Accelerated Recovery Program (ARP) For Compassion Fatigue

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Presented at the:
Thirteenth Annual International Society For Traumatic Stress Studies Conference
Queen Elizabeth Hotel
Montreal, QB, CAN
November 9, 1997

"The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering as well" (Figley, 1995, p. 2).

The only resource we had to help us cope with this emotional, physical and spiritual distress was ourselves" (Bloom, 1997, p.112) . In Dr. Figley's pivotal book Compassion Fatigue, he conceptualized an issue that has plagued many clinicians, emergency response workers, and other care-givers who work with traumatized populations. This work provided the language for the feelings of these challenged service providers. It then became exceedingly clear that the next step was developing strategies for addressing our own needs when we become victimized by our work.

Compassion fatigue (Figley, 1995) is the convergence primary traumatic stress, secondary traumatic stress (Stamm, 1995) and cumulative stress/burnout in the lives of helping professionals and other care providers. When helping others precipitates a compromise in our own well-being we are suffering from Compassion fatigue. The symptoms often mimic, to a lesser degree, those of our clients. Vicarious traumatization (McCann & Pearlman, 1990) is a related term that also depicts this phenomenon of the transmission of traumatic stress by observation and/or bearing witness to the stories of traumatic events. Secondary traumatic stress occurs when one is exposed to extreme events directly experienced by another and is overwhelmed by this secondary exposure to trauma (Figley & Kleber, 1995). Several theories have been offered but none has been able to conclusively demonstrate the mechanism which accounts for the transmission of traumatic stress from one individual to another. Figley (1995) hypothesizes that the caregiver's empathy level with the traumatized individual plays a significant role in this transmission.

Burnout, or cumulative stress, is the state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's environment resultant from our responses to the on-going demand characteristics (stress) of our daily lives (Maslach, 1982). High levels of cumulative stress in the lives of caregivers negatively affects their resiliency therefore making them more susceptible to compassion fatigue. The Silencing Response (Baranowsky, 1997; Danielli, 1984) 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' 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.

Figley (1996) defines Compassion Fatigue as:

A state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways:

- re-experiencing the traumatic events,
- avoidance/numbing of reminders of the traumatic event,
- persistent arousal
- Combined with the added effects of cumulative stress (burnout) (p. 11).

Compassion Fatigue has many symptoms and often parallel to the symptoms of the traumatized clients with whom caregivers are working. While compassion fatigue has been most often written

about in the rubric of psychotherapy as emotional contagion passed from client to clinician, there is growing evidence to support the trans-generational and societal transmission of this condition (Danieli, 1985; Baranowsky, 1997; Bloom, 1997). Some of the symptoms of compassion fatigue include:

- increased negative arousal,
- intrusive thoughts/images of clients' situations/traumas (or clinicians' own historical traumas),
- difficulty separating work life from personal life
- lowered frustration tolerance/outbursts of anger or rage
- dread of working with certain clients,
- marked or increasing transference/countertransference issues with certain clients,
- depression
- perceptive/assumptive world disturbances (i.e., seeing the world of terms of victims and perpetrators, decrease in subjective sense of safety)
- increase in ineffective and/or self-destructive self-soothing behaviors
- hypervigiliance
- feelings of therapeutic impotence or de-skilled with certain clients,
- diminished sense of purpose/enjoyment with career,
- diminished ego-functioning (time, identity, volition)
- decreased functioning in non-professional situations.
- loss of hope

Any of these symptoms could be signaling the presence of Compassion Fatigue.

The eruption of violence, personal degradation, and physical/ psychological violations disrupt our notions of the sanctity of our assumptive world (Janoff-Bullman, 1992; Rando, 1996). Such traumas can result in symptoms of Posttraumatic Stress Disorder. Posttraumatic stress effects individuals differently but is identified by three categories of symptoms: (1) intrusive thoughts, images and sensations; (2) avoidance of people, places, things and experiences which elicit memories of the traumatic experience, and (3) negative arousal in the forms hypervigiliance, sleep disturbances, irritability and anxiety. These symptoms combine to form a state of physical, emotional, cognitive and spiritual volatility in traumatized individuals, families and groups (van der Kolk, 1996; Janet, 1889). Persons who work closely with these groups and individuals are vulnerable to the contagion of this volatility. Some caregivers appear to be more resilient than others to the transmission of traumatic stress, however, any caregiver who continually works with traumatized individuals is at-risk for compassion fatigue.

