UNDERSTANDING COMPASSION FATIGUE

PREPARED FOR HOSPICE WELLINGTON

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Ryan Hill*, Oriana Vaccarino**, Kerry J. Daly***
*Research Shop Intern
**Research Shop Project Manager
***Faculty Member

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INTRODUCTION

The primary goal of this literature review is to understand compassion fatigue (CF) so that its effect on the caregiver can be minimized. This literature review will provide a definition of CF, and attempt to understand it within a framework that includes burnout, secondary traumatic stress, and compassion satisfaction. Who is at risk for developing CF, as well as the symptoms to look for, will be discussed. Literature dedicated to understanding CF in hospice and palliative care settings will be reviewed. Finally, strategies will be provided to both the caregiver experiencing the intrusive symptoms of CF, as well as to hospice management to help their own employees cope. Limitations of this report, and the CF literature in general, will be highlighted.

CF is important to understand and confront, because it reduces the capacity of the caregiver to assist their clients (Thieleman & Cacciatore, 2014, p. 34). Furthermore, CF is difficult to identify, and if one is not aware of what CF looks like, one cannot effectively manage the symptoms. This is important, as the consequences to an individual's psychological well-being can be severe (Joinson, 1992). Given the nature of caregiving professions, the sources of CF are often impossible to avoid (1992, p.116). If one is willing to accept that CF can be treated, as Charles Figley does (2002), then it is important to know what cues to look for, and investigate ways to help mitigate its effects. It is possible that a caregiver could be overcome by the stresses of their work, and lose their ability to be productive in their role (Conrad & Kellar-Guenther, 2006, p. 1073). By helping caregivers address CF, both the individual and the institution they work for will feel the benefits. For example, workplaces could see increased staff morale, less sick days taken, less turnover, and higher patient satisfaction (Boyle, 2011).

Consequences of CF go beyond the effects on productivity of the worker in the workplace. A person's relationships stand to suffer due to the intrusive symptoms. Furthermore, a person risks engaging in negative coping mechanisms, such as regularly turning to alcohol or drugs (Potter, et al., 2013, p. 180), withdrawing from social networks, or refusing to talk about stressors (Walker, Morin, & Labrie, 2012, p. 17). Additionally, with high levels of burnout associated with patient dissatisfaction in research (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010, p. 421), patients could feel the effects of an emotionally exhausted workforce. With North America experiencing an ageing population, an increase in demand for end-of-life services will naturally follow. Reducing CF's ability as a contributing factor to the life of a caregiver should be

considered high priority (Melvin, 2012, p. 606), for the sake of the caregiver, palliative care administration, and the patients themselves.

METHODS

This literature review used a variety of sources, which are available online or in academic journals. Sources were mainly accessed through Primo Central, an online search engine with access to millions of electronically-accessible journal articles. Supplemental resources were accessed via Google Scholar, or found on organization websites. The first key word used in searching these data bases was 'Compassion Fatigue'. Reports that turned up in this search were explored, which revealed related concepts such as 'Compassion Satisfaction', 'Burnout', 'Vicarious trauma, which were also investigated. 'Compassion Fatigue Strategies' and 'Compassion Fatigue Self-Care' were also searched. Finally, because this report is being produced for Hospice Wellington, 'Compassion Fatigue' and 'Hospice' or 'Palliative' care also searched for, in hopes of finding more relevant research.

The literature review focused on articles and reports published after the year 2000, in the interest of keeping the research current. However, articles published prior to the year 2000, which were frequently referenced in the newer literature, were consulted. Once a sufficient literature base was built through use of these search engines, additional resources revealed themselves through the references cited by articles and reports found. The titles of relevant resources were searched for through Primo, with most accessible online. No original data was collected for the production of this report.

UNDERSTANDING COMPASSION FATIGUE

Defining Compassion Fatigue

"Put simply, **compassion fatigue** is a professional hazard for those who choose to help others" (Alkema, Linton, & Davies, 2008, p. 104). It is a state of "psychic exhaustion" (Boyle, 2011). CF is mainly discussed in the traumatology (interdisciplinary study of the consequences of stressful events) literature (Figley & Boscarino, 2012, p. 1114). It is a response to a specific stress that results from exposure to the suffering of clients (Figley, 1995; Radey & Figley, 2007). Furthermore, CF is thought to affect the capacity of the caregiver in their working with patients (Figley, 2002, p. 1434).

While CF is thought to be the result of overexposure to the suffering of others over time (Berzoff & Kita, 2010), it can emerge "suddenly and without warning" (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013, p. 173). In addition to sustained suffering through others, it is also thought that individuals who experience CF do not keep up with their own self-care, and might lack proper supports in their workplace (Alkema, Linton, & Davies, 2008, p. 103). CF is something to be mindful of, if in a career dedicated to helping others.

CF is a concept which has been largely developed by Charles Figley, a notable in the traumatology field. He began his career writing about Post-Traumatic Stress Disorder (PTSD) before it was identified as such, referring to it as a stress disorder (Figley, 1978). His career as a researcher of trauma was largely inspired by his time serving in the Vietnam War, and subsequent experience as a war protester (Figley & Boscarino, 2012, p. 1114). In one article, Figley first recalls observing CF in a military nurse serving in Vietnam, whom Figley interviewed in 1971. This nurse spoke of troubling memories that "were associated with lots of psychological problems" as a result of not being able to save or alleviate the suffering of some patients (2002, p. 1434).

Figley did not immediately refer to this particular form of caregiver stress as CF; at the time, it was lumped in with war-related PTSD. It was only after his research expanded to people who witnessed the suffering of others that the conceptual roots of CF took hold (2002, pp. 1434-1435). Through the study of this phenomenon, Figley saw CF as a by-product of a caregiver's capability to empathize with this client, influenced by many other factors, including: the amount of effort a caregiver exerts to relieve suffering,

prolonged exposure to a client's suffering, the caregiver's own traumatic memories, and other life disruptions (e.g. financial difficulties). (Figley, 2002, pp. 1436-1438).

CF is unique to professions which dedicate themselves to helping others, so it is worth clarifying what is considered a caregiving profession. Those who have experienced CF generally come from fields in which there is first-hand exposure to trauma, or secondary exposure to trauma (by hearing people recall their experiences). CF can also occur when working with people who are unable to improve their life circumstances (Mathieu & Cameron, What is Compassion Fatigue?, 2013). Consider where researchers have turned their attention to study CF: in the medical field, with emergency department nurses (Hunsaker, Chen, Maughan, & Heaston, 2015), with military healthcare teams (Owen, 2014), and in oncology units (Sherman, Edwards, Simonton, & Mehta, 2006), all of which are thought to be occupations in which CF is a considerable risk.

CF has also been researched amongst those occupations providing non-medical care, such as: social workers (Adams, Figley, & Boscarino, 2008), psychotherapists (Figley, 2002; Jenkins & Baird, 2002), child welfare workers (Salloum, Kondrat, Johnco, & Olson, 2015), those working with the disabled (van Dierendpnck, Schaufeli, & Buunk, 1998), and the clergy (Jacobson, Rothschild, Mirza, & Shapiro, 2013). All of these occupations share a common thread: they work with people oftentimes under difficult circumstances. While this report will be concerned with CF and the challenges faced by hospice care professionals in particular, it also draws from the research above, as hospice workers share in common with the aforementioned professions, a caregiving relationship with the patient.

Related Concepts

Other terms frequently appear alongside CF in much of the literature. These terms could help us better understand CF in a wider context. One concept often discussed in the same breath as CF is job burnout. Burnout is thought by major researchers to comprise three elements: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment (Maslach, 1982). It manifests through "the erosion of emotional or physical strength and professional engagement as a function of a taxing work environment" (Sherman, Edwards, Simonton, & Mehta, 2006, p. 66). Factors that are thought to contribute to job burnout include low pay, low social recognition, and shift work (Alkema, Linton, & Davies, 2008, p. 103).

