Compassion Fatigue: Helplessness, Hopelessness & Burnout
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OBJECTIVES:
At the End of this Presentation the Participant will be able to:
1. Use and administer a compassion fatigue assessment tool
2. Differentiate burnout from compassion fatigue
3. List risk factors for compassion fatigue
4. Describe the benefit of compassion satisfaction

Outline:
I. Assessment tool
   A. Professional Quality of Life
      Elements Theory and Measurement Compass Satisfaction and Compassion Fatigue, Burnout, Secondary Traumatic Stress. Vicarious Traumatization and Vicarious Transformation
      http://proqol.org/
   B. Compassion Fatigue Self Testing
      http://psychink.com/rfiles/PrewkshpScales.doc

II. Definitions
   A. Burnout
      Burnout has to do with what we do, how we do it, and for how long we do it. It manifests as exhaustion or lack of energy, that is usually brought on by unreasonable work expectations, (of yourself or from others) or environmental work related stress. It has more to do with systems, processes and organizations, and how we fit into those modalities. It also has to do with lack of self care and poor boundary setting
   B. Compassion Fatigue
      Compassion Fatigue is about the helplessness that goes with caring; and is NOT about caring too much. Compassion Fatigue occurs when the caring involves seeing or hearing about the pain of others, and feel like you can not help; or it can come from being exposed to stories of pain and trauma and accumulate the feelings associated with it, without letting go of them.
   C. Vicarious Trauma
      Vicarious Trauma is experiencing a trauma in a secondhand way (hearing about it, seeing it, reading about it etc). Vicarious trauma can be listening to clients / patients or someone close to you personally: called secondary trauma. Or it can be trauma in your community state or country: which is called tertiary trauma.
   D. Secondary Traumatic Stress Response
      Secondary Traumatic Stress Response is what happens when an individual has a reaction: physically, spiritually mentally or emotionally to a trauma event that happened to another person or persons. The STSR if not dealt with can lead to a Secondary traumatic stress disorder which looks much like and mimics PTSD
   E. Compassion Satisfaction
      Compassion satisfaction is not necessarily job satisfaction which is usually related to what one does or thinks about their job. (although they do go hand in hand) Compassion satisfaction is more related to how one feels at the end of the day and how aware they are that they have made a difference
III. Risk factors
   A. Personal primary or secondary trauma history
   B. Being Blindsided
   C. Feeling of helplessness
   D. Lack of validation, support or minimization of trauma from others
   E. Lack of understanding or integration with one’s belief system
   F. Stress, illness, poor self care
   G. Inadequate Self Awareness
   H. Accumulative factor
   I. Other Risk factors: inexperience on the job, high caseload of trauma survivors (e.g., sexual violence), high caseload of traumatized children, working with child abuse/neglect perpetrators, poor or no supervision, frequent exposure to traumatic material, exposure to critical incidents, conflicts with co-workers or supervisors, climate of pervasive, ongoing change, excessive emphasis on efficiency, cost-effectiveness and competition, unforgiving environment. —If you can’t handle it, move aside…you’ll be replaced.

IV. Compassion satisfaction
Compassion satisfaction comes from an internal comfort that it is not your responsibility to fix the pain of another. It is only your responsibility to witness it, share it, show up and be fully present, and offer guidance on how to self soothe through that pain. With that also comes a sense of peace even when that individual refuses or resists that guidance you have still done your job, and done it well.

Summary
We in the helping professions get tired, but do not always know why…. Sometimes it is a gradual onset of fatigue producing symptoms in any one or all of five areas (mental, physical, behavioral, emotional, and spiritual). This fatigue is often a result of poor stress management skills and lack of self-care coupled with organization stress, systems and process issues. If not dealt with, and reversed, early in its onset, it can lead to burn-out. Burn-out is very difficult to reverse; it often requires a change of jobs or a change of professions.

Getting tired can also be caused by something else very real and exhausting emotionally; and that is listening to and sharing patients’ painful stories. It is like experiencing the trauma vicariously. This exposure to secondary trauma, has an effect on the listener over time and can contribute to something called compassion fatigue. Compassion fatigue is different from burn-out in the onset is more rapid, it is reversible, and it cannot be prevented unless one simply stops caring.

