Who Helps the Helper? How to Thrive, Not Just Survive

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Voice mail: (916) 715-5856
dmeelee@changecompanies.net www.changecompanies.net

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A. The Stress of Integration Implementation and a Changing Environment

1. Stresses for personnel, programs and team functioning

- treatment providers anger and frustration with the new vision of being welcoming, "every door is the right door", assessment within 24 hours, no more waiting list, high caseloads
- mental health agencies competing for funds with addiction treatment agencies
- clients dumped back and forth between fragmented systems
- lack of interdisciplinary cohesiveness in the treatment team
- staff morale and turnover problems

2. Issues in the clash between the addiction and mental health systems

- recovering counselors versus non-recovering clinicians
- abstinence mandated versus abstinence oriented
- care versus confrontation
- relapse – zero tolerance versus individualized treatment
- rehabilitation versus deinstitutionalization and community integration

3. Impact on Communication, Conflict Resolution and Coping

- The ideal of respectful, direct, collaborative and caring communication with clients, co-workers, other professionals, the community versus adversarial, discipline-specific and guild issue oriented turf battles

4. Productive versus counterproductive communication

(a) Going directly to a co-worker with whom there is an issue and explaining the issue clearly and respectfully. If the issue cannot be resolved, then the assistance of the supervisor is sought to facilitate communication and resolution. (Poor communication in this example might be talking about the conflict behind the co-worker's back in a derogatory manner; or gossiping about the person)

(b) When there is an issue between a supervisor and a supervisee that appears unresolvable to either person, it is the duty of the supervisor to suggest that a person higher in authority be consulted. (Poor communication in this example might be for the supervisor to realize the issue is unresolved, but offers no consultation with an objective third party; or for a supervisee to avoid expressing dissatisfaction with a proposed solution and then to hold in resentments and grudges; or for a supervisee to go "over the head" of a supervisee without first informing the supervisor of his or her plan)

(c) A staff person directs a complaint about a process or procedure to the person with the authority to address the complaint. (Poor communication in this example might be for the staff person to complain and spread negativity among co-workers without any constructive attempts to improve the process or procedure by working with others to find solutions.)

(d) Mutual respect and recognition of the increasing complexity of clients who now no longer fit into distinct mental health or addiction treatment "boxes" opens up dialog, cross-training and funding as recovering counselors and mental health therapists learn from each other; mental health administrators

collaborate and blend funding with alcohol and other drug service agencies; and clients no longer have to lie that they are suicidal in order to gain access to detoxification or addiction services. (Poor communication perpetuates the fragmentation, turf battles for funding, and stereotypical prejudices against psychiatrists and mental health who create or at least do not intervene with addiction and persist in prescribing mind-altering drugs.)

5. Boundaries and Ethics Problems

- Stressed teams sometimes cut corners or become demoralized; try to get their needs met with clients. With increased stress, it is easy to become lax about taking the correct action when presented with an unethical situation. Corrective actions include communication methods used to resolve the boundary and ethical concern.
- For example: When you observe a co-worker or supervisor acting unprofessionally your best choice of action is to: A) Ignore it, maybe he or she is having a bad day. B) Talk to your co-workers about it without confronting the individual yourself. C) Talk to your supervisor about it. D) Talk to the person directly, inquiring about the context for the situation before deciding to do anything else.

B. **Complex, Challenging Clients and Compassion Fatigue**

- Client populations served in era of cost-containment and increasing severity
- Managed care and its influence on treatment planning and service delivery
- Accountability and treatment outcomes - clinical skills and competency levels

1. Definitions

- "Compassion fatigue" is a term that refers to a gradual lessening of (compassion) over time. Compassion fatigue may occur when, due to the media saturation of stories and images of people who are suffering (e.g. images of starving children in Africa) people develop a resistance to these images. As the emotional impact of these messages lessens, their willingness to give reduces.

- In Charitable Giving: Compassion fatigue can be seen in the resistance of the general public to give money to a charitable organization; or other good causes due to overexposure. This is exacerbated by the increasing practice of charitable organizations requesting potential patrons bank details for ongoing monthly donations rather than one-time donations. "Overexposure" in this context refers to the repeated solicitation of donations or voluntary efforts from civilians by charitable agencies, often triggered by natural disasters, or disasters of a large scale.

- In Health Care Professions and Caregivers: Caregivers for dependent people can also experience compassion fatigue; this can become a cause of abusive behavior in caring professions. It results from the taxing nature of showing compassion for someone whose suffering is continuous and unresolvable. One may still care for the person as required by policy, however, the natural human desire to help them is no longer there.

- This phenomenon also occurs for professionals involved with long-term health care. It can also occur for loved ones who have institutionalized family members. These people may develop symptoms of clinical depression. Those who are primary care providers for patients with terminal illness are at a higher risk of developing these symptoms. In the medical profession, this is often described as "burnout". The more specific terms "secondary traumatic stress" and "vicarious trauma" are also used. Some professionals may be predisposed to compassion fatigue due to personal trauma.

