

Lingering Shadows

BY JASON CONTANT

For Bruce Kruger, the difficulties began shortly after he was forced to shoot and kill an escaped convict who was about to fire a shot at his partner, a young rookie police officer. With a double-barrelled sawed-off shotgun pointed at him, the trapped officer was desperately trying to hide under the dash of his police cruiser when Kruger had to act.

Now a retired detective inspector with the Ontario Provincial Police (OPP), the Bracebridge, Ontario resident does not want to talk about that fatal shooting on June 28, 1977 — one of many serious incidents he responded to during his 30-year career on the force that affected him psychologically and contributed to the development of post-traumatic stress disorder (PTSD).





IMAGE: ILLUSTRATION SOURCE : PAUL SCHLENBURG

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“Slowly and in a very insidious way, I developed all the signs and symptoms of PTSD including severe depression, alcohol abuse, horrendous nightmares, relationship problems, night sweats and extreme anger,” Kruger wrote in his 2010 article *PTSD — The Loneliest Injury in Policing!*, posted on the website of Tema Conter Memorial Trust, a charitable organization in King City, Ontario.

“My mental state created severe difficulties for me. Imagine sitting in a house and going into extreme fear at the sight of a silhouette of a gunman entering the residence with a raised weapon — only to discover it was your eleven-year-old grandson carrying a hockey stick back from the rink.”

By the time he retired in 2000, Kruger had never spoken to anybody about his symptoms, which he says had become severe by then. He had thought that his situation would improve after he retired. “I was going to hide this and hopefully beat it on my own,” he adds.

For former paramedic Vince Savoia, the breaking point came after responding to the call of Tema Conter, who was brutally murdered on January 27, 1988 by a convicted serial killer placed in a halfway house near her midtown Toronto neighbourhood. “That call pretty well, looking back, psychologically broke me as an individual,” says Savoia, founder and director of the charity he started in Conter’s name.

Both Kruger and Savoia know first-hand the struggles associated with their own personal trauma. By contrast, relatively little is known about secondary traumatic stress or compassion fatigue, terms which have only appeared in literature since the mid-1990s.

Even experts in the field disagree on their distinct definitions and how the terms differ, although most describe them as similar to Venn diagrams with overlapping circles. “There is a need for all of us in the field to actually get together and agree on a working definition,” opines Françoise Mathieu, director of Compassion Fatigue Solutions in Kingston, Ontario and a mental health and crisis counsellor.

SHADES OF GREY

For Mathieu, compassion fatigue refers to the gradual but profound emotional and physical exhaustion experienced by some caregivers and professionals who help, assist or counsel people.

However, it is a common misunderstanding that this condition affects only medical professionals, says Patricia Smith,

founder of the Compassion Fatigue Awareness Project in the San Francisco Bay area of California. The list of affected occupations is wide-ranging and includes social workers, journalists, lawyers, nurses, doctors, teachers, dentists, funeral directors, chaplains, psychologists, family caregivers and child advocates.

Dr. Anna Baranowsky, executive director of the Traumatology Institute in Toronto, describes compassion fatigue as a “secondary wound.”

By way of example, Smith says she used to do animal welfare work and was asked to put together a shelter-wide compassion fatigue project, including a self-test. It turned out that many of the workers who were not dealing with animals on the front lines, such as the executive director, administrative assistant, public relations representative and special events officer, had higher levels of compassion fatigue than the euthanasia technicians tasked with putting down the animals. “You just have to be in a caregiving environment to be at risk for compassion fatigue,” Smith says.

A job that exposes a worker to people in need and requesting assistance that is sometimes beyond the means of the worker, creates a real challenge, Mathieu suggests. “What we see is this shift in our view of the world and our ability to feel compassion and empathy for others,” she notes, adding that this numbing effect spills into the workers’ personal lives.

RED FLAGS

The warning signs that a worker may be suffering from compassion fatigue vary widely from individual to individual, but are similar to symptoms of chronic stress and overload, Mathieu notes.

