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[sam00913@yahoo.com](mailto:sam00913@yahoo.com) or  
316.655.0423

Compassion Fatigue: Caring for the Caregiver  
(An introductory workshop on Compassion Fatigue)  
by  
Rev. Samuel Wood  
Dawson United Methodist Church  
Wichita, KS

Welcome,

Congratulations on taking an important first step in becoming a more successful, resilient and joyful caregiver. Learning about Compassion Fatigue; its causes, symptoms, prevention and treatment help you “stay in the game” of caring for suffering persons, whether it be a family member, a person that you serve professionally or a victim of crime, accident, illness or natural disaster. If I can help you in any way, please let me know.

Blessings,

Sam

About the author:

Rev. Samuel Wood is a clergy member of the Kansas West Annual Conference of the United Methodist Church. His current appointment is to the Dawson United Methodist Church in Wichita, Kansas.

Rev. Wood's education included a BA/BS from the University of Missouri (Columbia), a Mdiv. from Saint Paul School of Theology (Kansas City), both an internship and residency in Chaplaincy that included psych., acute care and hospice settings, and advanced training in Traumatology. Traumatology is a specialized discipline that equips students to work with persons suffering from life altering traumatic experiences and to work with the professional and volunteer caregivers who assist such persons. Rev. Wood has earned advance certifications as a Certified Field Traumatologist, a Certified (Master) Traumatologist and as a Compassion Fatigue Educator.

Rev. Wood is prepared to assist your congregation, clergy group or professional group in understanding the issue of Compassion Fatigue more fully so that you will become a more resilient and skillful caregiver. If you would like to talk to him about workshops, advanced training or consultation after natural or man-made disasters, you may contact him at:

[sam00913@yahoo.com](mailto:sam00913@yahoo.com)

Or

316.655.0423

I hope the information contained in this workbook will benefit you in your compassionate mission.

Blessings,

Sam Wood

# Compassion Fatigue: Caring for the Caregiver

## Goals:

1. Provide an overview of Compassion Fatigue by the use of a “Compassion Fatigue Glossary”
2. Describe factors leading to Compassion Fatigue by the use of “Menu of Misconceptions”
3. Familiarize workshop with symptoms of Compassion Fatigue by describing a “Compassion Fatigue Trajectory”
4. Suggest practical ways of preventing CF by offering the “Caregiver’s Self-care Recipe”
5. List the actions necessary for recovery from Compassion Fatigue in a “Steps to Recovery”
6. Supply a Bibliography to support continued learning for Pastors and other Compassionate CareGivers.

## 1. A Compassion Fatigue Glossary

**Stress:** *The nonspecific response of the human organism to any demand placed upon it.* In other words, these demands may be physical (including health issues), emotional, interpersonal and/or spiritual. Stress has an initial impact of depleting physical, emotional, interpersonal and spiritual resources. (Stress Scale Tests found in the appendix)

**Suffering:** *A state of severe distress\* associated with events that threaten the intactness of the person.* (from Biology-online.org) (Not all stress is negative. Stress can be part of the challenges that support growth and vitality. Distress is “negative” stress that diminishes health, wellness and vitality. Interpretation often decides whether a stress is good stress or “distress”).

**Compassion:** *Deep awareness of the suffering of another coupled with the wish to relieve it.* (from yourdictionary.com)

**Compassionate Mission:** *Any endeavor by individuals, groups of individuals or organizations of alleviate the suffering of others.* The scope of the endeavor may range from individual to international. A key component is the interaction between the sufferer and persons coming to their aid.

**Compassion Fatigue:** 1) *A state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways including re-experiencing the traumatic event, avoidance/numbing of reminders of the event, and persistent arousal.* 2) *The natural consequence of stress resulting from caring for and helping traumatized or suffering people or animals.* It has been long recognized as an epidemic among emergency care workers and rescue personnel, and more recently has been widely acknowledged in all caregivers. Irritability, sleeplessness, emotional withdrawal, anxiety, isolation, and feelings of helplessness and inadequacy are among the reported symptoms. Although similar to critical incident stress (being traumatized by something you actually experience or see), with Compassion Fatigue you are absorbing the trauma through the eyes and ears of your clients. It can be thought of as secondary post-traumatic stress or vicarious Traumatization.