- In academic literature: The more technical term "secondary traumatic stress disorder'" may be used. The term "compassion fatigue" is considered somewhat euphemistic. Compassion fatigue

also carries sociological connotations, especially when used to analyze the behavior of mass donations in response to the media response to disasters.

(Reference: http://en.wikipedia.org/w/index.php?title=Compassion_fatigue&action=edit)

- Compassion Fatigue is the latest in an evolving concept that is known in the field of Traumatology as "secondary traumatic stress." Most often this phenomenon is associated with the "cost of caring" (Figley, 1982) for others in emotional pain.
- There are a number of terms that describe this phenomenon. It has been described as secondary victimization (Figley, 1982), secondary traumatic stress (Figley, 1983, 1985, 1989; Stamm, 1995; 1997), vicarious traumatization (McCann and Pearlman, 1989; Pearlman & Saakvitne, 1995), and secondary survivor (Remer and Elliott, 1988a; 1988b).
- A similar concept, "emotional contagion," is defined as an affective process in which "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions" (Miller, Stiff & Ellis, 1988, p.254).
- Finally, some view difficulties with client problems as one of simple countertransference and has been discussed within the context of PTSD treatment (Danieli, 1988; Herman, 1992; Maroda, 1991; Wilson & Lindy, 1994). However, the concept is encased in an elaborate theoretical context that is difficult to measure and traumatic issues from all others in the client-therapist transactions.
- The American Psychiatric Association's diagnostic disorders manual (DSM IV (APA, 1994) notes that Post-traumatic Stress Disorder (PTSD) is only possible when one is traumatized either directly in harm's way; or indirectly, as a parent. Both may experience trauma, though different social pathways. The latter pathway is called Secondary Traumatic Stress (COMPASSION FATIGUE). There are few reports of the incidence and prevalence of this type of stress reactions. However, based on secondary data and theory analysis, Burnout, Countertransference, worker dissatisfaction, and other related concepts may have masked this common problem (Figley, 1995). Vicarious traumatization, for example, refers to a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material and vulnerable to the emotional and spiritual effects of vicarious traumatization. These effects are cumulative and permanent, and evident in both a therapist's professional and personal life (Pearlman & Saakvitne, 1995, p. 151).
- Compassion Fatigue is a more user friendly term for Secondary Traumatic Stress Disorder, which is nearly identical to PSTD, except it affects those emotionally affected by the trauma of another (usually a client or a family member).

(Reference: Figley, Charles R.: "Compassion Fatigue: An Introduction". Florida State University Traumatology Institute, http://mailer.fsu.edu/~cfigley/CFintro.html)

- There is a cost to caring.
- Professionals who listen to the stories of fear, pain and suffering of others may feel similar fear, pain and suffering because they care. Professionals especially vulnerable to Compassion Fatigue (CF) include emergency care workers, counselors, mental health professionals, medical professionals, clergy, advocate volunteers, and human service workers. If you ever feel as though you are losing your sense of self to the clients you serve, you may be suffering from CF.
- The concept of Compassion Fatigue emerged only in the last several years in the professional literature. It represents the cost of caring about and for traumatized people. Compassion Fatigue is the emotional residue of exposure to working with the suffering, particularly those suffering from the consequences of traumatic events. Professionals who work with people, particularly people who are suffering, must contend with not only the normal stress or dissatisfaction of work, but also with the emotional and personal feelings for the suffering.

- Compassion Fatigue is NOT "burnout".

- Burnout is associated with stress and hassles involved in your work; it is very cumulative, is relatively predictable and frequently a vacation or change of job helps a great deal.

- Compassion Fatigue is very different. Compassion Fatigue is a state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways including reexperiencing the traumatic event, avoidance/numbing of reminders of the event, and persistent arousal. Although similar to critical incident stress (being traumatized by something you actually experience or see), with CF you are absorbing the trauma through the eyes and ears of your clients. It can be thought of as secondary post-traumatic stress.

- There are human costs associated with CF. Job performance goes down, mistakes go up. Morale drops and personal relationships are affected- people's home lives start to deteriorate, personality deteriorates and eventually it can lead to overall decline in general health.

(Reference: http://www.ace-network.com/cfspotlight.htm#WhatIs CF)

2. History of Compassion Fatigue

- Some say references to "compassion fatigue" were first made subsequent to the 2004 Indian ocean earthquake, where commentators noted the apparent decrease in donations for other natural disasters. This also occurred during the 2005 hurricane season

(http://www.abcactionnews.com/stories/2005/09/050923fatigue.shtml).

- In fact the term was used in the early 1990s by news media in the United States to describe the public's lack of patience, or perhaps simply the editors' lack of patience, with "the homeless problem," which had previously been presented as an anomaly or even a "crisis" which had only existed for a short time and could presumably be solved somehow.

(http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=8546109)

(Reference: http://en.wikipedia.org/w/index.php?title=Compassion_fatigue&action=edit)

- The concept of Compassion Fatigue has been around only since 1992 when Joinson used the term in a nursing magazine. It fit the description of nurses working with hospital emergencies. That same year Jeffrey Kottler (1992), in his book, *Compassionate Therapy*, emphasize the importance of compassion in dealing with extremely difficult and resistant patients. However, neither adequately defines compassionate. Indeed, the term is not listed in the index of his book. It was mentioned only once in the final chapter on "Rules of Engagement." Both authors, however, note how and why practitioners lose their compassion as a result of their work with the suffering.

