Work-Related Distress: A Primer on Compassion Fatigue

In this chapter we more thoroughly investigate the nature of work-related mental health, particularly burnout, secondary stress and stress reactions generally, and especially compassion fatigue among animal-care providers.

Work-Related Distress

Work-related mental health problems are one of the main challenges currently facing organizations, particularly because of their serious consequences for the organizations themselves and for individuals. Indeed, a direct link has been found among stress and heart disease, dissatisfaction at work, accidents, and certain forms of cancer. Work-related mental health problems are the primary cause of the increase in absenteeism rates. Not until the 1970s was there sufficient awareness of and some degree of attention given to workplace distress. Historically, work-related stress was perceived to be a problem only in high-pressure, low-paying jobs, such as teaching and social services.

Work-related stress is not a weakness, and workers don’t have to suffer with it. Employers have a duty to protect their workers’ health and safety at work, and a good employer appreciates any employee suggestions for reducing work-related stress. Such stress is a symptom of an organizational problem, not an individual weakness.
Work-Related Stressors

For the animal-care provider, examples of work-related stressors are endless.

- **Demands of the job of animal care.** Frequently this means having too much to do in too little time. It can also mean inadequate training and/or supervision or support for caring for animals and dealing with the public. On rare occasions it means boring or repetitive work or having too little to do.

- **Stressors of lack of clarity about responsibilities.** This frequently means feeling confused about how everyone on the staff fits in and/or having responsibility for looking after certain clients and owners.

- **Stressful relationships with fellow animal-care providers.** These include poor relationships with others (e.g., personality clashes, not feeling respected) or being bullied or the target of racial or sexual harassment.

- **Balancing work and home.** Sometimes this means having to deal with inflexible work schedules or emergency calls after hours, or when one’s personal life affects work performance. Working conditions stressors include being in physical danger from aggressive or sick animals or owners or being exposed to poor, unhealthy, and even dangerous working conditions (e.g., unsafe neighborhood or physical plant).

- **Stressors caused by management** (departmental supervisors, executive director, or board of directors). Among these stressors are the lack of control over one’s own schedule, work activities, and/or immediate environment; a lack of clear and consistent messages and decisions; a negative work culture; and the lack of rewards or support for successes. These chronic stressors on the animal-care worker can lead to a wide variety of negative outcomes, including workplace burnout.
Burnout in the Workplace

Burnout is defined most often as exhaustion of physical or emotional strength, usually as a result of prolonged stress or frustration. The concept of burnout emerged in the mid-1970s as a mental health issue. Work burnout doesn’t occur overnight however, unless the distress at work is addressed—no matter the cause, symptoms worsen and become harder to treat. Work-related burnout as a term was coined by Furstenberg (1978), but major developments emerged with the work of Maslach (1982). Work-related burnout is not limited to those who work with the traumatized, and it is as debilitating as in other fields. Burnout can be caused by conflict between individual values and organizational goals and demands, an overload of responsibilities, a feeling of having no control over the quality of services provided, awareness of little emotional or financial reward, a sense of a loss of community within the work setting, and inequity or lack of respect at the workplace (Maslach and Leiter 1997). Often the individuals who experience burnout are highly idealistic about helping others (Pines and Aronson 1988). Burnout also can be related to consistent exposure to traumatic material (Aguilera 1995).

Similar to secondary traumatic stress (STS), discussed later, burnout is a “process, not an event” (Farber 1983b, 3) “marked by physical, emotional, and behavioral indicators that can be easily recognized” (Aguilera 1995, 269), allowing for self-initiated intervention if the caregiver is trained and aware of the manifestations. The physiological responses include physical exhaustion, headaches, and hypertension. Not unlike STS, reactions to burnout include emotional exhaustion (Prosser et al. 1996), depression, and anxiety. Behavioral responses include boredom, decline in performance, insomnia, increased addictions or dependencies, interpersonal difficulties, and cognitive response such as self-doubt, blame, and general disillusionment (Farber 1983a; NiCarthy, Merriam, and Coffman 1984; Prosser et al. 1996). There can be a sense of reduced personal accomplishment and purpose; feelings of helplessness and hopelessness (Maslach 1982); impairment of family relationships (Farber 1983a); development of a negative self-concept and negative attitudes toward work, life, and other people; and nightmares (Pines and Aronson 1988).

