LIBERTY BAPTIST THEOLOGICAL SEMINARY

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AN EDUCATIONAL METHODOLOGY AND PROGRAM FOR THE MITIGATION

OF COMPASSION FATIGUE FOR COMBAT DEPLOYING CHAPLAINS

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A Thesis Project Submitted to
Liberty Baptist Theological Seminary
in partial fulfillment of the requirements
for the degree

DOCTOR OF MINISTRY

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By

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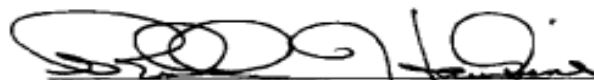
THESIS PROJECT APPROVAL SHEET

AN EDUCATIONAL METHODOLGY AND PROGRAM FOR THE PREVENTION
AND MITIGATION OF COMPASSION FATIGUE FOR COMBAT DEPLOYING
CHAPLAINS

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ABSTRACT

AN EDUCATIONAL METHODOLGY AND PROGRAM FOR THE MITIGATION OF

COMPASSION FATIGUE FOR COMBAT DEPLOYING CHAPLAINS

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Liberty Baptist Theological Seminary, 2009

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Combat deployment presents unique challenges to military chaplains. One such challenge relates to the Vicarious Traumatization, often called "Compassion Fatigue," faced by chaplains who minister to service members experiencing combat-related trauma. There is minimal literature addressing compassion-related stress for clergy, especially those working with combat trauma survivors. Much of the research and literature available has been limited to those in emergency services, medical and mental health professions. This groundbreaking project will draw upon the latest literature, research and empirical data, culminating in an educational methodology and program for compassion stress management for military chaplain combat deployment rotation care.

Abstract length: 98 words.

To all who serve and support those who wear the uniform

of the United States Armed Forces and serve in harm's way

for the furtherance of the Gospel and to my wife Stefanie,

who with patience and longsuffering walked the difficult

road of combat deployment and healing that brought this

project from experience to fruition, remembering that all

things work together for good to the Glory of God.

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LIST OF ABBREVIATIONS

AACC	American Association of Christian Counselors
ACL	Adjective Check List
AO	Area of Operation
ARP	Accelerated Recovery Program
CASEVAC	Casualty Evacuation
CF	Compassion Fatigue
CO	Commanding Officer
CONUS	Continental United States
CREDO	Chaplain's Religious Enrichment Development Operation
DISC	Dominance, Influence, Steadiness, Consciousness assessment.
DSM-IV-TR	Diagnostic and Statistical Manual, Version IV
MAW	Marine Air Wing
MBTI	Myers-Briggs Type Indicator
NATO	North Atlantic Treaty Organization
NIOSH	National Institute of Safety and Health
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PDTC	Professional Development Training Conference (Navy Chaplain Corps)

ProQOL	Professional Quality of Life
PTSD	Post Traumatic Stress Disorder
RMT	Religious Ministry Team
RP	Religious Program Specialist
UMT	Unit Ministry Team, Chaplain and Chaplain Assistant
US/USA	United States of America
USMC	United States Marine Corps
USN	United States Navy
XO	Executive Officer

AN EDUCATIONAL METHODOLOGY AND PROGRAM FOR THE MITIGATION
OF COMPASSION FATIGUE FOR COMBAT DEPLOYING CHAPLAINS

INTRODUCTION

This author serves as a United States Navy Chaplain and is an Operation Iraqi Freedom veteran. He has had the privilege of serving with the finest young men and women our country has to offer after being selected to serve as the first solely dedicated chaplain ministering to the II Marine Expeditionary Force Casualty Evacuation Team for OIF 04-06.2 at Al Taquaddum Air Base, Al Anbar Province, Iraq, from September 2005 through February 2006. This author was selected for this position due to his life experience and "inoculation" to trauma, having served as both a funeral service apprentice and a professional Firefighter and Emergency Medical Technician for over fourteen years. This author had the ability to "speak the medical lingo" coupled with "the experience" to gain instant credibility with the Marines and Sailors serving as corpsmen (affectionately known as docs) and providing the urgent medical care and casualty evacuation in the most dangerous area of war-torn Iraq, known as the "Sunni Triangle."

With confidence, experience and a sound theological and professional skill set, this author began to care for those who had already been deployed for a month in response to the commanding General's directive that a new chaplain billet be created to minister to those who were seeing the worst war had to offer. This was in response to the previous deployment rotation, where seven Hospital Corpsmen returning from combat were seeking psychological care. With life experience that included familiarity with traumatic situations and human mortality, this author, at the direction of his Commanding Officer, began to fly untold numbers of CASEVAC missions for the purpose of gaining

familiarity with the corpsmen's and air crew members' experiences in order to minister to them more effectively. This author also conducted debriefings after serious CASEVAC missions, as well as weekly debriefs, following the Critical Incident Stress Management model.[1] The around-the-clock operations and care for these Marines and Sailors serving on day and night crews created a workload that had no less than 86 and up to 112 documented work hours per week. Of those hours, there were no less than 40 hours per week in formal and informal pastoral counseling. By the time of redeployment to the continental United States, this author noticed major changes in his mood and taxing of his coping skills and personal empathic ability. Introspective questions arose in light of the recognition of these changes; namely, were these combat stress related injuries and are these reactions a sign of Post Traumatic Stress?

Upon redeployment home to the continental United States and a removal from the stimuli and stressors of the hostile environment, this author noticed he was still hyperstartled, but that condition faded after a few weeks. What was disconcerting was an ongoing stress reaction and response manifesting with a hyperarousal to anger that remained for over seven months and appeared to be exacerbated on heavy pastoral care and counseling days. Further, this anger was accompanied by a taxing of empathy and lack of job satisfaction. This author's wife and closest confidant noticed these changes and gave reflective feedback to this author on the symptomology and behavior changes displayed after deployment. This author began to consult with colleagues and screen himself for combat stress injuries and the common signs of Post Traumatic Stress

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[1] Jeffrey Mitchell, Jr. & George Everly, *Critical Incident Stress Management: A New Era and Standard of Care in Crisis Intervention* (Ellicot City: Chevron Publishing, 1997), 3.

Disorder (PTSD). What was noted is that this author did not have direct exposure to

traumatic events as they occurred, but rather exposure to those who had experienced

trauma first-hand and those who cared for them. It was only months later when this

author began to confer with other chaplains who served in field medical hospitals known

as Surgical Shock Trauma Platoons and subsequent CASEVAC chaplains who personally

described the same type of behavioral changes and reactions that he began to seriously

study and consider the issue.

At first this author was concerned that the symptoms were Post Traumatic

Stress Disorder. It was not PTSD in accordance with the *Diagnostic and Statistical*

Manual of Mental Disorders-IV-TR (DSM-IV-TR), as there was an absence of a single

traumatic event that could be pinpointed as a stressor or turning point with an immediate

adverse decline in emotional health; nor was there a revisiting of traumatic memories.

Rather, there was a period during and after the combat deployment with counselee

contact that created emotional highs and lows and culminated with a steady decline in

emotional health. There were symptoms of emotional numbness and lack of empathy, as

well as anger towards those this author counseled and even close family members who

would "whine" over seemingly trivial issues (as compared to the daily life or death issues

associated with combat). This author began to ask the question, did he just have

"burnout" or was it something different? Was there a classification or diagnosis that

would help to explain the shifts in one's schema, steady taxing of empathetic response

and reduced desire to interact and provide pastoral care that he and

his colleagues were experiencing? The answer to these questions lay in a little known

term called Vicarious Traumatization and the manifestation of what has come to be

known as Compassion Fatigue.

CHAPTER 1

WHAT IS COMPASSION FATIGUE?

Scores of service members, including military chaplains returning from Operation

Enduring Freedom and Operation Iraqi Freedom, are experiencing what has been

typically labeled Post-Traumatic Stress Disorder (PTSD), Adjustment Disorder, or even

Burnout.[2] These terms and clinical diagnoses account for the symptomology displayed

by those who have experienced first-hand traumatic events, as well as combat stress

related injuries,[3] but they fail to account for the taxing of empathetic response to clients

and long term fatigue experienced by the very nature of the chaplain's vocation as a

caregiver. Compassion Fatigue is often overlooked as the primary cause of adjustment-

related issues for chaplains returning to the continental United States after a combat

deployment, as it is not formally accounted for in the DSM-IV-TR manual.

Research on the effects of caring upon chaplains serving and caring for those in

combat is sparse at best. For this reason, one must draw upon the current research

available in complementary fields of professional caregiving. Over the past fifteen years,

new research conducted in the Emergency Service and mental health professions has

emerged, focusing on the numbing of empathic response and taxing of coping skills

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[2] C. W. Hoge, et al. "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, 351 (2004): 13.

[3] C. R. Figley & W. P Nash, *Combat Stress Injury: Theory, Research, and Management* (New York: Routledge, 2007), 18-39.

among first responders and medical care providers serving as caregivers to patients who have experienced traumatic events.[4] This research has a direct correlation to that of combat deployed military chaplains, who likewise have developed a professional responsibility, therapeutic alliance and professional relationship caring for those victimized by combat-related trauma. This research has relabeled such terms as "Burnout," "Countertransference"[5] and "Vicarious Traumatization" with the user-friendly term of "Compassion Fatigue,"[6] thereby accurately accounting for the synergistic affects associated with the cost of caring and the taxing of the emotional and empathic responses of caregivers and their associated coping skills.

Combat operations offer military chaplains repeated exposure to traumatic survivors similar to that experienced in the fields of emergency services and medical and mental health practitioners, thereby creating residual stress and fatigue from the compassionate, empathetic response associated with the care and repeated exposure to those victimized by traumatic events. As Hilfiker rightly states, "All of us who attempt to heal wounds of others will ourselves be wounded; it is, after all, inherent in the relationship."[7] Further, "combat stress is like no other, as are the memories it creates, and

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[4] Charles R. Figley, "Compassion Fatigue: An Introduction," *Gift From Within*, 2003, http://www.giftfromwithin.org/html/cmpfatig.html. (accessed February 14, 2008).

[5] Robyn L. Trippany, Victoria White-Kress and S. Allen Wilcoxon, "Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors," *Journal of Counseling & Development* 82 (Winter 2004): 32.

[6] B. Hudnall Stamm, "The ProQOL Manual" (Institute of Rural Health, Idaho State University, 2005).

[7] David Hilfiker, *Healing the Wounds. A Physician Looks at His Work* (New York: Pantheon Books, 1985), 207.

the subsequent consequences of these memories."[8] Though the fields of emergency

services and medical health practitioners differ from combat chaplaincy, the higher

degree and frequency of exposure to the traumatized is analogous. It is this repeated

exposure to suffering that is the catalyst for Compassion Fatigue.

The Compassion Fatigue Process

Dr. Figley has created a model to illustrate the cumulative and synergistic

effects of helping those traumatized. Further, Dr. Figley's model illustrates how the

normal process of helping can leave residual effects and taxing of empathy with repeated

and prolonged exposure to the traumatized and suffering. Without intervention and a

healthy regimen of self-care, one may advance through the Compassion Fatigue Process

from a place of residual compassion-related stress to the debilitation of Compassion

Fatigue.[9] Figure 1 illustrates the Compassion Fatigue Process and the associated

pathways and synergistic effects than can lead to Compassion Fatigue.

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[8] C. R. Figley & W. P. Nash, xv.

[9] Charles R. Figley, *Compassion Fatigue: An Introduction,* 2003, http://www.giftfromwithin.org/html/cmpfatig.html. (accessed February 12, 2008).
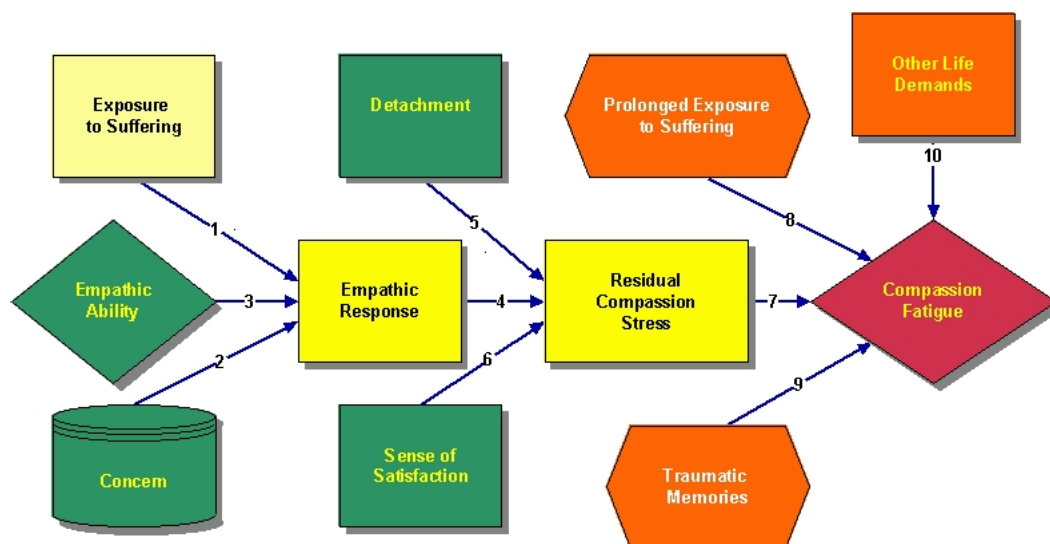
Figure 1. Charles Figley, "The Compassion Fatigue Process."[10]

The crux of Figley's model is that Compassion Fatigue cannot happen unless the clinician has empathic ability. The degree of that empathic ability determines resilience or vulnerability to Compassion Fatigue. With empathetic ability, there must be genuine concern for the client and their welfare, coupled with exposure to their suffering. This exposure to suffering generates an empathic response and emotional contagion.[11] It is the ability of the caregiver to detach from the client's material and gain a sense of satisfaction from helping that determines the clinician's health and the level of residual compassion stress that remains. All clinicians exposed to the traumatized will have some degree of residual compassion stress, but intentional self-care, education, the ability to detach from the client's material, coupled with a high degree of job satisfaction, are

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[10] Ibid.

[11] Jeni Tyson, "Compassion Fatigue in the Treatment of Combat-Related Trauma During Wartime," *Clinical Social Work Journal*, 35 (2007): 184.

inoculates that deter the progression to Compassion Fatigue. What is unique in Figley's model is the synergistic effect of repeated and prolonged exposure to suffering and the recognition of the influence of outside stressors in the life of the caregiver. This has major implications when related to combat deployed chaplains geographically separated from their families, coupled with the stressors of non-stop combat operations and caring for a populace with a higher saturation of traumatized clients. Empathetic resilience can be hampered by an ongoing and continuous exposure to those traumatized. In the final stages of the Figley model, the cumulative residual effects in the memory, coupled with the influence and stressors of one's own personal needs and life demands, have a direct impact on the clinician's resiliency and vulnerability to move from residual compassion stress into Compassion Fatigue.

Defining and Contrasting the Terms

As previously noted, Figley believes that the user-friendly term Compassion Fatigue is more palatable and accounts for many of the synergistic effects and influences that create the taxing of empathic ability and one's emotional coping abilities. This author agrees with Figley's synergistic hypothesis, but each of these unique terms such as burnout, Secondary Traumatic Stress and Vicarious Traumatization have distinctive elements that need to be delineated and defined to avoid confusion and to further identify their impact as part of the Compassion Fatigue Process. The uniqueness of each of the terms that will be examined and their qualifiers account for the difficulty in Figley and B. H. Stamm's attempts to resolve the nomenclature and commonality of terms which have

been used often interchangeably.[12]

Compassion Fatigue

The term "Compassion Fatigue" has only been around since 1992 when, in a nursing magazine, C. Joinson coined the phrase signifying the importance of "the cost of caring" for nurses who became compassionately attached to their patients as part of their duties.[13] Through the work of Joinson, there was a new focus on the nature of compassion and empathy for caregivers who were exposed to those suffering. The associated feelings of sympathy and sorrow, along with the caregiver's need to alleviate the patient's suffering and the associated effects from their sense of empathy, were now the focus of the cost of caring and cumulative effects connected with those therapeutic alliances. Compassion Fatigue was now launched as a term to define the synergistic impact and cumulative effects describing the cost of caring.

Gentry, Baranowsky, and Dunning define Compassion Fatigue as "the convergence [of] primary traumatic stress, secondary traumatic stress and cumulative stress/burnout in the lives of helping professionals and other care providers. When helping others precipitates a compromise in our own well-being, we are suffering from Compassion Fatigue."[14] Compassion Fatigue thus encompasses the synergistic cumulative effects of helping. It further causes distress in the physical, emotional, and

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[12] B. Hudnall Stamm, *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researches, & Educators* (Baltimore: Sidran Press, 1999), xxi.

[13] C. Joinson, "Coping With Compassion Fatigue," *Nursing*, 22:4 (1992): 116.

[14] Baranowsky, Dunning & Gentry, "Accelerated Recovery Program (ARP) For Compassion Fatigue," in *Thirteenth Annual International Society For Traumatic Stress Studies Conference held in Montreal, November 9, 1997*, (Sarasota: Compassion Unlimited, 1997), 1, pdf http://www.compassionunlimited.com/pdf/AcceleratedRecoveryProgram.pdf. (accessed March 1, 2009).

spiritual dimensions and impacts the cognition and schema of the clinician through the

transmission of the client's traumatic stress.[15]

Primary Traumatic Stress

"Primary traumatic stress"[16] was authored and defined by Charles Figley as

"direct exposure to, or witnessing of, extreme events and one is overwhelmed by the

trauma."[17] In this definition, an individual is present at the place of the traumatic event

and is personally exposed to the threat or perceived threat to one's own safety. This term

focuses on the impact of the trauma and would fit into the criterion in the DSM-IV for

post-traumatic stress. Figley argues that Post-Traumatic Stress Disorder should be

relabeled primary traumatic stress disorder. Further, he writes that where the same

symptomology for PTSD exists secondarily in victim helpers, it should be called

Secondary Traumatic Stress Disorder (STSD).[18] According to Figley, the only difference

delineating the two is exposure to the trauma event or exposure to the traumatized

victim.[19] What must also be noted is that primary traumatic stress does not account for

the taxing of empathy found in the helping relationship. Thus, primary traumatic stress

may be an influence in the combat chaplain's life when as a trauma survivor himself, he

employs his role as a caregiver and conjures traumatic memories when dealing with

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[15] Ibid.

[16] Taken from transcript for the PTSD 101 course from the Department of Veterans Affairs, National Center for PTSD. F. Gusman & P. Swales, *Course Transcript For: Vicarious Traumatization: Towards Recognition & Resilience-Building* (Washington, D.C.: by the author, 2007), pdf http://www.ncptsd.va.gov/ptsd/101// (accessed February 1, 2008).

[17] Ibid.

[18] Charles R. Figley, *Treating Compassion Fatigue* (New York: Brunner-Routledge, 2002), 19.

[19] Ibid.

trauma survivors. This illustrates the synergistic effects that influence the Compassion Fatigue Process, but Primary Stress is not the main pathway in the Figley Compassion Fatigue Process Model.

Secondary Traumatic Stress

The term "Secondary Traumatic Stress," according to Figley, is defined as "direct exposure to extreme events directly experienced by another and one is overwhelmed by the trauma."[20] This is similar to those who work in hospital Emergency Rooms dealing with trauma survivors and EMS workers who arrive on a trauma scene caring for victims with traumatic injuries. It has further been attributed to the stress experienced by those witnessing the live and re-televised events of September 11, 2001. This term therefore includes the element of witnessing the event, much like a chaplain in a motor vehicle convoy who witnesses a roadside bomb detonation injuring his or her fellow service members. This exposure to suffering is one of the main pathways of traumatic exposure, including Vicarious Traumatization, in the Figley Compassion Fatigue Process Model that may lead to Compassion Fatigue.

Vicarious Traumatization

"Vicarious Traumatization" has been defined by McCann and Pearlman as "the phenomena of transmission of traumatic stress by bearing witness to the stories of traumatic events."[21] Saakvitne and Pearlman further define Vicarious Traumatization as "the transformation of the therapist's or helper's inner experience as a result of empathic

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[20] Ibid.

[21] Ibid.

engagement with survivor clients and their trauma material. Simply put, when we open

our hearts to hear someone's story of devastation or betrayal, our cherished beliefs are

challenged and we are changed."[22] Vicarious Traumatization is thus the stress that is

transmitted to individuals through hearing about the trauma by nature of a personal or

professional relationship and the element of empathic ability present with the listener.

Vicarious Traumatic reactions involve profound changes in the schema and core aspect of

the counselor's self. These reactions involve changes in the counselor's identity, beliefs

and even memory.[23] This term has been used synonymously with the term "Compassion

Fatigue" but should instead be understood as a pathway and stressors that account for the

exposure to suffering, coupled with empathic ability, to produce compassion stress which

can ultimately lead to the condition of Compassion Fatigue.

Burnout

The term "Burnout" has been defined by Pines and Aronson as "a state of

physical, emotional, mental exhaustion caused by long term involvement in emotionally

demanding situations."[24] Figley states that it is "a result of frustration, powerlessness, and

inability to achieve work goals."[25] Maslach defines burnout sociologically, noting "it is a

syndrome of emotional exhaustion, depersonalization, and reduced personal

accomplishment that can occur among individuals who do 'people work' of some

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[22] Karen W. Pearlman & Laurie A Saakvitne, *Transforming the Pain: A Workbook on Vicarious Traumatization* (New York: W. W. Norton & Company, 1996), 25.

[23] Trippany, Kress and Wilcoxon, 31.

[24] Ibid.

[25] Figley, *Treating Compassion Fatigue*, 19.

kind."[26] Burnout thus is a "result of the general psychological stress of working with

difficult clients."[27] Maslach believes that burnout comes from an overextension and

emotional over-involvement in the needs of and demands imposed by others.[28] These

demands are heightened for chaplains in combat, where there is more exposure to

suffering and strained life situations, as well as a failure to remove oneself from the

environment and social contact with others: fundamental elements in the Figley

Compassion Fatigue Process. The result of this overextension is emotional exhaustion,

where emotional reserves are depleted, professional satisfaction diminishes and one

begins to detach and isolate as an emotional buffer.[29] This condition is analogous to

accounting, where expenditures exceed income and one becomes insolvent. In this case,

an emotional insolvency accrues for the caregiver, where emotional reserves are depleted

without a source of replenishment. Emotional expenditures thus exceed emotional

income.

     Maslach further notes several symptoms and behaviors associated with

burnout syndrome. In the sociological realm, caregivers lack motivation and reduce

contact with others, as they feel they can no longer give themselves to others in what has

been labeled the "silencing response."[30] When there is contact, the client is

depersonalized and "pigeonholed," whereby the caregiver responds to their "labeled

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[26] Christina Maslach, *Burnout: The Cost of Caring* (Cambridge: Malor Books, 2003), 2.

[27] Trippany, Kress and Wilcoxon, 31-32.

[28] Ibid., 2-3.

[29] Ibid., 3.

[30] Baranowsky, Gentry, & Dunning, 1.

categories" rather than their individuality.[31] Depersonalization, negative attitudes, cold

indifference, contempt and emotional callousness are clear symptoms of burnout

syndrome.[32] The negative attitudes and behaviors are not only externalized, but also

internalized.

Caregivers can begin to feel a deep sense of remorse or guilt in response to the

mistreatment of their clients or parishioners. This can lead to a poor self-image and

feelings of inadequacy. Professionally, caregivers may feel irrelevant or ill-equipped and

issue a "self-imposed verdict of failure." Depression may thus ensue, as well as possible

desertion of the caregiving profession.[33]

The answer to burnout is balance and maintaining an emotional "margin" in

one's life. Physicians practice what is known as "detached concern," representing a blend

of closeness for empathy and building a therapeutic alliance and distance to detach and

avoid over-personalization.[34] Further, a sense of rapport and support among colleagues

and the professional community can aid in preventing burnout and strengthen the social

support that is weakened with burnout. Later in this paper, a more detailed discussion will

address the difficulties associated with collegiality and social support in a military

culture.

Countertransference

Countertransference has been defined by Figley as "the mechanism of producing

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[31] Ibid.

[32] Ibid., 5.

[33] Ibid., 5-7.

[34] Ibid., 4.

helper symptoms…the unconscious attunement to and absorption of the victim's stresses and trauma."[35] Figley has also explained that Countertransference refers to a "counselor's emotional reaction to a client as a result of the counselor's personal life experience."[36] Thus, the counselor's own personal life experiences are stimulated in and around the counseling experience, creating an emotional contagion. This can be illustrated by the combat chaplain who, as a trauma survivor himself, shares a similar first-hand traumatic experience with the counselee and their own traumatic memories are aroused through the story of the counselee. Thus, the counselor's own Primary Traumatic Stress or other life experience and unconscious personal experiences create a personified response towards the counselee.

