper, a parent, or a spouse.

  Try this: Spend a full day tracking your anger and irritability. What do you observe? Any themes or recurrences? Any situations you regret in hindsight or where your irritability was perhaps out of proportion?
- **Exaggerated sense of responsibility.** "I can't leave; people are counting on me."[6] In her book *Trauma Stewardship*, Laura van Dernoot Lipsky suggests that helpers can develop "an inflated sense of importance related to one's work" and become addicted to the need to be needed: "Many people get hooked on involvement in others' lives: solving their problems, becoming a powerful figure for them, getting increasingly attached to the feeling of being needed and useful."[7]
- **Avoidance of clients.** Examples of this can be not returning a client's phone call in a timely fashion, hiding in a broom closet when you see a challenging family walking down the hall, delaying booking a client who is in crisis even though you should see them right away. Again, these are not behaviors that most of us feel proud of or that we are comfortable sharing with our colleagues and supervisors, but they do sometimes occur and then we feel guilty or ashamed, which feeds into the cycle of compassion fatigue.

Many of us work with some very challenging clients. If you do direct client work, I am sure that you can easily conjure up, right now, the portrait of an individual or a family that has severely taxed your patience and your compassion. One telephone crisis worker I once spoke to put it perfectly: "Why on earth is it a thousand times easier for me to talk to 25 different crisis callers in a day than if the same caller calls me 25 times in a row? I am, after all, paid to answer the phone and talk to individuals in crisis for 7 hours a day. That's my job. What is so depleting about the chronic caller?" And, I would add, why do we start feeling particularly irritated, avoidant, and unempathetic toward the chronic caller? The fact of the matter is that there is something inherently depleting about chronic crises. The best solution, if we cannot control our caseload, is to seek more training. The more we understand chronicity, the more compassion we can retain.

- **Impaired ability to make decisions.** This is another symptom that can make a helper go underground. Helpers can start feeling professionally incompetent and start doubting their clinical skills and ability to help others. A more severe form of this can be finding yourself in the middle of an intervention of some kind, and feeling totally lost, unable to decide what should happen next. I once had a mild version of this indecisiveness in the middle of a grocery store for what felt like hours after a grueling clinical day (I was working as a crisis counselor at the time and was dealing with very extreme situations and a very large volume of demand). I remember standing in the middle of the grocery store thinking, should I buy the chocolate chip cookies or the lemon creams? and being unable to decide between the two for what felt like hours. Difficulty making simple decisions can also be a symptom of depression.
- **Forgetfulness.** Many of us lead busy, hectic lives. Forgetting to turn off the coffeemaker once in a while is normal for all of us, but leaving the house without the baby can be a sign of overload.
- **Problems in personal relationships.** Avoiding social events with friends; not returning phone calls from your loved ones because you are too tired or emotionally exhausted; hearing complaints from your family, who find that you are frequently irritable and emotionally unavailable. Over time, you can become more socially isolated and lose important connections with others.
- **Attrition.** Helpers leaving the field, either by quitting or by going on extended sick leave.
- **Compromised care for clients.** This can take many forms: using the label *borderline* for some clients as a code word for *manipulative* is one common example. Whenever a diagnosis is being used in a way that pigeonholes a client, we are showing our inability to offer them the same level of care as other clients. There is evidence that clients with a BPD label (borderline personality disorder) frequently do not receive adequate care in hospitals, are not assessed for suicidal ideation properly, and are often ignored and patronized. Granted, clients with personality disorders can be extremely difficult

to work with, but when we lose compassion for them and start eye-rolling when we see their name on our roster, something has gone awry.

If you ever have the opportunity to go hear Dr. John Briere present, I highly recommend that you do. Dr Briere is a leader in the field of trauma treatment and research, with a particular specialization in working with individuals who have experienced childhood trauma. He is the director of the psychological trauma program at Los Angeles County and University of South California medical center. During his talks, Dr. Briere presents a wonderful perspective on the use (or rather, the misuse) of the diagnosis of BPD. He believes that the term is used to label clients who are in chronic emotional distress as difficult and draining (which they can be) but that the field is also misusing it as a dismissive and damaging label. He argues that a very large proportion of clients diagnosed with BPD have in fact complex post-traumatic stress disorder (PTSD), not BPD, and are very damaged because of their trauma experiences. They end up being revictimized by a system that cannot cope with their complex and frequent needs.[8]

There are many other examples of compromised care for clients but I think this is a particularly illustrative one:

"WE DON'T GET ENOUGH TRAINING:" A STORY OF COMPLEX PTSD

"Anne" is a 51-year-old woman who had a number of medical problems for which she was regularly in and out of the hospital. She had been seen by a number of physicians over the previous years. She was a woman with severe lung disease, COPD (chronic obstructive pulmonary disease). She had been in and out of emergency and ICU at times for her lung issues. She also had diabetes, chronic pain, high blood pressure, depression, and anxiety.