**Burnout:** *a state associated with stress and hassles involved in your vocation.* It is cumulative, is relatively predictable and frequently a vacation or change of job helps a great deal. Symptoms include: chronic fatigue, anger at those making demands, self-criticism for putting up with the demands, cynicism, negativity, and irritability, a sense of being besieged, exploding easily at seemingly inconsequential things, frequent headaches and gastrointestinal disturbances, weight loss or gain, sleeplessness and depression, shortness of breath, suspiciousness, feelings of helplessness, increased degree of risk taking

## **2. Menu of Misconceptions**

People on a compassionate mission often set themselves up for Compassion Fatigue because of a misconceived set of beliefs or goals that they carry with them into the compassionate mission.

1. I will “fix” the problem. (make everything O.K., save the world.....)
2. I am responsible for outcomes.
3. If I care enough, everything will be O.K.
4. The sufferer/victim will appreciate everything I do for them.
5. I will have enough resources (time, money, material, skills and training to fix things.
6. Significant people in my life with support and approve my absence from our relationship while I invest in this compassionate mission.
7. I know what I’m getting into.
8. I can do it alone.

9. If I'm spiritual enough, I can deal with the stress of working with suffering people.
10. My definition of success is.....

### **3. A Compassion Fatigue Trajectory**

There is a typical progression in the development of Compassion Fatigue. At any point in its progression Compassion Fatigue can be recognized, prevented, arrested and/or treated. Compassion Fatigue follows a trajectory that includes:

1. The Zealot Phase
  - a. Committed, involved and available
  - b. Solving problems/making a difference
  - c. Willing to go the "extra mile"
  - d. Displays high level of enthusiasm
  - e. Volunteers without being asked
2. The Irritability Phase
  - a. Begins to cut corners
  - b. Begins to avoid clients/patients
  - c. Begins to mock co-workers and clients
  - d. Begins to denigrate the people we serve
  - e. Inappropriate use of humor
  - f. Oversights, mistakes and lapses of concentration increase
  - g. Start distancing from friends and co-workers
3. The Withdrawal Phase
  - a. Enthusiasm turns sour
  - b. Clients become irritants instead of persons in need
  - c. Complaining about our work life and our personal life
  - d. Tried all the time, don't talk about what we do.
  - e. Start to neglect our family, clients, co-workers and ourselves
  - f. Avoid our own pain and sadness
4. The Zombie Phase
  - a. Our hopelessness turns to rage
  - b. We begin to hate people...any/all people
  - c. Others appear incompetent or ignorant to us
  - d. We develop a real disdain for our clients
  - e. We have...no patience...no sense of humor...or no time for fun
5. Pathology and Victimization vs. Maturation and Renewal

At any point that we recognize the development of Compassion Fatigue we can make the changes that will prevent

- A. Being overwhelmed and leaving the compassionate mission.
- B. Somatic Illnesses

- C. Perpetuity of Symptoms  
And that will allow the development of
- A. Hardiness
  - B. Resiliency
  - C. Transformation

### A word about “symptoms”

Symptoms are a widely varied as the compassionate missions we endeavor and as are our own predispositions and vulnerabilities. The following is a brief summary of Compassion Fatigue Symptoms:

- *Nervousness and anxiety* – Feeling anxious and in danger. Feeling fearful about going out. Being hyper-vigilant about your safety and you family’s safety.
- *Anger and irritability* – Feeling “angry at the world,” or feeling anger toward people you love and trust. Arguing often with relatives, friends or co-workers. Felling angry toward specific people or groups of people (including clients). Feeling aggressive or having a hard time controlling feelings of aggression.
- *Mood swings* – Having trouble controlling your emotions. Experiencing moods that go up and down. Feeling fine and then suddenly crying or feeling very anxious.
- *Flashbacks* – Intrusive thoughts related to your experience or the traumatic material of the persons you are assisting. This can mean experiencing nightmares containing images of the event or having spontaneous flashbacks and vivid memories of the experience. Flashbacks are often accompanied by physical sensations such as sweating or a racing heartbeat.
- *Difficulty concentrating* – Difficulty concentrating or making even simple decisions. Forgetting parts of your ordinary daily routine, like brushing your teeth, paying your bills or preparing meals.
- *Lowered self-esteem* – This can occur when you’re feeling as though you’re not doing enough to help, not doing everything “perfectly”, or feeling helpless to do anything to truly relieve another’s suffering.
- *Feeling less trusting of others and the world* – When you are continually immersed in a crisis, you may start to feel cynical and jaded by what you’ve been experiencing first hand.
- *Withdrawing from others* – Becoming emotionally distant and detached. Not wanting to talk about the event. Isolating from friends and family
- *Changes in appetite, sleep or other habits* – Not feeling hungry or forgetting to eat. Eating too much or nore than is healthy. Lack of interest in sex. Sleeping too much. Having trouble falling asleep or staying asleep. Having

nightmares related to the events you've been witnessing or hearing about in graphic detail.

- *Physical changes* – Physical symptoms like headaches, stomachaches, dizziness, heart palpitations or shortness of breath. Feeling shaky, panicky or very tired. Flu or cold-like symptoms. There is some evidence that Compassion Fatigue leads to a weakening of the immune system that can increase susceptibility to illnesses to which the individual might be predisposed, but would not otherwise have experienced.
- *Depression* –Feeling of sadness and grief. Feelings a loss of energy or a loss of interest or pleasure in ordinary activities. Changes in appetite or weight. Having memory difficulties, frequent crying episodes, feelings of hopelessness or suicidal thought. (If you are having suicidal thought, it is important to seek professional help immediately.)
- *Self-Medication* – Using drugs or other mood altering substances (the two substances of choice are alcohol and caffeine) to numb the pain and displacement that Compassion Fatigue is causing. Such retreats into self-medication can prevent the caregiver from recognizing or admitting their own suffering.
- *Self-Entitlement* – One of the most tragic symptoms of Compassion Fatigue is addictive, obsessive or anti-social behaviors that can include substance abuse, gambling, spouse and child abuse, infidelity, use of pornographic material or other risk taking activities. The caregiver can come to see himself or herself as the victim. Within the context of isolation, such a person can come to believe that they are “entitled to” do whatever they want to do.

## **4. A Caregiver's Self-Care Recipe**

### **1 part Self-Knowledge**

Before undertaking a compassionate mission, a careful self-assessment is important. Do you have the physical, emotion and spiritual strength to complete the task? Do you have significant unresolved trauma in your personal history? Are you at this moment in time under such distress as to be in need of care yourself? Do you have debilitating physical or psychological conditions that would interfere with the successful completion of your compassionate mission?

### **1 part Self-Examination**

Examine your motivation for undertaking the compassionate mission. Are you a crusader out to save the world? Are you committing out of guilt? Are you being pushed by an unrealistic sense of responsibility? Is your identification with the sufferer driving you to act? Do you have sufficient training, skills and temperament to complete the compassionate mission? Am I taking on this Compassionate Mission in order to avoid problems and responsibilities at home?

### **1 part Resourcing**

Are there additional training opportunities available? Do you have a team to partner with in support of your efforts? Are you part of an organization that will provide oversight or support? Are there governmental or institutional resources that can be included in your effort? Do you have access to medical, psychological and spiritual support for the length of your effort? Is your family and social network behind you?

### **1 part Expectations**

Are your expectations realistic? What is your measure of success? What about this Compassionate Mission remains unknown? Can you accept a lack of control of the process and outcome of this Compassionate Mission? Do you believe that God is ultimately in control and is working for the good of all, even in this suffering and your effort to alleviate this suffering?

### **1 part Self-Care Strategy**

Have you a clear understanding of your commitment? (how long, what is your responsibility)

Does your commitment allow for self-care, including personal hygiene, proper nutrition, adequate rest, exercise, alone time and relational time, and spiritual renewal.