The Etzion (1984) study explored the relationship between burnout and social support, since social support has been proposed as a major
resource to reduce harmful consequences of stress. Burnout was found to be significantly and positively correlated with stressors, while support is significantly and negatively correlated with burnout. Life support was more effective in moderating work stress for women, while work support was a more effective moderator for men. Women had significantly higher burnout and life stress than men, but enjoyed higher life support.

Prosser et al. (1996) reported that higher rates of burnout were found in community mental health workers than in hospital-based staff. Practice implications addressed the need to develop measures of prevention of burnout, especially for community mental health workers, and for the need for a greater understanding of the impact of long-term involvement on professionals and clientele. Stav, Florian, and Shurka’s 1987 study identified frequency and satisfaction of supervision as potential moderators of burnout in social workers in various settings.

For the purposes of this book and our focus on animal-care providers, the symptoms can be organized into five categories: poor motivation, workplace dread, alienation, aggression, and health problems.

**Poor motivation.** The reasons we choose a job are the same reasons we run from it. Most animal-care workers remember feeling motivated and ambitious at the beginning of their careers or employment. If you do as well, compare that with how you feel today. If you no longer care about doing an exemplary job, if your only aim is to get out of the office as early as possible, or if you find yourself doing only the minimum amount of work you can get away with—with no desire to advance yourself—you may have one of the symptoms of work burnout.

**Workplace dread.** There are many ways in which your work situation can become intolerable. You may dislike your boss, feel overloaded with work, resent that you are unappreciated, or think all of your clients are difficult to deal with. You may feel that your job is no longer challenging and your tasks have become mundane and repetitive. Feeling that you are stuck in a dead-end job can be demoralizing and can easily lead an animal caregiver to lose enthusiasm for his or her work. This feeling of dislike is also associated with work burnout.

**Sense of alienation.** Have you begun to feel isolated from your colleagues at work? Do you avoid social contact or conversation
with them? Have you begun to resent their good humor or ambition? Mentally separating yourself from work colleagues and others creates a sense of alienation. Animal-care providers in this situation often begin feeling left out (everyone else seems to like his or her job, why don’t I?), and these feelings only exacerbate other frustrations.

**Aggression.** Do you find yourself losing your temper faster than before? Does everything seem to get on your nerves? Animal-care providers who experience symptoms of work burnout often find that they have no patience for what they perceive as incompetence of others. They often want to—or do—snap at colleagues. All this, of course, only leads to further isolation in the workplace.

**Health problems.** Work burnout eventually manifests itself in some physical form. It is at this stage that most people finally recognize or admit that something may be wrong. The most common health symptoms are tension headaches, backaches, and other stress-related problems. Animal-care workers may also find that they cannot sleep. They may gain or lose weight and find that they are indulging in alcoholic beverages more than usual. Feelings of self-pity or depression are also common.

**Systemic Traumatology and Secondary Victimization in Families**

People can be traumatized either directly or indirectly (Figley 1982, 1995). **Secondary or systemic trauma,** most often found in the context of families, occurs when the victim is traumatized through the process of learning about the primary trauma experienced by a loved one or by the secondary victim’s frequent interactions with a primary trauma victim and his or her presentation of primary trauma symptoms. In contrast to a family member who is in harm’s way, other family members may become traumatized by *helping* the family member in harm’s way. Therefore, while the symptoms associated with primary and secondary trauma are remarkably similar, there is one fundamental difference.
Secondary Traumatic Stress Reactions

Animal-work practitioners, though not directly in harm’s way, show the classic symptoms of post-traumatic stress disorder (PTSD). As noted elsewhere (Figley 1995, 2002), the psychiatric symptoms of people directly in harm’s way (e.g., those hit by a car) are called *primary trauma survivors*. They are different from their caregivers, who are exposed to trauma indirectly. *Primary* trauma survivors with PTSD struggle to make sense of trauma memories. *Secondary* trauma survivors (caregivers) try to help primary trauma survivors (i.e., victims) with empathy and compassion and frequently experience symptoms similar to those of the victims. This is secondary or systemic trauma.