While there is little doubt that CF and burnout are related constructs, there is not always agreement as to how they relate. Sometimes it appears that burnout and CF are two different words used to describe the same phenomenon. For example, Lizano and Barak (2015) investigate public child welfare workers, assessing the particular compassion-related stress which accompanies their job; working with difficult cases, for example. In this discussion, CF is not mentioned. Christina Maslach (1982), a prominent burnout researcher, interviewed a psychologist who spoke about 'dealing with other people's sorrows', calling this individual a "classic case of burnout" (Maslach & Goldberg, 1998, p. 63). Other researchers might see this as experiencing CF. For example, Charles Figley sees CF in a very similar case in a counseling psychology student (2002, p. 1434). Figley may have been seeing a similar phenomenon, yet used a different word to describe it.

Other times, CF and burnout are distinguished by the authors who write about them. In a study of job stressors in female hospice nurses, the constant confrontation with death and dying, as well as unrefined coping strategies, are regarded as just a few of the many stressors that contribute to burnout (Payne, 2001). This implies that CF is a collection of emotionally exhausting factors that only partially contribute to burnout; other factors that are thought to play a role include conflict(s) with staff and fewer professional qualifications (Payne, 2001).

In trying to separate CF from burnout, another set of authors identified CF as the undesired ramifications of working with the traumatized, and an all-encompassing exhaustion from vicariously experiencing the suffering of others; burnout, on the other hand, was considered different because it creates an inability to function in one's role at work (Hunsaker, Chen, Maughan, & Heaston, 2015, p. 187). To Stamm (2010), burnout is one of the potential consequences of untreated compassion fatigue, with secondary trauma comprising the other potential consequence (Stamm, 2010, p. 8). Figley believes that a key distinction between CF and burnout is that while burnout may require a change of career or place of work within a field, CF is treatable once recognized (2002, p. 1436). Keidel sees CF as a form of burnout unique to the caregiving professions (2002, p. 200), where CF is just another type of stress that a caregiver has to cope with (Walker, Morin, & Labrie, 2012).

It is possible that the infancy of CF as a focus of study may play a role in why CF and burnout are sometimes confused as the same thing. However, burnout and CF can be differentiated insofar as burnout is primarily a reactional response to one's workplace

environment, whereas CF typically arises out of a relationship between oneself and those one cares for (Boyle, 2011). "Compassion fatigue is specific to those professionals in the helping professions" (Alkema, Linton, & Davies, 2008, p. 104) that a person who does not interact with people in their career would not experience.

While burnout can be experienced outside of caregiving occupations, researchers believe it to be a phenomenon experienced mainly in the 'people-oriented professions' (Maslach & Goldberg, 1998, p. 63), in which the service provided does not necessarily qualify as care (e.g. teaching, service industry). Whereas CF is the negative effect of experiencing others' trauma in some form, burnout is "an outcome of organizational stressors such as workload, work role confusion, tense work relationships with coworkers and supervisors, and lack of resources to do one's job" (Jacobson, 2012, p. 65). Research suggests that high levels of burnout are correlated with high levels of CF (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), and the strategies and interventions used to address either are similar. While burnout and CF appear to be distinct concepts, they are closely related.

Another concept mentioned frequently in this literature is **secondary traumatic stress (STS)**, synonymously known as secondary trauma or vicarious trauma. There is also some confusion as to exactly what STS is. Some authors believe secondary trauma is a synonym for CF (Salloum, Kondrat, Johnco, & Olson, 2015; Jenkins & Baird, 2002). Other researchers distinguish them, although sometimes vaguely; for example, one set of authors believe that CF "encompasses the concepts of secondary (vicarious) trauma and burnout" (Thieleman & Cacciatore, 2014, p. 34), a vague description which highlights the ambiguity that exists. While there remains a need for definitional clarity, CF appears to be a precursor leading to the development of secondary trauma or burnout (Stamm, 2010, p. 8), both of which could manifest if CF is left untreated (Leon, Altholz, & Dziegielewski, 1999, p. 44).

Figley prefers to distinguish CF from secondary traumatic stress; he believes STS is simply the behaviour and emotions resulting from knowing about a traumatic event experienced by another, whereas CF is a "state of tension and preoccupations with the traumatized patients by re-experiencing the traumatic events… it is a function of bearing witness to the suffering of others" (2002, p. 1435). Mathieu and Cameron (2013) separate STS from CF, but do not appear to believe that STS is the result of untreated CF. They turn to practical examples to illustrate their point: STS may be experienced by a parole officer by reading the content of their case lives. It would

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manifest in other aspects of the individual's life, such as in their level of confidence that their children are safe. CF, on the other hand, can be a constant preoccupation of mind with suffering clients, even when not at work.

A final related concept is **compassion satisfaction** (CS). It also appears to be unique to caregiving professionals, and pertains to the pleasure derived from engaging in one's work (Stamm, 2010, p. 12). As CF is viewed as the negative aspects of working in a caregiving field, CS is sometimes viewed as belonging on the opposite (positive) end of one spectrum with CF (Stamm, 2010, p. 8). There exists the possibility that having high levels of CS alleviates the impact of both burnout and CF (Conrad & Kellar-Guenther, 2006, pp. 1073-1074). This assertion is made largely on survey-based studies (Hunsaker, Chen, Maughan, & Heaston, 2015; Alkema, Linton, & Davies, 2008; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013). In other studies, low levels of CS and high levels of either burnout or CF have been measured (Salloum, Kondrat, Johnco, & Olson, 2015). While more research on the relationship is needed, the current research that is out there seems to indicate that an inverse relationship between CS and CF exists.

Who is at Risk?

A common theme in the CF literature is to identify those who would be most vulnerable to experiencing CF. For example, it is thought that certain personality traits, such as being perfectionistic or very self-giving, makes one susceptible to this form of stress (Keidel, 2002, p. 201). Caregiving professionals that see personal failure in any loss or suffering are also more vulnerable to CF (Figley, 1995). Characteristics of the client being cared for may also influence the experience of CF. For example, a 22-year HCP caring for a younger mother of two dying from breast cancer might feel its effects differently than a 60-year old HCP caring for a senior citizen (Keidel, 2002, p. 201). This comparative, as an example, acknowledges that CF tends to be experienced more intensely by the young or those new to the profession (Jones, 2005, p. 125). This trend has been noted elsewhere (Sherman, Edwards, Simonton, & Mehta, 2006, p. 74; Hunsaker, Chen, Maughan, & Heaston, 2015, p. 190).

A caregiver's level of empathy is also related to a person's risk for developing compassion fatigue. Simply stated, the more empathetic a person is, the more prone they are to CF (Potter, et al., 2013, p. 181; Abendroth & Flannery, 2006). More intelligent employees are likely at risk (Gentry & Baranowsky, 2013, p. 6), and those

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with high levels of education have shown high burnout scores in quantitative studies (Abendroth & Flannery, 2006, p. 347). The lack of self-confidence in communication skills is another important risk factor; if one feels that they could have communicated better with a client or their family after the fact, they may feel tentative in future approaches, a cycle which unnecessarily compounds the stress they feel (Pereira, Fonseca, & Carvalho 2011, p. 323). Those who are overworked, or take on large workloads themselves, are thought to be more vulnerable to experiencing CF (Gentry & Baranowsky, 2013, p. 6).