For instance, a worker may suffer from insomnia and physical ailments, such as gastrointestinal problems, recurrent colds, migraines and heartburn. They may also self-medicate, suffer from depression, and feel irritable or have problems concentrating.

“People talk about a real loss of innocence,” Mathieu relates, citing her personal experience of hearing about events in Rwanda and feeling alienated from her family. “You go home and you had a barbeque or something and people are talking about stuff and you’re thinking to yourself, ‘You have no idea what I just saw today.’ Your view of the world is permanently changed. Anyone who has worked with child abuse is never the same again.”

As the work scenarios faced by each individual are different, so too are the symptoms. Consider nurses, who could encounter critical incidents almost daily, notes Vicki McKenna, first vice-president of the Ontario Nurses’ Associ-

School of Hard Knocks

ation in Toronto. "What does that do to your psyche?" questions McKenna, who concedes that compassion fatigue is difficult to quantify.

"I know that's not very tangible, but you can see it and feel it in some units or areas or organizations when you start interacting with people that work there." The result is that some recent nursing graduates do not stay in the health care system very long due to the overwhelming demands, she contends.

Mathieu agrees the health care sector in particular is facing a real issue of retention, attrition and attracting new blood into the field. However, she notes that there has been an "explosion of openness" towards the topic of compassion fatigue in the last decade.

AGREE TO DISAGREE

Unlike PTSD, which is listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, there is currently no diagnostic criterion for compassion fatigue, Dr. Baranowsky notes.

She reports that a committee is looking at whether or not there should be diagnostic criterion for secondary traumatic stress types like compassion fatigue, as opposed to primary stress conditions, such as PTSD.

"It is a set of symptoms, it is not a disease," Smith says of compassion fatigue.

Dr. Baranowsky observes that there is a "latent vulnerability" in many of the caregivers. "In other words, they have had their own primary stress sometime in their past, something traumatic has impacted them and that latent vulnerability has made them more susceptible to these kinds of events in their career," she explains. "This is not the case in every single caregiver, but certainly we do see that as a pattern."

This often holds true for child welfare workers, notes Dr. Leslie Anne Ross, vice-president of the Leadership Center of the Children's Institute Inc. in Los Angeles, which offers programs and services for children traumatized by violence, among other things.

"These students, as they learn about how to do child trauma work, they also learn about the impact of vicarious trauma," a process in which a person is transformed by constantly listening to or responding to traumatic events. Dr. Ross says many of these students come into this field "because they have their own trauma history."

Although experts in the field generally agree that compassion fatigue, vicarious trauma and secondary traumatic stress are interwoven, there is disagreement on the exact distinction between the terms. In fact, there is even debate

Patricia Smith, the founder of the Compassion Fatigue Awareness Project in the San Francisco Bay area of California, believes in "post-traumatic growth." The term refers to positive psychological change

experienced as a result of struggling with highly challenging life circumstances. It also means that developing self-knowledge and insight, a sense of hope, healthy coping skills, strong relationships and personal perspective, can help build resilience and return a person to a healthy, functioning level.

"I don't suffer from that traumatic experience in talking

to others about their experiences, because I know that what I am providing is making a difference," says Smith, who cites the following tips for building resilience:

- explore personal motivations for working with trauma victims and identify personal strengths and challenges;
- change or expand job descriptions;
- learn to identify physical stress reactions and develop relaxation techniques; and,
- use technology and resources wisely, keeping to essentials and refraining from engaging in unnecessary phone or text messages).

