# Reforms of Elderly Long-Term Care Insurance System in Germany and Japan - Focused on the Development of Community Services for the Elderly with Consulting and Support Functions -

Hirokazu MURAKAWA
Kaori YASUMURA

## Introduction

Japan entered the 21st century with the prominent social trends of low birth rate and ageing population. The challenge regarding long-term care arose with the increasing number of the elderly who needs medical and social cares, attracted much attention and it became one of the biggest issues to consider in the latter half of the life for every older person in the country. This phenomenon is happening not just in Japan but also globally, especially in most of the developed countries. The governments are trying various ways to deal with this; Germany introduced long-term care insurance in 1995 that focuses on a social insurance model. The United Kingdom and the Northern European countries, including Sweden, employ tax-funded public service as its main provider with NPOs playing a certain roles, while the United States relies heavily on the market mechanism. The techniques and methods for assessment of needs and the care management that meet the needs of the elderly have also been developed against these backgrounds.

The present paper aims to explain and comment on the Japanese long-term care insurance system, its social background, the structure and the features of the services, drawing comparison with the recent trends in Germany. It also attempts to provide the mid-term vision for the Japanese system, based on the sustainability and on-site practical knowledge.

Among others, the revision of long-term care insurance law in 2005 in Japan, as well as the German long-term care reform of 2008 highlighted the need of the systems to function in a sustainable and balanced manner, the need for popularization of comprehensive community services, including dementia care, and collaboration with preventive system. The increase of the elderly population living alone and/or with dementia, along with the rapidly ageing population of large cities are imperative challenges.

In the era of rapid social and economic changes domestically and internationally, including the polarization of society with higher numbers of jobless, these reforms and supports clearly identify the roles of long-term care, medical care, pension, and employment systems in social policies and measures, which will contribute to creating more cohesive social policies.

# 1. German long-term care insurance reform in 2008 (Pflegereform 2008)

## 1-1

Preceding Japan, the long-term care insurance law was enacted in 1994 in Germany with the gradual implementation from 1995. The law went through several revisions and in 2008, a major reform (*Pflegereform 2008*), including a gradual increase of benefit payments and provision for more thorough care for dementia, was introduced. As in Japan, Germany faces challenges such as tight budgets for long-term care, increase in the numbers of elderly with dementia, and lack of care services and human resources. Though there are considerable differences, including the collection of contributions, the provision of cash benefit as well as the scope of the benefit recipients, the trends in the German reform provide a valuable suggestion for Japan to investigate its future long-term care insurance system.

As for the running of the long-term care insurance system, the care management function has been playing a significant role in Japan. On the other hand, in the original German system, the function equivalent to the Japanese care management was not clearly defined. Therefore, when applying for the benefits and services including long-term care, the elderly and their families were using the information providing service offered by the local authorities as well as consulting supports offered by care service providers. Several issues were pointed out regarding this situation, and the 2008 reform, which was implemented gradually from July 2008, created a consulting support and service coordinating function within the long-term care insurance system.

In this paper, an overall picture of the German long-term care reform of 2008 is firstly outlined and its issues are discussed. The focus is especially placed upon the newly created consulting support and service coordinating function, the care support centers (*Pflegestützpunkt*). After discussing its notable points and issues, we would like to move on to the investigation that seeks a favorable future of consulting support and service coordinating function in Japan.

## 1-2 The long-term care insurance reform in 2008 (Pflegereform 2008)

To cater for the ageing population and accompanying increase of the elderly in need of care, a major reform of the long-term care insurance system was introduced in Germany in 2008. The reform is focused mainly on the following areas; (1) benefit payment increase with focus on home care, (2) enhancement of information provision for the elderly in need of care and their families, (3) enhancement of comprehensive support for individuals with dementia, and (4) enhancement of the information provision regarding the quality of care-homes. To achieve these, the contribution rates were raised from 1 July 2008, to 1.95% of income (2.2% for those without a child). Especially notable points of the reform are explained further as follows:

**(1) Increase of benefit payments**

Monthly payments for care recipients will increase gradually till 2012. Table1 show the amounts given for individuals in need of care but who prefer to stay at home. Increase is most apparent in the benefits in-kind for at-home-care, compared to institutional care, with support enhancement of a shift from

institutional care, such as medical facilities, to homecare as well as an acceleration of benefit eligibility evaluation procedures.

**Table 1 Benefit levels for benefits in-kind**

| Care level（Monthly：€） | Pre2008 | 2008 * | 2010 | 2012 |
|---|---|---|---|---|
| Ⅰ | 384 | 420 | 440 | 450 |
| Ⅱ | 921 | 980 | 1,040 | 1,100 |
| Ⅲ ** | 1,432 | 1,470 | 1,510 | 1,550 |

*Amount payable from 1 July 2008

** Payment for most severe cases remains the same at 1,980EUR per month

（Bundesministerium für Gesundheit: Gut zu wissen-das Wichtigste zur Pflegereform 2008, Juni 2008)

**(2) Measures for dementia patients**

Homecare benefits were raised for those with severe incapacity for everyday life, such as severe dementia patients and mentally disabled individuals. It was 460 EUR per year before 2008 but was raised to 100 EUR (basic benefit) or 200 EUR (severe cases) per month, resulting in 1,200 - 2,400 EUR annually. This applies to those dementia patients in institutional care as well, enabling the institutions to provide additional cares and activities with extra staff for the patients.

**(3) Establishment of the care support centers (*Pflegestützpunkt*) as the comprehensive consultation provider**

This will be discussed in detail in the later sections.

**(4) Enhancement of nursing leave**

Those who work at a company with more than 15 employees are entitled to nursing leave for up to 6 months. Though the salary will not be paid during this period, the social benefit entitlement will continue.

**(5) Improvement of care quality**

A federal level of quality improvement measure (Expertenstandards) was introduced and care quality assessment was enhanced.

Every institution is obliged to accept a yearly inspection without notice. The resulting quality assessment report is published on the Internet, at the institution and *Pflegestützpunkt*.

The reform also includes guaranteeing of care workers' wages, support enhancement of self-help groups and volunteer activities as well as enhancing prevention and rehabilitation.

## 1-3 Notable points and issues of the reform[1]

The most notable and welcome point of the 2008 reform is the strong preference for homecare over

[1]The notable points and issues regarding the German long-term care reform of 2008 sums up the response of a questionnaire, sent to academics and care work practitioners in Germany by the author.

institutional care. Most of the frail elderly, in Germany or in Japan, want to continue living at their own home as long as possible. Promoting home care is also financially favorable compared to institutional care. However, it is not clear at this point whether the care quality and quantity required can be achieved, and further improvement may be necessary.

There is also a positive advancement regarding the benefit amounts for individuals with dementia. However the care service provision in terms of quality and quantity is not sufficient and it is imperative that measures are put in place to train qualified caregivers.

The biggest challenge is the finance. Demographic changes and the increasing number of individuals needing care will certainly reduce the contribution income and push up the cost. The long-term care insurance system in Germany was conceived originally as a partial insurance, rather than intending to cover all the living costs of the recipients. It is not clear at this point to what extent the long-term care benefit can cover the cost in future, and personal provision will become more important.

The possibility of a support system other than the social insurance provision, such as community-led services and volunteering, needs to be investigated as well. The ultimate goal is to make sure the frail elderly stay and receive care at home till the last possible stage, without becoming dependant on the public assistance. This in turn enables a comparative reduction of the cost over institutional care with increased quality of life for the elderly.

## 1-4 Long-term care insurance in Japan

Though there are considerable differences between the German and Japanese long-term care insurance systems, the German reform in 2008 provides several insights for Japan.

The first point is the issue regarding homecare services. The increase of the benefit amounts demonstrated the preference of homecare over institutional care in Germany, but this should not be taken just as a cost cutting measure to control expensive institutional care. The challenge is to make it a really supportive measure for the elderly to continue to live at home and be cared for as they wish. In order to achieve that, it is necessary to secure the quantity and quality of homecare services as well as to provide various out-of-the system services in order to meet the variety of needs of the elderly. So, establishing a function that collects and provides the information regarding long-term care, that also organizes the actual care effectively and efficiently, combining the services within and outside the official system, will become more important. The comprehensive community support center, which will be discussed in detail later, will be expected to play an important role here.

The second point is regarding the measures to cope with the increasing number of elderly with dementia. The benefits for those who have severe incapacity for everyday life including the elderly with dementia were significantly raised in the German reform. It is a welcome move; however, securing sufficient number of qualified staff is necessary. The issue of the elderly with dementia is becoming widely reported in Japan, but there are still many cases where the burden of caring for such individuals falls solely on the families. It is imperative to improve the dementia care system so that it offers easy-to-use services.

Financing these cares is the biggest challenge for both countries. Increasing numbers of the elderly and the individuals in need of care will put larger pressure on care budgets that both countries need to

address urgently. A reform that takes the cost effectiveness of the services into account is inevitable but the situation where necessary care is no longer provided for the individual in need of such care must be avoided. In the German reform in 2008, both the contributions and the benefit provision were raised at the same time. Its financial outcome as well as the long-term trends such as improvement of the life of the elderly in need to be monitored and analyzed carefully in future.

## 2. The consulting support and service coordinating function for the elderly in Germany

Under the reform in 2008, *Pflegestützpunkt* (care support center) were newly created as the comprehensive service provider for the elderly in need. Here, the background of establishing such a service and its overall function are summarized and its notable points and issues will be discussed. From there we will further provide some opinions regarding how consulting support organizations such as comprehensive community support centers in Japan should be run.

### 2-1 Establishment of the *Pflegestützpunkt* (care support center)

Traditionally in Germany, consultation and organizing the services for the elderly in need and their families were offered by municipal information service and care service providers. However, this was deemed to be unsatisfactory. The collaborative link between the municipal information service and the care service providers was weak and there was qualitative variability among the municipalities. The care service providers tend to work for their business interests. And the consultation for support had a too narrow scope. To counter these problems, *Pflegestützpunkt*, a 'one-stop-shop' for information, consultation, and service coordination was established. Following is a summary of *Pflegestützpunkt*. However, being a federal republic with a large part of the power lying at the state level, it is the states which decide matters concerning *Pflegestützpunkt*, including their establishment, thus there are wide regional differences.

**(1) Function**

*Pflegestützpunkt* offers comprehensive consultation to the elderly in need of care and their families. It also coordinates, organizes, and arranges long-term care, medical care, and official aid and other support services.

**(2) Consulting support service**

From January 2009, all individuals in need of care became legally entitled to access the care consultation (*Pflegeberatung*). All the municipalities are now obliged to offer those individuals comprehensive care support service; however, it is up to the individual whether to use this service or not. The care consultation includes provision of information regarding local care services inside and outside the long-term care insurance system as well as organizing and coordinating a comprehensive service package. Consultation is given by a care advisor (*Pflegeberater*) stationed at *Pflegestützpunkt*. The qualifications of a care advisor are not clearly defined, but social workers, geriatric caregivers and nurses are considered appropriate candidates and a senior level case management course is being set up. Related

organizations such as social workers institutes produced a shared guideline that requires the care advisor to have advanced expertise on case management, with on-site experience of at least one year after obtaining a qualification from a specialized higher education course.

