Caring for the carers: compassion fatigue and disenfranchised grief

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Introduction

Anyone in a helping and caring profession may at times experience compassion fatigue. Animal care workers – veterinarians, animal researchers, students, animal shelter workers – are all potentially at risk from such experiences. This paper describes the theoretical and practical aspects of the constructs of compassion fatigue, secondary traumatic stress, and vicarious traumatisation; and suggests a link with a particular type of grief process – disenfranchised grief. This grief is the 'grief of secrets', and can occur when normal and healthy grieving processes cannot happen, be they self-imposed or societal-imposed restrictions on the normal expression of grief.

Compassion fatigue, as a term, appeared in the literature in the late 1980s. It is used to describe a phenomenon whereby those working in a helping and caring relationship with others – both professional carers and non-professional carers – may become traumatised as a result of the work they do. Two other terms commonly used are *secondary traumatic stress disorder* and *vicarious traumatisation*. Figley (1995) describes secondary traumatic stress as being identical to compassion fatigue and defines it as "the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other – the stress resulting from helping or wanting to help a traumatised or suffering person". The other commonly used term, vicarious traumatisation, was described by Saakvitne and Pearlman (1996) as "an occupational hazard, an inescapable effect of trauma work. It is not something that clients do to us: it is a human consequence of knowing, caring, and facing the reality of trauma". The important statements in both of these definitions are that these processes are 'natural and human consequences' of working in a caring profession. An important, and often co-existing process, is that of compassion satisfaction. This was described by Beth Stamm (2005) as "the pleasure you derive from being able to do your work well".

Compassion fatigue and compassion satisfaction, as well as the related construct of burnout, can be measured. The usual measure employed is the professional Quality of Life scale – the ProQOL – a 30-item measure with three scales of 10 items each (Stamm 2009; www.proqol.org) . The scales are Compassion Satisfaction; Burnout; and Secondary Traumatic Stress.

The most recent conceptualisation of the relationship between these constructs is that compassion fatigue has two components. The first concerns things such as exhaustion, frustration, anger and depression typical of burnout. The second – secondary traumatic stress – is a negative feeling driven by fear and work-related trauma (Huggard et al. 2011). The ProQOL instrument should not be regarded as a diagnostic measure; rather, results should be taken as an indication of where the individual is at.

Signs and symptoms of compassion fatigue

Mathieu (2008) suggested that a useful way of looking at signs and symptoms of compassion fatigue

is to classify them as physical, behavioural, and psychological.

Physical signs and symptoms include:

- exhaustion;
- insomnia;
- headaches;
- increased susceptibility to illness;
- somatisation; and
- hypochondria.

Behavioural signs and symptoms include:

- increase in alcohol use (and other drugs);
- absenteeism;
- anger and irritability;
- avoidance of clients;
- impaired ability to make decisions;
- problems in personal relationships;
- attrition;
- compromised care for clients; and
- 'The Silencing Response'.

Psychological signs and symptoms include:

- emotional exhaustion;
- distancing;
- negative self image;
- depression;
- reduced ability to feel sympathy and empathy;
- cynicism;
- resentment;
- dread of working with certain clients;
- feeling professional helplessness;
- diminished sense of enjoyment/career;
- depersonalisation;
- fear;
- disruption of world view/heightened anxiety or irrational fears;
- increased sense of personal vulnerability;
- inability to tolerate strong feelings;
- problems with intimacy;
- intrusive imagery;
- hypersensitivity to emotionally charged stimuli;
- insensitivity to emotional material;
- loss of hope;
- difficulty separating personal and professional lives; and
- failure to nurture and develop non-work related aspects of life.

The 'Silencing Response', described by Baranowsky (2002), refers to the ways in which clinicians can "silence" their clients and patients. It may be a coping mechanism employed by those experiencing compassion fatigue, and plays out in both words and actions. Clients and patients are silenced by changing the conversation and diverting it to where the clinician wishes it to be, by shutting down the client's dialogue, by employing certain body postures that have the effect of distancing the carer from the client, by referring on to colleagues those clients whom the clinician is struggling to work with, and by not validating what the client is saying so that they feel their contribution to the relationship is unimportant.

What might be protective against developing compassion fatigue?