Anne was on high doses of painkillers for her joint and muscle pain. Her diagnosis was arthritis but her pain was often muscular as well. When I first met her, I explained that I found that she was on a lot of medications and that when I see someone who has a lot of pain issues that are not well controlled in spite of adequate doses of pain medications, I always ask about a history of abuse or trauma.

In this first clinic visit with me, Anne broke down and disclosed that she had been sexually assaulted by her uncle and then her brother from age 7 to age 14. Her mother did not believe her when she told her. Anne finally ran away at the age of 14. Anne stated that she had never told anyone other than her current husband about this. She stated that the multiple medical providers that she

had come in contact with had never asked her about a history of trauma.

As I got to know Anne, she displayed the classic behaviors of complex PTSD with the anxiety, affect dysregulation, depression, somatization. I was very surprised and disappointed that the medical system that she was involved in regularly had failed to identify this major underlying issue. This case very much exemplifies that complete lack of understanding of the issue of complex PTSD. Medical professionals are not trained to understand complex PTSD. Many have probably never even heard of it and yet these "problem" patients are often interacting with the traditional medical system where their somatic issues are poorly dealt with, only to recur again and again.

—As told by a family physician

- **The silencing response.** Eric Gentry and Anna Baranowsky—pioneers in the field of compassion fatigue research—put forward a concept called the *silencing response.* The silencing response is a process whereby we unknowingly silence our clients because the information they are sharing with us is too distressing for us to bear. The more we suffer from compassion fatigue, the more likely we are to use the silencing response: "The Silencing Response ... is an inability to attend to the stories/experiences of our clients and instead to redirect to material that is less distressing for the professional. This occurs when client's experiences/stories are overwhelming, beyond our scope of comprehension and desire to know, or simply spiraling past our sense of competency. The point at which we may notice our ability to listen becoming compromised is the point at which the Silencing Response has weakened our clinical efficacy."[9]

  Some examples of the silencing response are: "changing the subject, avoiding the topic, providing pat answers, minimizing client distress, boredom, feeling angry with the client, using humor to change or minimize the subject, faking interest or listening, not believing clients and not being able to pay attention to your clients."[10] An excellent full-length article by Anna Baranowsky about the silencing response appears in Charles Figley's book *Treating Compassion Fatigue.*

Psychological Signs and Symptoms

- **Emotional exhaustion.** A hallmark of compassion fatigue.
- **Distancing.** You find yourself avoiding friends and family, not spending time with colleagues at lunch or during breaks, and become increasingly

isolated. You find that you don't have the patience or the energy or interest to spend time with others.

- **Negative self-image.** Feeling unskilled as a helper; wondering whether you are any good at this job; feeling negative about yourself as a spouse, a parent, or a friend.
- **Depression.** Depressed mood, difficulty sleeping or oversleeping, impaired appetite, loss of interest in activities, fatigue and loss of energy, feelings of hopelessness and guilt, suicidal thoughts, difficulty imagining that there is a future.
- **Reduced ability to feel sympathy and empathy.** This is a very common symptom among experienced helpers. Some describe feeling numb or highly desensitized to what they perceive to be minor issues in their clients or their loved ones' lives. The old stereotype is the doctor who lets his child walk around with a broken arm for 3 days before taking him to hospital because he has missed the symptoms and minimized them as a slight sprain, or oncology nurses who deal with patients in severe pain who feel angry or irritated when a family member complains of a non-life-threatening injury.

  Reduced ability to feel empathy can also occur if you are working with a very homogeneous client population. After seeing hundreds of 20-year-old university students come through my crisis counseling office, I noticed two things happening: One, I would silently jump ahead of their story and fill in the blanks ("I know where this story is going"). Two, if I had just seen someone whose entire family had died in an automobile accident, I found it very difficult to summon up strong empathy for a student whose boyfriend had just broken up with her after 2 weeks of dating.