Who is at-risk for Compassion Fatigue?

Compassion fatigue may occur in a wide range of persons involved in providing aid to others (Jay, 1995). We have found that it is most prevalent among professionals and personal family members, friends, and associates of trauma survivors (Baranowsky, Gentry & Dunning, 1997; Beaton & Murphy, 1995). Psychologists, social workers, lawyers, disaster relief workers, nurses, psychiatrists, medical doctors, emergency service professionals, police, crisis phone-line attendants and shelter workers among others, are all susceptible to Compassion Fatigue.

When the therapist has encountered trauma through first-hand exposure this further heightens vulnerability to Compassion Fatigue (Baranowsky, Gentry & Dunning, 1997; Pearlman & McCann, 1995). Yet, in the emerging field of traumatology many of the therapists have such experience. Just as it is not uncommon to find ex-substance abusers counseling those currently trying to break away from addictions, likewise, it is not uncommon to find those who are personally knowledgeable about trauma trying to aid others who have faced terrible events.

We urge these clinicians and caregivers to develop and maintain good self-care disciplines (see Pathways To Healing) and also complete a periodic self-assessment of compassion fatigue

symptoms using the Compassion Fatigue Scale-Revised (1997, Figley, Baranowsky & Gentry).

The Good News

The Green Cross Project, under the direction of Charles Figley, Ph. D. , at Florida State University, has developed a brief treatment (5 session) protocol for professionals who are suffering the effects of Compassion Fatigue. We believe from our preliminary trials with the Accelerated Recovery Program (ARP) that Compassion Fatigue is responsive to intervention and may even be the incentive that leads to the enhancement of clinical skills and personal life enrichment in the same way that a crisis may precipitate change and growth in the lives of our clients.

Our vision has been to develop a program that would not only address the issues of compassion fatigue for the care-giver but to positively reinforce their future in their chosen role and improve their personal lives as well. Assisting the caregiver to move toward becoming their optimal personal and professional selves so that they may live and work with integrity has always been our mission. We believe that our program assists caregivers toward this goal.

This program was designed to assist the professional to implement strategies to regain functioning in their personal and professional lives that have been compromised due to Compassion Fatigue. The Accelerated Recovery Program makes a commitment to assist clinicians and care-givers address and resolve both the symptoms and the cause of compassion fatigue while, at once, helping them develop an integrated individual self-care discipline which enhances future resiliency to compassion fatigue. Caregivers may discover a need to continue their work beyond the scope of the Accelerated Recovery Program, however, we have found that they will be much better suited and prepared to manage the difficult sequelae of primary and secondary traumatic stress following the completion of this program. In addition to addressing the difficulties which are preventing the professional from performing at his/her optimal level, s/he will have the opportunity to learn, by experiential participation, state-of-the-art brief treatment procedures which they may utilize with their traumatized clients.

The Road Back Home

We have used the metaphor of "The Road Back Home" to describe our program because Compassion Fatigue seems to rob the professional of their sense of well-being, comfort, purpose, identity, and empowerment; all the qualities that one associates with being "at home". The experiences of being "at home" in our bodies, our work, our thoughts, and our spirit seem to diminish as the symptoms of Compassion Fatigue increase. The program we have created is designed with the hope of assisting helping professionals, to move rapidly toward comfort and empowerment in their professional and personal lives. Our program will challenge and assist the helping professionals in finding their own personal "road back home".

Treatment assists the helping professional in reconnecting with the sense of hope and empowerment with which they entered their chosen field. With this is accomplished, we encouraging them to learn, understand, and develop personal strategies for resolving the difficult experiences, which diminish hope and empowerment. Furthermore, the helping professional will be challenged to discover their "Silencing Response" both with their clients and themselves and to develop ways to navigate though this difficult impasse.

The Accelerated Recovery Program

The five-session treatment protocol is standardized and directed toward the completion of the following major objectives;

1. Identify, understand, and develop hierarchy of the events, situations, people and internal experiences which trigger symptoms of compassion fatigue in their lives. This will include the creation and discussion of the Professional Life-Line in which the professional will explore the trajectory of their career assessing the experiences that have contributed to Compassion Fatigue.
2. Review present personal methodologies of addressing these difficulties and begin

developing and maintenance of a self-care discipline in the following four areas:
 a. Skills Acquisition
 b. Self-Care
 c. Connection with Others
 d. Internal Conflicts
The Accelerated Recovery Program uses this self-help model that the caregiver develops throughout their enrollment in the program. This self-care plan is entitled Pathways To Healing and may be found in the attachments to this paper.