"Figley (1995) has explained that compassion fatigue is experienced by those individuals who help others in distress. These helpers may be subsequently traumatized through their efforts to empathize and show compassion. This often leads to inadequate self-care behaviors and increased self sacrifice in the helper role. Compassion fatigue has also been described as secondary traumatic stress (Figley, 1995) resulting from caring for patients in physical and/or emotional pain or stress."
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Unlike Post Traumatic Stress Disorder (PTSD) the caregiver does not physically experience the traumatic event but does experience the event emotionally by caring for the patient (Sabo, 2006).

Some symptoms of burnout and compassion fatigue are similar. However, the distinguishing factors include onset of symptoms and the effect upon the caregiver’s role. In burnout the onset is more progressive and may cause indifference, disengagement, and withdrawal from patients and the work environment. Compassion fatigue can be more acute in onset and may precipitate over involvement in patient care (Anewalt, 2009). In 1995, Figley commented that the presence of burnout could increase the likelihood of developing compassion fatigue.

Getting tired emotionally from listening to painful stories is very normal. Getting tired and staying tired, however, is not. Mental Health professionals can not afford to come to work tired, so what happens instead is the heart shuts down and detaches from personal connections to patients / clients. When that happens, whatever energy is left can be dispersed to do tasks, do the paper work and do the technical parts of the job. The clinician still shows up, on time, in the right attire, with all of the right customer satisfaction verbiage, but instead of providing compassionate, caring treatment, the person functions more like a robot.

Robots can do many things well, but the one thing a robot can not do well, is have a therapeutic relationship with a patient. Without that relationship, without those moments of making a difference, and without being truly connected to our patients, the caregiver begins to feel empty and unfulfilled. Empty and unfulfilled spots in the heart leave it wide open for some not so therapeutic feelings like anger, sadness, depression, guilt, frustration, sarcasm and regret. If those negative painful feelings aren’t dealt with, (when they are normal) then what can develop is a more severe state of mind and heart called secondary traumatic stress disorder (STSD) which looks like and acts much like PTSD. STSD, is more difficult to reverse and often requires professional treatment to reverse.

If compassion fatigue is addressed when it is just fatigue, just being tired, it can be REVERSED, and reversed easily.

Management of Compassion Fatigue involves and needs:
1. Awareness -Awareness of one’s emotional, physical, mental, behavioral and spiritual state.
2. Release - It requires active release of lingering thoughts and feelings and memories through ventilation (written or spoken).
3. Validation - It needs validation that this is a normal process, and these feelings are a normal part of caring.
4. Education - And it needs education about some basic things like self-care, healthy self-soothing, understanding the value of connection, the value of disconnection and the value of intention. It also involves the skill of transforming sympathetic nervous system responses (fight or flight) into para-sympathetic nervous system responses (relaxation, peacefulness and calmness).
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Caring with calm in the midst of painful chaotic circumstances is a skill that can truly make a difference in a person’s life. Mental Health professionals and healthcare workers alike can only care for another person **authentically** when they first do it for themselves.

Caring and compassion are necessary components of the work we do, and there is no such thing as caring too much. **Please continue to care and care deeply, but never come to work without first caring for and being compassionate with yourself.**

**Compassionate Satisfaction is the ultimate knowing that the light house is not responsible for the safety of the ship but only responsible to be the light!**

**Other Miscellaneous Tidbits**
(Gathered over the years from experience, from training and from research!)
(For more information on any of these topics please email me for further discussion)