  There are of course inherent risks associated with this reduced empathy and jumping ahead. Clients are not all the same, and we risk missing a crucial issue when we are three steps ahead of them. We always need to navigate the fine line between not being ambulance chasers who think every single person is a suicide risk and being numb to the point that we fail to ask basic risk assessment questions to everyone, including the person who looks just fine. The good news is that the solution to this is very simple: vary your caseload to stay fresh and stay on top of your professional development.
- **Cynicism and embitterment.** Eye-rolling at the brand-new nurse who is enthusiastically talking about an upcoming change or idea she has to improve staff morale, groaning when seeing a certain client's name on your roster, and cynicism toward your children's ideas or enthusiasm.

  Unfortunately, cynicism is rampant in high-stress environments such as health care and prisons. You may find yourself feeling cynical toward your colleagues, your clients, and your family and friends. Or you may be working in a very negative work environment where you are surrounded by cynical colleagues. Laura van Dernoot Lipsky writes: "cynicism is a sophisticated

coping mechanism for dealing with anger and other intense feelings we may not know how to manage."[11]

- **Resentment.** Resentment of demands that are being put on you by others, of fun events that are being organized in your personal life; feeling irritated with your best friend for calling you on your birthday; resentment of having to take an extra shift because your colleague is away on stress leave. Resentment can eat away at us like a poison and turn us into angry, brittle people. This in turn has a direct impact on the workplace atmosphere (and the mood in your home).
- **Dread of working with certain clients.** Do you ever look at your roster for the day and see a name that makes your stomach lurch, where you feel total anticipatory dread? Is this happening with greater frequency?
- **Feeling professional helplessness.** Feeling increasingly that you are unable to make a difference in your clients' lives. Being unable to help because of situational barriers, lack of resources in the community, or your own limitations. Some client situations are very complex and the chaos in their lives can run deep. Sometimes it is very hard for us as helpers to hang on to a thread of hope.
- **Diminished sense of enjoyment/career** (i.e., low compassion satisfaction).
- **Depersonalization.** Dissociating during sessions with clients. Again, this is a matter of frequency—many of us space out once in a while, and this is normal; but if you find that you are dissociating on a more frequent basis, it could be a symptom of VT. Have you ever driven home and not remembered the drive from work to your house? Most of us have done this more than once. Now how about this: have you even driven home from work, not remembered the drive home, and found that your car was filled with groceries you had no recollection purchasing?
- **Disruption of world view/heightened anxiety or irrational fears.** This is one of the key symptoms caused by vicarious traumatization. When you hear a traumatic story, or 500 traumatic stories, each one of these stories has an impact on you and your view of the world. Over time, your ability to see the world as a safe place is severely impacted. You may begin seeing the world as an unsafe place. Some examples of this are: A counselor who works with children who have been sexually abused becomes unable to hire a male babysitter for fear that the sitter will abuse her children. A physician forbids his children to ever chew gum after seeing a tragic event happen with a child and gum at his work. A prison guard develops a fear of home invasion after working with a serial rapist. An acquired brain injury therapist develops a phobia of driving on the highway after too many motor vehicle accident rehabs.

  A recent workshop participant told me that after working at a youth homeless shelter, she became obsessed with monitoring her teenage children's every move, convinced that they were using drugs and having unprotected sex. She finally realized she had gone too far when she started

lecturing her 10-year-old son's friends about methamphetamines and condoms, only to see their horrified faces at the breakfast table.

Some of this is inevitable. We call VT and CF occupational hazards for this very reason: As Laurie Anne Pearlman says, it is not possible to open our hearts and minds to our clients without being deeply affected by the stories they tell us. But what is important to notice is how severe these disruptions have become for you. We can also sometimes mitigate the impact by doing restorative activities (e.g., working with healthy children, working on a quilt for people with AIDS).