Who will you call if you start to feel overwhelmed? Have they agreed to partner with you during your compassionate mission?

Are you willing to moderate your use of caffeine and alcohol during this time?

Do you have the choice to withdraw from the compassionate mission if it becomes overwhelming?

What are your “stress reducing practices” that you will use during this effort? Name at least three.

### **1 part Plan for Re-entering a Normal Life**

Have you allowed for some “down time” after your compassionate mission? How do you plan to reconnect of significant others? Can you include them in your

processing of your experience by appropriate sharing? How can you benefit your greater circle of friends with the learnings that this compassionate mission has gifted you?

## 5. “Steps to Recovery”

(adapted from “Compassion Fatigue: A Crucible of Transformation” – J. Eric Gentry)

**“Intentionality”** - The initiation of effective resolution of compassion fatigue symptoms requires specific recognition and acceptance of the symptoms and their causes by the caregiver, along with a decision to address and resolve these symptoms. Many caregivers who experience symptoms of compassion fatigue will attempt to ignore their distress until a threshold of discomfort is reached. For many caregivers this may mean that they are unable to perform their jobs as well as they once did or as well as they would like due to the symptoms they are experiencing. For others, it may entail the progress debilitation associated with somatic symptoms or the embarrassment and pain associated with secretive self-destructive comfort-seeking behaviors. Whatever the impetus, successful amelioration of compassion fatigue symptoms requires that the caregiver intentionally acknowledge and address, rather than avoid, then symptoms and their causes. Additionally, the use of goal-setting and the development of a personal/professional mission statement had been found to be invaluable in moving away from the reactivity associated with the victimization of compassion fatigue and toward resiliency and intentionality of mature caregiving.

**“Connection”** - One of the ways trauma seems to affect us all, caregivers included, is to leave us with a sense of disconnected isolation. A common thread found with sufferers of compassion fatigue symptoms has been the progressive loss in their sense of connection and community. Many caregivers become increasingly isolated as their symptoms intensify. Fear of being perceived as weak, impaired, or incompetent by peers and clients, along with time constraints and loss of interest, have all be cited by caregivers suffering from compassion fatigue as reasons for diminished intimate and collegial connection. The development and maintenance of healthy relationships, which the caregiver uses for both support and to share/dilute the images and stories associated with secondary traumatic stress, may become a powerful mitigating factor in resolving preventing compassion fatigue symptoms. Through relational connections, the caregiver is able to gain insight and understanding that their symptoms are not an indication of pathological weakness or disease, but are instead natural

consequences of providing care to suffering individuals. With the enhanced self-acceptance attained through self-disclosure with and by empathetic and understanding peers, caregivers are able to begin to see their symptoms as indicators of the developmental changes needed in both their self-care and caregiving practices. A warm, supportive environment in which caregivers are able to discuss intrusive traumatic material, difficult clients, symptoms, fears, shame, and secrets with peers can be one of the most critical ingredients in the resolution and continued prevention of compassion fatigue.

**“Anxiety Management/Self-soothing”** – Attempting to provide caregiving services while experiencing intense anxiety is one of the primary means by which compassion fatigue symptoms are contracted and exacerbated. Alternately stated, to the degree that a caregiver is able to remain non-anxious; he/she will maintain resistance to the development of symptoms of compassion fatigue. The ability to self-regulate and soothe anxiety and stress is thought to be a hallmark of maturity. The mastery of these skills comes only with years of practice. However, if we fail to develop the capacity for self-regulation, if we are unable to internally attenuate our own level of arousal, then we are susceptible to perceiving as threats those people, objects and situation to which we respond with anxiety – believing that benign people, objects and situations are dangerous. Caregivers with well-developed self-regulation skills who do not resort to self-destructive and addictive comfort-seeking behaviors are unlikely to suffer symptoms of compassion fatigue. The caregiver should work toward maintaining a “non-anxious presence”. This non-anxious presence extends far beyond a calm outward appearance. Instead, it entails the ability to maintain a level of relaxed mindfulness and comfort in one’s own body. This ability to remain non-anxious when confronted with the pain, horror, loss and powerlessness associated with the traumatic experiences in the lives of the people we would help, of having the capacity to calmly “bear witness,” remains a key ingredient in the resolution and prevention of compassion fatigue.

