How to Better Serve Our Clients by Practicing Self Care: Understanding Compassion Fatigue and Countertransference

Stephen Langley, CAC & Marie Lanier, LCSW
<table>
<thead>
<tr>
<th>Name</th>
<th>Commercial Interests</th>
<th>Relevant Financial Relationships: What Was Received</th>
<th>Relevant Financial Relationships: For What Role</th>
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<tbody>
<tr>
<td>Stephen Langley</td>
<td>None</td>
<td>Salary</td>
<td>Executive Director</td>
<td>None</td>
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<td>Marie Lanier</td>
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<td>Salary</td>
<td>Manager, Program Development</td>
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Overview

❖ Compassion Fatigue (CF) and Countertransference (CT)
  ▪ What’s the Difference?
  ▪ Why We Care

❖ Countertransference – Defined
  ▪ How to address and make it work for you, not against you
  ▪ Managing countertransference in your organization
  ▪ Scared Expectations of Therapeutic Work

❖ Compassion Fatigue – in depth
  ▪ Personal and Institutional Risk Factors
  ▪ Protective Factors and Compassion Satisfaction (CS)
Overview (cont.)

❖ How CF, CS, and CT interrelate
❖ Increasing Compassion Satisfaction
❖ Institutional and Personal Self Care Planning
## Definitions - Compassion Fatigue vs. Countertransference

<table>
<thead>
<tr>
<th>Compassion Fatigue</th>
<th>Countertransference</th>
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<tr>
<td>• Macro – not related to individual clients</td>
<td>• Micro – based on interactions between worker and client on an individual basis</td>
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<tr>
<td>• Is preventable</td>
<td>• Is intrinsic to the helping process</td>
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<tr>
<td>• Is treatable</td>
<td>• Can be used to improve treatment outcomes</td>
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<tr>
<td>• Hinders the treatment process</td>
<td>• Is triggered by what is unconscious in the client AND worker</td>
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<tr>
<td>• Can be triggered by working with traumatized, suffering clients</td>
<td>• Can be instantaneous in the first and only interaction with a client</td>
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<tr>
<td>• Develops over time</td>
<td>• Does not typically lead to exhaustion</td>
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<tr>
<td>• Almost always leads to exhaustion</td>
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### Compassion Fatigue and Countertransference

#### Why We Care

<table>
<thead>
<tr>
<th>Compassion Fatigue</th>
<th>Countertransference</th>
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<tbody>
<tr>
<td>• Higher turnover rates</td>
<td>• If not dealt with effectively, can lead to mistakes made in therapeutic process</td>
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<tr>
<td>• Higher rates of physical illness</td>
<td>• If used appropriately, will lead to improved treatment outcomes</td>
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<tr>
<td>• Increased use of sick time</td>
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<tr>
<td>• Lower morale</td>
<td></td>
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<tr>
<td>• Lower productivity</td>
<td></td>
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<tr>
<td>• Burnout</td>
<td></td>
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<tr>
<td>• Clients report lower satisfaction with services</td>
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<tr>
<td>• Financial Cost</td>
<td></td>
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<tr>
<td>• Client deaths</td>
<td></td>
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<tr>
<td>• Medication Errors</td>
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Countertransference (CT) – Definitions over time

Classical – Freud 1910
• “the therapist’s unconscious, conflict based reaction to the patient’s transference. Unresolved conflicts originating in the therapist’s childhood are triggered by the patient’s transference and are acted out by the therapist” (Gelso, Hayes, & Hummel, 2011 p. 88).

Totalistic – 1950s
• Countertransference = ALL emotional, behavioral and thought reactions to the client

Complementary – 1990s
• The client enacts certain “pulls” on the therapist which garners a certain reaction in society, but not by the therapist. Investigation into the “pulls” helps the therapist understand the client.

Relational – 1990s
• CT is constructed by both the therapist and the client based on both parties needs, values, and unresolved conflicts
Countertransference – In a nutshell

An internal reaction to data that exists in ourselves and the selves of those we treat

- History
- Memories
- Behaviors
- Thoughts
- Spoken word
Countertransference – Working Against Us

- Collusion or enabling
- “Good Client” vs. “Bad Client”
- Misdiagnosis
- Misinterpretation of meaning
- Under or Over involvement
- Forgetfulness
- Poor treatment decisions
- Confusion
- Incorrect Assumptions
- Working too hard or not hard enough
- Misperception of clients
- Inaccurately conceptualize cases
Countertransference
Making it work for you and your clients

1. Mindfulness – awareness of feelings, thought, reactions, impulses
   • Observer mind
   • Curiosity
   • Vigilance
   • Objectivity

2. Use what you observe and find out!
   • Is the “pull” you’re feeling typical of other interactions common to the client?

