Chapter 2

Understanding the Cost of Caring

> The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter. The way we deal with loss shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance ourselves from life. We burn out not because we don't care but because we don't grieve. We burn out because we've allowed our hearts to become so filled with loss that we have no room left to care.
>
> **—Naomi Rachel Remen**
> *Kitchen Table Wisdom*, p. 52

In this chapter you are invited to:

- Read the definitions of *compassion fatigue, vicarious traumatization*, and related terms.
- Read the narrative "A Story of CF and VT" with your journal/notebook close at hand. Note your thoughts and reactions to the story.
- Complete the writing exercise.
- Discuss your reactions to the narrative and to the exercise with your group or with a friend.

A Normal Consequence of the Work

> I finally came to understand that my exposure to other people's trauma had changed me on a fundamental level. There had been an osmosis: I had absorbed and accumulated trauma to the point that it had become part of me, and my view of the world had changed.
>
> **—Laura van Dernoot Lipsky**
> *describing her own vicarious trauma in her book Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others, p. 3*

The helping field has gradually begun to recognize that workers are profoundly affected by the work they do, whether it is by direct exposure to traumatic events (for example, working as a paramedic, firefighter, police officer, emergency hospital worker); secondary exposure (hearing clients talk about trauma they have experienced, helping people who have just been victimized, working as child protection workers); or the full gamut in between (such as working with clients who are chronically in despair, witnessing people's inability to improve their very difficult life circumstances, or feeling helpless in the face of poverty and emotional anguish).[1]

Our primary task as helping professionals is to meet the physical and/or emotional needs of our clients and patients. This can be an immensely rewarding experience, and the daily contact with clients is what keeps many of us working in this field. It is a calling, a highly specialized type of work that is unlike any other profession. However, this highly skilled and rewarding profession can also look like this: increasingly stressful work environments, heavy case loads and dwindling resources, cynicism and negativity from co-workers, low job satisfaction, and for some, the risk of being physically assaulted by clients.

Compassion fatigue (CF) refers to the profound emotional and physical exhaustion that helping professionals and caregivers can develop over the course of their career as helpers. It is a gradual erosion of all the things that keep us connected to others in our caregiver role: our empathy, our hope, and of course our compassion—not only for others but also for ourselves. When we are suffering from compassion fatigue, we start seeing changes in our personal and professional lives: we can become dispirited and increasingly bitter at work; we may contribute to a toxic work environment; we are more prone to clinical errors; we may violate client boundaries and lose a respectful stance towards our clients. We become short-tempered with our loved ones and feel constant guilt or resentment at the never-ending demands on our personal time.

CF has been described as "the cost of caring" for others in emotional pain.[2] It can strike the most dedicated nurse, social worker, teacher, police officer, physician, and personal support worker alike. Ironically, helpers who are burned out,

worn down, fatigued, and traumatized tend to work more and work harder. As a result, they go further and further down a path that can lead to serious physical and mental health difficulties, such as depression, anxiety, substance abuse, chronic pain, other stress-related illnesses, and even suicide.

Compassion fatigue is an occupational hazard,[3] which means that almost every helper who cares about their patients/clients will eventually develop a certain amount of it, in varying degrees of severity. Charles Figley has called compassion fatigue a "disorder that affects those who do their work well."[4] The level of compassion fatigue that a helper experiences can ebb and flow from one day to the next, and even very healthy helpers with optimal work/life balance and self-care strategies can experience a higher than normal level of compassion fatigue when they are overloaded, are working with a lot of traumatic content, or find their case load suddenly heavy with clients who are all chronically in crisis. We do not develop compassion fatigue because we did something wrong—we develop it because we care, or because we *used* to care. Naomi Remen says it best, paraphrased from her quote above: We cannot walk through water without getting wet. We cannot do this work without being affected by it. (Well, that's not entirely accurate. We *can* do the work without caring, but everyone suffers—our colleagues, our clients, and our loved ones.)