Though the aforementioned terms have been characterized by the cited authors as unique, they have also been defined by others as synonymous. A better understanding is that each of the terms presented should be viewed as interrelated and synergistic as they relate to Compassion Fatigue; separately, however, they each have unique qualifiers and characteristics. With the terms related to Compassion Fatigue defined, it is easy to see why there can be great confusion in the use of these terms due to the similarity of symptomology. For the combat chaplain serving in harm's way as a caregiver, each of the previously defined terms has the potential to be a contributing factor to combat and compassion-related stress, which can ultimately lead to a condition known as Compassion Fatigue.

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[35] Figley, *Treating Compassion Fatigue*, 19.

[36] Trippany, Kress and Wilcoxon, 32.

Compassion Fatigue Symptomology

As Tyson notes, therapists experience collective shared trauma, which has a lasting impact on their professional and personal lives.[37] This shared trauma can create an "emotional contagion"[38] and alter the cognitive schemas of the caregiver, leading to silencing responses, disassociation with clients[39] and ultimately to the dissolution of one's ministry or caregiving practice. In order to preserve the total manpower force and chaplains as caregivers, it is important to identify the symptoms and behaviors associated with Compassion Fatigue.

The key differentiation between primary and secondary traumatic stress is physical presence, but the symptomology and stressors are similar. In secondary traumatic stress, the stressors are transferred from the traumatized patient to the caregiver. Key indicators of Compassion Fatigue include a recollection of the traumatized patient's material, detachment, avoidance of activities, decreased self-worth, psychological numbness, hopelessness and hyper-arousal. These symptoms extend beyond a thirty-day period and permeate the physical, mental, spiritual and behavioral aspects of the caregiver's life. [40] Charles Figley cites the following examples of Compassion Fatigue symptoms.

Cognitive

Caregivers experience lowered concentration, perfectionism, decreased self-

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[37] Tyson, 85.

[38] Stamm, *Secondary Traumatic Stress*, 11.

[39] Figley, *Treating Compassion Fatigue*, 155.

[40] Stamm, *Secondary Traumatic Stress*, 12.

esteem and can become apathetic. This translates into rigidity, minimization of issues

and lack of compassion when dealing with clients. Caregivers will be preoccupied with

the trauma material and can experience thoughts of self-harm or harm to others.[41]

Emotional

The aforementioned hyper-arousal experienced by those with Compassion

Fatigue can be best understood by comprehending the emotional symptoms associated

with CF. Emotional symptoms include hypersensitivity, emotional highs and lows and

feelings of powerlessness, fear and helplessness. Additional emotions include guilt

associated with survivorship, sadness, depression and a feeling of emotional and

empathic depletion.[42]

Behavioral

Behavioral symptoms associated with Compassion Fatigue include impatience,

irritability, moodiness, anger outbursts, hyper-startle, hyper-vigilance and becoming

accident prone. Other behaviors include losing items, forgetfulness, poor self-care,

putting the needs of others first, withdrawal from family, friends and clients, poor

appetite and sleep disturbances. Other behaviors include substance abuse and exercise

obsession as coping mechanisms.[43]

Spiritual

The horrific nature of trauma has the ability to shake the foundation of one's

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[41] Figley, *Treating Compassion Fatigue*, 7.

[42] Ibid.

[43] Ibid.

faith and world-view. Chaplains as caregivers are not immune to being spiritually shaken by traumatic material. Spiritual symptoms associated with Compassion Fatigue include questioning the meaning of life, God's purposes for loss and suffering and even if God exists. As caregivers, chaplains can experience a loss of purpose, self-satisfaction and efficacy, anger toward God, questioning religious beliefs, skepticism and loss of faith. [44]

Somatic

There is a direct psychosomatic relation with Compassion Fatigue. Somatic symptoms associated with Compassion Fatigue include profuse sweating, tachycardia, dizziness, difficulty breathing and shock. Caregivers may also experience more aches and pains, increased numbers of medical maladies, a decreased immune system and other somatic complains. [45]

Personal Relations

Compassion Fatigue is not isolated to the caregiver alone but permeates his personal and professional life. In the personal realm, Compassion Fatigue symptoms may include withdrawal and isolation, loneliness, decreased interest in intimacy or sex, mistrust, intolerance and increased interpersonal conflicts. Further, caregivers may project anger or blame upon those closest to them. Those caregivers who are parents may become overprotective and more aggressive in disciplinary actions. [46]

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[44] Ibid.

[45] Ibid.

[46] Ibid.

Work Performance

Compassion Fatigue has major implications for the professional life. CF symptoms include low morale and motivation, task avoidance, apathy and increased negativity. Caregivers may experience extreme irritability with clients and colleagues, thereby withdrawing from both with increased work absenteeism. This may also manifest with greater staff conflicts, poor work commitments and lack of appreciation for colleagues. [47] This decrease in work performance and the aforementioned symptomology are significant indicators for Compassion Fatigue. Supervisory chaplains and colleagues who note these traits and a corresponding decrease in work performance should seek Compassion Fatigue testing and counseling for chaplains and encourage the utilization of resources available for care.

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Compassion Fatigue and the DSM-IV-TR

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It should be noted that even with the aforementioned terms clearly defined and recognized in literature by experts in Psychology, Sociology and Traumatology, these terms and classifications are not listed in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR,* as they are currently sub-clinical. A closer look at the DSM-IV-TR 309.81 shows that Vicarious Traumatization and Secondary Traumatic Stress reactions can meet DSM-IV-TR (Criterion B – F) for Post Traumatic Stress Disorder with the exception of Criterion A1, namely direct personal experience or exposure to the traumatic event or life-threatening situation. [48] Rather, Compassion Fatigue speaks to the concept of

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[47] Ibid.

[48] American Psychiatric Association, *Diagnostic and Statistical Manual of Disorders, Fourth Edition, Text Revision* (Washington, DC: APA, 2000), 463-469.

"shared trauma" and its cumulative and collective effect on clinicians.[49]

One of the foremost experts on Compassion Fatigue is Dr. Charles Figley of the Figley Institute and Green Cross Academy of Traumatology. Dr. Figley is world-renowned for his work with veterans after the Vietnam conflict, and it was his work that led to the diagnosis and incorporation of PTSD in the DSM.[50] In his book *Treating Compassion Fatigue*, Figley offers a definition for Compassion Fatigue that synthesizes a broad range of terms used to explain Compassion Fatigue related-symptoms and aid in understanding Compassion Fatigue's lack of incorporation in the current DSM. Figley writes,

> There are a number of terms that describe this phenomenon. It has been described as secondary victimization, secondary traumatic stress, vicarious traumatization, and secondary survivor. A similar concept, 'emotional contagion,' is defined as an affective process in which 'an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions.[51]

Hence each of the terms seems to miss the cumulative effects for caregivers through the social pathway of clinical work and the therapeutic alliance gained through that pathway. Figley further writes that Compassion Fatigue moves beyond simple Countertransference and refers to a transformation in the therapist's inner experience and empathetic engagement in the client's trauma material, creating vulnerability in the clinician's emotional and spiritual schemas.[52] Hence, Figley defines Compassion Fatigue as a user-friendly term for "secondary traumatic stress disorder, which is nearly identical to PTSD,

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[49] Tyson, 183.

[50] Tyson, 184.

[51] Figley, *Treating Compassion Fatigue*, 2-3.

[52] Ibid, 3.

except that it applies to those emotionally affected by the trauma of another rather than

first-hand experience. Compassion Fatigue is therefore related to the cognitive schema of

the therapist's social and interpersonal perceptions or morale."[53] The issue for Figley is

clear, namely those who work with frequent exposure to those suffering and traumatized

themselves become wounded and suffer as a part of their work.[54] In each caregiver there

will be residual compassion-related stress. This compassion stress can have a cumulative

effect and if left untreated can lead to Compassion Fatigue.

Dr. Frank Ocheberg expounds upon this cumulative effect as he writes,

> First, you should understand that it's a process. It's not a matter of one day, you're living your life with a great deal of energy and enjoyment, and the next, you wake up exhausted and devoid of any energy - both physical and emotional. Compassion fatigue develops over time - taking weeks, sometimes years to surface. Basically, it's a low level, chronic clouding of caring and concern for others in your life - whether you work in or outside the home. Over time, your ability to feel and care for others becomes eroded through overuse of your skills of compassion. You also might experience an emotional blunting - whereby you react to situations differently than one would normally expect.[55]

It is those who suffer and begin to become burned out and dissatisfied in their work who

begin to absorb the traumatic stress of others cumulatively until their own individual

perceptions and value of self, family and friends diminish as their social support

community begins to suffer, along with their overall morale.[56] This is once again

illustrated through the "Compassion Fatigue Process."

Though efforts to ameliorate the nomenclature and terminology as it relates to

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[53] Ibid.

[54] Ibid., 5.

[55] Frank Ochberg, *When Helping Hurts: Sustaining Trauma Workers*, DVD, int. Frank Ochberg, 17 Min. (Camden: Gift From Within, 2006).

[56] Ibid., 6.

Compassion Fatigue in the field of Traumatology have failed, the synergistic effects and

of each of the aforementioned terms are clear. For the combat deployed chaplain, the

threat or perceived threat of personal mortality, witnessing the trauma of others, listening

to the stories of trauma survivors and other eyewitnesses, coupled with around–the-clock

operations without the opportunity to remove oneself for a "day off," influence the

Compassion Fatigue process. Noting the repeated pathways for compassion-related stress

unique to the combat deployed chaplain and with the United States in an ongoing war, a

question must be raised: is there a problem for our chaplains currently serving in combat?

CHAPTER 2

IS THERE A PROBLEM?

The Bosnian Experience

New information on Compassion Fatigue for caregivers is emerging as

Operation Enduring Freedom and Operation Iraqi Freedom continue. The present

conflict is not the first time the effects of Compassion Fatigue have emerged in chaplains

serving as caregivers in combat. The Bosnian Conflict and United Nations peacekeeping

operations from 1992-1995 produced literature and the first published study on

Compassion Fatigue for military chaplains after Canadian Military medical officials

began to notice an influx of chaplains for post-deployment care.[57]

The Canadian Forces Support Unit noted the lack of literature specific to

combat caregivers, specifically chaplains, and recognized that chaplains were at a higher

risk and vulnerability for Compassion Fatigue and post deployment difficulties and were

receiving little attention.[58] Thirty-one chaplains exposed to stressful military operations

and medically cleared of PTSD were evaluated, and several of these chaplains showed

signs of Vicarious Traumatization from the effects of combat exposure.[59] These results

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[57] George Zimmerman, "Care for the caregivers: A program for Canadian Military chaplains after serving in NATO and United Nations peacekeeping missions in the 1990s," *Military Medicine* (September 2000), 1.

[58] Ibid.

[59] Ibid.

caused the Canadian military to implement a program entitled "Care for the Caregiver"

that has become a mandated four-day retreat as part of the normal deployment process for

chaplains. The outcome of this program has been "an increased awareness of the negative

impact of deployment stress… insight, closure and spiritual renewal, reduced sense of

aloneness and ….value added through participant feedback, which was consistently

positive."[60] The Canadian military's recognition and program implementation serves as a

model for the United States military to remove chaplain institutional stereotypes in

seeking help and implementing a plan that adequately recognizes the need for caring for

their caregivers. By doing so, the Canadian military keeps their "force multipliers"

healthy and demonstrates a return on investment by increasing retention among

chaplains, who further keep other service members as part of the total force through their

pastoral care.

OEF/OIF

More recent literature for combat caregivers serving amidst Operations

Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) has emerged specifically

addressing Compassion Fatigue. In a 2007 United States Department of Veterans Affairs

study, the research noted that "clinicians exposed to the narratives of war trauma

survivors were at increased risk for developing secondary stress reactions, commonly

referred to as *Compassion Fatigue*."[61] The information from this study was briefly

reviewed by Tyson in a paper entitled *Compassion Fatigue in the Treatment of Combat-*

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[60] Ibid., 3.

[61] Tyson, 183.

Related Trauma During Wartime, noting the belief that Compassion Fatigue is emerging among caregivers treating traumatized military servicemembers. Further, a Defense Link news article states that the United States Army has begun a new program entitled "Care for the Caregivers," specifically for military care providers, including medical care professionals and chaplains, in response to the negative consequences of caring for the traumatized.[62]   In this article, Colonel Kathryn Gaylord, director of the Army Institute of Surgical Research's Care for the Caregiver Program, notes the price military caregivers are paying. The article goes on to say that

> [t]axed by deployments of their own and the complicated care of severely wounded servicemembers, caregivers are beginning to exhibit signs of trauma normally reserved for patients.[63]

This article and the U. S. Army's response demonstrate that there is an emerging issue for caregivers treating the physical, spiritual and mental health of traumatized servicemembers. In addition, there seems to be an ever-increasing number of traumatized servicemembers, as compared to past wars, due to medical and technological advances, including body and vehicular armor, which have created greater survivability. These two articles have focused on the belief that Compassion Fatigue is emerging as a significant issue for caregivers serving in Iraq and Afghanistan as well as in military healthcare facilities, but these articles have not produced empirical evidence to substantively reinforce that belief. Another Army report, however, does provide that type of data.

2005, the U.S. Army Surgeon General commissioned a study of the military

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[62] Elaine Wilson, "New Program Offers 'Care for Caregivers'," *Defense Link*, May 22 2008, sec. Article ID 49979, 1, 2008. http://www.defenselink.mil/news/newsarticle.aspx?id=49979/ (accessed March 1, 2009).

[63] Ibid.

behavioral health providers, including Primary Care providers and chaplains serving in

Operation Iraqi Freedom. The Mental Health Advisory Team found that

> [t]hirty-three percent of BH personnel reported high burnout, 27% reported low
> motivation, and 22% reported low morale. Fifteen percent agreed that the
> stressors of deployment impaired their BH job; in addition, 12% felt that their
> sensitivity to the needs of the Soldier had been adversely affected. Thirty-seven
> percent of PC personnel reported high burnout, 35% reported low motivation, and
> 35% reported low morale. Fifteen percent agreed that the stressors of deployment
> had impaired their medical job, and 14% indicated they had become less sensitive
> to the needs of Soldiers during this deployment. Sixteen percent of UMT
> personnel agreed or strongly agreed that the stressors of the deployment and
> combat impaired their job. They also reported low or very low personal energy
> (28%), personal motivation (23%), personal morale (18%), and high or very high
> personal burnout (33%). Some also reported having their mental (13%) or
> spiritual (15%) well-being adversely affected by combat or deployment
> stressors.[64]

With Unit Ministry Teams (UMT), including chaplains and Chaplain Assistants,

reporting 33% burnout and 16% agreeing that the stressors of deployment had impaired

their job performance, there appears to be a major issue for caregivers. In fact, these

statistics led to the report finding that some Unit Ministry Teams, Behavioral Health and

Primary Care providers are reporting Compassion Fatigue and Burnout. The report noted

the serious nature and need for focusing on these caregivers stating: "If our providers are

impaired, our ability to intervene early and assist Soldiers with their problems may be

degraded. It is vital to understand the processes of provider burnout and compassion

fatigue in order to prevent and intervene in order to preserve the care in our caregivers."[65]

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[64] Office of the U. S. Army Surgeon General, "Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHT-II) Report," (Washington: U. S. Army Surgeon General, 2005), B-9, pdf. http://www.armymedicine.army.mil/reports/mhat/mhat_ii/annex_b.pdf. (accessed March 10, 2009).

[65] Ibid., 22.

It is evident from the available literature that there is a significant issue for caregivers serving in support of the Global War on Terror and that further data and research are needed. In the absence of a significant amount of literature, this author has conducted his own interviews and complementary assessments to gain additional observational data and insight to the contemporary problem of Compassion Fatigue for chaplains. In the absence of a significant amount of literature and research for combat deployed chaplains, this author has conducted his own interviews and complimentary assessments to gain additional observational data and insight to the contemporary problem of Compassion Fatigue for chaplains.

Interviews

Interview A

Following a seven month deployment with a United States Marine Corps casualty evacuation unit during 2006, I interviewed a seasoned, multiple tour operational chaplain to see if the experiences that this author had from his CASEVAC ministry were mirrored or isolated. In the interview that took place six months after the chaplain's return to the United States, I asked the chaplain to describe his wartime experience and his ability to transition, reset and recover from that experience. He described the tragic loss of an aircraft with seven service members in the first weeks of his ministry and the toll it took upon him personally and upon his fellow service members. There were ongoing indirect fire attacks on his base and record-setting numbers of casualty evacuations being performed. His counseling load was high during the deployment and his counseling experiences had taken a dramatic toll on him emotionally and had translated to his interaction with his family since his return. At six months after his

deployment, the chaplain said,

> The deployment sucked the life out of me. It has affected my marriage, my family life and my relationship with God. I am extremely irritable, impatient and short tempered. I feel numb… everything is vanilla… careless. I have lost my drive and sense of empathy. I feel like I am just going through the motions. My spiritual life is dry; I am just going through the motions. I find myself doing things I ought not to be doing to feel better.[66]

This honest and fully disclosing interview turned into therapeutic counseling and an opportunity to educate the chaplain on Compassion Fatigue. The chaplain continues on his road to recovery and healing from this tour of duty.

Interview B

The following interview came from a very senior command chaplain serving with the Marine Corps Air Combat Element. In both the e-mail interview and post deployment interview, the Chaplain expressed early concern at his own emotional taxing after a religious ceremony at Mortuary Affairs for a deceased service member known as an "angel" that still "sticks in the memory bank today." In addition, this chaplain noted the toll and stress in his crew was relieved from the previous year of combat, when the casualty rates were much higher. He also noted the relief that came through the reduction of prolonged exposure to suffering and trauma after the 2007 troop surge and specifically after the visit by President Bush, where attacks by indirect fire almost halted and casualty rates decreased significantly. In the e-mail interview the senior chaplain writes,

> This [is] how I think we as chaplains are coping with the deployment and will continue to cope until we return. Before we arrived at Al Asad we had been

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[66] Anonymous, interview by Paul B. Greer, March 15, 2007, transcript.

warned of the secondary trauma we were likely to encounter while deployed. That was an issue for me; however, I looked forward to the experience of it because I was certain that the Lord had called me to this. The night of my arrival I was called to participate in an "angel" ceremony in the trauma unit run by the Navy. I was certain that the place where the ceremony was being held had been a torture area under Saddam's regime. It was just gruesome. My thought at the time was that we were going to have a long deployment. When we arrived we discovered that a chaplain watch had been established for the trauma unit due to a previous incident in which a chaplain assigned to 3rd MAW had broken down under the emotional pressure of taking care of trauma patients. The month of February was fairly busy for us and I spent several sessions in the unit waiting for casualties to arrive. There was one incident in which 4 live casualties were brought in and one "angel" in a bag that clearly revealed that the casualty was a victim of an explosion. The bag was basically a crumpled pile. That night I spent the night in my sleep talking to all the casualties and figured out from that experience how folks can suffer from combat stress. Shortly after that event the Army opened up its Level Three facility on the base and brought a chaplain along to serve in the facility. Co-incidentally, the military situation dramatically improved for those of us serving in our AO, and the US military casualties decreased dramatically…The involvement of the Navy Chaplains in ministry to casualties has almost come to a halt. To me this means that our stress levels are commensurate with what others are experiencing in our units. In addition, some of the chaplains here are supporting each other with fellowship and prayer. This is going to go a long way toward keeping us motivated and will affect the response you receive from your survey.[67]

Observational Study

In order to accurately assess the impact of Compassion Fatigue, this author offered an anonymous study for Chaplains from the Second Marine Expeditionary Force deploying to Iraq for OIF 06-08, giving them the opportunity to voluntarily participate in the Professional Quality of Life Revision for assessment.[68] A package was delivered to

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[67] The senior chaplain writing this e-mail has requested to remain anonymous. This e-mail was sent from Iraq during OIF 06-08.2 from Al Asad Air Base, Al Anbar Province Iraq. The term "angel" is military slang denoting a deceased American Military Service Member. Compassion Fatigue Report, e-mail message to Lieutenant Paul B. Greer, January, 2008.

[68] ProQOL R-IV used with express written permission of B. Hudnall Stamm. B. Hudnall

20 chaplains deploying; it included an instruction manual, introductory letter detailing the purpose of the study, statement of confidentiality and anonymity, and variables assessment; four assessments to be completed initially in the first week of deployment, mid-deployment, re-deployment and thirty days post-deployment, four self-addressed, postage-paid envelopes and a randomly chosen unique alphabetical and numerical identifier.[69] Appendix A offers a copy of these documents. Of the twenty packages distributed, only five packages were returned and two were complete through the entire deployment cycle. Though the results and sample size were limited, these assessments will serve for observational trends and anecdotal information.

The assessment revealed that those with the highest job satisfaction scale rating were the most resilient to Compassion Fatigue and had the lowest burnout and Compassion Fatigue scores. In addition, one assessment that had elevated scores in Compassion Fatigue initially scored high in job satisfaction at the initiation of the deployment assessment, but reduced in satisfaction from 5 "Very Often" to 2 "A Few Times" on job satisfaction by the end of deployment. Further, this chaplain scored higher on hyper-arousal and the highest on the inability to separate personal and professional life and increased in sensitivity twofold, as well as feeling "bogged down by the system." Overall, the assessments returned showed by mid-deployment at least a slight reduction in job satisfaction and slight increase in Compassion Fatigue scores, by an average of 1.5 on a scale of 0 to 5 utilizing the ProQOL R-IV; but overall job satisfaction averaged 3.75.

Stamm, *Professional Quality of Life Scale*, Revision IV ed. (Baltimore: Sidran Press, 2005), html http://www.isu.edu/~bhstamm// (accessed January 17, 2007).

[69] Appendix A.

This high job satisfaction level is the key discriminator between "burnout," which has a low job satisfaction rating and Compassion Fatigue, which has a high job satisfaction rating.[70]

The speed and pace of around-the-clock combat operations, coupled with cultural stressors, geographic separation from one's own family, combat exposure, threat to one's own mortality, observing the trauma of others and repeated exposure to the stories of others exposed to suffering illustrate the extreme stressors combat chaplains and other caregivers are exposed to. These extreme conditions demonstrate the need for a study and program for the educational methodology in the mitigation of Compassion Fatigue for combat deploying chaplains. It is evident through these interviews and assessments that a problem exists among chaplains serving in the Global War on Terror and that a program for care must be implemented.

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[70] Charles R. Figley, *The Art and Science of caring for Others without Forgetting Self-care* (Camden, Maine: by the author, 2007), 2, html http://www.giftfromwithin.org/html/artscien.html. (accessed February 16, 2008).

CHAPTER 3

CONTRIBUTING FACTORS

Are there factors that contribute to one being predisposed to Compassion Fatigue? What role does society and the associated cultural stereotypes for clergy play in the formation of pastoral chaplain ministries? Are there personality types that are predisposed to Compassion Fatigue? What about unresolved issues and motivations for ministry? Do these factors impact the Compassion Fatigue Process? This project will answer these questions and look at personality types, motives for ministry and cultural issues that contribute to the Compassion Fatigue Process.

Personal Characteristics and Needs

Once again this study draws on the work of Christina Maslach, who states that "personal characteristics" are a source of fatigue and burnout.[71] She further notes that those entering the helping profession often have high needs for approval to enhance their self-image and gain social acceptance, along with heightened expectations of self that often lead to a personal disillusionment.[72] Work thus becomes the avenue for self-gratification and shaping one's self-concept and can further lead to an over-commitment of time and energy, leading to emotional fatigue and burnout.[73] One must endeavor to

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[71] Maslach, 93-94.

[72] Ibid., 93.

investigate their motives for the helping ministry and how they may influence or predispose one to Compassion Fatigue.

As Pearlman, Figley, McCann and Saakvitne rightly note, the synergistic effects of CF create profound changes in ones' self-perception, cognitive schemas, identity and beliefs.[74] As such, one must begin to investigate their own call to ministry, motives, identity, faith, emotional stability, personality, temperaments and giftedness. This chapter will discuss these contributing factors and aid those engaged in pastoral ministry to wade through the myriad of factors that can make one emotionally and spiritually vulnerable to falling into Compassion Fatigue and what Carman Berry calls "The Messiah Trap."[75]

Personality

Clinical Pastoral Education teaches institutional chaplains to know what they are carrying into the patient's room they are about to enter. This encompasses skills, spirituality and their own emotional state. The same is true for those who enter into any helping profession, especially ministry. On the topic of burnout, Christina Maslach writes,

> Burnout does not occur for all people all of the time. There are clearly individual variations in the overall pattern – variations that seem to be related to differences in personality. By personality I mean the essential character of an individual – the mental, emotional, and social qualities or traits that combine into a unique whole. One's interpersonal style, method of handling problems, expression and control of emotions, and concept of self are all aspects of

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[73] Ibid., 94.

[74] Trippany, Kress & Wilcoxon, 31.

[75] Carmen Renee Berry, *When Helping You is Hurting Me: Escaping the Messiah Trap* (New York: The Crossroad Publishing Company, 2003), 18.

personality that have special significance for burnout.[76]

With the close correlation and synergistic impact of burnout in Compassion Fatigue, it behooves the caregiver to revisit and address motives for ministry and why they entered the helping profession, thereby addressing any impure motives or unresolved issues. Further, one must look to their personality type, drive, self-concept, esteem and confidence. Several tools and resources will be discussed to aid in this self-investigation and discovery.