**(3) Configuration**

*Pflegestützpunkt* makes it a principle to be neutral and independent, but it is allowed to be set up as a part of the existing consultation support organizations and care service providers.

## 2-2 Notable points and issues regarding *Pflegestützpunkt*

Notable and welcome points for setting *Pflegestützpunkt* are as follows: (1) Individuals in need of care and their family can solve problems regarding the provisions of health, long-term care insurance, and other related services at a one-stop organization. (2) The same dedicated care advisor continuously looks after a care recipient enabling comprehensive planning, coordination, and follow-up of the services, which in turn mitigates the burden of the care recipients and their family. (3) Comprehensive planning for each care recipient is expected to have a positive effect toward rationalizing limited budgets. (4) Care advisers at *Pflegestützpunkt*, in principle, do not belong to any care service providers, enabling avoidance of influence peddling.

With the establishment of care support centers, the support for service activities run by volunteers was enhanced. As a worsening of the insurance finance is expected in the future ageing society, enhancement of variety of services that do not depend on the social insurance is necessary. It is expected that *Pflegestützpunkt* will collect information about and coordinate various services including self-help groups and volunteer services outside the official benefits as well as playing a role in promoting and creating new services.

Meanwhile, problems are apparent too. First, it is up to the users whether they use their care consultation entitlement or not, thus it is unknown at this point how many people would take up the service and how effective it is. Since it is expected that the set-ups and management format of the centers would be varied, it is also difficult to verify the effectiveness of the operation in terms of promoting homecare and lessening the family burden. Though it is expected that enhancing at-home long-term care would reduce cost, setting up the new support centers, as well as increasing provision of the benefits owing to the increasing number of elderly clients would push up the cost considerably, thus financial outlook in future is still severe. And if the take-up of the care consultation entitlement is low, the expected effects, such as the mitigation of care recipients and families' burden and efficient use of services, would be generally low. The challenge is the actual functionality of *Pflegestützpunkt* and promotion of its existence to the would-be users.

## 2-3 The consulting support and service coordinating function for the elderly in Japan

In Japan, care management/care managers play a core function in consulting support and service coordinating. The German initiatives such as independent consultation, unified provision of information and service coordination, and introduction of a higher qualification path for care advisors with courses that

place importance on interpersonal support techniques as well as basic qualifications, should be watched carefully, since there are considerable benefits that Japan might be able to adopt in realistic ways.

In addition, the German initiative of *Pflegestützpunkt* may also give us some ideas regarding the comprehensive community centers of Japan that is currently functioning as the comprehensive consultation service for the elderly in need. In order to run care services within and outside of the long-term care insurance system efficiently, effectively, and responsively to the needs of the users, it is firstly necessary to form a close collaboration between consultation services, care planning entities, and care service providers. As the independent comprehensive consultation organization, the comprehensive community support centers can play an important role. Since there is a limit as to the extent of services the long-term care insurance system can offer, and since further budget tightening is expected in the long-term care area, it is clear that new services that do not rely on the system, such as volunteering and community specified services, will become more important. Development and coordination of such new services is one of the priorities that the comprehensive community support centers should address.

## 3. Main points of the Japanese reform of the long-term care insurance system and its development

### 3-1 Strategic viewpoints of the reform

The basic standpoint of the revision of the long-term care insurance (June 2005, in force from April 2006) is long-term sustainability; to create a system that functions continuously in a stable manner, taking the 2015 problem into consideration8) when the whole baby-boomer generation reaches retiring age. One of the biggest challenges is to change the system toward a more prevention-oriented one, and it is imperative to create a system in which the elderly lead healthy and active lives for as long as they can. At the same time the system needs to be able to cope with new challenges such as the increasing number of the elderly living alone or with dementia and the rapid population ageing of large cities8).

### 3-2 Shift to a prevention-oriented system

The linchpin of the reform is the ‘shift to a prevention-oriented system’. Looking through the 5 years trend since long-term care insurance was introduced in 2000, prominent increase of the elderly in need of care, who were registered as having relatively mild impairment, is observed 9).

With rapid ageing of the society as the background, the class 1 insured, who are over 65 years old, increased from 21.65 million, when the insurance started, to 25.16 million (as of April 2005). The number of the elderly registered as in need of care or support also increased by about 2 million, from 2.18 million (April 2000) to 4.11 million (April 2005) among which the biggest increase was of those with relatively mild impairment with ‘need of support’ and ‘need of care level 1’ categories. The total number of elderly who use the service doubled from the original 1.49 million to 3.23 million, showing that the system, which started in April 2000, is now well established in the society after 6 years.

With the increase in the use of the service, the cost of long-term care insurance almost doubled from 3.6 trillion yen in 2000 to 6.8 trillion yen in 2005 showing more than a 10% increase every year. The amount of the contributions is revised every 3 years and as the result of the increase in the service users,

the amount of class 1 contribution (contribution collected from those over 65 years old) jumped 13% from the first phase (2000-2002) to the second phase (2003-2005) with the national average of 2,950 yen per month, which further increased in the third phase (2006-2008) to 4,090 yen per month. It was calculated as approximately 4,270 yen per month for the fourth phase but settled to 4,080 yen per month (national average) by digging into the fund.

The definition, service contents and management of the so-called preventive measures benefit, which was provided as a part of long-term care insurance system for those registered as in need of support, was revised. New classification of support level was introduced and those registered as in need of support level 1 and 2 are now eligible to use the preventive measures care services.

## 3-3 Establishment of comprehensive community support centers and its issues

The elderly who live in a community have a variety of needs and problems. An increasing number of them living alone and/or with dementia (including early onset Alzheimer's and mild cognitive impairment), and new problems such as abuse of the elderly are emerging. The comprehensive community support centers are positioned to combat needs of these varied and complex elderly in order to function as the integrated consultation and support service provider 10) 11).

The main challenges that the comprehensive community support centers face are how to provide the service to those who may need preventive measures; identifying the individuals who may be classified as newly introduced and unique-to-Japan support level 1 and 2, and helping them to maintain and improve their everyday life capabilities. The contents of the support care services are defined from the viewpoint of maintaining and improving everyday life, new programs were introduced and the existing program reviewed. In addition to the existing services such as day center, programs such as motor function exercises, improvement of nutrition, and oral care were included. The widening of the scope of the service recipient is being requested to include not just those registered as in need of support, but also those who are officially 'independent' but may be frail and in need of certain support and care coordination.

Since the enactment of the Elderly Health Law of 1982, the importance of prevention has been pointed out along with treatment and rehabilitation, and it covers a wider spectrum nowadays, such as health promotion and prevention, illness prevention and treatment, and care preventive measures. However, there are large differences between the municipalities in terms of community-based prevention and life support programs, and those municipalities who have traditionally run the care services focused and limited on the elderly in need of real care are now urged to change. Either way, in order that the elderly including those living alone and/or with dementia can continue to live in the familiar environment with individual needs met, the most important is to overhaul and promote the service management system so that it is comprehensive and integrated in the community.

The comprehensive community centers firstly are to establish a prevention management system that is consistent and continual, that provides service to the elderly before they become registered as in need of support or care, and staffed by social workers, public health nurses, and chief care managers. In order to secure independence and fairness for service recipients as well as for the provider, the center management committees will run the service, of which the members are to be the municipality, community service

providers, and the representatives of the insured.

The comprehensive community centers are also to provide comprehensive consultation, work as the advocacy of the rights and entitlement, and create local networks as an independent organization 10)11), and, as with any new organization, such developments need to be monitored.

### 3-4 New type of approach – introduction and popularization of community-based services

In order for the elderly to continue their life in a community with which they are familiar, it is important that various services be offered at the village/town/city level12). For this reason, community-based services including such initiatives as small-scale multi-functional care, nighttime home-visit care service, group homes that are able to care for dementia patients and specially designated small-scale nursing homes were introduced. In principle, these services are available for the resident of any village/town/city as a rule and price are set at the village/town/city level. Approval procedures of the care care service providers have also been left to the village/town/city since April 2006.

With the introduction of the definition of 'everyday life area' set out in the third phase of the long-term care plan, village/town/city authorities need to enhance concrete measures taking new viewpoints and local needs into consideration.

The focus of the fourth phase plan, that covers the timescale of April 2009 onward, is the popularization of the community-based service, with a part of management criteria regarding small-scale multi-functional care and night-time home-visit care service amended in view of a 24x7 care approach.

### 3-5 Practical issues and quality improvement of group-home care

Since the introduction of the long-term care insurance, group homes for the elderly with dementia have been rapidly established with 9,800 facilities as of December 2008. They are playing a very effective role as social resources supporting the elderly with dementia and their families, and have been highly praised from several fronts, including overseas specialists, at the 20th Alzheimer's Disease International Conference held October 2004 in Kyoto. However, problems regarding the running of these group homes have become apparent recently, such as misconduct of staff and fire involving loss of lives (Nagasaki prefecture and Sapporo city).

Except for certain areas, the quantity of group homes is being fulfilled, so the improvement in quality, as well as the diversification of management configuration, is the challenge now. One of the examples of quality improvement initiatives is the support for the residents at terminal care stages. From April 2006, payment for such care was increased as well as the pay for the night-shift staff.

### 3-6 Residential care: promotion of unit care and reorganization of institutions

As a part of the long-term care insurance system reform, a new type of specially designated elderly care homes were introduced from 2003, and the unit care initiative (small scale residential care) is well underway. There are three types of residential care facilities for the elderly within the system and each of them has its own management challenges.

(1) Specially designated long-term care facility: the immediate challenge is to enhance the capability of providing sufficient terminal care, as well as to introduce and implement unit care approach.

(2) Long-term care and health facility: focus should be placed upon enhancement of rehabilitation provision. The challenge for the service providers and related organizations is to establish the preventive measures and short-term intensive rehabilitation services.

(3) Long-term care and medical facility: As the medical care structural reform is underway, the Ministry of Health, Labour and Welfare is proposing to create convalescent wards in general hospitals (December 2005), with a view achieving that by 2012. The basic purpose is to mitigate so-called 'social hospitalization' (hospitalization of the elderly for non-medical reasons), with the introduction of clear classification of medical treatment and long-term care.

As for the fourth phase (2009-2011), one that is drawing attention is the attempt to turn geriatric wards in hospitals into long-term care and health facilities. The challenge is to establish a care infrastructure and to set its direction in the community, including the development of aforementioned small-scale specially designated long-term care facilities as well as housing policies for the elderly.