Vicarious traumatization (VT) is a term that was coined by Laurie Anne Pearlman and Karen Saakvitne to describe the profound shift that workers experience in their world view when they work with clients who have experienced trauma. Helpers notice that their fundamental beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material. Vicarious trauma occurs when the stories we hear from our clients transfer onto us in a way where we too are traumatized by the images and details, even though we did not experience them ourselves. We then find it difficult to rid ourselves of the images and experiences they have shared with us. As Pearlman and Saakvitne explain, "It is not something clients do to us; it is a human consequence of knowing, caring, and facing the reality of trauma."[5]

VT is a cumulative process: we are not referring to the most difficult story you have ever heard; we are talking about the *thousands* of stories you don't even remember hearing. Where do those stories go at the end of your day? Have you ever found yourself struggling with intrusive images or nightmares that did not belong to you, but rather came from stories you had seen and heard at work? Have you found that your view of the world has changed because of the work that you do?

Some of us become increasingly numb to the pain and suffering of our clients; others feel profound sadness and anger at the unfairness of the world and many of us simply get overwhelmed. We were not provided with many tools to deal with this aspect of our work.

A FAMILY PHYSICIAN GRAPPLES WITH VICARIOUS TRAUMA

Vicarious trauma became real to me after about a month of working in a new practice. This was previously a "pain" practice with many of the patients being followed for chronic pain issues. As I got to know these people, I realized that their previous family doctors had never assessed them for trauma and abuse.

Soon every patient was disclosing significant stories of trauma to me. One day, I heard from six patients in a row about childhood neglect and abuse, sexual abuse by a private school teacher, violent partner abuse. These stories dominated the time I spent with patients. Some of these people had not disclosed to anyone ever before. This was overwhelming for me on a number of levels. First, I felt so sad. The stories of trauma are so unfair, particularly when a child is taken advantage of. Second, I was angry that these people had not been helped to deal with their issues and get some counseling. Third, I felt quite helpless, as I am not an expert in trauma issues, nor am I a counselor or a psychotherapist.

Over the ensuing days, I became preoccupied by the stories I had heard. I could not sleep at night. I also couldn't help but relive some of the horrors of the stories in my head. I did not want to share the trauma stories with others as I did not want to upset anyone else. The stories that I found so disturbing would be upsetting for others. I was paying less attention to my family. My children's shallow requests made me angry. I was irritable and very emotional. Twice, I walked into a meeting and broke into tears when someone me asked how I was.

Of course, this was classic vicarious trauma, which is a phenomenon I was aware of. But I still found it hard to recognize in myself. In retrospect, it is so obvious. But as one is experiencing the symptoms, there is a level of denial and hope that you can handle hearing all of these sad stories on your own.

—Dr. Rupa Patel, family physician

Aren't You Describing Burnout?

The simple answer is no. *Burnout* is a term that has been widely used to describe the physical and emotional exhaustion that workers can experience when they have low job satisfaction and feel powerless and overwhelmed at work. As Beth Stamm, a leader in the field, describes it, burnout refers to "the chronicity, acuity and complexity that is perceived to be beyond the capacity of the service provider."[6] This can most definitely affect many helping professionals in addition to compassion fatigue and vicarious trauma, but burnout does not necessarily mean that our view of the world has been damaged or that we have lost the ability to feel compassion for others.

Many nonhelping professionals suffer from burnout: in my counseling practice, I have worked with clients who were not in the helping field who felt severe

TERMINOLOGY: A NEED FOR MORE CLARITY

You have probably heard all sorts of terms that refer to the cost of caring, such as *secondary trauma, compassion stress, caregiver burnout, caregiver fatigue, bystander effect,* and several others. Nadine Najjar and colleagues recently did a review of all the research to date on compassion fatigue in cancer-care providers and they concluded that there is currently "an ambiguous definition of compassion fatigue that fails to adequately differentiate it from related constructs (e.g., burnout, secondary traumatic stress)."[7] Now, this is not really a problem for you as an individual helper, but it makes research difficult. Before we even carry out research on treating CF and VT, we need to be clear that we are all talking about the same thing. Beth Stamm says it best: "The controversy regarding secondary trauma is not its existence but what it should be called."[8] We are working on getting a set of working definitions we all agree on, but we're not there yet.

work-related burnout (e.g., someone working as an administrative assistant in a stressful real estate office, a factory worker, or an overtaxed call center worker). These individuals were frustrated and depleted by their work environment, but they did not find that their view of the world at large had been permanently transformed because of their work.