Temperament Analysis

Carl Jung is known as one of the foremost theorists in the study of personality, but the labeling of temperaments can be traced back as far as 300 A.D., to Aristotle.[77] An individual's nature can be difficult to describe or fit into such a label. In order to do so accurately, several credible assessments have been created to aid in describing an individual's temperament. In order to maintain continuity in language and behavioral blend descriptors, the Myers-Briggs Type Indicator (MBTI), Adjective Check List (ACL) and DISC temperament assessment tools will serve as a model for this paper.

Swiss psychiatrist Carl Jung noted eight patterns of behavior that manifest from inborn tendencies. These observations were developed and described in Jung's psychological type theory and are measured in the Myers-Briggs Type Indicator.[78] The MBTI assessment for this author revealed a personality preference that was "Introverted

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[76] Maslach, 104.

[77] Mels Carbonell, *Extreme Personality Makeover* (Blue Ridge: Christian Impact Ministries, 2006).

[78] Isabel Briggs Myers, *Introduction to Type: A Guide to Understanding Your Results on the Myers-Briggs Type Indicator* (Mountain View: CRP, Inc., 1998), 6.

Sensing with Extroverted Feeling and Judgment" (ISFJ).[79] Individuals with this

personality type can be extremely thoughtful, practical and have a high degree of loyalty

and responsibility to their family. As such, this author can recognize the formation of his

personality preferences through his early developmental years and how familial

emotional pain nurtured a high emotional sensing temperament which can be critical and

judgmental; which are ISFJ behavioral traits.[80] Furthermore, this author has highly driven

tendencies to prove competence and explain the high dominant competent (D/C)

personality descriptor indicated in the DISC assessment. Sensing and feeling are

personal contributors to highly empathic tendencies, as well as the dominant competent

traits that can lend to transference through the professional responsibility to care for those

entrusted to his ministry. Both of these personality traits can fall prey to both variables in

the aforementioned "Messiah Trap" and are contributors to compassion stress and

ultimately Compassion Fatigue if left unchecked.

There are additional personality traits that lend toward burnout and Compassion

Fatigue. Personalities that are introverted, weak and unassertive, as well as intolerant,

impatient or lacking self-confidence are also prone to burnout and Compassion Fatigue.[81]

With low self-worth and confidence, personal needs associated with the personality are a

factor. Personal needs such as approval and affection, reward and achievement,

autonomy and control are also indicators of personality traits that lend themselves to

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[79] Ibid., 15.

[80] Ibid.

[81] Maslach, 104-105.

Compassion Fatigue predisposition.[82] It is for this critical reason that chaplains must be completely familiar with their personality blends, how their strengths can be utilized for ministry and how unbalanced personality blends can be a contributing factor for burnout or compassion stress.

The Institutional Culture

The military as an institution has its own unique culture. As Figley notes, "one does not need to have ever worn a military uniform to have a conception of the stressors produced by modern warfare."[83] With twenty-four hour live media coverage around the world and the current state of affairs with the United States engaged in a two-front war, coupled with the tactics of terrorism, the picture of the stressors associated with military life has been at the forefront of the societal conscience through media broadcasts into the homes of Americans on a daily basis. But warriors will quickly inform those who have not experienced battle that the concepts from Hollywood to the news media can in no way convey the institutional camaraderie, esprit de corps and bonding dynamic that comes from military service, especially for those who have the shared experience of war. "The stressors themselves tell only part of the story of the impact of war on individuals. Equally fundamental is an appreciation of the shared attitudes, beliefs, and expectations that prevail within the military units as part of their shared culture and traditions. These culturally shaped attitudes and beliefs form a lens through which combat and operational

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[82] Ibid., 106-113.

[83] C. R. Figley & W. P. Nash, 11.

stressors can be either filtered or magnified."[84] The military culture and its associated

subcultures, especially the Chaplain Corps, must be examined for a full understanding of

the impact of the stressors associated with military ministry during a time of war.

The Competitive Nature

The military Chaplain lives within a unique military subculture of staff officers

that operates within the operational chain of command with combatant commanders, as

well as a service chain of command made up of fellow and senior chaplains within the

Chaplain Staff Corps. As such, chaplains are very competitive and are often ranked and

evaluated among fellow chaplains of the same rank. This creates a competitive

environment and is critical in understanding the chaplain's culture and the impact it has

as a contributing factor to the potential for Compassion Fatigue. In two interviews with

chaplains who tested positively on the ProQOL assessment for Compassion Fatigue, both

uttered the same words: that they "feel all alone." Both stated that the Navy Chaplain

Corps culture and competitive nature made them feel that they could not seek out help

from colleagues because they didn't know who they could trust. Conversely, in another

interview with a senior chaplain, he stated that he led a group of chaplains in war who

prayed for each other and sought out care from one another during difficult times. It is

clear from these interviews that in order for chaplains to get the best care possible, it will

take a top-down approach and recognition of the specific need to care for chaplains.

Further, there must be a cultural and institutional change that creates an atmosphere

where seeking help from colleagues and senior chaplains is encouraged, thereby shifting

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[84] Ibid.

the culture from one of competitiveness to collegiality. The aforementioned Canadian

Forces Chaplain "Care for the Caregivers" program serves as a model for this top-down

approach and should be incorporated in the United States Military Service branches'

individual Chaplain Corps.[85]

High Operational Tempo

The military culture and its associated subcultures are fast-paced, responsive

and fluid. The military is an organization poised for rapid expeditionary mobilization and

long term sustainment and deployments. In time of war, this evolution is heightened and

involves a high operational tempo and accompanying geographical separations, thereby

creating stress on the total force. These stressors are experienced by chaplains, service

members and families alike. The very nature of deployment adds life stressors that

directly impact resiliency. This is especially true with the transference of client material

to the chaplain in deployed ministry, thereby making chaplains more susceptible to

Compassion Fatigue in accordance with the Figley Compassion Stress Progression

Model.

War is always fluid and military tactics in the "doctrine of maneuver warfare"

aim to pit strengths against enemy weaknesses. This creates flexible and rapid responses

among military units to which chaplains are assigned and adds a new dimension of stress

that further taxes resiliency, in addition to already-existing compassion stress, for military

chaplains and caregivers. With around-the-clock operations that provide a "sleep when

you can" combat operational tempo, the deployed military chaplain will be challenged in

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[85] Zimmerman, 1.

the areas of self-care and resiliency, all while being bombarded with prolonged exposure to the traumatized. This ministry is not analogous to the typical parish pastor who deals with rare traumatic occurrences. Further, parish ministry does little to prepare the pastor serving as a military chaplain for this type of high operational tempo and around-the-clock pastoral care. The around-the-clock operations and accompanying needs of service members do not cease, day and night, and in the military culture must be addressed immediately after combat engagements or traumatic exposure in order to quickly diffuse the critical incident and to keep the mission going. As such, chaplain self-care is often the first thing sacrificed to keep the mission going as he or she serves as a force multiplier keeping war fighters in the fight.

Though military ministry and the military culture are unique from the typical American workplace, they are still related to the influence of the American society. As such, there are many correlations to the speed at which the American culture operates and cultural influences that relate to military members. One such correlation comes from Dr. Richard Swenson's book *Margin,* which addresses the issues of burnout, taxing of coping, self-care and emotional resiliency from high workloads and fast paced societies. As such, his work has major implications and adds valuable insight to military chaplains serving as caregivers.

The Need for "Margin"

As a physician, Dr. Swenson has spent years in the helping profession, assisting patients with their various ailments. Swenson noticed as part of his medical practice that there was an epidemic being experienced by the present generation that has never existed before. The epidemic, according to Swenson, was an overextension in the lives of those

living in a modern society in which progress has created a lifestyle that overextends

emotional energy, physical energy, time and finances.[86] This overextension can be

observed similarly in the military culture that creates high performance demands with a

"perform to serve" ethos, coupled with the rigors of around-the-clock combat operations

and multiple deployments, straining the force with little time for self-care. This

overextension is what the Swenson calls "overload,"[87] where people live "marginless"

lives, and it makes one susceptible to burnout.[88] Margin is defined by the Swenson as

"the space between our load and our limits…something held in reserves for

contingencies…the gap between rest and exhaustion."[89] When overload happens,

emotional and often physical pain ensues.

The Problem: Pain

As a former medical professional, Dr. Swenson has learned that it can be difficult

to diagnose what one cannot see; rather, what is treated are the symptoms until more

definitive testing can be conducted. Likewise, Swenson discusses the manifest symptoms

of pain in marginless lives, which he attributes to the technological advancements in

communication, medicine, and associated technologies and the accompanying results that

have ensued because of progress. These results include higher demands for productivity,

multi-tasking, and fast-paced, consumer-driven lives that have destroyed margin in

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[86] Richard A. Swenson, *Margin: Restoring Emotional, Physical, Financial, and Time Reserves to Overloaded Lives* (Colorado Springs: NavPress, 2004), 78.

[87] Ibid., 64.

[88] Ibid., 78.

[89] Ibid., 69.

relationships and ignored human limitations.[90] Swenson believes that to restore margin

and reduce pain, one must regain control and subjugate progress and redirect it toward

one's greater goals and needs, including self-care.[91]

  According to Swenson, the problem of pain is not exclusive to this generation, but

pain manifest today is found in a quantitatively measured increase in stress.[92] The author

documents and describes the American societal increase in work hour loss due to sick

leave, and increases in utilization of medical and psychological resources due to

"hyperstress,"[93] which is a new phenomenon in this generation. Contemporary stressors

that are unique to the modern American culture include increased societal mobility and

change, new time pressures and greater expectations in personal and professional lives,

distance in relationships and more competition.[94] The results are overloaded lives, with

physical and behavioral symptoms that have led to an increase in "burnout."[95]

  The answer to the aforementioned "progressive societal shift" and accompanying

overload of human limitations is the restoration of margin in one's life. This restoration

begins with an acceptance of human limits and creating boundaries for those limits to

avoid overloading. Chaplains are not immune to this epidemic. Philippians 4:13 says, "I

can do all things through Christ who strengthens me." This verse is often misapplied by

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[90] Ibid., 21-26.

[91] Ibid., 29.

[92] Ibid., 43.

[93] Ibid., 43-45.

[94] Ibid., 49-50.

[95] Ibid., 50-51.

Christian ministers to allow or justify overloading. Swenson addresses this perversion

when he states, "God did not intend this verse to represent a negation of life-balance."[96]

A better scriptural guide would be from the two great commandments from the synoptic

gospels. In Mark's gospel he writes, "'Love the Lord your God with all your heart and

with all your soul and with all your mind and with all your strength.' The second is this.

'Love your neighbor as yourself.' There is no commandment greater than these." This

scripture clearly teaches that one should care for their neighbor as themselves. If the

chaplain as a minister of God does not provide proper self-care and neglects himself, he

will do harm and neglect his parishioners. This violates the principle of "do no harm"

found in most ethical principles, including the American Association of Christian

Counselors, and could lead the chaplain to professional misconduct charges, including

dereliction of duty. Chaplains must learn their personal limitations and equally focus on

self-care, thus avoiding the "Messiah trap" that places the priorities of others over self-

care.[97]

Limits are real and when one's life becomes overly saturated to the point that

margin is decreased, burnout begins and the myriad of manifestations of those hurts,

including depression, hostility, apathy and the like become evident.[98] Unfortunately,

society, and more specifically the military, labels those who display this "overload

syndrome" and the aforementioned manifestations of overload as weak, apathetic, or

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[96] Swenson, 57.

[97] Berry, 46.

[98] Swenson, 58.

having a lack of commitment.[99] The problem is not apathy, but rather those overloaded

and burned out have saturated their lives to a point where they have exceeded their

threshold and innate coping skills. According to Swenson, the way to counter this

phenomenon is the restoration of "margin," where one chooses to carefully limit their

involvements and avoid the many areas in one's life that have absolutely no transcendent

importance."[100]

The Prescription: Margin

According to Swenson, "Margin is the space between our load and limits" and is

the opposite of overload.[101] Margin is the equalizer that grants freedom to accomplish

goals and objectives freely and makes oneself available for God's intended purposes.

Swenson believes that there are four primary areas of margin that are necessary in an

individual's life: emotional energy, physical energy, time and finances. Of these four

arenas, the author places the greatest priority on emotional energy.[102]

As a physician, the greatest "wounds" Swenson addresses in his practice are

wounds of the soma.[103] The reason, according to Swenson, is that one's capacity for

emotional discharge is limited and when reserves from within the context of margin are

depleted, pain is felt.[104] It is when these empathic reserves are depleted that Compassion

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[99] Ibid., 59.

[100] Ibid., 64.

[101] Ibid., 69.

[102] Ibid., 79.

[103] Ibid., 81.

[104] Ibid.

Fatigue sets in. Swenson estimates that between 22-28 percent of Americans suffer from mental health disorders and that this is the second highest rated "burden of disease."[105] According to Swenson, this American epidemic is not occurring in developing countries. The reason is the unparalleled level of stressors and velocity of the American society, coupled with the decrease of social supports of all kinds.[106] To restore emotional margin, Swenson prescribes fourteen different approaches that center on cultivating relationships and contacts, service, rest, laughter, and establishing limits that aid in periods of rest and cognitive reframing, centering on hope through biblical principles.

The second margin Swenson addresses is physical energy. He believes that there are three areas that contribute to a lack of energy, namely poor conditioning, sleep deprivation and obesity.[107] These poor lifestyle choices are what the author calls "the new morbidity," as 50 percent of all deaths are related to poor lifestyle choices.[108] He believes that our fast-paced society has decreased our sleep by an average of 2.5 hours per day and that our prosperity has caused an abundance of food that is genetically engineered and unhealthy, coupled with a cerebral society that is less active due to modern conveniences.[109] For chaplains and military caregivers, physical care and rest are essential in order to help the client, to give them the best counsel and to do no harm. In a Naval Aerospace Medicine study, utilizing the "Fatigue Avoidance Scheduling Tool"

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[105] Ibid., 83.

[106] Ibid., 85.

[107] Ibid., 95.

[108] Ibid., 95-96.

[109] Ibid., 96-98.

flight surgeons have noted that in one case an aviator was nine hours behind on sleep, which was equivalent to a 55 percent baseline for effectiveness, much worse than the equivalent of someone with a blood alcohol content of .08 and legally intoxicated.[110] This same study indicated that a worker logging 80 hours per week and an average of four to five hours a week of sleep per night has an impairment level equal to a blood alcohol content of .1 and is functionally impaired.[111] This author noted an average of over 80 hours per week as the norm during his tour in Iraq and with a high operational tempo, self-care suffers and fatigue will be the norm without intentional care to introduce physical margin.

To restore margin in physical energy, Swenson prescribes attention and lifestyle changes that focus on the three essentials of sleep, nutrition, and exercise.[112] Swenson views the human body much like a plant that must be fed, watered, rested and moved. With attention to these elements, physical energy can be improved and margin restored.

The next margin addressed by Swenson is that of time. The American society thrives on multi-tasking, doing more with less and being more productive. Swenson believes that this has produced a sense of urgency that creates "time pressure and time stress."[113] Swenson believes that the balance between work time and discretionary time is where the margin of time lay.[114] Swenson cites a NIOSH study that states that the

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[110] CAPT. Nick Davenport, USN, "Give This XO Some Rack Time: A Fatigue Scenario," *Approach: The Navy and Marine Corps Aviation Safety Magazine* 52, no. 5 (September - October 2007), 3.

[111] Ibid., 5.

[112] Swenson, 98-107.

[113] Ibid., 111.

[114] Ibid., 112.

average work year has increased nearly 700 hours over the past two decades and that

emotional exhaustion has increased 25 to 30 percent.[115] Progress has therefore not created

conveniences to create more time for leisure, but rather an increase of productivity

consuming more available time and reducing margin.

Swenson believes that there are areas in one's life that must have intentional

devotion, including personal time, family time, sharing time, and spiritual time with

God.[116] To restore margin in time, Swenson suggests setting time limits and learning to

say "no." By setting these limits, individuals will cut non-essential activities, remove

distractions such as television, more effectively prioritize tasks and remove unnecessary

activities from their schedule. This includes the 24 hour a day Blackberry e-mails that

accompany government-issued communications devices issued to Chaplains. Swenson

suggests focusing on the content, quality and quantity of service; time for God,

thankfulness and long range vision, all of which aid in restoring margin to one's available

time.[117] This is critical for military chaplains, as caregivers both in combat and in

garrison. As previously mentioned, these factors, along with large counseling case loads,

are contributing factors to burnout and Compassion Fatigue.

The Prognosis: Health

Swenson offers a prognosis for health by describing the result of restoring margin

to one's life, namely through emotional, physical, financial and spiritual health. All of

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[115] Ibid., 115.

[116] Ibid., 119-121.

[117] Ibid., 122-128.

these areas of health start with personal and professional contentment.[118] Contentment, which encompasses personal and professional satisfaction, lends support to margin and facilitates simplicity, balance and rest.[119] To avoid the relativism between contentment and discontentment, Swenson defines parameters by setting points that denounce the "prosperity ladder" and restore an understanding of what constitutes a need and a desire.[120] Manufacturing needs are what he calls "poison," which creates discontentment and a lack of peace. To restore peace, Swenson describes how to have peace in relationships, finances and work. This is accomplished by removing relativistic thinking, setting the points of contentment in relationships, finances and the like within Biblical parameters; and developing counter habits that that reshape and reframe thinking from covetousness to contentment.[121]

Health is not only restored through contentment, but also through simplicity. According to Swenson, simplicity has characteristics that are natural, free and unencumbered, leading to an uncluttered, focused and disciplined life with margin intact. Conversely, with the absence of simplicity, life is characterized by legalism, pride and an impoverished lifestyle ,wherein one is focused on accumulation and the next best thing.[122] This is a challenge to chaplains who operate in a hierarchical, promotion-based institution that elevates individuals based on performance.

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[118] Ibid., 151.

[119] Ibid.

[120] Ibid., 158-160.

[121] Ibid., 166-167.

[122] Ibid., 172-176.

Simplicity is difficult, according to Swenson, due to the American society's disrespect for the simplicity found in others, our own expectations, appetites, opinions, abundance, and lack of discipline.[123] To counter these pitfalls, individuals should focus on disciplines in the areas of finances, relationships, activities, exercise, relaxation, spiritual life and personal attitudes to restore margin. By living a simplistic life in light of scriptural teaching, one can find peace and a life that is unencumbered and undistracted from the Lord.[124] Chaplains must therefore balance and maintain their professional life and spiritual life, prioritizing on their walk with God.

Swenson also discusses health through balance and rest. Balance is difficult due to the myriad of demands that legitimately pull on our life, especially for caregivers who respond to the needs of others. Swenson suggests that caregivers manage these influences proportionately between "balance" and "excellence."[125] Swenson states that "we cannot achieve balance by stacking our priorities one on top of another… it fits better to think of God as central to everything and then build outward from that point."[126] There must be balance in one's priorities and "time is the key when we couple it with our goals, desires and responsibilities."[127] When one devotes too much time to one area, they become unbalanced. This is true with sacrificing familial, spiritual and social aspects for professionalism or vice versa. To regain balance, one must regain control of their

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[123] Ibid., 177.

[124] Ibid., 177-181.

[125] Ibid., 184-187.

[126] Ibid., 188.

[127] Ibid., 189.

schedule, place God centrally in their lives where He can begin to work outwardly, accept

the "no" given by others, and avoiding becoming ensnared and imbalanced by trying to

solve one's own balance problems with more actions that further add to the imbalance.[128]

Swenson also believes that health is found through proper rest. Swenson utilizes

the analogy directing individuals to move from the pace of a jet to that of a donkey.

Constant activity does not allow one to rest properly. Just as there must be physical

activity in one's life, there must also be balance and inclusion of physical rest. The reason

most individuals in American society have trouble resting is what Swenson calls restless

leisure. Society has infiltrated leisure time with work, as well as taking away time set

aside for rest and worship, such as the weekend and evenings. Leisure is therefore not the

same as rest. Swenson believes that Americans are living in a vacuum, where they are

more exhausted after a vacation than before due to the time being filled with activities.

Combine this with the aid of technology that keeps us connected to work while on

vacation, and rest cannot enter.

Swenson believes that the pursuit of success has created greater anxiety in

America and as a result, emotional rest is lacking. In addition, there is a psycho-somatic

relation between the physical and emotional when it comes to cognition and rest. This

means that one must intentionally get alone and seek a quiet place free from distractions

to secure rest.

The final element of rest described by Swenson is spiritual rest. Swenson

advocates the Biblical principle of the Sabbath rest. He believes the Sabbath rest is not

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[128] Ibid., 190.

only for physical, but also for emotional health.[129] Just as the Sabbath was made for rest, it was also made to be reflective and contemplative with God. This creates an attitude of what Swenson calls a "surrendered rest."[130] By surrendering one's rest time to God rather than priorities, work and tasks, one can find spiritual rest for the soul. As professional ministers, chaplains must prioritize the spiritual rest that allows them to be connected to God and effectively minister in the power of God.

Unresolved Issues

What motivates a person to ministry? For most, it is a clear sense of calling from God, and this calling principle is confirmed in the scriptures.[131] In Psalm 78:70-72, we see the work of God calling out young David to shepherd His people, as the scripture states:

> He…chose David His servant, and took him from the sheepfolds;…To shepherd Jacob His people, And Israel His inheritance. So he shepherded them according to the integrity of his heart, and guided them by the skillfulness of his hands.[132]

It is clear from Paul's writings in Ephesians 1:1 and 1 Timothy 1:1 that he was individually and uniquely called by God for ministry. The nature of the call to ministry is individually unique, but this call equally uses the spiritual gifts given by God and the personality, temperament and life experience of the individual as part of that calling. Paul

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[129] Ibid., 201.

[130] Ibid., 201-202.

[131] Henry T. Blackaby & Henry Brandt, *The Power of the Call* (Nashville: Broadman &Holman Publishers, 1997), 9.

[132] Ibid.

was called and experiences a radical conversion from a persecutor of Christianity to one vehemently proclaiming Christianity. It is the areas of "life experience" and previous sins or failures that can cause ministers to lose focus and develop false motives to "atone" for past mistakes or even traumatic childhood experiences during developmental years. Caregivers must address primary traumatic stress in their own lives due to the developmental trajectory into their adult life and the synergistic impact it plays in resiliency and susceptibility to Compassion Fatigue.[133]

In Carmen Berry's book *When Helping You is Hurting Me: Escaping the Messiah Trap*, the author speaks of those "set up for the Messiah Trap through the trauma they suffered in childhood."[134] According to Berry, neglected, abused and/or traumatized children from any number of bad experiences, including divorce or accepting major responsibilities too early in life, often grow into driven adults who attempt to help those who suffer from similar experiences in an attempt to heal from their own pain.[135] They are either trying to cope with unresolved issues or atone for their own failures. This driven need to help often leads to transference and accepting too much responsibility for others, with an associated rescuer mentality. This mentality keeps helpers preoccupied with the needs of others and unable to separate themselves from the problems of others, thus making them susceptible to Compassion Fatigue. Ultimately, the driving force and motive for ministry in these individuals is narcissistic, an attempt to heal their own wounds and a desire to prevent others from experiencing similar pain.

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[133] Baranoksky, Gentry, & Dunning, 6.

[134] Berry, 46.

[135] Ibid., 47.

One such example comes from Gordon MacDonald in his book *Ordering Your Private World*, where he distinguishes the difference between the "called" and the "driven." [136] According to MacDonald, called ministers are those who have an inner peace, purpose and identity, with pure, Godly motives for ministry. Conversely, driven ministers are those who are goal- and achievement–oriented, with a need for affirmation and daily consecration.[137] MacDonald states that behind the drive is a need for love and acceptance.[138] Rather than meeting this need by "ordering their private world," they pursue love and peace on an external level.[139] MacDonald therefore concludes that driven individuals must first self-assess themselves to determine their motives and then reflect upon those motives to see if they are impure. If the motives are deemed impure, chaplains must address any unresolved issues in order to minister effectively through the Spirit of God and not in the flesh for self-gratification. As part of the plan for self-care for deploying chaplains and caregivers, self-assessment will be a critical part of the program to deal with unresolved issues and improper motives, to reduce Compassion Fatigue susceptibility. Appendix B offers several resources from the Accelerated Recovery Program to assist chaplains in self-care. Further, the cited works of Berry and Swenson can play a major role in deployment rotation preparedness and care.

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[136] Gordon MacDonald, *Ordering Your Private World* (Nashville: Thomas Nelson, Inc., 2003), 29.

[137] Ibid., 40, 50, 52, 58.

[138] Ibid., 51.

[139] Ibid.

