Beyond Kale and Pedicures:
Can We Beat Burnout and Compassion Fatigue?

By Françoise Mathieu, M.Ed., CCC.

I have been locked out of the seminar room.

Peering through the glazing, I can see two dozen operating room nurses in scrubs, milling about inside the auditorium. The space is nearly full, and they are chatting and eating lunch. The session on compassion fatigue and self-care is about to begin, but the door is locked and I can't get in. I knock once, and then again a little bit louder. They can see me, but no one comes to unlock the door.

Problem is, I am the presenter, and this isn't starting out particularly well.

After a few minutes, the caterer, who has just delivered sandwiches to the team, unlocks the door from the inside and whispers to me on his way out: "I'm warning you, it's worse than high school in there." It turns out that this group has just learned that all of their summer leave has been cancelled, due to cutbacks, but this session is mandatory, so there they are, steaming mad, and not particularly inspired to discuss sleep hygiene and breathing with me.

Luckily, this isn't my first rodeo, so I am not too rattled. I am also lucky to rarely encounter such hostile audiences, but I *do* specialize in delivering training to high stress, high trauma-exposed helping professionals: prison guards, child welfare workers, trauma nurses and docs, and so many others who are trying to care for patients and clients in an increasingly challenging and under-resourced climate. But at this point, in 2011, I am starting to ask myself whether what I am teaching them is at all effective.

Many of my audiences express growing frustration at working in a system that feels broken, and no amount of kale and yoga can fix that overnight.

Have car, will travel

I became a compassion fatigue specialist by accident, or rather, by necessity. I completed my counselling degree nearly 20 years ago and I was very fortunate in receiving first-rate training at Columbia University and at the University of Toronto. Our courses explored issues of multiculturalism, racism, gender bias, addiction, transference, and many other challenging and stimulating topics.

The Columbia program was considered pretty cutting edge, and by virtue of its location and affiliations we had the opportunity to hear from guest lecturers who were truly thought leaders in the field. Once, our class attended a clinical demonstration with the renowned psychologist Dr. Albert Ellis. I didn't particularly like it - or him, for that matter, but these were invaluable opportunities to learn from the big guns. Our training invited rigorous self-reflection and an exploration of our own biases and assumptions.

However, in spite of all this excellent training, I never once heard any of my instructors mention the concepts of burnout, compassion fatigue (CF), vicarious trauma (VT), secondary traumatic stress (STS) or even use the words "self-care" in any of their lectures. I also received no training in psychological trauma, except for a brief mention in one lecture. After graduation, I soon discovered that in spite of the great pedigree of my alma maters, I was completely ill

equipped for the real world of mental health counseling.

Crisis work is what drew me to the field. Before pursuing graduate training, I had worked as a volunteer in a hospital emergency ward. We saw it all – multiple vehicle accidents, entire families wiped out by a drunk driver, children who had been harmed by their parents, heart attacks, overdoses. It was intense, sometimes shocking work and I absolutely loved it. Have you ever had this feeling that something is just a perfect fit? You just *know?* That's how I felt about crisis intervention. This was it, the career that had been waiting for me. I am sure that my attraction to crisis work was partly due to my own life history, having been the informal crisis counselor to members of my extended family during my teens, during a dark and tumultuous decade of traumas that befell us. This is not unusual – therapists are often drawn to the field for personal reasons, whether they fully recognize it or not.

Frankly, part of what I loved about crisis work was the adrenaline rush – the speed and intensity of the work, being able to rapidly triage clients and provide immediate relief – the crisis counselor is the port in the storm. Over my career as a crisis and trauma therapist, I worked with people from every walk of life: soldiers returning from Afghanistan and Rwanda, police officers, prison guards, physicians, suicidal students and many other individuals in distress. With little relevant training and minimal supervision, I pretty much flew by the seat of my pants during the first few years until I attended some outstanding trauma workshops that gave me the tools I sorely needed.

Over time, even though I loved the work, the stories began to haunt me, and they would sometimes interfere with my ability to relate to my friends and family. How does one go from hearing a soldier talk about a beach full of bloated corpses in the Rwandan genocide to helping a spouse pick a new couch? I also found that I was attracted to high trauma material in my personal life – reading books by incest survivors, watching movies about death, poverty and loss, volunteering at the local maximum security prison. I was living, breathing and sleeping other people's trauma, without a moment's thought about how this was impacting me or my loved ones.

Meanwhile, the volume of work continued to grow. I was employed in a very busy counseling center for several years and the waiting lists were colossal. I was really being to struggle with the ethics of telling a rape survivor that I wouldn't be able to see her for another 5 weeks because my schedule was completely jammed. Although the secondary exposure to trauma impacted me profoundly, I was far more upset about my working conditions and unmanageable workload, which were a perfect recipe for burnout, and I was much more distressed, morally, about turning clients away than I was about their trauma stories.