- Compassion fatigue and Burnout are not the same thing, however some authors do not differentiate those differences.
- Both burnout and compassionate fatigue can have physiologic and or psychiatric pathological implications.
- Burnout is preventable, and when red flags are caught early enough but once severe Burnout sets in, it is very difficult to reverse.
- Compassion fatigue / Secondary trauma have a faster onset, and faster recovery than burnout. Burnout is more insidious, and more difficult to recognize and harder to reverse.
- Compassionate fatigue is inevitable and is only preventable if you stop caring. But it can be reversed easily.
- People can be traumatized without actually experiencing harm or being threatened by harm. Trauma is often about perception.
- 60-66% of therapists have experienced some sort of trauma in their life time. (The kind of trauma that would put them at risk for PTSD)
- Other Risk factors for vicarious traumatic (VT) / secondary traumatic (ST) reactions are: Rigid inflexible world view or underdeveloped spirituality.
- Other effective interventions include: Vacations (travel has the tendency to expand one’s world view), exercise, socialization with quality people, emotional support form peers, pleasure reading, learning professionally, workshops, spiritual development, clarifying ones meaning and purpose in life, play, laugh, be creative, pursue spiritual avenues, journal dream, limit numbers of exposure to trauma patients. If possible, utilize healthy self soothing, know your limitations, take care of your body through nutrition, exercise, rest and relaxation, be ok with the gray area, and always maintain hope.
- It is as important to **give** supervision, as it is **getting** supervision. Giving and getting supervision both allows you to stay in touch with what you know and why you love being a therapist.
- When talking about your feelings, (without revealing the situation, or violating confidentiality), it is not enough to say: “I had a bad day”, but instead say: “I felt really helpless today, and was overwhelmed with how my patient’s story made me feel.”
-The feelings of helplessness can be softened, by acknowledging that we are responsible to our clients, but we are NOT responsible for the client.
- The most common beliefs that can be challenged by VT trauma are: Safety, Trust, Esteem, Intimacy, and Control.
- **Safety**: “This could have been me”, “This could have been my daughter.”
- **Trust**: After a trauma with human error, one could loose trust in someone else’s competence. (i.e.: after hearing a story of a pastor who molested a child, you can loose trust in all pastors) Or sometimes, you just stop trusting your own instincts. (Especially when you are blindsided)
- **Esteem**: Esteem of others is affected when you begin to look at every human being as being a potential threat to you. Self esteem is affected when you begin to doubt our ability to handle what is being presented to you.
- **Intimacy**: Hearing stories of horror affect your ability to engage in authentic relationships because it appears to be safer to remain distant and superficial.
- **Control**: The more helpless one feels in one area of their life, the more control that person will seek out in other areas or situations.
- **EARLY INTERVENTION** is a must.
- Interventions need to be individualized. Go with what works for you.
- All professionals who are at risk for VT should have a well defined ethical attitude about VT. The three major components are: 1. Awareness of the risk for VT, with a plan for ongoing interventions, so that one can continue to do this work. 2. Should never try to do this work alone. Having a relationship with and regular contact with another colleague who knows you well enough to know when something is wrong. 3. Having an ethical duty to self care
- **Empathy is the ability to experience what another person experienced.**
- All emotions are contagious. (both the positive ones and the negative ones.)
- 1990’s, research began to look at the role of mirror neurons in the brain and their association with CF. There is some speculation that the contagiousness of laughter and things like yawning may be connected to the function of the mirror neuron. There is a mimicking response observed, that may be triggered by these mirror neurons. The mirror neurons reflect the activity of someone else’s brain cells.
- This research continues into this century, and it is proposed that empathy is no longer just a cognitive / emotional response, but a physical somatic response
- Emotions in general, usually have a observable physical manifestation: (ie a smile or a frown). They are now studying the physical manifestation of empathy, and can see through use of video taping, how therapist, take on the postures, and body manifestations of their clients, thus putting them at risk for owning the same feelings of pain.
- Now the good news is, that physical mimicking can work both ways. When the therapist is finished feeling, the empathy for the client, and is ready (and it is appropriate,) the therapist can send back to the client empowerment energy / attitude, which is mimicked subconsciously and then they begin to feel less helpless.
- **Body AWARENESS** is a major therapeutic tool in VT prevention and intervention.
- Please note however that calmness and relaxation are not always synonymous. Calmness can be faked, relaxation is more genuine.
- The same is true with muscle tone and muscle tension. Muscle tension will put you at risk for VT, Muscle tone, will reduce your risk.