Many helpers are also at high risk for burnout due to working in difficult work environments with poor pay or little control over their schedule. Burnout can make us more vulnerable to CF and VT; an unsupportive work environment can create a fertile ground for cynicism and overwork. However, burnout itself can be fairly easily resolved: changing jobs can provide immediate relief to someone suffering from job-related burnout. This is not the case for CF and VT.

Moral Distress

Moral distress is a concept that comes from the field of medical ethics. Gail Mitchell defines it as something that occurs "when policies or routines conflict with ... beliefs about ... patient care."[9] It happens when there is "incoherence between one's beliefs and values and one's actions, and possibly also outcome" as George Webster and Françoise Baylis have explained.[10] Simply put, moral distress occurs when we are told to do things that we fundamentally disagree with or to which we are morally opposed: having to discharge a patient prematurely, knowing full well that they have no support in the community and will relapse immediately; having to perform life-saving measures on a patient that had a DNR (do not resuscitate) order that is being overridden by family members; having to cut corners on client care because of the sheer volume of work; and the list goes on. Over time, moral distress can be a significant contributing factor to compassion fatigue.[11]

MORAL DISTRESS IN THE HOSPITAL ENVIRONMENT

There was a chemotherapy drug that was not on the Provincial formulary but was being offered to a patient who was "well connected" and could afford to pay. As a result, the nurses in the outpatient clinic were expected to administer the drug to this patient, often with another patient with the same diagnosis sitting next to him/her. This created a great deal of moral distress for the nurses who felt it was inequitable—this became especially distressing when the patients started to talk to one another and then the patients who were not getting the treatment would ask the nurses why they were on a different treatment.

— Testimonial from an oncology nurse

Ethical dilemmas are what I respond to on a daily basis. They are not ordinary dilemmas but are situations where common sense is not helpful and what you usually do is not relevant. Ethical dilemmas are where there is no obvious right course of action, so there is a lot of moral distress, and in the end you are not left with more certainty but perhaps less. And this can be devastating and exhilarating—but over time it takes a toll, and if there is no renewal you begin to burn out. There is often conflict where deeply held views that clash are commonplace, and my job is to mediate, negotiate, and educate in these circumstances. Often people are left with moral residue. I feel like I have been party to something unethical. Detachment and resilience is important but sometimes hard to find. There is no peace in making tragic choices.

—Dr. Paula Chidwick, ethicist

When a physician orders a treatment that the nurse feels is too aggressive, and the patient has no hope of surviving or the quality of life will be greatly diminished, and the nurse feels the patient does not fully understand the implications of what he or she has agreed to, then the patient undergoes the treatment, does poorly, and the nurse is left to administer procedures that they believe are futile or will cause undue suffering. As one nurse describes, "and they gave him the treatment anyway, and he did not survive. ... It was very difficult to watch because you anticipated what the outcome was going to be at the outset, so to look after him day after day, it was hard, poking and prodding him, knowing that everything I did was not going to make a difference was extremely upsetting."

—Testimonial from an oncology nurse

Primary and Secondary Trauma

Primary trauma is caused by a traumatic event that happens to you—you are directly exposed to the trauma. In the context of helping professionals, there are two kinds of primary trauma:

Primary Trauma From Your Personal Life

This refers to trauma that you are carrying with you from your past (childhood abuse, having escaped a war, a traumatic loss in your personal life, surviving a motor vehicle accident, etc.). Research shows that more than 60% of helping professionals have a trauma history of their own, which may be why they chose this field of work (to make a difference, to give back, to share their learnings with others). That, in and of itself, is not a problem. The challenge arises when helpers go into the field without having done their own trauma work and are not aware of the ways in which their trauma history negatively impacts the work they do. It can also make us more vulnerable to developing vicarious trauma when bearing witness to our clients' pain and suffering.