## 3-7 Revision on residential care benefit: defrayment of accommodation and food costs by users and supplementary benefit

Up to now, the proportion of residential care users in the long-term care insurance system was approximately 25%, but the cost of financing such care exceeded 50%. In order to balance the burden of the users for homecare and residential care, as well as to adjust the long-term care benefits and pension provision, the costs for accommodation and food (cost of meals including the cost of preparation, and not just the cost of materials) at the long-term care facilities was placed outside the benefit and now users have to pay them. As for the accommodation cost, the revision aimed to redress the difference of the accommodation types (private room or dormitory) and as for the food, the cost of cooking food was added to the cost of materials. These extra costs of accommodation and food are settled between the user and the service providing facility.

As for the elderly who cannot afford to pay this extra cost, detailed measures are provided as a supplementary benefit. For example, those care users (applicants) in the insurance contribution class 1 to 3, the difference between the officially set ceiling, and the actual average accommodation and food cost (standard cost) of the facility is paid from the system as a supplementary benefit (specified long-term care resident service cost). The user cost mitigation schemes by social welfare corporations need to be utilized and popularized.

## 3-8 New aspects regarding the regulation of the agency service providers

As more and more varied entities come into the care providers' market, problems such as fraudulent claims are also increasing. With this in mind, the revised law includes clauses regarding information disclosure and reviewing of the regulations for the agency service providers, in order for the users to make appropriate choices and high quality service to be provided.

The agency service providers are now legally obliged to publish information regarding the service

contents as well as administrative performance so that the users can choose the appropriate care for themselves. The items to be disclosed include the features of the services, the costs, the physical features of the facility, and staff ratios. The one-way provision of the information can invite the manipulation of information, so the shift to a two-way interaction scheme is desirable where the requests and responses from the users are received and acted upon.

The regulation of agency service providers was tightened as part of the revision. When applying to be an authorized service provider, the application is now not accepted if the applicant or a board member has had his/her authorization withdrawn within the past 5 years. In the past, once the authorization was granted, authorized service providers could continue providing the services without renewal, but now, reapplication must be made every 6 years to eliminate sub-standard agency service providers.

## 4. Challenge for the future: service quality improvement and system stability

Several points regarding the future challenge of the long-term care insurance system are described below.

### 4-1 Service quality improvement and cultivation of human resources

Firstly, the issues regarding the cultivation of human resources, and staff education in order to improve the quality of long-term care services, must be addressed. Especially as for the care management, the pillar of the long-term care insurance system, the newly established 5 yearly renewal rule for the care managers and introduction of the chief care manager position is expected to improve the present situation.

Secondly, the issues regarding the home visit care, the central service in the non-residential care, must be addressed as follows in order to improve the quality; (1) identification of clear roles and responsibilities of service providers etc, (2) improvement in the quality of care workers (cultivation of human resources and staff training, positioning qualified care workers as its core), (3) identification of responsibilities and qualifications of managers in agency services providers.

Thirdly, the issues regarding the education and creation of the career path of the on-site care workers, who will play an important role in the promotion of the unit care approach in the facilities. Requirements on education and training to improve care quality have been often talked about in the past but they lacked clear consideration on the conditions of the work. It is essential, therefore, that the whole employment environment improve, including the worker's standard wage, as well as welfare and social security.

### 4.2 Restructuring of system of the long-term care insurance facilities

There are three types of residential care facilities for the elderly within the system; (1) Social and Nursing care Homes, (2) Nursing-care and health facility, and (3) Long-term care and medical facility. As for (3), with the medical care structural reform underway, the Ministry of Health, Labour and Welfare is proposing to create convalescent wards in general hospitals (21 December 2005), with the aim of achieving that by 2012. The basic purpose is to mitigate so-called 'social hospitalization' with the introduction of a clear classification of medical treatment and long-term care.

As for the fourth phase (2009-2011), one that is drawing attention is the attempt to turn geriatric wards in hospitals into long-term care and health facilities. The challenge is to establish a care infrastructure and to set its direction in the community, including the development of small-scale specially designated long-term care facilities that form a part of the aforementioned community-based care services and other residential facilities (private care homes, care houses, and dedicated rental accommodation for the elderly).

## 4-3 Sharing the burden in the mid to long-term future

The revision of 2005 also addressed the introduction of new contribution levels, taking into account the payment capability of the contributors, the enhancement of the power of municipalities (insurers), and the establishment of fairer assessments of individuals' care levels.

With the widening range of incomes in the 2nd tier of the contribution levels, it was divided in two to create the new 2nd tier and 3rd tier. It is important to note that the 'pay-as-you-can' approach became clear, with emphasis on the paying capability of the insured.

Also in the revision of 2005, the contribution collection system was improved, with the convenience of the users in mind.

Amalgamation of villages, towns, and cities continued during 2000 to 2010, and that must have enhanced the care infrastructure of the insurers (municipalities). Strengthening of the functionalities of the insurers, the managing entities of the long-term care system, on such issues as designation, guidance and monitoring of aforementioned community-based care services, as well as the stability of the infrastructure, all are of the utmost importance.

The trust in the nation's social security system, which has traditionally leant heavily on the social insurance method for its pension and medical insurance, has been shaken lately and new approach to funding is urgently sought.

## Conclusion: From the structural viewpoint of long-term care for the elderly

From the background of the introduction of the long-term care insurance and the recent revision, it is important to raise issues from the structural viewpoint13) that can be summarized as follows.

Since around the time of the introduction of long-term care insurance in 2000, the tendency is emerging to cram all kinds of problems that affect the elderly into the terminology 'care need', especially among the government administrations and care experts. That in turn has created the mindset of creating more and more services for the elderly 'in need of care', that again, in turn, rationalizes the agency care providers' sub-standard behaviors including fee-for-service system and maximization of profit. In order truly to support the elderly socially and generally, with elimination and correction of the sub-standard service providers, as revealed in the 'Comson scandal' in 2007, the following points need to be addressed.

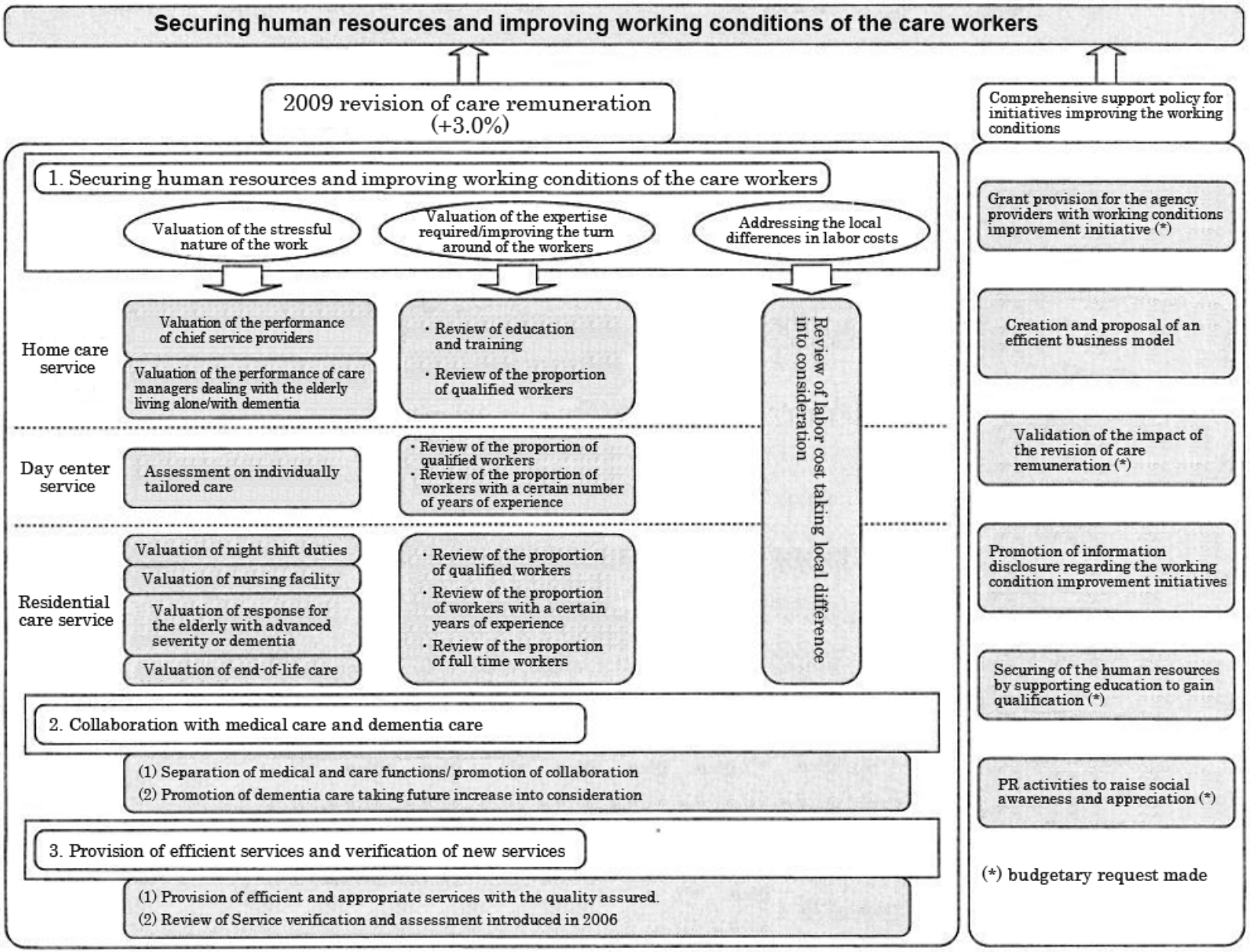
(1) Health promotion as a national value (Healthy Japan 21)
(2) Promotion of preventive healthcare with primary care as its core and streamlining of medical costs (reducing of long hospital stays)
(3) Unification of homecare and community-based care (catering for the everyday life needs of the elderly = introducing the viewpoint of stay-at-home care)

(4) Promotion of concrete preventive measures (development and popularization of health promoting, illness prevention, care-dependence prevention programs)
(5) Limiting and restructuring of residential care facilities (clear classification of care, medical, and residential facilities)
(6) Enhancement of accommodations for the elderly (specialized accommodation units for the elderly and group homes)
(7) Consolidation and localization of related policies based on improving QOL (improvement of residential environment, including the town planning level)
(8) Securing the human resources with care workers as its core and creating a career path for them
(9) Supporting the low income bracket elderly and reducing their charges & premium.
(10) Supporting Victims by Big earthquake of Eastern Japan in March 2011. especially Elderly, Children and Disable persons.