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-The better you know yourself, the quicker you will know when something is wrong. This refers to your body. The more aware you are of your internal physical gauges, the more you will be aware of your external world.
-It is important not to take on your client’s pain, any longer than the session. Use rituals to close out your session. You may want to use some symbolic trinket representing the pain of your client, and when they leave, drop it into a pretty box.
-It’s ok to empathize with your client, but try not to identify with them. Identifying with them, sets you up for personalization of their tragedy. You are right it could have happened to you, and maybe it almost happened to you, or something similar happened to you, but this particular story did not happen to you, so don’t own it.
-Between each client use rituals to disconnect from them. Open a window, get a drink (warm is better), go to restroom, pray, stretch, tone muscles etc.
-Do the same kinds of things at the end of the day, so that you don’t take home your patients or you work. Exercise after work, change clothes, read something fun, etc.

Early comments on compassion fatigue came from Carl Jung in 1907 as he commented on counter transference. He was concerned that participating in the patient’s darkly painful fantasy world of traumatic images would have deleterious effects for the therapist.

-Other studies on the effects of psychotherapy on the therapist surfaced in the 70’s, a few more in the 80’s and grew in numbers in the nineties.
-Research on Burnout became popular in the 70’s.
-But the psychological effects of traumas have been studied and described for over 150 years. (especially in the areas of shell shock, and combat fatigue). It was not formally recognized until the 1980’s and the whole field of traumatology was not really recognized until the 1990’s.
-Also in the 1990’s research specifically on the therapist reactions to listening to traumatic stories from their patients began to accumulate. That is when the words vicarious trauma, secondary trauma and compassion fatigue became familiar.

-Trauma is registered in two places: There is a quick path to the amygdala which will trigger the fight or flight sympathetic nervous system (SNS) response. The slower pathway goes to the thalamus which relays information to the neo cortex for processing. If the information is found to be non-threatening, then the process will be shut down or reversed with the parasympathetic nervous system. (PNS) What that looks like in real life is what you feel when you come across something that looks like a snake. You jump, and are afraid, and then the higher brain says it is a stick, and you begin to calm and walk by it.

-There is a very powerful mechanism which will block that inhibitory process, and that is the presence of stress hormones like cortisol. So when a normal fear reaction is triggered, and there is high stress levels, the parasympathetic nervous system has trouble shutting down the adrenal process of the fight or flight, and the person remains in a hyper arousal state. And although they are safe, they don’t feel safe, and in this state of fear, very little cognitive restructuring can occur.

