

Reports From the Field

Editorial Note: This section of the Journal is devoted to reports by traumatologists who have experience in applying traumatology principles in the field and have a perspective to share that the Editors believe is valuable but are published as they are submitted. Like a letter to the editor, this means of communication assures that the authors are able to share their perspective quickly and unedited. As with all articles published in this Journal, the Editorial Board encourages responses from the readership.

Near Ground Zero: Compassion Fatigue in The Aftermath of September 11

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The ripple effect of trauma, seen in the aftermath of September 11, create “circles of vulnerability”. The hardest hit are those closest to the epicenter and those who are psychologically closest to the victims, including family members, rescue workers and other helpers.

Working directly with victims and survivors of catastrophic events poses a psychological threat to the caregiver. Over the last decade, secondary traumatic stress, more commonly known as compassion fatigue, has been recognized as a major risk for helpers (Figley, 1995; Stamm, 1997).

Compassion fatigue poses a special problem in that healthcare workers may be reluctant to identify themselves as suffering symptoms of secondary traumatic stress. They see themselves as “there for the victims” and tend not to admit to needing help from the distress of hearing and seeing heart-wrenching stories of suffering, disaster, and ambiguous loss (Boss, 1999). It is necessary for those in leadership positions to attend to the potential for secondary traumatic stress in their workers.

The “shared fate” phenomena can compound the threat of compassion fatigue. To varying degrees caregivers may share the plight of those with whom they work. For example, mental health professionals who live and work in New York City are at risk for primary traumatization even prior to any professional involvement with survivors of September 11.

However, given the magnitude of the event and its impact on the United States, all Americans may feel like New Yorkers. Therefore, the mental health professionals who came to New York from throughout the US are also vulnerable to the shared fate phenomena. My work during the war in Bosnia (White, 1998) sensitized me to these issues. Colleagues in the Middle East, Ireland, Rwanda and other sites of ethnic conflict are well acquainted with the problem of trying to protect the mental health of the caretakers who are part of the traumatized community being served.

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Disaster Relief in New York

I was one of a number of certified traumatologists with Green Cross Projects asked to assist in their work with trauma victims of the September 11th World Trade Center disaster and in training New York area mental health professions in dealing with events of this type. Green Cross Projects was invited by Local 32B-J of the Services Employees International Union (SEIU) to provide assistance to its employees and members who were eyewitnesses to the event, either at the scene or from the Union's headquarters building nearby.

I was involved with the project from October 7 to 14, 2001 along with approximately 12 other mental health professionals who were certified traumatologists with GCP. We were the third group of volunteers, each participating for one week at a time. Our primary activity was to initiate contact with SEIU members, evaluate their trauma status, do brief interventions if appropriate and refer to the unions EAP and/or other resources. This activity took place at the union headquarters building in lower Manhattan. Several members of our team were engaged in teaching a series of 16 hour courses in trauma to local New York mental health professionals.

Compassion Fatigue. Green Cross Projects implemented several procedures for attending to compassion fatigue. There was a briefing at the beginning of the each workday where news updates were provided and the days scheduled was outlined. The leaders used this time, in part, to conduct an informal evaluation of the morale and mental health status of the volunteer therapists. Concerns which emerged were handled informally and on a one-to-one basis with the volunteer worker.

At the beginning of the week, one volunteer was selected to be the "Compassion Fatigue Specialist" for that week. This individual's sole task was to attend to the other volunteers. The job entailed doing hourly compassion fatigue checks with each volunteer. All participants were asked to return to the GCP "safe place" headquarters office at least once an hour to take a break, relax, and talk to the compassion fatigue specialist. The office was located in the top floor of the 23 story union headquarters building where most of the project took place.

At the end of the day a more extensive one hour debriefing was conducted. Part of the debriefing was to ask each participant to respond to a number of questions and issues which allowed for an evaluation of the group's compassion fatigue status.

I conducted a compassion fatigue analysis of the eight members of my team. During our final debriefing session, everyone completed Figley's "Compassion Fatigue and Satisfaction Self-Test for Helpers (CF Self-Test) (Figley, 1995; Stamm, 1997). This instrument yields scores on three scales (1) compassion satisfaction, which is a measure of satisfaction with care giving ability, pleasure in helping, making a contribution, etc. (2) compassion fatigue (discussed above), and (3) burnout, a measure of feeling hopeless and unwilling to deal with work, gradual onset as a result of feeling one's efforts make no difference, very high workload, etc).

Each scale contains a range of scores representing the potential or risk associated with the concept being measured:

- (1) The potential for compassion satisfaction: 118 and above = extremely high potential; 100 – 117 = high potential; 82 – 99 = good potential; 64 – 81 = modest potential; below 63 = low potential.
- (2) The risk for Burnout: 36 or less = extremely low risk; 37 – 50 = moderate risk; 51-75 = high risk; 76 –85 extremely high risk.
- (3) Potential for compassion fatigue: 26 or less = extremely low potential; 27-30 = low risk; 31-35 = moderate risk; 36-40 = high risk; 41 or more = extremely high risk.

Results

Data were obtained for five women and three men. The age range for the women was 35 to 54, for the men 33 to 56. These volunteers were all certified traumatologists with Green Cross Projects (<http://greencross.20m.com/>). Their professional identification included psychology, social work, marriage child and family counseling, and nursing.

Table 1 contains the scores for each volunteer on the three scales. As can be seen, all participants had compassion satisfaction scores in the good, high or extremely high. The average satisfaction score was 100.3 which represented high satisfaction. According to the instrument, no participants evidenced any indication of burnout. There were, however, three participants who showed signs of compassion fatigue (Female 1, 4, and 5) where two were in the high risk and one in the extremely high risk range.

Table 1. Scores on Figley's Compassion Fatigue Self-Test for Helpers

	Comp Satisfaction	Burnout	Comp. Fatigue
Female 1	92	28	36
Female 2	111	18	28
Female 3	120	25	28
Female 4	90	33	47
Female 5	106	21	40
Average female	103.8	25.0	35.8
Male 1	110	21	25
Male 2	103	14	24
Male 3	110	20	28
Average male	107.6	18.3	25.7
Average male & female	104	23.7	32.1

Discussion

There is obviously cause for concern for the three participants whose test scores suggested serious risk for compassion fatigue. Since the instrument was not given prior to involvement in the project, there is no way of knowing whether these three individuals were suffering from compassion fatigue prior to their involvement. Nonetheless, this suggests that some measure of compassion fatigue should be given on a formal basis prior to allowing someone to participate in Green Cross or other disaster relief efforts.

Indeed, perhaps a more careful screening should take place for a broad range of mental health issues and vulnerabilities. Green Cross Projects conducted phone interviews prior to inviting someone to participate in the New York September 11 program. It might be advisable to have individual in person interviews once volunteers arrive on site. Other procedures are being studied as a result of this preliminary evaluation.

Formal follow up evaluation is also advised. I would recommend the compassion fatigue self-test be retaken at one, three and six month follow up phases. In addition, each participant could receive a one month formal phone evaluation/debriefing follow up interview by Green Cross Projects staff.

Finally, Green Cross Projects is to be commended for the on site compassion fatigue evaluation and debriefing procedures implemented for the New York September 11 deployment. However, the current data suggest that careful consideration be given to evaluating potential participants more fully prior to involvement and also at regular follow up periods.

References

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