3. Self care
   • In and outside of work
Countertransference – In a nutshell (cont.)

Example:

“I was working with a client who is younger than my own children, experienced trauma and with special needs. Before I started working with the client, the client’s treatment team and I had an open discussion about countertransference. We identified where we would be most helpful acting in a modelling role (setting boundaries, accountability and structure) and how a parental role may hinder the client’s progress in treatment (infantilism, shaming, boundary blurring). . . I needed to be acutely aware of what I was saying to the client and how I was saying it in order to avoid acting like their parent. . . At the end of one session, the client stated “I love you” to me and wished me to have a safe evening. At that moment, the client was not aware of their behavior as it appeared a natural reaction. If I did not address the interaction, would I have been complicit in their own boundary blurring? If I acknowledged it, would the client understand my need to set the boundary and test the therapeutic relationship? At the next session, the client and I spoke about boundaries. We used this to process how they felt about being vulnerable and this allowed them to speak more about how they felt about their own parents. It allowed us to focus on what we needed to focus on.”
Managing Countertransference in Your Organization

Non-judgmental, curiosity-building, countertransference-savvy supervision

- CT is ESSENTIAL and INEVITABLE for meaningful change to occur – use it as a tool
- A way for unconscious items to be metabolized and processed, sometimes in a way that mere words will never express
- Explore pulls
- Understanding of worker’s unconscious motivations, impact of history
- Looking at how I shape you and how you shape me and how that impacts the trajectory of what happens next
Non-judgmental, curiosity–building, countertransference-savvy supervision

- Referral to therapy
  - When countertransference cannot be mediated by supervision
  - If CT reactions are affecting functioning
  - If CT reactions are negatively impacting therapeutic outcomes
  - If history of trauma has not been processed
  - If no history of therapy, ever
  - If current life events warrant additional support
Sacred Expectations of Therapeutic Work

✓ Empathic Engagement
✓ Compassion & Connection
✓ Reflective Listening
✓ Therapeutic use of self
✓ Therapeutic Alliance

“the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet”

(Remen, 1996 p.52).

“When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness . . . Listening, of this very special kind is one of the most potent forces for change”

(Rogers, 1995 p. 116).
Compassion Fatigue – What is it?

Psychic Exhaustion
• After serving traumatized, suffering individuals over time

Symptoms
• Lack of or reduction in ability to feel compassion and/or empathy
• Physical & Emotional exhaustion
• Nightmares
• Grief
• Anxiety
• Depression
• Sleep disturbance
• Physical Complaints
• Lateness or absenteeism
Compassion Fatigue – What it is not

Vicarious Traumatization & Secondary Traumatic Stress
- Can occur after working with trauma survivors and hearing about what occurred in their lives
- Symptoms
  - Mirror Post Traumatic Stress Disorder (PTSD)
  - Hyperarousal & Avoidance
  - Intrusive Thoughts
  - Changes in worker’s identity, values, worldview

Burnout
- Typically involving high case loads and unsupportive work environments
- Symptoms
  - Exhaustion
  - Hopelessness
  - Feeling ineffective at work
Compassion Fatigue – Personal Risk Factors

• Personal trauma history
• Working with trauma survivors
• Worker with trauma history working with trauma survivors
• Trainee/intern or less experienced
• Time spent working in the field of trauma counseling
• Younger age
• Working with children and/or in an inpatient setting
• Financial issues
• Poor health or other personal problems
Compassion Fatigue – Personal Risk Factors (cont.)

Coping style
- Task-focused vs. emotion-focused
- Self-criticism and giving up

Type of empathy
- Emotional reactivity/mimicry vs. understanding and perspective

Lack of personal efficacy

Burnout

Mismatch between expectation and reality of the job
Compassion Fatigue – Institutional Risk Factors

• High case load (especially with trauma survivors); high census; high acuity
• Mismatch between worker’s expectation and reality of the job
• Lack of autonomy
• Lack or recognition
• Isolation
• Unfairness
• Mismatch in values
• Rural location
• Inexperienced colleagues
• Working overtime
• Lack of leadership to help out in crisis situations
• Supervisor cynicism or incivility
Experiential Activity – Compassion Fatigue
Compassion Fatigue and Countertransference

When feeling burnt out, ineffective, anxious, depressed, tired
  • Decreased ability to be mindful, aware of inner and outer reactions
  • More likely to act out on “pulls”
  • More likely to miss opportunities to use CT effectively to create change
  • More likely to “tune out” and distance

Countertransference is more likely to be a liability than an opportunity as enactments produce the expected reaction, and client’s dysfunctional patterns emerge unaddressed in therapy
What can we do to help?!

