Compassion Fatigue: When the Helper Needs Help

This narrative is a first-person account of the impact of physical and emotional death on my life and the shattering of my illusion of invincibility and invulnerability. After several years of conducting psychological debriefings to emergency services personnel and developing training and graduate curriculum on crisis intervention theory, research, and practice, I was lulled into a false sense of security by thinking 'it could never happen to me. I was wrong. The basic tenets of crisis intervention and primary and secondary traumatization are discussed with relevancy to clinical practice. Concepts are exemplified by case study and application to personal experiences.

by
David C. Prichard

David C. Prichard, Ph.D., Assistant Professor of Social Work, School of Social Work, University of New England.

Author's Note

The reflections of situations experienced by the author have been altered only to the extent necessary to protect the identities and privacy of those involved. A special note of appreciation to the men and women who have devoted portions of their lives to providing assistance to those in need, even at the risk of their own physical and emotional health.

Nothing can make up for the absence of someone whom we love, and it would be wrong to try to find a substitute; we must simply hold out and see it through. That sounds very hard at first, but at the same time it is a great consolation, for the gap, as long as it remains unfilled, preserves the bond between us. It is nonsense to say that the gap will be filled; it will not be, but on the contrary, it will be kept empty, and so helps us to keep alive our former communion with each other, even at the cost of pain. (adapted from Dietrich Bonhoeffer)

As a Senior Mental Health Clinician with five years of experience working with individuals, families and professionals in crisis, I thought that I had witnessed it all and understood crisis theory. I was mistaken. It was not until a confluence of events in my own life occurred that I came to understand truly the impact that crisis has on an individual and came to appreciate the extreme pain and fear that often characterize those in crisis. This personal narrative reflects my own spiral into a state of crisis as I dealt with the impact of physical and metaphoric death, loss and grief in my own life.

Crisis Means Danger and Opportunity

In the Spring of 1987, I started work as a Senior Clinician with a community-based Emergency Services unit located in a community mental health center in one of the largest metropolitan areas in central Virginia. Initially my job responsibilities involved carrying a case load of six crisis clients per week and being on call weekly and on occasional weekends. I learned early on that the job was unpredictable and carried with it a great deal of responsibility. I was responsible for making the call as to whether or not there was cause, from a mental health perspective, to hospitalize individuals involuntarily who were suicidal, homicidal, or unable to care for themselves to the point of being a danger to self or others.

One of the first things I learned as a crisis worker is that the Chinese term for crisis *(weiji)* is composed of two characters which signify danger and opportunity (Wilhelm, 1967). I

quickly learned Slaikeu's (1990) definition of "crisis" as a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving and by the potential for a radically positive or negative outcome.

I can deal with this, I thought, as I started a five-year stint with the community-based crisis intervention program. I had grown up in relative poverty in an abusive and crisis-oriented family, with an absent father and a traumatized mother who coped as best she could with what life threw her way. This often involved dissociation, generalized anxiety, and panic attacks. As a child, I developed the ability to suspend my own reactions to situations, learning early on that a consistent foundation of support would not be forthcoming. My childhood experiences prepared me well, and as a crisis clinician I quickly became known for being unflappable, able to face and confront whatever situations were thrown in my path.

Primary Traumatization: The End of Naivete

Primary traumatization is described by Mitchell (1983) as any experience that results in unusually strong emotional reactions and that has the potential to interfere with the ability to function. As a clinician on an Emergency Services unit, I experienced the more gruesome, traumatic sides of life. As a direct line worker, I witnessed many traumatic events of those in crisis, and worked closely with fire, rescue, and police personnel (SWAT and hostage negotiation) responding to tragic events. My job was to listen, provide support, validate thoughts and feelings, and normalize experiences. But what about my reactions to the situations I witnessed? What was I to do with the intrusive imagery that accompanied me through most days?