Family members report experiencing emotional, cognitive, and behavioral symptoms similar to those reported by the primary trauma victim (Table 3.1). Barnes (2004) reports that the symptoms of secondary trauma reported in the literature include intrusive thoughts, nightmares, flashbacks, feelings of detachment and estrangement from others, restricted affect, avoidance of activities that remind them of the traumatic event, sleep disturbances, hypervigilance, and fatigue. It is clear that traumatized individuals, couples, and families can have a variety of problems that may or may not be presented initially to a health-care professional as being associated with a traumatic event and its post-traumatic aftereffects. Often problems seem to focus on the behavior of other family members or to be marital or couples’ issues that are consistent with secondary trauma rather than the primary post-traumatic symptoms of the trauma victim. This situation is often seen following an automobile accident or recovery from a life-threatening illness, such as cancer or a cardiac condition, after which family members experience symptoms they fail to connect with the original traumatic event. A good assessment of past traumatic events, including accidents and medical problems, is important for a health care professional to identify issues that underlie the surface problems.

Compassion Stress and Fatigue

“Compassion fatigue” was first used in discussions related to burnout in nurses exposed to traumatic work-related experiences (Joinson 1992). Nurses who are compassionate are far more than just empathic, according to Koerner (1995).
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<th>Cognitive</th>
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<td>Loss of meaning</td>
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<td>Decreased self-esteem</td>
<td>Survivor guilt</td>
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<td>Preoccupation with trauma</td>
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<td>Trauma imagery</td>
<td>Numbness</td>
<td>Sleep disturbances</td>
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<td>Apathy</td>
<td>Fear</td>
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<td>Rigidity</td>
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<td>Disorientation</td>
<td>Sadness</td>
<td>Hypervigilance</td>
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<td>Whirling thoughts</td>
<td>Depression</td>
<td>Elevated startle response</td>
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<td>Thoughts of self-harm or harming others</td>
<td>Hypersensitivity</td>
<td>Use of negative coping</td>
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<td>Self-doubt</td>
<td>Emotional roller coaster</td>
<td>(smoking, alcohol or other substance abuse)</td>
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<td>Perfectionism</td>
<td>Overwhelmed</td>
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<td>Minimization</td>
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<td>Impact on Professional Functioning</td>
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<th>Performance of Job Tasks</th>
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<td>Decrease in quantity</td>
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<td>Low motivation</td>
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<td>Avoidance of job tasks</td>
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<td>Poor communication</td>
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<td>Increase in mistakes</td>
<td>Apathy</td>
<td>Subsume own needs</td>
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<td>Setting perfectionist standards</td>
<td>Demoralization</td>
<td>Staff conflicts</td>
<td>Irresponsibility</td>
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<td>Obsession about details</td>
<td>Lack of appreciation</td>
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<td>Detachment</td>
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Compassion, a prerequisite for their job, is “based on a passionate connection...Passion moves one beyond feeling and emoting toward social action aimed at relieving the pain of others” (317). Koerner further states that having a compassionate style of practicing “demands risk coupled with a recognition of our own limitations” (317). The terms compassion stress and compassion fatigue began to be used synonymously with STS and PTSD, because compassion-fatigue reactions parallel a PTSD diagnosis, except that the traumatic event is the client’s traumatic experience that has been shared in the process of therapy or interaction with the client.

Most of the literature on compassion fatigue, however, has focused on psychotherapists who work with traumatized patients. In one of the earliest investigations, Hollingsworth (1993) assessed the responses of therapists working with female survivors of incest as part of her doctoral dissertation. The purpose of the investigation was to build a theory of the effects of such work on female therapists. All of the research participants had experienced lasting negative change in at least one of the following cognitive schema (“an abstracted knowledge structure, stored in memory, that involves a rich network of information about a given stimulus domain” [Janoff-Bulman 1989, 115]): trust of others, safety of children, intimacy, connectedness, esteem for others, and independence of power. General themes indicated included feelings of anger, disgust, sadness, and distress; difficulty maintaining relationships and boundaries; somatic responses; and intrusion symptoms. What Hollingsworth found was instructive. Effective strategies evolved for these female therapists that enabled them to work with this population of clients. These strategies included peer support, supervision and consultation, training, personal therapy, maintaining balance in one’s life, and setting clear limits and boundaries with clients. In addition, the study determined the existence of lasting positive changes, which had not been addressed in the literature at that time.

