Chaplaincy in the Time of COVID-19

Chaplaincy in the Time of COVID-19, is a resource to provide guidance, knowledge, and examples from the field to provide effective chaplaincy spiritual care to those people who have been impacted the Coronavirus (COVID-19) pandemic.

Chaplains provide spiritual care to persons throughout times of personal crisis, whether it be due to injury, illness, life changes, or other areas of distress.   The impact of an international pandemic can be the most distress-producing and potentially devastating event that persons can experience.   While the core skills and practice of professional chaplains remain the same, a pandemic is a time to review one's knowledge, skills, and interactions. New ways of thinking and practicing are required. The purpose of this material is to provide reminders of knowledge that may be previously held or, equally, new.

Guidance – Lessons from 9/11: Strategies for the Current Crisis

Communicate with your team.

In any crisis or disaster scenario circumstances can change daily or even sooner. In any event, assume that is the case. In the COVId-19 crisis, new data is coming out virtually every day from the US and from other countries that modifies how this virus is treated and the precautions that do and do not need to be taken. Visiting policies and protocols for communicating with families are evolving.

It is essential to know what the latest facts and policies are but also to know where and how policy and procedure is being developed so you can contribute as appropriate. Don't be afraid to respectfully ask about policies that seem to not be in the patient or family's best interest. But also, understand when it is time to abide by the rules and be a team player. In the middle of a code is not the time to challenge whether the chaplain should be allowed at the bedside. Treat your team members with respect and bear in mind that they also might need spiritual care. Many healthcare professionals have stated that they have never been more professionally scared and constantly anxious than during this COVID-19 pandemic.

Be flexible and creative. Insisting on doing it a certain way will not keep you on the team.

The first task is to understand why something is now being done in a certain way. Not allowing a chaplain to visit a patient in person is a current example. Just like in a patient visit, it is essential

to assess before you propose an intervention. Then, the intervention needs to be doable. Ask yourself why you feel so strongly about a certain way of doing things. Is this truly an issue of best practice or is this your need to do something the way you are comfortable with and have been taught? Be honest with yourself. Is there a viable alternative? Yes, it would be nice to be able to hold a patient's hand while we pray with them. However, it turns out that, for the most part, patients get the same benefit out of a prayer done over the phone or by Zoom if it's delivered in a caring and sincere manner.

If you do not have an answer to the "why not?" question in relationship to a new intervention or process, it is time to at least try it. Finally, understand that health care teams are most often not true democracies where everyone has an equal vote even when they claim to be. They are autocracies where the team lead (usually the physician) has the final say. You can voice your opinion respectfully but once the decision is made, it's time to play by that rule if you expect to continue to be included.

Stay within your scope of practice.

One of the big temptations, especially in a crisis, is to take up tasks that are not really within our lane, expertise, or training. Sometimes this is necessary. Right after the North Tower fell on 9/11, the little Downtown Hospital close by was flooded with people who needed the dust washed out of their eyes. Virtually everything else stopped while everyone went on a search for usable water and poured it on people's faces. That was a necessary but also temporary diversion from the chaplain's normal job.

However, all too often chaplains succumb to the temptation of volunteering or allowing themselves to be volunteered for jobs that really are within the scope of some other practice, usually social work or mental health. This situation puts the chaplain in the situation of doing tasks they are not really trained for, so do not do exceptionally well. This is not optimum patient care and chaplains are then vulnerable to being replaced by someone who is trained in that way. Instead, believe that chaplains have something unique to contribute to the care of patients. Those unique contributions are increasingly supported by evidence and most often welcomed by health care teams. Be confident and able to articulate clearly and succinctly what these contributions are. Chaplains have plenty to give without having to resort to trying to be something we are really not. Chaplains are even more essential now during this time of unprecedented stress and anxiety.

Pay attention to self -care.

This is a marathon not a sprint. It will not help if you burn out while striving to keep others from burning out. In a crisis, even more than during normal times, there will be much more work for the chaplain to do than there is time to do it. It will never be done - not tomorrow, not next week, not next year. The current crisis will have repercussions for years to come. It might even be true that others will not do the work as well as we would. That concern needs to be addressed by increasing the workforce, not increasing our individual workload.

The ingredients in self-care are well known to every chaplain - diet, physical exercise, sleep, a social life, and a spiritual practice. Everyone needs to keep all of these components in mind. We all know that self-care is much easier to say than to do and chaplains and health care professionals in general are not good at it. We need to do it for our patients. We need to model self-care in our own life and do our part to help the other members of our team adhere to them as well. Inserting a few seconds of quiet and reflection at the beginning of a daily meeting or huddle can have a lot of power. Setting some personal and professional boundaries – even in the midst of the pandemic – can also serve to reinforce self-care.

Knowledge – Emergency or Crisis

A resource for chaplains working with a crisis response chaplaincy is *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional, and National Tragedy.* The mission of disaster spiritual care, according to book editors Roberts and Ashley (2008) is:

"To provide appropriate short-term and long-term care for people who have been afflicted by both the initial trauma and the ongoing disaster situation. The goal is to provide sensitive spiritual and emotional care to affected individuals and families by representing the person's culture, religious tradition, and faith communities…. to help those affected draw upon their own emotional and spiritual resources in the midst of their pain."