Client Situations that Haunted Me:

The woman, desperate for a child, carrying a bundle with her around the trailer park, her dead dog, swaddled in a blue blanket, cradled in her arms;

The terrified cat bound to a chair with coat hangers, held captive by a psychotic man, its rotting sibling, found later, locked in the roll-top desk in the basement;

The young girl held hostage at gunpoint by her crack addicted father who later was killed by a smoke bomb exploding against his chest;

The pre-adolescent girl sexually abused by her father (she's the age of my niece, for god's sake);

The Vietnam veteran who insisted on bringing a "worry stone" into sessions, a defused grenade clutched in his palm;

The psychiatrist, the physician, the judge, the police officer (colleagues all) hospitalized respectively as homicidal, suicidal, delusional, and psychotic;

The bright young woman, hearing voices ("your medication is poison," "he's the devil"), killed the demons during a wild, high-speed drive down the wrong side of a four-lane highway ending in her death and the deaths of three others (the papers said suicide; I knew better);

The minister seeking help for his kind, frail, bed-bound mother, her bedroom ceiling a cockroach version of an L.A. freeway, her legs frozen in a cast of excrement two years in the making (she died two weeks later);

The gentle, sensitive, shy young man, traumatized as a child and prone to anxiety, nearly killing us both after overdosing on Lithium and forcing my car off the road;

The middle aged woman in the back seat of the police cruiser, naked and masturbating violently with a cross, her face contorted with inner rage, her curses spat out in madness;

The man hearing voices that his mother, his father were the devil and should die, weeks later the mutilated, rotted bodies found stuffed down a water culvert;

The suicidal client who pulled the trigger while on the crisis hotline, the bullet entering his eye, coursing though the gray brain mass and splattering when it hit the inside back of his skull (blue-grey eye replaced by glass);

Gunshots, helicopter rotors overhead, spotlights, flashing

blue and red lights, sirens, doors slamming, police radios crackling, news vultures circling around.

While it was easy to identify which events impacted me after my direct involvement, it was only after several years of informally debriefing my colleagues that I came to realize that listening to the stories of my colleagues and conducting psychological debriefings of emergency services personnel impacted me. I was finding it more and more difficult to shake some of the gruesome images described in debriefings, and some of the images became so vividly imprinted upon me that it was as if I had actually experienced the event. I came to recognize what I was experiencing as secondary traumatization, or compassion fatigue. I was becoming numb to these images and increasingly I experienced them as "stories" rather than "narratives"; fictionalizing their experiences, I sought safety in distancing myself from the pain of reality.

Secondary Traumatization

Awareness of secondary traumatization evolves out of conceptualizing emotional contagion as an affective process in which individuals experience emotional responses parallel to another person's actual or anticipated emotions (Miller, Stiff, & Ellis, 1988; Prichard, 1996). Figley (1995) suggested distinctions between primary and secondary traumatic stress disorder:

Secondary traumatic stress disorder is a syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress. (p.8)

My position as a crisis clinician entailed conducting psychological debriefings to Emergency Services personnel throughout the state. My colleagues and I heard the narratives of dozens of EMS personnel who needed to tell their stories and to have their reactions normalized. During debriefings emergency respondents describe in gruesome and stark detail the sights, smells, touch, taste, and sounds of traumatic events. Images of many of their experiences inhabit the same place as my own memories. With time, it becomes difficult to distinguish between them. These are the nightmare images that visit at night . . .

Secondary Images that Haunted Me:

A firefighter working a train wreck, with an ax, liberating the flesh of the dead from the tangle of a wrecked train;

An elderly woman in a rocker on her back porch, perhaps seeking relief from the heat, her bloated watermelon-like corpse bursting the rocker after a week in the steamy humidity of a Virginia summer;

Five teenagers en route to the excitement of the county fair, the car and bodies a merged gory mess the height of my knees, crushed by a tractor trailer;

A young, blond haired, blue eyed girl in a sun dress playing on the side of a country road, dead within hours, her stomach eaten away from ingesting pesticides sprayed on the roadside;

A young man alone in his apartment on a Saturday night, the radio on, brains, blood, and skull fragments splattered like fireworks on the bedroom wall, a gun still in his mouth;

A baby lying quietly on his back in a crib, a stuffed brown teddy bear at his little feet, blue-faced, broken ribs, the smell of white baby food vomit filling the air, total stillness;

A psychotic father cradling his infant daughter, the torso he made headless, the head lying in the bathtub;

The group of men scuba diving in the cool, clear water, their Lieutenant floating away, throat slit and knife in the back . . . it was called fragging–killing the superior officer to avoid being killed by his inexperience;

A young attractive couple taking a drive in the cool Fall at dusk, desperate screams for help, the smell, the taste, the sound of burning flesh, hair, and rubber comingling as she is trapped in her car

beneath a burning tractor trailer and burns slowly to death, flames extinguished and re-ignited over the eternity of a two hour span, her husband uninjured watching in horror. (Only later, after I conducted the debriefing with men and women, bloodied and still in their emergency gear and smelling of burnt flesh and rubber, did I discover the victim was a colleague and a friend.)

