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Supporting ourselves:
Groupwork interventions for compassion fatigue

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Abstract: *Compassion fatigue, also known as secondary traumatic stress, can result from a social worker working with traumatized clients in all areas of social work. If affected by compassion fatigue, the social worker will begin to experience Post Traumatic Stress Disorder-like symptoms, which can have a deleterious effect on his/her personal and professional life. If the symptoms of compassion fatigue are left untreated, it could lead to ethical concerns with the client or leaving the social work profession. It is extremely important for the social worker to seek individual help to treat the symptoms and effects of compassion fatigue; however, it is also important to seek out the assistance of therapeutic support groups. This paper will discuss various strategies that can be employed in therapeutic support groups for social workers to help them ameliorate the effects of compassion fatigue.*

Key words: *compassion fatigue; social workers; groupwork; support groups; group interventions*

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Introduction

Working with traumatized clients can be personally and professionally harmful to a social worker. Being subjected to the client's traumatic material on a consistent basis can lead to the development of compassion fatigue, which is when the social worker will experience Post Traumatic Stress-like symptoms, simply from listening to their client's traumatic events (Figley, 1995). Literature has been written on the importance of support groups and different group interventions, although this literature is somewhat limited. This paper seeks to discuss the different strategies that can be implemented to mitigate the harmful effects of compassion fatigue.

What is compassion fatigue?

Compassion fatigue, also known as either secondary victimization or secondary traumatic stress disorder, is a fairly new phenomenon that may occur among helping professionals who work with traumatized clients (Figley, 1995). Compassion fatigue occurs from listening to the traumatic events experienced by a client, which, in turn, has the potential to traumatize the social worker (Figley, 1995; Kinzel & Nanson, 2000; O'Halloran & Linton, 2000; Simon, Pryce, Roff, & Klemmack, 2005). Compassion fatigue can result from one acute exposure to a client's traumatic material, which differentiates this phenomenon from the concepts of burnout and vicarious trauma (Collins & Long, 2003). Burnout results from working with people over an extended period of time and affects professionals regardless of the clientele with whom they work (Maslach, 1982). Vicarious trauma is the result of an accumulation of incidents across many therapeutic treatments with clients who have experienced sexual abuse and assault (Pearlman & Saakvitne, 1995a; 1995b). Vicarious trauma also results in permanent negative cognitive shifts in the therapist's world-view (Pearlman & Saakvitne, 1995a; 1995b).

The effects of compassion fatigue can be extreme. The symptoms, such as nightmares of the event, sudden re-experiencing of the event, depression, irritability, and difficulty concentrating, may affect a social worker who is experiencing compassion fatigue. If the indicators of

compassion fatigue are not recognized and acknowledged in a timely manner, clients could become at risk of ethical and quality of care issues, which could affect the client and subsequent treatment. This quality of care issue could possibly place the client in a harmful relationship with the social worker, ultimately leading to further abuse or neglect due to the social worker ignoring the client's needs. Furthermore, social workers can experience problems with their coping skills, a decrease in the social worker's sense of accomplishment, damaged spirituality, and various interpersonal problems (Cunningham, 2003; Dane & Chachkes, 2001; Iliffe & Steed, 2000; Pearlman & Saakvitne, 1995b).

Working with traumatized victims contributes to a social worker developing compassion fatigue (Kinzel & Nanson, 2000; O'Halloran & Linton, 2000; Simon et al., 2005). The client's constant recollection of the traumatic event may trigger an emotional response within the social worker exposing him or her to traumatic stress. This response can be exceptionally detrimental to a social worker's mental and physical health, personal and professional life, and overall quality of living (Figley, 1995; O'Halloran & Linton, 2000).

Why groupwork?

Groupwork remains an important aspect of social work practice. The results of several recent reviews of the literature indicate that groupwork is an effective, often the preferred, treatment modality for individuals experiencing a range of difficulties, including substance abuse, mental illness, and psychological trauma (Kessler et al., 2005; Weinberg et al., 2005; Weiss et al., 2004). The skills and knowledge of groupwork remain the foundation to four out of five areas of social work practice (Trevithick, 2005). With roots strongly planted in groupwork, it would seem a natural process for social workers to manage their own experiences with compassion fatigue.