-There are three necessary factors to trauma recovery: Relaxation, (reducing the SNS response and activating the PNS response), Reciprocal inhibition, (the ability to find relaxation in the presence of the exposure to the trauma or to the reliving o the trauma) Cognitive restructuring. (Finding the resolution though belief systems or finding meaning
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and purpose in the trauma.)
- There is a 5 session copyrighted accelerated intervention for VT / CF called “ARP” Accelerated Recovery Program. (Gentry)
- There is also a 17 hour “Training as treatment program” that is based on and includes the ARP protocol, which addresses intentionality, connection, self soothing / anxiety reduction, self care, a narrative, feelings and self supervision.
- Intentionality is the acceptance and recognition of VT, CF symptoms with a commitment to deal with them. It addresses the avoidance and denial that is often associated with VT / CF. It also is about developing a mission statement and goals that drive the individual personally and professionally towards resiliency, and mature care giving.
- Connection to people and peers forces a person, to get through their fear that they are weird or crazy, into a realization that this is a normal response to abnormal exposure to trauma, even if it is through hearing the stories of trauma. This also supports self disclosures, and reduces the need for secrets, and closed off, compartmentalized fragmented feelings. Ongoing prevention of CF requires the discussion of any fear, shame, guilt, intrusive material or secrets with peers and colleagues.
- Self soothing / anxiety reduction is the hallmark of maturity. Being able to live in a state of “non anxious presence” (NAP) is key to managing future potential crises and traumas. NAP is not something that can be mastered in one session, but is something that needs to be practiced and used when life is not traumatic. It is a technique used to facilitate the PNS, so that we may stay relaxed and calm. Good gauge of a NAP is a relaxed pelvic floor. Being in this state allows one to be empathetic, compassionate and bear witness as a spectator. It is about relaxed mindfulness and comfort in ones own body.
- Self care is the ability to refuel and refill in healthy individualized ways. Therapeutic outcomes are impacted by the relationship between the client and therapist almost more than anything else. That relationship is not going to be optimal if the therapist doesn’t have a satisfying life outside, of work, and expects the majority of their needs to be met in the work environment. A satisfied, person with a full grateful life can, by example, can offer hope and options to anyone coming for treatment. (practicing what you preach)
- A narrative involves a time line of events and experience that led a person into the care giving profession, as well as a timeline and description of the events that led up to any experience or feeling of CF / VT. It is also about knowing and being able to describe what drives your professional style and approach.
- Feelings that surface during your narrative need to be dealt with in some format that capitalizes on reciprocal inhibition. (Simultaneously inducing relaxation response as memories of pain, trauma and stress are re-lived.) EMDR, (Eye movement dissociation and reprogramming), NLP (neuro linguistic programming) Anchoring techniques and TIR (Trauma Incident Reduction) are all great for that. But any method that uses exposure / relaxation is good too.
- Self supervision can be done, using both a self created perfect letter from a supervisor, (the letter you really want to get) compared and contrasted with the letter, that you think you actually deserve. The healing comes from the resolution and coming together of the two.
- Exercise is the single most important factor in the CF prevention program

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- CF is simply an opportunity to grow.  
- As we open up our heart to the stories of devastation, or betrayal, our cherished beliefs are challenged and we are changed forever.  
- Vulnerability to VT is unavoidable if you remain empathetic.  
- Counter transference and compassion fatigue are very distinct constructs, but impact one another.  
- Symptoms of compassion fatigue: no energy or time for oneself, disconnection from loved ones, social withdrawal, increased sensitivity to violence, cynicism, despair, prolonged sadness, hopelessness, sleep disturbances, decrease self esteem, alterations in sensory experiences, changes in identity etc.  
- The necessary components to good mental health when dealing with trauma patients: Awareness, Balance and Connection.  
- Awareness of own needs, own emotions, own body, own resource and strengths, own limitations. To be aware on this level it requires time, and quiet.  
- Balance between work, play and rest. Balance between mind, body and spirit.  
- Connection to others breaks the silence of unacknowledged inner pain.  
- VT is also an organizational issue, in that it can lead to poor clinical performance, high turnover, absenteeism and decreased cohesiveness.  
- The Chinese symbol for “crisis” includes ones that represent danger and one that represent opportunity. CF, if not met with awareness and intervention can lead to danger, or it can be an opportunity to re evaluate your beliefs and find new meaning and purpose in life.  
- There are many dichotomies in trauma work. You can be exhausted, but can’t sleep. You can have no energy or have hypo manic energy. You can have a mind that shuts down and can’t focus, or a mind that won’t shut off.  
- Traumas, primary or secondary can “Freeze” memory into the cell. The goal in trauma healing is to get the memory unfrozen and moving into a flow.  
- Before you can offer healing to others, you must address self honesty, personal responsibility, suspend judgment and attachment to unhealthy or useless beliefs, and learn to express oneself based on the trust of ones own tuition. Freud says we repeat behavior rather than remember them. We draw to ourselves, behaviors that will allow us to repeat feelings we have for the purpose of resolution. Once we remember that this is what happened, then we can consciously work through and resolved those feelings without repeating the circumstances. In Trauma work, we often react to our clients, without realizing that we are reliving an old event. Once we realize we are reacting to the old event, we can have a new reaction to the current event that will be more about health and healing. Counter transference is repeating not remembering. You can have similar issues to our client and work with them, if you are remembering, not repeating.  
- In helper professions, especially the medical profession, there is a strong need to be right, a strong need to fix. When what we are doing is not working, then we begin to fight for being right, and in that fight, we become tense and set ourselves up for traumatic reactions.  
- That tension and stress in general can also lead to Cardio vascular disease, Muscular Skeletal disorders, work place injuries, Gastro intestinal problems and immune dysfunction.  
- When that stress is addressed, studies have shown a decrease in medication errors (by
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50%) and a decrease in malpractice claims (by 70%).
-Albert Einstein said that energy and matter are interchangeable, so then energy and information are interchangeable. Based on that logic, then when we take in negative information, pain... it affects our energy in a negative way. So much so that our brains have a hard time understanding it or even processing it.
-Our hearts however are 5000 times more powerful than our brains. (we know this because we can measure the electromagnetic field of both)
-The Chinese and Indians have known this for centuries, and use the heart for healing.
-We assist our patients on a regular basis to open their heart, but often forget to keep our hearts open.
-When we shut down our heart, and can no longer feel compassion, we have just lost our greatest tool in healing our clients. The best way to open ones heart is to begin by loving oneself fully and completely,
-When our heart shuts down, our body stops listening to our mind, and our mind stops listening to or body.
-To get things open, and to get the flow moving, one must move, and breathe and move and breathe together.
-Most professionals, or intelligent people will freely agree that movement, and breath are integral part of health. But in reality few of those who admit to its usefulness actually use those interventions.
-Trauma patients instinctively know if you can handle their pain. And if you can, they will show up.
-It is ok to connect and be completely with your client in the moment. But be sure you know how to disconnect between clients. (Using rituals if necessary) Saving notes and calls or documentation to another day or time.. prolongs the disconnect process.
-Red flags: If you find yourself saying or thinking: “How can I enjoy life, with so many people suffering?” “If I can’t console you, then I must be a failure or a bad therapist” “Is she on the schedule again?” If you find yourself getting, cynical, or sarcastic. If you find yourself being annoyed or even enraged on a regular basis by your clients. If you stop feeling anything, when you hear the stories of pain or when your brain goes blank, or when you can’t shut it down. When all you want to do is sleep, and when you can never sleep. When you can’t tell the difference between hunger and a craving. When your soul becomes weary. When you fake fun. When you make a comment, cry or fly off the handle, and don’t know where it came from.