The list goes on, and it pains me to this day to reflect on the primary traumatic stress experienced by the victims and their families, the secondary traumatic stress experienced by the emergency respondents, and now the compassion fatigue experienced by me as witness to those secondarily traumatized. The emergency respondents will have the scenes of traumatic incidents forever imprinted in their minds; these images, described to me in graphic detail during debriefings, are now part of my memory, as if my own. While I was fortunate at the time to have the love and understanding of my wife, an MSW who also conducted psychological debriefings for emergency services personnel, I sometimes wonder about the compassion fatigue we experienced with one another due to the nature of our jobs and our supportive relationship.

Crisis as an Experiential Phenomenon: Helping the Helper

One of the hazards of working in the crisis field in a large metropolitan area is that almost anything that one experiences in one's own life, outside

of the job, pales in comparison. And significant traumatic events may seem trite and trivial in light of the experiences of many of the clients with whom one works daily. Thus when I simultaneously lost two of the most significant people in my life, through death and divorce, I was little prepared for the crisis state into which I was thrown.

When I initially learned of my father's cancer, I handled it through working, an area in which I felt I had some measure of control. I developed training programs on death and dying and on secondary traumatization of professionals dealing with loss and grief, while continuing to pick up new clients dealing with grief and loss issues. I realize now how desperately I was trying to understand death and attempting to gain some control over my feelings of helplessness as I watched my father, my friend and mentor, experience a slow, painful, drawn-out death.

With the healing gift of time, I look back now with great appreciation for my father's handling of his death, and am amazed at the ability of the psyche to push the hurt and pain aside, to allow me to recall the power of bearing witness to my father's dying. I recall sitting at his bedside in the hospice, holding his hand and lapsing in and out of sleep with him . . . dreaming about camping with him and going through a whirlwind tour of the times we had together. We had a short ritualistic farewell . . . words

are forgotten now, but the look in his eyes and the feeling of connection will be a part of me forever.

After five years of ministering to those whose lives had been turned topsy turvy and helping others deal with the fall-out from the inevitable traumas of life, I watched helplessly as my own life began spinning out of control. This can't be happening, I told myself repeatedly. This was a too mundane and everyday occurrence compared to the tragedies I witnessed nearly every day on the job. I felt in control when talking a jumper down off a bridge; why was this affecting me so? People die, people divorce everyday . . .

Compassion Has a Price: A Hazardous Background

When conducting psychological debriefings with emergency personnel, I often suggest to participants that everyone has a situation out there that has his/her name on it. We may not yet have encountered the call that will throw us into a state of emotional disorganization and disequilibrium, but inevitably the call comes. What determines whether a particular individual will react to a specific situation depends on the "hazardous background" of the person.

Even as my personal life began to unravel, I watched with somewhat detached professional curiosity as I became unable to cope with the simplest crisis situations.

I was raised by an emotionally unavailable father and

an emotional unstable mother who abandoned the family during my adolescence. I had spent too much of my childhood providing emotional stability for my mother to learn how to connect with many of my own feelings. Now that I was being put to the test, I had nothing from my background from which to draw. Crises happened to my mother and to clients. . . not to me. I could handle anything, like my father. . . but death was handling him. . . I didn't have a role model for dealing with this. My family background did not provide me with the tools to cope with my own anxieties, fears, and insecurities; and my education, while helping me to understand what was happening to me, did not prepare me for the experience of utter despair and feelings of helplessness and hopelessness.

Vulnerability

An important component of falling into crisis is one's vulnerability. When we are no longer able to cope using our usual repertoire of coping behaviors, we feel extreme vulnerability. During this time there is great opportunity for both productive and destructive growth (Slaikeu, 1990). The hazardous material that left me vulnerable and defenseless began with my wife moving out three months prior to my father's death, and peaked six months later on our anniversary date. Certainly the stress of extremely difficult professional responsibilities contributed to the vulnerability. I was familiar with

dealing with the death and loss experienced by others. It was out there, external, apart from me, and safe. The more I viewed grief and loss as something that happened to others and was external to me, the more isolated and separated I became from my own emotions.

Man Overboard: A Precipitating Event

The crisis experience is precipitated or touched off by a specific event (Slaikeu, 1990). It is the proverbial straw that broke the camel's back. I had witnessed many such incidents in my work as a crisis clinician.