National Voluntary Organizations Active in Disaster (VOAD) has been the leading coordinator for organizations that respond to disasters. The National VOAD is not an operational or programmatic agency, but rather a roundtable or association for voluntary organizations that respond to disasters. The Emotional and Spiritual Care Committee, which includes professional chaplains, has developed numerous resources for responding to disasters. All are available for download in the VOAD Resource Center.

- National VOAD Disaster Spiritual Care Guidelines
- Quick Reference to the National VOAD Disaster Spiritual Care Guidelines
- Light Our Way: A Guide for Spiritual Care in Times of Disaster for Disaster Response Volunteers, First Responders, and Disaster Planners (available in English and Spanish)
- Disaster Spiritual Care Points of Consensus
- CDC NVOAD ESC Presentation: Mental Health and Spiritual Care in Emergencies

Organizations such as the American Red Cross, the leading responder to disasters, utilize the VVOAD guidelines as the foundation of their Disaster Spiritual Care Standards and Procedures Disaster Cycle Services Standards & Procedures.

Knowledge – Psychological First Aid

According to the National Child Traumatic Stress Network, "Psychological first aid is an evidence-informed, flexible, modular intervention to assist survivors and responders in the immediate aftermath of a disaster. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping" (Brymer, 2006).

In the aftermath of a traumatic experience, experts suggest that the majority of those impacted will have temporary distress and will not have long-lasting impairment or dysfunction. In a review of 160 empirical studies of disaster survivors, Norris (2006) and colleagues determined that 41% of studies documented a significant level of lasting impairment in survivors. In light of this reality, providing immediate, skilled psychological first aid will be essential for a substantial percentage of people who are impacted by a traumatic experience such as a pandemic.

Psychological first aid is a compassionate and supportive response designed to assess and address acute post-disaster *distress* and mitigate the development of long-lasting psychological *dysfunction*.

You do not need to be a trained or licensed mental health professional to administer psychological first aid. In the aftermath of a widespread disaster, there will never be enough mental health professionals to address the sizeable and needs of those affected. In an effort to equip a volunteer corps of PFA responders, both the National Child Traumatic Stress Network (NCTSN), Johns Hopkins Center for Public Health Preparedness, and Bloomberg School of Public Health have created excellent online training programs available free to the public.

The NCTSN course can be accessed here.

The online Coursera MOOC (massive open online course) can be accessed here.

This section will provide an overview of the key tenets and principles of psychological first aid based on the work of NCTSM and Johns Hopkins.

8 Key Actions

Psychological first aid is characterized by 8 core actions (Brymer, 2006).

1. Contact and Engagement	After assessing which survivors appear to need immediate assistance, responders approach survivors with sensitivity to cultural/personal preferences for language, personal space, eye contact, and touch. Responders introduce themselves and their role and begin to build trust and rapport using active listening. Responders address any immediate physical needs.
2. Safety and Comfort	Responders help to restore a sense of safety and comfort by ensuring physical safety, providing accurate information as requested, support social and familial connections, attend to children, the elderly, and those with special needs, support those who have just received bad news, support connection to spiritual and cultural forms of comfort.
3. Stabilization	After identifying survivors who appear to be intensely distressed (glassy-eyed, unresponsiveness, strong emotions, physical reactions), engage in activities that help survivors calm and reorient themselves.
4. Information Gathering	Informal and ongoing assessment of survivors' current needs (behavioral, emotional, physical, cognitive, cultural, spiritual), current losses, history, and background relevant to the trauma and any referrals provided.
5. Practical Assistance	Discuss and clarify immediate needs for food, water, clothing, shelter, medication, and connection to loved ones. Create an action plan. Act to address needs.
6. Connection with Social Support	Re-establish and enhance connections to primary support persons and community resources.
7. Information on Coping	Provide basic information on stress responses including physical, emotional, cognitive, and spiritual reactions. Offer coping tools such as relaxation techniques, self-care, and emotional self-regulation skills.
8. Connection with Collaborative Services	Provide appropriate referrals and contact information to resources to enhance support and foster resilience.

Actions 1 and 2

1. Contact and Engagement	After assessing which survivors appear to need immediate assistance, responders approach survivors with sensitivity to cultural/personal preferences for language, personal space, eye contact, and touch. Responders introduce themselves and their role and begin to build trust and rapport using active listening. Responders address any immediate physical needs.
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Connecting to a person to establish trust and create safety, are especially important for those who are overwhelmed emotionally, physically and cognitively. Identifying persons who are exhibiting signs of high levels of distress is key. These more distressed individuals are particularly at risk for long-term dysfunction. Stabilization and information gathering are key interventions for psychological first aid responders.

Video: *Trauma Reminders from Responding to Crisis in the Aftermath of Disasters*. PFA Online Videos. 2010. This video demonstrates helping a survivor re-establish feelings of safety and comfort while helping the survivor address possible trauma reminders.