YOU ARE NOT CRAZY!!!!!! You are having a “Normal reaction to abnormal events”
-It is ok to isolate and withdraw into a cave for the purpose of healing, but its not ok to do that long-term or for the purpose of living that way permanently..
-75% or more of our clients have been traumatized so you will hear stories, and you will be blindsided by the power of the stories from time to time, and if you are a good therapist you will experience vicarious trauma reactions.
-The brain can not differentiate between same and similar. Your client’s stories may be similar to yours, but they are not yours. They are similar, not the same
-Be sure you have time in your day to feel your feelings, not just talk about them or intellectualize them. To release or transform them you actually have to feel them.
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- Feed your body with good nutrition, exercise, water, and sleep, feed your mind with learning, and pleasure, feed your soul with joy, pleasure and gratitude.
- Memory is in the cells of the body, it not just in the brain.
- Four great sources of information are the face / forehead, the neck / shoulders, the depth and type of breathing and the pelvic floor.
- You will not be able to do this job well for long without physical release through movement, exercise and breathe. Listen to the body, breathe, move, and listen to the body.

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Secondary trauma of compassion fatigue in caretaker and helping professions
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Compassion Fatigue
http://home.earthlink.net/~hopefull/TC_compassion_fatigue.htm

Self care guidelines:
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Professional organizations and other resources:
http://www.icisf.org

International Critical Incident Stress Foundation
http://www.atss.info

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http://www.corporatecrisis.net/home.html

Corporate Crisis Management
http://www.compassionunlimited.com

Welcome to Compassion Unlimited, Inc.
http://www.greencross.org

Green Cross Foundation
http://mailer.fsu.edu/~cfigley/TraumatologyInstitute.html

Charles Figley (the father of compassion fatigue)
http://www.giftfromwithin.org/html/articles.html

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