Many competent caregivers are “most vulnerable to this mirroring or contagion effect. Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress...resulting from helping or wanting to help a traumatized or suffering person” (Figley 1993, 1). If the signs of STS are ignored,
secondary traumatic stress disorder (STSD) may develop. Caregivers with compassion fatigue begin to dream their clients’ dreams, experience intrusive thoughts or images (Cerney 1995), and/or experience distress or physiological reactions to reminders of that client’s traumatic experience. Symptoms may be exhibited as active efforts to avoid thoughts, feelings, activities, and situations that remind one of the client’s traumatic events. There could be a decrease in interest in activities that once brought pleasure or relief of stress; affect can be diminished as well. Compassion fatigue evokes hyperarousal symptoms such as sleep disturbances, difficulty concentrating, high startle response, feelings of agitation or irritability, or hypervigilance (Figley 1995).

Compassion fatigue can affect not only caregivers, but their family and closest friends as well, because they are a system of support (Cerney 1995). The “contagion effect” (Figley 1993) can be transmitted to the support system. Caregivers “may traumatize their families by their chronic unavailability and emotional withdrawal, perhaps in the same way that trauma victims sometimes traumatize those around them” (Cerney 1995, 140). This distancing may occur when caregivers do not believe anyone would be able to understand the distress they are experiencing as a result of such intense and difficult work (Dutton and Rubinstein 1995).

Research on compassion fatigue has suffered from conceptual and methodological limitations. Conceptually, researchers have attempted to differentiate compassion fatigue from job burnout, vicarious trauma, and general psychological distress, but the terms have remained imprecise (Jenkins and Baird 2002; Salston and Figley 2003; Sabin-Farrel and Turpin 2003). There has also been little research on how compassion fatigue relates to a history of trauma, social support, coping strategies, or the stress process in general (Schauben and Frazier 1995; Kassam-Adams 1999; Salston and Figley 2003). Lack of conceptual clarity has hindered implementation and measurement of these concepts and impaired empirical development. Several compassion-fatigue scales have been proposed, but there have been few validation studies, with almost no information on the psychometric properties of the scales used (Figley 1999; Gentry, Baranowsky, and Dunning 2002; Stamm 2002).
Previous studies have also often failed to include a comparison group that has not been exposed to traumatized clients (to control confounding variables such as the counselor’s own trauma experiences), to examine organizational or other factors that may increase the vulnerability of a therapist to compassion fatigue, and to implement research to assess the causal relationship between client exposure and compassion fatigue (Pearlman and MacIan 1995; Schauben and Frazier 1995; Jenkins and Baird 2002). The consequence of these conceptual and methodological problems has been contradictory results and the general finding that most professionals providing trauma therapy have little difficulty coping with the demands of their work (Sabin-Farrel and Turpin 2003). Conceptual clarity and more rigorous study designs, we think, can assist in identifying the professional caregivers most vulnerable to compassion fatigue and advance our understanding of the potential occupational and environmental hazards of this work.

To address these limitations, Boscarino and C.R.F. conducted the first comprehensive test of the concept of compassion fatigue by comparing social workers in the New York metro area who were or were not exposed to traumatized clients (Boscarino, Figley, and Adams 2004). Experience suggests that individuals working in the caring and psychotherapeutic professions are among those to provide mental health services to disaster victims suffering from psychological trauma following catastrophic events. Yet few studies have focused on the emotional exhaustion that comes from working with such clients, referred to as compassion fatigue, and how this differs from other occupational hazards, such as job burnout. In their 2004 study, Boscarino, Figley, and Adams used recently validated scales to predict compassion fatigue and job burnout related to providing services to those affected by the World Trade Center (WTC) attacks of 2001. The study data were based on a random survey of 236 social workers living in New York City, over 80 percent of whom reported being involved in post-WTC disaster counseling efforts. Their analyses indicated that, controlling for demographic factors, years of counseling, and personal trauma history, compassion fatigue was positively associated with WTC recovery involvement (p < .001) and negatively associated with having a supportive work environment (p < .01). In contrast, job burnout was negatively associated with having a supportive work environment (p < .01), but not associated with WTC involvement.
or WTC counseling efforts. The results support all major aspects of the original formulation of compassion fatigue (Figley 1995).