Actions 3 and 4

3. Stabilization	After identifying survivors who appear to be intensely distressed (glassy-eyed, unresponsiveness, strong emotions, physical reactions), engage in activities that help survivors calm and reorient themselves.
4. Information Gathering	Informal and ongoing assessment of survivors' current needs (behavioral, emotional, physical, cognitive, cultural, spiritual), current losses, history, and background relevant to the trauma and any referrals provided.

Video: *Full Simulation Video.*   Coursera and John Hopkins Bloomberg School of Public Health. This video identifies key actions and techniques used by the responder to help stabilize, comfort and gather necessary information from a woman in distress.

A Survivor Current Needs Assessment in Found in Appendix F, *Psychological First Aid Worksheets* of the *Psychological First Aid: Field Operations Guide.*

Actions 5 through 8

5. Practical Assistance	Discuss and clarify immediate needs for food, water, clothing, shelter, medication, and connection to loved ones. Create an action plan. Act to address needs.
6. Connection with Social Support	Re-establish and enhance connections to primary support persons and community resources.
7. Information on Coping	Provide basic information on stress responses including physical, emotional, cognitive, and spiritual reactions. Offer coping tools such as relaxation techniques, self-care, and emotional self-regulation skills.
8. Connection with Collaborative Services	Provide appropriate referrals and contact information to resources to enhance support and foster resilience.

Video: *News Footage of Fires in Oakland California*.   Global Tube Truth. 1991.

When watching this video, consider the following:

1. What are Timothy's immediate needs? What actions need to be taken? How would you address those needs?
2. Who/what are Timothy's sources of support? How might you connect him to his primary sources of support?
3. What issues of spiritual distress is Timothy wrestling with? How would you articulate them? Respond to them? Document them?
4. How is Timothy coping? What might you tell him about stress and coping with stress? What tools for coping with stress would you use with him? Do you think this technique from the 5-minute video below, *Breathing Techniques from Responding to Crisis in the Aftermath of Disasters, would* be effective with Timothy? Why? Or why not? How would you teach these if you were unable to have personal contact with a person?
5. What referrals will Timothy need? What resources will help support him and foster his resilience?

Video: *Breathing Techniques from Responding to Crisis in the Aftermath of Disasters.* PFA Online Videos. 2010.

Resources:

- *Psychological First Aid: Field Operations Guide.* National Center for PTSD.
- *Psychological First Aid: Guide for Field Workers.* World Health Organization. 2011.
- *PFA Mobile.* National Center for PTSD.

Knowledge – Communication

Communication is defined in many ways. The word "communication" comes to us in English from the two Latin words: communis, a noun, which means "commonality," and communicare, a verb, which means "to make common." The use of texts, email, and video conference, are all potential forms of communication. For this resource, we will narrow our focus to functionally be interpersonal communication as defined by the Oxford Dictionary: "The successful conveying or sharing of ideas and feelings". Notice the inclusion of the word, "successful." One of the most problematic components of communication between people is the potential success of the transmission of an idea or emotion. The issue is two-fold:

- Whether the person with whom you are communicating successfully understands the idea or the emotion that you were trying to convey as you communicated.
- Whether your attempt to communicate your idea or emotion was successful.

Communication can be tricky in the best of circumstances. The many layers of difference between two people attempting to understand one another – age, gender, race, ethnicity,

culture, religion, dialect, language, social and emotional intelligence and facility, educational background, socio-economic context, power or positional authority differentials, to name a few - lead to an almost infinite number of opportunities in which the two people can misunderstand one another.

It is incumbent upon the chaplain to be pro-actively intentional with how she communicates – with patients, families, colleagues, and other members of the response team.

A chaplain must constantly be self-aware of the many layers of difference between themselves and the person with whom he or she is interacting. One should not assume to know each of these differences explicitly, but can and should often ask for clarification, as well as for explicit feedback about what the person with whom they are interacting heard and understood. This can lead to the most effective communication possible, where what the chaplain is attempting to say is what the person hears, and what the person is attempting to say is what the responder understands to be said. This sounds simple. It is not always so.

Miscommunication

For communication to be successful, both the person speaking and the person hearing the message need to be part of the process. Sometimes, there are misunderstandings encountered which result in the failure of receiving the message properly. Miscommunication occurs when two people have a conversation or another form of communication but come away with different understandings of what was said or communicated. Therefore, the communicator must be skilled enough and check whether the message has been understood clearly.

There can be several barriers to communication, and to be effective one must understand what these barriers are and ways in which to overcome them.

For those in the midst of an emergency or disaster, one of the most common barriers is information overload. The experience is overwhelming emotionally, physically, and spiritually which impacts how well someone can hear, assimilate, and understand what is being spoken. There is likely a great deal of noise as well as many conversations taking place at once. It is essential not only to use good interpersonal skills, including how to approach a person appropriately and the best timing to speak but also good control of the information that you want to convey and doing so clearly.

People are usually interested in receiving messages which are truly significant to them, and when trying to interpret the situation around them their perceptions may be different from usual or heightened. Miscommunication can occur when the speaker is not aware of what those perceptions may be or tries to communicate information that is in conflict with them without clarifying them first.

