

## COMPASSION FATIGUE

### A Concern for Mental Health Policy, Providers, & Administration

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#### ABSTRACT

This project examined the impact of compassion Fatigue on the quality of care as an emerging issue for mental health care policy reform. A key questions in the study was whether on not compassion fatigue should be a concern for mental health policy. Using both a policy analysis and an empirical study, the study explored the nature of individual and organizational self-care domains for mental health providers and providers in training. The results indicated that compassion fatigue should be considered at the administrative and policy levels. Suggestions for further research and potential administrative interventions are identified.

#### INTRODUCTION

Simplistically, secondary traumatic stress (STS) is the presence of PTSD-like symptoms in a caregiver—more likely tied to the patient's Criterion A1 experience than their own—mixed with the provider's life experiences (cf. Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 1995).

The burgeoning body of theoretical and empirical work in this area suggests that STS should be a concern for individual mental healthcare providers and providers-in-training. Moreover, if in fact, STS is present, it is likely affecting the quality of care and therefore not only a concern for individual providers but also for mental health administration and even healthcare policy. Clinical evidence suggests that STS can be managed or prevented with a combination of personal, professional and administrative or policy interventions. While there are no causal explanations for development or cure at this point, the best available literature suggests individual and organizational factors combine in complex ways to give form to important risk and protective factors for developing STS (e.g., Figley, 1995; Pearlman & Saakvite, 1995; Stamm, 1995).

STS was operationalized as Compassion Fatigue (CF). Figley (1995) posits that CF is a natural consequence of working with people who have experienced extremely stressful events. CF develops as a result of the provider's exposure to their patients experiences combined with their empathy for their patients.

CF, like burnout, can challenge a provider's ability to render effective services and maintain personal or professional relationships. Contrasted with CF which is sudden and

acute, burnout is a gradual wearing down of the provider by the feelings of being overwhelmed by one's work and incapable of effecting positive change (Figley, 1995). While different from CF, burnout may be an important risk factor for CF (Beaton & Murphy, 1995; Cerney, 1995; Chrestman, 1995; Dutton & Rubenstein, 1995; Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 1995; Weiner, 1989). To understand how such work affects providers, it is important to understand both burnout and CF.

STS theory predicts that professionals affected by STS are at a higher risk to make poor professional judgments than those professionals who are not affected (Munroe, 1995; Pearlman & Saakvitne, 1995; Williams & Sommer, 1995). Examples of poor professional judgment could include mis-diagnosis, poor treatment planning, or abuse of patients. Conversely, STS theory predicts that personal, professional, and organizational support may provide protective factors to mediate some risks for developing STS.

This study addressed both individual and organizational variables to examine potential risks and mediating factors in the development of Secondary Traumatic Stress (see Figure 1). First, an empirical analysis was undertaken to examine the level of CF, overall quality of life, and professional practice environments. Second, using the data gathered in the empirical study, combined with the extant literature, a policy analysis examined the administrative and political feasibility, efficiency, and effectiveness of six administrative interventions.

#### METHOD

**PARTICIPANTS:** 113 females and 66 males completed the instruments. Data were collected from 5 locations: (a) the 1996 ISTSS Conference (Boston, MA; n=29), (b) Alaska Public Health Nurse Annual Convention (Anchorage, AK; n=20), (c) American Red Cross (Anchorage, AK; n=10), (d) InterPsych (an international, Internet based, professional mental health organization; n=19), and (e) University of Alaska Anchorage (n=101). Demographic information is summarized in Table 1

**PROTECTION OF PARTICIPANTS:** There was no physically invasive aspects to the study; there was some risk of emotional distress. Participants were advised to discontinue participation if they became distressed. A list of mental health resources was provided. The informed consent outlined the subject's rights and the researchers obligations in line with the American Psychological Association code of ethics, the ethical recommendations of the ISTSS Ethics Workgroup (Sommer, Williams, Stamm & Harris, 1994), and the University of Alaska Anchorage IRB. Weekly and as needed team meetings provided researcher debriefing.

**MEASURES & PROCEDURES:** Data was collected in two ways: (a) hardcopy instrument packages, (b) electronic copy. All participants received identical packages (either paper or electronic) containing informed consent and instruments.

*Demographic, Personal, and Professional Practice Habits.* This form was developed for this study and included information about personal and family demographics; personal habits regarding friendships, diet, exercise, sleep; and professional practice habits including training, types of activities done and computer knowledge and access.

*Compassion Fatigue Self test for Practitioners* (Figley, 1995; Figley & Stamm, 1996). This 40-item self-report measure of CF and Burnout has alphas ranging from .76-.94. Interpersonal Capacity was operationally defined as CF and burnout.

*Life Satisfaction Scale* (Kopina, 1996), Quality of life was measured by a 35-item self-report measure of life satisfaction with three sub-scales: (a) Subjective State (alpha=0.76), (b) Life Conditions (alpha=0.81), (c) Life Spheres (alpha=0.89).

*Stressful Life Events Scale* (Stamm et al., 1996). This 20-item self-report measure was used to identify stressful experiences throughout a participants life, with an alpha of 0.76.

In total, 305 packages were distributed (not including the web site); 179 were returned, yielding an overall response rate of 59%. All scales were compared in a series of 2 (sex) x 3 (level of training) ANOVA's using SPSS 4.1 on a VAX/VMS V6.1.