The final straw for me was the comprehensive examinations in May for my doctorate in social work. Ironically, the focus of my examination was crisis, primary and secondary traumatization. I continually put off preparing for the four-day examination. When I did begin to gather information to study, I found myself unable to focus on the content. I could no longer evaluate the material in an objective, analytic manner. My head was exploding, and I felt saturated with feelings of hurt, pain, sadness, and loss. I felt in desperate need to get out of my head and into the feelings that saturated my being. Everything I read appeared so insignificant compared to the grief that I was experiencing myself in the moment. How could I be studying about crisis in this academic way when my own life was in an inexorable slide into crisis, and when emotions over which I had no control were

overwhelming the cognitive safety and security of the academic pursuit. It was with great difficulty that I humbly acknowledged to my Chair that I could not pull myself together to take the exams. At last I gave in to profound grief.

Treading Water: Coping Behaviors

In many ways I feel that I forestalled the crash until that summer when I knew that I would have more time to deal with my personal issues. For the two years prior to the death of my father and the death of my marriage, my primary coping behavior was extreme overwork. In the six months prior to his death, I was employed full time as a crisis clinician, maintained a half-time private practice, and taught three graduate MSW courses as an adjunct faculty member. For a time, work very effectively allowed me to avoid dealing with my grief.

How many times had I helped clients in crisis examine their coping behaviors and strategize how to cope with a stressful situation? I found myself going through my own list of coping strategies now. I exercised fanatically, shared my feelings in individual and group supervision and in training, processed with anyone who would listen, and tried an antidepressant (but stopped after one day, unable to accept that I was really *that* depressed and feeling too much like one of my "clients"). I tried alcohol but failed miserably at this desperate attempt to deaden the

pain and decrease my anxiety (it increased my anxiety and made me feel even more out of control). When I came to the end of my coping list, I was confronted with the terrifying realization that my life was spinning hopelessly out of control and that I didn't know how to fix it.

When I recognized that my primary line of defense, immersion in academia, no longer offered comfort or even a safe hiding place, I knew that I was in for a rough ride. Requesting an extension on my comprehensives, I rode out the conclusion of the three courses I was teaching, allowed my private practice to dwindle, and suddenly had a great deal of free time. I also became involved with a wonderfully nurturing and supportive colleague who cradled me through the storm. I needed the relationship for survival, and I will be forever grateful.

Drowning: The Precipitant

The fallout from events leading to a crisis is the "precipitant." With the pressures of comprehensive exams, private practice, and adjunct teaching gone, and finally the time available to grieve, I recall almost consciously giving myself permission to slip into an abyss of grief, loss, and despair.

My chest was tight, the sharp pain I'd been experiencing the past several days undiminished by my feeble attempts to rest on my office couch. Convinced that I was having a heart attack, I wrote a quick note to

my twin brother, Jon, and called my doctor. He saw me immediately, reassured me that the EKG indicated no abnormalities, and scheduled a stress test was for the next morning. I slept fitfully, the pain still omnipresent. My appetite gone, I forced down a light breakfast, drove the five miles to the clinic, and was seen immediately. I was drawn, tired, rundown, fatigued. As the nurse wired me for the stress test, I rested on the edge of the examination table. The nurse explained that the test consisted of monitoring my vital signs as I walked on a treadmill of ever increasing incline. This would continue until my pulse reached 162. Before any activity started, the nurse took my resting pulse—it was a sky high 164. The test continued, with the technicians deciding to allow my pulse to climb to 180. I passed the test and my pulse dropped to 140 after the examination.

What was happening to me? I felt as if I were going crazy. My thoughts were like molasses, and I felt a sense of derealization when communicating with others; when engaged in conversations I felt that I was a disembodied person watching myself from a distance. When I slept at all, I would frequently wake in the middle of the night, heart pounding with extreme anxiety. I found myself pacing the floor at night, knowing that I needed to sleep, but unable to close my eyes. I lost 25 pounds in the course of six months and was now a gaunt skeleton of my former self. While I was not suicidal, I did experience intrusive

thoughts of my own violent death—my head being decapitated or blown off with a shotgun. My head felt completely muffled, as if my thoughts had to seep through thick baffles of cotton before emerging, or as if my voice were muffled by submersion in water. Feeling completely helpless with and hopeless about my situation, I experienced crying spells and would tear up with almost no provocation. I was raw, my defenses gone, my emotional core exposed to the world.