Figley (1995) believed that four major factors contribute to the development of CF: ignoring self-care, unaddressed personal trauma, the inability to control work stressors, and the level of job satisfaction. Figley believed that these four factors worked together to produce different results, depending on the presence or absence of each of the factors. For example, a person with an excellent self-care plan may not be able to overcome unresolved trauma, or they have yet to control work stressors in a healthy way (Radey & Figley, 2007, p. 207).

Being aware of what might put someone at risk in developing CF may help caregivers or those that they work for help prevent its onset, and could try to adapt to any of these risk factors with preventative measures. For example, if one accepts (as research discussed above suggests) that those new to the profession are more susceptible to CF, administration could choose to provide more resources and looking out for these individuals. However, it is unlikely that every case of CF can be prevented, and caregivers and their employers need to be prepared for this reality. Knowing what symptoms to look for is essential in order to manage CF.

The Symptoms to Look For

Thankfully, CF is believed to be treatable (Figley, 2002), but in order to treat it, one must be able to recognize the symptoms. Some symptoms of CF in workers include a reduced level of empathy for clients, exhaustion in the workplace, expressed hopelessness, or concerns from the employee that their work is intruding in their personal life (Leon, Altholz, & Dziegielewski, 1999, p. 44). Caregivers may have trouble getting sufficient sleep, or could experience depression or anxiety (Alkema, Linton, & Davies, 2008, p. 103). Other intrusive symptoms could be difficulty concentrating, a negative outlook on the world, exhaustion, and irritability (Mathieu & Cameron, 2013).

There may be feelings of impotence in dealing with clients, or a lack of purpose in one's career (Gentry, Baranowsky, & Dunning, 1997).

Boyle (2011) lists six ways in which CF manifests itself, and the symptoms to look for. First, she reasons that CF has an emotional component: the individual may be easy to irritate, communicate a lessened enthusiasm or sense of hopelessness, or feel overwhelmed. CF also affects an individual's intellectual skills; concentration may be impaired, with a weakened attention to detail. Physically, the person may feel a lack of energy, strength, and endurance. CF also affects relationships with others; a person may start to come across as insensitive or indifferent, and may isolate themselves from their social circles. A person's work life is also affected: the person may start to show up late, or be absent altogether. Once at work, the person may avoid more intense cases and may show a diminished ability to perform their job. Finally, a person's spirituality is affected, where the person shows a lack of interest in being introspective or spiritually aware. These six aspects of a person's life that can be affected by CF help illustrate its potential for invasiveness.

Some researchers observe that the symptoms for CF mimic some symptoms associated with PTSD, such as intrusive thoughts, avoiding stimuli associated with a traumatic experience, and unwanted arousal such as anxiety, irritability, or hypervigilance (Gentry & Baranowsky, 2013, p. 4). These symptoms, and some of the other symptoms discussed above, may be difficult to detect. Open lines of communication with staff, as well as good observational skills, are two prominent ways in which CF could be detected (Najjar, Davis, Beck-Coon, & Doebbeling, 2009)

Measuring Compassion Fatigue: The Professional Quality of Life Survey

Often the ProQOL survey is used to measure CF in the literature (Jacobson, Rothschild, Mirza, & Shapiro, 2013). The ProQOL built upon and "replaces the Compassion Satisfaction and Fatigue Test, the Compassion Fatigue Test and Compassion Fatigue Self-Test" (ProQOL.org, 2012) that have been used in earlier studies of CF (e.g. Conrad & Kellar-Guenther, 2006). The Compassion Fatigue Tests were developed by Figley (1995), who also assisted in the development of the ProQOL scale (Bride, Radey, & Figley, 2007). Sometimes researchers choose to use the ProQOL along with other locally developed resources (Alkema, Linton, & Davies, 2008). The survey can be administered to individuals or to groups (Stamm, 2010).

Studies evaluating the reliability or validity of the ProQOL survey are scarce. The ProQOL Manual self-assesses itself, claiming "there is good construct validity with over 200 published papers" (Stamm, 2010, p. 13). Only one independent evaluation resource, evaluating the Turkish version of the ProQOL, could be found. The entire article has not been translated to English, but the abstract describes their version of the ProQOL as a "valid and reliable instrument" (Yesil, et al., 2010). Follow this link to access the Concise Professional Quality of Life Training Manual, which contains the ProQOL survey, as well as the instructions to both administer and interpret. This is a good resource for academic researchers, or administrators who want to evaluate CF in their workplace. This resource is free.

COMPASSION FATIGUE IN THE HOSPICE

Although traumatology is a field in its infancy (Figley & Boscarino, 2012), and CF is a relatively new concept, research still exists that looks at CF in hospice care professionals (Keidel, 2002; Alkema, Linton, & Davies, 2008; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013; Jones, 2005). Anyone in a caregiving profession is susceptible to CF, but the challenge is unique in a hospice setting, where workers "are constantly exposed to experiences of loss, awareness of their own mortality, and the termination of intense relationships" (Keidel, 2002, p. 201). Because of the nature of their work, HCPs may feel inadequate in controlling their client's suffering symptoms, or could even be frustrated with the client's family situation (2002, p. 201). While it might be natural for an outsider to think that HCPs would adapt to their frequent exposure to the dying process, "death with dignity is easy to say but hard to watch" (2002, p. 202).

This constant exposure to others' (and their own) mortality is thought to be a contributor to CF (Leon, Altholz, & Dziegielewski, 1999, p. 43). In the hospice, the client-caregiver relationship is often intense and short-term (Leon, Altholz, & Dziegielewski, 1999, p. 51), and caregivers often witness an acute decline in the physical and psychological abilities of some, which creates unique emotional challenges for HCPs (1999, p. 44). In addition, HCPs are frequently interacting with families going through a difficult time with the impending passing of a relative, which could be exacerbated by complicated family dynamics (Melvin, 2012, p. 607). Frustration over the allocation of society's resources to those working with vulnerable groups, such as the elderly, could intensify the effects of CF (Leon, Altholz, & Dziegielewski, 1999, p. 43).

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Some researchers have used surveys to explore levels of CF and related concepts in the hospice. One study found where CS scores were high, burnout and CF scores were low. The strength of the relationships did differ, further reinforcing that separating these concepts makes sense (Alkema, Linton, & Davies, 2008, p. 113); another study found similar results (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013). In interviewing six hospice care nurses with at least 10 years of experience, Melvin (2012) wanted to know whether hospice care put individuals at risk for CF. She found that "without adequate coping strategies, the participants were at risk of developing CF" and that one interviewee was probably experiencing CF at time of interview (p. 608). After discovering that 78% of the 216 nurses were at moderate-to-high risk for CF, Abendroth and Flannery concluded that nurses in hospice care "are especially vulnerable to the risk of CF" (2006, p. 347).

However, HCPs and others working in end-of-life care also have the ability to develop a level of CS that other professions might not have. Those working with the dying often report a 'profound satisfaction' being able to be frequently present for this intimate part of life (Berzoff & Kita, 2010, p. 348). A hospice might also benefit from the mentality that it provides a transitioning into death, where end of life is the accepted outcome. Some caregiving professions, particularly in the medical field, might see end of life as a failure to save (Keidel, 2002, p. 201). To constantly be around persons at the end of life makes one "aware daily of the gifts of living, and …exposure to the dying makes what is important in living very immediate" (Berzoff & Kita, 2010, p. 348). Because of the nature of their work, HCPs feel as if they are making a significant contribution to this world (Pereira, Fonseca, & Carvalho, 2011, p. 323). While working in end-of-life care has its challenges, it has benefits, too. However, CF is a reality that should be addressed so that workers may better enjoy the benefits of their chosen career path. Understanding the phenomenon, recognizing the symptoms, identifying the predispositions, and using tactics to help prevent or reduce the effects of CF are essential in trying to accomplish this. The next section will be dedicated to strategies that people use to cope with CF.