- The dictionary meaning of compassion is a "feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster, 1989, p. 229). Some would argue that it is wrong for a practitioner to have deep feelings of sympathy and sorrow for their client's suffering. And certainly practitioners must understand their limitations in helping alleviate the pain suffered by their clients.

- Yet, most systematic studies of the effectiveness of therapy point to the therapeutic alliance between client and clinician, the ability to empathize to understand and help clients (Figley & Nelson, 1989). If it is not present, it is highly unlikely that therapeutic change will take place. The most important ingredients in building a therapeutic alliance include the client liking and trusting her or his therapist. And these feelings are directly related to the degree to which the therapist utilizes and expresses empathy and compassion.

(http://mailer.fsu.edu/~cfigley/CFintro.html)

3. What Compassion Fatigue Looks Like

Compassion Fatigue is related to the cognitive schema of the therapist (social and interpersonal perceptions or morale). We can be traumatized by helping suffering people in harm's way as well as being in harm's way ourselves. Examples of Compassion Fatigue symptoms abound

Examples of Compassion Fatigue Burnout Symptoms

Cognitive	Emotional	Behavioral	Spiritual	Personal Relationships	Physical/ Somatic	Work Performance
Lowered concentration	Powerlessness	Impatient	Questioning the meaning of life	Withdrawal	Shock	Low morale
Decreased self-esteem	Anxiety and Guilt	Irritable	Loss of purpose	Decreased interest in intimacy or sex	Sweating	Low motivation
Apathy	Anger/rage	Withdrawn	Lack of self-satisfaction	Mistrust	Rapid heartbeat	Avoiding tasks
Rigidity	Survivor guilt	Moody	Pervasive hopelessness	Isolation from others	Breathing difficulties	Obsession about details
Disorientation	Shutdown	Regression	Anger at God	Over protection as a parent	Aches and pains	Apathy
Perfectionism	Numbness	Sleep disturbance	Questioning of prior religious beliefs	Projection of anger or blame	Dizziness	Negativity
Minimization	Fear	Nightmares	Loss of faith in a higher power	Intolerance	Increased number and intensity of medical maladies	Lack of appreciation
Preoccupation with trauma	Helplessness	Appetite changes	Greater skepticism about religion	Loneliness	Other somatic complaints	Detachment
Thoughts of self-harm or harm to others	Sadness	Hypervigilance		Increased interpersonal conflicts	Impaired immune system	Poor work comm.
	Depression	Elevated startle response				Staff conflicts
	Emotional roller coaster	Accident proneness				Absenteeism
	Depleted	Losing things				Exhaustion
	Overly sensitive					Irritability
						Withdrawal from colleagues

Source: Charles R. Figley, Ph.D., Florida State University Traumatology Institute, Tallahassee, Florida

C. **Changing the program mission and vision** – organizational culture

- **The Culture Iceberg Exercise** – Unwritten Rules/Norms and Beliefs/Assumptions
- Gather team members to re-visit the **Mission, Vision and Values** of the health care system involved in the upcoming or active change process

Addiction counselors may not be interested in working with those "crazy" psychiatric patients; and mental health clinicians may not be interested to in working with "those people - those out of control alcoholics and addicts". In fact that is part of the reason they chose the agency and field of work in the first place. Now they are suddenly expected to work with people with both problems (not that they weren't actually working with them anyway). The juices for working with co-occurring disorders don't automatically flow with administration's declaration of a new direction.

A good place to start in any system's change that requires team members to challenge their attitudes, perspectives and comfort zone of work competence is to meet together to understand the context for and collaborate in fashioning the new Mission. This provides the opportunity for all to take responsibility for re-committing to their job; or for deciding that they are not interested in, or committed to the new Mission.

A discussion of Values allows the team to develop principles before policies, procedures and personalities provoke the inevitable disagreements over what to do if a client shows up to treatment having used alcohol or some other drug on the way. Or what to do when a client refuses to take medication; or when a client wants to stop methamphetamine or heroin, but keep drinking alcohol or smoking marijuana? Discussing and naming the Values before the actual situation arises provides the anchor to guide the practice when things get tossed around.

- For example, suppose one Value was: Relapse in addiction and mental health are both addressed as crises in a person's treatment requiring evaluation of the crisis and revision of the service plan. Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person's substance use or mental health crisis.

- Discussion of all the issues in developing such a Value statement engages all team members in fruitful attitudinal and clinical practice implications

2. Develop specific implications for each Value that arises out of the discussion of the new Mission and Vision

Just about every agency and company has a Mission Statement that very few team members can even recall, let alone articulate and speak to the real implications of the Mission.

- See if you can repeat right now your agency's Mission Statement without looking it up.
- Or you have always thought of it as being so generically lofty, "motherhood and apple pie" and so broad as to be of little practical use in the dilemmas and pressures of daily life on the job.