One of the many goals of groupwork, is that it decreases isolation, improves mutual support and facilitates feelings of acceptance and hope (Gitterman, 2005). As social workers we can be hesitant to deal with our own feelings of isolation and trauma that come with compassion fatigue. Authors have discussed the professional isolation faced by social groupwork practitioners (Bergart & Simon, 2004). As social

workers pour out of their cup to fill our client's cup, we can easily forget how to replenish our own supply. The framework of groupwork for the professionals allows us to examine relationships of peer support. This is especially important as the level of stress and risk factors for compassion fatigue increase.

Groupwork has also shown to be successful in ameliorating the symptoms and effects of compassion fatigue (Figley, 1995). This is important because participation in groups could ultimately help in preventing burnout, which may ultimately lead to leaving the social work profession. Several studies have shown the importance of groupwork in remedying the effects of compassion fatigue, such as Critical Incident Stress Debriefing, Stress Inoculation Training, music therapy, Interactive Psychoeducational Group Therapy, and self-care exploration groups (Hilliard, 2006; Johnson & Lubin, 2000; Meichenbaum, 1996; Myers & Wee, 2002; Radey & Figley, 2007). However, after conducting a thorough search of the literature utilizing Academic Search Complete, no current information was discussed on how social workers can use groupwork to mediate the symptoms and effects of compassion fatigue.

No symptoms/ 'protective factors'

Literature has demonstrated that not all social workers develop compassion fatigue or burnout from their employment (Dane & Chachkes, 2001). There are a myriad of reasons that contribute to the protective factors that shield a social worker from compassion fatigue and burnout.

Most importantly, workers who are not exposed to traumatized clients do not develop compassion fatigue as frequently as those workers who consistently work with traumatized victims (Arvay, 2001). Boscarino, Figley, and Adams (2004) found that social workers, who did not have direct contact with survivors of a terrorist attack, did not experience any of the aspects of compassion fatigue, compared to the social workers who did work with survivors of the attack. This could be considered a protective factor from compassion fatigue.

If social workers have regular supervision and consultation they will be apt to reduce or prevent their risk of compassion fatigue and burnout (Lloyd, King, & Chenoweth, 2002). This can be due to the social worker

being provided with the opportunity to talk openly about the symptoms that they may be experiencing. The social worker's supervisor may be able to identify the initial symptoms of compassion fatigue and refer the social worker to outside treatment. Access to peer-based support groups consisting of co-workers and/or various other professionals may also decrease the symptoms of compassion fatigue and burnout (Arvay, 2001; Clemens, 2004; Lloyd et al., 2002). Diversifying one's caseload and maintaining appropriate work boundaries, such as taking vacations, can be utilized to help prevent symptoms (Badger, Royse, & Craig, 2008).

Wynkoop and Gerstein (1993) describe specific aspects that protect a social worker from developing stress, which uncontrolled and untreated could lead to the potential advancement of compassion fatigue. A social worker's personality has the capability to shield him/her from the effects of stress. It is proposed that if a social worker has a perfectionist personality, he/she has the predilection of developing stress and burnout in the work setting (Cherniss, 1980).

Cherniss' seminal research on burnout infers that the social worker's perception of their job duties and job performance may prevent compassion fatigue and burnout (1995). If a social worker perceives the job duties as enjoyable and non-threatening or non-stressful and has a high degree of accomplishment, then the risk of compassion fatigue will be minimized. Moreover, social workers who subscribe to an internal locus of control are more resistant to stress than those social workers who believe in an external locus of control (Muhonen & Torkelson, 2004).

Risk factors of compassion fatigue

When one or more of the protective factors is missing, it can be insinuated that the social worker has the potential of developing compassion fatigue. Various risk factors influence a social worker's propensity to develop compassion fatigue. The most prominent risk factor is the social worker's own personal history of trauma, especially if the social worker did not seek any sort of treatment for the experience (Kinzel & Nanson, 2000; Salston & Figley, 2003). However, Bell's (2003) qualitative study indicated that if a social worker had resolved their own traumas through therapy or some other means, they were less likely to

experience compassion fatigue. These results were in accordance with Way, VanDeusen, Martin, Applegate, & Jandle's (2004) study.

Another major risk factor is the amount of exposure to traumatized clients. As previously mentioned, it is interesting to note that social workers who work in a supervisory role do not report experiencing compassion fatigue as frequently as those social workers who work with traumatized clients on a daily basis (Nelson-Gardell & Harris, 2003). Therefore, social workers who do not work with traumatized clients may not experience compassion fatigue symptoms (Boscarino et al., 2004). Good empathic skills are critical for the development of a satisfactory working relationship with the traumatized client. However, the degree of empathy that a social worker possesses also predisposes them to symptoms of compassion fatigue. The more empathy for their clients a social worker has, the more vulnerable they are to the effects of compassion fatigue (Bride, 2007; Figley, 2002).