Though the vision for 2015, when the baby boomers enter the age of retirement, is getting somewhat clearer with the securing of the mid-term stability of the long-term care system, we cannot be optimistic for the long-term future. We need to look carefully, along with the reforms of medical insurance and pension systems, into the strengthening of the social security structural reform as well as mid to long-term financing, including the possibility of raising consumption tax rates and restructuring of ring-fenced welfare tax etc. A reform agenda with the keyword, 'constructing comprehensive community care system' will be tabled in 2011, which is expected to be introduced in the fifth phase starting April 2012, following the amendment of the law.

## Quotes and references


1 Tokyo Metropolitan Foundation for Social Welfare and Public Health (2005): Turning point in long-term care- The mechanism of the new system and current situation in Germany
2 Matsumoto K. (2007) : German Social Security III – The long-term care insurance. Sinzansha
3 Bundesministerium für Gesundheit: Gut zu wissen–das Wichtigste zur Pflegereform 2008, Juni 2008
4 Richter E. (2008):Gerangel um Pflegestützpunkte. *Forum Sozialstation* 150/ Feb. 2008, 8-10
5 Richter E. (2008): Pflegestützpunkte: Länder entscheiden, Kassen zahlen. *Forum Sozialstatio*n 151/ Apr. 2008, 12-14
6 Wißmann P. (2003): Case Management. In: Zippel C, Kraus S (Hg.): Soziale Arbeit mit alten Menschen. Berlin: Weißensee Verlag,121-137
7 Wißmann P. (2003): Informations-, Beratungs- und Vermittlungsstellen für ältere Menschen. In: Zippel C., Kraus S. (Hrsg.): Soziale Arbeit mit alten Menschen. Weißensee Verlag, Berlin
8 The Ministry of Health, Labour and Welfare (2004): Care for the elderly in 2015
9 Health and Welfare Statistics Association (2005): Annual shift of long-term care insurance related statistics – The major statistic data for 5 years since the establishment of the insurance system
10 The Ministry of Health, Labour and Welfare (2005): Comprehensive community support center guide
11 Preparing to establish comprehensive community support centers. (2006): *Support Vol.14*, Daiichi-hoki
12 Miyajima W. (2006): Small-scale multi-functional care. Community health and welfare policies study group. *Community health and welfare case study*. Daiichi-hoki March addition
13 Murakawa H. (2004): The principles of the care of the elderly. The Elderly care practice case study. Daiichi-hoki




Source: The Ministry of Health, Labor and Welfare, December 2008

# Multiple Regression Analysis of Compassion Fatigue/ Satisfaction Questionnaires, and Correlation between these Questionnaires and Care Providers' Behavior (FR behavior) in Japanese Child Welfare Facilities

Takashi Fujioka

【Abstract】

The purpose of this study was to examine multiple regression analysis of Compassion Fatigue/ Satisfaction Questionnaires and Correlation between these questionnaires and care providers' behavior in Japanese child welfare facilities.

Through the hierarchical OLS regression analysis , experience as a care provider is very important for examining Compassion Satisfaction. It was predicted that Compassion Fatigue and Satisfaction will impact the burn out separately. The author constructed the linear multiple regression equation on Burnout risk, Compassion Fatigue and Compassion Satisfaction. The second purpose of this study is to ascertain the relationship of Compassion Fatigue /Satisfaction with FR(Frightened/ Frightening) behavior.

The hierarchical regression analysis was conducted to assess the relationship between Compassion Fatigue, Compassion Satisfaction, and FR behavior. As a result, only one factor , PTSD significantly effects Total FR behavior. From the results of Correlation between four factors of Compassion Fatigue and the three factors of FR behavior among care givers in child welfare facility, Frightened behavior in FR behavior have the significant correlation with Dissociation behavior, Secondary Traumatic Stress, PTSD, Denial tendency, and Trauma experience. Frightening behavior in FR behavior has a significant correlation with PTSD only in Compassion Fatigue. Depersonalized behavior in FR behavior check lists have a significant correlation with Dissociation behavior, and PTSD. Dissociation behavior has a significant correlation with all four factors in Compassion Fatigue.

Through the results, we discussed that "Trauma- dominance Compassion Fatigue" would be easy to cause a stronger dissociation tendency, and the degree of the burnout tendency would be different by the state of children with some problems and disorders, how to live in family and community, especially in the childhood. In other words, the care providers would be exposed to compassion fatigue, particularly secondary wound-related stress, in addition to own trauma experience. That is, the care providers must be exposed to trauma experiences of children double more while they are exposed to their own trauma experience.

【Keywords】
Compassion Fatigue , Compassion Satisfaction, Dissociation, FR behavior,
Burnout risk, Secondary Traumatic Stress(STS), Third Traumatic Stress (TTS)

Recently there are some researchers who think that burnout seems to be connected with the concept of Secondary Traumatic Stress or Compassion fatigue, especially among workers who contact with injured, disordered or traumatized persons. A caregiver or a supporter who listens to the story by injured people is hurt by the story at the same time. A clinical social worker or a therapist who works as a helper, a caregiver, and a supporter with injured, disordered or traumatized persons experiences the drawing out of earlier memories in which he or she has been hurt. In Japan there are many researches on Secondary Traumatic Stress and Compassion Fatigue/Satisfaction, but it is necessary to investigate these concepts from the standpoints of Japanese situation and culture in Japanese clinical field and facility(FujiokaT,, 2004,2005,2006,2007,2008,2010; Fukushima,M.2009; Kon,Y.&Kikuchi,A. 2007; Shinozaki,T.2007;Nishi ,M.&Nojima,K.2002).

When burnout risk/ compassion fatigue were prevented for care workers or care providers , for example through consultation of support measures, training, and collaboration, maltreated children would be supported from the viewpoint of attachment to developmental disability, and a state of the staff as "a container of attachment" would be kept in good condition. I have challenged that many care givers would be good container through the clinical attachment approach, for example the use of 'Life Script of Attachment', and self-monitoring by Compassion Fatigue Self Check Test. The purpose of this study is to examine the effect of self-monitoring by Compassion Fatigue/Satisfaction Self Check Test to Burn out risk, and to investigate the relationship of these questionnaires with inadequate approach, FR behavior by care providers to children in Japanese Child Welfare Facility.

***Meaning of Compassion Fatigue***

A Care giver has "Compassion Fatigue" by being an care giver, and by balance with "Compassion satisfaction " which is joy of being a care giver , which is assumed to protect from risk of burnout (Figley,1995). Originally, in the English word of "Compassion", there are meanings such as "intense feelings, eagerness, passions such as anger, intense love" in Passion. We use the word of Compassion, it means that Com – means "with". So when we say "Compassion with" , we always feel "passion with together". In addition to this meaning, I find that Passion means martyrdom. I think that " Compassion" means "become a martyr with hurt persons/especially maltreated abused children" in the clinical child welfare field. It means profoundly to be with abused children and neglected children.

***Dissociation and Compassion fatigue***

Social workers, care workers and case managers working in welfare facilities and agents have a wide range of stresses in performing their duty. Specifically, when they are concern with and support the clients who had severe traumatic experiences, there is a possibility that care workers and case managers and

social workers themselves have to confront their own trauma. Moreover, the specialty of the helpers, the building of sympathy and relationship with clients, increasingly means placing them in the process of extending to the situation of burnout. In this case, the dissociation which is a peculiar reaction to the trauma, happens to the side of the helper. The helper sometimes cuts off his/her character, personality and feelings in the process to the burnout. Fujioka(2005) pointed out the importance of the process of burnout and reexamined the process in through the concept of dissociation. As a result, the author suggested the possibility that the helper confronts the situation of the similar phenomenon-dissociation-as clients. To prevent such a high risk situation, the necessity of the self check list about the burnout and compassion fatigue was suggested. Dissociation is the key concept of Pierre Janet, especially this concept connects trauma and the attitude of protecting hurt mind.

***Secondary Traumatic Stress or Compassion fatigue and the idea of Pierre Janet***

Fujioka (2006) discussed secondary traumatic stress or compassion fatigue though some concepts of Pierre Janet. He pointed out that treatment for Trauma follows two ways, to be confronted or to confront with traumatic experiences. One is to confront trauma directly, and the other is to confront trauma indirectly. The relationship between fatigue and traumatic memory was indicated in P. Janet's idea.

When human being continues to confront trauma for long time, he/she avoids feeling pain, bitterness, tightness and suffering and creates a condition of dissociation. In case of Compassion Fatigue, the same situation or dissociation will be created in the mind for long time. But as Janet pointed out, keeping trauma means continuing to feel serious fatigue. I think that compassion fatigue has two meanings, one is fatigue by traumatized children and the other is fatigue by care givers' own trauma. Perhaps the treatment to traumatized children means severe situation for care givers with severe trauma through the relationship with children who have some problems, some disorders or severe trauma.

I think that discussion about Treatment for traumatized children means the profound examination on preventing Compassion Fatigue.

I discussed that it is necessary to investigate the relationship of compassion fatigue and personal dissociation tendency. Perhaps many Japanese people have high dissociation tendency, so there will be strong connection between compassion fatigue and personal dissociation tendency. If the expert in child welfare facility has some traumatic experiences in his or her life, the relationship with traumatized children would draw out pain or specific memories in the past time. He or she may be always exposed to the traumatic memory or the traumatic emotion. If the supportive atmosphere would be prepared for him or her, he or she might not be exposed to a risk of dissociation, and not feel Compassion Fatigue so severely.

***Compassion Fatigue in two facilities in Japan***

Fujioka(2008) discussed secondary traumatic stress or compassion fatigue in relation to the concepts of the helper's own trauma and stress. He distributed questionnaires to facility A (16 people; 2 male 14 female), facility B (22 people; 12 male, 10 female). The results showed that the degree of compassion satisfaction was low in both facilities in Japan. Even a certain level (level 2) poses a comparatively high

(40%) risk of burnout, while for 60%, there was low risk of burnout (together, 0;A,B provides equipment for level 3,4 of a high domain). However, 36% occupied the classified level 4,5 and nearly 40% was in a state of high compassion fatigue. The possibility is suggested that compassion fatigue becomes high before actual burnout. A social worker may sense the degree of this compassion fatigue early, and it is an important precaution to plan some countermeasures before it becomes severe burnout, and forces the social worker to take leave of absence from duty or to resign.

The discussion in Fujioka(2008) is conducted from 4 standpoints. 1.Third Traumatic Stress ; Traumatic stress in a family who has a caregiver, care worker, and/or social worker. 2. Defense against "Family Burnout" of a helper. 3. The construction of relations between place of work and everyday life. 4.The treatment for dissociation and the construction of integration of daily life as a worker in the people-supporting field and as a member of family and community. It was necessary to investigate Compassion Fatigue about other people in Japanese Child Welfare facility through the standard of Compassion Fatigue/Satisfaction in Japanese.