If a person is inattentive, which can easily occur in an emergency or disaster situation, misunderstandings and miscommunication can occur. Some individuals simply cannot absorb exactly what other people tell them, perhaps because of the crisis situation that they are in, or they are not interested in the moment of what the message is that the speaker is trying to relay.

Speech difficulties or hearing problems can be hindrances that result in miscommunication. Ensure that you are paying attention to the person you are attempting to speak to and screen for any disabilities that may be present.

How something is said is often more important than what. Miscommunication can occur when the speaker uses buzzwords that the listener may not understand. Unclear pronunciation of words or speaking too fast can also make it difficult for a person to understand what is trying to be communicated.

Supportive Spiritual Listening – Chaplain Bob Kidd

Chaplain Bob Kidd's approach contextualizes the communication to be that of a chaplain's context and role. In *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook* he calls his listening and responding approach "spiritually supportive listening". Kidd describes general principles for effective spiritually supportive listening:

- The first states that the chaplain "encourages the speaker to take all possible conversational initiative" (Ibid. 93). This does not mean the chaplain sits back and is a passenger in the communication, but, rather, that the chaplain allows for silence, and for the other person to dictate the direction and scope of the conversation.
- The second principle is that the chaplain stays "attuned to the present" (Ibid. 93). This echoes both of the previous models, in that the chaplain should guard against a wandering mind or seek to minimize formulating a response while listening.
- The final overarching principle is also similar to the previous models, in that the chaplain is to "stay as objective as possible during conversations" (Ibid. 94). This is the nonjudgmental presence that is so key to the effectiveness of chaplaincy care.

Kidd continues that there are three fundamental groups of skills and/or techniques, distinguished by their complexity: basic responses, facilitating responses, and intense interaction responses. The tools within the basic responses belt include literal repetition, reflecting, paraphrasing, and summarizing.

- **Literal repetition** is helpful when the other person reiterates or repeats an important word or phrase. However, this skill needs to be deployed judiciously, as overuse or inopportune appropriations of it can come across as parroting or even mocking someone. Reflecting echoes Carkhuff's call for attending to the emotional content that is behind a statement. Here, a chaplain does not so much respond with the same words another person is using, but rather emphasizes the emotional component of the interaction. It becomes a way for the chaplain to honor the underlying intensity of a situation being shared and invites a response of confirmation, clarification, or correction by the other person.
- **Paraphrasing** allows the other person to hear their own narrative but from a slightly different perspective. It can help move the conversation both forward and deeper, as it slows the conversation down and allows the other person to reflect on the narrative they have been sharing.

- The final basic response would be **summarizing.** This allows the chaplain to serve as a transition, either to a different narrative or to a graceful exit from the conversation.

The next group of techniques is called facilitating responses, which include: open-ended questions, buffering, understatement/euphemism, and tell-me-more/minimal encouragement.

- **Open-ended questions** invite the other person to elaborate on something they have said or to begin sharing a new narrative. A good example would be "What is it that you have found to give you hope and strength when you have had struggles in the past?" A chaplain should be judicious in the use of open-ended questions, as it can come across like an unwelcome interview or probing if overused. One specific one to avoid is "How are you today?"
- **Buffering** helps to soften the impact of intense emotional or difficult topics. It gives the other person an out if they would like to take it. For example, a chaplain may begin a question with the buffering language, "you may not wish to discuss this much in depth at the moment, but . . ." The indirect nature of the disclaimer gives space for the other person to engage at the depth most comfortable to them.
- The **understatement/euphemism** technique is something to be alert for within the other person's narrative, but also to use with intentionality on the part of the chaplain. Euphemisms for death ("passed away") or deeper emotions ("I'm disappointed she did this") are common. These are often used when the other person has something important to convey, but are in some way unable to express them directly. When a chaplain notes the use of an understatement or euphemisms, it can help engage that difficult topic through the strategic use of the same ones. It is as if the person is inviting a conversation, and then setting the ground rules for what is allowed to be said explicitly.
- The **tell-me-more/minimal encouragement** skill is useful for the chaplain to use when inviting more interaction. The tell-me-more response ("tell me more about . . . ", "I'd like to hear more about . . .", "I'd like to focus on . . .", and "say more about . . ." for example) is a way for the chaplain to guide the discussion. As such, one should use these intentionally as a strategic tool to help engage the other person. On the other hand, the minimal encouragement comments ("Hmm," "I see," and "yes, please continue" for example) allow the other person to direct the narrative. One caution with the minimal encouragement tool is that it can be easy to fake when a chaplain is mentally elsewhere or preoccupied.

Kidd's final category of effective spiritually supportive listening include the intense interaction responses: calling attention and hovering**. Calling attention** should only be used once some trust and rapport are developed in the relationship between the chaplain and the person being served. This serves as a naming of the hard thing which has gone unnamed, and potentially unnoticed, by the other person. Some examples include statements such as "I see your tears and wonder what they are saying," and "I've noticed that you've talked about everyone in your family except your dad," or "It looks like every time we start talking about leaving rehab and going home your foot starts tapping" (Ibid., 101). This is, in a way, the chaplain pressing the other person to disclose something that has been unstated prior to the use of this technique. A chaplain needs discernment about when and how to deploy this skill.