Finally, after several years of working in mental health, I felt stuck in an unresolvable dilemma: I loved trauma work and yet trauma work was damaging me. Was there a way to stay in this field while remaining healthy and grounded? I wasn't sure. Self-care was not a topic on anyone's lips in my circle of colleagues.

Is that all there is?

Then, one day, in 2001, a co-worker drew my attention to a newly released book on something called "vicarious trauma", and that was a light bulb moment for me. I started reading everything I could get my hands on about burnout, compassion fatigue, and secondary trauma. Over time, I gained a solid understanding of the problem and incidence rates, but the literature was fairly slim on ways to resolve the issue.

What worked to reduce or even prevent the problem? Other than a self-care checklist, and recommendations to exercise and eat healthily, there didn't seem to be much else on offer at the time. Seeing a training gap and a pressing need among helping professionals, a close colleague and I designed a compassion fatigue workshop and began offering it across the country. It wasn't hard to make the case for the problem - there was plenty of data to support our message - but we had to look long and hard for evidence-based research on *solutions* to compassion fatigue and secondary trauma. So, we worked with what we had, and focused our workshops on individual self-care. We did not realize at the time that we were part of an emerging trend.

In fact, since the 1990s, when research on compassion fatigue and secondary trauma initially started, an entirely new industry of helper wellness has grown: workshops, books, retreats and videos, all aiming to "help the helper". Armed with new data, many human service organizations jumped on the bandwagon and focused almost exclusively on self-help strategies to support their staff. HR departments began running workshops for staff on healthy eating, work-life balance and "stress busting". Some organizations implemented regular fitness breaks and staff appreciation days.

This single-minded focus on self-care and wellness is not entirely surprising: North America is an enthusiastic self-help culture - we embrace the latest books on weight loss and decluttering with gusto and we celebrate Dr. Oz and Oprah as they recommend the next new cure to life's travails.

The problem is that these initiatives didn't really work - many staff stayed away from the wellness sessions, rates of burnout did not decrease significantly and staff morale continued its downward spiral. To be fair, it made sense for

workplaces to focus on helper self-care: it was inexpensive, easily implemented and it didn't require major systemic change - it was something concrete that they could do. But maybe, in our enthusiasm to find solutions to CF and STS, we all jumped the gun a little bit.

Does Self Care Work?

Pioneers in the field of compassion fatigue and secondary traumatic stress research say that they were caught off guard by the enthusiastic response that they received when they published their initial findings in the 1990s. One colleague recently told me: "It was a bit like trying to put the toothpaste back into the tube - people were very excited about this new idea of compassion fatigue, and the notion of self-care caught on like wildfire but meanwhile, the field was still in its infancy. There wasn't even agreement on a *name* for this phenomenon, let alone what really worked to prevent or reduce it."

In fact, to this day, terminology continues to be hotly disputed: It is *burnout, compassion fatigue, vicarious trauma, secondary trauma, compassion stress, moral distress, empathic strain?* Are they one and the same or are they clearly distinct concepts? The debate rages on. Meanwhile, back in the trenches, helping professionals of all stripes are trying to do the best they can while working within an increasingly compromised system.

In the past few years, new research has finally emerged which suggests that it is time for a more sophisticated understanding of the best ways to manage and reduce CF and STS - one that goes beyond healthy eating and massages. Intrigued by the field's growing focus on wellness practices to reduce CF and STS, Toronto-based researchers Ted Bober and Cheryl Regehr investigated whether self-care was *in fact* effective in reducing STS in trauma counselors. Their 2006 study found that although

their subjects *believed* that leisure activities and self-care would reduce their secondary trauma symptoms, that did not turn out to be the case: therapists did *not* engage in these self-care practices more often when they believed in them, and when they *did* take better care of themselves, it unfortunately did not reduce their trauma scores.

Essentially, self-care was not working in reducing STS, in spite of agencies spending tens of thousands of dollars on workplace retreats and work-life balance workshops. In fact, Bober and Regehr argued, organizations were beginning to unwittingly blame their staff for not managing their lives better - the message was now "if you had better work-life balance, you wouldn't be so overwhelmed with the workload and the trauma stories."

Meanwhile, the workload continued to increase, and the resources to disappear. As one social worker recently told me: "They tell us that overtime is no longer allowed, and that this is for our own wellness. I suspect it's really about budget cuts, to be honest, and that they are using the self-care excuse to encourage us to stop working at closing time. But in truth, our caseloads are so huge we can't get all the work done in a regular workday. So, what are we supposed to do? Let children die so that we can go all home at five?"

 Nine years have passed since Bober and Regehr's research was first published, and we finally have plenty of solid data that supports the findings that self-care, alone, cannot prevent STS and CF in helping professionals. We now know that the most effective solutions are linked to workload, a reduction in trauma exposure, staff feeling effective through experiencing success in their work, better social support and, finally, taking a long hard look at the systemic problems in the way service is being delivered. Yet, in spite of this, the emphasis of workshops and workplace initiatives remains heavily focused on individual self-care and work-life balance. Why are we not translating the new research findings into practice? First, we need to figure out how to do this in a depressed economy.