STRATEGIES TO COPE

Charles Figley is optimistic that the effect of CF can be minimalized. He believes that education on CF is both essential and beneficial for treatment, as with education on any mental or physical condition. Figley also believes that desensitization to stressors, controlled exposure to these stressors, and enhancing one's social network are

considered essential in addressing CF (2002, pp. 1438-1439). Over time, many researchers of CF have also offered strategies to help cope with CF. Self-care recommendations are seen most frequently, though there are also actions that can be taken by employers which could help their employees cope with workplace stress. The roles of both the individual and the employer in alleviating the suffering caused by CF will be discussed.

Self-Care

Self-care is essential in preventing or mitigating the effects of CF. Caregivers often forget to look after themselves, and it is this lack of care that is thought to contribute to one feeling CF's effects (Leon, Altholz, & Dziegielewski, 1999, p. 59). Five strategies that could be useful in self-care will be discussed: workplace-specific coping strategies, education, proper work-life balance, debriefing, and holistic approaches. While self-care may help to decrease CF, little empirical research exists that proves one strategy is better than the other (Alkema, Linton, & Davies, 2008, p. 105). It is possible that some strategies may work for certain people and not for others.

Keidel (2002) offers some advice for the hospice worker to better navigate the stresses of the workplace. She recommends constant monitoring of emotional investment into clients, and cautions the hospice worker to not get over involved. She encourages the caregiver to avoid perceiving himself or herself as a 'saviour' to the patient, and to also remain vigilant in attending to the patient's need (p. 202-203). If working with a challenging family, obviously going through a difficult time, it is important to see the situation from their perspective (p. 202). It is highly likely that the stresses of losing a loved one is affecting the family's behaviour, and it is important to not take any perceived slights personally (Melvin, 2012, p. 607). Ultimately, a hospice caregiver must be active in changing their behaviour or discussing issues with others, but accepting and adapting to what cannot be controlled is equally important to being at one's best in the workplace (Keidel, 2002, p. 202). Interviews with hospice care professionals revealed that establishing boundaries between caregiver and patient was essential for self-preservation and continuation in their role (Melvin, 2012, p. 609).

Education may also be an important intervention strategy. Education can help develop communication skills, so that employees may offer better support to clients and their families. Furthermore, education programs could be designed to focus on end of life care and "emotional-support competencies" (Boyle, 2011). Looking at studies

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investigating burnout in palliative care units and hospices, Pereira and colleagues (2011) found that a major risk factor for burnout was a "lack of self-confidence in professionals' own communication skills with patients and relatives" (p. 322). It is believed that communication skills can be developed through education or training programs focusing on professional development (Boyle, 2011; Pereira, Fonseca, & Carvalho, 2011).

Achieving a proper balance between one's life inside and their time spent outside of the workplace is considered by some to be an essential CF intervention strategy. This means that a caregiver must dedicate time to nurture themselves, with activities they enjoy (Boyle, 2011). Some research even suggests that self-care strategies which focused on work-life balance were found to be more effective than strategies that focused on the physical, psychological, or self-care in the workplace (2008, p. 114). For example, incorporating play into one's life is thought to prevent and decrease CF, with one set of authors recommending hoop dancing as a way to bring play, or the seeking of joy, into one's life (Sanchez & Johnson, 2014). While physical relaxation is important, cognitive relaxation (e.g. reading, meditation) is just as beneficial (Walker, Morin, & Labrie, 2012, p. 15). Keidel recommends establishing a supportive social network, and while being able to 'get things off your chest' with members of this network is an obvious benefit, she cautions to not share workplace distress with everyone. She believes that keeping some social circles isolated from your professional life could create a temporary escape from that environment, where one can completely take their mind off of work (2002, p. 203).

Debriefing amongst colleagues can be an effective way of managing CF (Sherrod, 2005). However, caregivers should be cautious of the contagious effect that sharing trauma can have colleagues. When stress is shared with a co-worker, the possibility exists that the listener had little choice in whether they wanted to receive the information (Mathieu, 2013). Low Impact Debriefing, also referred to as Low Impact Disclosure, is thought to mitigate this effect (Mathieu, 2008). Low impact Debriefing involves self-awareness, fair warning, consent, and limited disclosure. Being self-aware means acknowledging that the listener can be affected by your stress, and understanding what information is important to share, and which details should be left out. Finding a way to give the listener warning that a debriefing is about to begin, gives the listener time to prepare. Additionally, getting consent from the listener gives them an opportunity to reschedule if necessary. Finally, limited disclosure asks the caregiver to

leave out more graphic details in the information shared (Mathieu, Low Impact Debriefing, 2013).

Sally Hill Jones offers a more holistic approach. Drawing from experience as a hospice social worker, counselor, and researcher, she offers a comprehensive five-point self-care plan that provides caregivers means to relieve the chronic stress they experience (2005). She recommends focusing on the following five dimensions: physical, emotional/cognitive, relational, spiritual, and motivation maturation. Physical self-care involves having regular health checkups, exercising regularly, and experimenting with relaxation techniques such as yoga (2002, p. 125). Emotional self-care involves expressing feelings through any art form, amusement through hobby or sport, or even allowing oneself to cry. Relational self-care involves paying attention to red flags that could affect one's relationships with others in the workplace, which could involve distancing oneself or even over-relying on one's relationships.

Jones recommends setting boundaries in relationships at work, as well as resolving conflict with colleagues in a positive way. Spiritual self-care is also recommended, and can be tailored to any belief system. Finally, an employee is encouraged to constantly re-assess one's motivation to work in hospice care; it may begin out of motivation to provide care to people in a way that they never received, but it should evolve to accept "the variety of death experiences encountered in the hospice" (Jones, 2005, p. 125).

Clearly there are plenty of suggestions for self-care in the literature, and the theme of 'looking out for yourself' is often in the same discussion as CF. Additional self-care resources are available; for example, the Compassion Fatigue Workbook is a self-help book designed to assist the caregiver in coping with CF in their lives.. While self-care is likely integral to managing CF symptoms, , Francois Mathieu, the author of the workbook just mentioned, cautions elsewhere that self-care cannot be relied on solely to address CF; and that professionals cannot be left "feeling completely along while struggling with CF and burnout" (Mathieu, 2011, p. 6). While the role of other stakeholders will be discussed, it is first worthwhile to consider the role that compassion satisfaction plays in helping to alleviate the effects of CF.

The Role of Compassion Satisfaction

As mentioned earlier, there is some literature indicating that CS has an opposite relationship with CF (Conrad & Kellar-Guenther, 2006) or burnout (Sherman, Edwards,

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Simonton, & Mehta, 2006, p. 73) in other caregiving professions. It is difficult to recommend enhancing one's level of CS in their work, as developing satisfaction is not something that can be forced. However, one can gain insight into "understanding what contributes to compassion satisfaction" so that caregivers can attend to these aspects (Radey & Figley, 2007, p. 208). To these authors, ignoring self-care is considered to be one factor, which has been discussed at length here. Affect, meant by the authors to refer to one's disposition (e.g. if you are cheerful), is also thought to be important. Access to resources also influences levels of CS and CF; not only wealth and physical resources at one's disposal, but knowledge as well.

For example, Radey described her experiences running a youth camp and being new to the city she was working in, and not feeling comfortable in her new role, and how this exhausted her (2007, p. 209) as an example of how resources may affect the way one reacts to stress that leads to CF. While CS cannot be forced upon a caregiver, the authors believe that an individual can influence their own affect, increasing resources to manage stress, and developing a healthy self-care program. In turn, one might be able to improve upon their positivity ratio scores and get more satisfaction out of their work. On the other hand, there is also support for the notion that having proper social supports in place (as discussed in the section on self-care) may create conditions for CS to emerge (Mathieu, 2011, p. 7), as opposed to the idea that the ability to take satisfaction in one's work is more of an inherent personality trait.