Finally, **hovering** "involves deftly broaching the intended subject for discussion, allowing the speaker to explore it as much as possible, and then gently bringing the conversation back when they stray off topic". This can be helpful when the topic of discussion is difficult or viewed as risky by the other person, such as an end-of-life discussion, grief, or other similarly emotionally charged topics. It is important, as always, when using hovering for the chaplain to always respect the other person's boundaries and cues.

Knowledge – Cultural Humility

Cultural humility is grounded in demonstrating respect to the ways in which persons, families, and groups understand and interact with the world around them, including their beliefs and values. Respect provides the foundation for whether a sense of trust will be developed within the relationship between a client and the service provider team, the plan of care that is mutually developed, and the client's willingness to participate in that plan.

Cultural humility always includes an active invitation to invite those whose culture, beliefs and values are different from yours to teach you what is important for them regarding their beliefs, values, practices, and other life issues.

In order to provide sensitive and effective care to persons from cultures that are different from ours, two things must occur. First, the chaplain must have an awareness of his or her own cultural background, values, and beliefs and the recognition of how they influence our attitudes and behaviors. This is important in recognizing that one's personal experience is not normative for the experiences of those from different cultures.

Communication Strategies

Several strategies can be useful when communicating with someone from another culture.

- Ask persons how they want to be addressed. The best rule of thumb is to address all adults by their surnames unless specifically given permission to use their first name. Many cultures are more formal; therefore, it may be considered a lack of respect to use first names.
- Keep in mind the variations in not only how words are spoken (tone, volume, rate), but how nonverbal interactions take place in both one-on-one and group conversations.
- Monitor the tone and volume of your voice. For those who have a naturally loud voice, it is important to realize that in some cultures, loudness can be interpreted as a sign of disrespect. On the other hand, be aware that in some cultures, a loud voice does not convey anger, but is rather a way of communicating important issues.
- Avoid the use of slang, idioms, or medical jargon that assumes familiarity with "American" life, culture, and the provision of care.
- It is often helpful to give information in different ways and use pictures and other non-verbal forms of communication.

- Gestures can be helpful; however, it is important to know that some, such as finger-pointing; can be interpreted as an aggressive or shaming gesture.
- Members of the team may use direct eye contact to convey sincerity and the importance of information. For some, such as many Native American tribes and Asian cultures, direct eye contact is avoided especially with people who are considered to be in authority.
- Touching and personal-space vary from culture to culture. For example, people from Western cultures may feel uneasy when someone stands less than three feet away in a conversation, however, many people from Middle Eastern cultures often stand almost nose to nose. There are cultures and spiritual traditions that believe that the soul rests in the head and persons may be uncomfortable or distressed when someone pats them or a family member on the head or ruffles their hair.
- Western culture tends to be precise and ruled by dates and the clock: meeting times are set and persons and/or their families are expected to be present. However other cultures think differently and pay less attention to the hour or day than to the event themselves. When setting times for meetings, it can be helpful to put it into the context of having a discussion about specific beliefs, values, and/or events regarding the patient's care rather than vague reasons such as "an update".
- Discussing issues such as informed consent, advance directives, or regulations can be upsetting and frightening to those whose cultural or spiritual beliefs teach that talking about an event may make it happen. Other cultures' conceptual frameworks simply don't include the concept of "what if".
- Cultural differences can affect how patients and families will experience conversations about spiritual issues related to pain, suffering, loss, complicated and anticipatory grief, and life review. These concepts may be unfamiliar or taboo. Professionals need to: listen closely to what patients and families are saying; gently explore their beliefs and values; become familiar with cultures they may not have encountered before by using available resources; and be willing to adapt their spiritual screening, history, or assessments accordingly.

Examples of Helpful Statements to Use:

1. Ask what the person and/or family what their style of communication is: "I want to be respectful of your personal and family culture and traditions. It would be helpful to me if you shared how you like to have a conversation. Are there things I should know that are uncomfortable to talk about? Are there certain persons that we as your care team need to be talking to first?"
2. Show openness to the patient's sense of spirituality and religious practice. "I am here to support you in your spiritual and religious needs, no matter whether you are part of a faith tradition or no tradition. Would you be willing to share with me about your beliefs?"
3. Seek an understanding of the patient's perception of pain and suffering. "Some people think of pain as more than just their body reacting to illness. Do you find strength in your spiritual/religious beliefs, or are there another understanding of pain and suffering within your culture that you would be willing to share?"
4. Move slowly into conversations about terminal illness and death. "What brings you sadness or anxiety?"

Chaplains can and should use their expertise to model culturally sensitive behavior for the interdisciplinary team. Often chaplains will function in the role of cultural broker for the team and organization as they identify client and family beliefs, practices, and values, communicate them to the rest of the team, and seek ways to respect and integrate those beliefs and practices into how the person is cared for.