One task that can help counteract this common phenomenon is to move beyond the Mission, Vision and Values to a comprehensive exploration and listing of all the implications for each Value. To continue with the example Value above that "Relapse in addiction and mental health are both addressed as crises in a person's treatment requiring evaluation of the crisis and revision of the service plan. Suspension or discharge from treatment and zero tolerance of relapse will not apply to either a person's substance use or mental health crisis."

What would be the implications of such a Value? The list could include:

- If a crisis of substance use, suicidal, violent or self-mutilation behavior, psychosis, mood instability etc. should occur, all clients will receive timely assessment to address any immediate needs; and to revise the treatment plan to improve the client's progress and outcome
- If a client's relapse triggers reactions in other clients, this provides the opportunity to assist both the relapsing client, as well as helping other clients learn from their reactions to the relapse and crisis.
- No client will be excluded from treatment due to the recurrence of symptoms of their addiction or mental illness. However, if a client deliberately undermines treatment by enticing others to use substances or by violating boundaries with violence or impulsive behavior, discharge is appropriate for the client who cannot be engaged in accountable treatment.

D. **Caring for the Helper and Others**

- Self care – "Love your neighbor as yourself" It is hard to care for others if you don't care for yourself. The professional in the human services field uses their humanity and their reactions and values and feelings just as a surgeon uses a scalpel or forceps or surgical thread to help people. Blunt, defective or faulty surgical equipment seriously affects the care, comfort and outcome of surgery.

- The quality of the clinician's self-care impacts the ability to communicate respectfully, directly, and with compassion; and to cope with stress. If one is feeling stressed, tired, off-balance, preoccupied and unsafely vulnerable, it is difficult to hear what others are saying without being defensive; and hard to say what you need without "second guessing" yourself or having the energy to assert yourself in an empowered manner.

- "Self care" encompasses taking personal responsibility for ones physical, mental, emotional and spiritual health. This allows the professional to achieve sufficient serenity, peace of mind and healthy detachment to be assertive without being aggressive; accepting while still expecting accountability; and an active team member and therapist without being argumentative or authoritarian.

❑ Assertive but not Aggressive – each member of the team has a responsibility to deal with any issue that interferes with his/her ability to be present therapeutically with clients and with the treatment team e.g., if a clinician disagrees with the way a co-worker is running group or treating a client to the extent that the disagreement is affecting how the clinician is treating the client or the co-worker, it is his/her right and responsibility to communicate that concern. To not do so is to create an environment of harbored feelings, opinions and attitudes that can compromise care for clients and care for self and each other. (What would you tell a client to do if they were unhappy with their roommate or peer in group?)

The concern is to be expressed in respectful, compassionate, non-aggressive and non-violent ways. But being assertive also means confidently offering new ideas, looking for ways to be creative and improve treatment, team functioning, communication, policies and procedures.

❑ Accepting but expect Accountability – accepting a person, whether client or team member, involves meeting the person "where they are at" and respecting their right to be who and what they are as a person. It does not mean, however, that there is no accountability for following through on agreements made in a participatory treatment plan or staff development plan. Acceptance with accountability enhances personal responsibility, empowerment and a therapeutic atmosphere of safety, healing and hope.

For example, if a client feels that a counselor will be accepting of anything they say, even that they might not want to be sober or emotionally well, it promotes client honesty to say what they really think, not what they think is the right thing to say in the program or group session. However, accountability empowers the client to test out their perspectives about controlled drinking or abstinence without attending AA or ability to decrease anxiety without practicing progressive relaxation. Healing and hope is advanced if clients and team members understand that there are solutions to be discovered, discussed and supported to be found; progress to be made without having to be perfect; and an atmosphere of growth, honesty and respect. Accountability reassures clients and team members that if something is going wrong, it will be addressed and not allowed to "blow up" into a crisis that may be too difficult or too late to resolve. Accountability promotes hope because it means we will be proactive while there is a chance to make changes, rather than reactive which feels more like watching someone "shoot themselves in the foot" and then saying "I told you so".

❑ Active team member but not Argumentative or Authoritarian – being "active" means willingness to resolve conflicts or raise concerns before they poison relationships (client, co-worker, community). But it is not just about problems and conflicts as expected as they will be. It also involves creativity, innovation, quality improvement, interest in outcomes and looking for solutions. Feeling "centered", confident and serene allows active involvement to be actualized without argumentativeness and authoritarianism. Taking care of self is not self-centeredness or selfishness. It is the foundation for compassion, empathy and the ability to listen and share with openness, directness and honesty.

E. **From the Files of Dear Sugar**

(Reference: Radhika Jones: "Woman of Letters: How *Wild* author Cheryl Strayed became the queen of advice" TIME Magazine June 25, 2012 pp 60-63.)

