November 10, 2017 • Volume 39, Number 21

oncology-times.com

ONCOLOGY TIMES

Independent News on HEMATOLOGY / ONCOLOGY

# Don't Allow Compassion Fatigue to Force a Professional Crash & Burn

BY VALERIE NEFF NEWITT

Every flight attendant says it: "When the oxygen mask drops down, secure your mask first before assisting others." Oncologists are always "in flight," under tremendous pressure at a high clinical altitude. They serve as both pilot and attendant for their patients, answering medical mayday calls while helping patients grapple with life-and-death stress. But medical professionals do not always heed the safety warning of securing their own emotional stability first. And without that professional "oxygen" they can—and do—hit the turbulence of compassion fatigue.

CME Article

Charles Figley, PhD, the Paul Henry Kurzweg MD Professor and Distinguished Chair in Disaster Mental Health at Tulane University and School of Social Work, New Orleans, helped coin the term he has

Continued on page 6

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# Young Cancer Survivors Lag Behind Healthy Counterparts in HPV Vaccination

BY MICHELLE PERRON

Survivors of childhood cancer—who already face a greater risk for HPV infection than their counterparts unaffected by cancer—are lagging behind the U.S. population in HPV vaccination uptake, a recent study found. Despite their increased vulnerability to HPV-related morbidity (*PLoS One* 2013; 8:e70349), only a small proportion of young cancer survivors are receiving this recommended vaccine (*J Clin Oncol* 2017: doi:10.1200/JCO.2017.74.184).

This research found that HPV vaccination rates among young cancer survivors are low, and that lack of provider recommendation and perceived barriers to vaccine receipt appear to be responsible.

"We know that HPV vaccine uptake was suboptimal in the general population, but there were no comprehensive

Continued on page 10

# First-Line Treatment Options for CLL

BY WILLIAM G. WIERDA, MD, PHD

Treatments for chronic lymphocytic leukemia (CLL) have experienced significant progress over the past 3-5 years. Survival is markedly improving with new small molecule inhibitors, especially for high-risk patients, such as del(17p) CLL. Standards of care are rapidly evolving with expanding options, and forthcoming results of several phase III trials will amplify this. Having numerous treatment options could make first-line and salvage management of CLL very challenging for the general oncologist.

First treatment is the best opportunity to use the most effective agents to achieve the deepest and most durable remission. This holds for chemoimmunotherapy (CIT)-based treatments and oral small molecule inhibitors of the B-cell receptor signaling pathway, such as the Bruton's tyrosine kinase inhibitor ibrutinib. High-risk cytogenetic abnormalities like del(17p) and complex karyotype are less common in untreated patients and emerge as a more common occurrence among patients with relapsing disease. Reasonable and effective salvage options must also be available, since none of the standard treatments is curative.

The median age at diagnosis is 72, and most patients don't need treatment until years after diagnosis, so age is a significant consideration in selecting first-line therapy. Older patients don't tolerate myelosuppressive or immunosuppressive CIT well; have increased risk for ibrutinib-associated toxicities; and have geographic, financial, and access limitations.

There are few absolutes regarding first-line therapy, but one applies to

Continued on page 17



PERIODICALS

# Don't Allow Compassion Fatigue to Force a Professional Crash & Burn

*continued from page 1*

described as a state experienced by those helping people in distress. It refers to such an extreme state of tension and preoccupation with the suffering of those being helped that it is traumatizing for the provider/helper. Enveloped in their own efforts to empathize and be compassionate, providers often fall victim to poor self-care and extreme self-sacrifice. The cumulative effect of all of this can be compassion fatigue and symptoms similar to post-traumatic stress disorder (PTSD).

Figley first identified compassion fatigue as a unique affliction when he was studying practitioners working with combat veterans in the early 1980s. Being a Vietnam veteran himself, he started a Society for Traumatic Stress Studies in 1985, comprised of more than 300 practitioners and researchers focusing on trauma, including clinicians who worked with veterans.