Resource: *[Handbook of Patients' Spiritual and Cultural Values for Health Care Professionals.](#)* HealthCare Chaplaincy Network. 2014.

Knowledge – Self Care

Compassion Fatigue

Compassion Fatigue occurs when someone constantly experiences indirect trauma that is, by providing care and services to others rather than experiencing the trauma themselves.

What does Compassion Fatigue look like? Figley, who is the pre-eminent traumatology researcher and whose work laid the foundation for much of the current concepts of Compassion Fatigue, presents the following information as a helpful breakdown of what the symptoms of Compassion Fatigue may look like:

Cognitive:

- Lowered concentration
- Decreased self-esteem
- Apathy
- Rigidity
- Disorientation
- Perfectionism
- Minimization
- Preoccupation with the experienced trauma, or trauma in general
- Thoughts of self-harm or harm to others

Emotional:

- Powerlessness
- Anxiety
- Guilt
- Anger / rage
- Survivor guilt
- Shutdown
- Numbness
- Fear
- Helplessness

- Sadness
- Depression
- Emotional roller coaster (being "emotionally labile")
- Depleted
- Overly sensitive

Behavioral:

- Impatient
- Irritable
- Withdrawn
- Moody
- Regression
- Sleep disturbance
- Nightmares
- Appetite changes
- Hyper-vigilance
- Elevated startle response
- Accident proneness – increase in clumsiness
- Losing things

Spiritual:

- Questioning the meaning of life
- Loss of purpose
- Lack of self-satisfaction
- Pervasive hopelessness
- Anger at God
- Questioning of prior religious beliefs
- Loss of faith in a higher power
- Greater skepticism about religion

Personal Relations:

- Withdrawn
- Decreased interest in intimacy or sex
- Mistrust
- Isolation from others (especially self-isolation)
- Overprotection as a parent
- Projection of anger or blame
- Intolerance
- Loneliness
- Increased interpersonal conflicts

Somatic:

- Shock

- Sweating
- Rapid heartbeat
- Breathing difficulties
- Aches and pains
- Dizziness
- Increased number and intensity of medical maladies
- Other somatic complaints
- Impaired immune system

Work Performance:

- Low morale
- Low motivation
- Avoiding tasks
- Obsession about details
- Apathy
- Negativity
- Lack of appreciation
- Detachment
- Poor work commitments
- Staff conflicts
- Absenteeism
- Exhaustion
- Irritability
- Withdrawal from colleagues"

Compassion Fatigue has the potential to seriously impeded overall staff well-being, resilience, and even basic functioning. Someone with Compassion Fatigue will not exhibit all of these symptoms, but rather these symptoms describe someone who may well be experiencing Compassion Fatigue. The list is descriptive rather than prescriptive in that way.

Burnout

Burnout is closely associated with both Compassion Fatigue and Compassion Satisfaction. Burnout is mostly seen as secondary to Compassion Fatigue. It is "associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment" (Ibid.).

Aycock and Boyle describe the term Burnout as outdated and encourage researchers to focus instead on Compassion Fatigue, as the term Burnout "does not truly depict the result of the longitudinal workplace ramifications of sadness and despair on staff" (2009). However, the term is still used widely today and the chaplain should be familiar with it and its implications.

Like compassion fatigue, burnout involves a feeling of emotional exhaustion, physical depletion and fatigue, feelings of helplessness, a negative self-concept, and negative attitudes towards work, life, and others. (Maslach and Jackson, 1981). When not addressed, it can lead to a loss of competency and productivity in work as well as having a negative impact upon one's own sense of well-being.

Ways to Address Compassion Fatigue and Burnout

There has been much research seeking the best practice evidence for addressing Compassion Fatigue in medical personnel which can be adapted for use with teams. Aycock and Boyle (2009) listed six strategies to survive stress and prevent Compassion Fatigue and Burnout:

- "Practice Responsible Selfishness – incorporating activities that renew or re-energize may help staff better respond to the needs of others.
- Separate work from home – Emotional decompression, such as physical activity, imagery tactics, techniques of distraction, or any combination of these, could be helpful.
- Develop positive support groups – Structured support groups or peer support may offer active listening, empathy, and problem-solving as a resource.
- Refuse to be a victim – daily determination of the type of person the professional wants to be despite the challenges of the work environment can make a significant impact.
- Remember to laugh – life provides multiple opportunities for this palliative agent.
- Re-define success – death is a frequent outcome that can lead to discouragement and defeat. Realization of the impact of compassionate care may provide professionals with the knowledge that they have made a difference."

Boyle (2011) later lists the following as approaches to addressing Compassion Fatigue:

- **"On-site counseling** by a therapist, counselor, social worker, or chaplain trained in the provision of emotional support for healthcare providers experiencing real or potential compassion fatigue. These resources must be visible, accessible, and offer practical solutions for staff. Employee assistance programs can also provide support.
- **Support groups for staff**. Although it is difficult for staff to participate in these groups during their working hours, the benefits of peer support and consultant guidance in addressing emotional issues cannot be underestimated. Groups and/or workshops offered during evening or weekend hours, or in retreat settings may have better attendance by staff.
- **De-briefing sessions** can serve to identify helpful and non-helpful approaches to pivotal events in clinical practice. These sessions should be viewed not as critical reviews but rather as instructive, to help staff mature and develop new skill competencies in their work settings.
- **Massage** sessions also provide both mental and physical breaks from the stress of caregiving.
- **Bereavement** interventions, for example, funeral attendance, memorial service participation, and the sending of sympathy cards to families can help with grief

resolution. This is especially true when the team has formed a special bond with the patient and/or family.