***Factor Analysis on Compassion Fatigue and Satisfaction in 110 persons in Japanese child welfare facilities.***

Based on investigation by Japanese edition of questionnaires developed by Figley,C. et al., Fujioka(2007) studied the basics toward standardization of these questionnaires to relate to compassion satisfaction and compassion fatigue. Furthermore, he suggested coping methods for burnout and compassion fatigue based on them.

As a result of data analysis, four factors of "satisfaction in relations with fellow workers", "satisfaction in relations with users", "satisfaction as nature of care workers or social workers " and "feeling of satisfaction in life" were extracted on compassion satisfaction.

On compassion fatigue, four factors of "compassion fatigue accumulated as substitution-related trauma", "denial feelings", "PTSD-like compassion fatigue" and "a trauma experience of care worker or social worker oneself" were extracted.

From these results, it was suggested that there were 2 types of compassion fatigue; one is "**Trauma-dominance Compassion Fatigue**" that has a certain trauma recurred, and another is "**Stress-dominance Compassion Fatigue**" that has the possibility to become a new trauma.

About burnout standards by Figley,C. et al., correlation with the burnout standards that Maslach,C. et al made was high and **the result was provided that factor structures were approximately similar**.

It was suggested that the general scores of compassion satisfaction, compassion fatigue and burnout affects burnout prevention, coping with compassion fatigue and awareness of compassion satisfaction.

Especially "considerably high danger " group occupies 35%, and "high danger " group occupies 17%, while " high- risk compassion fatigue" groups occupy 52% together. This suggests the necessity of support for care workers or social workers in all child care or child welfare facilities.

Correlation of measures on compassion satisfaction, compassion fatigue and burnout with coping methods with burnout, burnout in family and disagreement of policies of nursing and treatment were examined in Fujioka(2007). 1, When a care worker or a social worker who feels bitterness and tightness is supported by peers, friends, and families, compassion satisfaction becomes high. 2, Feelings that bitterness

and tightness are supported by peers, friends, and families may prevent from high depersonalization tendency. 3, A person who feels enough compassion satisfaction does not give **Third Traumatic Stress(TTS)** (for example, negative behavior and negative verbal expression to family. 4, A feeling of emotional exhaustion is related to third traumatic stress. 5, Disagreement of a nurturing policy between an administrator and a care worker or social worker lead the whole risk of burnout to a higher degree. 15 items were suggested as anti-burnout coping skills for compassion fatigue such as "inflection of a self-check list".

***Factor Analysis on Compassion Fatigue and Satisfaction in 212 persons in Japanese child welfare facilities.***

From the standpoint of many research on Compassion Fatigue/Satisfaction, Fujioka(2010) examined some support programs in relation with burnout measures and compassion fatigue and satisfaction. As a result of data analysis of 212 persons, he was able to get a result similar to Fujioka (2007). About Compassion Satisfaction, four factors were extracted. Four factors were named as follows; "satisfaction in relations with fellow workers", " satisfaction in relations with a child or children", " satisfaction in the nature of care workers or social workers", and "feeling of satisfaction in life"

About compassion fatigue, four factors of "compassion fatigue accumulated as a substitution-related trauma", "denial feelings", "PTSD-like compassion fatigue" and "a trauma experience of care worker or social worker oneself" were extracted.

Correlation of these factors with Burnout Standard made by Maslach, C. and Jackson proved to be statistically significance. On this basis, the following points were suggested. 1 Compassion satisfaction showed significant negative correlation with "the emotional consumption feeling" that was a lower factor and "de-personification" of standardized burnout measures, and equilateral correlation with "sense of accomplishment of each individual" was suggested. 2 With a feeling of consumption and de-personification, equilateral correlation with Compassion Fatigue was suggested. But Compassion Fatigue was not related with personal sense of accomplishment. 3 A meaningful difference is seen in the number of years in Compassion Satisfaction. It was suggested that for ten years, it was necessary to regard care givers to be a professional care provider. 4 **Compassion Fatigue accumulated as a substitution-related trauma (Secondary Traumatic Stress) was related to Third Traumatic Stress by care givers' families**. 5 There was an association between Compassion Fatigue or Satisfaction and Burn out. Third Traumatic Stress(TTS) is key concept for supporting a care giver's family.

***Third Traumatic Stress of Care givers' and Social Workers' Families***

The family of a care giver has the possibility to be exposed to Third Traumatic Stress. I suggest that members in care worker's family have further stress if care workers receive Secondary Traumatic Stress from children with some troubles and clients and he/she can not deal with as Secondary Traumatic Stress or Compassion Fatigue. Fujioka (2007, 2008) called this " Third Traumatic Stress (TTS)". It is very important for a care worker to receive enough support from families , fellow workers, and social system as good environment.

***Compassion Fatigue and the methods/attitudes of Child Care Support***

The author thinks that Child Care Support is support for Parents and Care- Workers. It is important for child care workers to investigate the relation of the main point of attachment parenting with Compassion fatigue or Satisfaction. For child care, it is necessary to construct pro-support, pro- help to Parents and Care givers. "The problem" that children have, "a problem" and "a feeling of maladjustment" are "the points of contact of a relation with care givers and children". Problems in attachment become the point of contact with children. A look at such " problems“ is very important. The author thinks that Compassion Fatigue /Satisfaction affects occupational commitment just like FR(Frightened/ Frightening) behavior. But nobody has investigated this standpoint on Compassion fatigue/Satisfaction and Burnout. Especially, FR action (including an expression / a gesture etc.) “Frightened or Frightening” (FR) is very important in the area of Child welfare facility. An inappropriate action for parenting is a point to "let a child feel fear" with an abused child. A care giver who has various "unsolved models" was hurt (a trauma), and cannot arrange experiences.

When burnout risk/ compassion fatigue were prevented for care workers, for example; consultation of measures supports, the training, collaboration, maltreated children would be supported from a viewpoint of attachment to developmental disability, and a state of the staff as "a container of attachment" would be kept in good conditions. The author have challenged that many care givers would be good container through clinical interview and insight to own self by ‘Life Script of Attachment’, and self-monitoring and self-awareness by Compassion Fatigue Self Check Test.

When relations with the staff and children become complicated, feelings of satisfaction with children are reduced, and that compassion fatigue increase mainly on substitute trauma. In this way it is thought that further examination of compassion fatigue and compassion satisfaction as support programs to abused children effectively.

***Purpose of the study.***

The purpose of this study is to conduct a multiple regression analysis of Compassion Fatigue/ Satisfaction Questionnaires and examine the correlation between those Questionnaires and Care Providers’ Behavior in Japanese Child Welfare Facilities.

To that purpose, we had three primary research questions: (1) Is there an association between Burn out and Compassion Fatigue/Satisfaction ?; (2)Is there an association between three control variables and Compassion Fatigue/Satisfaction ? : and (3) Does Compassion Fatigue /Satisfaction effect care provider’s professional commitment as FR(Frightened/ Frightening) behavior on the standpoint of clinical attachment approach ?

## Methods

***Sample and Procedures***

For purpose (1)(2) data was obtained from some child welfare facilities in Japan. The author distributed a questionnaire to each facility. Explanation of the research was conducted at a workshop. The

purpose of the questionnaire, the observance of obligation of keeping secrecy, management of personal information, a way of entry were explained to all care providers in each facility. I had each staff fill out the questionnaire and collected them later. These were unsigned. Study questionnaires were coded in a manner that prevented duplicate responses while maintaining anonymity of respondents. Completed questionnaires were received from 212 respondents.

For purpose (3) data was obtained from some child welfare facilities in Japan. The same procedure was used as purpose (1)(2). Study questionnaires were coded in a manner that prevented duplicate responses while maintaining anonymity of respondents. Completed questionnaires were received from 61 respondents.

***Measures***

***Compassion Fatigue/Satisfaction Scale -Original Version- (66 items)***

We used Care giver Compassion Fatigue/Satisfaction was measured with the Compassion Fatigue/ Satisfaction Scale (Original version, Figley and Stamm,2002; Japanese Translated version , Fujioka 2007). The Compassion Fatigue/Satisfaction Short Version is a 66-item self- report instrument that instructs respondents to indicate how frequently they experienced each of 66 symptoms during the previous week using a 6-choice, Likert-type response format ranging from never (0) to very often (5). The 66 items of the Compassion Fatigue/Satisfaction and burn out are designed to be congruent with the 26 symptom criteria of Compassion Satisfaction, the 23 symptom criteria of Compassion Fatigue and the 17 symptom criteria of Burn out (Figley and Stamm, 2002).

***FR behaviors.***

The author constructed new check lists about FR behavior with reference to Main, M., & E. Hesse (1996) and Abrams,K.Y., Rifkin,A.& Hesse,F. (2006) .

For example, parts of FR behavior Check lists are as follows; I change how to put out and intonation of a voice suddenly . I change an expression suddenly. I suddenly access a child. I take no notice of crying. I leave a crying child and go to other places. I stare with a look letting a child be afraid. I will not dare to look at a child. I contact in a voice letting a child be afraid. I scowl at a child. I contact a child with no expression. I take an incomprehensible action for even myself . I contact a child stickily. I contact not to harm a mood of a child. I contact a child with a frightening face. I hurl negative words at a child. I am irritated and put up a hand to a child. I catch a child and strongly shake it.

FR behavior Check lists is a 25-item self- report instrument that instructs respondents to indicate how frequently they experienced each of 25 symptoms during the previous week using a 5-choice, Likert-type response format ranging from never (1) to very often (5). These FR behavior Check lists have three factors, Frightened behavior, Frightening behavior and De-personalized behavior by Factor Analysis.

***Dissociation behaviors.***

The author picked up the five items from the daily dissociation check lists of Masuda (2006) . The check lists is a 5-item self- report instrument that instructs respondents to indicate how frequently they

experienced each of 5 symptoms during the previous week using a 5-choice, Likert-type response format ranging from never (1) to very often (5).

***Compassion Fatigue/Satisfaction Scale -Short Version -(34 items)***

Care giver Compassion Fatigue/Satisfaction was measured with the Compassion Fatigue/Satisfaction Scale (based on Figley and Stamm,2002; Fujioka 2007,2010). The Compassion Fatigue/Satisfaction Short Version is a 34-item self report instrument that instructs respondents to indicate how frequently they experienced each of 34 symptoms during the previous week using a 5-choice, Likert-type response format ranging from never (1) to very often (5). The 34 items of the Compassion Fatigue/Satisfaction are designed to be congruent with the 17 symptom criteria of Compassion Satisfaction and 17 symptom criteria of Compassion Fatigue by factor analysis of 66 original items of Compassion Fatigue/ Satisfaction self check lists (Figley and Stamm,2002). These Compassion Fatigue/Satisfaction Scale -Short Version - have 8 factors; **4 factors on Compassion Fatigue,(1,Secondary Traumatic Stress or compassion fatigue accumulated as a substitution-related trauma, 2,PTSD-like compassion fatigue, 3,Denial Feelings , 4,Trauma Experience of care worker or social worker oneself ) and 4 factors on Compassion Satisfaction (1,satisfaction in relations with fellow workers, 2 satisfaction in relations with a child or children, 3, satisfaction as nature of care workers or social workers, and 4,feeling of satisfaction in life)** by Factor Analysis(based on Figley and Stamm,2002; Fujioka 2007, 2010).