Symptoms and effects of compassion fatigue

Compassion fatigue symptoms are similar to Post Traumatic Stress Disorder (PTSD) symptoms, which include depression, anxiety, sleep disturbances, feelings of incompetence, low self-worth, intrusive imagery, numbing or avoidance of working with traumatic material from the client (APA, 2000). Compassion fatigue results from listening to a victim's traumatic accounts (Figley, 1995; O'Halloran & Linton, 2000). It differs from PTSD, which results from the personal experience of a traumatic event (APA, 2000). Social workers experiencing compassion fatigue also suffer from a myriad of physiological complaints and may begin to use and abuse substances, as a form of 'escapism' from these physical problems. Social workers may also experience a decrease in their sense of personal accomplishment, problems in their personal lives, and a decrease in spirituality (Dane & Chachkes, 2001; Figley, 2002; Jenkins & Baird, 2002).

If compassion fatigue is not identified and treated in a timely manner, ethical dilemmas may occur regarding the appropriate treatment of the traumatized client (Everall & Paulson, 2004). In addition, in Section 4.05 of the National Association of Social Workers (NASW) Code of Ethics (1999), it is mandated that social workers not let their impairment

obstruct their treatment of a client. A social worker who is suffering from compassion fatigue is more likely to cancel or miss appointments, steer the client away from discussing their traumatic event, and discourage the client recalling the traumatic event for fear that they might anger or hurt the social worker.

Compassion fatigue manifests in the social worker through their experiencing and displaying boredom (which can covey a lack of interest in the client) and a reduction in the social worker's ability to empathize with the client. Experiencing compassion fatigue can also lead to a decreased ability to complete work-related tasks. Boundary issues could arise when the client becomes afraid to discuss the traumatic event for fear of angering the social worker (Everall & Paulson, 2004). Social workers may feel anger toward their client when the client did not follow through with a goal that was set in treatment. Social workers may begin using and abusing alcohol or drugs as a result of their untreated compassion fatigue (Myers & Wee, 2002). They may also experience a disruption in their self-esteem and skills competency (Everall & Paulson). Compassion fatigue can cause problems within the social worker's work environment ranging from insufficient job productivity or ineffectiveness to job loss (Salston & Figley, 2003). More problematically, compassion fatigue has the ability to lead to burnout (Figley, 1995; 2002).

Group strategy

Critical incident stress debriefing (CISD)

Critical Incident Stress Debriefing (CISD) is a long-term group intervention that may aid social workers who work with traumatized clients, usually from the same significant traumatic event (Mitchell, 2004). CISD is most likely to be used with social workers and other helping professionals who respond to emergency situations, such as man-made or natural disasters, which can be extremely stressful to the provider of services (Myers & Wee, 2002). It is important to note that the leader of this group should be trained in CISD techniques and also should have a wide knowledge base regarding 'issues of stress, posttraumatic stress disorder, psychotrauma, crisis intervention, the nature and functions of emergency services work, and the biological

aspects of disasters in general' (Dembert & Simmer, 2000, p. 241). The group facilitator should also be well-versed in identifying symptoms and effects of compassion fatigue.

CISD is a seven-phase debriefing model of intervention and should be provided at least 24-72 hours after exposure to the traumatic event and/or the provision of services to the traumatized client. Each session may last up to three hours and is led by a highly trained individual in CISD. There are a total of seven stages in the CISD process. The first stage, called the 'introduction' stage, establishes the group and allows the social workers to understand the CISD process. It also details the expectations of the CISD support group. The 'fact' stage, which is the second stage, asks the group members to talk about themselves and their role in the disaster. The third phase, the 'thought' phase, allows the group members to talk about the disaster and their immediate thoughts about the disaster. The fourth stage, the 'reaction' stage, allows the social workers to talk about what was the most difficult aspect of the disaster. This stage encourages the social workers to articulate their emotions, without restraint, about the disaster. The fifth phase, called 'symptoms', focuses on the group member's possible traumatic symptoms from being a part of the disaster. The sixth phase, 'teaching', discusses stress-management techniques and the importance of implementing these techniques. Lastly, the seventh stage, 're-entry', allows for closure to the CISD process. During this last stage, any further questions are answered, plans for returning to the group member's daily practices are discussed, and any additional information can be shared (Mitchell & Everly, 1995).