Primary Trauma Caused by Work-Related Exposure

This type of primary trauma exposure occurs in the line of duty: working as a firefighter, a search and rescue operator, being a first responder to an accident or a crime scene, being involved in a stakeout or negotiating a hostage taking, working in a war-torn country in unsafe conditions. What makes it *primary* is that it is happening *to* you. During this traumatic situation, you are potentially in harm's way and/or you are overwhelmed by the horror or terror of the situation.[12]

Secondary Trauma

Secondary trauma is caused by a *secondary* exposure to trauma: you are not in actual danger; you are not at the scene of the traumatic event seeing firsthand the results of a shooting rampage or an accident. Instead, those stories are described to you verbally, in writing or through audio or video recordings. Secondary traumatic exposure can happen through counseling a client who is retelling a story of abuse, reading case files, debriefing a colleague or a client, sitting in court and hearing graphic testimonies, or watching a disturbing movie or traumatic news footage. In addition to the secondary trauma they are exposed to in the line of duty, many first responders such as firefighters and paramedics are at risk of developing primary trauma from their repeated exposure to traumatic events.

Both primary and secondary trauma exposure can lead to posttraumatic stress disorder (PTSD), an anxiety disorder that can develop after exposure to a traumatic event (or a series of traumatic events). It is characterized by re-experiencing (having nightmares or intrusive thoughts about the traumatic event), avoidance

(e.g., avoiding triggers: not going in a car after an accident, avoiding churches if the trauma took place in a church), chronic tension and irritability, insomnia, difficulties with concentration and memory, and emotional numbing.[13]

Unfortunately, PTSD in helping professionals is often missed by family doctors or other health care professionals who have not received training in vicarious trauma or compassion fatigue. If you seek help from a health care practitioner for what you suspect is CF/VT related, make sure you check first whether they are familiar with these concepts. In fact, very few health care professionals have received even the most basic trauma training, and many trauma-related illnesses go undetected and untreated or get misdiagnosed and treated as depression or anxiety without a full context of the contributing factors.

What Is the Difference Between Compassion Fatigue, Vicarious Trauma, Secondary Trauma, and Burnout?

These four terms are complementary and yet different from one another. While *compassion fatigue* refers to the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate, the term *vicarious trauma* describes the transformation of our view of the world due to the cumulative exposure to traumatic images and stories. This is accompanied by intrusive thoughts and imagery and difficulty ridding ourselves of the traumatic experiences recounted by our clients. *Secondary traumatic stress* (STS) is the result of bearing witness to a traumatic event (or to a series of events), which can lead to PTSD-like symptoms (hearing a graphic account of abuse, debriefing first responders, etc.). I would argue that VT is the result of many STS events. *Burnout* has to do with the stress and frustration caused by the workplace: having poor pay, unrealistic demands, heavy workload, heavy shifts, poor management, and inadequate supervision; and as mentioned above, this can happen in any occupation.

TRAUMA EXPOSURE RESPONSE: A NEW TERM TO DESCRIBE SECONDARY TRAUMA AND VT

Laura van Dernoot Lipsky recently proposed a new term, *trauma exposure response*, which she defines as "a transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet. This transformation can result from deliberate or inadvertent exposure, formal or informal contact, paid or volunteer work … We are talking about ways in which the world looks and feels like a different place to you as a result of your doing your work."[14] Primary and secondary trauma and VT would fall under the umbrella of *trauma exposure response*.

What Is the Difference Between CF and Depression?

> Employees who considered most of their days to be quite a bit or extremely stressful were over three times more likely to suffer a major depressive episode, compared with those who reported low levels of general stress.
>
> **—Canadian Mental Health Association[15]**

Dr. Richard Thomas, a clinical psychologist with many years of experience working with trauma survivors, explains the difference between CF and depression in the following way: "Depression is a recognizable mental illness defined in the *DSM-IV-TR*. Compassion fatigue ... is more of an occupational hazard, for those in the helping professions—akin to an on-the-job type of safety hazard, if you will. My analogy: CF for helpers is roughly the emotional hazard equivalent to the physical hazards of fishermen working on an arctic fishing boat. Of course, if you change the circumstances to something healthier, the symptoms of the stress can mitigate and resolve with time. Chronic CF can certainly lead to depression, anxiety, addiction, or a host of other mental or physical illnesses, if it is not recognized and addressed effectively."[16] I would also add that having a history of depression and/or anxiety disorders can make a helping professional more vulnerable to compassion fatigue and vicarious trauma.