**“Self-care”** – Closely associated with self-management is the concept of self-care, or the ability to refill and refuel oneself in healthy ways. It is quite common for caregivers to find themselves anxious during and after working with suffering individuals. Instead of developing a system of healthy practices for resolving this anxiety – such as sharing with colleagues, exercise, medication, nutrition and spiritual practices – many caregivers find themselves redoubling their work efforts. Frequently this constricting cycle of working harder in an attempt to feel better creates a distorted sense of entitlement that can lead to a breach of personal and professional boundaries. Many caregivers have reported falling prey to compulsive behaviors such as overeating, overspending, or alcohol/drug abuse in

an effort to sooth the anxiety they feel from the perceived demands of their work. Other admit to breaching professional boundaries and ethics when at the low point in this cycle, distortedly believing that they “deserve” this “special” treatment or reward. When caregivers fail to maintain a life that is rich with meaning and gratification outside their compassionate mission, then they will often look to their work as the sole source of these commodities. It is completely understandable that this orientation would produce symptoms in caregivers. Conversely, when caregivers responsibly pursue and acquire this sense of aliveness outside the closed system of their compassionate mission, then they are able to engage in work with suffering people while sharing the resources of their own fullness, meaning and joy.

One of the most important aspects of this category of self-care is the development and maintenance of a regular exercise regimen. On other single behavior seems as important as regular aerobic and anaerobic activity. In addition to exercise, good nutrition, artistic expression, meditation/ mindfulness, outdoor recreation, and the practices of our faith all seem to be important ingredients to a good self-care plan.

Some caregivers have compassion fatigue symptoms that seem to be caused by working in situations that require skills that the caregiver does not have. Skill acquisition is a powerful way of reducing the impact of compassion fatigue symptoms. If your compassionate mission is within a professional setting, continuing education will offset the anxiety produced from being out of your depth.

**“Narrative”** - The creation of a time-line narrative of a caregiving experience that identifies the experiences and persons from which the caregiver developed primary and secondary traumatic stress is invaluable in the resolution of compassion fatigue symptoms, especially those associated with secondary traumatic stress. This narrative processing of the compassion mission will bring into the open both the troubling and rewarding aspects of the experience.

**“Desensitization and Reprocessing”** – By repeated use of narrative processing and prayerful remembering of the experience within the context of supportive relationship, the intensity of the caregiver’s primary and secondary traumatic stress and the cessation of intrusive symptoms often give way to a sense of rebirth, joy and transformation. This important step in the treatment of compassion fatigue should not be minimized. It will often require the facilitation of someone trained in a range of desensitization and reprocessing techniques. (EMDR, TIR, TFT, EFT). During this time mobilization of the caregiver’s full spiritual resources

including pastors, chaplains, counselors and prayer partners can be profoundly helpful.

**“Self-supervision”** – There are certain distorted belief and cognitive style that frustrate complete recovery from compassion fatigue. This is especially true for the way in which we supervise and motivate ourselves. Caregivers recovering from the symptoms of compassion fatigue will need to soften their critical and coercive self-talk and shift their motivational styles toward more self-accepting and affirming language and tone if they wish to resolve their compassion fatigue symptoms. For many this is a difficult, tedious and painstaking “breaking of bad habits” process than can take years to complete. Techniques that remind the caregiver of their good qualities, their “successful” efforts, while teaching them to value themselves will open the door to a self-management style that will be encouraging and will allow the self-loathing that often reinforces compassion fatigue symptoms to be removed. Understanding where in your life you learned harsh, non-constructive self-management will go a long way to free the caregiver from the “no win” attitude that leads to compassion fatigue.