What would your advice be:

1. To a divorced man in a new relationship who asks when he should say "I love you".

2. To a man wondering if he should have children.

3. To a woman grieving for her stillborn daughter.

4. To a 22 year-old wondering what Sugar would tell her 20-something self.

F. **Finding Systems Solutions to Key Frustrations**

Goals:

- To translate any frustration experienced at work into a solution that both eliminates the condition which causes the frustration and contributes to the achievement of the agency's strategic objective and each associate's personal objectives
- To translate all frustrations with people into conditions in the business in order to find systems solutions
- To efficiently build systems solutions

A frustrating condition is a series of *specific* recurring events in the business over which you feel you have little or no control. It is an undesirable pattern of specific events that can be eliminated by the installation of a system.

1. Defining the Frustrating Condition -Three Types

(a) A technological frustration is where your concern is clearly and undeniably a matter of systematology. You are simply asking for information or a system to install in order to eliminate a particular condition. This is systemic thinking. For example:

- "I don't know what questions to ask in an interview"
- "I don't know what our census is at any given moment"
- "I don't know how to determine our cash position"
- "I don't know how to improve my crowded work space"

(b) A self-directed frustration is where what is bothering me most I consider being *myself* as the source of the frustration or problem at work. Where a technological frustration is a reflection of "I don't know how," a self-directed frustration reflects, "I can't," or "I won't." For example:

- "I find myself too accommodating to a staff member's request for schedule or job description changes in order not to lose a good staff member. But then it creates gaps and other complications for the program and me"
- "I find it hard to balance the importance of client needs with my needs."
- "I'm too nice when it comes to conflict or disciplinary measures, sometimes causing problems to continue, or wondering if people feel like they got away with something."
- "I allow myself to get distracted too easily when it comes to sticking to a schedule or getting my paperwork done. It's easy to find excuses and put work off."

When you see *yourself* as the problem, your focus is on *your* need to change rather than on the result in your business that you're assuming a change in you will produce. You make it impossible for yourself to ask the questions necessary to get the job done systemically as long as you are waiting to change. When you get yourself out of the way, you can begin to ask productive questions such as:

- "What would a change in job status or schedule change request process look like that would make it possible for me to accommodate requests as much as possible and so retain good staff?"
- "What kind of disciplinary or termination system would both give me what I need and be fair to my supervisees?"
- "What kind of time management or scheduling system would provide me with the least distractions and assist in getting my paperwork and other duties completed?"

Once you are able to ask the result-oriented questions that will focus your attention on changing the business instead of yourself, you will begin to identify options that your self-directed focus prevented you from considering.

(c) An outer-directed frustration is where what is bothering me most is something I largely hold someone else or something else as accountable for the undesirable condition at work i.e., ""he/she/they/it can't...."; or "he/she/they/it won't....". For example:

- "Joe makes my job hard because he doesn't follow procedures and I have to constantly check to see if he did what he was supposed to do. And, then, I don't get my job done."
- "She has a negative attitude and it infects others."
- "Other professionals have unrealistic expectations of what we do at our program."
- 'Due to boundaries, I don't have people with whom to check out my perception of reality.'
- 'Bill is always undermining the team by gossiping behind people's back"
- "The pool of counselors out there is so limited that we can't hire qualified people.'

A similar problem exists here. When you view someone or something outside as the cause of your frustration, there is the need to change something you cannot control. You cannot change people, time, the pool of counselors, the economy or when a person gets sick. You can only change those things you *do* have control over, namely your business. Thus while there certainly are outer-directed frustrations, it will not service your efforts to define problems or solutions in outer-directed terms. Success depends on the creation of a system designed to produce a specific result. Whenever your focus is on people, you are forever searching for extraordinary ones. When you focus on the system, you need only find people who are willing to help you build and use it.

In this context, the frustration with Joe above is not viewed as an employee problem, but rather a management problem, a technological problem requiring a technological solution.

- The question to be asked in finding a solution is not, "How can I get Joe to follow procedures?"

- but, "What's missing in the structure of our business that is permitting Joe to not follow procedures and create more work for me in checking up on him?".

Finding technological solutions to people problems will allow you to move forward and minimize frustrations. This involves redefining your people problems in technological terms and seeing them first as technological frustrations. To achieve this involves translating your self-directed or outer-directed frustrations into a specific condition in the business. Two points are important in this process:

- You can only change those things over which you have control – you only have control over your business; and changing the structure of your business is the only way to get what you want from it
- Determining what to change demands that you be willing to look *very specifically* at it is about your business that is not working – what it is about your *business* (not people) that has produced your original self- or other-directed frustration. Getting specific about the frustration will tell you *how* to eliminate it by moving the frustration from a thought or feeling to a condition in *the business* that you can do something about.

In many cases, you will find the self-directed or outer-directed frustration you identify is the expression of a generalized thought or feeling you are having about the business such as:

- "I don't have enough time to do the things I want to do."
- "My people aren't giving me what I need."

G. **Translating the Self- or Other-Directed Frustrating Condition**

1. In order to translate the self- or outer-directed frustrating condition into a frustrating condition in the business, these are the questions to ask:

- "How is my business specifically impacted by my frustration?". For example, an answer as regards the "Joe frustration" might be that Joe is not meeting his commitments on time.
- "What's an example of when this newly identified frustration occurs?". Or "What's an example of when Joe is not meeting his commitments on time?". He doesn't keep his paperwork up to date in a timely fashion.
- "What's the result I'm not getting in my business?". e.g., I am not getting treatment plan reviews on time.