YOU CAN SUFFER FROM VT WITHOUT SUFFERING FROM CF—AND VICE-VERSA

If I work as the assistant to a forensic psychologist and my task is to type the case files of violent sex offenders, I may be traumatized and deeply disturbed by the content of what I read. This may, in turn, affect my sex life, my feelings of safety for my children, or my ability to watch television (signs of vicarious trauma). I may still, however, have plenty of energy to talk to my friend who is going through a difficult time at home and I may not find that my work has caused me to feel deeply exhausted in my interactions with colleagues. But then again, I may experience all of the above.

If I work as a nurse in a long-term care facility helping patients who suffer from chronic illnesses, I may feel incredibly drained, fatigued, and unable to give any more at home or at work (signs of compassion fatigue); but I may not have become contaminated with graphic details of terrible things that people have experienced (car accidents, stories of sexual abuse, etc.). My world view about most things may still remain fairly intact.

BEWARE: GOING TO A TRAUMA CONFERENCE COULD BE TRAUMATIC!

I was recently at a conference where the keynote speaker was introduced as an American expert in compassion fatigue. Her keynote speech consisted of two main parts: During the first part of her presentation, she showed us images of several first responders and told us about the ways in which they had committed suicide following a traumatic event (e.g., a firefighter who had helped survivors of the Oklahoma City bombing of the Federal Building, the first responder who rescued Baby Jessica many years ago). The speaker then said that these were examples of compassion fatigue. I was perplexed and waited to see where she was going with this.

She then talked about the importance of listening to our inner voice and told us about having recently met Aron Ralston, author of the book *Between a Rock and a Hard Place*. He is the American hiker who fell in a Utah canyon and had to amputate his arm to free himself back to safety. The keynote speaker then proceeded to tell us in graphic details the step-by-step process Ralston used to amputate his arm. The audience was groaning audibly and there was a wave of discomfort throughout the room. I sort of lost the message of her keynote at this point, and was just sitting there trying to fight a wave of nausea and feeling angry about this secondary traumatization.

I really don't think this speaker intended to traumatize the audience with her story. But two things occur frequently, even among specialists in the field: The first is the terminological confusion I mentioned earlier (the first responders in her story likely had PTSD, which led to their suicides. They may very well have had compassion fatigue, but the stories she told were not about CF—they were about primary trauma.) The second is that trauma specialists have become so desensitized to the graphic nature of the stories we've seen and heard that we sometimes inadvertently end up retraumatizing our audiences (for a strategy on how to prevent this, read Chapter 5, "Low-Impact Debriefing").

Who Cares About the Difference Between These Terms?

The distinction between burnout, CF, VT, and primary and secondary trauma is important to provide you with the tools you need to clearly understand the factors that lead to you developing CF or VT: the more we know about the problem, the more we are able to develop strategies to prevent and modulate the impact of what we experience. It is also important to understand what we are bringing to the work we do in terms of our own primary trauma. But if you find that you're not sure "what you have," don't worry; I will explore this further in the coming chapters.

REFLECTION

Reading through the definitions of these terms, do you recognize these elements in yourself? Is your job challenging because of the types of client situations you have to deal with, or because of the volume of work, or due to a toxic supervisor (or all of the above)?

Bringing This Closer to Home: *Your* CF/VT/Burnout and Primary Trauma

Helpers can experience compassion fatigue, vicarious trauma, burnout, and moral distress simultaneously. CF, VT, and moral distress are cumulative over time and evident in our personal and professional lives. They are also occupational hazards of working in the helping field. We will discuss this in the next sections of the workbook.

My Story of Vicarious Trauma and Compassion Fatigue

Vicarious Trauma

I started working in this field when I was 21. My first experience was working as a volunteer in a hospital emergency ward in England as a "befriender." The task of the befriender was to comfort relatives whose loved ones had suffered an acute trauma or were very medically unstable. Family members were ushered into a special room to await news from medical staff. The befriender would offer to make a cup of tea or simply chat.

Understandably, the relatives in the family room were often highly distressed and some of them had also just been exposed to a traumatic event. Imagine that you go to a bar with your best friend, and he is stabbed in a knife fight, he gets rushed to hospital, and you end up waiting in the relatives' room. You will have a traumatic story to share with the first person who asks you how you are doing. If your child has been gravely injured in a car accident and you were driving the car but were miraculously unhurt, you will be sitting in that room waiting to hear life or death information about your child; and in this hospital, the befriender would be the person sitting there with you.