On the brink

The Rust Belt, home of the automotive sector, was hit particularly hard by the financial collapse of 2008. In the steel town of Hamilton, Ontario just 60 miles north of Buffalo, rates of social assistance claims increased by 30% in just one year following the downturn. This was accompanied by significant layoffs in all sectors of social services, especially in child protection. For helping professionals working in homelessness, social assistance and other community services, their clients' realities hit awfully close to home: many of the mental health staff's spouses had also lost their jobs. A year after the financial crisis, one Hamilton-based welfare worker said to me: "I am *one* paycheck away from being one of my own clients." How do you set those stresses aside, as a case worker, and remain present for your clients? How do you cope with the moral distress of having to turn away individuals in crisis because your agency no longer has the resources to help them? The truth is that the economic downturn further strained an already fragile, overtaxed system and, as a direct result, human service staff is now struggling more than ever before.

Significant demographic changes are also at our doorstep: Our workforce is ageing rapidly, and many of us are now part of the "sandwich generation" where we try to juggle our children's needs while simultaneously caring for elderly parents. Attracting good talent - and retaining them - is also because a cause for concern. The new generation of workers, the Millennials, (also known as "Generation Y") who were born in the 1980s-90s are not, as a whole, willing to sacrifice their health and personal lives for the job, and

keeping them is becoming increasingly difficult. If working in mental health was already a challenge a decade ago, how will we sustain ourselves now that the resources are even scarcer?

Laurie Barkin is a San Francisco-based psychiatric nurse. She is the author of a poignant memoir of compassion fatigue and vicarious trauma in a hospital setting. Reading *The Comfort Garden: Tales from the Trauma Unit* is like watching a slow motion train wreck: At the start of the book, we are in the mid 1990s and Barkin, a highly experienced mental health professional, is trying to adjust to the arrival of Managed Care in her institution. I recently spoke to Barkin who explained: "When it was ushered into our hospital, the substance of our weekly psychiatric consult departmental meetings abruptly shifted from discussing issues related to providing excellent patient care to the business of patient care. Entire staff meetings were devoted to the minutiae of filling out billing forms. On multiple occasions we were reminded that initial consultations were reimbursed at a much higher rate than follow-up consultations. Our productivity was measured only in numbers, first as an entire group, followed by the smaller groups of which we were comprised—psych nurses, psychologists, and psychiatrists—and finally as individual clinicians. It felt like a horse race. It seemed that 'quality of care,' a long-held value within our department, ceased being relevant in this new world."

Over time, in this busy inner city hospital, the volume of work rose and access to support and debriefing eroded. In hindsight, Barkin sees the loss of peer supervision time as a significant contributor to her stress symptoms: "Although historically, our department was never big on "processing feelings," the advent of Managed Care decreased the frequency of these discussions from occasional to "Do it on your own time." Day after day we clinicians witnessed the carnage caused by interpersonal violence, life-threatening accidents, chronic illness, suicide attempts, AIDS, poverty, substance abuse, lack of resources, depression, broken homes, and lives characterized by chaos and hopelessness. In my opinion, denying us time within group meetings to discuss the nature of our work and how we were coping with the stress of it, contributed to feelings of isolation, despair, compassion fatigue, and burn-out."

Barkin says that even basic safety was a daily concern for hospital employees: "Institutional denial regarding issues of safety also compounded staff stress levels. We were acutely aware that nothing prevented weapons from being brought into the hospital. Before a parking structure was built, many staff vehicles were vandalized. After a night on-call, a medical intern was pistol-whipped on his way to his car. A new social worker was horrified to learn that perpetrators of domestic violence were seen in the same clinic as victims. A trauma nurse practitioner resigned in part because she was tired of worrying about being caught in the crossfire of gang violence in her clinic."

Finally, after five years of trying to make things work, Barkin throws in the towel, and resigns. The hospital loses yet another highly skilled practitioner. Laurie Barkin left because she realized that working in this institution was jeopardizing her health and her family life, and that she had completely lost faith in management's willingness to implement any real changes. By the end, she also felt very isolated from most of her co-workers.

Barkin's memoir is a cautionary tale for the rest of us - it presents the hard truth about the price helping professionals pay when managed care has systematically stripped away the structure that allowed them to do their work safely and ethically. In her book, she writes: "*Sometimes I feel like that's what we do at the hospital. We*

hold up the weight of the world. And, in doing so, we hear screams and witness the suffering that sometimes becomes our screams and our suffering, only we choke it back and continue bearing the weight without complaining and without acknowledging that we too need relief."

The Comfort Garden won the Book of the Year Award in 2011 from the American Journal of Nursing. It is one of the only memoirs of its kind that describes the process of an individual developing CF, STS and burnout and while so skillfully laying out the organizational contributing factors.