- **Attention to spiritual needs** is paramount as so much of the tragedy, sadness, and sense of futility that staff may experience is associated with life and death issues.
- **Assisting staff to integrate self-care plans into goal setting** in conjunction with annual performance appraisals may assist in addressing the need for, and expectation of countering compassion fatigue".

Meadors and his colleagues (2011) found that "having a culture that encourages providers to take some time off, ensures that providers eat during their shift, and promotes self-achievements is essential for minimizing the likelihood of compassion fatigue" (2008). Portnoy recommends that the following should be done to address Compassion Fatigue and Burnout:

- "Create an open environment where employees have a venue for mutual support. Encourage employees in meetings and with supervisors to talk about how they are affected by their work.
- Offering training that educates employees about burnout and compassion fatigue and how to recognize the symptoms.
- Share the caseload among team members, particularly the most difficult cases.
- Make time for social interaction among teams. Social events and a yearly retreat away from the workplace can build cohesion and trust.
- Encourage healthy self-care habits such as good nutrition, sleep, taking work breaks.
- Reward effort and offer flexible work hours.
- Offer training that focuses on self-care and life balance as a way to build resilience to stress"

Strategies such as these can be either attempts to prophylactically help prevent compassion fatigue and burnout, or attempt to address it once it is being experienced. Both pro-active and responsive strategies are the staff's attempts to potentially enhance their compassion satisfaction and mitigate their compassion fatigue and burnout. Instead of walking through each of these listed above, they are presented as representative of what the research and literature recommend as ways to best address Compassion Fatigue. The majority of the strategies from the research are familiar terrain to chaplains seeking to provide care to team members, and there will be numerous concrete interventions they can utilize to address Compassion Fatigue and Burnout in subsequent sections of this module.

For example, looking through the lists above, there are several strategies are focused on the team person's social support as it relates to his or her work. Chaplains can encourage both formal and informal debriefings following intense emotional experiences. Formal debriefings will be discussed below in the sections on psychological first aid and Critical Incident Stress Debriefings. Informally, they can ask responders whom it is they speak with to process the intense experiences that have at work, and encourage them to do so following especially stressful circumstances. If a responder shared that they did not have anyone to share the intensity of their work, a chaplain can brainstorm with that staff person of people in their social and professional circle who might serve that role for them.

Resources:

- *Tips for Disaster Responders: Understanding Compassion Fatigue.* Substance Abuse and Mental Health Services Administration. 2014.
- *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others.* Laura van Dernoot Lipsky. 2009. ISBN-10: 157675944X.

Moral Distress

Moral distress is defined as "the physical or emotional suffering that is experienced when constraints (internal or external) prevent one from following the course of action that one believes is right" (Pendry, 2007). Many intuitively associate moral distress with the military, where a soldier may well have reservations or second thoughts about actions or inactions taken in a wartime theater. However, first responders and health care workers also experience moral distress. Often this is associated with providing care they feel is futile or unethical. Moral distress is experienced when the team member sees something happening, and especially if they feel they are contributing to something happening, that goes against their own values or ideals. "When [nurses] cannot do what they think is right, they experience moral distress that leaves a moral residue" (Corley, 2002).

This is then complicated by the fact that they are the front line care providers. Chaplains should have a basic understanding of moral distress as a possible contributor or complicating factor with the spiritual distress, compassion fatigue, and burnout among other team members with whom they work.

Resource:

- *A Broader Understanding of Moral Distress.* Ulrich and Grady. 2018.

The American Association of Critical-Care Nurses has produced a helpful document seeking to help organizations address moral distress in their critical care nursing staff, *The Four A's to Rise Above Moral Distress.* It may be a useful tool for chaplains to have in working with team members.

The Four A's are:

- "**ASK**: Review the definition and symptoms of moral distress and ask yourself whether what you are feeling is moral distress. Are your colleagues exhibiting signs of moral distress as well?
- **AFFIRM**: Affirm your feelings about the issue. What aspect of your moral integrity is being threatened? What role could you (and should you) play?

- **ASSESS**: Begin to put some facts together. What is the source of your moral distress? What do you think is the "right" action and why is it so? What is being done currently and why? Who are the players in this situation? Are you ready to act?
- **ACT**: Create a plan for action and implement it. Think about potential pitfalls and strategies to get around these pitfalls" (Epstein, 2010).

Emotional Resilience

The U.S. Department of Health and Human Services defines individual resilience as having the ability *to withstand, adapt to, and recover from adversity.* (2015). Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress. (APA.2019). However, research has shown that resilience is ordinary, not extraordinary; it is not a trait that people either have or do not have. It involves behaviors, thoughts, and actions that can be learned and developed in anyone.