Increase *compassion satisfaction*

- “Ability to receive satisfaction from caregiving” (Heaslip et al., 2013 p. 256)
- Work derived pleasure
- “Positive aspects of working in helping professions . . . Pleasure derived from helping, affection for colleagues, and a good feeling resulting from the ability to help and make a contribution” (Maddox & Turgoose, 2017 p. 172)
- “The potential for positive aspects of helping professions to develop” (Maddox & Turgoose, 2017 p. 179)
Increasing Compassion Satisfaction – For an Institution

Look at systemic, institutional triggers

- Case load – including make up of % trauma survivors, who is provided cases with higher acuity
- Survey workers – job fit, values, fairness, current level of CF & CS
  - Professional Quality of Life (ProQOL) (Stamm, 2005)
  - Area of Work Life Scale (AWS), (Leiter & Maslack, 2004)
  - Maslach Burnout Inventory (MBI), (Schaufeli et al. 1996)
- Autonomy
- Self care – what is the message?
- Availability of needed resources

Increase number of experienced workers

Institutionalized meditation practice
Increasing Compassion Satisfaction – For an Institution

Empowerment and increasing sense of efficacy
• Specialized training in trauma
• Trainings and utilization of evidenced based practices
• Recognition & Rewards
• Supervision
• Increase in session mindfulness – Components of Enhancing Clinician Engagement and Reducing Trauma Model (CE-CERT) (Miller & Sprang, 2017)

Increase opportunities for community
• Group supervision
• Social support – mentorship, accountability partner, organized activities
Increasing Compassion Satisfaction – For the worker

Self Care Plan
• Therapy
• Exercise

Advocacy
• Where do I lack power? At work? Personally?

Mindfulness & emotional awareness
• What do I need, how am I feeling

Supervision – more for trauma survivors, trauma workers, less experienced

Wellness
• Sleep
• Diet
• Social Support – personally and at work
# Work/Life Self-Care Worksheet

<table>
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<tr>
<th>WORK</th>
<th>LIFE</th>
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<tbody>
<tr>
<td>□  Supervision</td>
<td></td>
</tr>
<tr>
<td>□  I am honest/ bring up challenging cases</td>
<td></td>
</tr>
<tr>
<td>□  Countertransference is discussed</td>
<td></td>
</tr>
<tr>
<td>□  Time spent in supervision is adequate for my skill level, amount of current trauma cases, and time in the field</td>
<td></td>
</tr>
<tr>
<td>□  I feel respected by my supervisor</td>
<td></td>
</tr>
<tr>
<td>□  Match between job and expectations</td>
<td></td>
</tr>
<tr>
<td>□  I feel recognized and rewarded by my organization</td>
<td></td>
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<tr>
<td>□  I have autonomy at work</td>
<td></td>
</tr>
<tr>
<td>□  I have access to the resources I need</td>
<td></td>
</tr>
<tr>
<td>□  I have or am getting the training I need to feel effective in my work</td>
<td></td>
</tr>
<tr>
<td>□  I am taking advantage of opportunities for community and social support at work</td>
<td></td>
</tr>
<tr>
<td>□  I have mindfulness tools/practices that I use</td>
<td></td>
</tr>
<tr>
<td>□  When feeling overwhelmed or stressed, I have coping skills that are effective at work</td>
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For unchecked boxes above — what do I need to do or advocate for?

*My plan:*

| □  I engage in activities I enjoy |
| □  I take vacations/staycations regularly |
| □  I stay home when I am ill |
| □  My finances are not causing me stress |
| □  I spend time with friends and family |
| □  I get enough rest |
| □  I feel physically healthy |
| □  I feel mentally healthy |
| □  My personal life is not causing me stress |
| □  When feeling overwhelmed or stressed, I have coping skills that are effective |
| □  I have a personal meditation or other mindfulness practice |
| □  If needed, I am engaging in therapy |

For unchecked boxes above — what do I need to do or act on?

*My plan:*
Experiential Activity

- Self Care Worksheet
- Activity
In summary . . .

- Countertransference
- Compassion Fatigue
- Compassion Satisfaction
- Self Care
- What we can do – institutionally and personally
References


References (cont.)