Battling the Taboos

Sadly, Laurie Barkin's story is not unique - helping professionals often describe feeling completely alone while struggling with CF and burnout. A very real roadblock comes from our own resistance as professionals - our difficulty accepting that we may be negatively impacted by our work. Although most mental health professionals claim to be open to accessing therapy when they need it, the data doesn't bear this out: one recent study indicated that only 60% of counselors and social workers would be willing to seek help if they needed it. Granted, it was better than the meager 15% of police officers who said the same, but shouldn't it be close to one hundred percent? If *therapists* do not believe that therapy is safe or effective, isn't that a problem? Confidentiality and fear of losing face are frequently mentioned as deterrents to seeking help, as is denial. Before exploring solutions to CF and STS, we, the helping professionals, need to acknowledge that the problem exists, something that has proven to be more difficult for many of us than one would expect.

Last year, Dr. John Bradford, one of Canada's top forensic psychiatrists, shocked the entire country by going public about his work-induced secondary traumatic stress on National Television. It was stunning and unprecedented: Bradford spoke openly of his acute emotional distress, substance use, suicidal ideation and struggles with PTSD. Dr. Bradford had worked as an expert witness in some of the most high profile sexually-motivated murder cases of the past decades in both England and Canada. Many of these crimes involved graphic video footage of rape, torture and homicide, all of which he was required to watch in order to conduct his psychiatric assessment. By going public, Bradford broke a long held taboo in our field – outing himself as a helping professional with mental illness. The psychiatrist admitted on air that, until his breakdown, he had openly doubted the existence of STS and PTSD in helping professionals: "I thought I was this tough guy, I'd done this before, this should go away [but] I'm not a sceptic anymore, […] now I know, it's real." It was quite a brave gamble, especially for someone who is still active in the field. However Dr. Bradford may have felt that at his age, nearing retirement, he could afford to take the risk. He also recently recused himself from an upcoming trial – a gruesome murder case, which was videotaped and broadcast on the internet by the perpetrator. The respected clinician felt that the potential triggers were too much for him. So far, Dr. Bradford has received praise from his peers for his courage and for taking a stand to normalize this occupational hazard. Perhaps it is a step in the right direction, but the audible gasps that greeted his broadcast speak volumes – mental illness in helping professionals still carries a heavy stigma.

The Climate We Create - The Culture We Feed

Practitioner impairment is a complicated phenomenon and is often the result of a combination of compassion fatigue, burnout, secondary trauma, moral distress and sheer overload from the incredibly hectic lives many of

us lead. So, what is the solution? How do we unpack the contributing factors so that we can find a path forward? How do we become, or continue to be, healthy, grounded professionals who also have a life?

In 2008, Toronto-based Kyle Killian's research confirmed previous preliminary findings suggesting that social support was vitally important for a healthy workplace: "Individuals in the helping professions who reported greater social support suffered less psychological strain, had greater job satisfaction, and greater compassion satisfaction," Killian wrote. The cruel irony is that one of the first casualties of compassion fatigue and burnout in the workplace is connection with others – we develop a "poverty mentality" and nitpick one another on the length of breaks, or the fact that one person always leaves early to pick up their children at daycare. Unhappy staff engages in office gossip and create cliques where they vent about the inequities of the work, or where they compete to share graphic stories from their trauma cases over the lunch hour. In essence, on the road to burnout, we lose compassion for one another as staff members.

Research shows that we also lose compassion towards our own selves – we become hypercritical of our decisions, actions and behaviors: "Why did I say that, what's wrong with me?" "Why am I not doing a better job with this client?" "I slept in again today and missed my workout, what a lazy slob I am". Helping professionals are not known, in general, to be a group that is kind and generous towards itself.

Although recent research shows that the best solutions to CF reside in helping professionals' working conditions, this does not mean that we, as professionals, are helpless. We cannot blame our workplaces entirely for our CF and STS – we also need to take personal responsibility. Trauma specialist Laura Van Dernoot Lipsky is deeply concerned by what she sees as a disturbing trend among helping professionals - the development of a form of abdication: "I really do think that there is a huge seduction and addiction to being externally focused e.g. 'you don't get my boss, I'm in a dysfunctional agency, you don't understand…' When we get overwhelmed we fall into reductionist binary thinking: things are either good, or they are bad. There is no more grey possible. We collapse and oversimplify things. But people also have to take personal accountability, and family and community and professional accountability to how they are contributing to increasing the suffering to parts of the web, or how they are contributing to alleviating suffering, and we simultaneously really need to have an aspiration of how can we continue to make large scale long term change." The solutions, it turns out, are complex and multi-layered. Is that really a surprise?