While a phenomenon such as resilience has been suggested as offering protection against developing compassion fatigue, the relationship between compassion fatigue and resilience has only recently been explored. Huggard (2009), in a study of 253 hospital-based doctors, found a positive and significant relationship between compassion fatigue and resilience. Similar positive and significant relationships were also found between empathy, spirituality, and emotionality, and compassion fatigue. In the same study, significant and negative relationships were found between resilience, empathy, spirituality, emotionality, and burnout; and between resilience, spirituality, emotionality, and compassion satisfaction. Those items in the measures that had the strongest negative and significant relationship with compassion fatigue are shown in Table 1.

Results from the study showed that individuals with high scores in these items had low scores in compassion fatigue. Although a causal relationship was not sought nor demonstrated, these results suggest that the more resilient and emotionally competent an individual is, the less likely they are to be experiencing compassion fatigue.

Support and self-care strategies

Saakvitne and Pearlman (1996) offer a useful approach to self-care. They describe this as the *A: B: C Model.* "A" is an *awareness* of our needs and the limits of our physical and emotional resources. "B" is the *balance* between our activities, work, play, and rest. "C" is

Table 1 Items in the Resilience and Emotionality scales that were negatively and significantly related to compassion fatigue.

Resilience Scale (Personal Strengths subscale)	Emotionality Scales (Emotional Competence subscale)
I can deal with whatever comes up	I feel confident in my ability to care for patients exhibiting strong emotional distress
I believe that past success gives confidence for new challenge	I am aware of my emotions as I experience them
I see the humorous side of things	I feel confident in my ability to understand my own emotional responses to my patients' distress
I believe that coping with stress strengthens	I feel competent in my ability to understand the reasons for my patient's strong emotional distress
I tend to bounce back after illness or hardship	I feel confident in my ability to care for the emotional as well as the physical needs of my patients
I believe I give my best effort no matter what	I feel able to initiate access to additional support, if required, to help me to understand and manage my emotions in relation to my patients
I believe I should act on a hunch	

the *connection* to oneself, others, and something larger. Mathieu (2008) describes a four-stage approach to managing compassion fatigue. Step 1 is to take stock of the stressors in one's life, both at work and at home. Step 2 is to enhance self-care at home and at work and to work at improving one's work-life balance. Step 2 also includes the "12 Top Tips for Carers". These are:

- take stock of where you are at;
- start a self-care 'good idea' collection;
- rebalance your workload and find time for yourself every day;
- delegate more;
- have a transition from work to home;
- learn to say NO more often;
- assess the level of traumatic experiences or traumatised clients you are working with;
- learn more about compassion fatigue;
- actively engage in a supervisory relationship – either one-on-one or in a peer group;
- look at increasing the level of professional development and training;
- ask the question – should I work part-time or change the mix of my work; and
- develop healthier lifestyle choices of eating and exercise.

Saakvitne and Pearlman (1996) provide a useful *Self-Care Inventory* for assessing one's physical, psychological, emotional, spiritual, and workplace or professional self-care.

Step 3 involves developing compassion fatigue resiliency. This may include relaxation techniques, mind-body practices, and focusing on improving one's workplace and professional practice in the four dimensions of the organisation, peer groups, individual activities, and professional associations.

Organisational approaches include establishing 'top-down' support and acknowledgement of the consequences of working in emotionally demanding roles and a commitment to staff to assist them in managing this. Peer group approaches include 'peer monitoring' and 'looking out' for one's colleagues, creating an organisational culture of fun and a sense of belonging, and monitoring workloads. Individual practices include participating in effective professional supervision, being able to access defusing and debriefing sessions, giving attention to appropriate boundaries between one's private and professional life, engaging in positive self-statements, and actively working at improving, or maintaining a healthy work-life-home balance. At the individual level, practices such as acknowledging success and developing

strategies for disengagement from work (establishing the boundaries between professional and private lives), developing a greater tolerance for set-backs, and the use of rituals for managing stressors and separating work from home, play an important part in maintaining a healthy balance. A useful approach in this dimension is to utilise a personal debriefing model at the end of each work day. This ritual aims to celebrate the successes of the day and to develop strategies for disengagement from a work-life and re-enter a private life (Huggard & Huggard 2008). Professional association activities include being engaged with one's professional bodies by attending training events and conferences and working to establish and enhance professional networks. These four dimensions are discussed in more detail by Vachon and Huggard (2010).