I had never done any counseling work before this—and needless to say, it was a pretty rapid and brutal introduction to the world of trauma (both physical and emotional). I remember feeling shocked and very shaken many evenings when returning home from work. I had no idea what was really happening to me except that I felt overwhelmed by what I had witnessed and also felt pretty incompetent at helping the people I met there. But I also loved the work—it felt like the right place for me, although that may seem contradictory. I found it deeply satisfying and unlike any other work I'd ever done.

I remember biking home in the evenings with my eyes as big as saucers, full of the stories I had heard, and then walking in the door and debriefing myself all over my scientist husband, who did not work in the field of trauma and who did not have training to deal with some of the stories I shared with him. I would slime

> *him with all the gory details of my shift. One day, after telling him a particularly harrowing story involving children and loss of life, I saw how horrified he was and I started thinking about the contagious effect of my words.*
>
> *Once I had debriefed from my shift, I would immediately turn on the TV to watch a show called* Casualty: Life in the ER. *I was so full of stories from the emergency ward that it seemed difficult to think about other things. Going out with friends, all I wanted to talk about were stories from the ER—what I had seen and heard. I also began finding that my view of the world was being tainted by my work: during car rides on the highway, I would have flashes of cars crashing, of drunk drivers smashing into us.*

These images are examples of vicarious trauma: being traumatized by the stories that we are bearing witness to during the course of our work.

There are many examples of ways in which exposure to difficult stories contaminates helpers: Many cancer care workers will tell you that for them, a headache is a sure sign of metastatic brain tumor. Many child protection workers confess to having a very difficult time hiring male babysitters for fear that they will molest their children, and that for them, any bruise on a child is a sign of abuse. The examples abound and are specific to the type of trauma you are exposed to during your work.

A Loss of Innocence

> *We fast forward to several years later—I now had two young children and was volunteering once a week in my son's kindergarten class. Initially, I enjoyed going into the classroom—it felt like a pure, simple way of reconnecting with young children and it also felt like a wonderful break from my work with soldiers and prison guards. Except that during my second day of volunteering, I noticed that one of my son's classmates had a bruise on his arm. Then I also noted that he did not seem to be wearing proper winter boots, and his lunch seemed meager and unhealthy. I started thinking of child protection scenarios and wondering what I should do. It felt as though I was starting to see potential child abuse everywhere I turned. Going to the public library, I would notice the disheveled mother who was being a bit short with her child, and I was taken away from enjoying my time at the library with my own children, always thinking to myself, "Should I intervene?"*

Think about your line of work. Has this happened to you? Different trades describe this loss of innocence in various ways: some people who work in prisons say that they have lost a sense of safety in their own homes because they work with offenders who have described to them, in great detail, home invasions and burglaries they have committed. When I worked in a university setting, I began seeing all female students as suffering from bulimia and all male students as pot-smokers who were failing on their exams. Of course, this was completely inaccurate, but my world view had become skewed by my repeated exposure to certain stories.

Compassion Fatigue

In the late 1990s I started working at a university counseling service as a crisis counselor. I worked there for 7 years (including a few baby breaks). When I initially considered working at the student counseling service, I hesitated at first, thinking that it wasn't going to be sufficiently challenging for me to deal with what I thought would be "small student issues" (relationship breakups, poor grades, and career dilemmas). I wanted to do emergency work—front-line, exciting stuff.

I couldn't have been more off base. I was the first person to hold the title of crisis counselor there and was exposed to a very high volume of clients and an incredible range of life issues—from complex sexual abuse histories that the clients had never disclosed before, to survivors of war traumas, to people coming for help in the middle of a full psychotic episode. Drastic province-wide budget cuts also meant that referral resources in the community were dwindling and I was often left dealing with highly complex problems with very few resources.

During my first few years as a crisis worker, I did not really notice that I was being profoundly affected by my work. I enjoyed what I did, although I often felt exhausted both physically and emotionally and frequently avoided social events. However, during the final 2 years at the counseling service, I started noticing the following behaviors:

Anger and Irritability

I became extremely irritable with my colleagues. I resented the fact that they took lunch breaks while I was working nonstop, and I felt angry at the cheerful and positive demeanor of our support staff.