CHAPTER 4

A PLAN AND PROGRAM FOR DEPLOYMENT ROTATION CARE

In Saint Luke's Biblical account of Jesus being led down the Via Dolarosa toward his Calvary crucifixion, Luke points out in Chapter 23:26 that there was a point at which Jesus reached such an extreme state of exhaustion that physically, he could not bear the load of the cross alone. The Roman officials grabbed a bystander named Simon and laid the cross upon him. This illustration reminds those in ministry and the helping profession that we cannot bear the whole load of caring for others alone. Yet we are told in Galatians 6:2 to "carry each other's burdens, and in this way you will fulfill the law of Christ." It is the carrying of these burdens that most ministers are very familiar with and sacrificially get caught up in what Carmen Berry calls "The Messiah Trap."[140] Is one to take care of others at the detriment of one's own personal needs? Is this what God intended for mankind as a burden bearer? Certainly not! So the question is raised, what was the law of Christ spoken of in Galatians 6:2?

The Synoptic Gospels in Matthew 22, Mark 12 and Luke 10 help to answer the aforementioned question. The Mark account states in verses 30-31, "Love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength. The second is this. Love your neighbor as yourself. There is no commandment greater than these." Love your neighbor as yourself. As pastors, chaplains and caregivers,

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[140] Berry, 14.

if one typically cared for their parishioners or clients in the manner in which one performed self-care, one would probably become unemployed in a short period of time due to the harm inflicted. Typically, a poor theology of self sacrifice has developed among chaplains that does not align with scriptural teachings. What God intended in Mark 22:30-31, by application, is that self-care is equally as important as pastoral care. Dr. Tim Clinton has put it this way: "You can't give well, what you don't do well." If one is not taking adequate care of themselves, they inevitably may inflict more harm than good upon their parishioners. It is for this purpose that a very intentional plan of self-care must be put in place for chaplains, instituted through a formal program of care and education to assist chaplains and those in professional military helping occupations, as part of their entry level educational formation and combat deployment care.

A Top-Down Approach

Christina Maslach in her book *Burnout* discusses candidly the role organizations play in the quality of life of their members and the greater potential that exists to prevent burnout utilizing a top-down approach.[141] Collegiality and social support, as well as professional development, play key roles in reducing job-related stress and must be fostered by leadership. As Compassion Fatigue is cultivated in certain types of work environments, institutionalized education, modifications, and improvements must be implemented in these environments at the organizational level. For chaplains this is critical, as the Chaplain Corp in each service is responsible for education, professional development and core competencies. It will take a top-down approach and change in

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[141] Maslach, 181-183.

culture to address the problem of Chaplain Compassion Fatigue and promote care for the caregiver.

The Canadian Example

The Mental Health Department of the Canadian Forces Support Unit's (Ottawa) "Care for the Caregivers" program serves as a model for a top-down program that recognizes the need for institutional change and caring for primary caregivers. As previously mentioned, the military chaplain culture is extremely competitive and does not promote an environment for seeking collegial assistance or institutional care. As such, a top-down approach that recognizes the needs of chaplains as caregivers and the creation of a mandated deployment rotation Compassion Fatigue Management program is necessary to care for the caregivers. The Chaplain Corps in each military branch have professional development training conferences (PDTCs) and are currently phasing the merger of the Army and Navy Chaplain schools into one schoolhouse. These two venues may prove to be the catalyst and springboard for creating institutional change.

The Professional Development Training Conference Pathway

The United States Navy Chaplain Corps, to which this author belongs, has an annual Professional Development Training Conference (PDTC) that is mandated for all non-deployed chaplains to attend. This venue brings chaplains of all ranks together, and often the Chief and Deputy Chief of Chaplains address conference participants. The opportunity exists for the leadership of the Chaplain Corps to create an institutional change by implementing a Compassion Fatigue educational and management program as the main topic of the yearly PDTC. This venue offers the opportunity for the leadership and chaplains to address concerns and implement institutional change, thereby creating a

culture of mentoring and seeking support without fear of career setbacks. To date,

Compassion Fatigue has only been addressed at this training venue in the 2008 PDTC,

with one hour devoted to an awareness of the subject as a subtopic. The official approach

thus far has fallen short of the needs of the institutional members.

It is this author's recommendation that the U.S. Navy Chaplain Corps and her

sister service Chaplain Corps retain the services of Dr. Charles Figley of the Green Cross

Academy of Traumatology and adjunct faculty to teach the series of PDTCs held across

the United States, utilizing his *You Too! Wellness Weekend* and *Compassion Stress

Management Class* as the instructional material for the PDTC to promote education and

wellness, ultimately reinvesting in chaplains for force multiplication and chaplain

retention. The cost for this training opportunity is $5,000.00 per day for Dr. Figley to

present and/or $2,500.00 per day for adjunct faculty to present, plus travel expenses. The

Figley Institute provides all training materials, which are built into the instructor fee,

regardless of class size. This training program would bring in the foremost expert in

Compassion Fatigue and draw on Dr. Figley's wealth of experience in treating Vietnam

War veterans with PTSD and his work in the field of Traumatology with the current War

on Terror. This would make an excellent educational baseline, thereby addressing the

current chaplain population serving in the Navy and creating the necessary top-down

institutional change.

The Chaplain's Basic Course Avenue

With current chaplains being brought to an educational baseline and

incorporating a program for self-care, future chaplains will need to be brought into the

fold. As such, the Chaplain's Basic School would serve as the best venue for a

compassion stress management educational program. To do so, the Chaplain School faculty could be educated as Compassion Fatigue Educators and Compassion Fatigue Therapists from the Figley Institute at a cost of $145.00 per course, per person. These classes can be taken online by the faculty and could be funded through the Chaplain School operating budget (OPTAR). In addition, it is recommended that the Compassion Stress Management Course be taught by the Chaplain School instructors to all newly assessed chaplains, which would allow these chaplains to take the Compassion Fatigue Educator Equivalency Test from the Green Cross Academy of Traumatology and become certified before joining the fleet, at a cost of $160.00 per chaplain.[142] This program would teach self-care principles for new chaplains and keep them prepared for upcoming operational tours and deployments, thereby creating an inside-out transformation through a new generation of chaplains. This training would further allow chaplains to enter the fleet prepared and equipped before being faced with combat and exposure to those traumatized by war--better equipped as counselors and caregivers to these individuals.

A Deployment Rotation Program

The previously mentioned top-down approach to institutionalized change is ambitious, but there is an imminently more pressing need with the current War on Terror as chaplains continue to deploy to Iraq, Afghanistan and the world at large. In an interview with a chaplain serving with the Chaplain's Religious Enrichment Development Operations (CREDO), he noted the need and his desire to create a resetting retreat for chaplains returning for OEF/OIF to decompress from their wartime ministries.

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[142] Charles R. Figley, *Green Cross Academy of Traumatology*, html http://www.greencross.org/Default.aspx?pageID=56262/ (accessed February 18, 2008).

He was having difficulty in determining what program to offer. This discussion led this author to investigate programs for deploying and redeploying chaplains. The following is this author's synthesis from reviewing courses available and programs offered, coupled with his Compassion Fatigue education and personal compassion stress experiences, in an effort to create a program unique for military chaplain care.

The CREDO Avenue

CREDO is a funded program administered by the CREDO/Spiritual Fitness Division-assigned Chaplain Staff that focuses on educational and retreat-oriented spiritual fitness programs for military members. CREDO budgeting, program delivery setup and networking with local retreat centers is the most logical choice for this venue and is recommended to serve as the hub for chaplains and other military caregivers' deployment rotation care programs. As such, for the deployment rotation program success, all CREDO-assigned chaplains should be certified through the Green Cross Academy of Traumatology as Compassion Fatigue Educators and Compassion Fatigue Therapists, as a baseline for deployment rotation program implementation.

Pre-deployment

In an effort to be proactive, rather than responsive to the needs of chaplains after a deployment, an institutionalized, mandated pre-deployment retreat for chaplains should be implemented that follows the benchmarks of the *MASTERS Process* offered by Dr. Figley,[143] which will educate participants on Dr. Figley's *Compassion Fatigue*

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[143] Charles R. Figley, *The MASTERS Process: Transforming Your Career and Life* (Camden, Maine: by the author, 2003), 1, html http://www.giftfrowithin.org/html/mastrpro.html. (accessed January 15, 2008).

Process.[144] The *MASTERS Process* offers seven building blocks for self-care, beginning

with motivation for change, assessment, self-reflection, transformation, evaluation,

review and study.[145] These building blocks can be accomplished and supplemented by the

Figley program by utilizing the book and workbook by Carmen Berry entitled *When*

Helping You is Hurting Me: Escaping the Messiah Trap, along with additional

assessment tools contained in Appendix B.

Berry's book and the associated workbook do an excellent job of preparing the

reader and program participant for the journey of transformation, causing the reader to

question their motivation for ministry and address any improper motives. This builds

upon the motivational block in Figley's *MASTERS Process* model. Additionally, there

are multiple assessments built into the workbook that address the mental memory picture

of one's past to release the reader from pain and allow them to move forward with proper

motives. The final chapters of Berry's book walk the reader through a program of self-

care and stimulate motivation for initiating a self-care enterprise.

In addition to the Berry book, it is recommended that the program include

personality and temperament inventories for greater self-awareness of personal

motivators in ministry and empathic ability as contributing factors for Compassion

Fatigue. As noted in the Figley Compassion Fatigue Progression Model, empathic ability

is necessary for Compassion Fatigue, and resiliency comes from the ability to detach

from client material. Certain personalities that are altruistic and high in the realm of

feelings, sensing and introverted tendencies, as outlined in the Myers-Briggs assessment,

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[144] Figley, 2002.

[145] Figley, *The MASTERS Process,* 1-3.

would be at a greater risk of falling into Compassion Fatigue due to their greater difficulty in detachment and heightened empathic tendencies.

In order to help workshop participants avoid burnout, they must determine their current baseline for job satisfaction and self-care. This pre-deployment program will include several assessments as part of the educational and self-reflective evaluation process for transformation. These pre-deployment workshop assessments are included in Appendix B and include *The Professional Quality of Life Scale* (ProQOL),[146] the *Holmes-Rahe Stress Scale*,[147] *Basic Needs at Work Checklist*,[148]*Building Personal Resilience,*[149]*Daily Spiritual Experiences Scale,*[150]and the *Ego Resiliency Scale.*[151] The assessments will create the necessary self-reflection to see where shortfalls in self-care exist to produce an awareness of the need for change or reinforce positive aspects of self-care.

This workshop will conclude with chaplains creating a detailed, formal and written self-care plan to be presented before their peers at the conclusion of the retreat.

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[146] Stamm, *ProQOL.*

[147] Thomas Holmes & Richard Rahe, "The Holmes-Rahe Life Stress Scale," *Journal of Psychosomatic Research* 2 (1967), html http://www.bhicares.org/pdf/manual/indepthassessment/homesrahestressinventory.pdf. (accessed February 15,2008).

[148] Used with permission of The Figley Institute Cheryl Richardson, *Basic Needs Checklist* (Lifechangers: by the author, 2000).

[149] Used with permission from The Figley Institute Williams & Poilula, *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms* (2002).

[150] Lynn Underwood & J. Teresi, "The Daily Spiritual Experiences Scale: Development, Theoretical Description, Reliability, Exploratory Factor Analysis, and Preliminary Construct Validity Using Health Related Data," *Annals of Behavioral Medicine* 24, no. 1 (2002).

[151] Used with permission from the Figley Institute J. Block & Kreman, *Ego Resiliency Scale* (by the author, 1996).

This should be built upon the Green Cross Academy of Traumatology's "*Standards of Self-Care Guidelines*"[152] (Appendix B). With a solid educational foundation, written self-care plan and accountability for self-care as part of the pre-deployment preparation for chaplains, compassion stress symptoms should be minimized and a reduction in chaplains experiencing Compassion Fatigue can be realized.

Mid-deployment

Care for chaplains during deployment creates one of the greatest challenges to those charged with chaplain development. Chaplains, while deployed, may be geographically centered close to each other or in highly mobile and expeditionary ministries accompanying their troops. As such, creating a program for chaplain care during deployment must be highly flexible. One possibility would be to offer online access to chaplains as part of a deployment care program that also offers online self-assessment tools with feedback, educational presentations, encouraging studies, counseling referral and online chat with anonymity. One solution would be to create an online Chaplain Care webpage, maintained by the Chaplain School Staff as a special project, that would also serve as the hub for empirical study intake and assessment for the Chaplain Corps and Department of Defense, thereby assessing stress on the Chaplain Corps force and emotional health.

The online webpage would be universally accessible within a Department of Defense intranet connection with an anonymously created unique user ID and pass code

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[152] *Green Cross Academy of Traumatology Standards of Self-Care Guidelines* (Camden, Maine: by the author), html http://www.traumatologyinstitue.com/mod/resource/view.php?id=450/ (accessed February 16, 2008).

for access. With anonymity, a variables assessment could be included that notes rank, area of operation (AO), type of unit, age range, and ministry experience in the initial login. This user ID would then allow for tracking of intake information in each assessment completion to determine Compassion Fatigue, job satisfaction and burnout. Each time the user logs in, an abbreviated ProQOL assessment can be given to check the current compassion stress level. In addition, this score could be auto-generated in the program and give instant feedback to the chaplain on their Compassion Fatigue and burnout risk assessment.

In addition to the intake and feedback instruments on the webpage, there could be a collegial chat and discussion forum, monitored by a CF Therapist trained Chaplain who oversees this project at the Chaplain's School to assist in collegial care, brainstorming and addressing current deployment trends among fellow chaplains. The anonymity would allow for honest disclosure and help to reduce the institutional biases accompanying the competitive rank structure. In addition, the Chaplain School CF project officer could create Power Point or video chapter lessons from the aforementioned Swenson book *Margin: Restoring Emotional, Physical, Financial, and Time Reserves to Overloaded Lives* to assist with care during around–the-clock operations so that chaplains can avoid overextending themselves.

Another element that would assist chaplains during their deployment would be to mandate weekly chaplain group debriefings and defusing sessions with the in-theater psychologist. Much like the Clinical Pastoral Education model used in many hospitals, chaplains are required to have weekly debriefings on the events of the week and to tell their story as part of the decompression process for self-care. This event and avenue for

decompression is rare at best with operational chaplains. In addition, chaplains should have a thirty minute bi-monthly debriefing session with a psychologist as part of a plan of care for chaplains. This would aid in offering a different perspective, accountability and someone outside the chaplain corps who can recognize compassion stress symptoms and injuries to help mitigate these injuries and institute a plan for care before the chaplain progresses into Compassion Fatigue.

Post-deployment

Even with all of the pre- and post-deployment classes required for military members on Post Traumatic Stress Disorder and combat stress-related injuries, the unique issues addressed by chaplains as military caregivers are not fully addressed, nor is the emotional taxing from empathetic caregiving and counsel. To address these issues with chaplains and other military caregivers, a post-deployment retreat is necessary after the shared experience of combat has concluded. In an effort to address the compassion stress accumulation, once again a CREDO-based post deployment resetting retreat is needed. This author believes that the best resetting retreat will encompass an educational methodology on Compassion Fatigue symptomology, assessment and an opportunity to decompress and enter into a recovery model that transforms Compassion Fatigue or residual compassion stress injuries into a physical, emotional, cognitive and spiritually restorative flow.

There are several resources that will assist in the restoration process. These resources include the book and workbook by La Rowe entitled *Breath of Relief:*

Transforming Compassion Fatigue Into Flow[153] and *Transforming the Pain: A Workbook on Vicarious Traumatization*[154] by Saakvitne and Pearlman. These workbooks and accompanying Digital Video Disk would serve as an excellent resource as the program text for assisting chaplains and military caregivers in transitioning from their deployment.

The most successful and empirically tested model to assist chaplains is the Gentry, Baranowsky and Dunning *Accelerated Recovery Program (ARP) for Compassion Fatigue.*[155] This program addresses CF symptomology, triggers, resource utilization, personal history, arousal reduction methods, grounding and containment skills, impediments to efficacy, conflict resolution, and a supportive aftercare plan through a proven educational methodology.[156] ARP promotes pathways to resiliency, assisting with anxiety management, narrative journeys to wellness, exposure resolution for Secondary Traumatic Stress, and cognitive restructuring utilizing logotherapy to aid participants experiencing CF in finding meaning through their individual narrative.[157] These educational programs and brief treatment protocols will assist chaplains and other caregivers in functioning and moving forward from their combat experiences by addressing these negative experiences and minimizing the impact of transference and counter-transference when re-entering the post-deployment pastoral ministry setting.

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[153] Karl D. LaRow, *Breath of relief: Transforming Compassion Fatigue Into Flow* (Vancouver: Healer-Warrior, Inc., 2008).

[154] Karen W. Saakvitne & Laurie Anne Pearlman, *Transforming the Pain: A Workbook on Vicarious Traumatization* (New York: W. W. Norton & Co., 1996).

[155] Figley, *Treating Compassion Fatigue*, 123.

[156] Ibid, 129.

[157] Ibid, 129-131.

It is recommended that the United States Navy and sister services contract Dr. J. Eric Gentry with Compassion Unlimited for the two-day Accelerated Recovery Program retreat at a cost of $799.00 plus travel expenses. For the U. S. Navy, this resetting retreat could be funded jointly by the Bureau of Naval Medicine and the Chaplain Corps, utilizing CREDO/Spiritual Fitness Division as the hub for facilitating retreats synchronized with each main body transition. This full circle approach to care, from pre-deployment to post-deployment, would create a full spectrum program and caregiving plan for chaplains and other military caregivers at a minimal expense for the total force serviced by this program. Additionally, by contracting Dr. Gentry and Compassion Unlimited, the program includes licensed counselors as facilitators, which will aid in creating a therapeutic alliance and identifying individual care plans for program participants. The utilization of contracted counselors and facilitators who are non-military will impact program participation and effectiveness, which in interviews has proven to be a major factor among chaplains and Medical Corps clinicians in seeking help.

Another program for ongoing care for chaplains and clinicians is to follow the Military One Source Program, which funds six free counseling sessions with a private clinician. This resource would allow for ongoing transition and chaplain debriefing over four to six months with a non-military counselor. A list of specialized providers trained in compassion stress management could be coordinated and provided at the resetting retreat to provide access to unique Traumatology and post-combat counseling.

CHAPTER 5

VALIDATION

Validating the Educational Methodology

Several elements of this educational methodology and the program proposed in

chapter 5 have been employed through differing venues by this author and subject matter

experts. This author has tested elements of the program outlined in chapter 5 by utilizing

an educational methodology. The effectiveness of this approach and program content

have been validated by participant feedback surveys and post-deployment interviews with

key military leaders and chaplains. Further, experts such as Dr. J. Eric Gentry have

documented the validity of the educational methodology through the Accelerated

Recovery Program Advanced Individual Compassion Fatigue Training-As-Treatment

study offering "the only evidence-based treatment of Compassion Fatigue in the

world."[158]

The CASEVAC Training Example

In 2006, this author was invited to develop an educational program for the II

Marine Expeditionary Force, Special Operations Group, CASEVAC Team training

program under the leadership of the program manager, Hospital Corpsmen Senior Chief

Robert Brown. The agenda for the program's development was to aid these corpsmen

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[158] J. Eric Gentry, *Accelerated Recovery Program Advanced Individual Compassion Fatigue Training-As-Treatment* (Sarasota, FL: by the author, 2009), 1, http://www.compassionunlimited.com/pdf/ARP-TwoDay.pdf.

with the unique combat stressors specific to corpsmen as caregivers with a therapeutic

relationship with the wounded. Prior to this program, seven CASEVAC hospital

corpsmen serving during OIF 04-06.1 and four serving during OIF 04-06.2 were being

seen by Naval Medicine Psychiatry for a variety of issues relating to their combat

experiences. Utilizing research and literature relating to emergency service personnel and

from this author's CASEVAC Team ministry and counseling experiences with corpsmen,

the fundamental issue to address was not combat stress, but rather compassion-related

stress from Vicarious Traumatization and Secondary Traumatic Stress and associated

empathic taxing from the therapeutic alliance between caregiver and patient.

A program was developed that was unique to the CASEVAC Hospital

Corpsmen and differed from the combat stress and Post Traumatic Stress Disorder briefs

that were standard operating procedure for pre-deployment education. Rather, the course

developed by this author reflected upon the Figley Compassion Fatigue Process and

Master's Process model and education in Compassion Fatigue, Secondary Traumatic

Stress, Vicarious Traumatization and self-care plan development. Further elements of the

program included Critical Incident Stress Management, coping techniques, anger

management, and resource availability and referral. This course was delivered to three

separate teams deploying to Iraq, with 68 members receiving the training. Senior Chief

Brown reported that of those receiving the training, zero had been referred to Naval

Medicine for psychological care post-deployment. There was therefore a significant drop

in CASEVAC Hospital Corpsmen since the employment of this educational methodology

and training medium.

Compassion Fatigue Deployment Surveys

From 2007 through 2008 this author, under the leadership of the Second Marine Air Wing Command Chaplain Captain Stephen Epperson, conducted a Compassion Fatigue educational brief and ProQOL survey with chaplains preparing to deploy to Iraq. Further, this survey was additionally conducted one month into the deployment, at the third month (mid-deployment), upon re-deployment to CONUS and three to six months post-deployment. The results have been analyzed and discussed in Chapter 3 and survey documents are contained in Appendix A. Members who participated in this study also participated in a chaplain resetting retreat and Compassion Fatigue training and roundtable discussion.

A Chaplain Retreat and Conference Experiment

In 2008, under the leadership of the Second Marine Air Wing Command Chaplain Captain Ronnie King and Deputy Wing Chaplain Lieutenant Commander Carl Koch, a resetting retreat and conference for the returning combat deployed religious ministry team members (RMTs) and pre-deploying RMTs was attended by 38 chaplains and religious program specialists (RPs). This author produced a three-day agenda that included an educational program for Compassion Fatigue re-assessment, distribution of Compassion Fatigue literature, ProQOL survey results received during deployment (Appendix A), lessons learned and open discussion about Compassion Fatigue, pre-deployment awareness, decompression and resetting techniques. Further, there were specially designed social events and family events to aid in reconnecting and reintegrating with families and into a non-combat American culture.

This retreat was a top-down approach addressing compassion-related stress and

care for caregivers, which included the forward deployed command chaplain discussing his experiences in surgical shock trauma care and mortuary affairs. With command leaders openly discussing their compassion-related stressors and experiences, this author found that the more junior personnel were comfortable following suit. This top-down approach with command leader buy-in is essential to the success of a compassion stress management program and setting the tone within the chaplain culture to be willing to seek help. Only with the cultural stereotypes removed can an open and honest discussion take place in the Navy Chaplain Corps community.

The 38 participants in this resetting retreat completed survey feedback forms. Participants were asked to score the program overall and in each individual course session and social activities. The measure utilized was a standard scale rating from 1 to 10 on quality, with the additional opportunity to make comments on the presentation and presenter. The scale values were as follows: 1 poor, 3 fair, 5 neutral, 7 good, 9 great and 10 excellent, with even numbered intermediate numerical ratings. With 38 feedback forms received, the overall resetting style retreat program agenda scored a 9.54 average. The session on Compassion Fatigue, which included the education, ProQOL review and roundtable discussion, scored a 9.83 average. Participant feedback and quotes for this session included, "This session was the most valuable portion of the program. I only wish more time was devoted to this topic and discussion." Of the 38 feedback forms, 12 noted that more time should be devoted to the subject of Compassion Fatigue. Another survey question that was asked was, "What were the most valuable parts of the conference?" Over sixty-five percent (65.75) answered favorably that the session on Compassion Fatigue was the most valuable, followed by the social dinner cruise.

Another comment of great value was, "It was great to break the enlisted Sailors and

Officers apart for the discussion in order to create a greater atmosphere for openness that

may not exist in mixed company. Our discussion was very helpful." The top-down

approach and educational methodology in a resetting retreat were thus a success in

addressing compassion-related stress.

Experiential Impact and Commander Feedback

Commanders were also very supportive of the previously outlined program and

offered the following statement after receiving pre-deployment Compassion Fatigue

awareness training through the previously mentioned retreat and conference. This

comment was submitted by LCDR Carl Koch and validated by the Wing Chaplain CAPT

Ronnie King while serving deployed to Iraq, reflecting upon the training they received.

> As Deputy Wing Chaplain for the 2nd Marine Aircraft Wing, Cherry Point, NC, I had the privilege and opportunity to receive the insightful and outstanding training provided by Chaplain Paul Greer during the Wing Chaplain's Pre-Deployment Conference. Now that I'm currently deployed to Iraq, I have first-hand awareness and experience with the challenges that come through Compassion Fatigue and this understanding is completely due to Chaplain Greer's excellent training. Based on the model he proposed at our training, Chaplains are actively engaged in a degree of honest and compassionate fellowship that I have not experienced on any other deployment. I sincerely believe that the training he offered, and the practice of lessons taken from that training, are directly responsible for the spiritual and emotional well being of our Wing Forward Chaplains.[159]

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[159] Chaplain Koch is stationed at Al Asad Air Base, Al Anbar Province Iraq at the date of his writing and attended the June 28-30 2008 Wing Chaplain's Conference and compassion fatigue seminar. Second Marine Air Wing Forward LCDR Carl P. Koch, Deputy Command Chaplain, Compassion Fatigue Response and Reflection, e-mail message to LT Paul B. Greer, Chaplain, United States Navy, March 5, 2009.