**Traumatic Countertransference and Vicarious Trauma Responses**

In addition to compassion fatigue and secondary traumatic stress reactions are two other closely related terms that we discuss briefly.

*Countertransference to the traumatized.* Although countertransference is linked to psychoanalytic theory and has been in the literature for many years (Neumann and Gamble 1995), it had limited use for understanding STS reactions among practitioners. The more contemporary perspective on countertransference involves the spontaneous or evoked responses of the therapist in regard to information provided, behaviors exhibited, and/or emotions displayed by the traumatized client. Danieli (1996) describes countertransference related to working with clients presenting massive traumatic experiences as traumatic, or event, countertransference:

Countertransference reactions...inhibit professionals from studying, correctly diagnosing, and treating the effects of trauma. They also tend to perpetuate traditional training, which ignores the need for professionals to cope with massive real trauma and its long-term effects. (196)

One study (Hayes et al. 1991) identified characteristics that potentially manage the countertransference effects in the context of delivering psychotherapy. Although not noted elsewhere, countertransference may play some role in the context of delivery services by animal-care workers. Hayes et al. found that self-integration, stress management, conceptualizing, empathy, and self-insight are associated with managing countertransference. Therefore, managing countertransference is seen more as a function of personality composition and is related to unresolved conflict within the therapist.

Caregivers working with survivors suffering from exposure to cruelty often experience reactions and find the cruelty fairly easy to visualize, thereby potentially keeping the provider from remaining engaged with the client. That is, as a way of defending themselves from hearing the client/survivor's traumatic material, providers may
dissociate to some degree, distance themselves, question the veracity of the story being told, experience somatic responses, and be overwhelmed with feelings of grief or helplessness. If the traumatic experiences “touch” on any personal traumatic history, the therapist may become somewhat numb and not hear the client (Danielli 1996).

Whether confronting classical or traumatic countertransference, a therapist must possess a healthy character structure, be able to control anxiety, actively use conceptual skills, be able to maintain empathy while disengaged from the process of identification, and work on bringing unconscious material into conscious awareness to manage countertransference effectively (Hayes et al. 1991). Managing countertransference is essential because of the possibility of developing STS.

Vicarious trauma (VT). In the process of providing services to survivors, caregivers are exposed to traumatic material that begins to affect their world view, emotional and psychological needs, belief system, and cognitions, which develop over time. VT is a result of empathic engagement with survivors’ trauma material (Pearlman and Saakvitne 1995; Schauben and Frazier 1995). It is recognized as normal, predictable, and inevitable, yet, if caregivers do not work with the transformation that is taking place, it can have a serious effect on them as individuals and as professionals. It can also affect interpersonal relationships (McCann and Pearlman 1990; Pearlman and Saakvitne 1995).

Janoff-Bulman (1989) discusses the fact that everyone has beliefs and assumptions, and these are often challenged when one experiences stressful life events, including a traumatic experience. The assumptions have also been identified as “schemas,” as previously cited. The three basic assumptions include the perceived benevolence of the world, the meaningfulness of the world, and the worthiness of self. When a person is victimized or traumatized, these assumptions can be challenged.

VT can be addressed through acceptance and recognition of the changes that occur, through giving oneself permission to limit exposure to the pain of clients, and to expand one’s knowledge about trauma generally and its direct and indirect effects on caregivers in particular. It is also important to be sensitive, when in the course of providing care to clients, to caregivers’ feeling increased VT-related distress and why. Then one can use that information to better set limits with clients.
A study by Lee (1995) explored the development of STS from the perspective of compassion fatigue and VT. The purpose of the study was to determine the degree of STS among marriage and family therapists (MFTs) and the major factors that cause it. The study found that MFTs were often exposed to traumatized clients (63 percent of clients with a diagnosis of PTSD on average). It was not surprising that this group of MFTs scored higher levels of (secondary) traumatic stress than did medical students. Yet MFTs were found to experience little cognitive disruption. Indeed, MFTs’ STS was directly related to their cognitive schemas and their level of satisfaction with their total caseload. Similarly, the more hours they were exposed to clients’ traumatic material, the greater the MFTs’ distress (e.g., intrusion scores).

