Chapter 13

Secondary Trauma, Compassion Fatigue, and Burnout: Risk Factors, Resilience, and Coping in Caregivers – Summary

This chapter addresses issues of secondary trauma, and other ways in which care providers can be adversely affected by engaging in this challenging work. An overall description of secondary trauma is further illustrated by examples of ways in which the multiple traumas, stressors, and frustrations that our clients face can be manifested in care givers themselves. Recommendations are then made in terms of preventing and treating these potentially debilitating symptoms.

* Description of secondary traumatic stress
* Contributing factors
* Paralyzing parallels
* Prevention and treatment

Secondary Trauma, Compassion Fatigue, and Burnout: Risk Factors, Resilience, and Coping in Caregivers

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In the dream, the sun has been blocked out, and all of the familiar environs are shrouded in shadow. The sleeping therapist cannot make out the face of her pursuer, who seems to blend in and out of the shadows, but she feels mounting dread as the pursuer draws nearer no matter what evasive action she takes. Straight roads become cul-de-sacs, and she consistently loses her bearings in previously well-known surroundings. She awakens just before the pursuer reaches out to touch her. She is in her bed, breathing heavily and perspiring. Her heart rate is elevated and it takes her over an hour to fall back to sleep. She does not readily make the connection between her nightmare and the trauma history she had taken earlier in the week from a survivor of torture, until she shares her dream with colleagues at her clinic.

Description of Secondary Traumatic Stress

There is a broad array of terms used to describe the range of psychological and physiological effects observed in those caregivers who work closely with traumatized individuals and populations. Theorists, (i.e. Eisenman, Bergner, & Cohen, 2000; Figley, 1995a; Hesse, 2002; Holmqvist & Andersen, 2003; Joinson, 1992; Kinzie, 2001; Miller, Stiff, & Ellis, 1988; Trippany, WhiteKress, & Wilcoxon, 2004) list and describe some of the terms used in the psychological literature, such as: secondary victimization,

vicarious traumatization, compassion fatigue, empathetic strain, emotional contagion, countertransference, burnout, and secondary traumatic stress.

Figley (1995a) argues for the inclusion of secondary traumatic stress disorder (STSD) as a diagnosis to parallel PTSD in psychiatric texts. He looks at the level of exposure to a traumatic event needed to meet criterion for potential PTSD, as described in the DSM-IV (APA, 1994). He states that people can be traumatized without actually being harmed or threatened with harm, they only need to learn "about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (APA, 1994, p. 424). Kleber (2003) posit that exposure to a traumatic event (whether primary or secondary) can be determined if the person experiences the following two elements: *powerlessness* – the inability to influence or alter the occurrence; and *disruption* – where the certainties and assumptions in one's worldview are irrevocably altered.

Figley (1995a) continues that secondary traumatic stress reactions may occur in family members, friends, community members, and in the professionals who are providing care to the directly traumatized individuals. As such, providing support for the people who are indirectly traumatized can help to strengthen the support network and improve the quality of care for the people directly traumatized by horrific events. This is in addition to providing symptom relief for those, including clinicians, who may be suffering the ill-effects of STSD.

The effects of burnout and secondary traumatic stress described in the literature seem to be quite similar, despite the fact that they can be distinguished as overlapping yet distinct concepts. Theorists argue that burnout emerges gradually, and is a result of emotional exhaustion, while secondary traumatic stress (often called "compassion fatigue") can emerge

suddenly (Figley, 1995a; Figley & Kleber, 1995; Hesse, 2002; Pines & Aronsen, 1988; Trippany et al., 2004).

The symptoms of secondary stress have often been considered as a form of countertransference in the psychiatric literature, but current theorists point out the subtle, yet significant differences (Hesse, 2002; Trippany et al., 2004). These theorists point out that countertransferential attitudes are linked to a therapist's past experiences and sub-conscious processes. This is in contrast to secondary trauma issues, in which the pre-existing personal characteristics of the therapist may have little to nothing to do with their reactions to the traumatic material (Hesse, 2002). Countertransferential attitudes should not be discounted or ignored, however, particularly when care providers treating trauma survivors are survivors of trauma themselves. This is frequently the case with resettlement workers who provide care for refugees, and who are often traumatized refugees themselves.

It has been the experience of clinicians from the Bellevue/NYU Program for Survivors of Torture, who have conducted numerous trainings and workshops across the nation with refugee resettlement agencies, that resettlement workers and other caregivers report varied reactions to working with uprooted, traumatized populations that are similar to the types of reactions detailed in the literature on burnout, compassion fatigue, and secondary traumatic stress. Many of these reactions can be organized according to Kahill's (1988) five categories: physical, emotional, behavioral, work-related, and interpersonal.