The Accelerated Recovery Program Educational Methodology Study

The Accelerated Recovery Program (ARP), as outlined by this author as part of the program for chaplain deployment rotation care, serves as the only Compassion Fatigue mitigation program that has been empirically studied and proven effective. ARP is a five-session protocol developed in 1997 by Gentry, Baranowsky and Dunning under the direction of Charles Figley at Florida State University.[160] This "education as treatment" protocol has been validated through multiple studies and draws upon Narrative Therapy, Eye Movement Desensitization Reprocessing, Time-Limited Trauma Therapy, NLP/Hypnotherapy, Though Field Therapy, Burnout Interventions, Stress Resiliency Research and Anxiety Management Skills.[161] The Accelerated Recovery Program was used for the first time with twelve workers providing care to traumatized individuals following the Oklahoma City Murrow Building bombing, with statistically successful treatment.[162] Gentry writes,

> it was decided that a collection of baseline data for comparison was necessary to compare outcome and effectiveness of this program approach and educational methodology. The collection of baseline and outcome data would be conducted from the first training that was implemented in January of 1999. Baseline and Compassion Fatigue post-training scores from compassion fatigue, compassion satisfaction and burnout subscales of the Compassion Satisfaction/Fatigue Self-Test (Figley, 1995; Figley & Stamm, 1996) were collected. Data were analyzed for 166 participants who successfully completed the CCFS Training between January 1999 and January 2001 (Gentry, 2000). The protocol demonstrated clinically and statically significant results ($p < .001$) when pre-training and post-training scores on the compassion fatigue, compassion satisfaction and burnout subscales of the Compassion Satisfaction/Fatigue Self-Test (Figley & Stamm, 1996) were compared.[163]

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[160] Figley, *Treating Compassion Fatigue*, 128.

[161] Gentry, *Compassion Fatigue: The Crucible of Transformation*, 37-61.

[162] Ibid. 47.

[163] Ibid, 47-48.

Figure 2 illustrates the pre-training and post-training ARP study outcome and impact on
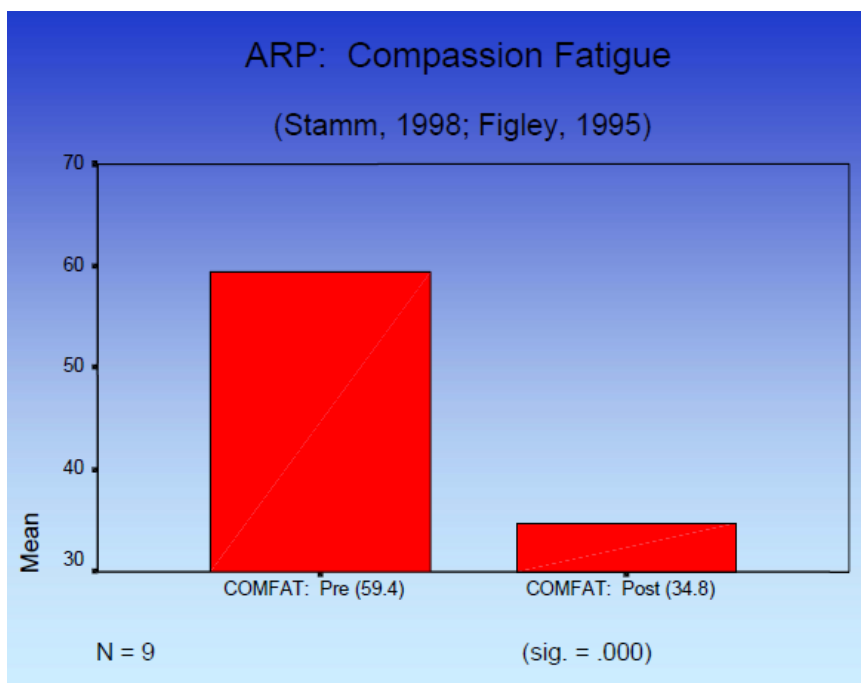
Compassion Fatigue.

Figure 2. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training Compassion Fatigue study. [164]

Figure 2 demonstrates that Compassion Fatigue was significantly reduced through the

implementation of the Accelerated Recovery Program. Further, there was a significant

increase in compassion and professional satisfaction, as illustrated in Figure 3.

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[164] J. Eric Gentry, dir., *Accelerated Recovery Program For Compassion Fatigue* (Sarasota: Compassion Unlimited, 2009), power point slides, http://www.compassionunlimited.com/pdf/PowerPointPresentation.pdf. (accessed March 7, 2009).

ARP: Compassion Satisfaction

(Stamm, 1998)

COMSAT: Pre (84.2)   COMSAT: Post (108.9)

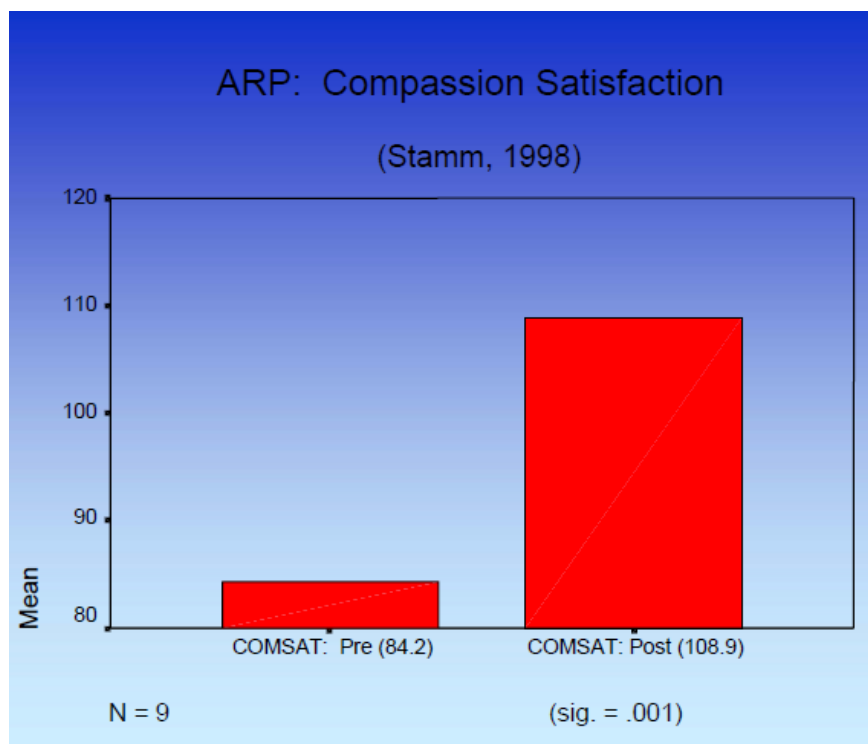N = 9   (sig. = .001)

Figure 3. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training compassion satisfaction study. [165]

Burnout was also compared and contrasted utilizing the Accelerated Recovery Program

educational methodology. Figure 4 illustrates the significant decrease in burnout by
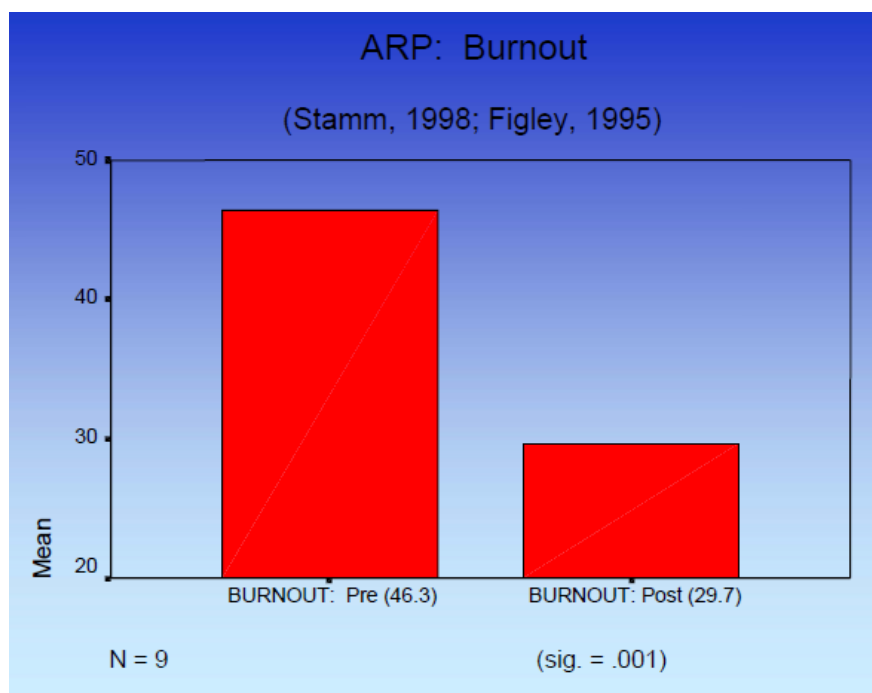
those who participated.

[165] Ibid.

ARP: Burnout

(Stamm, 1998; Figley, 1995)

N = 9   (sig. = .001)

Figure 4. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training burnout study. [166]

 The significant reduction in burnout following ARP implementation has profound

implications when applied to the context of military chaplains and around-the-clock

operations. Further, Vicarious Traumatization has the most significant impact and, when

related to Compassion Fatigue and the ability to recover from trauma, was also studied

with the Accelerated Recovery Program. Figure 5 illustrates the significant results in

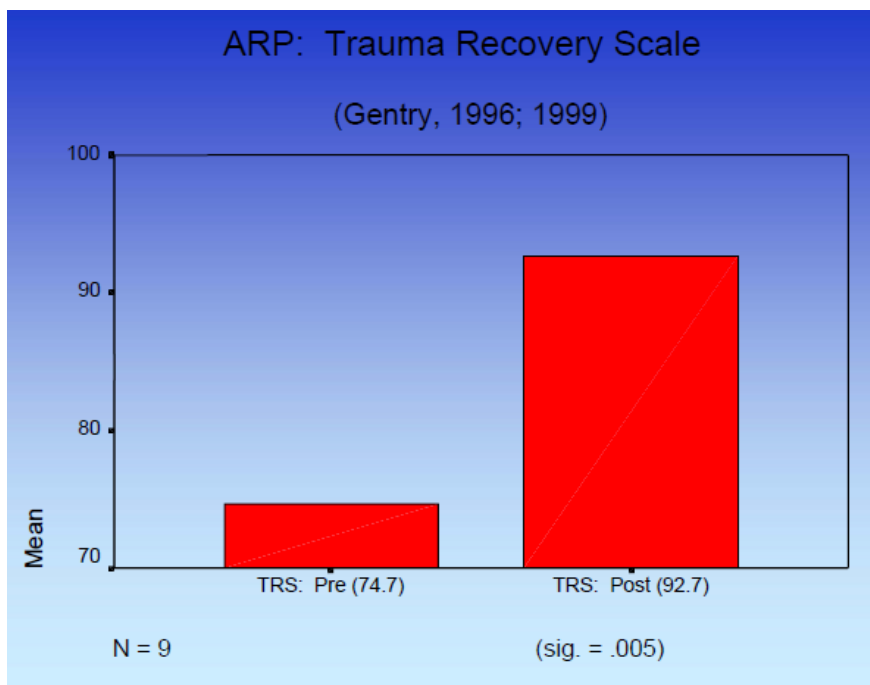promoting healing and recovery from Vicarious Traumatization with this program.

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[166] Ibid.

Figure 5. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training trauma recovery study. [167]

In addition to these statistics, data was collected on the impact of the Accelerated Recovery Program on general psychological symptoms such as PTSD, substance dependency, suicide, Generalized Anxiety Disorder, disassociation and Soma. Figure 6 illustrates the positive benefit and impact of the ARP on these general psychological issues.

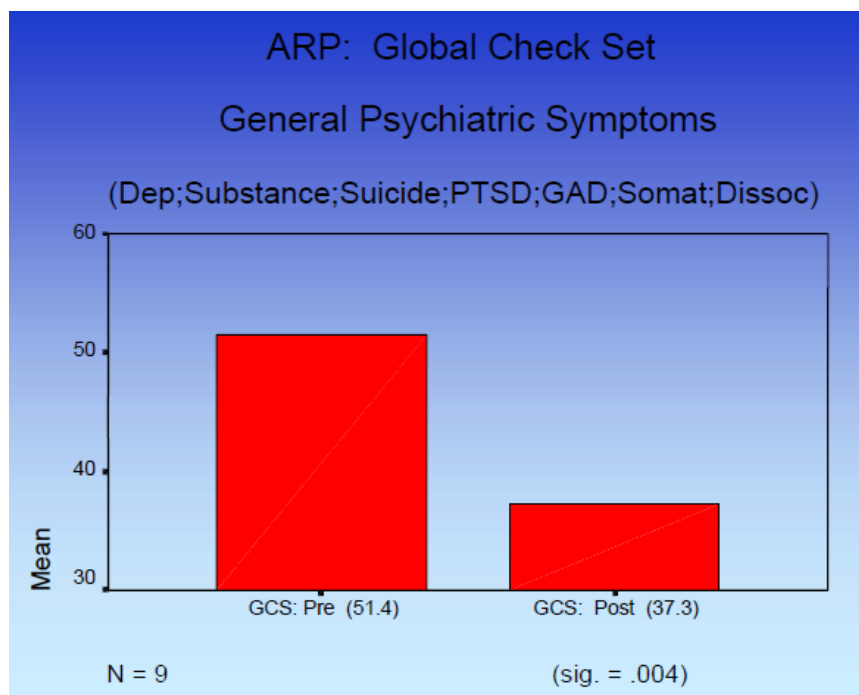[167] Ibid.

Figure 6. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training general psychiatric symptoms study. [168]

With a reduction in these life impacting disturbances, clinical stress was also considered

in relation to the Accelerated Recovery Program. Figure 7 illustrates how stress is

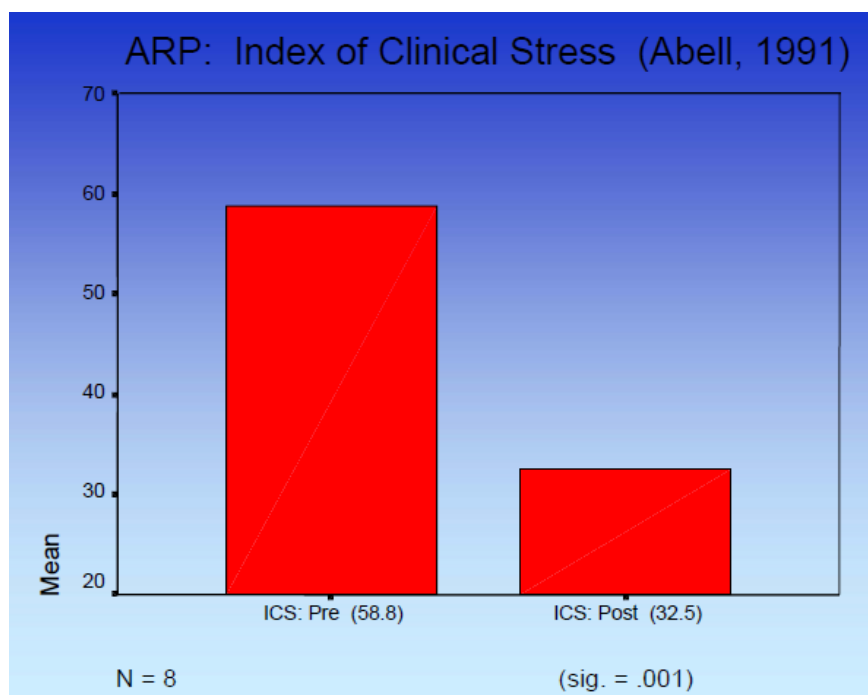significantly reduced through the education methodology offered through the ARP.

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[168] Ibid.

Figure 7. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training index of clinical stress study. [169]

It is evident from the data that the Accelerated Recovery Program and the five step model has a significant impact on reducing Compassion Fatigue, burnout, clinical stress and general psychological dysfunctions, but is the education methodology the avenue for treatment of Compassion Fatigue? Figure 8 demonstrates the impact of the educational methodology.

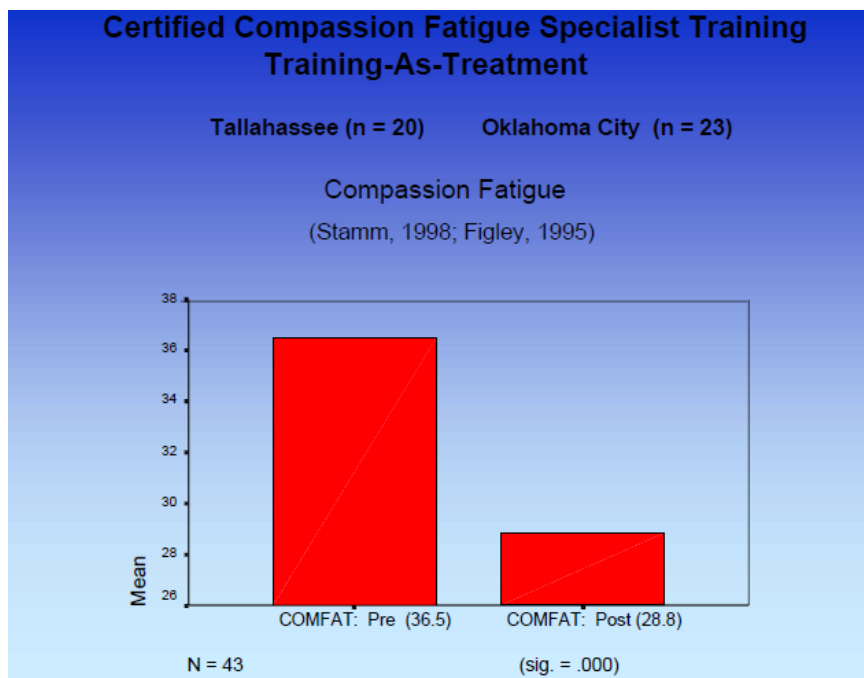[169] Ibid.

Figure 8. J. Eric Gentry, "The Accelerated Recovery Program" pre-training and post-training Training-As-Treatment study. [170]

The data and work by Stamm, Figley, Gentry, Baranowsky, Dunning and Abel conclusively support the Accelerated Recovery Program and the educational methodology as the correct approach for mitigating the effects of Compassion Fatigue. This approach has significant implications in approaching a program of care for combat deploying chaplains and military caregivers exposed to the rigors of war.

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[170] Ibid.

CHAPTER 6

LET THE HEALING BEGIN: TRANSFORMING THE PAIN OF COMPASSION
FATIGUE INTO FLOW

The keys to the prevention of Compassion Fatigue are education and a self-
care plan. Even with these mechanisms in place, however, compassion-related stress is

inevitable. Experts such as Pearlman, Ochberg and Figley concur in their writings that as

long as caregivers are engaged in helping trauma survivors and have empathic ability,

they will experience compassion-related stress. Once again utilizing the Figley

Compassion Fatigue Process model, one may begin to address the process for healing.

Each element of the Figley process can aid in identifying the synergistic elements that

influence the progressive flow into Compassion Fatigue or how a plan for care and

healing can redirect that flow into a healthy detachment and sense of personal and

professional satisfaction. This chapter will offer a variety of approaches to aid those,

specifically post-deployed combat chaplains, suffering with compassion-related stress

and Compassion Fatigue.

Re-deployment

For the Chaplain returning from deployment, most would think that the

separation from the combat environment would be enough the stop the stimulation of

combat-related stressors. This is not the case. As previously noted, the Figley model

makes it clear that Compassion Fatigue is a synergistic process. Removal from a hostile

area will assist in decreasing the likelihood of experiencing Primary Traumatic Stress and

Secondary Traumatic Stress, but the nature of the chaplains' ministry caring for their troops once they return to CONUS is ongoing and the exposure to those suffering through Vicarious Traumatization continues. This repeated exposure to suffering personnel is a critical point for chaplains to be honest when addressing difficulties in resetting post-deployment. If they themselves are wounded and the signs of Compassion Fatigue are evident, they must be even more vigilant in self-care and honest enough to ask for help and refer counselees to other chaplains and military counseling services.

Post-deployment external factors and life events continue to impact the coping abilities and psyche of the chaplain. The very nature of combat deployment impacts the chaplain's systems and is a major factor accounted for in the Figley model for other life demands which influence the Compassion Fatigue process. Redeployment to CONUS heightens these external factors and demands. The chaplain himself must reintegrate into a society and culture from which he or she has been removed, as well reconnect and reintegrate with his or her own family. The emotional process experienced by the chaplain, as with other members of the military and their families, has been labeled "The Emotional Cycle of Deployment."[171]

The Emotional Cycle of Deployment

The emotional cycle of deployment was presented by Pincus, House, Adler and Christenson in a paper introduced by the United States Army after the Bosnian Conflict as part of their deployment readiness training. This training paradigm has further been

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[171] Simon H. Pincus, Robert House, Joseph Christenson and Lawrence Adler, "The Emotional Cycle Of Deployment: A Military Family Perspective," *U. S. Army Hooah 4 Health*, 2009, http://www.hooah4health.com/deployment/Familymatters/emotionalcycle.htm. (accessed March 7, 2009).

utilized by the other U.S. Armed Forces in a similar manner to explain the emotional

experience associated with combat deployment. Though a few sources differ on whether

there are five or seven stages in the Emotional Cycle, the overall process explains the

emotional factors that accompany deployment, to which there is a significant impact on

the chaplain when dealing with compassion-related stress. Figure 9 serves to illustrate

the Emotional Cycle of Deployment.
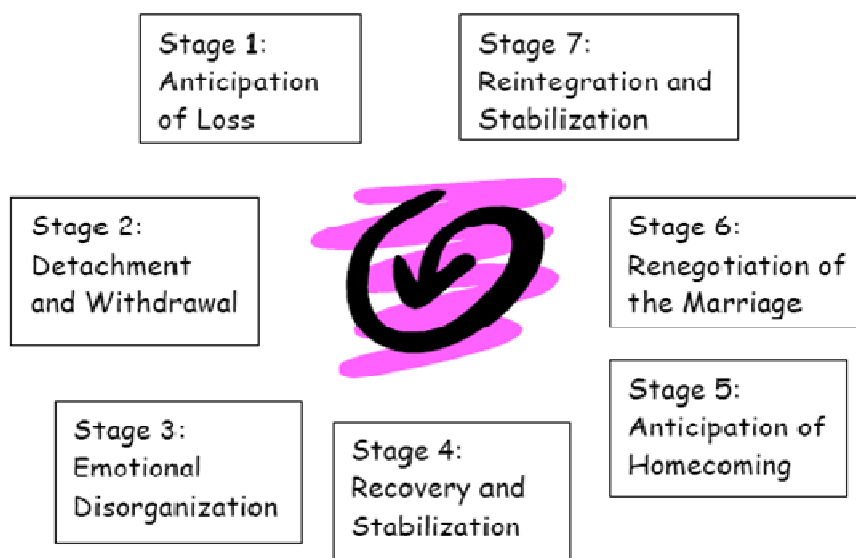
The Emotional Cycle of Deployment

Stage 1:
Anticipation
of Loss

Stage 7:
Reintegration and
Stabilization

Stage 2:
Detachment
and Withdrawal

Stage 6:
Renegotiation of
the Marriage

Stage 5:
Anticipation of
Homecoming

Stage 3:
Emotional
Disorganization

Stage 4:
Recovery and
Stabilization

Figure 9. Simon H. Pincus, Robert House, Joseph Christenson and Lawrence Adler, "The Emotional Cycle of Deployment." [172]

In the Emotional Cycle of Deployment, stages 1 and 2 are associated with pre-

deployment. This is initiated when orders are communicated and received, thus

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[172] Ibid.

producing grief reactions. Stage 3 usually enters during pre-deployment and during the

initial phase of deployment, when the geographical separation occurs. For the purpose of

this paper, this author will focus on the impact of stages 4 through 7, as they relate more

specifically to the external factors that influence coping with compassion-related stress.

Stage 4 is identified as the stage when coping mechanisms regain control and normal

emotional functioning returns. In this stage the individual can accommodate and cope

with the stress of geographic separation and deployment. This is a significant factor in

that if the chaplain or their family has difficulty in reaching this stage, coping and/or

external factors play a significant role in the Compassion Fatigue Process. Stage 5 also

plays a significant role, as the homecoming anticipation may create certain expectations

in the military member's return that can be realistic, idealistic or unfulfilled. The

heightened anxiety accompanying Stage 5, coupled with the return to CONUS and

familial reintegration, influence stress and the Compassion Fatigue flow process. Stages 6

and 7 are the most significant stages for external factors for the chaplain and the impact

on the Compassion Flow Process. Without familial stabilization and support, personal

coping and resiliency will continue to be impacted and healing from compassion-related

stressors will be hampered.