***Control variables.***

Based upon previous research linking them to independent and dependent variables, the following three control variables were included in the study questionnaire: care giver age, gender, experience. Experience was operationalized as the number of years working in a child welfare facility.

**Data analysis**

Data were analyzed with the Statistical Package named SPSS. First, a hierarchical ordinary least squares regression analysis was conducted to assess the relationship between Compassion Fatigue and Compassion Satisfaction and the relationship between these questionnaires with FR behavior . Next multiple regression analysis was conducted to assess the relationship between Compassion Fatigue, Compassion Satisfaction and Burn out. In addition to these analyses the correlation between four factors of Compassion Fatigue/Satisfaction and the three factors of FR behavior among care givers in child welfare facility were determined.

## Results

***Sample Characteristics***

For investigating purposes (1) and (2), Table 1 presents the descriptive statistics for demographic and other key variables. 212 study participants had five age groups; 20's(50%), 30's(30.2%), 40's(8.5%), 50's(9.9%), 60's(1.4%). Gender ; male(45.3), female(54.7). The sample had an average of 8.14 years (SD

= 8.30) of experience. Scores on the Compassion Satisfaction Scale ranged from 29-119 with a mean of 72.887 (*SD* =14.980). Scores on the Compassion Fatigue Scale ranged from 8-77 with a mean of 34.821 (*SD* =13.433 ). Scores on the Burn out Scale (Figley and Stamm, 2002) ranged from 9-61 with a mean of 35.283 (*SD* =10.084).

**Table 1. Descriptive statistics for key variables (n = 212).**

| | Number (%) | Mean (SD) | Range |
|---|---|---|---|
| Gender | | | |
| Male | 96 (45.3) | | |
| Female | 116 (54.7) | | |
| Age | | | |
| 20's | 106 (50 ) | | |
| 30's | 64 (30.2) | | |
| 40's | 18 ( 8.5) | | |
| 50's | 21 ( 9.9) | | |
| 60's | 3( 1.4) | | |
| Experiences (Years) | | 8.140 ( 8.300) | |
| Compassion Satisfaction | | 72.887 (14.980) | 29-119 |
| Compassion Fatigue | | 34.821 (13.433) | 8-77 |
| Burn out (Figley and Stamm 2002) | | 35.283 (10.084) | 9-61 |

For investigating purposes (3) new study participants attended this study. 61 study participants had five ranges of age; 20's(67.2%), 30's(27.9%), 40's(0%), 50's(3.3%), 60's(1.6%). Gender ; male(24;39.34%),fem ale(37;60.66%). The sample had an average of 5.32 years (*SD* = 5.82) of experience.

***Multiple regression analysis***

Table 2 displays the results of the hierarchical OLS regression analysis for predicting Compassion Satisfaction among care givers in a child welfare facility. Of the three control variables entered in Step 1 only experience significantly predicted Compassion Satisfaction. When Compassion Fatigue was added in Step 2, only experience was significant. Compassion Fatigue did not predict Compassion Satisfaction.

**Table 2. Hierarchical regression analysis predicting Compassion Satisfaction among care givers in child welfare facility.**

| Step 1 | | | | |
|---|---|---|---|---|
| | B(se) | β | *p* | $R^2$ |
| Age | -1.845 (2.063) | -0.038 | 0.111 | |
| Gender | -1.150 (2.063) | -0.038 | 0.578 | |
| Experience | 0.315 (0.145) | 0.174 | 0.031* | |
| | | | | 0.026 |
| Step2 | | | | |
| | B(se) | β | *p* | $R^2$ |
| Age | -1.751 (1.153) | -0.122 | 0.130 | |
| Gender | -1.300 (2.061) | -0.043 | 0.529 | |
| Experience | 0.307 (0.145) | 0.170 | 0.035* | |
| Compassion Fatigue | -0.109 (0.076) | -0.098 | 0.155 | |
| | | | | 0.035 |

* p<.05

Table 3 displays the results of the Multiple regression analysis for predicting Burnout among care givers in child welfare facility. In MRA Compassion Fatigue and Compassion Satisfaction significantly predicted Burn out.

**Linear multiple regression equation ;**

**Burnout risk = 0.490×Compassion Fatigue + (-0.163×Compassion Satisfaction) + 30.123**

**……. (a)**

**Table 3. Multiple regression analysis predicting Burnout among care givers in child welfare facility.**

| | B(se) | β | *p* | $R^2$ |
|---|---|---|---|---|
| Compassion Fatigue | 0.490(0.036) | 0.652 | .0001** | |
| Compassion Satisfaction | -0.163(0.033) | -0.242 | .0001** | |
| Constant Term | 30.123(2.841) | | | |
| | | | | 0.516 |

Table 4 displays the results of the hierarchical OLS regression analysis for predicting FR behavior. The hierarchical regression analysis was conducted to assess the relationship between Compassion Fatigue, Compassion Satisfaction, and FR behavior. Step 1 FR behavior regressed on the three control variables. Step 2 added the Compassion Fatigue variable in addition to the three control variables to determine if Compassion Fatigue predicts FR behavior. Step 3 added Compassion Satisfaction as a predictor variable in addition to the control variables and Compassion Fatigue.

**Table 4. Hierarchical regression analysis predicting FR Behavior among care givers in child welfare facility.**

| Step 1 | | | | |
|---|---|---|---|---|
| | B(se) | β | *p* | $R^2$ |
| Age | 1.058 (2.808) | 0.093 | 0.708 | |
| Gender | -4.135 (2.537) | -0.215 | 0.109 | |
| Experience | 0.035 (0.401) | 0.021 | 0.931 | |
| | | | | 0.054 |
| Step2 | | | | |
| | B(se) | β | *p* | $R^2$ |
| Age | 1.239 (2.109) | 0.109 | 0.591 | |
| Gender | -2.059 (2.109) | -0.107 | 0.333 | |
| Experience | -0.135 (0.329) | -0.083 | 0.684 | |
| Compassion Fatigue | 0.553 (0.104) | 0.587 | 0.0001** | |
| | | | | 0.380 |
| Step3 | | | | |
| | B(se) | β | *p* | $R^2$ |
| Age | 1.203 (2.316) | 0.106 | 0.606 | |
| Gende | -2.198 (2.173) | -0.114 | 0.316 | |
| Experience | -0.128 (0.332) | -0.079 | 0.703 | |
| Compassion Fatigue | 0.538 (0.116) | 0.570 | .0.0001** | |
| Compassion Satisfaction | -0.033 (0.107) | -0.0376 | 0.756 | |
| | | | | 0.381 |

Table 5 displays the results of the Multiple regression analysis for predicting FR behavior. The Multiple regression analysis was conducted to assess the relationship between Compassion Fatigue, Compassion Satisfaction, and FR behavior.

**Linear multiple regression equation ;**

**FR behavior = 0.550×Compassion Fatigue + (-0.007×Compassion Satisfaction) +32.8756**

**……. (b)**

**Table 5. Multiple regression analysis predicting FR behavior among care givers in child welfare facility.**

| | B(se) | β | *p* | $R^2$ |
|---|---|---|---|---|
| Compassion Fatigue | 0.550 (0.106) | 0.594 | .0001 ** | |
| Compassion Satisfaction | -0.007 (0.099) | -0.008 | 0.945 | |
| Constant Term | 32.876(6.995) | | | |
| | | | | 0.357 |

Table 6 displays the results of the h Multiple regression analysis for predicting FR behavior. The hierarchical regression analysis was conducted to assess the relationship between four factors of Compassion Fatigue and FR behavior.

**Linear multiple regression equation ;**

**FR behavior = 0.381 × Secondary Traumatic Stress + 1.167 × PTSD + (-0.039×Denial Feeling) + 0.157×Trauma Experience + 31.356 ……. (c)**

**Table 6. Multiple regression analysis predicting FR behavior among care givers in child welfare facility.**

| | B(se) | β | *p* | $R^2$ |
|---|---|---|---|---|
| Secondary Traumatic Stress | 0.381 (0.324) | 0.151 | 0.244 | |
| PTSD | 1.167 (0.211) | 0.5916 | .0001 ** | |
| Denial Feeling | -0.039 (0.457) | -0.0096 | 0.932 | |
| Trauma Experience | 0.157 (0.387) | 0.0488 | 0.687 | |
| Constant Term | 31.356 | 2.286 | | |
| | | | | 0.466 |

Table 7 displays the results of Correlation between four factors of Compassion Fatigue and the three factors of FR behavior among care givers in child welfare facility.

4 factors of Compassion Fatigue contained Secondary Traumatic Stress, PTSD, denial tendency, trauma experience . 3 factors of FR behavior contained Frightened behavior, Frightening behavior, Depersonalized behavior.

**Frightened behavior in FR behavior have the significant correlation with Secondary Traumatic Stress, PTSD, denial feeling, trauma experience in Compassion Fatigue and Total FR Behavior , Dissociation behavior . Frightening behavior in FR behavior has significant correlation only with PTSD in Compassion Fatigue.** Total FR Behavior have the significant correlation with Dissociation Behavior. **Depersonalized behavior in FR behavior check lists has significant correlation with Dissociation behavior, PTSD in Compassion fatigue.** Dissociation behavior has significant correlation with all four factors in Compassion Fatigue (Secondary Traumatic Stress, PTSD, Denial feeling, Trauma experience).

**Table 7. Correlation between four factors of Compassion Fatigue and the three factors of FR behavior among care givers in child welfare facility.**

| Behavior | Frightened Behavior | Frightening Behavior | Depersonalized Behavior | Total FR Behavior | Dissociation Behavior |
|---|---|---|---|---|---|
| Frightened Behavior | 1.0000 | | | | |
| Frightening Behavior | -0.0007 | 1.0000 | | | |
| Depersonalized Behavior | 0.1967 | **0.521**** | 1.0000 | | |
| Total FR Behavior | **0.608**** | **0.692**** | **0.804**** | 1.0000 | |
| Dissociation Behavior | **0.643**** | 0.123 | **0.329**** | **0.541**** | 1.0000 |
| Secondary Traumatic Stress | **0.590**** | 0.075 | 0.119 | **0.394**** | **0.439**** |
| PTSD | **0.359**** | **0.488**** | **0.552**** | **0.662**** | **0.500**** |
| Denial Feeling | **0.457**** | -0.058 | 0.021 | 0.219 | **0.440**** |
| Trauma Experience | **0.338**** | 0.124 | 0.221 | **0.333**** | **0.325*** |
| Total Compassion Fatigue | **0.588**** | **0.274*** | **0.366**** | **0.597**** | **0.594**** |

* p<.05 **p<.01

4 factors of Compassion Fatigue (Secondary Traumatic Stress, PTSD, Denial Feeling, Trauma Experience )

3 factors of FR behavior (Frightened Behavior, Frightening Behavior, Depersonalized Behavior)

Table 8 displays the results of Correlation between four factors of Compassion Satisfaction and the three factors of FR behavior among care givers in child

welfare facility. Frightened behavior in FR behavior has significant negative(-) correlation with satisfaction as nature of care workers . Frightening behavior and Depersonalized behavior in FR behavior have no significant correlation with four factors in Compassion Satisfaction. Total FR Behavior has significant negative(-) correlation with satisfaction in relations with a child or children. Dissociation Behavior has significant correlation with Total Compassion Satisfaction, especially satisfaction in relations with a child or children and satisfaction as nature of care workers.