Irritability with co-workers can be a symptom of compassion fatigue: you begin to feel resentful of colleagues and start to feel that you are doing all the work. Interestingly, research shows that individuals in the early stages of CF work harder rather than less. They can appear to be the most dedicated of staff (albeit humorless), take on extra responsibilities, and come to work early and leave late. Helpers with early CF often describe feeling overwhelmed with the workload, and say they have great difficulty setting limits and going home at the end of a shift. They often worry about their patients or clients and sometimes feel guilty about going home to a better environment than their clients' own situations.

Avoidance of Meetings

I started avoiding staff meetings as much as possible. This was largely because I felt frustrated hearing about more and more funding cuts and less resources for my clients, and also because I did not feel that I had time to stop and attend meetings. I felt that I should be seeing clients and trying to tackle my mounting waiting list.

Unfortunately, missing staff meetings on a regular basis also means that we are losing opportunities to debrief with our colleagues. If numerous staff members

stop attending meetings or peer supervision meetings because they are too busy with client work, staff morale can suffer.

Predictability of Client Issues

The clients I was working with were mostly 18- to 24-year-olds from similar backgrounds, and I started finding myself predicting ahead of time what my clients were going to talk about. This did not happen all the time, but often enough, I would find myself listening to a new client and I would think to myself: "Yup, I know what she's going to say next ... I know where this is going."

If you have ever worked with a highly homogenous client population, this may have happened to you as well. What is problematic about this behavior is that we stop asking important questions, which may cause us to miss key issues. Of course, with experience, we develop competence and confidence, and we become highly skilled at what we do. The problem, however, is that with confidence can also come complacency. Complacency can also lead us to make faulty assumptions about our clients—not asking a well-dressed professional whether she uses street drugs, assuming that a mother on social assistance is not taking proper care of her children, and others.

Avoiding Difficult Topics With Clients

I have had helpers confess that they do not screen for suicide or homicide because they do not "have time to deal with it" or do not know how to respond to such concerns. Many health care professionals tend to avoid asking trauma- or abuse-related questions for fear of opening a Pandora's box with the client. The truth is that many of us were not properly trained to deal with abuse and suicidal ideation.

Feeling Discouraged About Lack of Referral Resources—Moral Distress

The reality for most of us is that we are doing more work with less and less resources. It can be very difficult to send someone away who is clearly in need but for whom we have nothing to offer. I was turning people away on a daily basis in my work as a crisis counselor, and that was probably the most difficult aspect of my job. It completely contradicted my reasons for choosing this line of work.

Failure to Get a Life

In my great wisdom, I thought it would be a good idea to volunteer after-hours at the local maximum security prison and *volunteer to be on the board of directors of an eating disorder outreach program while working as a crisis counselor.*

This is not uncommon among helpers: First of all, our choice of career in the helping professions usually means that we are naturally inclined to help others and tend to be on the giving rather than the receiving end in our personal life as well as at work. Secondly, many of us volunteer on boards and help charitable organizations because we believe in giving back to our community. The problem is that, at some point, we have nothing left that is our own, which means that we cannot replenish ourselves.

Fatigue and Exhaustion at the End of the Day

I used to get home and be utterly exhausted, even though I had not necessarily worked a long shift, had slept 9 hours the previous night, and had not done any physical exercise. I was often puzzled when friends of mine, who were not in this field, would tell me about going to exercise class at night, after work. That seemed completely unimaginable for me.

My partner would come home and want to watch the news or talk about current events, and I would shut him down—I felt completely spent and only wanted to tell him about the most difficult stories I had heard, but I did not have much patience or tolerance for anything else. I also felt very easily overwhelmed by television—there was, I felt, far too much violence and sadness on TV. It did not feel like an escape for me.

I started becoming more and more interested in the phenomenon of CF and VT and began understanding that the exhaustion, irritability, and anger were being caused by my work but had to do with far more than a large caseload: I was being transformed and even sometimes damaged by the stories I was bearing witness to.

MAKING IT PERSONAL HOMEWORK: REFLECTION EXERCISE

In your journal/notebook, note your reactions to the narrative above: "My Story of VT and CF."