In spite of our field's recent infatuation with stress-busting and self-care, it turns out that the suggestion that we should focus on the self, the system *and* the organization simultaneously was there all along: Laurie Anne Pearlman, one of the pioneers of this research, suggested as early as 1996 that we needed to address the problem at all three levels. But sometimes, when practitioners feel trapped working in a highly toxic workplace, it seems as though individual strategies are the only thing within their control, and that may, in some cases, be true. I have worked with some prison staff and hospital workers who were truly in survival mode – their management was so dysfunctional that all they could do is keep their head down and try to survive on a daily basis, or look for another job. A chilling example of this is described in a recent memoir by two child protection workers. *"A culture of fear: an inside look at Los Angeles County's department of Children & Family Services"* by Julian Dominguez and Melinda Murphy reads like a modern day horror story. Whether LA County's DCFS is truly as toxic as the authors argue is not

for me to say, but this first person account provides stark examples of what can happen when the system is stretched way past its breaking point.

Difficult Choices

During a recent conversation, Kyle Killian suggested to me that one of the additional challenges we face in the helping professions is that many of us struggle with workaholism, and agencies enable and encourage that phenomenon: "The problem is, we get busy, and we get tunnel vision, and you don't take personal days or vacations, or hang out with people at the local watering hole--you just don't have time." Killian suggested that it was important for people to work in a place where there are some feedback mechanisms in place, and some degree of predictability: approximately *when* you will be leaving the building: "That's not what a lot of workaholics do, they plan to leave at 5:30, but they leave at 7. It's a choice, in a way, but you are feeling pressured to stay for various reasons. Is someone tracking whether individual staff is truly taking their personal days and vacation days? Administrators are also there to help workers stay healthy. Role modeling is important. I worked with an institution that frequently had meetings that went until 4:30-5:00pm. Sometimes when people are a bit further along the life cycle, e.g. they don't have kids to pickup from daycare, they don't care, and you are left as the lone voice in the room."

Deb Thompson is a clinical psychologist who was a self-confessed workaholic until she had a profound realization: "one Sunny Sunday, about 11 years ago, my blonde little 7 year old daughter asked me not to go into work that day, as was my habit, to write reports." Thompson had been pushing herself hard in private practice, juggling a gruelling schedule of assessments, medical-legal work and therapy, working about 55 hours a week. "I was well versed in keeping

on trucking and ignoring how unhappy I was to be missing out on fun with my family and time for recharging and wellness for me. I was overweight, out of shape, stressed, and at risk for a heart attack." But Thompson was also, as she says "very responsible and stoic", and when her husband got laid off, leaving them with twin babies and a toddler to feed, she went into overdrive to keep them afloat.

When her daughter confronted her on that weekend morning, Thompson knew that she could no longer ignore the gnawing unhappiness that she had been experiencing: "the deep knowing that I was not spending my one and only life well was harder and harder to suppress, and with my sweet girl's plaintive question, I had an epiphany." So she went into work that day and blocked all new medical-legal referrals, a very lucrative source of work for a therapist. Although it took two years to close all of her cases, she had stemmed the tide. Thompson, a successful former high school athlete who was now 85 lbs. overweight, started exercising again. She also took a long hard look at her finances. Part of the motivation in carrying such a heavy workload had been to meet her significant financial needs. Her family lived in an expensive part of town, in a large house with a steep mortgage: "I was challenged to see that the deep and wide price of staying in a big house downtown was not wise given the toll on me. I was encouraged to see that my kids could adjust to moving and to a lifestyle based on a lower income. I wanted to have the energy to bake muffins in the evening with a kid."

Deb Thompson now has a much smaller practice, a simpler office with no staff and much lower overhead: "I wanted to feel less spread thin, and continue to invest in my healthy lifestyle" Thompson explains. These changes also allowed her to drop the excess weight and maintain a regular fitness regime for over ten years now. "I absorbed a drop in income by downsizing at

home and at work, which was not easy, but I have continued to make a living, and take most pleasure in activities that are very low cost like music, reading, writing, cooking, biking, hiking and visiting friends." Thompson concludes: "Overall, it has been an evolving process of letting go, and letting come, and I am glad to be living a more spacious, rich, aligned and connected life, knowing that I am doing all I can to stay vibrant and happy."

I think that many of us can relate to Deb Thompson's dilemma: it's hard to unpack the financial piece from the rest of the work that we do. We need to balance our need to earn a living and keep a roof over our heads with the equally important needs to have a healthy, realistic schedule, and a life outside of work. As a private practitioner, I always had to juggle with my schedule, trying to see enough clients to make a good income, and not so many that I would burn out. But here's the question that few of us who are self-employed are comfortable answering: have you ever taken on a client because you needed the money rather than because you felt that you were the absolute best clinician for them? I once knew a therapist who saw 9-12 clients a day. This was not an exception, it was a regular regime for her – *nine to twelve* consecutive hours of therapy per day. I heard from clients that she sometimes fell asleep in sessions, which was not surprising. This therapist was a deeply caring person, with a practice specializing in sexual abuse and trauma. I think that she found it difficult to turn clients away. She had also made some bad investments and was struggling financially, which no doubt also influenced her decision to see so many clients.