Lastly, Step 4 is where a commitment to engaging in improvements and changing to a more healthy approach to managing stress is made.

Management and treatment of compassion fatigue

Being witness to traumatic events experienced by significant others can result in compassion fatigue and those who are affected can experience symptoms associated with post-traumatic stress disorder (PTSD). The cluster of symptoms seen in those severely affected include intrusive imagery (nightmares, flashback images), hyper-arousal (feeling constantly on guard), hypervigilance (constantly scanning for threat and danger), and avoidance (engaging in strategies that avoid exposure, or the memories of exposure, to past trauma and re-experiencing the traumatic events). One approach to treatment is the Accelerated Recovery Programme (Gentry et al. 2002), a five-step structured therapy programme aimed at assisting individuals in reducing the intensity, frequency and duration of symptoms associated with compassion fatigue. The main goals of the programme include:

- symptom identification;
- recognising compassion fatigue triggers;
- identifying and utilising existing resources;
- reviewing personal and professional trauma history;
- mastering arousal reduction techniques;
- learning skills that help manage anxiety;
- reviewing the balance in one's life and consciously deciding upon improvements;
- resolving impediments to efficacy;
- initiating conflict resolution; and
- implementing supportive aftercare plans.

A more general approach to trauma therapy is that described in the *Three Phase Model of Trauma* by Judith Herman (1992). Her approach is firstly safety and stabilisation (gaining internal and external control); then remembrance and mourning (reconstruction of the trauma story, having someone bear witness); and finally reconnection (redefining oneself in the context of meaningful relationships, gaining closure).

Disenfranchised grief

The term "disenfranchised grief" refers to circumstances where, for one reason or another, an individual's loss cannot or is not recognised by the person's social group or wider society. It may not just be experienced by individuals, a community may also suffer a 'silent and secret' grief. There are three key elements to this form of grief: a lack of recognition is given by others to the relationship; there is a lack of recognition given to the loss; and lastly, there is a lack of recognition of the person suffering the loss as a griever. Our societies and communities establish the rules that govern the ways and extent to which we experience and demonstrate our grief. These rules include describing what losses one grieves; the ways in which we grieve our losses; who legitimately can grieve these losses; and in what ways, and to whom, others will respond with sympathy and support (Doka 2002).

A possible and previously unexplored association is that between compassion fatigue and disenfranchised grief, and may come about when the events being grieved for are such that they cannot be acknowledged publicly and discussion of the events either does not occur or is limited to a small group of individuals. The grieving processes are restricted and impeded and normal outward expression of grief cannot be made. In a paper presented at the 2008 ANZCCART Conference, Dr Dianne Gardner (2008) discussed the grief and distress experienced by staff involved in the euthanasia of animals.

While the possible traumatic consequences of being involved in euthanasia may be experienced by those directly involved as a primary traumatic experience, secondary trauma or compassion fatigue may also be experienced by those primarily involved as well as by those associated with that primary group of people. This group can include colleagues, research students, and family members of the researchers.

It is possible that restrictions, either perceived or real, in expressing grief, may be thought to be imposed by society upon those involved in the euthanasia of animals. This may occur if stigmatisation is associated with euthanasia. If this does occur, it could lead to the grief being disenfranchised and not being able to be expressed or acknowledged by others, and in healthy and constructive ways. This speaks to the importance of the support needed by animal care staff and researchers, and the encouragement of those involved in euthanasia to actively seek out and develop strategies that, as publically as possible, permit a meaningful grieving process.

Conclusion

The possible trauma experienced by those involved in the euthanasia of animals must not be underestimated. If not addressed and managed, this may lead to the development of compassion fatigue and secondary traumatic stress. Disenfranchised grief may be a possible consequence of euthanasia due to a more restricted expression of grief. Healthy, appropriate, and meaningful grief rituals must be developed by staff engaged in animal care and research that enables them to fully explore any sadness and distress relating to their work. Organisational and collegial support needs to be available that encourages staff participation in practices such as debriefing and professional supervision, and without any stigma. Lastly, discussions about grief processes and the possible consequences of euthanasia in relation to animal research need to be held with students and emerging researchers in order to better prepare them for their future scientific and clinical work.

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