Not getting treatment plan reviews on time is a frustrating condition in the business that you can deal with far more effectively than the original outer-directed frustration because:

- It can be eliminated by the installation of a system
- It is specific and when it is solved, it moves you closer to being able to get your work done and enhance the whole health of the agency/business

2. After you have identified the frustrating condition i.e., the specific, technological frustration, you want to quantify it wherever possible. This assists you in ultimately determining the most appropriate solution by giving you a clear understanding of the precise nature of the condition. This involves the following kinds of questions:

- "What percentage of the time does this frustrating condition occur?" For example, the answer in the "Joe" case might be 75% of the time.
- "How many times does this frustrating condition occur each (*day/week/month*) on the average?" The answer might be that Joe is four days late in turning in his treatment plan reviews each month
- "How many treatment plan reviews have been expected?" The answer might be nine are expected per month; and that Joe thus turns in six (75%) of his treatment plan reviews an average of four days late each month.

These questions can lead to the most appropriate solution such as, "If we can't eliminate every late treatment plan review, can we cut them down to 20% or two per month?" Or, "If Joe's late plans are as high as 75% late, are we making unrealistic demands on his time and duties?" Quantifying with "real" numbers is far more valuable than approximating. Approximations might simply serve to reinforce an inaccurate perception. Through actual quantification, you might discover a very different condition than you thought existed.

(The material above has been adapted from Gerber Business Development Corporation's Key Frustration Process. Michael Gerber, E-Myth Worldwide, 131B Stony Circle, Suite 2000, Santa Rosa, CA 95401 (707) 569-5600; (800) 221-0266; E-mail: info@e-myth.com; Web: www.e-myth.com)

H. **Surviving Integration as a Conscious Choice and Process**

- Develop your own primary aim or personal mission statement and values so you can know when you are "off track" in you personal mission and self-care. For example, my mission statement is:

  I am actively creating a unique forum using my talents of bridging the gap for people between disparate fields and concepts, in a very persuasive, challenging and inspiring manner; simultaneously influencing systems in a global way for the greater good, with rich personal satisfaction and financial reward.

  Mindfulness – awareness of body and feelings
  Spaciousness – expansiveness and open mind
  Seeing Through – not reactive
  Spiritual Nourishment – non-egocentric; gain nourishment from others' success
  Loving Presence – being there without resentment

Describe your primary aim or personal mission in two words e.g., Building Bridges. Does it match the mission of your agency in the area of communication and self-care?

I. **Key Supervision Issues and Solutions in a Change Environment**

1. Normalize conflict in the team. If there aren't disagreements, someone is wimping out and not advocating for their beliefs

It is highly unlikely that you can assemble a team of mental health and addiction treatment professionals, some of whom are in their own personal recovery, without there being conflict over when and what and if to use medication. Or on how to deal with substance use while in treatment. Or on whether to immediately detox a long time alcohol dependent, Klonopin user who believes it is absolutely necessary for his anxiety disorder. The problem isn't the fact of disagreements or conflict. The problem is if you don't have a functioning conflict resolution policy. Practice disagreeing without being disagreeable:

"Doctor, would you be willing to share with me your evaluation and history data you got, so I can understand the information I got from the client? I am concerned that the addictive sleeping medication you have prescribed clashes with my sense of the evaluation being that the client has a severe addiction illness. I want to be sure I am clear on our work together with this client."

If the physician responds that he or she was unaware that the patient was using substances to any great extent, let alone substance dependent, then your questions have provide more comprehensive information. The physician may indicate that indeed he or she is aware of the substance use problem, but is using the potentially addicting sleeping medication only during the initial detox. phase as an engagement strategy. You might be more comfortable leaving things alone and seeing what happens.

- Check if you have a conflict resolution policy
- Do you know where it is and what it says?
- Do all team members know how to use the policy?

Conflict Resolution Policy and Procedure

Policy Rationale:
Disagreements, differences of opinion, varying clinical perspectives on assessment and treatment, and interpersonal conflicts are inevitable among interdisciplinary team members. Because of different life experiences, training, theoretical orientations and familiarity with recovery, personnel can be expected to encounter clinical, administrative and team- functioning conflicts. If conflicts are not evident from time to time, it is likely that one or more members of the team is not speaking up assertively for what they believe in. They may not be advocating for their perspective, to the possible detriment of the people served, and also the health of the team.
Given all this, disagreements and conflict are normal. The following procedures will ensure safe and effective care for the people served, and promote healthy team functioning. Faithful adherence to these procedures is a performance expectation of all staff.

Procedure:
1. Each team member has the right and obligation to ask for clarification and discussion about any behavior, decision or treatment intervention that could compromise high quality care.

2. If the question arises as a result of an individual team member's behavior, decision or treatment intervention, then the discussion should occur at the lowest level possible, directly face-to-face.