The Search for Meaning: Resolution

Is there ever true resolution? Viney (1976) suggested that resolution evolves through a process which includes restoration of equilibrium, cognitive mastery of the situation, and development of new coping strategies. Slaikeu (1990) defined positive resolution as working through the crisis event so that it becomes integrated into the fabric of life, leaving the person open instead of closed to the future.

My experience suggests that resolution occurs through making sense of what has happened and attaching meaning to traumatic experience, recognizing and accepting that one is forever changed by the experience. The dual loss of the support of my wife and the death of my father threw me into disequilibrium and disorganization. My view of myself as invincible has been forever altered. It took months of living minute to minute, then hour to hour, and

finally day to day before I could feel that some kind of equilibrium had been established–different from before, but equilibrium nonetheless.

I used the doctoral comprehensive exams in October as a concrete task to pull me through my painful grief. I passed, and immediately handed in my resignation as a crisis clinician. Finally I could breathe. I was beginning to accept the reality of the death of my father and the meaning that it held for me (disappointment that we hadn't had more time together, that he had not been more "real" with me, that I had never known many aspects of his world, grief over what might have been, but never was, in our relationship, loss of the idealized father and acceptance of the *reality* of our relationship). With the one-year anniversary of my separation from my wife, I began to accept this loss (it would take much longer to rebuild the trust shattered by feelings of betrayal and abandonment and to trust in *myself* and my ability to make good decisions).

I took several measures to simplify my life; I cut down on the private practice, completed the doctoral course work, and settled into a very simple, uncomplicated relationship with a wonderful woman. I felt in many ways reborn, that I had entered a maelstrom and emerged alive. I will never be quite the same person. Crises change us forever.

Crisis *Is* Opportunity: Letting Go and Moving Forward

It has been several years now since my divorce and I have come to terms with thinking of myself as "divorced." Though we reside in different parts of the country, my ex-wife and I maintain a friendship. The loss of my father has been more difficult, psychically. I have learned to integrate the physical absence of my father with the previous emotional one and learned to appreciate him for who he was in life and what he means to me in death.

Perhaps the most important lesson I learned was that crisis comes in many forms. It need not be a natural or human-made disaster, such as those experienced so frequently by police officers and firefighters. It is the meaning that is attached to the precipitating event that holds the key to understanding the crisis. Crises are frequently misunderstood by those experiencing them. All too frequently the focus is on the precipitating event rather than the meaning attached to it. We as mental health professionals and academicians also need to be wary of perceiving ourselves as invincible to that which we are treating and/or studying. We need to beware of the seductive feelings of invulnerability that may accompany being an academician or a mental health professional.

Epilogue: Rising from the Ashes

Now I live in a beach house on the coast of Maine with my two cats, a mountain bike, and a kayak. I continue to work at maintaining a reasonable teaching load in my faculty position in an MSW program, consult regularly with crisis teams and mental health clinics throughout New England, and strive for intimacy in relationships with friends and family. The intrusive images of death and dying that once filled my head have been supplanted by the sights, the smells, the sounds, the taste, the feel of the Maine coast–deep magenta sunrises over the Atlantic that awaken me most mornings. . . ever-changing sunsets that end the day with me most evenings. . . the sound of ocean breezes, beckoning. . . and sea gulls. . . chimes. . . and water lapping at the shore. . . the smell of fresh salt water, brine, sea grass.

Like the mythical Phoenix, I am rising from the ashes. □

REFERENCES

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

Miller, K., Stiff, J., & Ellis, B. (1988). Communication and empathy as precursors to burnout among human service workers. *Communication Mono graphs,* 55(9), 336-341.

Mitchell, J. (1983). When disaster strikes . . . The critical incident stress debriefing process. *Journal of Emergency Medical Services,* 8, 36-39.

Prichard, D. (1996). *The primary & secondary impact of critical incident stress on police officers and domestic partners.* (unpublished dissertational. Virginia Commonwealth University)

Slaikeu, K (1990). *Crisis intervention: A handbook for practice and research (2nd edition)* Boston: Allyn & Bacon.

Viney, L. (1976). The concept of crisis: A tool for clinical psychologists. *Bulletin of the British Psychological Society,* 29, 387-395.

Wilhelm, R. (1967). *The book of changes* or *The I Ching.* Princeton, N.J.: Princeton University Press.