Lee’s research was consistent with an earlier study by Pearlman and Maclan (1995), which found that more experienced caregivers had fewer disruptions in self-trust than did those who are inexperienced. The difference was even greater when the inexperienced caregivers had little or no supervision.

Schauben and Frazier (1995) explored the effects on female mental health professionals of working with sexual assault survivors specific to STS from a perspective of VT and PTSD symptoms. They also explored the effects of therapists’ victimization histories and their coping mechanisms for job-related stress. The results indicated that therapists with higher percentages of survivors in their caseload reported more cognitive schema disruptions, more VT, and more PTSD symptoms. The five most common coping mechanisms used were associated with lower levels of symptoms. Prior trauma history of the therapists and the interaction term were not significant.

**Toward a Humane Workplace**

Understanding the importance of a supportive work environment for preventing or helping to mitigate work-related distress, how can managers help? Let us look first at the signs of work-related distress among animal-care providers; at strategies for discussing and implementing a program of self-care, stress management, and instilling a sense of achievement; and at accentuating resilience and resiliency in the workplace.
Symptoms
The many signs of secondary stress or compassion fatigue among animal-care providers are listed in Table 3.1. It should be obvious in reviewing these symptoms that distress associated with dispensing compassion is pervasive and potentially long lasting. Later we talk about those who may feel that they are stuck. The first step in the process of confronting compassion stress and fatigue is a self-assessment. Indeed, the research on animal caregivers (see chapters 5 and 6) shows them experiencing considerable compassion fatigue, yet on average they love their jobs and derive considerable satisfaction from caring for animals.

Self-Assessments and Confronting the Problems
Once it is clear that something needs to be done beyond reducing or eliminating the emotionally toxic elements within the work environment, the time comes to manage one’s responses effectively, both at work and away. Please refer to appendix A, where you will find the Academy of Traumatology’s Standards of Self-Care, along with guidelines for following these standards.

The Need for Transformation for Those Who Are Stuck
“Stuck” is knowing that you have work-related distress, particularly compassion fatigue, but are unsure how and when to change. The Green Cross Foundation (www.GreenCross.Org) initiated a major program, The You Too! Wellness Weekend™, in 2005. Participants come together in a relaxed environment for three days to focus on themselves. Most are professionals and volunteers who work with the most challenging of clients and situations and who view their work as a “calling.” Most have the tendency to help others and forget about themselves. These are the primary candidates for compassion fatigue.

The You Too! Wellness Weekend™ does far more than educate participants about burnout and the symptoms of STS. Participants
learn about who is most vulnerable not only to job-related stress but also to themselves—not just professionally but personally, spiritually, interpersonally. Participants learn what they want for the rest of their lives; develop a plan for attaining it; and identify the people, places, and things (real and imagined) that are blocking them from realizing their hopes and dreams.

Some of these things are associated with specific skills and knowledge (e.g., stress management, spirituality, intuition-development, and self-healing) learned during the weekend. These features emerge directly from the research literature in self-improvement and career development because that is what so many in the caring field need now. This is why the Green Cross Foundation has focused so much energy and so many resources on this project.

The most challenging part of the You Too! Wellness Weekend™ is enabling participants to make changes in their lives. Similar to keeping New Year’s resolutions, the intent is there—what is lacking is follow-through. This is where the Green Cross Foundation’s MASTERS Process of Wellness Transformation helps to insure follow through. The process requires, for example, adopting the right attitude toward wellness in our lives, starting with the intention to change parts and patterns of our lives. The process is challenging but well worth the effort, because in the end the participants’ lives are happier, healthier, and more productive. From more than two decades of research in human resources, change-required commitment, analysis, planning, and experimentation, the MASTERS Process of Wellness Transformation provides a description of (or prescription for) seven building blocks for life transformation. It is not easy, it is not based on faith or social support or anything other than a total commitment on the part of the participants to first recognize that they have neglected themselves for too long and, as a result, have neglected those they love and serve as well. Here then are the seven building blocks as related to our participants at the foundation’s You Too! Wellness Weekend™.