## **6. Bibliography:**

For the electronically savvy, here is the ultimate page for links on the subject of compassion fatigue:

[http://home.earthlink.net/~hopefull/TC\\_compassion\\_fatigue.htm](http://home.earthlink.net/~hopefull/TC_compassion_fatigue.htm)

For all you others, enjoy sorting your way through the following:

Arlen, S.B. (1990, June). Good selfishness. Bereavement Magazine, pp. 10-11.

Borysenko, J. (1987). Minding the body, mending the mind. New York: Bantam Books.

Callanan, M. & Kelly, P. (1992). Final gifts. New York: Poseidon Press.

Cameron, J. (1992). The artist's way. New York: G.P. Putnam's Sons.

Caring for the caregiver: Coping with the death of a patient. (1990, May), Bereavement Magazine, pp- 26-27.

Carter, R. & Golant, S. K. (1994). Helping yourself help others: A book for caregivers. New York: Times Books.

Charney, A.E., & Pearlman, L.A. (1998). The ecstasy and the agony: The impact of disaster and trauma work on the self of the clinician. In P. Kleespies (Ed.), Emergency psychological services: The evaluation and management of life-threatening behavior, pp. 418-435. New York: The Guilford Press.

Deits, B. (1988). Life after loss. A personal guide dealing with death, divorce, j( change and relocation. Tucson, AZ: Fisher Books.

Feldstein, M. A. & Gemma, P. B. (1995). Oncology nurses and chronic compounded grief. Cancer Nursing, 18, 228-236.

- Figley, C. (Ed.). (1995). Compassion fatigue: Secondary traumatic stress disorders from treating the traumatized. New York: Brunner/Mazel.
- Figley, C.R. (Ed.). (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.
- Heinrich, K. & Killeen, M. E. (1993). The gentle art of nurturing yourself. American Journal of Nursing, 93(10), 41-44.
- Katherine, A. (1991). Boundaries: Where you end and I begin. Park Ridge, IL: Parkside Publishing Corporation.
- Klein, A. (1989). The healing power of humor. Los Angeles: Jeremy P. Tarcher, Inc.
- Larson, D.G. (1993). The helper's journey: Working with people facing grief, loss and life-threatening illness. Champaign, IL: Research Press.
- McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3 131 - 149.
- Miller, E.E. (1986). Self imagery: Creating your own good health. Springfield, IL: Human Services Press.
- Osmont, K. (1990). More than surviving, caring for yourself while you grieve. Omaha, NE: Centering Corporation.
- Pearlman, L.A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B.H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators, pp. 51-64. Lutherville, MD: Sidran Press.
- Pearlman, L.A., Saakvitne, K.W., et al. (1995). Vicarious traumatization I: The cost of empathy. Ukiah, CA: Cavalcade Productions, Inc.
- Pearlman, L.A., Saakvitne, K.W., et al. (1995). Vicarious traumatization II: Transforming the pain. Ukiah, CA: Cavalcade Productions, Inc.
- Saakvitne, K.W., Pearlman, L.A., & the Staff of the Traumatic Stress Institute (1996). Transforming the pain: A workbook on vicarious traumatization. New York: W.W. Norton.
- Schauben, L.J., & Frazier, P.A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. Psychology of Women Quarterly, 19(1), 49-64.
- Smith, D. (1994). The Tao of dying. Washington, DC: Caring Press.
- Springer, L. K. (1992). Caregiver characteristics as seen by patients, family, and caregivers. The Forum, 7-9.
- Taigman, M. (1996, June). Can empathy and compassion be taught? Journal of Emergency Medical Services, pp. 43-48.
- Travis, J. W. & Callander, M. G. (1990). Wellness for helping professionals. Mill Valley, CA: Wellness Associates.
- Vineyard, S. (1989). How to take care of you. Downers Grove, IL: Heritage Arts Publishing.
- Wolfelt, A.D. (1997). How to care for yourself while you care for the dying and bereaved. Fort Collins, CO: Companion Press.