**Table 8. Correlation between four factors of Compassion Satisfaction and the three factors of FR behavior among care givers in child welfare facility.**

| Behavior | Frightened Behavior | Frightening Behavior | Depersonalized Behavior | Total FR Behavior | Dissociation Behavior |
|---|---|---|---|---|---|
| Frightened Behavior | 1.000 | | | | |
| Frightening Behavior | -0.001 | 1.000 | | | |
| Depersonalized Behavior | 0.197 | **0.521**** | 1.000 | | |
| Total FR Behavior | **0.608**** | **0.692**** | **0.804**** | 1.000 | |
| Dissociation Behavior | **0.643**** | 0.123 | **0.329**** | **0.541**** | 1.000 |
| Satisfaction in relations with fellow workers | -0.104 | -0.054 | -0.211 | -0.176 | -0.207 |
| Satisfaction in relations with a child or children | -0.202 | -0.144 | -0.206 | -0.265* | **-0.265*** |
| Satisfaction as nature of care workers | **-0.351**** | 0.086 | -0.207 | -0.240 | **-0.468**** |
| Feeling of satisfaction in life | 0.006 | 0.071 | -0.119 | -0.021 | -0.115 |
| Total Compassion Satisfaction | -0.222 | -0.031 | -0.250 | -0.246 | **-0.351**** |

* p<.05 **p<.01

4 factors of Compassion Satisfaction (Satisfaction in relations with fellow workers, Satisfaction in relations with a child or children, Satisfaction as nature of care workers, Feeling of satisfaction in life)

Table 9 displays the results of Multiple regression analysis predicting Three factors of FR behavior among care givers in child welfare facility. We investigated each Criterion Variable. As a result, Frightened behavior in FR behavior has significant correlation with Secondary Traumatic Stress or compassion fatigue accumulated as a substitution-related trauma. And Frightened behavior has significant –tendency correlation with Denial Feeling(p=0.068 † < .10 ). Both Criterion Variable, Frightening Behavior and Depersonalized Behavior have significant correlation with PTSD-like Compassion Fatigue.

**Table 9. Multiple regression analysis predicting Three factors of FR behavior among care givers in child welfare facility.**

| Criterion Variable; Frightened Behavior | | | | |
|---|---|---|---|---|
| | B(se) | β | *p* | $R^2$ |
| Secondary Traumatic Stress | 0.590 ( 0.176) | 0.453 | 0.001** | |
| PTSD | 0.159 (0.115) | 0.156 | 0.172 | |
| Denial Feeling | 0.461 (0.248) | 0.221 | 0.068 | |
| Trauma Experience | -0.082 (0.210) | -0.049 | 0.698 | |
| Constant Term | 10.841 (1.241) | | | |
| | | | | 0.408 |
| Criterion Variable; Frightening Behavior | | | | |
| | B(se) | β | *p* | $R^2$ |
| Secondary Traumatic Stress | -0.075 (0.169) | -0.066 | 0.660 | |
| PTSD | 0.476 (0.111) | 0.538 | 0.0001 ** | |
| Denial Feeling | -0.300 (0.239) | -0.165 | 0.214 | |
| Trauma Experience | 0.052 (0.202) | 0.036 | 0.798 | |
| Constant Term | 11.137 (1.195) | | | |
| | | | | 0.272 |
| Criterion Variable; Depersonalized Behavior | | | | |
| | B(se) | β | *p* | $R^2$ |
| Secondary Traumatic Stress | -0.133 (0.1700) | -0.113 | 0.435 | |
| PTSD | 0.533 (0.111) | 0.576 | 0.0001 ** | |
| Denial Feeling | -0.200 (0.240) | -0.105 | 0.408 | |
| Trauma Experience | 0.187 (0.203) | .124 | 0.362 | |
| Constant Term | 9.378 (1.201) | | | |
| | | | | 0.330 |

† p<.10 * p<.05 **p<.01

## Discussion

The purpose of this study was to examine multiple regression analysis of Compassion Fatigue/ Satisfaction Questionnaires and determine the correlation between those Questionnaires and Care Providers' Behavior in Japanese Child Welfare Facilities.

### *An association between Burn out and Compassion Fatigue / Satisfaction*

Through the hierarchical OLS regression analysis , when Compassion Fatigue was added in Step 2, only experience was significant. Experience is very important in thinking about Compassion Satisfaction. The author described the relationship between experience and Compassion Satisfaction in Fujioka(2007) . Fujioka(2007) indicated that Compassion satisfaction changes up and down every year after beginning to work, and numerical value of Compassion satisfaction is stabilized from 7 years to 10 years.

In this study, Compassion Fatigue did not predict Compassion Satisfaction. It was predicted that Compassion Fatigue and Satisfaction will impact burn out separately. So the author constructed the linear

multiple regression equation (a) as follows;

**Burnout risk = 0.490 × Compassion Fatigue + (-0.163 × Compassion Satisfaction) + 30.123**

We have to investigate the reason of the influence to Burn out. This was first challenge to construct the numerical formula, Burnout risk and Compassion Fatigue / Satisfaction.

***The relationship of Compassion Fatigue /Satisfaction with the interaction between care providers and children, just like FR(Frightened/ Frightening) behavior***

The hierarchical regression analysis was conducted to assess the relationship between Compassion Fatigue, Compassion Satisfaction, and FR behavior. Step 1 FR behavior regressed on the three control variables. But we had no significant effect of three variables to FR behavior. Next it was indicated that the Compassion Fatigue predicts the FR behavior significantly. Step 3, we added the third factor, Compassion Satisfaction. We did not find significant effect in this research. So the author constructed the linear multiple regression equation (b) as follows;

**FR behavior = 0.550 × Compassion Fatigue + (-0.007 × Compassion Satisfaction) + 32.8756**

**……. (b)**

The hierarchical regression analysis was conducted to assess the relationship between four factors of Compassion Fatigue and FR behavior as follows;

**FR behavior =0.381 × Secondary Traumatic Stress + 1.167×PTSD**
**+ (-0.039×Denial Feeling) + 0.157 × Trauma Experience + 31.356**

**……. (c)**

These were first challenge to construct the numerical formula, FR behavior and Compassion Fatigue / Satisfaction.

A hierarchical regression analysis was conducted to assess the relationship between four factors of Compassion Fatigue and FR behavior. PTSD significantly affected FR behavior. **PTSD is an important factor in four factors of Compassion Fatigue.**

Fujioka(2005) described that compassion fatigue has two kinds, one is stress-based compassion fatigue and the other is trauma-based compassion fatigue. It is thought that FR behavior is connected with stress-based compassion fatigue.

Table 7 displays the results of Correlation between four factors of Compassion Fatigue and the three factors of FR behavior among care givers in child welfare facility. Frightened behavior in FR behavior has significant correlation with Secondary Traumatic Stress, PTSD, denial feeling, trauma experience. Frightened behavior in FR behavior seems to be connected to a care provider's trauma or scar in childhood. It is necessary for a care provider to confront his or her own trauma experience with a supervisor .

Frightening behavior in FR behavior has significant correlation with only PTSD in Compassion Fatigue. Frightening behaviors are inadequate for care providers, but it is possible to deal with PTSD

before it leads to severe FR behavior, if care givers can notice beforehand. Depersonalized behavior in FR behavior check lists have significant correlation with Dissociation behavior, PTSD. Depersonalized behavior in FR behavior

Depersonalized behavior can be dealt with before it leads to severe FR behavior. Dissociation behavior has significant correlation with all four factors in Compassion Fatigue (Secondary Traumatic Stress, PTSD, Denial feeling, Trauma experience). In this study we confirmed the relation between Dissociation and Compassion Fatigue. It could be determined that Fatigue and Dissociation were related closely, just as Pierre Janet already described in 19 century.

In addition, we found that three parts of concepts of FR behavior connect with each part of Compassion Fatigue. Especially Frightened behavior in FR behavior connect with all aspects of Compassion Fatigue. And Frightening Behavior has significant correlation only with PTSD in Compassion Fatigue. It could be ascertained that FR behavior and Compassion Fatigue are closely related.

Table 8 displays the results of Correlation between four factors of Compassion Satisfaction and the three factors of FR behavior among care givers in child

welfare facility. Frightened behavior in FR behavior has significant negative(-) correlation with satisfaction as nature of care workers . Satisfaction as nature of care workers will be developed by training, workshop and supervision. For Protecting FR behavior by care workers we have to construct career development system in Child welfare facility. Monitoring the nature of care workers is very important for support to care workers.

Frightening behavior and Depersonalized behavior in FR behavior have no significant correlation with four factors in Compassion Satisfaction. Total FR Behavior have the significant negative(-) correlation with satisfaction in relations with a child or children. Satisfaction in relations with a child or children is main part of compassion Satisfaction with children. Dissociation Behavior has significant negative(-) correlation with Total Compassion Satisfaction, especially satisfaction in relations with a child or children and satisfaction as nature of care workers. Awareness and talking about satisfaction in relations with a child or children and satisfaction as nature of care workers have the role of protection from consequences of dissociation in the field of facility.

Table 9 displays the results of Multiple regression analysis prediction. Frightened behavior in FR behavior has significant correlation with Secondary Traumatic Stress or compassion fatigue accumulated as a substitution-related trauma. And Frightened behavior has low correlation with Denial Feeling(significantly tendency; $p=0.068$). Frightened behavior will be connected to a care giver's own trauma, so Secondary Traumatic Stress and denial feeling will be activated in a care giver when contacting with abused children. Both Criterion Variable, Frightening Behavior and Depersonalized Behavior have the significant correlation with PTSD-like Compassion Fatigue. For protection of burnout and inadequate behavior to children, it will be very important to be aware of and to treat PTSD-like symptoms among care givers and supervisors.