3. Identify resources (external and internal) available to the professional which can be utilized to develop and maintain resiliency to compassion fatigue.
4. Learn and master state-of-the-art negative arousal reduction techniques.
5. Learn and master state-of-the-art grounding and containment skills.
6. Contracting for self-care, boundary-setting, and skills acquisition.
7. Explore, reframe, and reprocess impediments to potency utilizing Eye Movement De-sensitization and Reprocessing (EMDR).
8. Learn and master video-dialogue, a technique for internal conflict resolution and self-supervision.
9. Development of self-administered after-care plan (Pathways to Healing).

Program Protocol

Session One: Assessment/Evaluation

A thorough assessment and evaluation is be completed with each care-giver who enrolls in the accelerated recovery program. A full exploration of the symptoms that the professional is experiencing will be discussed along with the events of his/her professional and personal life which have contributed to these symptoms.

We recognize that discussion of these events will be difficult and, often times, intimidating for the professional. With this in mind we have placed the onus of responsibility for disclosure upon the professional and while we will offer the strictest confidentiality we respect any wishes that s/he has to not disclose any information.

The following assessment tolls will be utilized in the Accelerated Recovery Program:

1. Compassion Fatigue Scale-Revised (Figley 1995; Baranowsky & Gentry, 1997)
2. Silencing Response Scale (Baranowsky, 1997)
3. Solution-Focused Trauma Recovery Scale (TRS) (Gentry, 1997)

Between-session: Personal Mission Statement

Session Two: Personal & Professional Time-Line

1. Welcome and discussion of treatment goals/mission statement.
2. Categorizing these goals into the following three areas:
   a. Skills Acquisition
   b. Self-Care
   c. Internal Conflicts
   d. Connection with Others
3. Overview of program and informed consent
4. Progressive relaxation script (Gentry & Schmidt, 1996)
5. Safe-Place Visualization (Gentry & Schmidt, 1996)
6. Telling the story.
7. Re-connection with hope and empowerment at beginning of career a. Inventory of experiences which have combined to create Compassion Fatigue b. Review of past (week, month, year) to assess the specific situations which are triggers and catalysts of Compassion Fatigue.

Between-session Project: Professional Time-Line (graphic narrative)

Session Three: Re-framing & Reprocessing

1. Review of Session Two
2. Discussion of Time-Line:
   a. Professional Goals
   b. Personal Goals
   c. Primary & Secondary Trauma
   d. Silencing Response
   e. Trajectory of Hope
3. Review of vicarious traumatic situations (triggers & catalysts)
4. Review of self-regulation strategies for managing these situations (i.e., Thought Field Therapy)
5. EMDR (Shapiro, 1996) with Target Experience/Memory which encapsulates most salient impediment.

Between-session Projects:

1. Development/implementation of self-care/NAR plan
2. Letter from The Great Supervisor
   a. Omni-benevolent
   b. Omniscient
   c. The things the professional most needs/wants to hear from a supervisor.

Session Four: SUPERVISING THE SELF: Externalization

1. Review of previous sessions.
2. Identifying areas where professional needs skills acquisition and contracting to acquire these skills.
3. Identifying areas where professional needs to introduce, practice and master self-soothing/NAR/boundaries/self-care.
4. Video Dialogue (Holmes & Tinnin, 1995) with internal polarities/conflicts.
   a. Read Great Supervisor Letter on videotape
   b. Video-dialogue taking the negate stance
   c. Continue dialogue towards negotiation

Between-session Project: Complete Pathways To Healing

Session Five: Closure and Aftercare

1. Review of program/goals
2. Inventory of incomplete goals
3. Addressing four Pathways to Recovery
   a. Skills Acquisition
   b. Self-Care
   c. Connection with Others
   d. Internal Conflict Resolution
4. Board of Directors (Baranowsky, 1997) guided imagery exercise
5. Aftercare
6. Closure

NOTE - It is highly possible that these techniques may exacerbate and/or expose a primary trauma in the history of the helping professional. We will be utilizing a specialized protocol of each brief procedure which, if primary traumatic stress becomes activated, will be designed to contain these experiences and sequelae while refocusing upon Compassion Fatigue Symptom Reduction. The helping professional who experiences the emergence of primary traumatic material will be offered

confidential individual treatment for these symptoms if s/he chooses.