**Building Block One: Motivation.** Intention is setting your mind to a particular task; motivation is the force needed to actually carry out the task. People make New Year’s resolutions with every good
intention, but without adequate energy and action, they never even try to fulfill their intention. Motivation is required, not only to set goals for a life plan for wellness, but also to establish a workable plan, carry it out, and fine-tune it to actually acquire wellness at the most appropriate level, a level that is at the lowest level or highest level depending upon the resources of the person seeking wellness, such as the time or money available. The MASTERS Process of Wellness Transformation will never be completed unless there is sufficient motivation throughout the process. Thus, we define motivation in the Process of Wellness Transformation as the intention, commitment, energy, and sustenance to complete transformation to the most appropriate level.

Building Block Two: Assessment. Assessment requires motivation. It is completing a battery of tests and procedures that result in additional information about how we are functioning with regard to stress, coping, and social support. It also includes efforts to discover our hopes and dreams about future functioning. Assessment in some ways is a mirror, providing images of our psychosocial and emotional functioning that, when observed, reveal where improvements are needed.

Thus, we define assessment in the process of wellness transformation as the gathering of factual and objective information that informs us from where we are now to where we want to be and which may lead to a healthier and happier self.

Building Block Three: Self-reflection. The next building block in the transformation process toward wellness is self-reflection. Self-reflection begins after the process of assessment and involves careful consideration of what this information represents to the person in his or her journey toward transformation. Self-reflection requires honesty, concentration, and vision. This building block is critical in fairly interpreting the self-assessment, and not only in identifying the areas that require change and development. Self-reflection requires recognizing and retaining one’s strengths, satisfactions, and sustenance throughout the transformative process and for the rest of one’s life. Too often we ignore or do not appreciate our positive features—our kindness, compassion, sensitivity, civility, humor—and become transfixed by what we are missing and want to acquire. C.R.F. defines self-reflection in the process of wellness transformation as the process of taking stock of what to keep and what to change to ensure lifelong wellness.
Building Block Four: Transformation. One of the most important building blocks, transformation reflections lead to constructing the first draft of a life plan for wellness and transformation for the rest of one's life. It is a process by which we make explicit what we perceived in the assessment results and considered in the self-reflection process. It is transforming information and insight into a solid, measurable, usable wellness life plan. We define a person's life plan as a never-ending, always evolving set of standards and activities that assure wellness for him or her. We define wellness transformation as a process of shifting from one mind-set that lacks wellness to one that embraces and moves toward wellness. We define transformation reflection as the process by which we concentrate on what we need to acquire and retain wellness in contrast to where we are at the time, and we do this reflecting in a state of peace and calm (i.e., being centered) rather than under duress or in distress.

Building Block Five: Evaluating. The fifth building block in the MASTERS Process of Wellness Transformation is evaluation, the process of seeking, finding, and learning about those life skills that are tools for achieving our life plan for wellness. Life skills for wellness are defined as those skills that help us become and remain healthy and happy and in a constant state of wellness. These life skills include but are not limited to our ability to select and/or consume the right (1) physical activities, (2) nutrition, (3) stress management and desensitization, (4) spirituality, (5) sense of humor, (6) self-awareness, and (7) other resources, skills, and techniques to acquire and retain wellness. We define evaluating for wellness as the process of learning about the life skills necessary for acquiring and retaining wellness, learning these skills, and practicing them on a regular basis.

Building Block Six: Reviewing. Reviewing for wellness includes two review processes following acquisition and practice of the necessary life skills. The first review involves reviewing one's life up to the present. It involves identifying major life achievements and catastrophes and considering when they happened, why they happened, and what one learned from the experience at the time and at present. The second review process involves reviewing and (if needed) revising the current draft of one's life plan for wellness, in light of newly acquired skills and the results of the life review. We define reviewing for wellness and transformation as the dual process of learning from the past with newly acquired life skills and formulating the best life plan to complete and retain the transformative process.
Building Block Seven: Studying. The final building block of the MASTERS Process of Wellness Transformation is studying, which begins when the wellness life plan is implemented. Rarely are plans perfect, and most often they require some adjustments. What one studies is how the life plan is working and whether any obvious adjustments are required to make it work better. The longer one lives with the life plan for wellness, the fewer changes and adjustments are necessary. In the first year, however, studying the life plan leads to many, many changes and adjustments for peak wellness. We define studying the wellness plan as the process of carefully measuring the benefits and costs of each element of the plan. Using such an analysis will help the person make improvements to the plan to insure that it is useful long into the future.