- **Increased sense of personal vulnerability.** See above.
- **Inability to tolerate strong feelings.** Read about the silencing response above. This can also occur with family, friends, and colleagues.
- **Problems with intimacy.** As a couples counselor I heard many stories about relationship challenges including differences of opinion about money management, parenting, household chores, in-laws, and sex and intimacy. Many helpers confess that they come home completely uninterested in the idea of having sex with their spouses. As one client said to me, "I come home, after giving and giving to all of my patients all day. Then I give to the kids, then I clean up and get ready for the next day. Finally, it's 9:30 p.m. and all I want to do is collapse in bed with a trashy novel. Then my husband comes upstairs and wants to have sex, and I feel like saying, 'Are you kidding me? I'm all done. Please leave me alone.'" And these are not necessarily couples with significant preexisting marital problems. The depletion caused by the job *is* the problem. Of course, better communication and educating spouses about the realities of CF can help greatly. Helpers who work with sexual abuse survivors may also find that their work intrudes on their ability to enjoy a healthy sexual relationship with their partner.
- **Hypervigilance.** When I run workshops, I can always tell which participants work in law enforcement: they always sit with their backs to the wall and a clear view of the door. Why do they do this? If you ask them, they will tell you that it's second nature to them, they simply have a reflex to sit somewhere where you can see any incoming (i.e., potentially threatening) person and also be able to get out of the room rapidly if there ever was an emergency. This is a form of hypervigilance that has been learned on the job. Some prison staff also tell me that they are more fearful of home invasions and have developed a ritual to secure their homes as a direct result of the work they do with inmates who specialize in breaking and entering. Many counselors who work in the field of sexual abuse describe feeling suspicious toward any male sports coach, cub leader, and so forth who approaches their child.

  Trauma survivors often experience hypervigilance due to past trauma events (e.g., you had to hide whenever a siren sounded and now any sound that resembles a siren makes you go into a state of panic, or for a moment, without even thinking about it, you move to duck under a desk). As helping

professionals, we can internalize our clients' high levels of alert. As Lipsky says, we can "feel like we're always 'on.' Even during times where there is absolutely nothing that can or should be done."[12]

- **Intrusive imagery.** This is another symptom of vicarious trauma: Finding that your clients' stories are intruding on your own thoughts and daily activities. Some examples are having a dream that does not belong to you; having difficulty getting rid of a disturbing image a client shared with you; being unable to see a rope as a benign rope, after someone has shared a graphic suicide story with you; or having certain foods be unappealing to you after hearing about certain smells or sounds from a war veteran. It is not unusual for those intrusive images to last a few days after hearing a particularly graphic story, but when they stay with you beyond for more than a couple of weeks, you are likely having a secondary traumatic stress experience. (You can read an excellent description of this in Eric Gentry's article *Compassion Fatigue: A Crucible of Transformation*; see the Bibliography for more details).
- **Hypersensitivity to emotionally charged stimuli.** Crying when you see the fluffy kittens from the toilet paper commercial; crying beyond measure in a session that is emotionally distressing (welling up is normal; sobbing is not).
- **Insensitivity to emotional material.** Sitting in a session with a client who is telling you a very disturbing or distressing story of abuse, and you find yourself faking empathy, while inside you are thinking either, I've heard much worse, or, Yup, I know where she is going with this story; I wonder what's for lunch at the canteen.

  I know a wonderful family doctor who eventually realized that she was struggling with VT. She used to share, at our dinner table, extremely graphic stories of medical procedures of horrible growths or cancerous tumors (usually in the nether regions) with our 3- and 5-year-old children sitting with us. She seemed completely unaware of the children's horrified looks on their faces, never mind the adults.

  Other examples are finding that you are watching graphically violent television and it does not bother you in the slightest, while people next to you are recoiling in horror.
- **Loss of hope.** Over time, there is a real risk of losing hope—losing hope for our clients (that they will ever get better) and maybe even hope for humanity as a whole.
- **Difficulty separating personal and professional lives.** I have met many helping professionals who, quite frankly, have no life outside of work. They work through lunch, rarely take their vacations, carry a beeper or smart phone at all times, and are on several committees and boards related to their work. They are also always on call to help their family and are the "caregiver extraordinaire" for everyone around them. I once knew a helping professional who carried her work cell phone at all times. I used to see

her at daycare, frequently answering client calls at 7:30 a.m. while dropping her children off. I was very curious about this and asked her later what her working hours were and she said proudly, "Oh, I start at 9 a.m. but clients can reach me any time of day or night." This person worked at the local hospital and belonged to a large roster of social workers there, with their on-call beepers on a rotating basis. None of the other social workers at the hospital took client calls at 7:30 a.m. unless they were at work or on call, but she had lost the ability to separate her professional life from her personal life.

- **Failure to nurture and develop non-work-related aspects of life.** Many of the helpers that I meet confess that they have lost touch with the hobbies, sports, and activities they used to enjoy. Some tell me that they collapse in bed at the end of their workday, too tired to consider joining an amateur theater group, go curling, or join a book club. Yet "having a life" has been identified as one of the key protective elements to remaining healthy in this field.

EXERCISE: DEVELOPING AN EARLY WARNING SYSTEM

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 CF.