"We were a fairly unusual group," he told *Oncology Times*. "As of the third or fourth year, I recognized that a number of members were dropping out of the society, though the overall numbers continued to grow. When I approached these professionals who dropped out, most said it was from 'burnout.' But I'd known people who had gotten burned out, and this seemed different. Rather, these individuals were talking about triggers from their interactions with patients. The triggers were painful and they found themselves avoiding those patients. This was not burnout."

Figley said he tried to identify the active ingredients of this unique condition. "I would hear clinicians say, 'I find myself numbing out, because I can't do anything to help these patients. I feel so helpless. I feel I am failing them.' In other words, it wasn't a single traumatic event and all of a sudden they had PTSD," he explained. "Rather, it was this growing, ongoing sense of responsibility for their patients' lives that affected them. They explained it just wasn't worth it to them to keep going, because they simply couldn't calm down after they talked to these particular patients."

It's an easy leap to apply this understanding to oncologists, oncology nurses, and others working in the cancer-directed medicine, said Figley. "Oncology is one of the more challenging areas of medicine because death is all around—it is inherent in the field. Providers are expected to buck up and get hardened somehow. By comparison, if you are someone who works outside in the cold and your hands get chapped and your skin gets broken, you eventually come inside. You heal. But it's not like that for providers—particularly those who are especially compassionate and empathic. They can't just come in from the cold and heal. They peer into their patients' eyes every day and see looks of desperation. They listen to their fears. They notice their hearts racing. They hear their labored breathing. They take it all in. Providers want to be heroes for their patients, but they have human limitations. They don't always have control of their patients' lives. They need to realize that is OK."

## A Personal Recollection

Sean Fischer, MD, is a Medical Oncologist at Providence Saint John's Health Center in Santa Monica, Calif. He remembers his own struggle with the secondary trauma he experienced after several years of private practice. "The hardest part, for me personally, was the feeling of personal disappointment and guilt when patients for whom I was directly responsible died from their cancers. These were people with families I got to know intimately—I became a central part of their lives. The constant cycle of loss started to lead to many hallmark symptoms." Fischer said emotional, mental, and physical exhaustion; reduced sense of personal accomplishment or meaning in work; isolation and decreased interactions with others; and a disconnection of symptoms from real causes were all recognizable aspects of compassion fatigue.

He eventually came through the storm of trauma by shifting his focus away from that gnawing guilt and toward the family he loved. "I ultimately found my outlet in enjoyment of crucial family time with my wife and four daughters and by focusing on physical fitness and healthy nutrition," Fischer explained. "Unfortunately, not all individuals exposed to this very troubling phenomenon identify such solutions and may find solace in more destructive outlets such as alcohol or substance abuse. It is important that these caregivers are identified so they can receive the much needed assistance they require."

## Recognizing Compassion Fatigue

Part of the problem, however, may be a lack of recognition of compassion fatigue by providers as it starts to take grip.

Marla Vannucci, PhD, Licensed Clinical Psychologist and Associate Professor of Psychology at Adler University, Chicago, shed light on this aspect. "The people who are most at risk for compassion fatigue are exactly the people who will not recognize it in themselves. People who are drawn to oncology as doctors and nurses hold high expectations of themselves. Some individuals may even have a savior complex; and that doesn't have to be pathological," she clarified. "There are just some people who simply want to help and to save others. They have the best of intentions."

> "The reality is super heroes are in comic books, not in real life. You are a human being. You have to take care of yourself first to be able to take care of others."

She went on to note that people with such high expectations of themselves may also be less forgiving of themselves if they see signs of compassion fatigue cropping up. "They might actually avoid responding to those signs because they may see them as a sign of weakness or a signal that they need to work even harder."

Asked to delineate the signs that might be evident, Vannucci said, "It is important to realize that it isn't just one thing that defines compassion fatigue, but usually a cluster of symptoms. These include a sudden loss of compassion—a dip in bedside manner from someone who always was very responsive. The provider may suddenly refer to the symptom or disease instead of the patient, become insensitive to family members, use black humor, or be unresponsive to real humor. There may be clinical errors that occur, or a general decline in care."