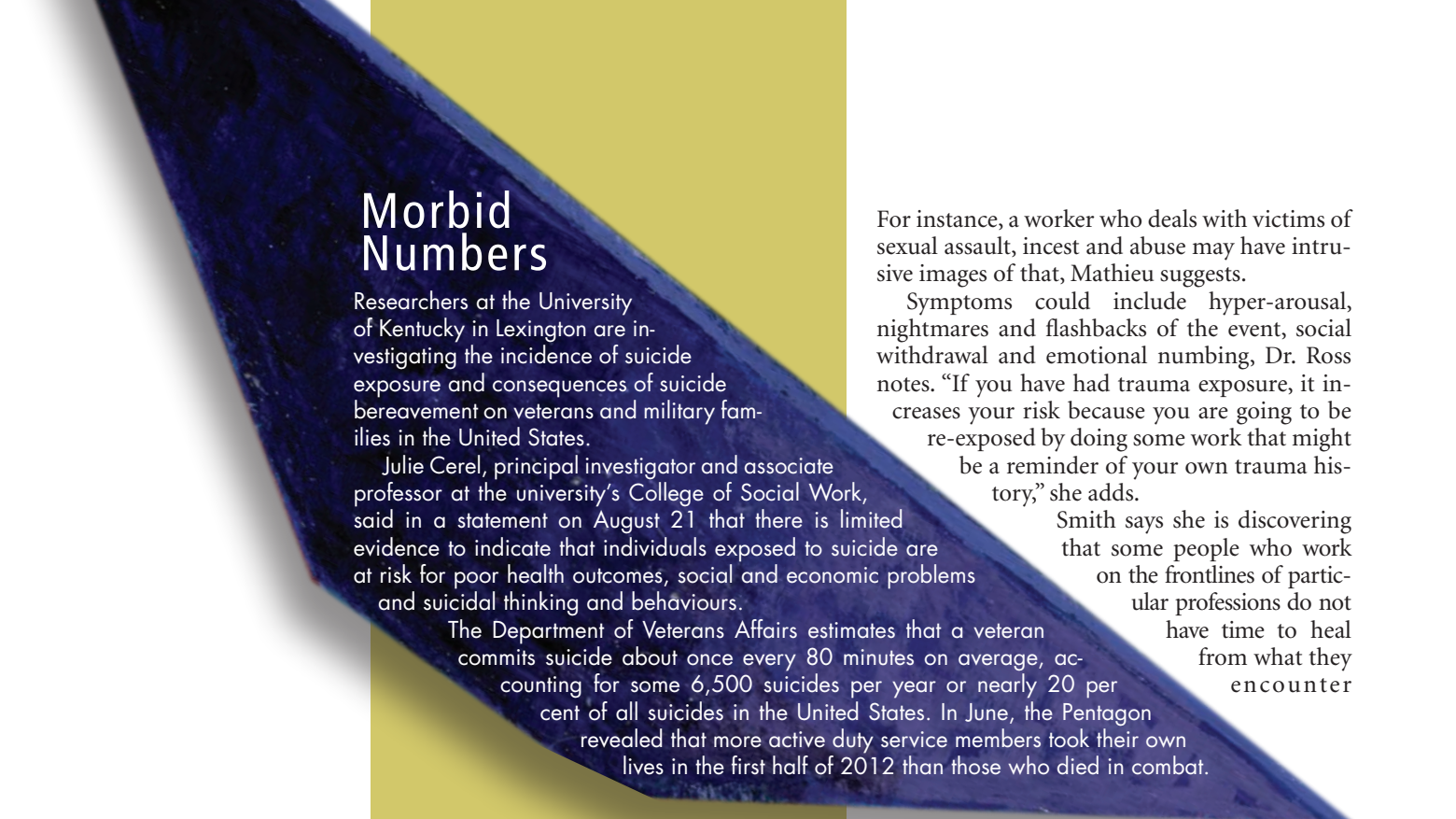
on whether or not a person can work in a caregiving environment without being impacted by it or developing some form of vicarious trauma.

"People who are truly caring individuals cannot do this work day in and day out and not be profoundly affected by it," Mathieu argues, although he notes that compassion fatigue can be caught early and addressed. "Some people are more resilient than others and have more tools, but the idea that we can eradicate compassion fatigue, I think, is crazy," he says. "It is a normal consequence of doing a good job."