How Administrators Can Help Their Caregivers Cope

While self-care strategies are seemingly endless and an essential tool in mitigating the effects of CF, workplace administration can also play prominent roles. Self-care strategies are likely necessary for managing levels of stress in any occupation, but self-care on its own may be insufficient in treating CF (Walker, Morin, & Labrie, 2012, p. 1). Recently, research has been calling for a more comprehensive approach, one in which the focus is "on the self, the system and the organizations simultaneously (Mathieu, 2011, p. 7). For example, organizational health researchers have found that workplaces with a manager who is supportive and flexible helps improve overall employee wellness (Mathieu & Cameron, 2013).

Implying that there is a role for administrators to play in helping their workers deal with workplace stress does not necessarily mean there is fault to be found within individual administrators. For example, it might be the case that a manager has

employees that are caught up in the endless requirements of their jobs and working long past they are supposed to be off-shift; 'workaholism' is certainly a culture created within many professions (Mathieu, 2011, p. 8). In situations such as these, it is possible that workplace administration has greater leverage in trying to control the hours of their workers for their own overall wellness (Mathieu, 2011, p. 4). What is being suggested here is that managers try to be more aware that seemingly harmless occurrences in the workplace could be compounding the stress that staff are feeling (Mathieu, 2011).

Hospice administration have the ability to intervene if symptoms of burnout or CF in their staff begin to emerge. Focusing on death, the main stress of the job, may not be necessary. Instead, keeping a consistent schedule, as well as minimizing confusion in tasks and roles, could help decrease the risk of burnout (Keidel, 2002, p. 204). Allowing for greater staff autonomy and sharing in relevant decision-making processes could also be effective (Sherman, Edwards, Simonton, & Mehta, 2006, p. 76). Furthermore, if nurses are assigned to work with specific clients, working with varied types of clients could be beneficial. This has been recommended to social workers in the past (Leon, Altholz, & Dziegielewski, 1999, pp. 58-59), and could also be employed in a hospice context. In addition to good caseload management, reducing a person's hours who has recently been involved with a difficult case may be one strategy to mitigate the effects of that trauma (Mathieu & Cameron, What is Compassion Fatigue?, 2013). A 2007 survey of HCPs in the United States revealed that high staffing levels and good benefit packages may help in reducing staff turnover rates (Luo, Lin, & Castle, 2012).

Employees could also attend conferences that focus on skill development. For example, Hospice Palliative Care Ontario (HPCO) hosts an annual conference, which features workshops that focus on current and relevant issues. In 2015, workshops focused on getting people involved about planning end-of-life care in advance, assisted suicide, and elderly advocacy (Hospice Palliative Care Ontario, 2015). The Alberta Hospice Palliative Care Association hosts a similar full day workshop-style education program known as the Roadshow, which brings palliative care training to rural Alberta. The 2015 Roadshow focused on how to offer more compassionate palliative care to clients, whereas the 2014 Roadshow focused on self-care (Alberta Hospice Palliative Care Association, 2015).

Holding monthly meetings with staff members provides an avenue for administration to communicate with their employees about what is necessary to manage CF. Knowledge about CF accompanied by the offering of counselling and other

resources may expose employees to phenomenon that they might not even be aware of (Mathieu & Cameron, 2013). While recommendations for self-care can certainly be discussed, some organizations have replaced self-care strategies with team building exercises in their monthly discussions (Walker, Morin, & Labrie, 2012, pp. 19-20). Encouraging staff to maintain professional boundaries with their clients is also recommended (2012, p. 24). As well, recognizing accomplishments is helpful in maintaining a positive atmosphere in the work place (2012, p. 24).

Workplace Administration may also benefit from proactive workplace interventions that attempt to alleviate stress associated with caregiving. Interventions could include on-site counselling, staff support groups, or de-briefing sessions at the end of shift or after a particularly stressful moment (Boyle, 2011). These strategies are based on the idea that social support in the workplace is helpful for the worker to adapt to the chronic stress that comes from a caregiving occupation. While on-site counselling by trained professionals allows one to be less cautious about the information they share, accessibility to counsellors when they required by the individual most may not always be possible (Mathieu, 2008).

Staff support groups could provide a forum to defuse any ongoing tension between employees, and to allow for productive problem solving (Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007), but one runs the risk of increasing the stress levels of their colleagues whilst they relieve theirs (Mathieu, 2008). While some professionals will choose to debrief amongst themselves, it is likely that sometimes leadership is required to encourage staff to share their stress (Hanna & Romana, 2007). Knowing the right time to initiate a debrief is an important skill for someone in a management role to develop; once employees start to withdraw, start to show less interest in their work, or even sigh excessively, this may suggest that a debrief is needed (Hanna & Romana, 2007, p. 39).

Debriefing skills should be developed in both managers and employees. While the timing of an intervention is important, knowing how to properly conduct a debrief will help make the moment more impactful. Given that hospice workers regularly confront permanent loss, Critical Incident Stress Debriefing (CISD) might be a beneficial intervention strategy when a staff member suffers from a particularly difficult loss (Mitchell, 2009). While CISD was designed for emergency responders, it has been adapted for other medical and social personnel (Dyregrov, 1997, p. 590).

CISD involves seven phases (introduction, fact-gathering, emotional reflection, describing your reaction, describing symptoms, teaching to manage, and re-entry into the workplace) in which a small (5-7 people) group is led by a trained mental health professional that is designed to operate as a form of first aid for a person's mental health (Mitchell, 2009, p. 2). This intervention should be held 24 to 72 hours after this incident, to ensure that the caregiver is ready to discuss the incident in depth (Mitchell, 2009, p. 3). Some research on CISD reveals encouraging results; those who underwent CISD show less mental health issues, and less problems with addiction. Workplaces that use CISD have reported lower turnover and less sick time used (Mitchell, 2009, pp. 6-8). However, conflicting research suggests that that CISD may not be helpful in reducing traumatic stress (Sherrod, 2005, p. 17).

Process Debriefing is another debriefing method available to the caregiver. It is based upon the phase system that CISD introduced, but places more emphasis on group processes (Dyregrov, 1997). Within this model, a mental health professional is not necessarily required to lead the debriefing process, and in some cases peer support (others in your profession who will know what you are going through) is thought to be more beneficial (Dyregrov, 1997, p. 593). However, the group leader is required to be trained. The group leader is joined by a co-leader who serves as a role model to other group members on how to interact with the person leading the session (p. 594). The leader emphasizes group cohesion, and encourages leaning on one another as a form of coping, but takes into account pre-existing group dynamics when determining how much cohesiveness to recommend (Dyregrov, 1997, p. 598). While there are other psychological debriefing strategies available, all seem to contain the same elements: the intervention is in a group setting, there is opportunity for participants to unload their stress, and participants are provided with resources to cope with their stress (Sherrod, 2005, p. 2).

Determining which combination of these suggestions to use with one's own employees will likely be decided upon a combination of time and resources available. Workplace administration must be cautious in not being too over-demanding with meetings or other activities trying to address CF. Mathieu (2011, p. 12) draws upon an interview with a professional in social work, who humourously cautions that employees could come to suffer from 'committee fatigue' just as easily as they come to suffer from CF. Achieving a balance between being uninvolved to being too intrusive is a difficult balance, but feedback from staff may help to guide these decisions.