Other symptoms may include isolation/disconnection, mental health symptoms like depression and/or anxiety, an inability to make decisions, and loss of pleasure in one's own life including a cessation of normal everyday pleasures like biking or going to the movies or time with the family.

"There may be an over-immersion in patients' lives, resulting in not wanting to leave the hospital, taking work home, being unable to take a break," said Vannucci. "And then there is the opposite extreme—having a real dread of seeing particular patients. Compassion fatigue can also involve physical reactions—headaches, weight gain or loss, insomnia."

Jennifer L. FitzPatrick, MSW, LCSW-C, CSP, Founder of Jenerations Health Education, Chester, Md., author of *Cruising Through Caregiving:*

*Continued on page 7*

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Learning Objective for This Month's CME Activity: After participating in this CME activity, readers should be able to identify strategies to recognize and prevent compassion fatigue.

## COMPASSION FATIGUE

*continued from page 6*

*Reducing the Stress of Caring for Your Loved One,* and an instructor of gerontology at Johns Hopkins University, Baltimore, said sometimes the dread goes all the way to harboring negative feelings about the very patients most in need of help.

"This is why we say taking care of yourself is not only in the best interest of you as a provider, but also in the best interest of your patients," she commented. "Providers who experience compassion fatigue are prone to getting sloppy on the job, taking inadequate notes, not keeping notes updated properly, or simply making mistakes. This has a huge spin-off effect on patients and their families."

Figley said that, while compassion fatigue knows no global boundaries, its effects are harsher on Western cultures compared to Eastern counterparts. "Western cultures are rather mechanistic. We hold an evidence-based, matter-of-fact, hard-ass attitude toward our capability and medicine. It is very different in regions influenced by Asian cultures," Figley explained. "They assign much more of a spiritual component to healing and to medicine. Many practice mindfulness, and as such focus their attention on their minds, bodies, and spirit rather than simply being client-centered. Providers there understand the need to refresh themselves to be able to care for their patients. It is not always that way here in the U.S."

Figley said that because of an inherent Western "… fear of showing emotional weakness in a male-dominated 'house of medicine,' there are some providers who believe it is not their job to empathize with patients, but merely to explain to patients and not be concerned about the emotional reactions. For those, compassion fatigue does not pose the same level of threat because there is so little compassion to fatigue. However, Vannucci posited that it is those very characteristics of empathy and compassion that make for a stellar medical provider. "If you never felt this way, you probably wouldn't be good at your job," she commented.

William Helm, AOBTA certified master instructor at the Pacific College of Oriental Medicine, San Diego, has worked with oncology nurses fighting work-induced stress. "My best advice to health care providers is to ask for help," said Helm. "But everyone is asking them for help, and they rarely seek if for themselves. Dealing with people on the edge of death requires maintaining some kind of emotional distance. The term 'mindfulness' is used a lot lately, and it is somewhat of a cliché. But in reference to compassion fatigue, it is relevant. It has to do with paying attention to your own state of mind and your own state of being—being able to center inside yourself. This allows you to be present with the patient in a given moment, allows you to give them the compassion they need, and yet still maintain your own center, or that necessary emotional distance. When you become overly empathetic with people, you can lose your center in the process. Then the tragedies, the person's pain and uncertainty affect you more deeply. With such fatigue overload, it is hard to relax and recharge."

Eastern cultures point the way to relief, said Helm. Tai chi, yoga, qigong, mindfulness, and other forms of meditation emphasize relaxation, awareness, and finding your center in your body, he noted. "There are many ways that can help you to keep yourself in firm focus and not shut down or get drained. This then allows you to be emotionally responsive to people without harm to yourself," he explained.

Short of practicing Eastern arts, Helm said just walking regularly or getting out of the office can lower stress levels. "Self-care, in the form of massage, acupuncture, or some of the modalities that are used to reduce stress in the general population would be very helpful to health care providers," Helm said, "but they just don't make time for it."