Options for Further Work:

1. All helping professional will be offered the option of continuing individual treatment. This treatment could include: a. Primary traumatic event/traumatic stress
   b. Secondary traumatic stress
   c. Grief work
   d. Problematic clients/therapeutic impasse
   e. Personal blockages/inhibitions
   f. Phobias
   g. Stress reduction/management
2. All individual treatment will attempt to employ brief treatment protocols (where applicable) such as EMDR (Shapiro, 1995), TFT (Callaghan, 1994), TIR (Gerbode, 1989), TLTT(Tinnin, 1989, 1994), V/KD (Bandler & Grinder, 1979)
3. Groups may be offered
4. Training/consultation in treating traumatic stress may be offered
5. Assistance in establishing study groups/peer supervision
6. Opportunity for membership in Green Cross Project
7. Membership in Traumatic Stress E-Mail Forum
8. Apply for Registered Traumatologist for assistance in disaster relief and other emergencies Discussion

The Accelerated recovery Program was developed at Florida State University's Psychosocial Stress Laboratory. It was initially developed as a three (3) session model and sessions One and Five were added as the authors practiced the protocol with each other rotating as client, practitioner and observer. Session One was added when the authors discovered that primary traumatic stress was becoming and important and potentially confounding factor in the treatment protocol. Unresolved primary traumatic stress in the life of the clinician, we soon discovered, significantly negatively impacted the clinician's resiliency to compassion fatigue. The most difficult challenge that the authors faced in the development of this protocol was to: (a) develop a program which assisted the impaired clinician to address and resolve his/her symptoms of compassion fatigue, while, at once, (b) respectfully addressing and challenging the clinician to resolve any primary traumatic experiences which may be contributing to the symptoms identified in the assessment process.

We resolved this dilemma by offering a program that addresses and assists with the resolution of the etiology of compassion fatigue in the professional life of the clinician: primary traumatic stress, secondary traumatic stress and cumulative stress. However, if the care-giver identifies primary traumatic experiences in his/her developmental trajectory and/or adult life, then we offer and urge this care-giver to continue treatment with the ARP therapist following their completion of the Accelerated Recovery Program to resolve their traumata. The fifth session was added to reinforce this position as well as offering a comprehensive closure and debriefing protocol. The fifth session also serves as a transition from clinician-assisted recovery to self-managed recovery and self-care via The Pathways To Healing.

The Accelerated Recovery Program for Compassion Fatigue was alpha tested (4/97 - 10/97) with ten (10) caregivers who were Marriage & Family doctoral students, nurses, MSW students, trauma therapists (South Africa & Bosnia) and a death-penalty mitigation specialist. All ten (10) caregivers reported improvement in functioning and a lessening of compassion fatigue symptoms. One caregiver experienced an acute and marked decrease in functioning as a primary traumatic event for which she had been previously amnestic became figural in her treatment, however, she was able to regain functioning and reported that the ARP was helpful in her healing process.

Conclusions

The Accelerated Recovery Program for Compassion Fatigue combines several trauma brief treatment protocols (Time-Limited Trauma Therapy, Thought Field Therapy, Eye-Movement Desensitization, Video-Dialogue, Visual/Kinesthetic Dissociation, Hypnotherapy) with a comprehensive assessment (Compassion Fatigue Self Test - Revised, Solution-Focused Trauma Recovery Scale, The Silencing Response Scale, Structured Clinical Interview) and self-administered

self-care plan (Pathways To Healing). This constellation of treatment/training strategies, distilled into five (5) sessions, seems to have combined to provide an effective means for caregivers who suffer with compassion fatigue to address and resolve many of their symptoms. While there is yet no empirical data on the efficacy, utility, and/or safety of this approach, many of the protocols from which the program borrows have shown promise in each of these areas. Therefore, the authors of this program offer this protocol to clinicians who work with caregivers who suffer from compassion fatigue as the first comprehensive treatment program of its kind. We hope that clinicians will join us in beginning to utilize this protocol in treating impaired professionals and assist us in continuing to develop and refine its utility.

In the coming year, we plan to begin systematic outcome research on the efficacy and utility of the Accelerated Recovery Program for Compassion Fatigue.

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