COMPASSION FATIGUE IN Katrina's

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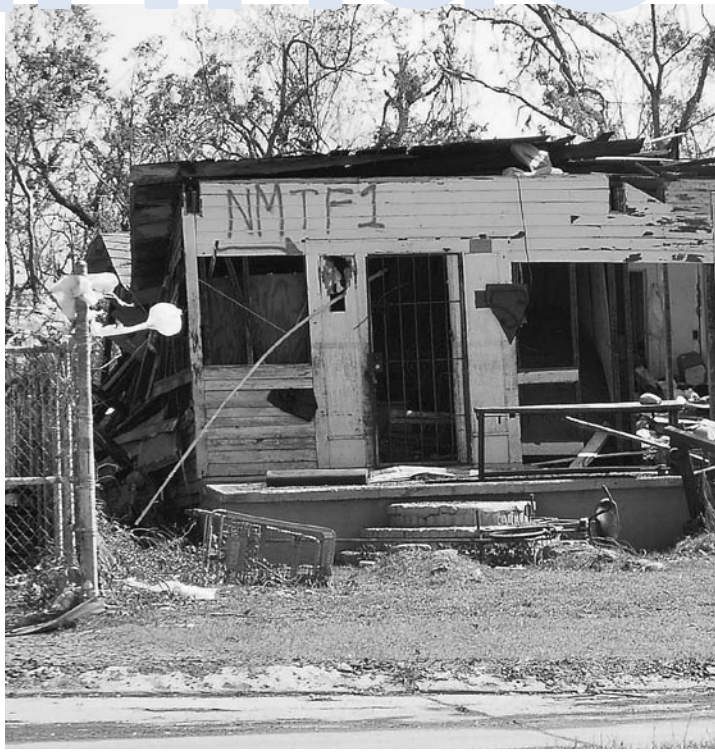

Shirley Colvin faces a familiar frustration. A suicidal patient has overdosed and needs inpatient psychiatric care. Colvin, a licensed clinical social worker at Ochsner Medical Center in New Orleans, spends hours trying to find a bed. The patient lingers in the emergency room for over 24 hours awaiting placement. A facility is finally found over five hours away, which means the patient's family can't be involved in her recovery.

Colvin knows that each day brings similar scenarios—overwhelming patient needs with few resources. Colvin describes the mood among her coworkers as "pervasive sadness. People are still so raw. It's like a scab, not a scar. Most of us are exhausted."

Hurricane Katrina brought compassion fatigue into the limelight as nothing else has before. Helping professionals by the thousands are affected by their work in the aftermath of Katrina. Many, like Colvin, are working in difficult settings with traumatized people in devastated communities.

My interest in compassion fatigue developed through my work with survivors in the Gulf Coast area following Katrina. I spent eight days in the Southern University shelter in Baton Rouge about a month after Katrina hit. I returned about five months after the storm to work with a SAMHSA team in the FEMA trailer communities for 10 days. I have provided workshops on compassion fatigue for Ochsner Medical Center and Volunteers Of America in New Orleans. During these trips I saw firsthand the tremendous demands placed on mental health workers. They deal with incredible needs and woefully limited resources. Many of them have suffered massive personal losses as well—their homes, loved ones, possessions, and neighborhoods.

Many of these workers do not realize how much they suffer along with their clients. They are not taking time to address their own stress and compassion fatigue, and only know they are exhausted and overwhelmed. They know they are in rough shape, but may not have a name for their symptoms, and they have no self-care plan to enable them to continue in their work for the long haul. Most work harder and longer than they did before Katrina and their caseload acuity has intensified dramatically.

They are overwhelmed, irritable, easily startled, and have sleep problems. They have intrusive thoughts and images and have a hard time separating their work lives and their personal lives. They note symptoms of depression, feel inadequate and ineffective, are

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withdrawing socially, and do not laugh as easily. Many have increased physical complaints, a lower sex drive, and emotional numbness. They encompass the majority of symptoms of compassion fatigue.

One comment on a workshop evaluation indicates both the level of distress and the lack of knowledge about its cause. "Wow," the person writes, "I had no idea what was going on with me. I am so glad to know I am not going crazy."

Colvin is still haunted by a mentally ill homeless patient she worked with. He was discharged to a homeless shelter and returned to the emergency room two days later. He had returned to his old neighborhood, trying to go back home. Not only was his house gone, his neighborhood was destroyed. He became disoriented and panicked, which led to a crisis and another emergency room visit. This was not the first time he had gone to his neighborhood with similar results. He is drawn to go back home, but home is no longer there. "I wonder what happened to him," Colvin shares. "I think about him a lot."

There are certain features of a disaster that increase the risk of trauma workers developing compassion fatigue. Katrina had every one of those features: life threatening danger or physical harm; exposure to gruesome death, bodily injury, dead or maimed bodies; extreme environmental or human destruction; loss of homes, valued possessions, neighborhoods or communities; loss of communication with or support from close relatives; intense emotional demands; extreme fatigue, weather exposure, hunger, or sleep deprivation; extended exposure to danger, loss, emotional or physical strain; and exposure to toxic contamination.

The secondary trauma that comes from working in a disaster area can be seen at the time of the crisis and during its immediate aftermath. Those who work in long-term follow up who may not have even been present for the initial traumatic event can also experience compassion fatigue.