Can you relate to this? Do you agree/disagree? Is it bringing something up for you?

Consider taking some time to write down your own narrative of compassion fatigue, vicarious trauma, moral distress, and burnout. Providing you are not sharing graphic images or traumatic stories, consider sharing this narrative with a close friend or colleague.

If you are part of a group: at your first meeting/teleconference, share with one another how the narrative and the descriptions of CF and VT resonate with your own experiences. Note: It is highly recommended that everyone in the group read Chapter 5, "Low-Impact Debriefing," before your first meeting.

WRITE YOUR OWN NARRATIVE

Take half an hour aside and write your own narrative of CF and VT. How would you tell the story of the work (or the caregiving) you have done? How did you start noticing the impact it was having on you?

Here are some questions to help you along:

1. Where do the stories go?
   What do you do at the end of a workday to put difficult stories from clients away before you go home?
2. Were you trained for this?
   Did your training offer you any education on self-care, compassion fatigue, vicarious trauma, or burnout? If it did, how up-to-date are you on those strategies? If it didn't, how much do you know about these concepts?
3. What are your particular vulnerabilities?

There are two things we know for sure about the field of helping: (a) a large percentage of helpers have experienced primary trauma at some point in their past, which may have led them to being attracted to the field in the first place; (b) personality types who are attracted to the field of helping are more likely to be highly attuned and to feel empathy toward others, which makes them good at their job *and* also more vulnerable to developing CF, VT, and burnout.

What are your vulnerabilities?

4. How do you protect yourself while doing this very challenging work?
5. Reread the story of your career as a helper.
   What have been the biggest challenges in your current job? Think broadly: client challenges, organizational challenges, interpersonal, societal, others? More specifically about your actual job, what have been or are the biggest challenges: your work schedule, colleagues, office layout, others?
   How did you come to realize that your work was having a significant impact on you and on your life?

Once you have written your story, take some time to review what you have written, and look for themes and patterns. What aspects of your CF/VT have to do with the nature of your work? What aspects have to do with your own history or family of origin? Can you see how the nature of your place of work may have impacted on your levels of CF and VT? Can you see how

your own history or family of origin may have contributed to your levels of CF and VT?

If you feel comfortable doing so, consider discussing this with a colleague, friend, or counselor.

If you don't feel ready to do this, can you write down a few jots about your career path, what jobs you have had, and how they may have impacted you? For example:

1986 Kitchen helper—positive impact: negative impact:
1990 Volunteer at women's shelter—positive impact: negative impact:

If you are part of a group, discuss with one another how this chapter resonated with your own experiences of VT and/or CF.

Endnotes

1. This section is adapted from an article entitled "Running on Empty," originally published in the Spring 2007 issue of *Rehab & Community Care Medicine*.
2. Figley, C.R. (Ed.). (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel, p. 1.
3. Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton.
4. Figley, C.R. (1995). p. 5.
5. Saakvitne, K.W., & Pearlman, L.A., & Staff. (1996). p. 25.
6. Figley, C.R. (1995). p. 12.
7. Najjar, N., Davis, L.W., Beck-Coon, K., & Doebbeling, C.C. (2009). Compassion fatigue: A review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology, 14*(2), 267.
8. Stamm, B.H. (Ed.). (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd Edition). Lutherville: Sidran Press, p. 5.
9. Mitchell, G.J. (2001). Policy, procedure and routine: Matters of moral influence. *Nursing Science Quarterly, 14*(2), 110.
10. Webster, G.C., & Baylis, F.E. (2000). Moral residue. In S.B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (p. 218). Haggerstown, MD: University Publishing Group.
11. "As discovered in research by Corley, 2002; Meltzer & Huckabay, 2004; and Severinsson, 2003, emotional exhaustion (a main component of burnout and compassion fatigue) has been significantly correlated with the frequency of moral distress." Leslie MacLean, personal communication, 2011.
12. Thank you to Diana Tikasz for this.
13. Butcher, J.N., Mineka, S., Hooley, J.M., Taylor, S., & Antony, M.M. (2007). *Abnormal psychology Canadian Edition*. Toronto: Pearson Canada.
14. van Dernoot Lipsky. (2009). p. 41.