Professional Intervention Strategies

Recently, researchers have developed stress-reduction programs designed to target burnout and CF which they could bring into the workplace. The following programs will be discussed: Compassion Fatigue Solutions, the Accelerated Recovery Program (Gentry, Baranowsky, & Dunning, 1997), the Compassion Fatigue Resiliency Program (CFRP) (Potter, et al., 2013), and the ATTEND model (Cacciatore & Flint, 2012).

Compassion Fatigue Solutions

Compassion Fatigue Solutions is an organization that works with individuals and organizations to help tame the effects of CF. Based out of Kingston, Ontario, their team includes professionals with backgrounds in social services, healthcare, mental health, and conflict management (Compassion Fatigue Solutions, 2015). Their website is a great place to start if looking for interactive solutions and tools to deal with CF symptoms. They come with a respected reputation, already having worked with various organizations, including the Department of Justice, Sick Kid's and Mount Sinai hospitals, and the Alzheimer's Society.

For organizations looking for CF resources for their employees, Compassion Fatigue Solutions offers either half or full day workshops, and caters to individual organizational needs. They also offer organizational health assessments. An annual conference is held where leaders in the CF field provide up-to-date information. Individuals also have access to resources on the Compassion Fatigue Solutions website, where virtual seminars and workbooks are made available for those whose organization is unaware of or unable to provide these resources to their employees.

The Accelerated Recovery Program

The Accelerated Recovery Program (ARP), is a five session intervention program designed to treat "professionals who are suffering the effects of Compassion Fatigue" (Gentry, Baranowsky, & Dunning, 1997). It was developed by The Green Cross Project, which was at that point under the direction of Charles Figley. The program is guided by the philosophy that CF robs a person of their professional sense of identity, and attempts to reclaim this within them. Some of the main objectives of the ARP are: first, to understand how CF emerges through an interaction of people, situations and events. Second, self-care discipline is developed, while also focusing on skills acquisition,

connecting with others, and resolving conflict. Third, resources are provided to the caregiver so that resiliency to CF can be maintained. Participants also learn negative arousal reduction techniques, containment skills, and boundary setting (Gentry, Baranowski, and Dunning, 1997). Other objectives are listed, but not explained with any depth, as it appears the program developers intend for the program to be discovered while they administer it.

The ARP was divided into five sessions, where each of the objectives listed above are addressed. It draws from a variety of therapies, such as cognitive behavioural therapy or narrative therapy, incorporating burnout and stress resiliency research (Gentry J. , Accelerated Recovery Program for Compassion Fatigue). This program appears to be designed to empower caregivers to discuss the stress they experience, and to assist individuals in developing their own self-care programs. The designers of the program noted that the symptoms of CF are similar to those experienced when afflicted by PTSD, and designed the program infusing elements of PTSD treatment programs (Gentry & Baranowsky, 2013, p. 3). The ARP soon evolved to become a program designed for mental health professionals, "to teach other health professionals to utilize the ARP in their practice" (Gentry & Baranowsky, 2013, p. 2). Testing the efficiency of their programs, the developers found that those who underwent training were able to alleviate CF symptoms, and be symptom free for years in some cases (2013, p.2).

ARP training is available online in Canada through the Traumatology Institute website for mental health professionals, who can then use the principles of the ARP in their own practice. (Traumatology Institute, 2015). The course is currently called Compassion Fatigue Specialist Training, and is available for a fee. Caregivers who are not traditional mental health therapists could also benefit by consulting a local mental health professional about how to implement the principles of the ARP into their own lives.

Compassion Fatigue Resiliency and Recovery Program

The Compassion Fatigue Resiliency Program (Potter, et al., 2013) bases itself upon the ARP, but is designed to educate the caregiver on how to take care of themselves on their own. This program attempts to alleviate symptoms associated with CF specifically, promoting "resiliency through self-regulation, intentionality, self-validation, connection, and self-care" (2013, p. 182). Self-regulation involves learning

proper relaxation, and developing the ability to actively reduce the impact of negative stimuli in the moment. Intentionality involves giving one's full effort while at work. Self-validation involves living in a way in which the acceptance of others is not a primary motivation, but living and working by one's own moral code. The program emphasizes connection in the workplace, ensuring strong social supports. Self-care involves all that has previously been discussed on the topic (Potter, et al., 2010).

In a small study of 14 oncology nurses, there was evidence that ProQOL and Maslach Burnout Inventory scores improved in the participants who completed the five-week program (Potter, et al., 2013). This is the one independent study that could be found that tests how good the program is at achieving its goals. The CFRRP is available online for about $30, and in-class training is available.

Mindfulness-Based Stress Reduction

Mindfulness-Based Stress Reduction, introduced by Kabat-Zinn (1990), could be a way to address CF, and may help to positively influence how the caregiver perceives their role. For example, one study assessed whether mindfulness, which involves living in the moment and accepting these moments in a nonjudgmental manner (Thieleman & Cacciatore, 2014, p. 35), and how it relates to CF and CS. Some believe that mindfulness can be learned, and that Western civilization could borrow from meditative practices seen most prominently in Buddhism. "Mindfulness is the central tenet of Buddhist meditation", (Turner, 2009, p. 96), and if an individual is able to incorporate mindfulness into their thinking, one can decrease mental and physical suffering (Thieleman & Cacciatore, 2014, p. 35). Mindfulness-based stress reduction therapies have been used to treat anxiety, depression, addiction, and other problems associated with the mind (2012, p. 64), and has shown to increase coping ability with vicarious trauma (Shapiro, Schwartz, & Bonner, 1998; Gilbert, 2005; Cacciatore & Flint, 2012, p. 68).

Consider the ATTEND model as an example of Mindfulness-Based Stress reduction therapy, which borrows from the teachings of Kabat-Zinn. It is a program which can be used to support clients and caregivers alike (Cacciatore & Flint, 2012). The ATTEND model is a 30-hour intensive training program (Thieleman & Cacciatore, 2014, p. 35). It was designed to help individuals cope specifically with bereavement (p. 65). ATTEND is an acronym to organize the six concepts on which the program

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focuses: (A)ttunement, (T)rust, (T)herapeutic touch, (E)galitarinism, (N)uance, and (D)eath education.

According to this model, the caregiver benefits from attuning themselves to clients (those near death or their family members), and developing a relationship of trust with them. Therapeutic touch is meant in the literal sense; touch has been thought to reduce stress and improve intimacy between caregiver and their client. A focus on egalitarianism urges the caregiver to remain humble in their interactions with clients experiencing loss, and to be comfortable with not having all the responses to their questions and concerns. Nuance involves paying attention to detail, and includes the suggestion that the caregiver be culturally competent. Finally, being educated and keeping clients educated about death is important. This program claims to improve the capacity of the caregiver in all of these areas (Cacciatore & Flint, 2012, pp. 65-67; Thieleman & Cacciatore, 2014, pp. 35-36).

Little evidence that mindfulness helps people cope with CF exists, beyond the lead researcher's self-evaluation (Thieleman & Cacciatore, 2014). However, the possibility that the ATTEND model as a mindfulness-based stress reduction strategy is effective in treating CF is encouraging. While the ATTEND model appears to be available only locally in the US, it was highlighted because information on the program was readily accessible, and targeted bereavement directly. Mindfulness-based stress reduction resources are available in Canada through the Mindfulness Institute. They offer an intensive 8-week program which will be held in Spring 2016 in Edmonton, Alberta. They also offer customized retreats.

Limitations of this Report

First, the limitations of this report should be acknowledged. This report was intended as a literature review of what CF is as well as the strategies of how to cope with them; therefore no original data was collected. Also, this literature review attempted to cover as much material as possible for a broad understanding of CF; the information on concepts such as CS and burnout, for example, are deserving of literature reviews on their own. Entire papers dedicate themselves to self-care strategies, or well-established programs meant to target CF. The point being made here is that this literature review should be treated as a brief summary of the information available, possibly serving as a portal to other resources.