Self-care is not something we figure out once and for all and get the certificate and put it on our wall. You can't say, "I completed a course and now I'm a certified expert in my own self-care."

You know how radiology technicians wear a little widget (called a dosimeter) that monitors how much radiation they have been exposed to? That's what I visualize we should all wear: a little self-care wellness dosimeter, (Figure 6.1).

It would always be on, and it would beep once when we're getting slightly overloaded, twice when we are headed for a big doozy of a week, and maybe give us an electric shock when we're headed for a total crash!

I would now like to you try to visualize your own self-care wellness dosimeter: What would it look like for you? What would be a symbolic way for you to regularly take stock and check in with yourself?

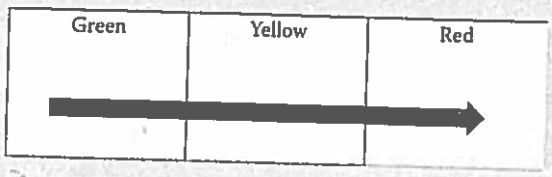

Figure 6.1 Self-care wellness dosimeter.

Most of us have a built-in warning system for general stress: for example, I get tight in the shoulders and neck when I'm starting to get overloaded; my best friend gets a migraine. You can probably name your own symptoms, but do you know what your CF warning signs are?

With the image of your dosimeter in mind, try to visualize that you place it back in its dock every night. This dock downloads the stress and trauma exposure you have had and gives you a reading.

In reality, this can be a 2-minute "how am I doing today?" process, or maybe for you it's journaling at the end of the day, or a simple "how did my day rate on a scale of 1–5?"

This is why learning to recognize one's own symptoms of compassion fatigue can serve as an important check-in process, as it can allow us to develop a warning system for ourselves. Being able to recognize that one's level of compassion fatigue is creeping up to the red zone allows us to implement strategies rapidly before things get worse.

MAKING IT PERSONAL HOMEWORK

After reading through the list of warning signs, spend 15 minutes completing this writing exercise. If you are working with a group, consider sharing some of your signs and symptoms with one another.

MY WARNING SIGNS: WRITING EXERCISE

1. What signs and symptoms stand out most for me?
2. What signs and symptoms do I bring home with me most often?
3. What signs and symptoms do I experience at work?
4. What do I have to lose if I don't deal with the effects of this occupational hazard?
5. What do I stand to gain if I move toward improved self-care?
6. Who will be the biggest supporters of my self-care?

RECOMMENDED READING

To read more on signs and symptoms:

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

Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton.

van Dernoot Lipsky, L. & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler.

In her book *Trauma Stewardship*, Laura van Dernoot Lipsky has an excellent conceptualization of symptoms, which she calls, "The 16 warning signs of trauma exposure response." (p. 47)

Endnotes

1. Mathieu, F. (2010). Adapted from a blog post published on www.compassionfatigue.ca. http://compassionfatigue.ca/moving-out-of-the-red-zone-of-compassion-fatigue-getting-feeling-back-in-our-toes/
2. Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Routledge.
3. Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: W.W. Norton; Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W.W. Norton; Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Routledge; Gentry, J.E., Baranowsky, A.B., & Dunning, K. (1997). Accelerated recovery program for Compassion Fatigue. Paper presented at the meeting of the International Society for Traumatic Stress Studies, Montreal, Quebec, Canada; van Dernoot Lipsky, L. & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler.
4. van Dernoot Lipsky, L. & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler, p. 81.
5. Maté, G. (2003). *When the body says no.* Toronto: Vintage Canada, p.6.
6. van Dernoot Lipsky, L. (2009). p. 111.
7. van Dernoot Lipsky, L. (2009). p. 111.
8. For more information on complex PTSD, see: Courtois, C.A., & Ford, J.D. (2009), *Treating complex traumatic stress disorders.* New York: Guilford Press.
9. Gentry, J.E., Baranowsky, A., & Dunning, K. (1997). http://www.tir.org/research_pub/research/compassion_fatigue.html
10. Baranowsky, A.B. (2002). The silencing response in clinical practice. In C.R. Figley (Ed.), *Treating compassion fatigue.* New York: Brunner-Routledge.
11. van Dernoot Lipsky, L. (2009). pp. 103–104.
12. van Dernoot Lipsky, L. (2009). p. 65.