Dr. Ross is of the mind that a compassionate and empathetic person can be emotionally affected by the work without necessarily being adversely impaired by it.

And not everybody is affected in the same way. For Savoia, it all boils down to a worker's perception of the job and the types of critical incidents they respond to. "I have known many doctors and nurses and paramedics and firefighters who have had very successful careers and not experienced PTSD or vicarious trauma," he offers.

Savoia estimates the prevalence of PTSD in



Morbid Numbers

Researchers at the University of Kentucky in Lexington are investigating the incidence of suicide exposure and consequences of suicide bereavement on veterans and military families in the United States.

Julie Cerel, principal investigator and associate professor at the university's College of Social Work, said in a statement on August 21 that there is limited evidence to indicate that individuals exposed to suicide are at risk for poor health outcomes, social and economic problems and suicidal thinking and behaviours.

The Department of Veterans Affairs estimates that a veteran commits suicide about once every 80 minutes on average, accounting for some 6,500 suicides per year or nearly 20 per cent of all suicides in the United States. In June, the Pentagon revealed that more active duty service members took their own lives in the first half of 2012 than those who died in combat.

For instance, a worker who deals with victims of sexual assault, incest and abuse may have intrusive images of that, Mathieu suggests.

Symptoms could include hyper-arousal, nightmares and flashbacks of the event, social withdrawal and emotional numbing, Dr. Ross notes. "If you have had trauma exposure, it increases your risk because you are going to be re-exposed by doing some work that might be a reminder of your own trauma history," she adds.

Smith says she is discovering that some people who work on the frontlines of particular professions do not have time to heal from what they encounter

the general population is about eight per cent, although research indicates that this percentage is two to three times higher — somewhere between 16 and 24 per cent — for workers in Canada's emergency services sector.

Others, like himself, have a tendency to personalize incidents and may be adversely affected, he says, citing the Tema Conter call he attended more than two decades ago. "My partner is still on the job and he is enjoying every day of it. Same call, two different people, two different reactions," Savoia observes. "I'm not saying he doesn't care; he knows how to compartmentalize his job and personal life and he does that very effectively."

CHIPPING AWAY

To better understand the difference between compassion fatigue and secondary trauma, Mathieu cites a caregiver for someone at a very advanced stage of Parkinson's disease. The caregiver is depleted and has grown tired and impatient — in other words, demonstrating classic signs of compassion fatigue.

On the other hand, a hearing officer at the Parole Board of Canada whose job is to read files before a hearing may not necessarily have compassion fatigue, but could have trauma from "repeatedly being exposed to stories and photos of abuse. But a nurse working at a long-term care facility, she may not have secondary trauma at all," Mathieu illustrates.

The symptoms of secondary traumatic stress can overlap with those of compassion fatigue, but there can be some common distinctions.

on a daily basis. Consider a coroner, who not only witnesses death, but must also review files and images of a variety of fatalities. "Can you imagine every day looking at pictures from a coroner's office of a traumatic death, such as a shooting or a gang-related thing?" Smith asks. "You never heal from that."

GETTING PERSONAL

Sometimes, professionals can also encounter a work scenario where the victim reminds them of someone they intimately know, such as an emergency room nurse caring for a severely injured child reminiscent of the caregiver's own flesh and blood. Dr. Baranowsky says that type of secondary wound can be very traumatizing to the worker.

Wayne Chacun, a paramedic who responds to incidents in Virden, Manitoba, knows all about providing treatment to people he personally knows in the town of about 3,000 people. Chacun, who is also a member of the Manitoba Government and General Employees' Union, says staying detached to some degree has helped him deal with the stresses of his job. "You go to work on somebody and they may not survive, but you see their family members all the time or you may have known them, they may be your neighbour," he says.

Chacun used to be part of a critical incident stress debriefing team, but he says he "went off that because one of the things I found was when I went and heard how they felt on calls all the time, it started to negatively impact me."