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There are also some limitations of the CF literature in general that are worth discussing. A major limitation is the many definitions that exist for CF in the literature, and the sometimes confusing way it is differentiated from related terms, such as burnout or STS. Burnout and CF especially are often very closely related "and sometimes ambiguously defined" (Potter, et al., 2010, p. 57). As a result, being able to empirically identify CF has been difficult (Najjar, Davis, Beck-Coon, & Doebbeling, 2009, p. 274). While some clarity is required to separate these concepts, they are all terms that try to put into words what caregivers experience working with clients who are suffering (Gentry & Baranowsky, 2013). Furthermore, it is possible that these concepts are complex enough that many definitions could be correct; one definition does not always have to win out over the other.

Issues in studying CF, and whether or not CF is properly being detected in the workplace, should also to be taken into account. For example, one set of authors who found low risk for burnout but high risk for CF, reasoned that perhaps those who have burned out had quit their jobs (Conrad & Kellar-Guenther, 2006), and would likely be inaccessible to conventional sampling methods. Therefore, survey results of those currently working in an organization may not tell the entire story. Those who do not want to rely on survey data may turn to other more firm statistics, such as turnover rates, to conduct their inquiry. While Canadian data could not be found for this research, the US-based 2007 National Home and Hospice Care Survey revealed that, depending on one's role, three month turnover-rates were found to be occur in 10-15% of staff in a hospice setting (Luo, Lin, & Castle, 2012). But what does this figure say about CF, in particular? Deciding to leave a job could happen for a variety of reasons, of which CF may only play a partial role.

CONCLUSIONS

This report has attempted to help the reader better understand what CF is, relating it to other concepts that are often mentioned in the same discussion. It highlighted the study of CF as an important undertaking because of the consequences it has for caregivers and those close to them, patients, and entire organizations. It has reviewed research that looks at CF in hospice and palliative care specifically, identifying the unique challenges faced by this professional caregiver. It identified the ProQOL survey as the current prominent research tool for those looking to measure levels of CF within their own or others' organizations.

The main goal of this paper, however, was to understand CF in order to identify ways to help cope with the intrusive symptoms that CF brings on. It highlighted strategies of self-care which the caregiver could implement into their routine both inside and outside of work. It also offered ways in which workplace administration could get involved in reducing the effect of CF in the workplace, providing approaches that a manager could take to debrief with their employees and make their workplace a nurturing place. Should administration feel that assistance in helping their employees cope with CF is required, this report also introduced importable options which are designed to provide this relief.

CF is a treatable condition, but is not easy to detect without sufficient training and proper understanding of the phenomenon. Those who choose to provide care or services to those suffering deserve relief from the natural stress that accompanies their chosen profession, and hospice care professionals are part of this group. It is hoped that this report provides a starting point for professionals in hospice care to understand and help cope with the powerful effects of CF, on both the body and mind.

REFERENCES

Abendroth, M., & Flannery, J. (2006, November). Predicting the Risk of Compassion Fatigue. *Journal of Hospice and Palliative Nursing, 8*(6), pp. 346-356.

Adams, R. E., Figley, C. R., & Boscarino, J. A. (2008). The Compassion Fatigue Scale: Its Use With Social Workers Following Urban Disaster. *Research on Social Work Practice, 18*(3), pp. 238-250.

Alberta Hospice Palliative Care Association. (2015). *2016 Hospice Palliative Care Association Roadshow*. Retrieved from AHPCA.ca: http://ahpca.ca/2016-alberta-hospice-palliative-care-association-roadshow/

Alkema, K., Linton, J. M., & Davies, R. (2008). A Study of the Relationship Between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals. *Journal of Social Work in End-of-Life & Palliative Care, 4*(2), pp. 101-119.

Berzoff, J., & Kita, E. (2010). Compassion Fatigue and Countertransference: Two Different Concepts. *Clinical Social Work Journal, 38*, pp. 341-349.

Boyle, D. (2011, January 31). Countering Compassion Fatigue: A Requisite Nursing Agenda. *The Online Journal of Issues in Nursing, 16*(1).

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring Compassion Fatigue. *Clinical Social Work Journal, 35*, pp. 155-163.

Cacciatore, J., & Flint, M. (2012). ATTEND: Toward a Mindfulness-Based Bereavement Care Model. *Death Studies, 36*, pp. 61-82.

Compassion Fatigue Solutions. (2015). *About Compassion Fatigue Solutions*. Retrieved from Compassion Fatigue Solutions: https://compassionfatigue.ca/about/

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect, 30*, pp. 1071-1080.

Dyregrov, A. (1997). The Process in Psychological Debriefings. *Journal of Traumatic Stress, 10*(4), pp. 589-605.

Figley, C. R. (1978). *Stress disorders among Vietnam veterans: Theory, research, and treatment.* New York: Brunner/Mazel.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Figley, C. R. (2002). Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care. *Psychotherapy in Practice, 58*(11), pp. 1433-1441.

Figley, C. R., & Boscarino, J. A. (2012). The Traumatology of Life. *The Journal of Nervous and Mental Disease, 200*(12), pp. 1113-1120.

Gentry, J. (n.d.). *Accelerated Recovery Program for Compassion Fatigue.* Retrieved from Compassion Unlimited: http://www.compassionunlimited.com/pdf/PowerPointPresentation.pdf

Gentry, J. E., & Baranowsky, A. B. (2013). *Compassion Fatigue Resiliency - A New Attitude.* Retrieved from Traumatology Institute: http://psychink.com/ti2012/wp-content/uploads/2013/10/Compassion-Resiliency-A-New-Attitude.pdf

Gentry, J., Baranowsky, A., & Dunning, K. (1997, November 9). *Accelerated Recovery Program for Compassion Fatigue.* Retrieved from Traumatic Incident Reduction Association: http://www.tir.org/research_pub/research/compassion_fatigue.html

Gilbert, P. (2005). *Compassion: Conceptualization, research, and use in psychotherapy.* London: Routledge.

Hanna, D. R., & Romana, M. (2007, August). Debriefing after a crisis: What's the best way to resolve moral distress? Don't Suffer in Silence. *Nursing Management*, pp. 39-47.

Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010, September). Compassion Satisfaction, Burnout, and Compassion Fatigue Among Emergency Nurses Compared With Nurses in Other Selected Inpatient Specialties. *Journal of Emergency Nursing, 36*(5), pp. 420-427.

Hospice Palliative Care Ontario. (2015). *2015 HPCO Conference Highlights*. Retrieved from HPCO.ca: http://www.hpco.ca/conference/highlights/

Hunsaker, S., Chen, H.-C., Maughan, D., & Heaston, S. (2015). Factors That Influence the Development of Compassion Fatigue, Burnout, and Compassion Satisfaction

in Emergency Department Nurses. *Journal of Nursing Scholarship, 47*(2), pp. 186-194.

Jacobson, J. M. (2012). Risk of Compassion Fatigue and Burnout and Potential for Compassion Satisfaction Among Employee Assistance Professionals: Protecting the Workforce. *Traumatology, 18*(3), pp. 64-72.

Jacobson, J. M., Rothschild, A., Mirza, F., & Shapiro, M. (2013). Risk for Burnout and Compassion Fatigue and Potential for Compassion Satisfaction Among Clergy: Implications for Social Work and Religious Organizations. *Journal of Social Services Research, 39*, pp. 455-468.

Jenkins, S. R., & Baird, S. (2002). Secondary Traumatic Stress and Vicarious Trauma: A Validation Study. *Journal of Traumatic Stress, 15*(5), pp. 423-432.