In terms of physical symptoms, resettlement workers and other caregivers have complained of headaches, stomach aches, general fatigue, joint pain, and becoming sick more frequently with colds, flu etc. Emotionally, these workers have reported sadness, depression, irritability,

anxiety, hyper-arousal, as well as feelings of helplessness and hopelessness. In addition, some have reported an increase in feelings of cynicism, discouragement, disbelief, personal vulnerability, and pessimism. These feelings may accompany behavior changes such as increased substance abuse, and work-related behavior changes such as tardiness, absenteeism, intolerance of other clients' problems, and "lackluster" work performance in general. Caregivers may also notice changes in their communication patterns, more dramatic mood swings, increased irritation, social withdrawal, and a lack of patience with the concerns or problems of other colleagues and/or family members (Kahill, 1988; Kinzie, 1994; Kleber & Figley, 1995). The parallels between these reactions and those found in people who have been directly traumatized will be discussed a little later in this chapter.

Contributing Factors

Potential contributing factors to secondary traumatic stress are varied and insidious. One of the primary factors that contribute to secondary traumatic stress is the ability to empathize, which is a hallmark of a caregiver's ability to engage in effective therapeutic treatment with traumatized clients. Empathy can help a caregiver to understand a client's experience, but it may also make them vulnerable to being traumatized themselves (Figley, 1995b; Wilson & Lindy, 1994). As many caregivers have experienced trauma, or may be refugees themselves, the possibility for empathic strain is even greater than one would usually find in a therapeutic milieu (Figley, 1995a; Kinzie, 1994).

Other potential issues that may exacerbate adverse psychological reactions on the part of service providers may be that some caregivers have expressed feeling that they are "doing something small" in the face of massive tragedies. Some caregivers have complained that their efforts may help particular individuals or families, but it will not affect the root causes of the problems. These types of thoughts may foster a sort of powerlessness, or a "what's the use?" attitude, that can make it increasingly difficult for caregivers to feel a sense of positive accomplishment from their work (Kleber, 2003).

Other caregivers and theorists describe situations in which a worker may feel less than competent in their interactions with clients. This may be because of cultural or linguistic barriers, but more often it may stem from the worker's perception that the client's problems are beyond their capacity to effectively intervene in a way that is helpful to the client (Maslach & Johnson, 1981). Caregivers may also feel that there is too much work to do in too short a time, and that they have lost the ability to set their own pace and priorities in their work (Rench, 1996).

These thoughts can lead to a worker feeling powerless, and potentially hopeless, when engaging with a survivor of torture in their clinic. These perceived failings may impact a therapist's self-image in terms of their overall competence as an effective therapist (Hesse, 2002; Trippany et al., 2004). These feelings may be exacerbated when the caregiver has internalized an "idealized image" of the client as deserving the best of treatment and outcomes (Eisenman, Bergner, & Cohen, 2000). A caregiver may feel that his or her efforts, no matter how sincere, are not sufficient for such a deserving client. Or, conversely, the caregiver may harbor "savior"

fantasies which can also erode reasonable expectations as to the probable outcomes of treatment (Kinzie, 1994; Smith, 2003).

Resettlement workers and other caregivers may also experience frustration with inadequate resources and funding at their particular clinic or agency. These same workers may also feel frustrated by the bureaucratic structures in many of the service provision agencies that they are called on to help navigate (Barr, 1984; Karger, 1981; Rench, 1996). When one considers the multiple social needs of a traumatized refugee, the opportunities for bureaucratic roadblocks are numerous, and the roadblocks can have extremely important implications for the traumatized refugee's well-being. As workers discuss their encounters with the immigration/asylum system, housing bureaucracies, educational systems, financial assistance services, medical and insurance bureaucracies, and other such entities, one can see how unpleasant or frustrating interactions with these important resources can lead a worker to feel less than supported or respected in their efforts.

Care and service providers may also harbor feelings of ambiguity about a particular client or group of clients that can reduce their confidence that they are indeed "doing the right thing." Doubt may arise as to the client's veracity in detailing the history of their traumatic experiences. Some clients may exaggerate details of their trauma to help ensure that they receive asylum or other social service benefits. Other clients may have antagonized service providers by being especially demanding, unappreciative, and manipulative, and it may come to light that a "victim" may have also been a perpetrator of human rights offenses themselves (Eisenman et al., 2000). These scenarios can also have significant impact on a service providers' ability to engage fully and find fulfillment in their work.

In addition, if a caregiver feels isolated within their family or social circles regarding the challenging nature of their work, it can also exacerbate emergent feelings of burnout and compassion fatigue. A caregiver may feel that "no one else will understand," or may ask themselves "who wants to listen to this stuff anyway?" and may feel increasingly withdrawn emotionally from those who have been close to them throughout their lives. This reduction in the effective utilization of one's support networks is yet another potentially pernicious effect of working with highly charged traumatic material (Rench, 1996; Spahn-Nelson, 1996).