At the time of Katrina, thousands of people went to the Gulf Coast to help with evacuations, medical care, shelter operations, victim recovery, animal rescue, mental health, law enforcement, and to provide many other critical tasks. Those early responders dealt with extreme conditions and horrible jobs. They were hot, sleep deprived, hungry, dirty, physically exhausted, and emotionally drained. Many were away from their own families, yet many were local people who helped in spite of their own losses. These folks saw massive destruction, dead bodies, and a ruined city. They were the first to hear the stories of terrified survivors, and they dealt with the raw emotions, despair, chaos, and horror of those early days.

Those experiences continue to have a harrowing impact on many of those who were in the initial wave of helpers.

There are some things that stick with you for a very long time—certain sights, sounds, smells, experiences, and people don't easily fade from memory.

It is easy to become preoccupied with the traumatized people you help. During my first trip, I got to know a woman in the shelter who became suicidal late one night. As we were outside talking, she walked out in front of traffic, and said she wanted to kill herself by jumping off a nearby bridge. She had been in jail when Katrina hit, and had some frightening experiences as the water rose and

the prisoners were still trapped in their cells. They were finally released into the water and escorted to a bridge where armed guards watched them. They had no food, drinking water, or bathroom access. When the prisoners feared they would drown on the bridge, they became agitated and shots were fired. She was terrified. In the shelter, when she became suicidal, we had to call law enforcement for assistance. When they appeared, she became completely panicked, clearly a result of her earlier trauma.

As I ended my time working in the shelter, I wondered about several of the people to whom I had become close. I was preoccupied with so many of them, and had a strong desire to know how they were doing, where they were living, and if they had found missing family members. Their stories of loss and trauma stuck with me after I returned home. I often thought of the woman I was with that night, and wished I could know how she was faring.

A curious thing happened months later when I returned to work in the FEMA trailer communities. I was working with a family and noticed a familiar looking woman sitting outside of a trailer. I approached her, and saw it was the woman from the shelter. She recognized me and jumped up so we could hug. What had felt unsettled and unfinished now felt somehow resolved and completed. What a gift it was to be able to reconnect with her and to continue to have contact with her.

Many of the people who are now working to help Katrina survivors were also there at the time of Katrina. Community mental health workers, clergy, law enforcement, health care providers, and social workers are some of those who are continuing on with follow up work. These long-term workers face some additional hardships that come along with doing this work over the long haul.

These long-term follow up workers develop relationships with survivors. They are exposed to the ongoing aftermath of this disaster and are trying to provide services in an area where there just aren't resources available. Every day when they read the newspaper or watch television, they hear more about Katrina. Everywhere they look they see evidence of Katrina; ruined neighborhoods, boarded up businesses, churches reduced to rubble, and a changed landscape. They face an increased crime rate, closed hospitals, and infrastructure still in need of repair. They have no clear timeframe on when things may return to normal, but expect it may be many years.

What can be done? The good news is that while this problem is huge in scope, there is a lot that can be done to bring relief.

Developing a self-care plan to address the symptoms of compassion fatigue is something that can be very helpful. Many workers I speak with look forward to an annual vacation to bring them some relief, but that is far too infrequent an event to bring any lasting relief.

I encourage people to list things they can do on a daily basis to help them feel refreshed, relaxed, and restored. When I mention this in a workshop, I am often surprised by how hard it is for those in the helping professions to do. So many helpers are unaccustomed to taking care of themselves that they have no regular practice of self-care. The list of self-care activities may include exercise, yoga, prayer, sleep, reading, writing, and listening to music. Some people list doing something creative, using medication as needed, getting counseling, doing something fun, laughing, and connecting with good friends.

Employers can help by offering clinical supervision, support groups, and resources for their employees who may be experiencing symptoms of compassion fatigue.

Meeting the needs of large numbers of workers can be a challenge for employers. Employers may have many employees who could benefit from information about compassion fatigue, but who don't get that valuable information for several reasons. Agency funds are tight, and workers are already taxed by their workload and don't feel they have time to tend to themselves. Our culture places great value on self-sufficiency and inde-

pendence, and admitting we need help is difficult for many of us.

One agency I worked with had such difficulty planning a workshop on compassion fatigue that my contact person finally apologized with just a trace of irony, "It has been hard to keep our heads above water."

Compassion fatigue is beginning to get more attention, like in this issue of *Family Therapy Magazine*. Many people still need to know about compassion fatigue, and this sort of exposure will provide much needed information. Knowing the symptoms and developing a self-care plan can reduce the effects of compassion fatigue for many in the helping professions.

Although her job remains stressful, Shirley Colvin is tackling her own symptoms of compassion fatigue. "I do yoga and get massages. I have started painting again and I am hard at work on Mardi Gras floats. Those creative outlets help a lot. Katrina changed our lives forever and it is still really hard to deal with. But we are finding joy and meaning again." ❍

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PROFESSIONAL RESOURCES

FIGLEY INSTITUTE, www.figleyinstitute.com
GIFT FROM WITHIN, www.giftfromwithin.org
GREEN CROSS, www.greencross.org
PROQOL (compassion fatigue self test), www.isu.edu/~bhstamm/TS.htm
SIDRAN, www.sidran.org
TRAUMATOLOGY ACADEMY, www.traumatologyacademy.org

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