The Family System Influence

Figley and Nash write that "deployment to a war zone is a transformative

process for everyone connected to the enterprise."[173] The family system has a major role

to play in the recovery and healing from deployment for every military member. As noted

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[173] C. R. Figley & W. P. Nash, 2.

in the Emotional Cycle of Deployment, stages 6 and 7 take approximately six to twelve weeks to process, as new normalcy is established in the family based on each member's unique experiences during the deployment. These two stages of reintegration must be thought of in light of the family systems theory. Just as a pebble cast into a pond creates a ripple, so to the reintegration of the chaplain back into his or her family creates a ripple effect throughout the family system, felt by all. The level of enmeshment, cohesiveness and other family dynamics will affect this process of stabilization in the home and thus the ability to cope and work through the compassion-related stress and combat experiences. In this author's interviews with several chaplains, family support has been the critical factor in recovery from Compassion Fatigue and was the building block for this author's recovery, followed by Compassion Fatigue education. Support from the family and care for the family of a chaplain suffering from Compassion Fatigue is critical for both the individual and the family to heal from the stressors of combat deployment.

Signs of Compassion Fatigue

Just as the family is critical in the healing process, it is equally important that they are educated and recognize the signs of Compassion Fatigue. As noted in earlier interviews and in this author's own experience, the family was the first to notice the signs of compassion stress, and the inability to detach from client trauma often plays out in the home and family system of the chaplain with anger, lack of empathy and isolation. Families of chaplains and military caregivers must therefore be included in Compassion Fatigue education.

According to Clemens, McCann and Pearlman, Compassion Fatigue can mimic

the symptoms of the traumatized one works with.[174] Figley notes "a state of tension and preoccupation with the individual or cumulative trauma of clients."[175] These symptoms reflect the PTSD triad of indicators, including intrusion, avoidance and hypervigilance, and can mirror symptoms of burnout.[176] These symptoms "form a state of physical, emotional, cognitive and spiritual volatility in traumatized individuals, families and groups…and are hypothesized to encompass the primary CF symptomology."[177] Other symptoms include depression, difficulty separating work from one's personal life, lowered frustration tolerance, increased anger with outbursts, marked increase in transference/countertransference, shifts in world-view and belief system, loss of hope, lowered functioning, low competence and self-esteem and ineffective coping and soothing behaviors.[178] These symptoms and responses are clear indicators of CF and a need for care for the caregiver and need to enter a process for healing.

Process for Healing

It cannot be overstated that a plan for self-care is critical in preventing Compassion Fatigue. Quite often those experiencing Compassion Fatigue have failed to enact and maintain a self-care plan and have fallen into what Carmen Berry calls the "Messiah Trap."[179] For this author, placing the needs of others first and failing to enact a

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[174] Figley, *Treating Compassion Fatigue*, 124.

[175] Ibid., 125.

[176] Ibid.

[177] Ibid.

[178] Ibid.

[179] Berry, 14.

plan for self-care were the most manageable factors that were neglected during his combat deployment. Therefore, those experiencing Compassion Fatigue must return to the basics and develop and implement a self-care plan.

Self-care Plans

Several books offer significant aids and accompanying workbooks to assist in the healing and recovery process as well as developing a plan for self-care. One such book is Saakvitne and Pearlman's *Transforming the Pain: A Workbook on Vicarious Traumatization* and Figley's *Treating Compassion Fatigue.* Several professional organizations also offer resources, including the American Association of Christian Counselors, who offer the *Courageous Living* series, which includes material on Compassion Fatigue, as well as The Green Cross Academy of Traumatology. Green Cross has offered guidelines in developing a self-care plan by addressing the physical, psychological, social/interpersonal and professional areas.[180] A detailed list of guidelines is offered in Appendix B of this paper and is recommended for developing one's personal plan.

Transformation

As previously noted, Compassion Fatigue involves profound changes in the core aspects of the counselor's self, cognition and belief system.[181] As such, these aspects

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[180] Charles Figley & Kathleen Figley, "Standards Of Self Care," *Green Cross Academy Of Traumatology*, 2009, http://www.greencross.org/index.php?option=com_content&view=article&id=184&Itemid=124/ (accessed March 9, 2009).

[181] Kress, Trippany and Wilcoxon, 31.

must be addressed as part of the healing process to "transform the pain into flow."[182]

Cisney and Ellers of the American Association of Christian Counselors suggest that a

transitional plan must include care in the areas of emotional, spiritual, relational and

physical well being.[183] In each of these realms, one must create a strategy to improve the

quality of life that has eroded as part of the Compassion Fatigue process.

Saakvitne and Pearlman offer a CF transforming strategy in three categories to

address the stress associated with Vicarious Traumatization: self-care, nurturing activities

and escape.[184] Further, they provide a model to transform the despair by creating and

infusing meaning, much like Logotherapy; challenging negative beliefs and assumptions;

and by initiating participation in community building activities. For chaplains this can be

a unique challenge. As noted by this author, the Chaplain Corps community can be

difficult to connect with due to the nature of competition in a military institutional setting

with promotions and the associated authoritative hierarchy. One may experience greater

difficulty in healing if one's faith and spiritual beliefs have been diminished due to the

pain of Vicarious Traumatization. To combat these issues, Saakvitne & Pearlman give the

ABC's of addressing CF with awareness, balance and connection.[185] Awareness includes

being attuned to one's own needs, limits, emotions and resources by education and

assessment. Further, one must practice mindfulness and acceptance of these limitations.

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[182] Karen Saakvitne, Laurie A. Pearlman, *Transform the Pain: A Workbook on Vicarious Traumatization* (New York: W. W. Norton and Company, 1996), 71.

[183] *Courageous Living. Compassion Fatigue: Caring for the Caregiver*, DVD, ame. Kevin Ellers and Jennifer Cisney, (Forest: AACC, 2007).

[184] Saakvitne & Pearlman, 72.

[185] Ibid., 75-76.

One must also create an inner balance and equilibrium with work, play and rest, including

limiting client scheduling, relaxation techniques and a regimented sleep schedule.

Ultimately, there must be a connection or re-connection to oneself, others and in a larger

sense, community, personally, professionally and organizationally. The authors even go

so far as to recommend re-engaging clients under supervision as part of the reconnection

process.[186]

Accelerated Recovery Program

As noted by Stamm, Figley, Gentry, and Abell, the educational methodology

and Accelerated Recovery Program is the only empirically proven system for treating

Compassion Fatigue for healing. The ARP is a five-session brief therapy treatment

program designed to reduce the intensity, duration and frequency of Compassion Fatigue

symptomology. It is flexible and adaptable to individual treatment, small to large groups

and workshop formats and can be developed to train trainers.[187] ARP goal outcomes are

to aid in CF symptom identification and triggers, identification and utilization of

resources, arousal reduction methods, grounding and containment skills, conflict

resolution, and implementation of a supportive aftercare plan utilizing the

"PATHWAYS" self-care program.[188] The ARP components include building a

therapeutic alliance with another caregiver, self-assessment utilizing CF profiling,

anxiety management, narrative and restorative storytelling, exposure and resolution of

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[186] Ibid.

[187] Figley, *Treating Compassion Fatigue*, 129.

[188] Ibid.

Secondary Traumatic Stress, cognitive restructuring with self-care integration, and the "PATHWAY" self-care plan for self-directed resiliency.[189] PATHWAY acts as a buffer and means for distress resolution, focusing on healthy lifestyles, minimizing distress and optimizing satisfaction. The five primary pathways for this are resiliency skills, self-management and care, connection with others, skill acquisition, and internal and external conflict resolution.[190]

The Accelerated Recovery Program combines several brief therapy treatment models and can easily be utilized by individuals or groups. For the individual chaplain or caregiver, self education can be accomplished by the Green Cross Academy of Traumatology or through Compassion Unlimited. For the Chaplain Corps, this program can be utilized through CREDO by training CREDO chaplains, or contracting at minimal expense for group resetting retreats as previously outlined and offers the best hope for those suffering from Compassion Stress symptoms.

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[189] Ibid., 129-131.

[190] Ibid., 131-132.

CONCLUSION

It is evident from the body of research available, personal testimonies and interviews conducted by this author that a problem with compassion stress and Compassion Fatigue exists among combat deploying chaplains. As such, a top-down recognition and approach to addressing the issue is necessary for the overall health and retention of chaplains as caregivers and force multipliers in the United States military.

An education methodology and program for current, future and deploying chaplains is critical to mitigate the growing problem of Compassion Fatigue among military chaplains as the United States enters its eighth year of war. Combat deployment presents unique challenges to the military chaplain as a confidant to service members experiencing familial and traumatic loss associated with combat deployment. L. A. Pearlman has astutely observed that "[a]s long as we are engaging empathetically with trauma survivors and feeling responsible to help in some way, we are going to experience Vicarious Traumatization."[191] This paper has demonstratively proven that the cost of caring is inescapable and must be addressed to preserve the force of military chaplains serving in a time of war.

This paper has further demonstrated the necessity of a top-down approach to change the cultural stereotypes and cultural climate for chaplains from competitive to

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[191] L. A. Pearlman, "Notes From Rwanda." *Gift From Within*, http://www.giftfromwithin.org/

collegial in order to facilitate proper care and resource utilization by chaplains. By

implementing the recommended educational methodology and program for Compassion

Fatigue mitigation contained in this document, chaplain retention, quality of care and

professional quality of life will increase and the unknown long term negative effects of

war on combat veteran chaplains may be minimized. It is evident by direct statements,

empirical data and personal testimonies that education and awareness have been

increased by this project and noteworthy assistance has impacted those affected by

Compassion Fatigue. This project has therefore served as a success and is now limited

only in scope by its level of implementation and further development as the Global War

on Terror continues and new lessons are learned.

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(accessed May 30, 2006).

APPENDIX A

CHAPLAIN INTERVIEW DOCUMENTS

Dear Colleague,

Nothing ever quite prepares us for the amazing difficulties and joys that we find ministering to those in combat. During this war, we have learned a great deal about the psychosocial needs of individuals in crisis and how we as Chaplains can best help take care of ourselves while we try to help others.

In an effort to better understand the needs of caring for caregivers, I am conducting a study as part of my Doctor of Ministry dissertation to understand the effects of caring upon those who experience the trauma of war vicariously through pastoral ministry and counseling. The distribution of this study has been approved by the 2nd Marine Aircraft Wing Chaplain and will be distributed to all Wing Chaplains deployed in OIF 06-08. In addition, sister service chaplains are invited to participate.

Why is there a need for such a study?

- Helping people puts Chaplains in direct contact with the lives of those hurting. As a caregiver, especially in a combat zone, compassion and empathy for those you help has both positive and negative aspects. With the trauma experienced by those in combat, Chaplains are at a greater risk for developing Compassion Fatigue (CF) through vicarious traumatization.

- There is no published literature or study on Compassion Fatigue (CF) among combat deployed Chaplains.

- This study will lead to a thesis project that includes management and intervention models for avoiding and managing Compassion Fatigue (CF).

What is the methodology?

There will be a series of professional assessments developed by Dr. B. H. Stamm of Idaho State University, designed to assess professional satisfaction and the effects of CF. These assessments will be distributed through this package as the instrument for intake and information. Each assessment should be completed in the prescribed timeline, and then mailed in the pre-addressed envelope provided. Each assessment includes the individual ID # randomly assigned, ensuring anonymity to solicit full disclosure. The package includes the following assessments and their prescribed timeline for completion.

- Variables Assessment (completed pre-deployment or up to the first 30 days of deployment).
- 1st Professional Quality of Life Assessment (ProQOL) completed at the beginning of the deployment).
- 2nd ProQOL (completed mid-deployment).
- 3rd ProQOL (completed at the end of deployment before re-deployment).

-     4th ProQOL (completed 30-60 days after re-deployment).

We are including a reminder card to assist you in completing these assessments in the proper timeframe to maintain the study's integrity. In addition, we are including a brief pocket card that you may carry with you to remind you of how important it is to take care of yourself and those working with you. The strategies suggested are based on the experiences of other people working in crises and upon research from around the world. Please feel free to print as many copies as you like and to share this card with others. If you would like more information about caring for yourself in difficult work, please visit the following website at http://telida.isu.edu or the *Actions Without Boarders* Psychosocial.org website that provides information for pre-deployment, in the field and re-entry.

I recognize the enormity of your task and your commitment to serving God and those entrusted to your care. With the many tasks associated with field ministry, I would like to thank you for your selflessness and compassion as you work to help others. Thank you for assisting in this study. It is my desire that the completed project will assist chaplains in understanding the effects of compassion fatigue and lead to greater educational and management techniques that will help to care for caregivers.

Very respectfully,

LT Paul B. Greer, CHC, USN

Assessment 1   ID# 3P4QP

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

5   1.   I am happy.
4   2.   I am preoccupied with more than one person I *[help]*.
4   3.   I get satisfaction from being able to *[help]* people.
4   4.   I feel connected to others.
1   5.   I jump or am startled by unexpected sounds.
4   6.   I feel invigorated after working with those I *[help]*.
1   7.   I find it difficult to separate my personal life from my life as a *[helper]*.
1   8.   I am losing sleep over traumatic experiences of a person I *[help]*.
1   9.   I think that I might have been "infected" by the traumatic stress of those I *[help]*.
1   10. I feel trapped by my work as a *[helper]*.
1   11. Because of my *[helping]*, I have felt "on edge" about various things.
4   12. I like my work as a *[helper]*.
1   13. I feel depressed as a result of my work as a *[helper]*.
1   14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
4   15. I have beliefs that sustain me.
4   16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
4   17. I am the person I always wanted to be.
3   18. My work makes me feel satisfied.
1   19. Because of my work as a *[helper]*, I feel exhausted.
4   20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
2   21. I feel overwhelmed by the amount of work or the size of my case/work/load I have to deal with.
4   22. I believe I can make a difference through my work.
1   23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
4   24. I am proud of what I can do to *[help]*.
1   25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
2   26. I feel "bogged down" by the system.
4   27. I have thoughts that I am a "success" as a *[helper]*.
3   28. I can't recall important parts of my work with trauma victims.
3   29. I am a very sensitive person.
4   30. I am happy that I chose to do this work.

Professional Quality of Life Satisfaction Variables Assessment

ID# _3 P 4 Q P_

Thank you for your willingness to participate in this study. Please answer each question as it relates to your ministry. You will only have to complete this assessment of variables once and your anonymity will be retained; so please answer all questions fully.

1. What is the average number of hours per week you spend in counseling? *30*

2. How many years have you served in professional ministry? *2 5 +*

3. How many years have you served in the Chaplain Corps? *18*

4. What is your age?   25-30   31-35   36-40   40-45   46-50   50-55   *(56+)*

5. What type of unit do you serve with? (Ex. MAW, MEU, Mortuary Affairs, Marine Battalion, Combat Engineers, CASEVAC, SSTP, etc.)
    MAW + COALITION

6. How many combat deployments (including this deployment), have you served? *2*

7. How many hours a week do you work with trauma victims/survivors? *5*

8. Highest level of education (Ex. 2 masters, Ph D x 2, D Min)?
    2 MA

9. What is your faith group? *RC*

10. How many units of CPE do you have? *ONE*

This concludes the assessment. Thank you for your participation. If you have questions, you may contact Chaplain Paul Greer via e-mail paul.greer@usmc.mil in strict confidence.

End of deployment

ProQOL R-IV

ID#_3P4af

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

_5_ 1. I am happy.

_4_ 2. I am preoccupied with more than one person I *[help]*.

_4_ 3. I get satisfaction from being able to *[help]* people. ,

_4_ 4. I feel connected to others.

_2_ 5. I jump or am startled by unexpected sounds.

_4_ 6. I feel invigorated after working with those I *[help]*.

_2_ 7. I find it difficult to separate my personal life from my life as a *[helper]*.

_1_ 8. I am losing sleep over traumatic experiences of a person I *[help]*.

_1_ 9. I think that I might have been "infected" by the traumatic stress of those I *[help]*.

_1_ 10. I feel trapped by my work as a *[helper]*.

_2_ 11. Because of my *[helping]*, I have felt "on edge" about various things.

_4_ 12. I like my work as a *[helper]*.

_0_ 13. I feel depressed as a result of my work as a *[helper]*.

_0_ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.

_5_ 15. I have beliefs that sustain me.

_3_ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

_4_ 17. I am the person I always wanted to be.

_4_ 18. My work makes me feel satisfied.

_3_ 19. Because of my work as a *[helper]*, I feel exhausted.

_3_ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.

_4_ 21. I feel overwhelmed by the amount of work or the size of my case/*work*/load I have to deal with.

_4_ 22. I believe I can make a difference through my work.

_1_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.

_4_ 24. I am proud of what I can do to *[help]*.

_1_ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.

_5+_ 26. I feel "bogged down" by the system.

_3_ 27. I have thoughts that I am a "success" as a *[helper]*.

_1_ 28. I can't recall important parts of my work with trauma victims.

_5_ 29. I am a very sensitive person.

_5_ 30. I am happy that I chose to do this work.

30 days post-deployment

ProQOL R-IV

ID# _3P4QP_

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the _last 30 days_.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

_5_	1.	I am happy.
_4_	2.	I am preoccupied with more than one person I *[help]*.
_5_	3.	I get satisfaction from being able to *[help]* people.
_5_	4.	I feel connected to others.
_1_	5.	I jump or am startled by unexpected sounds.
_3_	6.	I feel invigorated after working with those I *[help]*.
_3_	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
_1_	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
_1_	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
_0_	10.	I feel trapped by my work as a *[helper]*.
_1_	11.	Because of my *[helping]*, I have felt "on edge" about various things.
_5_	12.	I like my work as a *[helper]*.
_0_	13.	I feel depressed as a result of my work as a *[helper]*.
_0_	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
_5_	15.	I have beliefs that sustain me.
_5_	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_5_	17.	I am the person I always wanted to be.
_4_	18.	My work makes me feel satisfied.
_2_	19.	Because of my work as a *[helper]*, I feel exhausted.
_4_	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
_3_	21.	I feel overwhelmed by the amount of work or the size of my case/*work*/load I have to deal with.
_5_	22.	I believe I can make a difference through my work.
_0_	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_4_	24.	I am proud of what I can do to *[help]*.
_0_	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
_3_	26.	I feel "bogged down" by the system.
_4_	27.	I have thoughts that I am a "success" as a *[helper]*.
_1_	28.	I can't recall important parts of my work with trauma victims.
_4_	29.	I am a very sensitive person.
_5_	30.	I am happy that I chose to do this work.

Assessment 1

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

ID# *A142G5*

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

4	1.	I am happy.
2	2.	I am preoccupied with more than one person I *[help]*.
5	3.	I get satisfaction from being able to *[help]* people.
4	4.	I feel connected to others.
2	5.	I jump or am startled by unexpected sounds.
3	6.	I feel invigorated after working with those I *[help]*.
4	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
0	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
0	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
0	10.	I feel trapped by my work as a *[helper]*.
2	11.	Because of my *[helping]*, I have felt "on edge" about various things.
5	12.	I like my work as a *[helper]*.
0	13.	I feel depressed as a result of my work as a *[helper]*.
0	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
3	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
4	17.	I am the person I always wanted to be.
4	18.	My work makes me feel satisfied.
2	19.	Because of my work as a *[helper]*, I feel exhausted.
5	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
3	21.	I feel overwhelmed by the amount of work or the size of my case/*work*/load I have to deal with.
5	22.	I believe I can make a difference through my work.
0	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
5	24.	I am proud of what I can do to *[help]*.
0	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
1	26.	I feel "bogged down" by the system.
4	27.	I have thoughts that I am a "success" as a *[helper]*.
0	28.	I can't recall important parts of my work with trauma victims.
5	29.	I am a very sensitive person.
5	30.	I am happy that I chose to do this work.

Professional Quality of Life Satisfaction Variables Assessment

ID# _A142G5_

Thank you for your willingness to participate in this study. Please answer each question as it relates to your ministry. You will only have to complete this assessment of variables once and your anonymity will be retained; so please answer all questions fully.

1. What is the average number of hours per week you spend in counseling?

    5-8

2. How many years have you served in professional ministry?

    21

3. How many years have you served in the Chaplain Corps?

    2

4. What is your age?   25-30   31-35   (36-40) 40-45   46-50   50-55   56+

5. What type of unit do you serve with? (Ex. MAW, MEU, Mortuary Affairs, Marine Battalion, Combat Engineers, CASEVAC, SSTP, etc.)

    MAG

6. How many combat deployments (including this deployment), have you served?

    1

7. How many hours a week do you work with trauma victims/survivors?

    Very Few

8. Highest level of education (Ex. 2 masters, Ph D x 2, D Min)?

    MAsters

9. What is your faith group?

    S. Baptist

10. How many units of CPE do you have?

    Zero

This concludes the assessment. Thank you for your participation. If you have questions, you may contact Chaplain Paul Greer via e-mail paul.greer@usmc.mil in strict confidence.

Mid-deployment

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

ID#____*A14265*

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the **last 30 days**.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

4	1.	I am happy.
2	2.	I am preoccupied with more than one person I *[help]*.
5	3.	I get satisfaction from being able to *[help]* people.
5	4.	I feel connected to others.
3	5.	I jump or am startled by unexpected sounds.
5	6.	I feel invigorated after working with those I *[help]*.
2	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
0	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
0	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
0	10.	I feel trapped by my work as a *[helper]*.
0	11.	Because of my *[helping]*, I have felt "on edge" about various things.
5	12.	I like my work as a *[helper]*.
0	13.	I feel depressed as a result of my work as a *[helper]*.
0	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
3	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
3	17.	I am the person I always wanted to be.
4	18.	My work makes me feel satisfied.
4	19.	Because of my work as a *[helper]*, I feel exhausted.
4	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
3	21.	I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.
5	22.	I believe I can make a difference through my work.
0	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
4	24.	I am proud of what I can do to *[help]*.
0	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
2	26.	I feel "bogged down" by the system.
3	27.	I have thoughts that I am a "success" as a *[helper]*.
0	28.	I can't recall important parts of my work with trauma victims.
3	29.	I am a very sensitive person.
5	30.	I am happy that I chose to do this work.

Assessment 1

ProQOL R-IV

ID# 1F2RS

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

4	1.	I am happy.
2	2.	I am preoccupied with more than one person I *[help]*.
5	3.	I get satisfaction from being able to *[help]* people.
4	4.	I feel connected to others.
0	5.	I jump or am startled by unexpected sounds.
4	6.	I feel invigorated after working with those I *[help]*.
0	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
0	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
0	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
0	10.	I feel trapped by my work as a *[helper]*.
0	11.	Because of my *[helping]*, I have felt "on edge" about various things.
5	12.	I like my work as a *[helper]*.
0	13.	I feel depressed as a result of my work as a *[helper]*.
0	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
4	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
4	17.	I am the person I always wanted to be.
4	18.	My work makes me feel satisfied.
1	19.	Because of my work as a *[helper]*, I feel exhausted.
4	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
0	21.	I feel overwhelmed by the amount of work or the size of my case/*work*/load I have to deal with.
4	22.	I believe I can make a difference through my work.
0	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
4	24.	I am proud of what I can do to *[help]*.
0	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
0	26.	I feel "bogged down" by the system.
4	27.	I have thoughts that I am a "success" as a *[helper]*.
0	28.	I can't recall important parts of my work with trauma victims.
1	29.	I am a very sensitive person.
5	30.	I am happy that I chose to do this work.

Professional Quality of Life Satisfaction Variables Assessment

ID# *1F2RS*

Thank you for your willingness to participate in this study. Please answer each question as it relates to your ministry. You will only have to complete this assessment of variables once and your anonymity will be retained; so please answer all questions fully.

1. What is the average number of hours per week you spend in counseling?

   10-15

2. How many years have you served in professional ministry?

   18 years

3. How many years have you served in the Chaplain Corps?

   13 years

4. What is your age?   25-30   31-35   36-40   40-45   46-50   50-55   56+

5. What type of unit do you serve with? (Ex. MAW, MEU, Mortuary Affairs, Marine Battalion, Combat Engineers, CASEVAC, SSTP, etc.)

   CASEVAC

6. How many combat deployments (including this deployment), have you served?   *2*

7. How many hours a week do you work with trauma victims/survivors?

   1 hour

8. Highest level of education (Ex. 2 masters, Ph D x 2, D Min)?

   M Div

9. What is your faith group?

   Christian Church (Disciples of Christ) CC DC

10. How many units of CPE do you have?

    10 units

This concludes the assessment. Thank you for your participation. If you have questions, you may contact Chaplain Paul Greer via e-mail paul.greer@usmc.mil in strict confidence.

Mid-deployment

ID#_____

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the **last 30 days**.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

2	1.	I am happy.
1	2.	I am preoccupied with more than one person I *[help]*.
4	3.	I get satisfaction from being able to *[help]* people.
4	4.	I feel connected to others.
1	5.	I jump or am startled by unexpected sounds.
4	6.	I feel invigorated after working with those I *[help]*.
1	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
1	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
1	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
1	10.	I feel trapped by my work as a *[helper]*.
1	11.	Because of my *[helping]*, I have felt "on edge" about various things.
5	12.	I like my work as a *[helper]*.
1	13.	I feel depressed as a result of my work as a *[helper]*.
1	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
4	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
4	17.	I am the person I always wanted to be.
4	18.	My work makes me feel satisfied.
1	19.	Because of my work as a *[helper]*, I feel exhausted.
4	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
2	21.	I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.
4	22.	I believe I can make a difference through my work.
1	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
4	24.	I am proud of what I can do to *[help]*.
1	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
2	26.	I feel "bogged down" by the system.
4	27.	I have thoughts that I am a "success" as a *[helper]*.
1	28.	I can't recall important parts of my work with trauma victims.
2	29.	I am a very sensitive person.
5	30.	I am happy that I chose to do this work.