It turns out that wellness practices are probably a great idea for *everyone* - therapists, circus acrobats and accountants alike. During the past year, I had to research and write this lengthy piece while juggling a busy work and family schedule. I am a writer, a consultant, keynote speaker, business owner and a parent. I travel extensively and have a heavy workload. And so, to cope with this busy time I made sure to exercise daily, practiced yoga several times a week, meditated, ate greens, drank lots of water, avoided excess alcohol and caffeine, tried to get enough sleep, connect with others and have some leisure time. I find that these practices are essential to my well-being. Sure, I can go a few days without them, but I start feeling unwell fairly quickly and that would also be true for many of my overextended civilian friends.

Self-care and work-life balance are wonderful tools to manage the pressures of life, and perhaps live a little longer, and it is likely that they are particularly important for those of us who work in high stress, high trauma settings, but it is now clear that these strategies alone cannot compensate for unsustainable caseloads, excessive trauma exposure, toxic work environments and lack of training.

After seven years working as a crisis counsellor in a busy clinic, I quit. I left a permanent position with full benefits to work in private practice with no job security and no pension fund. Although I was definitely suffering from vicarious trauma from the thousands of terrible stories I had heard, my main reason for leaving had more to do with burnout and moral distress: inadequate pay, insufficient supervision and inadequate referral resources – those are the things that wore me down, over time.

It turns out that for me, and research shows for many others in the field, the clincher was regaining control over my schedule. I can say without a doubt that this was the single most important factor in reducing my burnout and compassion fatigue. The fact is that in my new job, I was still doing high trauma work, perhaps even more than before, as I had been given a contract to work with soldiers from our local

military base. But I was the one setting my schedule. If I wanted to see four clients in a row and then go for a run, I could do that. If I wanted to take every Friday afternoon off to do groceries and work on a Saturday instead, that was completely my choice. I also felt relieved to no longer have to contend with office gossip and naysayers, something I had always found incredibly draining. Of course, not everyone can (or wants to) work in private practice. In fact it's not a very sustainable model for an entire health care system. So we need to find ways to bring that kind of flexibility to our workplaces.

To use Laurie Anne Pearlman's model, then, we need to become personally and professionally accountable. That still leaves a burden of responsibility on the organizations, and the systems we work within.

Is there a *Google* of Mental Health Services?

Over the past decade, Silicon Valley has led the way to crafting what seems to be the optimal workplace: beautiful work environments, flexible schedules, plenty of leisure time, free healthy food in the cafeterias, and, it seems, happy and productive employees. No wonder *Google* gets over a million job applicants per year. Wouldn't it be wonderful to do the same in health care? Unfortunately, the helping professions lack the tech leader's deep pockets. We also have to contend with a uniquely complex work environment - one that includes regular exposure to trauma and high stress. Organizational health expert Dr. Patricia Fisher has a solution, but to attain it, she argues, agencies need to be willing to invest in attracting and training strong leaders.

When things go terribly wrong in a prison, hospital or a child welfare office (such as a prolonged labour dispute, a mass casualty event, or the death of a child in care), senior management often turns to Dr. Patricia Fisher for

help. Fisher is a clinical psychologist and trauma specialist with many years of experience working in workplaces with high stress and trauma exposure. In a recent conversation, Fisher, who is a close colleague of mine, explained that in order for real change to occur at an organizational level, it is essential to understand that not all workplaces were created equal: those with high stress exposure need a specialized approach. "Trauma exposure has immense consequences for organizational health and capacity. This is such a fundamental problem and yet it is typically invisible." Based on her vast experience, Fisher argues that it is a mistake to try and use garden-variety human resource strategies with high stress, high trauma workplaces. Working in a trauma-exposed workplace is nothing like working in an IT department, so why would we try to apply the same employee health solutions to both?

In fact, Fisher's research shows that organizations are often trying to solve their HR problems in completely the wrong order: "we need to understand that we are working with complex human systems, not machines". Fisher argues that one of the key elements for a healthy organization is strong leadership - the healthier the manager, the healthier the team as a whole: "Leadership is critically important, but we need to remember that leaders are people too and are often themselves struggling with stress effects and require support and training to help them meet their mandate and keep their staff engaged and well." Another crucial area of focus must be on attracting and retaining good quality staff, something that is proving to be a significant challenge these days, with Boomers retiring and Millennials unwilling to sacrifice their health to the job.

Patricia Fisher has developed one of the only comprehensive organizational health models that address the very complex needs of helping professionals. She brings a whole new way of

seeing organizations, and her success rate is impressive. At the end of the first year of a recent contract with a province-wide corrections division, Fisher was able to see a significant increase in workforce engagement, respectful environment, improvement in staff management relations and a marked rise in job satisfaction rates. But to achieve this, Fisher needed senior management on board. In fact, she argues, you will not find a success story that does not have strong leadership as its base.