**POLICY ANALYSIS** The administrative implications of six interventions (see Figure 3), were examined in four areas: (a) *effectiveness* of reducing the risks of STS; (b) *efficiency* or cost/benefit ratio; (c) *administrative feasibility* of the fiscal and administrative implications; and (d) *political feasibility* listing legal or professional standards related to the intervention.

## RESULTS

The data presented here were part of a larger study addressing the potential effects of health policy on the well-being of providers, represented through the Individual & Organizational self-care domains outlined in Figure 1. These data focus on provider wellbeing; specifically the interpersonal capacity and quality of life across sex (male, female) and levels of training (Bachelors, Masters, Doctorate). Additional information about the demographics, professional practice habits, training history are included on Tables 1 and 2 and Figure 2.

Thirty-seven percent reported a high risk of CF (n=67) and 54% a high risk of burnout (n=97). There was a main effect of training level for both CF ( $F_{2, 66}=4.26$ ;  $p=0.018$ ) and burnout ( $F_{2, 66}=3.135$ ;  $p=.05$ ). Post hoc analyses showed that Masters level providers were at a significantly higher risk of developing CF and burnout than the group as a whole. Conversely, bachelor level providers were at a significantly lower risk of developing CF and burnout than the group as a whole. In both analyses doctoral level providers were at moderate risk.

The Life Satisfaction subscale showed an interaction of sex by training level ( $F_{2, 72}=4.304$ ;  $p=.02$ ). Post hoc analyses showed male doctoral level had a significantly higher quality of life than the group. Conversely, female doctoral and male masters level reported significantly lower life satisfaction than the group as a whole. Female masters and all bachelor level reported a moderate level of life satisfaction. There were no significant differences in the Life Conditions or Life Spheres.

## DISCUSSION

Is STS a concern for mental healthcare providers? Certainly the current literature and the data collected in this study suggest that it should be. This data shows that 1 of 3

providers reported a high risk of developing STS, and 1 in 2 providers reported a high risk for developing burnout. It is ironic that there are so many affected providers in a field designed to provide care.

Is STS a concern for mental health administration and policy? In many ways, the health of an organization depends upon the health of its staff. This is especially important for industries, like health care that rely, not on the production of machine measured products, but upon the providers' accurate perception, sound judgment, and decision making. These faculties are often challenged when providers are worn down by either their work environment (burnout) or by the content of their work (STS).

The current trends in healthcare to reduce administrative overhead have lead to things such as increased paperwork, increased workloads, and the elimination of support systems. While these cuts may demonstrate short term savings, the long-term savings associated with these changes are difficult to measure (e.g., time saved, appropriate treatment, etc.). The effect of the cuts may only come to light when they reach crisis states. These short-term cost-cutting reductions are particularly unfortunate because many of the support systems which may be important positive mediators in STS are currently in place, relatively inexpensive to maintain, and may increase the quality and decrease the cost of care.

For example better management of case loads (Chrestman, 1995; Kassam-Adams, 1995; Pearlman, 1995; Munroe, 1995), using internet and e-mail resources to enhance access to consultation and information (Stamm & Pearce, 1995), increased staff time (Catherall, 1995; Pearlman, 1995a; Munroe, et al., 1995), adequate leave time (Pearlman, 1995a; Munroe, 1995), adequate insurance that includes mental healthcare (Catherall, 1995; Pearlman, 1995a; Munroe, 1995), and adequate clinical and administrative supervision (Catherall, 1995; Munroe, 1995; Pearlman, 1995; Stamm & Pearce, 1995).

To examine the administrative implications of these six interventions, a policy analysis was done focusing on four areas: (a) *effectiveness* of reducing the risks of STS; (b) *efficiency* or cost/benefit ratio; (c) *administrative feasibility* of the fiscal and administrative implications; and (d) *political feasibility* listing legal or professional standards related to the intervention (see Figure 3).

At minimum this preliminary data warrants further research. If these results are supported through future epidemiological studies, it should become incumbent upon healthcare agencies to provide support systems that mediate the risks of developing STS and burnout. Additionally, training programs should develop modules that introduce providers in training to these risks and provide them strategies for recognizing when they are affected by their work and where to seek support.

While these data represent a minute sub-set of all mental health providers, it is clear that health and mental healthcare providers routinely interact with patients who have been affected by traumatic life events. According to Kessler, et al., (1995) about 50 % of women and 60% of men have reported a criterion A1 event, although only about 8% actually meet DSM IV criteria for PTSD. While exposure to a patient's trauma history may not lead to STS, the theory suggests that is a necessary risk factor.

Personal trauma history is certainly an important component of STS; in this sample 100% of the participants reported likely Criterion A1 events. This raises a number of empirical and administrative questions. Empirically, are providers with or without trauma histories at higher risk of developing STS? STS theory suggests that providers with a personal trauma history would be at higher risk due to increased exposure (e.g., Williams & Sommer, 1995). On the other hand, personal trauma history could be a protective factor because the provider may be less naïve and may have had a chance to learn positive coping strategies. Unexposed providers may have a greater abrogation of expectations and therefore be affected. Or, they may be stronger. Administratively, what kinds of support systems, training programs, or interventions should be available for providers working with trauma survivors?

The main thing that organizations and providers can do is to create an atmosphere that supports its staff and colleagues as well as it supports the patients it serves. Additionally, administrators and policy makers need to make policies that account for the organizational and financial goals of the institution without compromising the wellbeing of providers.

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