Appendix B

Standards of Self-Care Guidelines

Green Cross Academy of Traumatology

I. Purpose of the Guidelines

As with the standards of practice in any field, the practitioner is required to abide by standards of self-care. These Guidelines are utilized by all members of the Green Cross. The purpose of the Guidelines is twofold: First, do no harm to yourself in the line of duty when helping/treating others. Second, attend to your physical, social, emotional, and spiritual needs as a way of ensuring high quality services for those who look to you for support as a human being.

II. Ethical Principles of Self-Care in Practice

These principles declare that it is unethical not to attend to your self-care as a practitioner because sufficient self-care prevents harming those we serve.

1. Respect for the dignity and worth of self: A violation lowers your integrity and trust.
2. Responsibility of self-care: Ultimately it is your responsibility to take care of yourself and no situation or person can justify neglecting it.
3. Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

III. Standards of Humane Practice of Self-Care

1. Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
2. Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
3. Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
4. Sustenance modulation: Every helper must utilize self restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since it can compromise their competence as a helper.

IV. Standards for Expecting Appreciation and Compensation

1. Seek, find, and remember appreciation from supervisors and clients: These and other activities increase worker satisfactions that sustain them emotionally and spiritually in their helping.
2. Make it known that you wish to be recognized for your service: Recognition also increases worker satisfactions that sustain them.
3. Select one or more advocates: They are colleagues who know you as a person and as a helper and are committed to monitoring your efforts at self-care.

V. Standards for Establishing and Maintaining Wellness

Section A: Commitment to self-care

1. Make a formal, tangible commitment: Written, public, specific, and measurable promises of self-care.
2. Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Section B: Strategies for letting go of work

1. Make a formal, tangible commitment: Written, public, specific, and measurable promise of letting go of work in off hours and embracing rejuvenation activities that are fun, stimulating, inspiriting, and generate joy of life.
2. Set deadlines and goals: The letting go of work plan should set deadlines and goals connected to specific activities of self-care.

3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Section C: Strategies for gaining a sense of self-care achievement

1. Strategies for acquiring adequate rest and relaxation: The strategies are tailored to your own interest and abilities which result in rest and relaxation most of the time.
2. Strategies for practicing effective daily stress reductions method(s): The strategies are tailored to your own interest and abilities in effectively managing your stress during working hours and off-hours with the recognition that they will probably be different strategies.

VI. Inventory of Self-Care Practice—Personal

Section A: Physical

1. Body work: Effectively monitoring all parts of your body for tension and utilizing techniques that reduce or eliminate such tensions.
2. Effective sleep induction and maintenance: An array of healthy methods that induce sleep and a return to sleep under a wide variety of circumstances including stimulation of noise, smells, and light.
3. Effective methods for assuring proper nutrition: Effectively monitoring all food and drink intake and lack of intake with the awareness of their implications for health and functioning.

Section B: Psychological

1. Effective behaviors and practices to sustain balance between work and play
2. Effective relaxation time and methods
3. Frequent contact with nature or other calming stimuli
4. Effective methods of creative expression
5. Effective skills for ongoing self-care
   a. Assertiveness
   b. Stress reduction
   c. Interpersonal communication
   d. Cognitive restructuring
   e. Time management
6. Effective skill and competence in meditation or spiritual practice that is calming
7. Effective methods of self assessment and self-awareness

Section C: Social/interpersonal

1. Social supports: At least five people, including at least two at work, who will be highly supportive when called upon
2. Getting help: Knowing when and how to secure help—both informal and professional—and the help will be delivered quickly and effectively
3. Social activism: Being involved in addressing or preventing social injustice that results in a better world and a sense of satisfaction for trying to make it so

VII. Inventory of Self-Care Practice—Professional

1. Balance between work and home: Devoting sufficient time and attention to both without compromising either.
2. Boundaries/limit setting: Making a commitment and sticking to it regarding:
   a. Time boundaries/overworking
   b. Therapeutic/professional boundaries
   c. Personal boundaries
   d. Dealing with multiple roles (both social and professional)
   e. Realism in differentiating between things one can change and accepting the other
3. Getting support/help at work through
   a. Peer support
   b. Supervision/consultation/therapy
   c. Role models/mentors
4. Generating work satisfaction: By noticing and remembering the joys and achievements of the work

VIII. Prevention Plan Development

1. Review current self-care and prevention functioning
2. Select one goal from each category
3. Analyze the resources for and resistances to achieving goal
4. Discuss goal and implementation plan with support person
5. Activate plan
6. Evaluate plan weekly, monthly, yearly with support person
7. Notice and appreciate the changes