### Prevention Tactics

Figley said the best tact is to do something before compassion fatigue becomes entrenched; make a plan for stress management and a realistic self-care plan. He is hopeful that a 2016 model of Compassion Fatigue Resilience (CFR) included in a paper he co-authored will supply providers and others with "… a tool to determine who is at risk for secondary stress disorder [compassion fatigue] or to cultivate desirable levels of CFR" (*Traumatology* 2017;23(1):112-123).

The model shows that secondary traumatic stress can be caused by exposure to suffering, empathic ability, empathic concern, prolonged exposure to suffering, re-awakened traumatic memories, and other life demands. It also suggests these can be mitigated through self-care, detachment, sense of satisfaction, and social support. The result of these specific risk and protective factors lowers secondary traumatic stress and increases compassion fatigue resilience.

Figley suggested providers may best learn coping strategies from others in the field who have overcome the pressures. "Those who have survived 20-30 years of doing this have figured it out. They have learned this whole ballet of stress management. They can be wonderful mentors to the rest of us."

In an everyday, on-the-job practical sense, Figley emphasized that providers must first and foremost stop harming themselves. "Stop putting yourself into harm's way without building sufficient resilience to high secondary stress from patient care. Become more effective at self-care and avoid self-medicating, and harmful overcompensations like too much exercise or overeating. Accept that you are only a child of God, not God himself. Give yourself time off when you go home. Relax, refresh. Have the courage and self-discipline to turn off your pager or your cell phone. Make that conscious decision, within the context of what is acceptable by your organization."

FitzPatrick said physicians should be reminded they do not need to know *everything* or be the source for every answer. "Doctors are not omniscient; they cannot solve every single problem. Clearly doctors are great at diagnosing, prescribing, treating. But when they take on the job of all social support, that is just too much," she admonished.

"It is important to keep a patient from being totally dependent on a doctor when there are other people within a practice or department who can supply answers," she offered. "Those answering the office/clinic/department phone must be prepared to deflect calls and direct patients to a counselor, or a non-profit organization, or a support group, when appropriate. Have brochures available in the office about other resources, such as the American Cancer Society or various support groups. Patients need to be educated to the fact that doctors are only part of the solution."

Vannucci stressed a major preventive measure/antidote to compassion fatigue. "I would advise personal counseling or therapy," she said, adding with humor, "but then I would, being a psychologist. The point is providers need a place to be able to talk this out. It could be in the form of a support group or simply getting together with colleagues and expressing your experiences. Find someone to talk to who 'gets' it."

She also suggested providers "… need to learn to sit with it. Use mindfulness or meditation to feel what you are feeling, instead of just pushing the feelings away. Then try to grasp the fact that this is normal. It is actually about the strength in you, not a weakness. Furthermore, it is your job to take good care of yourself. It is your job to address and work through these feelings. None of this is about you as a person; it is about you as a professional."

Fischer added still another wrinkle of importance. "Most oncologists have recognized or experienced this phenomenon sometime in their career. But one point that is often overlooked in many busy oncology practices is that *all* staff members are susceptible to compassion fatigue—from oncology nurses to front staff employees," he stressed. "The trauma of seeing patients they have come to know and care for, sometimes for extended periods of time, succumb to their illness most certainly can contribute to compassion fatigue for everyone. It is important that all involved in providing oncology care are educated about this phenomenon and are provided the proper educational and supportive resources to assist with dealing with this very real issue."

Figley agreed. "One time I was at a luncheon discussing compassion fatigue. While we were eating, a nurse leaned over and whispered in my ear, 'Nurses can't make mistakes because people die.' That was her reality. Imagine living with that pressure. But the reality is super heroes are in comic books, not in real life. You are a human being. You have to take care of yourself first to be able to take care of others."

You are in flight; be the first to strap on the mask. OT

*Valerie Neff Newitt is a contributing writer.*