Assessment 1

ProQOL R-IV

ID# 9QP32

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

4	1.	I am happy.
4	2.	I am preoccupied with more than one person I *[help]*.
3	3.	I get satisfaction from being able to *[help]* people.
1	4.	I feel connected to others.
1	5.	I jump or am startled by unexpected sounds.
4	6.	I feel invigorated after working with those I *[help]*.
2	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
4	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
3	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
3	10.	I feel trapped by my work as a *[helper]*.
2	11.	Because of my *[helping]*, I have felt "on edge" about various things.
4	12.	I like my work as a *[helper]*.
1	13.	I feel depressed as a result of my work as a *[helper]*.
2	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
4	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
3	17.	I am the person I always wanted to be.
4	18.	My work makes me feel satisfied.
2	19.	Because of my work as a *[helper]*, I feel exhausted.
3	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
3	21.	I feel overwhelmed by the amount of work or the size of my case/*work*/load I have to deal with.
1	22.	I believe I can make a difference through my work.
4	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
4	24.	I am proud of what I can do to *[help]*.
2	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
3	26.	I feel "bogged down" by the system.
3	27.	I have thoughts that I am a "success" as a *[helper]*.
1	28.	I can't recall important parts of my work with trauma victims.
2	29.	I am a very sensitive person.
4	30.	I am happy that I chose to do this work.

Professional Quality of Life Satisfaction Variables Assessment

ID# _9QP32_

Thank you for your willingness to participate in this study. Please answer each question as it relates to your ministry. You will only have to complete this assessment of variables once and your anonymity will be retained; so please answer all questions fully.

1. What is the average number of hours per week you spend in counseling?

   _6_

2. How many years have you served in professional ministry?

   9 yrs

3. How many years have you served in the Chaplain Corps?

   _7_

4. What is your age?   25-30   31-35   36-40 (40-45) 46-50   50-55   56+

5. What type of unit do you serve with? (Ex. MAW, MEU, Mortuary Affairs, (Marine Battalion) Combat Engineers, CASEVAC, SSTP, etc.)

6. How many combat deployments (including this deployment), have you served?   _1_

7. How many hours a week do you work with trauma victims/survivors?

   _3_

8. Highest level of education (Ex. 2 masters, Ph D x 2, D Min)?

   2 masters; EBD

9. What is your faith group?

   Baptist

10. How many units of CPE do you have?   _0_

This concludes the assessment. Thank you for your participation. If you have questions, you may contact Chaplain Paul Greer via e-mail paul.greer@usmc.mil in strict confidence.

#2

Mid-deployment

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never   1=Rarely   2=A Few Times   3=Somewhat Often   4=Often   5=Very Often

4	1.	I am happy.
2	2.	I am preoccupied with more than one person I *[help]*.
4	3.	I get satisfaction from being able to *[help]* people.
3	4.	I feel connected to others.
2	5.	I jump or am startled by unexpected sounds.
1	6.	I feel invigorated after working with those I *[help]*.
1	7.	I find it difficult to separate my personal life from my life as a *[helper]*.
1	8.	I am losing sleep over traumatic experiences of a person I *[help]*.
1	9.	I think that I might have been "infected" by the traumatic stress of those I *[help]*.
1	10.	I feel trapped by my work as a *[helper]*.
2	11.	Because of my *[helping]*, I have felt "on edge" about various things.
4	12.	I like my work as a *[helper]*.
2	13.	I feel depressed as a result of my work as a *[helper]*.
2	14.	I feel as though I am experiencing the trauma of someone I have *[helped]*.
5	15.	I have beliefs that sustain me.
5	16.	I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
4	17.	I am the person I always wanted to be.
5	18.	My work makes me feel satisfied.
2	19.	Because of my work as a *[helper]*, I feel exhausted.
3	20.	I have happy thoughts and feelings about those I *[help]* and how I could help them.
1	21.	I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.
4	22.	I believe I can make a difference through my work.
1	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
5	24.	I am proud of what I can do to *[help]*.
0	25.	As a result of my *[helping]*, I have intrusive, frightening thoughts.
1	26.	I feel "bogged down" by the system.
3	27.	I have thoughts that I am a "success" as a *[helper]*.
1	28.	I can't recall important parts of my work with trauma victims.
4	29.	I am a very sensitive person.
4	30.	I am happy that I chose to do this work.

APPENDIX B

TOOLS FOR ASSESSMENT AND SELF-CARE

THE ACCELERATED RECOVERY PROGRAM

Compassion Satisfaction/Fatigue Self-Test for Helpers

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self -test helps you estimate your compassion status: This includes your risk of burnout, compassion fatigue and satisfaction with helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics **in the last work week**. Then follow the scoring directions at the end of the self-test.

0	1	2	3	4	5
Never	**Rarely**	**A Few Times**	**Somewhat Often**	**Often**	**Very Often**

Items About You

_____1. I am happy.
_____2. I find my life satisfying.
_____3. I have beliefs that sustain me.
_____4. I feel estranged from others.
_____5. I find that I learn new things from those I care for.
_____6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
_____7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
_____8. I have gaps in my memory about frightening events.
_____9. I feel connected to others.
_____10. I feel calm.
_____11. I believe that I have a good balance between my work and my free time.
_____12. I have difficulty falling or staying asleep.
_____13. I have outburst of anger or irritability with little provocation
_____14. I am the person I always wanted to be.
_____15. I startle easily.
_____16. While working with a victim, I thought about violence against the perpetrator.
_____17. I am a sensitive person.
_____18. I have flashbacks connected to those I help.
_____19. I have good peer support when I need to work through a highly stressful experience.
_____20. I have had first-hand experience with traumatic events in my adult life.
_____21. I have had first-hand experience with traumatic events in my childhood.
_____22. I think that I need to "work through" a traumatic experience in my life.
_____23. I think that I need more close friends.
_____24. I think that there is no one to talk with about highly stressful experiences.
_____25. I have concluded that I work too hard for my own good.
_____26. Working with those I help brings me a great deal of satisfaction.
_____27. I feel invigorated after working with those I help.

Compassion Satisfaction/Fatigue Self-Test for Helpers - CONTINUED

0	1	2	3	4	5
Never	Rarely	A Few Times	Somewhat Often	Often	Very Often

____28. I am frightened of things a person I helped has said or done to me.
____29. I experience troubling dreams similar to those I help.
____30. I have happy thoughts about those I help and how I could help them.
____31. I experienced intrusive thoughts of times with especially difficult people I helped.
____32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
____33. I am preoccupied with more than one person I help.
____34. I am losing sleep over a person I help's traumatic experiences.
____35. I have joyful feelings about how I can help the victims I work with.
____36. I think that I might have been "infected" by the traumatic stress of those I help.
____37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
____38. I remind myself to be less concerned about the well being of those I help.
____39. I have felt trapped by my work as a helper.
____40. I have a sense of hopelessness associated with working with those I help.
____41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
____42. I wish that I could avoid working with some people I help.
____43. Some people I help are particularly enjoyable to work with.
____44. I have been in danger working with people I help.
____45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment
____46. I like my work as a helper.
____47. I feel like I have the tools and resources that I need to do my work as a helper.
____48. I have felt weak, tired, run down as a result of my work as helper.
____49. I have felt depressed as a result of my work as a helper.
____50. I have thoughts that I am a "success" as a helper.
____51. I am unsuccessful at separating helping from personal life.
____52. I enjoy my co-workers.
____53. I depend on my co-workers to help me when I need it.
____54. My co-workers can depend on me for help when they need it.
____55. I trust my co-workers.
____56. I feel little compassion toward most of my co-workers
____57. I am pleased with how I am able to keep up with helping technology.
____58. I feel I am working more for the money/prestige than for personal fulfillment.
____59. Although I have to do paperwork that I don't like, I still have time to work with those help.
____60. I find it difficult separating my personal life from my helper life.
____61. I am pleased with how I am able to keep up with helping techniques and protocols.
____62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
____63. I have thoughts that I am a "failure" as a helper.
____64. I have thoughts that I am not succeeding at achieving my life goals.
____65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
____66. I plan to be a helper for a long time.

TRS

TRAUMA RECOVERY SCALE

PART I

___yes___no   I have been exposed to a traumatic event in which *both* of the following were present:

a. experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, *AND*

b. my response involved intense fear, helplessness or horror.

- If yes is answered please complete Part II & III;
- If no is answered complete Part III (omit Part II)

PART II

Directions: Please read the following list and check all that apply.

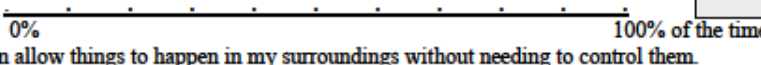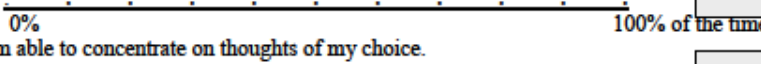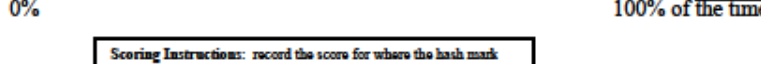| Type Of Traumatic Event	Number of Times	Dates/Age(s)
□ 1. Childhood Sexual Abuse	_____	___ ___ ___
□ 2. Rape	_____	___ ___ ___
□ 3. Other Adult Sexual Assault/Abuse	_____	___ ___ ___
□ 4. Natural Disaster	_____	___ ___ ___
□ 5. Industrial Disaster	_____	___ ___ ___
□ 6. Motor Vehicle Accident	_____	___ ___ ___
□ 7 Combat Trauma	_____	___ ___ ___
□ 8. Witnessing Traumatic Event	_____	___ ___ ___
□ 9. Childhood Physical Abuse	_____	___ ___ ___
□ 10. Adult Physical Abuse	_____	___ ___ ___
□ 11. Victim Of Other Violent Crime	_____	___ ___ ___
□ 12. Captivity	_____	___ ___ ___
□ 13. Torture	_____	___ ___ ___
□ 14. Domestic Violence	_____	___ ___ ___
□ 15. Sexual Harassment	_____	___ ___ ___
□ 16. Threat of physical violence	_____	___ ___ ___
□ 17. Accidental physical injury	_____	___ ___ ___
□ 18. Humiliation	_____	___ ___ ___
□ 19. Property Loss	_____	___ ___ ___
□ 20. Death Of Loved One	_____	___ ___ ___
□ 21. Terrorism	_____	___ ___ ___
□ 23. Other:_____	_____	___ ___ ___
□ 24. Other:_____	_____	___ ___ ___
□ 25. Other:_____	_____	___ ___ ___
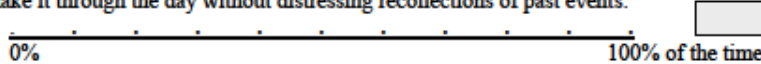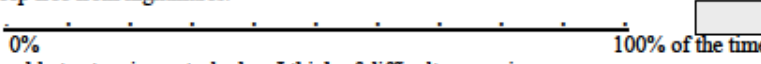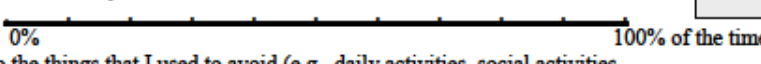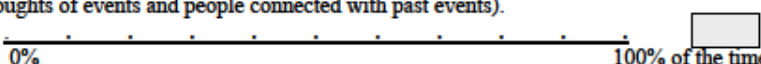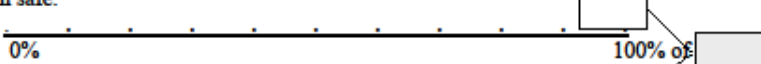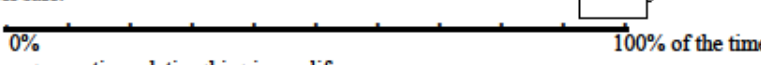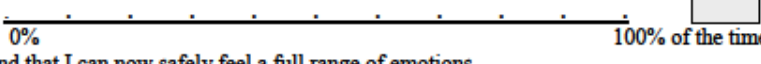
Comments: _____
_____
_____

TRS TRAUMA RECOVERY SCALE

J. Eric Gentry

PART III

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.

    0% · · · · · · · · · 100% of the time

2. I sleep free from nightmares.

    0% · · · · · · · · · 100% of the time

3. I am able to stay in control when I think of difficult memories.

    0% · · · · · · · · · 100% of the time

4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).

    0% · · · · · · · · · 100% of the time

5. I am safe.

    0% · · · · · · · · · 100% of the time

    I feel safe.

    0% · · · · · · · · · 100% of the time

6. I have supportive relationships in my life.

    0% · · · · · · · · · 100% of the time

7. I find that I can now safely feel a full range of emotions.

    0% · · · · · · · · · 100% of the time

8. I can allow things to happen in my surroundings without needing to control them.

    0% · · · · · · · · · 100% of the time

9. I am able to concentrate on thoughts of my choice.

    0% · · · · · · · · · 100% of the time

10. I have a sense of hope about the future.

    0% · · · · · · · · · 100% of the time

AS − FS

Scoring Instructions: record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

Interpretation: 100 – 95 (full recovery/subclinical); 86 - 94 (significant recovery/mild symptoms); 75 – 85 (some recovery/ moderate symptoms); 74 (minimal recovery/severe); below 35 (possible traumatic regression)

Mean Score

Silencing Response Scale (Baranowsky, 1996, 1998)

INSTRUCTIONS: This scale was developed to help caregivers identify specific communication struggles in their work. Choose the number that best reflects your experience using the following rating system, where 1 signifies rarely or never and 10 means very often. Answer all items to the best of your ability as they reflect your feelings over the previous two work weeks.

```
1=Rarely/Never ——2——3——4——5——6——7——8——9—— 10=Always      Sometimes
```

(1)_____ Are there times when you believe your client(s) is repeating emotional issues you feel were already covered?

(2)_____ Do you get angry with client(s)?

(3)_____ Are there times when you react with sarcasm toward your client(s)?

(4)_____ Are there times when you fake interest?

(5)_____ Do you feel that listening to certain experiences of your client(s) will not help?

(6)_____ Do you feel that letting your client talk about their trauma will hurt them?

(7)_____ Do you feel that listening to your client's experiences will hurt you?

(8)_____ Are there times that you blame your client for the bad things that have happened to them?

(9)_____ Are there times when you are unable to believe what your client is telling you because what they are describing seems overly traumatic?

(10)_____ Are there times when you feel numb, avoidant or apathetic before meeting with certain clients?

(11)_____ Do you consistently support certain clients in avoiding important therapeutic material despite ample time to address their concerns?

(12)_____ Are there times when sessions do not seem to be going well or the client's treatment progress appears to be blocked?

(13)_____ You become negatively aroused when a client is angry with you.

(14)_____ Are there times when you cannot remember what a client has just said?

(15)_____ Are there times when you cannot focus on what a client is saying?

TOTAL = _____

GLOBAL CHECK SET (GCS, Baranowsky & Gentry, 1998)

Name:_____ Date:_____ BirthDate:_____ Sex: M ⬜ F⬜

Instructions: Read through each statement responding to items in a manner that best describes your experience over the previous 2 work weeks. Some questions relate to the present and some to the past, respond accordingly.

		Never	Rarely	Some times	Frequently	Almost Always
1-a.	I drink alcoholic beverages daily.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
2-d.	I feel sad, empty or become tearful.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
3-s.	I feel hopeless or worthless.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
4-p.	I have been exposed directly or indirectly (i.e., family, friend) to a traumatic event.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
5-x.	I worry and feel anxious.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
6-i.	My body is usually pain free.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
7-c.	I am unable to clearly recall past traumatic experiences.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
8-a.	I use illegal drugs daily.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
9-d.	My sleep is disrupted or I awake tired.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
10-s.	I have a positive and cheerful attitude to life.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
11-p.	I have frequent recollections to a traumatic incident. (i.e., thoughts, dreams, flashbacks).	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
12-x.	I seem to be unable to control my worries or fears	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
13-i.	I worry about my health.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
14-c.	I do not know how I came to be at some place.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
15-a.	Drug or alcohol use interferes with my work ability.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
16-d.	I am no longer interested in the activities I used to enjoy.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
17-s.	I think about ending my life.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
18-i.	I have not been well due to diagnosed physical illness(es).	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
19-c.	I easily recall important personal information about myself.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
20-a.	Drugs/alcohol have negatively impacted my personal life.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
21-d.	I have a lot of energy.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
22-s.	I have a specific plan to end my life.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
23-p.	I am quick to anger.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
24-x.	I always feel on edge.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
25-i.	I have frequent headaches.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
26-c.	I act out of character and feel I don't know myself.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
27-a.	Drugs or alcohol are a problem in my life.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
28-d.	I have lost or gained more than 10 lbs. recently.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
29-s.	I fear that my life will never improve.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
30-p.	I avoid people, places or things that are trauma reminders.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
31-x.	My concentration is good.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
32-i.	I am afraid I will become seriously ill in the future.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
33-c.	I feel outside of myself - detached like an observer.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4
34-p.	I am fairly relaxed and do not startle easily.	⬜ 4	⬜ 3	⬜ 2	⬜ 1	⬜ 0
35-x.	I feel irritable most of the time.	⬜ 0	⬜ 1	⬜ 2	⬜ 3	⬜ 4

____ + ____ + ____ + ____ + ____ + ____ + ____ - ____
d   a   s   p   x   i   c   TOTAL GSC SCORE

Index of Clinical Stress (Abel, 1991)

Name:_____   Date:_____

This questionnaire is designed to measure the way you feel about the amount of personal stress that you experience. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

    1=None of the time
    2=Very little
    3=A little of the time
    4=Some of the time
    5=A good part of the time
    6=Most of the time
    7=All of the time

1. _____ I feel extremely tense.
2. _____ I feel very jittery.
3. _____ I feel like I want to scream.
4. _____ I feel overwhelmed.
5. _____ I feel very relaxed.
6. _____ I feel so anxious I want to cry.
7. _____ I feel so stressed that I would like to hit something.
8. _____ I feel very calm and peaceful.
9. _____ I feel like I am stretched to the breaking point.
10._____ It is very hard for me to relax.
11._____ It is very easy for me to fall asleep at night.
12._____ I feel an enormous sense of pressure on me.
13._____ I feel like my life is going very smoothly.
14._____ I feel very panicked.
15._____ I feel like I am on the verge of total collapse.
16._____ I feel like I am losing control of my life.
17._____ I feel that I am near the breaking point.
18._____ I feel wound up like a coiled spring.
19._____ I feel that I can't keep up with the demands on me.
20._____ I feel very much behind in my work.
21._____ I feel tense and angry with those around me.
22._____ I feel I must race from one task to the next.
23._____ I feel that I just can't keep up with everything.
24._____ I feel as tight as a drum.
25._____ I feel very much on edge.

Score: _____

COMPASSION FATIGUE ASSESSMENT PROFILE

1. Compassion Satisfaction/Fatigue Self Test (Stamm & Figley, 1998, 1995)
Measures
- Compassion Satisfaction
- Compassion Fatigue
- Burnout

Scoring
- Circle the following 23 items: 4, 6-8, 12-13, 15-16, 18, 20-22, 28-29, 31-34, 36, 38-40, 44.
- Put a check by the following 16 items: 17, 23-25, 41-42, 45, 48, 49, 51, 56, 58, 60, 62-65.
- Put an "X" by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
- (Add the numbers you wrote next to the items for each set of items and note:)
- Add all circled numbers for your *Compassion Fatigue risk factor:* TOTAL = _____
26 or less=extremely low risk; 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.
- Add all numbers with checks beside them for your *Burnout risk:* TOTAL = _____
36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.
- Total numbers marked "X" for *Compassion Satisfaction factor:* TOTAL= _____
118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63-0=low potential.

FURTHER INTERPRETATION (Figley, In Press)
Distinguish between changing jobs & changing ways: Look as your 3 sub-scores and the various combinations:

Score	Burnout Level	ComFat* Level	ComSat** Level
High	High Burnout	High CF	High Satisfaction
Medium	Mod Burnout	Mod CF	Mod Satisfaction
Low	Low Burnout	Low CF	Low Satisfaction

Change Careers: High Burnout, High CF, Low Satisfaction
Change Jobs: High Burnout, Low CF, High Satisfaction
Stay & Manage Stress: Low Burnout, High CF, Mod Satisfaction
Change Client: Low Burnout, Low CF, Low Satisfaction

*ComFat: Compassion Fatigue Level
** ComSat: Compassion Satisfaction Level

2. Trauma Recovery Scale (Gentry, 1996, 1998)
Measures
- PART I: Respondent's belief whether or not they meet Criterion A. (DSM-IV) for PTSD. This refers to whether they have been exposed directly or indirectly to a traumatic incident.
- PART II: History of traumatic experiences
- PART III: Relative recovery and stabilization from traumatic experiences.

Scoring
- PARTS I & II do not require scoring.
- PART III: Take the mean of the two answers for item #5 and add to the scores on all other items. Divide by ten and you will arrive at a mean score. If score is < 50 then significant traumatic stress; If score is > 75 then significant recovery (or minimal traumatic stress).

3. Silencing Response Scale (Baranowsky, 1996, 1998)
Measures
- The silencing response
Scoring
- To score total all response scores to arrive at the sum of scores.
- High risk = 95 - 150; Moderate risk = 41 - 94; Some risk = 21 - 40; Minimal risk = 0 - 20.

4. Global Check Set (Baranowsky & Gentry, 1998)
Measures
- Psychological Disorders - including **Depression(d)** (# 2, 9, 16, 21, 28), **Substance Use(a)** (# 1, 8, 15, 20, 27), **Suicidality(s)** (# 3, 10, 17, 22, 29), **PTSD(p)** (# 4, 11, 23, 30, 34), **Generalized Anxiety Disorder(x)** (# 5, 12, 24, 31, 35), **Somatization(i)** (# 6, 13, 18, 25, 32), and **Dissociation(c)** (# 7, 14, 19, 26, 33).

Scoring
- Total sum of scores as listed on scale items (Total GSC Score)
- For greater clarification total sub-scores for subscales above (d, a, s, p, x, i, c)
- Higher Scores signify greater psychological distress - compare scores over time
- Scores of $\geq$ 70 = significant psychological symptomatology
- This scale is not to be used for diagnostic purposes.

5. Index of Clinical Stress (Abel, 1991)

Measures
Subjective individual stress

Scoring

- Reverse scores for Items 5, 8, 11, 13
- Add Reversed Item scores then add Remaining Item scores to get the Total Score

$$\underline{\hspace{2cm}} + \underline{\hspace{2cm}} = \underline{\hspace{2cm}}$$
(Reversed Items)   (Remaining Items)   (Total Score)

- Subtract total # completed items (25 on scale) from Total Score to get Item Score

$$\underline{\hspace{2cm}} - \underline{\hspace{2cm}} = \underline{\hspace{2cm}}$$
(Total Score)   (#Items complete)   (Item Score)

- Multiply Item Score by 100 to get Adjusted Score

$$\underline{\hspace{2cm}} \times \underline{\ 100\ } = \underline{\hspace{2cm}}$$
(Item Score)   (Adjusted Score)

- Multiply # of completed items (25 on scale) by 6 to get Divisor

$$\underline{\hspace{2cm}} \times \underline{\ 6\ } = \underline{\hspace{2cm}}$$
(#Items complete)   (Divisor)

- The Adjusted Total is divided by the Divisor to get the Total ICS Score

$$\underline{\hspace{2cm}} / \underline{\hspace{2cm}} = \underline{\hspace{2cm}}$$
(Adjusted Total)   (Divisor)   (Total ICS Score)

- Total ICS Score should range between 0-100

Scores > 30 = significant stress

MISSION STATEMENT INSTRUCTIONS (Alternate Short Version)

On your journey toward wellness and recovery from Compassion Fatigue we invite you to explore your early memories of being a caring person, how this led you to become a working caregiver, what that means to you and what keeps you from achieving your ideal in your work.

Please consider the following categories and try to answer them being in general or as specific as you wish. This is an exploration and therefore there can be no right or wrong approach or answer. Follow your instincts on this one and they will send you in just the right direction.

YOUR PROFESSIONAL DEVELOPMENT
*What is it about you that led you toward helping others?

PERSONAL & PROFESSIONAL ETHICS
*What are the values that you will never compromise in your work with clients?

COMMITMENTS
*What are you committed to offer clients? What are you committed to offer yourself?

STRENGTHS: Clients & your own
*What do you believe about your clients? What about your own strengths?

YOUR IDEAL
*If you were to become your ideal caregiver how would life look to you?

ROADBLOCKS AND BAD TRAFFIC
*What impediments keep you from this ideal?