3. If resolution is not achieved, either person has the right and obligation to seek consultation from a team member who is next higher in the organizational structure. However this is openly suggested and discussed together before calling in such a person. Sometimes such discussion finally resolves the conflict; while at other times, seeking such consultation will be necessary.

4. If resolution is not achieved even with this consultation and three-way discussion, each person has the right and obligation to seek consultation from a team member who is now next higher in the organizational structure. This again is openly discussed together before calling in such a person. This process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of a calling in a consultant outside of the organization, if necessary.

5. If there is a question or conflict about administrative, clinical, or other issues that affect the whole team or agency, then it is the person's right and obligation to bring the concern to group supervision or an equivalent team meeting.

6. The group supervision or team meeting addresses the concern in a timely fashion so as to maintain the healthy functioning of the team for the good of the people served. If the issue is unresolved, any team member has the right and obligation to openly suggest consultation from a person who is next higher n the organizational structure. As before, this process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of a calling in a consultant outside of the organization if necessary.

7. A team member may require supervision to assist in resolving conflicts at the lowest level possible. However, supervision is not a substitute for open discussion of the conflict between or amongst team members. Follow-through on these conflict resolution policies is a performance expectation, and will be included in areas monitored in employee evaluations.

2. Everybody has a territory, but nobody has a kingdom

Programs need the "gut", intuitive wisdom of the recovering staff members and their spiritual commitment to recovery. But they also need the objective skepticism of the mental health professional skilled in living with diagnostic ambiguity. It may be quite a while before further evaluation and time make it clear what the best course of treatment should be.

Integrated treatment needs programs that provide a "kingdom" of diverse services, levels of care, wet, damp and dry living supports, engagement and motivational services, medications, case management, mutual help groups, community resources and the list goes on. Each of our territories are critical, but only as they function in harmony with the whole.

- What is your territory?
- Can you advocate for it without competitiveness and ill will?
- How can all the territories in your region work together to create the kingdom co-occurring disorders deserve?

3. Individualized Staff Supervision Plan

(a) Work with team members to adhere to their own staff development plan as you would in engaging a client into collaborative and accountable treatment

When a client presents for services, what drives the treatment planning process should be an alliance around the goal, methods and means in the context of a strong therapeutic emotional bond. A parallel process should drive the development of an individualized staff development plan.

When a new Mission requires team members to re-commit to work in that agency, each team member can ponder the following steps. Supervisors and Change leaders can help facilitate that personal exploration in the context of a strong, supportive, safe work environment:

- *What do you want that makes you choose to work here, especially with the new Mission*? For example, being honest, do you just want a paycheck especially if you are close to retirement? Or are you getting ready to go to graduate school and want to be on the cutting edge of new directions? Or are you wanting a paycheck and not wanting to change what you are doing – in which case, your plan may be to transition out of the system if you are taking responsibility for your personal sanity and self-care

- *Where are you at as regards the new directions the Mission promotes? What is your attitude, stage of change, comfort and competence level?* For example, if you see no reason to change the Mission, your individualized staff development plan will require focus on consciousness-raising. What information do I need to convince me of the need for change, before I am ready to focus on actually expanding knowledge and skills? If you are eager to be on the cutting edge of new technologies and methods, your development plan might have you responsible to lead the team in a journal club; or planning the in-service training curriculum; or being the local change agent champion.

- *How best would you make the transition to new skills necessary to promote the new Mission?* Do you learn best by observation; trial and error; didactic presentations; individual supervision; group peer supervision; discussion of case examples; viewing videos; on the job coaching etc.? Your individualized plan would include the methods and means that will most likely produce timely, efficient and effective expansion of your knowledge and skills.

(b) Taking personal responsibility to prepare for supervision ahead of time

- Think first of what are your most challenging, frustrating clients or issues to resolve
- Decide on what is the *one* take-home knowledge, skill or application that you plan to actually do something about differently as a result of supervision. (You don't have to choose only one, but get at least one.)
- Break that one thing down into steps e.g., I will read a paper or book about this insight; or I will do my assessment of one client differently this next week based on what I learned.
- Don't try to change everything all at once, because the secret of success is to aim low.
- Make sure you do at least one of those steps this week, rather than file your notes for future more careful reading and application

(c) Continuity and accountability in supervision

1. Session Rating Scale – is the supervision a good fit for the supervisee; does the supervisee feel heard and understood?
2. Outcome Rating Scale – it performance improving; how is it measured?
3. Doing something different – changing clinical practice and supervision based on the results of ongoing, real time measurement of alliance and outcome

(d) Documenting supervision

- Equally as important as documenting client progress – increases continuity and accountability
- Documenting performance for staff improvement plans and disciplinary action when necessary
- Supervisor is assisting in work performance and is not the supervisee's therapist – EAP supervisory training

J. **Nonviolent Communication**

- Using Empathy to Defuse Danger – Empathize, rather than put your "but" in the face of an angry person *(P.96 Rosenberg, Marshall B (1999): "Nonviolent Communication – A Language of Compassion")*