***Compassion Fatigue of Trauma Dominance and Compassion Fatigue of Stress Dominance***

Fujioka(2005) described that compassion fatigue has two types of, **Trauma-dominance Compassion Fatigue(TDCF) and Stress- dominance Compassion Fatigue(SDCF).** In **Stress- dominant** Compassion Fatigue, the trauma may be deeply and profoundly hidden in the mind, and stress would be felt in a situation of work. I think Trauma-dominance Compassion Fatigue would be easy to cause a stronger dissociation tendency, and the degree of the burnout tendency would differ by the state of a child, how to live in family and community and how to live in the past, especially in childhood. Deep sadness (grief, sorrow, lament) and profound trauma will draw out compassion fatigue for a care giver or a care provider who continues to be exposed to Trauma-dominance Compassion Fatigue and experiences dissociation unconsciously under those situations. Children who had a severe trauma will draw compassion fatigue of trauma dominance of a care provider easily. I think that under these helping situations with abused or traumatized or neglected clients(children or elderly people or handicapped people), compassion fatigue would be easy to connect to severe burnout situation. In this study we found dissociation tendency is connected with all four factors in Compassion Fatigue (Secondary Traumatic Stress, PTSD, Denial tendency, Trauma experience). I have to emphasize that dissociation tendency is a key concept of Compassion Fatigue. P. Janet already pointed out the relationship between traumatic memory and psychological fatigue in the latter part of 19 century or early 20 century. The author discussed this point through compassion fatigue and dissociation in child welfare facilities. In other words, when care providers are exposed to compassion fatigue, particularly secondary wound-related stress, their own trauma experience may be drawn out. And care providers must be exposed to trauma experiences of children doubly more while they are exposed to their own trauma experience. This is Trauma- dominance Compassion Fatigue.

***Further tasks in these area***

Fujioka(2010) described four tasks of support programs as follows. 1, Necessity of enhancing investigations in other child welfare facilities. 2, Continuity of investigations. 3, Necessity of construction of individually-related examination about Compassion fatigue/Satisfaction and FR behavior or Clinical Attachment Approach. 4, Necessity of construction of **the Academic Domain on Support for Care Giver or other professionals for users and clients.**

The author emphasized in this study that it is necessary to investigate the relationship of professional approach to clients with Compassion Fatigue and satisfaction. Perhaps it is very important for the protection of burnout or inadequate behavior in care providers and social workers to examine these subjects on Compassion fatigue/Satisfaction.

## References

Abrams,K.Y., Rifkin,A.& Hesse,F. 2006. Examining the role of parental frightened/frightening subtypes in predicting disorganized attachment within a brief observational procedure. Development and Psychopathology, 18,345-361.

Boscarles, J.A., R.Figley and Richard E. Adams 2004. Compassion Fatigue following the September 11 Terrorist Attacks: A study of Secondary trauma among New York

Bowlby, J. 1969. Attachment and Loss: Vol. 1 New York: Basic Books.

Cherniss, C. 1980. Professional Burnout in Human Service Organization. Praeger, New York.

Figley, C. R. 1982. Traumatization and comfort : Close relationships may be hazardous to your health. Keynote address for Families and Close Relationships : Individuals in Social Interaction, Conference at Texas Tech University, Lubbock, TX.

Figley, C. R. 1985. Trauma and its wake: Study and treatment of PTSD. Newyork:Brunner /Mazel.

Figley, C. R. 1989. Helping traumatized families. San Francisco : Jossey-Bass

Figley, C. R. (Ed.) 1995. Compassion fatigue : Coping with secondary traumatic stress disorder in those who treat traumatized. Brunner/Mazel : New York

Figley, C. R. (Ed.) 1998. Burnout in Families : The Systemic Costs of Caring. CRC Press : New York.

Figley, C. R. 1999. Compassion Fatigue : Toward a New Understanding of the Costs of Caring. In B. H. Stamm (Ed.) Secondary Traumatic Stress. Lutherville, MD : Sidran Press.

Figley, C. R. (Ed.) 2002. Treating Compassion Fatigue . Brunner-Routledge : New York. p107-119.

Figley, C. R. 2006. Lectures on Compassion Fatigue at the Seminar for Social Workers, Medical Doctors and Marriage, Couple Counselors in Florida.

Figley, C. R. 2007. Private discussion at Florida State University (2007/02/24)

Figley, C. R. & Stamm, B. H/ 1996. Review of the Compassion Fatigue Self-Test. In B. H. Stamm (Ed.), Measurement of stress, trauma, and adaptation. Lutherville, MD : Sidran Press.

Freudenberger, H. J. 1974. Staff burnout. Journal of Social Issues, 30, 159-165.

Freudenberger, H. J. 1975. Staff burnout syndrome in alternative institutions. Psychotherapy, 12 (1), 73-82.

Freudenberger, H. J. 1977. Burn-out: Occupation hazard of the child care worker. Child Care Quarterly, 6(2), 90-99.

Freudenberger, H. J. 1986. The issues of staff burnout in therapeutic communities. Journal of Psychoactive Drugs, 18(2), 247-251.

Fujioka, T. 2004. Burnout and Secondary Traumatic Stress in Care Workers and Case Managers Working in Welfare Facilities. Annual Report of Japan College of Social Work, Vol.40. 13-29. (In Japanese with English summary)

Fujioka, T. 2005. Secondary Traumatic Stress and Dissociation in Care Workers, Case Managers and Social Workers Working in Welfare Facilities and Agents.

Study Report of Japan College of Social Work, Vol.52, 149-163. (In Japanese with English summary)

Fujioka, T. 2006a. Compassion Fatigue and Dissociation -Through The Clinical Approaches by Pierre Janet- Journal of Social Policy and Social Work Vol.10. 23-33. (in English)

Fujioka, T. 2006b. Secondary Traumatic Stress (Compassion Fatigue), Burnout and Compassion Satisfaction in Care Workers, Case Managers and Social Workers Working in Welfare Facilities and Agents. Study Report of Japan College of Social Work, Vol.53. 27-52. (In Japanese with English summary)

Fujioka, T. 2007. On the Structure of Compassion Satisfaction and Compassion fatigue in Child welfare facilities. Study Report of Japan College of Social Work, Vol.54, 5-116. (In Japanese with English summary)

Fujioka, T. 2008. Compassion Fatigue in Japan. Journal of Social Policy and Social Work Vol.12 5-13. (in English)

Fujioka, T. 2010. On the Construction of Support Program for Care Givers in Child Welfare Facilities on the Standpoint of Compassion Fatigue. Study Report of Japan College of Social Work . Vol.57, (in Japanese with English abstract ) (in print)

Fukushima, M. 2010. Compassion Fatigue and Empathy among Victim Support Workers- With Use of Questionnaire Study-. Study Report of Japan Women's University. Vol. 16, 85-100. (in Japanese with English abstract )

Hochschild, A, R. 1983. The managed heart. Berkeley : University of California Press.

Janet, P. 1889. L'automatisme psychologique. Paris: Felix Alcan.

Reprint: Societe Pierre Janet, Paris, 1973.

Janet, P. 1897. L'influence somnambulique et le besoin de direction. Revue Philosophique, 43, I, 113-143. Also in P. Janet

(1898a), Névroses et idées fixes, Vol. 1 (pp. 423-484). Paris: Félix Alcan. (Reprint: Société Pierre Janet, Paris, 1990.)

Janet, P. 1923. La médecine psychologique. Paris, Flammarion.

Janet, P. 1925. Psychological Healing, vols 1,2. New York, Macmillan.
(original publication: Les medications psychologiques,vols 1-3. Paris, Felix Alcan, 1919).

Joinson, C. 1992 .Coping with compassion fatigue. Nursing, 22(4), 116-218.

Kon,Y.& Kikuchi,A 2007. An Attempt to Construct a Scale of Compassion Fatigue and Its Related Affects. Study Report of Department of Social Work, Iwate Prefectural University. Vol.9, 23-29. (in Japanese with English abstract )

Kubo M. 2004. The Psychology of Burnout. Science Publishing Co. (In Japanese)

Main, M., & E. Hesse 1996. Disorganized and disorientation in infancy Strange Situation behavior. Phenotypic resembalance to dissociative states. In l.Michelson and W. Ray (Eds.) Handbook of dissociation: theoretical, empirical, and clinical perspectives. New York, Plenum Press, 107-138.

Masuda,R. 2006. Discriminant validity and item context of Normal Dissociation Scale-short form- Correlation with splitting-projection and depersonalization/derealisation- Kyushu University Psychological Research. Vol.7 117-123.

Maslach, C. 1976. Burn-out. Human behavior, 5(9), 16-22.

Maslach, C. and Jackson, S.E. 1981 The Measurement of Experienced Burnout. Journal of Occupational Behavior, 2: 99-113.

Nishi, M. & Nojima,K. 2002. STS in the shelter staff. Kyushu University Psychological Reseach. Vol.3,157-165.( in Japanese with English abstract)

Orlans, M. & Levy, T. M. 2006. Healing Parents-Helping Wounded Children Learn to Trust & Love. Child Welfare League of America, Inc. ; Washington.

Pearlman, L. A. 1999. Self-Care for Trauma Therapists : Ameliorating Vicarious Traumatized. In B. H. Stamm(Ed.) Secondary Traumatic Stress. Lutherville, MD : Sidran Press.

Pearlman, B.& Hartman,E.A. 1982. Burnout:Summary and future research. Human Relations,35,283-305

Pines, A. M., Aronson,E. 1988. Career Burnout:Cause and Cures(2nd ed). Free Press,New York.

Pines, A. M., Aronson, E. & Kafry, D. 1981. Burnout: From tedium to personal growth. New York: Free Press.

Pines, A. & Maslach,C. 1980. Combating staff burnout in child care centers: A case study. Child care quarterly ,9,5-16.

Shimizu T., Tanabe T., and Nishio Y. (Eds), 2002. Burnout in Social Worker- the actual state and the treatment. Chuouhouki Publishing Co. (In Japanese)

Shinozaki, T. 2007. Factors related to compassion fatigue among Children's Home staff members. Child Abuse and Neglect. Vol.9, No.2 . 246-255. (in Japanese with English abstract)

Stamm, B. H. (Ed.) 1999. Secondary Traumatic Stress : Self-Care Issues for Clinicians, Researchers, &Educators. Lutherville, MD : Sidran Press.

Stamm, B. H. 2002. Measuring compassion satisfaction as well as fatigue: Developmental
history of the Compassion Satisfaction and Fatigue Test. In C. R. Figley (Ed.), Treating compassion fatigue (pp. 107–119). New York: Brunner-Routledge.

Stamm, B. H. 2003. Professional Quality of Life: Compassion Fatigue and
Satisfaction Subscales, R-(Pro-QOL) http://www.isu.edu/~bhstamm (2005/2/25)

Stebnicki, M. A. 2010. Empathy Fatigue:Healing the Mind, Body, and Spirit of Professional Counseloors. Springer Pub. Co.