There is not a single accepted set of components of resilience, however, a guide can be these characteristics and contributing factors:

- Sense of control - believing that the actions one takes will affect the outcome of an event rather than blaming external causes
- Optimism – hopefulness and confidence about the future
- Altruism – selfless concern for the well-being of others through words and actions
- Moral compass – having an internalized set of values and objectives that guide one's ethical behavior and decision-making:
- Spirituality – a sense of finding meaning and purpose in something outside oneself
- Social support –those with strong social support networks are better equipped to bounce back from difficulties that are experienced
- Problem-solving skills - able to look at a problem and envision a successful solution
- Courage to face fears– being willing to leave their comfort zone and confront their challenges and fears
- Meaning or purpose – meaning is what is held as significant; purpose is an aim or goal
- Survivor - avoiding thinking like a victim
- Able to ask for help - finding and utilizing resources for physical, emotional, and spiritual needs
- Tenacity - being able to persevere
- Composure - having the ability to identify, understand, and act on one's own emotions and physical signs of stress

Resources:

- *What Trauma Taught Me about Resilience.* Charles Hunt. TEDxCharlotte. 2016.
- *The ABCs of Resilience.* Kathryn Meisner at TEDxYMCA Academy. 2014.
- *Resilience Now.* Joan Borysenko at TEDxGrandRapids. 2012.

- *Individual Resilience: Factsheet for Responders*. U.S. Department of Health & Human Services. 2015.

COVID-19 Specific Resources

- *A Time for Compassion.* Spiritual Care Association. 2020.
- *Covid-19 Resources.* Supportive Care Coalition. 2020.
- *Chaplaincy Innovation Lab COVID-19 Resources.* *Chaplaincy Innovation Lab, 2020.*
- *Blessing for Our Beloved Healthcare Community.* Hennepin Healthcare. 2020.
- *A Blessing for our Community.* Hennepin Healthcare. 2020.
- *Coronavirus Anxiety - Helpful Expert Tips and Resources.* Anxiety and Depression Association of America. 2020.
- *Managing Fears and Anxieties around the Coronavirus (COVID-19*). *Harvard Divinity School. 2020.*
- *Coping with COVID-19 Anxiety*. Ohio Department of Health. 2020.
- *Mental Health and Coping during COVID-19.* ATM Division of Student Affairs. Counseling & Psychological Services. 2020.

Examples

Chaplaincy care during a pandemic requires flexibility and creativity.   Chaplains have shared the following examples of how they are providing support and care:

- We all have full remote capabilities and use this to connect to patients, families, staff and each other 99.9% of the time in order to conserve PPE for bedside staff and provide the broadest possible coverage. When we have to be present, we are not visitors, but part of the interdisciplinary team.

- Some of the chaplains are working in house but seeing most of their patients virtually. She spent half the day yesterday in the office calling and then saw two patients in person in the PM. They are fully expecting to be working fully virtual soon.

- I am considered essential non-direct medical staff. I am not allowed to see patients, but can meet with the families who are allowed to stay. These families are confined to the hospital and are not allowed to leave. If they do, they cannot return. I am also allowed to visit only 1 unit/floor/day. I meet with families in my office or when I'm on their unit. I call families to check-in and provide emotional and spiritual support. I still meet with staff everywhere, cafeteria, hallway and my office. I met with our admissions team yesterday in a conference room maintaining social distancing. I was FaceTimed in and another called in. After checking in, I walked them through a guided meditation. They later expressed how helpful it was as they were hiding behind "I'm good, I'm ok". We put

together a PowerPoint presentation to be shown on the units on their monitors. Next week, the plan is to meet with staff. [Note: Many seem to be conflating the designation of "essential" with the assumption that their spiritual care be provided in person. This may be confusing the city/county/state declaration of some workers as "essential" and the hospital institutions or systems designated of a worker as "essential." Chaplains, especially now in this time of unprecedented crisis, are more essential now than ever. This does not mean that they are automatically working face to face with those they serve – be it patients, families, or staff.]

- We get a list of long stay patients each week. Press Ganey tells us that patients who are in the hospital for a long time are the most dissatisfied patients. We contact them by phone each week and let them know that they are not alone, what spiritual/religious services are available to them and find out about any wants or needs they may have that we can refer on to the interdisciplinary team.

- It is our current 'best practice initiative' to contact all patients who have new DNR designations to offer support and chaplain care. One of our residents is working to refine our 'script' so that the care we offer is consistent and focused on the patients' needs, hopes and resources.

- Chaplains contact persons who are in isolation and who may feel anxious and frightened.

- Although we cannot currently have in-person worship services in our tiny chapel, services are still ongoing and are televised to patient in their rooms.

- We do "virtual anointing" when requested.

- We put together what is called a survival kit. What we are doing right now is putting together a well-care gift baggy. It consist of tea bags, Life Savers, Hall's, honey for the tea (individual sizes) and a little note saying how much we appreciate them. This is for all staff not just nurses.   Our plan and execution is vetted by the Infection Control Department.