Humane Society University’s Approach

The mission of The Humane Society of the United States (HSUS) is to create a humane and sustainable world for all animals, including people. Through education, public policy advocacy, and the promotion of best practices in all facets and at all levels of animal welfare work, it seeks to forge lasting and comprehensive changes in attitude and behavior; relieve animal suffering; prevent abuse and neglect; and protect wild animals and their environments.

Humane Society University (HSU) is an essential component of The HSUS’s commitment to the promotion of professional practices within the animal-control and -sheltering community. Animal-care and animal-control personnel, wildlife rehabilitators, and animal organization volunteers and board members are HSU’s primary constituencies. This makes HSU virtually unique as a corporate university whose target audiences consist of individuals associated with a range of independent groups not affiliated with its parent organization.

HSU began to incorporate courses and seminars on professional leadership development to help animal-care and -control personnel gain the skills and knowledge necessary for job success and career advancement. Through HSU The HSUS has moved toward a comprehensive strategy for promoting professionalization and its corollary benefits, meeting a long apparent need for advanced training.

Background and survey research concerning the needs of the field
directly influence HSU’s emphasis on courses on social marketing, compassion fatigue, humane education, and the relationship between cruelty to animals and interpersonal violence. These concerns are central to animal protection work.

From the perspective of the animal-care and animal-control field, in which funding for training is extremely limited, distance learning is an especially promising development. It eliminates time, inconvenience, and expenses associated with travel and accommodations, and permits employees to pursue coursework without having to abandon their daily responsibilities.

The intensity of work-related stress among animal-shelter employees has created a heavy demand for compassion fatigue workshops—which acknowledge and attempt to address the impact of high-pressure responsibilities on shelter personnel. Animal caregivers are among the most susceptible to compassion fatigue because of the toll that performing euthanasia takes on their psyche. Unlike other caregivers, animal caregivers do not have patients who can verbally express their pain and suffering; they instead must rely on their own experience to make decisions for their patients. This phenomenon, the so-called care-killing paradox, is discussed in HSU-sponsored workshops, as is how to recognize the signs of compassion fatigue, how the signs affect individuals and their employers, and, finally, how to manage the signs themselves. These day-long workshops detail the history of compassion fatigue, how to distinguish compassion fatigue from other daily life stresses, and the typical symptoms of compassion fatigue. Students complete a self-test (appendix B) and score the test to determine their risk for compassion fatigue.

During the workshops students learn to develop coping strategies that will focus their energies on alleviating their symptoms. Students learn techniques to alter the stresses in their lives and why the need exists to develop a balanced lifestyle. In-class exercises help students understand how a balanced lifestyle will help alleviate compassion fatigue. The focus of the exercises is typically career, money, health, family, and friends, among other topics. At the end of the course, individualized action plans are developed that will help students to
increase the level of satisfaction they experience in each of the above areas.

Most important in HSU’s recent planning has been the introduction of an enhanced online component, especially in management, humane education, and anti-cruelty law enforcement training. The HSUS has made a strong commitment to online education, purchasing a superior learning platform, recruiting new course developers and instructors, forging new strategic partnerships, and increasing its marketing of online training programs.

**Conclusion**

It is not easy to change, and life change is often reactive rather than proactive. That is, most of us change as a result of a catastrophe—the death of a loved one, ill health, an accident, or other calamity. Changing often requires the help of others—friends, colleagues, or professionals we pay for their services. Some people have little difficulty seeking help. Others find it nearly impossible. Still others for various reasons rarely consider that they need help. Yet the *You Too! Wellness Weekend*™ transformation requires some form of reaching out and securing help. There are some stumbling blocks to transformation, including what C.R.F. has described as the stress-coping personalities. C.R.F. defines them as *a set of traits and characteristics associated with the way stress is perceived and managed, with special attention to the way people seek, secure, and use help.* Change is never easy; you need a plan. We believe that, more than any other education and training, those who work with the traumatized first need to turn inward and examine if and how things need to change and develop a strategy for doing so—for the benefit of everyone.