## Appendix:

- 1. Stress Scale Tests**
- 2. Common Responses to trauma and Coping Strategies**
- 3. ProQOL R-IV**

## **STRESS SCALE FOR ADULTS**

In the following table you can look up representative changes in your life and see how much stress value each of these changes is adding to your life. NOTE ANY ITEM THAT YOU MAY HAVE EXPERIENCED IN THE LAST TWELVE MONTHS. Then, total up your score.

(Adapted from the "Social Readjustment Rating Scale" by Thomas Holmes and Richard Rahe. This scale was first published in the "Journal of Psychosomatic Research", Copyright 1967, vol.II p. 214. It is used by permission of Pergamon Press Ltd.)

STRESS	EVENT VALUE
DEATH OF SPOUSE	100
DIVORCE	60
MENOPAUSE	60
SEPARATION FROM LIVING PARTNER	60
JAIL TERM OR PROBATION	60
DEATH OF CLOSE FAMILY MEMBER OTHER THAN SPOUSE	60
SERIOUS PERSONAL INJURY OR ILLNESS	45
MARRIAGE OR ESTABLISHING LIFE PARTNERSHIP	45
FIRED AT WORK	45
MARITAL OR RELATIONSHIP RECONCILIATION	40
RETIREMENT	40
CHANGE IN HEALTH OF IMMEDIATE FAMILY MEMBER	40
WORK MORE THAN 40 HOURS PER WEEK	35
PREGNANCY OR CAUSING PREGNANCY	35
SEX DIFFICULTIES	35
GAIN OF NEW FAMILY MEMBER	35
BUSINESS OR WORK ROLE CHANGE	35

CHANGE IN FINANCIAL STATE	35
DEATH OF A CLOSE FRIEND (not a family member)	30
CHANGE IN NUMBER OF ARGUMENTS WITH SPOUSE OR LIFE PARTNER	30
MORTGAGE OR LOAN FOR A MAJOR PURPOSE	25
FORECLOSURE OF MORTGAGE OR LOAN	25
SLEEP LESS THAN 8 HOURS PER NIGHT	25
CHANGE IN RESPONSIBILITIES AT WORK	25
TROUBLE WITH IN-LAWS, OR WITH CHILDREN	25
OUTSTANDING PERSONAL ACHIEVEMENT	25
SPOUSE BEGINS OR STOPS WORK	20
BEGIN OR END SCHOOL	20
CHANGE IN LIVING CONDITIONS (visitors in the home, change in roommates, remodeling house)	20
CHANGE IN PERSONAL HABITS (diet, exercise, smoking, etc.)	20
CHRONIC ALLERGIES	20
TROUBLE WITH BOSS	20
CHANGE IN WORK HOURS OR CONDITIONS	15
MOVING TO NEW RESIDENCE	15
PRESENTLY IN PRE-MENSTRUAL PERIOD	15
CHANGE IN SCHOOLS	15
CHANGE IN RELIGIOUS ACTIVITIES	15
CHANGE IN SOCIAL ACTIVITIES (more or less than before)	15
MINOR FINANCIAL LOAN	10
CHANGE IN FREQUENCY OF FAMILY GET-TOGETHERS	10
VACATION	10
PRESENTLY IN WINTER HOLIDAY SEASON	10
MINOR VIOLATION OF THE LAW	5