What has helped, Chacun says, is being able

to access a psychologist through his employee assistance plan. "There is always this stereotype of showing weakness and not wanting people to think you are not able to handle the job, when in actuality, this is one of the ways to handle the job and help you deal with it and stay in the career longer," he argues.

COPING MEASURES

With regards to compassion fatigue, Dr. Baranowsky says there is something about it that is "softer" than diagnosing an individual with PTSD. "We want to always give the professional their sense of empowerment and not take that away, give them the sense that they are always in a position where they can make sense of his, make good sense of the work they do because we don't really want to lose these very valuable people in our field," she says.

Fortunately, there are various coping strategies and organizational changes that can be implemented to help minimize the effects of secondary traumatic stress or compassion fatigue.

For compassion fatigue particularly, Mathieu says working part-time, job sharing or combining two jobs so that a person is not doing frontline work all the time can help. Giving staff flexibility over their schedule, such as allowing them to choose shifts or stop in the middle of a work day to drop off a child before coming back to work can also benefit.

Social support, regardless of whether that is offered through an employee assistance plan, colleagues or family members and friends, is key. Mathieu acknowledges that compassion fatigue does affect morale, which can result in co-workers turning on each other. "That creates a toxic work environment," she cautions, noting the irony of social support in this context. "How can you support each other if you are all back-biting each other all the time?"

For secondary trauma, Dr. Ross recommends that employees who may be at risk conduct a self-assessment and keep a look out for training opportunities. They should also consult someone who is trained in the field of secondary trauma to identify risk factors, symptoms and triggers to help establish an individual strategy.

Savoia adds that workers can also adopt preventive coping strategies — such as ensuring that they remain physically and psychologically healthy, eating the right foods, learning about signs and symptoms — before that bad call comes their way.

"A lot of the emergency service responders react to this as a reaction to an event as opposed to pre-planning for it," Savoia says. He advises that workers should try to do some physical activity within 24 hours of an incident to help

burn off the extra adrenaline in their system.

Other strategies include avoiding alcohol and drugs, including stimulants like caffeine; having access to a timely and thorough debriefing when there has been a critical event; praying, meditating or yoga; getting back into a normal routine; and considering the option of using prescribed medications to aid sleep if experiencing symptoms, such as flashbacks.

BABY STEPS

For Kruger, things have come a long way since he shot and killed the escapee in 1977. At that time, "my counselling consisted of a supervisor telling me not to brag about it," he recounts.

Progress, however, has been painstakingly slow. By 1984, the OPP had started a peer support program for stress. Kruger recalls contacting a peer counsellor, but was warned that the process was not confidential.

"I didn't want to be humiliated, embarrassed, I didn't want to lose my opportunities at promotion, I didn't want to be stigmatized with a mental illness," he says. It was only a few years ago that Kruger received treatment at the Homewood Health Centre, a well-known treatment facility in Guelph, Ontario.

Mathieu points out that when she became interested in the issue of compassion fatigue 12 years ago, there were only three books and one workshop on the topic. In the last decade, more and more people have become receptive to the condition, although she concedes that in law enforcement, "we are just barely started."

That slow progress is now being addressed by the Ontario ombudsman. In March of 2011, the ombudsman reported that an investigation will be conducted into the OPP's handling of operational stress after Kruger filed a complaint with the support of 29 officers. The ombudsman's report was expected to be released in mid-October.

"We have got to bring this out of the closet and into the open, and that is why I insisted I go ahead with this complaint," Kruger says. "They have ignored the total devastation this is doing to so many officers and many officers have committed suicide due to PTSD," he charges.

The release of the ombudsman's report has gotten the ball rolling for PTSD compensation, but what will happen with compassion fatigue and secondary traumatic stress remains to be seen, as both have only just appeared as a blip on the radar. **•HS**

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"He knows how to compartmentalize his job and personal life."