These are just some questions designed to stir your thinking on this topic. Give yourself some time to think about your personal Mission Statement, then take the plunge and commit your thoughts to paper. However, make sure to offer yourself creative license in this endeavor. Remember, there is no right or wrong Mission Statement and, chances are, it will be in continual evolution as long as you practice in this field. This is a wonderful gift to give yourself and can be a source of empowerment and inspiration for you in the future. Enjoy.

LETTER FROM
"THE GREAT SUPERVISOR"

This letter should be written to yourself from an omniscient (all knowing) and omni-benevolent (all good) source. It should reflect the nurturance, support and validation that you have wanted and needed to hear from someone in authority. It should focus upon your strengths, assets and goodness. This will be a challenge for some ... the more honest and sincere that you make this letter, the more benefit you will receive from the work that will come with it in subsequent sessions.

Dear _____,

_____
_____
_____
_____

_____,

_____

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[192] J. Eric Gentry et al. *Compassion Fatigue Pre-workshop Self Testing* (Toronto, Canada.: privately printed, 1997), http://www.psychink.com/rfiles/PrewkshpScales.doc/ (accessed March 1, 2009).

COMPASSION FATIGUE WORKSHOP DOCUMENTS

Basic Needs @ Work Checklist			
Adapted from *Life Makeovers* (2000) by Cheryl Richardson			
Self-Care @ Work	**Yes**	**No**	**Comments/Reflections**
Do I take a lunch break every day and do something unrelated to work?			
Do I work reasonable hours?			
Do I schedule "breathing room" every day so I can step back, and reevaluate my priorities.			
Is my office free of clutter?			
Do I have adequate lighting and clean air?			
Do I delegate work to free my time and empower others?			
Do my family/friends honor my work time? If no, have I asked them?			
Do I have blocks of uninterrupted time without distractions and interruptions?			
Do I have a DO NOT DISTURB sign?			
Have I scheduled specific times for returning phone calls and checking e-mail?			
Have I stopped taking on more than I can handle?			
Do I drink enough water when I am at work?			
Do I have comfortable shoes/slippers at my office?			
Do I schedule time off from work (sick leave and/or vacation time) to take care of myself?			
Do I have someone to talk with about my professional life?			
Do I have creature comforts that make my office pleasant? (music and other sounds, aroma, artwork)			
Do I say yes to commitments that I later regret?			

Basic Self-Care Needs Assessment[1]			
Basic Self-Care Needs	Yes	No	Goal
Do I usually get enough sleep?			
Do I usually eat something fresh and unprocessed every day?			
Do I allow time in my week to touch nature, no matter how briefly?			
Do I get enough sunlight, especially in wintertime?			
Do I see my medical practitioner at least once a year?			
Do I see a dentist every six months?			
Do I get regular sexual thrills?			
Do I get enough *fun* exercise?			
Am I hugged and touched amply?			
Do I make time for friendship? Do I nurture my friendships?			
Do I have friends I can call when I am down, friends who really listen?			
Can I honestly ask for help when I need it?			
Do I regularly release negative emotions in a healthy manner?			
Do I forgive myself when I make a mistake?			
Do I do things that give me a sense of fulfillment, joy and purpose?			
Is there abundant beauty in my life?			
Do I allow myself to see beauty and to bring beauty into home and office?			
Do I make time for solitude?			
Am I getting daily or weekly spiritual nourishment?			
Can I remember the last time I laughed until I cried?			
Do I accept myself for who I am?			

Building Personal Resilience5

The following list contains numerous characteristics that combine to form resilience. Check off all items which now describe you.

I have a good self concept.
I have good self-esteem.
I am sensitive to the needs of others.
I am generally cooperative with others.
I am socially responsive.
I have a good sense of humor.
I am able to postpone getting my needs met (I can delay gratification).
I am generally flexible.
I can control my impulses when I need to do so.
I believe in the future and plan for it.
I have a good support system.
I recognize that I have many opportunities available to me.
I respect individual human beings.
I respect appropriate authority.
I am able to look for more than one solution to a problem.
I am able to plan ahead.
I have hobbies and interests beyond my traumas.
I have a positive view of life and see life's joys (as well as its sorrows).
I can problem solve and have a strategy which I use.
I have a sense of spirituality.
I celebrate myself regularly.
I celebrate others regularly.
I believe that I have some level of control over myself and others.
I would rather take action than wait for something to happen to me.
I am able to find meaning even in bad things.
I am someone others like and love.
I am able to find someone to help me when I need it.
I can ask questions in a creative way.
I have a conscience that allows me to see my own goodness.
I have a "knowing" about things that happen to and around me.
I can disengage and separate from others if they are not good for me.
I can attach to others and connect.

DAILY SPIRITUAL EXPERIENCES SCALE

"The list that follows includes items you may or may not experience. Please consider how often you directly have this experience, and try to disregard whether you feel you should or should not have these experiences. A number of items use the word 'God.' If this word is not a comfortable one for you, please substitute another word which calls to mind the divine or holy for you."

	Many times a day	Every day	Most days	Some days	Once in a while	Never or almost never
I feel God's presence.						
I experience a connection to all of life.						
During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.						
I find strength in my religion or spirituality.						
I find comfort in my religion or spirituality.						
I feel deep inner peace or harmony.						
I ask for God's help in the midst of daily activities.						
I feel guided by God in the midst of daily activities.						
I feel God's love for me, directly.						
I feel God's love for me, through others.						
I am spiritually touched by the beauty of creation.						
I feel thankful for my blessings.						
I feel a selfless caring for others.						
I accept others even when they do things I think are wrong.						
I desire to be closer to God or in union with the divine.						

	Not at all	Somewhat close	Very close	As close as possible
In general, how close do you feel to God?				

Underwood, Lynn G., and Teresi, J., "The Daily Spiritual Experience Scale: Development, Theoretical Description, Reliability, Exploratory Factor Analysis, and Preliminary Construct Validity Using Health Related Data," *Annals of Behavioral Medicine* 2002, 24(1):22-33.

EGO RESILIENCY SCALE (J. Block & Kremen, 1996)

This scale consists of 14 items, each responded to on a 4-point Likert scale, ranging from 1 (*does not apply at all*) to 4 (*applies very strongly*). Fourteen Questions record and add up your score.
Let me know how true the following characteristics are as they apply to you generally:

	1 Does not apply at all	2 Applies slightly	3 Applies somewhat	4 Applies very strongly
1. I am generous with my friends.				
2. I quickly get over and recover from being startled.				
3. I enjoy dealing with new and unusual situations.				
4. I usually succeed in making a favorable impression on people.				
5. I enjoy trying new foods I have never tasted before.				
6. I am regarded as a very energetic person.				
7. I like to take different paths to familiar places.				
8. I am more curious than most people.				
9. Most of the people I meet are likable.				
10. I usually think carefully about something before acting.				
11. I like to do new and different things.				
12. My daily life is full of things that keep me interested.				
13. I would be willing to describe myself as a pretty "strong" personality.				
14. I get over my anger at someone reasonably quickly.				

Scoring Interpretation

Score	47-56	35-46	23-34	11-22	0-10
	Very High Resiliency Trait	High Resiliency Trait	Undetermined Trait	Low Resiliency Trait	Very Low Resiliency Trait

Healthy Coping Strategies		
Cognitive	**Emotional**	**Behavioral**
o Moderation o Write things down o Make small, daily decisions o See the decisions you are already making o Giver yourself permission to ask for help o Plan for the future o Get the most information you can to help make decisions o Anticipate needs o Remember you have options o Review previous successes o Problem solve o Have a Plan "B" o Break large tasks into smaller ones o Practice, Practice, Practice	o Moderation o Allow yourself to experience what you feel o Label what you are experiencing o Give yourself permission to ask for help o Be assertive when necessary o Keep communication open with others o Remember you have options o Use your sense of humor o Have a buddy with whom you can vent o Use "positive" words and language o Practice, Practice, Practice	o Moderation o Spend time by yourself o Spend time with others o Limit demands on time and energy o Help others with tasks o Give yourself permission to ask for help o Do activities that you previously enjoyed o Take different routes to work or on trips o Remember you have options o Find new activities that are enjoyable and (mildly) challenging o Set goals, have a plan o Relax o Practice, Practice, Practice
Spiritual	**Interpersonal**	**Physical**
o Moderation o Discuss changed beliefs with spiritual leader o Meditation o Give yourself permission to ask for help o Practice rituals of your faith/beliefs o Spiritual retreats/workshops o Prayer o Remember you have options o Mindfulness o Find spiritual support o Read Spiritual literature o Practice, Practice, Practice	o Moderation o Give yourself permission to ask for help o Take time to enjoy time with trust friend/partner o Hugs o Healthy boundaries o Remember to use "I" statements o Use humor to diffuse tense conversations o Play together o Talk with trusted partner/ friend o Apologize when stress causes irritable behavior or outbursts o State needs and wants as clearly as possible o Practice, Practice, Practice	o Moderation o Aerobic exercise o See doctor and dentist o Routine sleep patterns o Minimize caffeine, alcohol, and sugar o Give yourself permission to ask for help o Eat well-balanced, regular meals o Drink water o Wear comfortable clothes o Engage in physical luxuries: spa, massage, bath, exercise trainer o Remember to breathe – deeply o Take mini-breaks o Practice, Practice, Practice

The Gentry/Baranowsky (1997) Model of Compassion Fatigue
PRIMARY TRAUMATIC STRESS
+/x (synergistic effect)
SECONDARY TRAUMATIC STRESS
+/x (synergistic effect)
BURNOUT
COMPASSION FATIGUE

Compassion Fatigue Symptoms

Intrusive Symptoms
- Thoughts and images associated with client's traumatic experiences
- Obsessive and compulsive desire to help certain clients
- Client/work issues encroaching upon personal time
- Inability to "let go" of work-related matters
- Perception of survivors as fragile and needing the assistance of caregiver ("savior")
- Thoughts and feelings of inadequacy as a caregiver
- Sense of entitlement or specialness
- Perception of the world in terms of victims and perpetrators
- Personal activities interrupted by work-related issues

Avoidance Symptoms
- Silencing Response (avoiding hearing/witnessing client's traumatic material)
- Loss of enjoyment in activities/cessation of self care activities
- Loss of energy
- Loss of hope/sense of dread working with certain clients
- Loss of sense of competence/potency
- Isolation
- Secretive self-medication/addiction (alcohol, drugs, work, sex, food, spending, etc.)
- Relational dysfunction

Arousal Symptoms
- Increased anxiety
- Impulsivity/reactivity
- Increased perception of demand/threat (in both job and environment)
- Increased frustration/anger
- Sleep disturbance
- Difficulty concentrating
- Change in weight/appetite
- Somatic symptoms

Suggestions for Compassion Fatigue Prevention and Resiliency
If you or someone you know is experiencing symptoms of compassion fatigue, the following suggestions may be helpful. Please check with your family physician to assure that there are no physical illnesses associated with these symptoms first.

- Become more informed. Read Figley (1995), Stamm (1995) and/or Pearlman &

Saakvitne (1995) to learn more about the phenomena of Compassion Fatigue, Vicarious Traumatization, and Secondary Traumatic Stress. One book that is especially helpful is *Transforming The Pain: A Workbook on Vicarious Traumatization* by Saakvitne and Perlman (1996).

• Join a Traumatic Stress Study Group. A weekly, bi-weekly or monthly meeting of trauma practitioners can become an excellent sanctuary in which the caregiver can both share (therefore diluting) traumatic stories as well as receive support. Check with the ISTSS (www.istss.org) for a group that may meet in your area or start one of your own. There are several on-line support resources also. You can find some of these resources through the excellent David Balwin's Trauma Pages (http.//www.trauma-pages.com) in the "Resources" section.

• Begin an exercise program today (see your physician first). Exercise is one of the most important ingredients to effectively manage stress and anxiety and keeps us buoyant and energized while working with heinous trauma.

• Teach your friends and peers how to support you. Don't rely upon random remarks from friends and colleagues to be helpful. Instead, let them know what is most helpful for you during times of stress and pain. You may choose to offer the same to them in a reciprocally supportive arrangement. Periodic or regular professional supervision may also be helpful, especially during a rough time.

• Develop your spirituality. This is different than going to church, although church may be part of your spirituality. Spirituality is your ability to find comfort, support, and meaning from a power greater than yourself. We have found this quality necessary for the development of self-soothing capacity. Meditation, Tai Chi, church/synagogue, Native American rituals, journaling, and workshops are all examples of possible ways in which to enhance one's spirituality.

• Bring your life into balance. Remember that your best is ALWAYS good enough. You can only do what you can do, so when you leave the office (after 8 hours of work)…leave the office! Perseverating on clients and their situations is not helpful to them, you, or your family. You can most help your clients by refueling and refilling yourself while not at the office. Live your life fully!

• Develop an artistic or sporting discipline. Take lessons and practice as well as play and create. These are integrative and filling experiences. It is paradoxical that when we feel drained, we need to take action instead of sinking into the sedentary "couch potato." Taking action will be rewarded with a greater sense of refreshment and renewal, while activity avoidance will leave us even more vulnerable to the effects of stress the next day.

• Be kind to yourself. If you work with traumatized individuals, families, and/or communities, your life is hard enough already. You do not need to make it more difficult by coercive and critical self-talk. In order to become and remain an effective traumatologist, your first responsibility is keeping your instrument in top working condition. Your instrument is YOU, and it needs caring for.

• Seek short-term treatment. A brief treatment with some of the accelerated trauma techniques (i.e., EMDR) can rapidly resolve secondary traumatic stress symptoms.[193]

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[193] J. Eric Gentry, "Compassion Fatigue: The Crucible of Transformation," *Journal of Trauma Practice* 1, no. 3/4 (2002), 57-61, Adobe PDF

http://www.compassionunlimited.com/pdf/CrucibleofTranformation.pdf. (accessed March 7, 2009).

The Holmes-Rahe Life Stress Inventory
The Social Readjustment Rating Scale
INSTRUCTIONS: Mark down the point value of each of these life events that has happened to you during the previous year. Total these associated points.

Life Event	Mean Value
1. Death of spouse	100
2. Divorce	73
3. Marital Separation from mate	65
4. Detention in jail or other institution	63
5. Death of a close family member	63
6. Major personal injury or illness	53
7. Marriage	50
8. Being fired at work	47
9. Marital reconciliation with mate	45
10. Retirement from work	45
11. Major change in the health or behavior of a family member	44
12. Pregnancy	40
13. Sexual Difficulties	39
14. Gaining a new family member (i.e.. birth, adoption, older adult moving in, etc)	39
15. Major business readjustment	39
16. Major change in financial state (i.e.. a lot worse or better off than usual)	38
17. Death of a close friend	37
18. Changing to a different line of work	36
19. Major change in the number of arguments w/spouse (i.e.. either a lot more or a lot less than usual regarding child rearing, personal habits. etc.)	35
20. Taking on a mortgage (for home, business, etc..)	31
21. Foreclosure on a mortgage or loan	30
22. Major change in responsibilities at work (i.e. promotion, demotion, etc.)	29
23. Son or daughter leaving home (marriage, attending college, joined mil.)	29
24. In-law troubles	29
25. Outstanding personal achievement	28
26. Spouse beginning or ceasing work outside the home	26
27. Beginning or ceasing formal schooling	26
28. Major change in living condition (new home, remodeling, deterioration of neighborhood or home etc.)	25
29. Revision of personal habits (dress manners, associations, quitting smoking)	24
30. Troubles with the boss	23
31. Major changes in working hours or conditions	20
32. Changes in residence	20
33. Changing to a new school	20
34. Major change in usual type and/or amount of recreation	19
35. Major change in church activity (i.e.. a lot more or less than usual)	19
36. Major change in social activities (clubs, movies,visiting, etc.)	18
37. Taking on a loan (car, tv,freezer,etc)	17
38. Major change in sleeping habits (a lot more or a lot less than usual)	16
39. Major change in number of family get-togethers ("")	15
40. Major change in eating habits (a lot more or less food intake, or very different meal hours or surroundings)	15
41. Vacation	13
42. Major holidays	12
43. Minor violations of the law (traffic tickets, jaywalking, disturbing the peace, etc)	11

Now, add up all the points you have to find your score.

150pts or less means a relatively low amount of life change and a low susceptibility to stress-induced health breakdown.

150 to 300 pts implies about a 50% chance of a major health breakdown in the next 2 years.

300pts or more raises the odds to about 80%, according to the Holmes-Rahe statistical prediction model.

Stress Vulnerability Scale[4]

In modern society, most of us can't avoid stress. But we can learn to behave in ways that lessen its effects. Researchers have identified a number of factors that affect one's vulnerability to stress – among them are eating and sleeping habits, caffeine and alcohol intake, and how we express our emotions. The following questionnaire is designed to help you discover your vulnerability quotient and to pinpoint trouble spots. Rate each item from 1 (always) to 5 (never), according to how much of the time the statement is true of you. Be sure to mark each item, even if it does not apply to you – for example, if you don't smoke, circle 1 next to item six.

	Always		Sometimes		Never
1. I eat at least one hot, balanced meal a day.	1	2	3	4	5
2. I get 7-8 hours of sleep at least four nights a week.	1	2	3	4	5
3. I give and receive affection regularly.	1	2	3	4	5
4. I have at least one relative within 50 miles, on whom I can rely.	1	2	3	4	5
5. I exercise to the point of perspiration at least twice a week.	1	2	3	4	5
6. I limit myself to less than half a pack of cigarettes a day.	1	2	3	4	5
7. I take fewer than five alcohol drinks a week.	1	2	3	4	5
8. I am the appropriate weight for my height.	1	2	3	4	5
9. I have an income adequate to meet basic expenses.	1	2	3	4	5
10. I get strength from my religious beliefs.	1	2	3	4	5
11. I regularly attend club or social activities.	1	2	3	4	5
12. I have a network of friends and acquaintances.	1	2	3	4	5
13. I have one or more friends to confide in about personal matters.	1	2	3	4	5
14. I am in good health (including eye-sight, hearing, and teeth).	1	2	3	4	5
15. I am able to speak openly about my feelings when angry or worried.	1	2	3	4	5
16. I have regular conversations with the people I live with about domestic problems - for example, chores and money.	1	2	3	4	5
17. I do something for fun at least once a week.	1	2	3	4	5
18. I am able to organize my time effectively.	1	2	3	4	5
19. I drink fewer than three cups of coffee (or other caffeine-rich drinks) a day.	1	2	3	4	5
20. I take some quiet time for myself during the day.	1	2	3	4	5

ProQOL R-IV
PROFESSIONAL QUALITY OF LIFE SCALE
Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the **last 30 days**.

0=Never	1=Rarely	2=A Few Times	3=Somewhat Often	4=Often	5=Very Often

_____ 1. I am happy.

_____ 2. I am preoccupied with more than one person I *[help]*.

_____ 3. I get satisfaction from being able to *[help]* people.

_____ 4. I feel connected to others.

_____ 5. I jump or am startled by unexpected sounds.

_____ 6. I feel invigorated after working with those I *[help]*.

_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.

_____ 8. I am losing sleep over traumatic experiences of a person I *[help]*.

_____ 9. I think that I might have been "infected" by the traumatic stress of those I *[help]*.

_____ 10. I feel trapped by my work as a *[helper]*.

_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.

_____ 12. I like my work as a *[helper]*.

_____ 13. I feel depressed as a result of my work as a *[helper]*.

_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.

_____ 15. I have beliefs that sustain me.

_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

_____ 17. I am the person I always wanted to be.

_____ 18. My work makes me feel satisfied.

_____ 19. Because of my work as a *[helper]*, I feel exhausted.

_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.

_____ 21. I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.

_____ 22. I believe I can make a difference through my work.

_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.

_____ 24. I am proud of what I can do to *[help]*.

_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.

_____ 26. I feel "bogged down" by the system.

_____ 27. I have thoughts that I am a "success" as a *[helper]*.

_____ 28. I can't recall important parts of my work with trauma victims.

_____ 29. I am a very sensitive person.

_____ 30. I am happy that I chose to do this work.

Green Cross Academy of Traumatology
Standards of Self Care Guidelines

I. Purpose of the Guidelines

As with the standards of practice in any field, the practitioner is required to abide by standards of self care. These Guidelines are utilized by all members of the Green Cross. The purpose of the Guidelines is twofold. First, do no harm to yourself in the line of duty when helping/treating others. Second, attend to your physical, social, emotional, and spiritual needs as a way of ensuring high quality services to those who look to you for support as a human being.

II. Ethical Principles of Self Care in Practice.

These principles declare that it is unethical not to attend to yourself as a practitioner because sufficient self care prevents harming those we serve.

1. Respect for the dignity and worth of self. A violation lowers your integrity and trust.
2. Responsibility of self care. Ultimately, it is your responsibility to take care of yourself and no situation or person can justify neglecting it.
3. Self care and duty to perform. There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self care.

III. Standards of Humane Practice of Self Care

1. Universal right to wellness. Every helper, regardless of her or his role or employer, has a right to wellness associated with self care.
2. Physical rest and nourishment. Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
3. Emotional Rest and nourishment . Every helper deserves emotional and spiritual renewal both in and outside the work context.
4. Sustenance Modulation. Every helper must utilize self restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since it can compromise their competence as a helper.

IV. Standards for Expecting Appreciation and Compensation

1. Seek, find, and remember appreciation from supervisors and clients. These and other activities increase worker satisfactions that sustain them emotionally and spiritually in their helping.
2. Make it known that you wish to be recognized for your service. Recognition also increases worker satisfactions that sustain them.
3. Select one or more advocates. They are colleagues who know you as a person and as a helper and are committed to monitoring your efforts at self care.

V. Standards for Establishing and Maintaining Wellness

Section A. Commitment to self care

1. Make a formal, tangible commitment. Written, public, specific, and measurable promises of self care.
2. Set deadlines and goals. The self care plan should set deadlines and goals connected to specific activities of self care.
3. Generate strategies that work and follow them. Such a plan must be attainable and followed with great commitment and monitored by advocates of your self care.

Section B. Strategies for letting go of work

1. Make a formal, tangible commitment. Written, public, specific, and measurable promise of letting go of work in off hours and embracing rejuvenation activities that are fun, stimulating, inspiring, and generate joy of life.
2. Set deadlines and goals. The letting go of work plan should set deadlines and goals connected to specific activities of self care.
3. Generate strategies that work and follow them. Such a plan must be attainable and followed with great commitment and monitored by advocates of your self care.

Section C. Strategies for gaining a sense of self care achievement

1. Strategies for acquiring adequate rest and relaxation. The strategies are tailored to your own interests and abilities which result in rest and relaxation most of the time.
2. Strategies for practicing effective daily stress reductions method(s). The strategies are tailored to your own interests and abilities in effectively managing your stress during working hours and off-hours with the recognition that they will probably be different strategies.

VI. Inventory of Self Care Practice -- Personal

Section A. Physical

1. Body work. Effectively monitoring all parts of your body for tension and utilizing techniques that reduce or eliminate such tensions.
2. Effective sleep induction and maintenance. An array of healthy methods that induce sleep and a return to sleep under a wide variety of circumstances including stimulation of noise, smells and light.
3. Effective methods for assuring proper nutrition. Effectively monitoring all food and drink intake and lack of intake with the awareness of their implications for health and functioning.

Section B. Psychological

1. Effective behaviors and practices to sustain balance between work and play
2. Effective relaxation time and methods
3. Frequent contact with nature or other calming stimuli
4. Effective methods of creative expression
5. Effective skills for ongoing self care
        a. Assertiveness
        b. Stress reduction
        c. Interpersonal communication
        d. Cognitive restructuring
        e. Time management
6. Effective skill and competence in meditation or spiritual practice that is calming
7. Effective methods of self assessment and self-awareness

Section C. Social/interpersonal

1. Social supports. At least five people, including at least two at work, who will be highly supportive when called upon
2. Getting help. Knowing when and how to secure help – both informal and professional – and that the help will be delivered quickly and effectively
3. Social activism. Being involved in addressing or preventing social injustice that results in a better world and a sense of satisfaction for trying to make it so

VII. Inventory of Self Care Practice – Professional

1. Balance between work and home. Devoting sufficient time and attention to both without compromising either.
2. Boundaries/limit setting. Making a commitment and sticking to regarding:
        a. Time boundaries/overworking
        b. Therapeutic/professional boundaries
        c. Personal boundaries
        d. Dealing with multiple roles (both social and professional)
        e. Realism in differentiating between things one can change and accepting the others
3. Getting support/help at Work through:
        a. Peer support
        b. Supervision/consultation/therapy
        c. Role models/mentors
4. Generating Work Satisfaction. By noticing and remembering the joys and achievements of the work

VIII. Prevention Plan development

1. Review current self-care and prevention functioning

2. Select one goal from each category
3. Analyze the resources for and resistances to achieving goal
4. Discuss goal and implementation plan with support person
5. Activate plan
6. Evaluate plan weekly, monthly, yearly with support person
7. Notice and appreciate the changes[194]

[194] C. R. Figley & Kathleen Figley. Green Cross Academy of Traumatology, *Standards of Self Care* (Hugo, MN: by the author, 2009), Adobe PDF http://www.greencross.org/index.php?option=com_content&view=article&id=184&Itemid=124#/ (accessed March 7, 2009).

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