A recent *New York Times* op-ed entitled *"Why you hate work"* by Tony Schwartz and Christine Porath supports Fisher's assertions: "Put simply," the authors write, "the way people feel at work profoundly influences how they perform." Schwartz and Porath identify "four core needs" in employees: physical, emotional, mental and spiritual. Improved productivity and employee satisfaction is a direct result of ensuring that those needs are addressed in staff: "physical, through opportunities to regularly renew and recharge at work; emotional, by feeling valued and appreciated for their contributions; mental, when they have the opportunity to focus in an absorbed way on their most important tasks and define when and where they get their work done; and spiritual, by doing more of what they do best and enjoy most."

Schwartz and Porath argue that one of the main obstacles to implementing these changes is getting senior leaders to actually put them into place: "We often ask senior leaders a simple question: if your employees feel more energized, valued, focused and purposeful, do they perform better? Not surprisingly the answer is almost always Yes." Next we ask, "So how much do you invest in meeting those needs?" an uncomfortable silence typically ensues." Why are senior leaders often unable or unwilling to put in place the policies that are needed to ensure a healthier, more productive workplace? The authors suggest that we are challenging

significant inertia and deeply rooted practices and beliefs: Creating such a large shift at the senior level of some organizations is not unlike getting a huge freighter to change its course. It takes time, and plenty of strong data to support the case of implementing change that may, in the short run, look more costly than business as usual. Once senior management is on side, you then need to obtain staff buy-in, which can be very difficult to obtain.

Getting buy-in

"Why are staff not coming to our lunchtime wellness sessions?" a manager in a busy Los Angeles legal clinic recently asked me, "we try to provide body breaks, staff appreciation days, and exercise classes, but our employees don't attend. What are we doing wrong?"

It turns out that this well-meaning agency, and many others like it, may be putting the cart before the horse: recent studies have shown that obtaining employee buy-in requires a deeper understanding of workplace stress and that focusing exclusively on employee wellness may be a mistake. Conversely, some organizations have become highly vocal champions of employee health and wellness on paper alone, but the truth on the ground is far from rosy: I worked with a nursing group a few years ago who flat out refused to wear their agency's new button pin which said something like "at this agency, we provide compassionate care" because they believed it was patently untrue – this organization had recently been drastically restructured, workload demands were unsustainable, positions had been abolished and rates of depression and anxiety were soaring among staff. It was evident that the problem was organizational, rather than insufficient yoga.

Like the Los Angeles legal centre, many agencies are genuinely concerned about the health and well-being of their staff and are

anxious to provide quality client care and reduce sick leave and attrition. Unfortunately, economics play a significant role - organizations are trying to improve working conditions in a context of severe budgetary cutbacks and a dramatic increase in workload. So, how do we move forward and integrate the new compassion fatigue findings in our work so that we can become a healthier workforce?

Pat Baigent, a social worker and director of support and recovery services for a community mental health agency in Ontario has been working hard to implement strategies to reduce compassion fatigue in her agency. She agrees that getting staff to engage can sometimes be a challenge: "People have difficulty with change - even sometimes when the change is good. I've heard that it can take many years to change the culture of an organization so I am trying hard to be patient. Many staff view management efforts with suspicion and pessimism. It seems like some staff are afraid to hope. Even talk at my work about plans for home offices and flexible schedules (things that would have been viewed as a pipe dream under old management) are not well received. It can be really hard to continue to champion the positive changes whilst feeling disappointed with the negativity."

Baigent observes that staff also sometimes experience "committee fatigue" and are fed up with having to fill out yet another survey, or take part in one more focus group. She adds: "negative voices can seem so much louder than the positive ones. It's difficult to find ways to amplify the voices of the staff that are adapting and thriving in the changing culture. It often seems that most of our energy is spent trying to pull negative staff "along" with us as we change." Baigent concludes that there is no quick fix, and that she and her colleagues need to be patient and hold steady: "We had to acknowledge that evidence of compassion fatigue is all around us and it will challenge both

our staff and our organization for some time to come."

Dr. Patricia Fisher agrees and emphasizes that it is important to remember that change takes time, and high stress, high trauma workplaces may be more mistrustful and reactive to new policies and initiatives coming from senior management, no matter how well meaning they are.

This isn't About Perfection

Nestled between several much larger health care facilities, Mount Sinai hospital is a 450-bed acute care teaching institution located in the heart of Toronto's downtown. Like many Jewish hospitals in North America, Sinai was originally created nearly one hundred years ago in response to anti-Semitic discrimination and a lack of services for Jews and other vulnerable groups.