Defusing. There is another form of CISD, called defusing, that usually lasts 20-45 minutes and is most often used at the end of the work day, and therefore, it is only one session in length. This session allows the social worker to discuss the day's work and how the social worker may have reacted to the cases that have been witnessed. The goals for defusing is to provide group support, discuss coping strategies, helping to reduce the stressful feelings associated with the disaster work, and provision of additional resources or referrals if the social worker should need them. However, defusing has been shown not to be as effective as the full CISD process (Myers & Wee, 2002).

The Accelerated Recovery Program (ARP) model

The Accelerated Recovery Program (ARP) was developed in 1997 to treat the helping professionals that were affected by compassion fatigue. ARP is a five session model to attend to the prevention and treatment of compassion fatigue (Gentry, Baranowsky, & Dunning, 2002). This model can be presented to individuals or in a group setting and has been found to be effective in recognizing the symptoms of compassion fatigue in social workers (Gentry et al., 2002).

The goals of ARP are to identify the symptoms of compassion fatigue and recognize what issues may trigger compassion fatigue symptoms, through reviewing group members' personal and professional history. The model discusses resources and skills that the group members can utilize to prevent or to treat symptoms of compassion fatigue. The model teaches group members how to initiate conflict resolution and discusses a unique aftercare plan, called PATHWAYS, to support the social worker after the group sessions have ended (Gentry et al., 2002). This aftercare plan, which heavily focuses on maintaining the resiliency and self-management skills learned in the Accelerated Recovery Program, is self-administered, which may help in preventing any additional compassion fatigue issues (Gentry et al., 2002).

Stress inoculation training

A treatment modal, which has not yet been tested for its effectiveness for the prevention or treatment of compassion fatigue, is Stress Inoculation Training. Although there is no empirical support for this training in specifically preventing compassion fatigue, it can increase the coping skills that could help to prevent the onset of compassion fatigue. Stress Inoculation Training is a three-phase intervention, lasting between 8-15 sessions, and can be conducted in a support-group setting (Meichenbaum, 1996).

During phase one, group members are encouraged to discuss the stressful situation and how they are particularly susceptible to stress. The second phase is where coping skills are taught to the social workers and will then be practised with one another, to ultimately be put into practice outside of the group environment. The last phase of the program teaches the group members how to apply their newly learned coping

skills to various other stressors that they may come upon in their private and professional lives.

This treatment program could be beneficial for those social workers who are experiencing compassion fatigue. As previously mentioned, compassion fatigue symptoms may result from working with traumatized clients (Figley, 1995). One of the effects of compassion fatigue is damage to one's coping skills (Dane & Chachkes, 2001). It may become increasingly difficult for the social worker to manage their compassion fatigue symptoms, due to the lack of suitable coping skills. Therefore, a program that discusses the stressors in the social worker's private and professional lives, and how to implement appropriate coping skills to mediate these stressors, may help to protect the social worker from experiencing compassion fatigue. In a group environment, this would be critical as the mutual aid process between members helps to develop and reinforce coping skills.

Music therapy

Music therapy has been shown in several studies to reduce the amount of burnout that helping professionals may experience (Bittman, Bruhn, Stevens, Westengard, & Umbach, 2003; Brandes et al., 2009; Cheek, Bradley, Parr, & Lan, 2003). Since burnout and compassion fatigue can lead to high rates of turnover and feelings of demoralization, a study conducted by Hilliard (2006) evaluated the effectiveness of music therapy in ameliorating compassion fatigue among hospice social workers, nurses, and chaplains. This study also sought to increase team building behaviors through music therapy. Although the results of the study were inconclusive as to whether or not the hospice worker's compassion fatigue was alleviated, this initial study suggests that the support of a therapeutic group will help to build cohesiveness in a work-related team setting and foster co-worker support, which may in turn help to prevent the onset of compassion fatigue (Bergel, 2007; Boscarino et al., 2004; Way et al., 2004).

Interactive psychoeducational group therapy

Another form of group therapy for helping professionals is Interactive Psychoeducational Group Therapy (IPGT). This is a time-limited, 16-week,

therapeutic group that works with workers who may be experiencing PTSD. This group is highly structured and involves 'lectures, cognitive restructuring, exposure to traumatic memories, and homework' (Johnson & Lubin, 2000, p. 151). What makes this therapeutic group unique is that it advocates for the discussions of the PTSD symptoms among the group environment. There are three main goals in IPGT; the first goal is to educate the group members about how their traumatic experience has affected their lives. The second goal is to allow the group members to understand the difference between PTSD symptoms and normal behaviors. The last goal is to eventually reduce the PTSD symptoms, which will enable the group members to live their lives as they once did and ultimately increase the group members' self-esteem and reinforce their strength as an individual (Johnson & Lubin, 2000).