TOTAL SCORE \_\_\_\_\_

## STRESS SCALE FOR YOUTH

STRESS	EVENT VALUE
DEATH OF SPOUSE, PARENT, BOYFRIEND/GIRLFRIEND	100
DIVORCE (of yourself or your parents)	65
PUBERTY	65
PREGNANCY (or causing pregnancy)	65
MARITAL SEPARATION OR BREAKUP WITH BOYFRIEND/GIRLFRIEND	60
JAIL TERM OR PROBATION	60
DEATH OF OTHER FAMILY MEMBER (other than spouse, parent or boyfriend/girlfriend)	60
BROKEN ENGAGEMENT	55
ENGAGEMENT	50
SERIOUS PERSONAL INJURY OR ILLNESS	45
MARRIAGE	45
ENTERING COLLEGE OR BEGINNING NEXT LEVEL OF SCHOOL (starting junior high or high school)	45
CHANGE IN INDEPENDENCE OR RESPONSIBILITY	45
ANY DRUG AND/OR ALCOHOL USE	45
FIRED AT WORK OR EXPELLED FROM SCHOOL	45
CHANGE IN ALCOHOL OR DRUG USE	45
RECONCILIATION WITH MATE, FAMILY OR BOYFRIEND/GIRLFRIEND (getting back together)	40
TROUBLE AT SCHOOL	40
SERIOUS HEALTH PROBLEM OF A FAMILY MEMBER	40
WORKING WHILE ATTENDING SCHOOL	35
WORKING MORE THAN 40 HOURS PER WEEK	35

CHANGING COURSE OF STUDY	35
CHANGE IN FREQUENCY OF DATING	35
SEXUAL ADJUSTMENT PROBLEMS (confusion of sexual identity)	35
GAIN OF NEW FAMILY MEMBER (new baby born or parent remarries or adopts)	35
CHANGE IN WORK RESPONSIBILITIES	35
CHANGE IN FINANCIAL STATE	30
DEATH OF A CLOSE FRIEND (not a family member)	30
CHANGE TO A DIFFERENT KIND OF WORK	30
CHANGE IN NUMBER OF ARGUMENTS WITH MATE, FAMILY OR FRIENDS	30
SLEEP LESS THAN 8 HOURS PER NIGHT	25
TROUBLE WITH IN-LAWS OR BOYFRIEND'S OR GIRLFRIEND'S FAMILY	25
OUTSTANDING PERSONAL ACHIEVEMENT (awards, grades, etc.)	25
MATE OR PARENTS START OR STOP WORKING	20
BEGIN OR END SCHOOL	20
CHANGE IN LIVING CONDITIONS (visitors in the home, remodeling house, change in roommates)	20
CHANGE IN PERSONAL HABITS (start or stop a habit like smoking or dieting)	20
CHRONIC ALLERGIES	20
TROUBLE WITH THE BOSS	20
CHANGE IN WORK HOURS	15
CHANGE IN RESIDENCE	15
CHANGE TO A NEW SCHOOL (other than graduation)	10
PRESENTLY IN PRE-MENSTRUAL PERIOD	15
CHANGE IN RELIGIOUS ACTIVITY	15
GOING IN DEBT (you or your family)	10
CHANGE IN FREQUENCY OF FAMILY GATHERINGS	10
VACATION	10
PRESENTLY IN WINTER HOLIDAY SEASON	10
MINOR VIOLATION OF THE LAW	5

TOTAL SCORE \_\_\_\_\_

We have asked you to look at the last twelve months of changes in your life. This may surprise you. It is crucial to understand, however, that a major change in your life has effects that carry over for long periods of time. It is like dropping a rock into a pond. After the initial splash, you will experience ripples of stress. And these ripples may continue in your life for at least a year.

So, if you have experienced total stress within the last twelve months of 250 or greater, even with normal stress tolerance, you may be OVERSTRESSED. Persons with Low Stress Tolerance may be OVERSTRESSED at levels as low as 150.

OVERSTRESS will make you sick. Carrying too heavy a stress load is like running your car engine past the red line; or leaving your toaster stuck in the "on" position; or running a nuclear reactor past maximum permissible power. Sooner or later, something will break, burnup, or melt down.

What breaks depends on where the weak links are in your physical body. And this is largely an inherited characteristic.

### **Stress symptoms affect different parts of the body**

#### **Brain OVERSTRESS**

Fatigue, aches and pains, crying spells, depression, anxiety attacks, sleep disturbance.

#### **Gastrointestinal Tract**

Ulcer, cramps and diarrhea, colitis, irritable bowel.

#### **Glandular System**

Thyroid gland malfunction.

#### **Cardiovascular**

High blood pressure, heart attack, abnormal heart beat, stroke.

#### **Skin**

Itchy skin rashes.

#### **Immune System**

Decreased resistance to infections and neoplasm.

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