Since its inception, Mount Sinai has aimed to stay true to its heritage of offering care to those who need it most, and filling a void for those who have nowhere else to turn. This philosophy has also influenced their approach to staff well-being. Sinai has high rates of employee engagement, and a leadership structure that believes in a culture of employee health at all levels, from the cleaning staff to the CEO. The hospital has developed a series of programs and initiatives such as a stress resiliency course called the "Stress Vaccine", an online module that is now available to health-care workers worldwide. The hospital has a poet in residence, an active wellness committee, and many initiatives aiming to turn Sinai into a magnet hospital for new staff. They also have a commitment to reviewing the efficacy of their programs regularly, based on employee feedback.

Social worker Christine Bradshaw, a Mount Sinai staff member, speaks glowingly about the initiatives implemented by senior leadership. In

the emergency room, the hospital has a social worker who covers nights and weekends, allowing Bradshaw to work Monday to Friday and to leave at 4pm each day: "Knowing that someone is coming to take over when I leave for the day is huge in reducing my stress."

To make this work, there is no one magic pill, explains Melissa Barton, the hospital's director of occupational health and wellness. Barton explains that in order to succeed in implementing effective CF and VT reduction initiatives, flexibility is key: "We stick with the program when it's working, but sometimes you have smatterings of programs and they lose relevance, or stickiness. So we spend a lot of time thinking about our strategy to bring in new initiatives. Basically, we have an overarching strategy: what do we want to do? What holds them all together? Everything that we are offering to staff is about improving our reflective capacity on the emotional wellbeing side of things."

Last winter, Barton was instrumental in having a compassion fatigue workshop delivered to over 400 Sinai employees, with pre and post measures to assess the effectiveness of the training (which, in the interest of full disclosure, I must tell you I delivered). A firm believer in capacity-building, Sinai also secured funding to hire me to bring an intensive Compassion Fatigue Train the Trainer course to the hospital. 20 specially selected members of staff were trained as CF educators and are now equipped to deliver this workshop across the entire institution.

What makes a real difference, social worker Christine Bradshaw says, is that senior management at this hospital walks the talk on employee health and wellness: "At Sinai, leaders don't just *talk* about workplace stress – we have permission to vent or have a bad day or feel impacted by the work, because STS and CF are acknowledged, they are discussed from the very first day of staff orientation. It feels like we are

allowed to say that some stories will affect us, so we aren't afraid to speak up when we need a debrief, or a break."

For Melissa Barton, the roots of Sinai's success is embedded in the institutions priorities: "our agency is really committed to building leaders at all levels, to foster leadership at all levels, to provide a world class patient experience. In order to do that, we need to have caregivers who are healthy, who are able to reflect - not just react. We want staff who respond to patients in a thoughtful way."

Asked to provide words of advice to other institutions, Barton says that "anyone trying to have a healthy workplace initiative in a hospital needs to be able to link it strategically. If you don't, then you will be alone in trying to hold a torch on your own, and that is not sustainable." Bradshaw concludes: "this isn't about a perfect hospital, but it's about a hospital that doesn't just pay lip service to CF and VT, they value they staff, and their patients."

In her excellent 1999 book on work life balance, *Take time for your life,* Cheryl Richardson said that we should not "confuse difficult choices with no choices." As individual practitioners, we may be called on to do some painful self-assessments about the choices we make, about the cost of staying in an unhealthy workplace. Difficult choices are still filled with possibility, if we dare.

During a recent meeting I had with *Trauma Stewardship* author Laura Van dernoot Lipsky, she concluded by throwing down a challenge to all of us: "The leaders that I trust are those who have had deep personal process and can make changes on a very large scale. Archbishop Desmond Tutu spent a lot of time praying and meditating, as did the Dalai Lama. They have some big practices." Each of us, Lipsky argues, has a responsibility to do the same if we are to

remain healthy while working in this profoundly challenging field, and also to ensure that we are not causing harm to those who turn to us for help and support.

Compassion Fatigue's *eminence grise* Dr. Charles Figley has long argued that it is an ethical duty for us to ensure that we are grounded and healthy so that, in turn, we can be present and able to provide the best possible care to our clients. Knowing what we know now, we could also argue that it is an ethical responsibility for organizations to provide a healthy working environment for its staff.

Vicarious Trauma specialists Pearlman and Saakvitne sounded the alarm bells twenty years ago when they expressed concern about agencies putting dollars ahead of clients: *"When an organization serving trauma survivors focuses solely on revenue, to the exclusion of quality of care for its clients and quality of life for its employees, it supports vicarious traumatization."*

"Patient-centered care" has become a common buzzword over the past decade. But we need to ask ourselves whether we can truly offer patient-centered care without ensuring that our staff has all the tools available to do their work in a way that is sustainable for them, for clients and for the institution as a whole.

If we are serious about addressing the problem of CF and VT among helping professionals, we need to get leaders on board, and we need to combat staff's resistance and scepticism. But the final piece of the puzzle is equally important: we need to take ownership of our own personal contribution to the climate we work in and the culture we are creating.

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