  - When we listen for their feelings and needs, we no longer see people as monsters
  - Listen to what people are needing rather than what they are thinking about us
  - "Violence in any form is the tragic expression of our unmet needs" *(P.78)*

- Listening for Feelings and Needs – No matter what others say, only hear what they are:

  4. Observing
  5. Feeling
  6. Needing
  7. Requesting

(Center for Nonviolent Communication Website: www.cnvc.org; San Francisco Bay Area: www.baynvc.org)

(The Center for Nonviolent Communication, 2428 Foothill Boulevard, Suite E. La Crescenta, CA 91214 USA
Tel: (818) 957- 9393 Website: www.cnvc.org)

The Nonviolent Communication Model

(P.149 Rosenberg, Marshall B (1999): "Nonviolent Communication – A Language of Compassion")

Honestly *expressing how I am* without blaming or criticizing	Empathetically *receiving how you are* without hearing blame or criticism
1. The concrete actions I am *observing* (seeing, hearing, remembering, imagining) that are contributing to my well-being: *"When I (see, hear)….."*	1. The concrete actions you are *observing* (seeing, hearing, remembering, imagining) that are contributing (or not contributing) to your well-being: *"When you (see, hear)….."*
2. How I am *feeling* in relation to these actions: *"I feel…."*	2. How you are *feeling* in relation to these actions: *"do you feel…."*
3. The life energy in the form of *needs,* values, desires, expectations or thoughts that are creating my feelings: *"because I am (needing)….."*	3. The life energy in the form of *needs,* values, desires, expectations or thoughts that are creating your feelings: *"because you are (needing)….."*
Clearly *requesting* that which would enrich my life without demanding	Empathetically *requesting* that which would enrich your life without hearing any demand
4. The concrete actions I would like taken: *"and I would like you to….."*	4. The concrete actions you would like taken: *"and would you like me to……?"*

- In expressing appreciation be more specific than "Good job"

Marshall Rosenberg points out that expressing appreciation is more powerful and meaningful to the person you are recognizing if you use the same principles that work in nonviolent communication about conflicts. When you tune into a person's feelings and needs, you are more likely to empathize, really understand each other and resolve conflicts.

The same makes expressions of appreciation powerful.

So here is the parallel process if you want to show appreciation to a person that really communicates:

1. Observing means to state what you are seeing, hearing, experiencing that you appreciate

   Examples: (a) "When I saw how you worked with that angry client…."
   (b) "When I heard your in-service training…."
   (c) "When you understood and supported me in the staff meeting when everyone was criticizing me…."

2. Feeling means to state how you feel succinctly about that observation

   Examples: (a) "When I saw how you worked with that angry client, I was so impressed and grateful…."

(b) "When I heard your in-service training I felt inspired and excited…."
(c) "When you understood and supported me in the staff meeting when everyone was criticizing me, I felt so touched and reassured…."

3. Needing means to then state what human need(s) that was fulfilled by the situation

   Examples: (a) "When I saw how you worked with that angry client, I was so impressed and grateful because you met my need for competence, compassion and safety that your good work guaranteed."
   (b) "When I heard your in-service training I felt inspired and excited because I really needed relief and new ideas to cope with my frustration and burn-out."
   c) "When you spoke up and supported me in the staff meeting when everyone was criticizing me, I felt so touched and reassured because I need understanding and appreciation for how hard it is to manage such a tight budget"

This may all sound a bit stilted and formulaic and heart-felt expressions of appreciation will communicate no matter how you say it. And I'm not saying that every appreciation has to be a long drawn out deep and meaningful communication

There's nothing wrong with:

- "Nice work"
- "Great!"
- "Thanks a lot"
- "You rocked!"
- "Good job"
- "Really appreciate it"
- "You're the best"

But if you take the time to think first for yourself what feelings and needs were met by the person you are recognizing and share on that basis, it is so much more powerful if spoken or written in this way.

Ethical and Boundary Dilemmas

1. What do you do if a client brings you a gift?

2. If you make a home visit, what do you do if they offer you food?

3. Self help/mutual help groups – a client shows up at a meeting at which you are a member. What do you say to the client; and what about sponsorship, sharing, changing groups?

4. Photos of family or significant others in your office – OK or not; what is appropriate or not?

5. You find you have children who are in the same class as the child of your client – what do you do?

6. What are your guidelines about self-disclosure?

7. What is your practice and guidelines about hugs and touch with clients?

8. What is your practice about responding to calls, messages and interruptions while with a supervisee?

9. What are your guidelines about clothing & language e.g., style, footwear, jewelry; cursing; four letter words?

10. How do you handle transference and countertransference?

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External links

* [http://mailer.fsu.edu/~cfigley/CFintro.html Compassion Fatigue: An Introduction] by Charles R. Figley of the [[Florida State University Traumatology Institute]]
* [http://www.ace-network.com/cfspotlight.htm What is compassion fatigue?]
* [http://home.earthlink.net/~hopefull/TC_compassion_fatigue.htm A set of links to articles about compassion fatigue]
* [http://cmc-consulting.ca] for links to articles on compassion fatigue and information on training and workshops on the topics

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