This group approach, which has been found to be useful with people who have PTSD, may also be helpful for social workers who are experiencing compassion fatigue. The group model highlights education of the PTSD-like symptoms that compassion fatigue produces and teaches the group members how to navigate the difference between PTSD and normal behaviors. Participation in this 16-week therapeutic group may help to increase the awareness of compassion fatigue symptoms, and this may help to protect group members from experiencing any further issues with compassion fatigue. This is an exciting area of research that needs to be explored further to help social workers who are experiencing compassion fatigue.

General self-care exploration groups

Lastly, a general self-care support group for social workers could prove to be useful to staving off compassion fatigue. This support group could be conducted in the place of employment or could be established outside of the agency, in an Employee Assistance Program (EAP). EAP's focus is on working specifically with employees regarding crisis and other immediate psychosocial issues. The most important aspect of the support group is to endorse an environment of safety and acceptance and constant support of one another.

During the course of the group, a 'buddy system' could be set up among the members of the support group. This would allow the group member to have contact with another member, after the weekly or

monthly compassion fatigue support group meetings. The 'buddies' would be in contact with one another to monitor their stress levels, feelings of compassion fatigue, and functional levels. This would help to monitor and prevent any compassion fatigue experiences (Myers & Wee, 2002). It is critical for the social worker who works with trauma cases to be able to defuse at the end of each day, especially if the social worker works in a highly stressful environment containing many traumatic events.

Some subject areas to discuss during a general self-care support group meeting for social workers would be the importance of caring for oneself. Topics of importance would be to discuss the significance of increasing exercise and activity, to help mitigate the symptoms of compassion fatigue (Myers, 1994). It would also be useful to have a visiting lecturer talk about self-care strategies with the group. Politsky (2007) discussed the usefulness of initiating a meditation group to help decrease the effects of compassion fatigue among oncology nurses. In combination with increasing exercise, it is also helpful to talk about adequate nutrition and necessary amounts of sleep, which if left un-discussed could lead to increased stress levels, ultimately exacerbating any symptoms or effects of compassion fatigue.

Another topic to discuss during the self-care support group is the importance of positive self-talk, such as 'I'm doing well', 'I am doing the best that I can', and 'I am a good social worker'. Using positive self-talk and self-encouragement can increase the positive feelings that one can have for oneself, thus limiting the effects of compassion fatigue (Figley, 1995; Myers, 1994). Gaining knowledge of appropriate forms of humor has also been shown to provide relief from the symptoms of compassion fatigue (Moran, 2002). Furthermore, learning boundary-setting mechanisms may prevent compassion fatigue. This could be in the form of initiating a set amount of time devoted to self-care to balance the social worker's work life from his/her home life (Yassen, 1995).

An extremely important topic to talk about in the self-care support group would be the value of taking vacations, pampering oneself during the time off, and developing hobbies or outside interests that will keep one's mind off the work environment (Dutton & Rubenstein, 1995). It is also noted that reading, journaling, participating in art or any other creative process may help protect against the effects of compassion fatigue (Myers & Wee, 2002).

Lastly, if the leader of the support group finds that a particular social worker is not being helped or requires additional help in combating the effects of compassion fatigue, a referral to a mental health professional or to the social worker's Employee Assistance Program (if the social worker's agency should have one) is appropriate. This will ensure that the social worker is receiving individual counseling to help contend with compassion fatigue.

Conclusion

Compassion fatigue can have a harmful effect on a social worker's personal and professional life. Without initiating boundaries and participating in support groups, compassion fatigue can lead to a host of ethical, personal, and professional issues. It could also lead to professional burnout. It is suggested that participation in support groups can strengthen the protective measures used to guard against the development of compassion fatigue. Support groups for social workers who work with traumatized clients are extremely important to prevent and treat the phenomenon of compassion fatigue. Suggestions for future research would include evaluating the role of gender in accessing groups to ameliorate compassion fatigue, the assessment of the greater role of supervision in protecting against compassion fatigue, and a more in-depth study of group and/or peer support in the provision of care for social workers who work with traumatized clients.

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