Jenkins, S. R., & Baird, S. (2002). Secondary Traumatic Stress and Vicarious Trauma: A Validational Study. *Journal of Traumatic Stress, 15*(5), pp. 423-432.

Joinson, C. (1992). Coping with Compassion Fatigue. *Nursing, 92*, pp. 116-121.

Jones, S. H. (2005). A self-care plan for hospice workers. *American Journal of Hospice & Palliative Medicine, 22*(2), pp. 125-128.

Kabat-Zinn, J. (1990). *Mindfuless meditation for everyday life.* New York: Dell.

Keidel, G. C. (2002). Burnout and compassion fatigue among hospice caregivers. *American Journal of Hospice and Palliative Care, 19*(3), pp. 200-205.

Le Blanc, P. M., Hox, J. J., Schaufeli, W. B., Taris, T. W., & Peeters, M. C. (2007). Take Care! The Evaluation of a Team-Based Burnout Intervention Program for Oncology Care Providers. *Journal of Applied Psychology, 92*(1), pp. 213-227.

Leon, A. M., Altholz, J. A., & Dziegielewski, S. F. (1999). Compassion Fatigue: Considerations for Working with the Elderly. *Journal of Gerontological Social Work, 32*(1), pp. 43-62.

Lizano, E. L., & Barak, M. M. (2015). Job burnout and affective wellbeing: A longitudinal study of burnout and job satisfaction among public child welfare workers. *Children and Youth Services Review, 55*, pp. 18-28.

Luo, H., Lin, M., & Castle, N. G. (2012). The Correlates of Nursing Staff Turnover in Home and Hospice Agencies: 2007 National Home and Hospice Care Survey. *Research on Aging, 35*(4), pp. 375-392.

Luo, H., Lin, M., & Castle, N. G. (2012). The Correlates of Nursing Staff Turnover in Home and Hospice Agencies: 2007 National Home and Hospice Care Survey. *Research on Aging, 35*(4), pp. 375-392.

Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. Paine, *Job Stress and BUrnout* (pp. 29-40). Beverly Hills: Sage.

Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology, 7*, pp. 63-74.

Mathieu, F. (2008). *Low Impact Disclosure.* Retrieved from Compassion Fatigue Solutions: http://www.compassionfatigue.org/pages/LowImpactDisclosure.pdf

Mathieu, F. (2011). *Beyond Kale and Pedicures: Can We Beat Burnout and Compassion Fatigue.* Retrieved from Compassion Fatigue Solutions: https://compassionfatigue.ca/wp-content/uploads/2015/05/BEYOND-KALE-AND-PEDICURES-FINAL.pdf

Mathieu, F. (2013). *Low Impact Debriefing.* Retrieved from Compassion Fatigue Solutions: http://compassionfatigue.ca/wp-content/uploads/2008/10/Short-LID-article.pdf

Mathieu, F., & Cameron, R. (2013). *What is Compassion Fatigue?* Retrieved from Compassion Fatigue Solutions: https://compassionfatigue.ca/what-is-compassion-fatigue/

Melvin, C. S. (2012). Professional compassion fatigue: what is the true cost of nurses caring for the dying? *International Journal of Palliative Nursing, 18*(12), pp. 606-612.

Mitchell, J. T. (2009). *Critical Incident Stress Debriefing.* Retrieved from Info-Trauma: http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf

Morgan, W., & Morgan, S. (2005). Cultivating attention and empathy. In C. Germer, R. Siegel, & P. Fulton, *Mindfulness and psychotherapy* (pp. 73-90). New York: Guilford.

Najjar, N., Davis, L. W., Beck-Coon, K., & Doebbeling, C. C. (2009). Compassion Fatigue: A Review of the Research to Date and Relevance to Cancer-care Providers. *Journal of Health Psychology, 14*(2), pp. 267-277.

Owen, R. P. (2014). Compassion Fatigue in Military Healthcare Teams. *Archives of Psychiatric Nursing, 28*, pp. 2-9.

Payne, N. (2001). Occupational stressors and coping as determinants of burnout in female hospice nurses. *Journal of Advanced Nursing, 33*(3), pp. 396-405.

Pereira, S. M., Fonseca, A. M., & Carvalho, A. S. (2011). Burnout in palliative care: A systematic review. *Nursing Ethics, 18*(3), pp. 317-326.

Potter, P., Deshields, T., Berger, J. A., Clarke, M., Olsen, S., & Chen, L. (2013, March). Evaluation of a Compassion Fatigue Resiliency Program for Oncology Nurses. *Oncology Nursing Forum, 40*(2), pp. 180-187.

Potter, P., Deshields, T., Divanveigi, J., Berger, J., Cipriano, D., Norris, L., & Olsen, S. (2010). Compassion Fatigue and Burnout: Prevalence Among Oncology Nurses. *Clinical Journal of Oncology Nursing, 14*(5), pp. 56-62.

ProQOL.org. (2012, March 21). *A Note on Older Versions of the ProQOL.* Retrieved from ProQOL.org: http://www.proqol.org/ProQol_Test.html

Radey, M., & Figley, C. R. (2007). The Social Psychology of Compassion. *Clinical Social Work Journal, 35*, pp. 207-214.

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, pp. 54-61.

Sanchez, C., & Johnson, L. (2014). Hoop Dancing to Prevent and Decrease Burnout and Compassion Fatigue. *Journal of Emergency Nursing, 40*(4), pp. 394-395.

Shapiro, S., Schwartz, G., & Bonner, G. (1998). Effects of mindfulness stress reduction on medical and premedical students. *Journal of Behavioral Medicine, 21*, pp. 581-598.

Sherman, A. E., Edwards, D., Simonton, S., & Mehta, P. (2006). Caregiver stress and burnout in an oncology unit. *Palliative and Supportive Care, 4*, pp. 66-81.

Sherrod, J. A. (2005, October 21). The Effect of a Debriefing on Compassion Fatigue Levels in Public Health Nurses After Hurricanes Charley, Frances, Ivan, & Jeanne. *Florida State University*.

Slocum-Gori, S., Hemsworth, D., Chan, W. W., Carson, A., & Kazanjian, A. (2013). Understanding Compassion Satisfaction, Compassion Fatigue and Burnout: A survey of the hospice palliative care workforce. *Palliative Medicine, 27*(2), pp. 172-178.

Stamm, B. H. (2010). *The Concise ProQOL Manual, 2nd Ed.* Pocatello: ProQOL.org.

Thieleman, K., & Cacciatore, J. (2014). Witness to Suffering: Mindfulness and Compassion Fatigue among Traumatic Bereavement Volunteers and Professionals. *Social Work, 59*(1), pp. 34-41.

Traumatology Institute. (2015). *Compassion Fatigue Specialist Training*. Retrieved from Traumatology Institue: http://psychink.com/ticlearn/sample-page/compassion-fatigue-courses/compassion-fatigue-specialist-therapist-207/

Turner, K. (2009). Mindfulness: The Present Moment in Clinical Social Work. *Clinical Social Work Journal, 37*, pp. 95-103.

van Dierendpnck, D., Schaufeli, W. B., & Buunk, B. P. (1998). The Evaluation of an Individual Burnout Intervention Program: The Role of Inequity and Social Support. *Journal of Applied Psychology, 83*(3), pp. 392-407.

Walker, E., Morin, C., & Labrie, N. (2012, October 1). Supporting Staff at Risk for Compassion Fatigue. Region of Peel.

Yesil, A., Ergun, U., Amasyali, C., Er, F., Olgun, N. N., & Aker, A. T. (2010). Validity and reliability of the Turkish version of the professional quality of life scale. *Archives of Neuropsychiatry, 47*(2), p. 111.