Paralyzing Parallels

One may notice that the effects of secondary traumatic stress are similar to the effects of PTSD, which frequently affect survivors of torture and refugee trauma. The literature regarding secondary traumatic stress consistently makes the point that the ill-effects felt by clinicians working with traumatized populations often mirror the symptoms experienced by those who have been directly traumatized (i.e. Figley, 1995a; McCann & Pearlman, 1990). Beyond mimicking the symptoms of intrusion, avoidance, and hypervigilance associated with PTSD, secondary traumatic stress and burnout may mirror depressive symptoms, such as hopelessness and decreased energy, in addition to other psychological problems associated with refugee trauma (Figley & Kleber, 1995; Pines & Aronsen, 1988).

Certain theorists have put forth the notion of Constructivist Self-Development Theory [CSDT], and have demonstrated how working intimately with survivors of trauma can affect a therapist's cognitive schemas (Hesse, 2002; McCann & Pearlman, 1991; Trippany et al., 2004).

These theorists posit that working with trauma survivors can affect therapists' views of their own frame of reference regarding themselves and the world: their belief systems; their sense of safety, trust, and control; their sense of independence and self-esteem; and their ability to be emotionally intimate with others.

For example, caregivers' may be affected by scenarios in which they feel that they are only doing something small in the face of great obstacles. Their worldviews and belief systems may be altered to the point that they feel that it's no use to continue with such small endeavors in a world filled with evil. These feelings may mirror the feelings of powerlessness and hopelessness that frequently confront traumatized clients.

Caregivers may lose the sense of trust in governmental and other systems (such as the immigration services) that are ostensibly set up to assist refugees and asylum seekers, but may end up putting additional strains on the situation. When caregivers feel as though they do not have sufficient time to complete their work, or when they feel less than competent in their dealing with clients, these feelings may run parallel to clients' feelings of being overwhelmed by insurmountable challenges.

There are other similarities in the way clients and caregivers may react to the reported trauma experiences and the subsequent recovery process. Caregivers who feel less than competent, or who may idealize their clients, run the risk of denigrating their own skills and placing unrealistically positive expectations on another person (Eisenman et al., 2000). This is not dissimilar to a client who has been violently disempowered, and may feel as though they are undeserving of assistance.

At times, the client may also idealize the caregiver, which can have some therapeutic benefits in terms of a transitional object, but can be

counterproductive over time if the client is not able to internalize positive feelings about themselves and take proactive action to improve their situation (van der Kolk, 1996). The caregiver may also join the client in avoiding pertinent issues linked to the trauma (Hesse, 2002). Holmqvist & Andersen (2003) call this avoidance "collusive resistance" (p. 294).

Other potential parallels that may adversely affect the therapeutic process are: that therapists may seek praise within the dyad in order to bolster their shaken self-esteem; therapists may be so full of rage that they preclude their client's ability to say anything positive about the people who may have mistreated them, or admit that that they too participated in abusive behavior; or that therapists may over-medicate or hospitalize patients too often to compensate for their feelings of helplessness or incompetence (Hesse, 2002).

An empirical study by Holmqvist & Andersen (2003) shows that therapists who work predominately with trauma survivors feel less objective and enthusiastic over time, and that they show significant decreases in empathy. The same study showed a 10% prevalence rate of secondary traumatic stress among the therapists sampled.

The fact that some caregivers report feelings of frustration with bureaucratic procedures, isolation, personal devaluation, or some feelings of ambiguity about the nature of their work or the client they are working with may also parallel the realities faced by survivors of torture and refugee trauma. Clients are often frustrated by a lack of tangible progress in their immigration, educational, and professional struggles in the US. They often report feeling isolated or "all alone" with their traumatic memories, and may also be ambivalent about engaging in a therapeutic relationship with a stranger. They may doubt the efficacy of the treatment they are offered, and

may have reservations about engaging with the particular caregivers they are working with.

The following recollection from a senior clinician in our program from when they were a trainee is an illustration of the insidious parallels that may exist:

> *I remember going to my supervisor and explaining that I felt like a complete fraud, and that I had no idea what I was doing during my first session with the survivor. My supervisor asked about the general progression of the session. I shared that it was a severely depressed man from an Eastern African country who literally bore scars from his torture experiences on his face. He was tearful, frightened, and so sad that he could barely keep his head off of the desk in my office.*
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> *When my supervisor asked how I recalled feeling during the session (apart from feeling like a fraud), I responded that I felt lost. I remembered not knowing what to say, and not being sure what we could accomplish together in treatment. I remembered being scared and tense. I worried that the survivor would not find me credible. I felt sad and was overwhelmed with the immensity of the problem. I literally felt like fleeing the room.*
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> *My supervisor and I began to explore how the survivor may have been feeling during the session. As I shared my impressions, I realized that the survivor was also giving signals that he was feeling lost, unsure, scared, vulnerable, and overwhelmed. He may have also harbored a desire to flee the room.*

My supervisor helped point out that not only was I not "a fraud," but I was actually in tune with many of the survivor's fears and anxieties. My tangible discomfort during the session, and in its aftermath, was only a diluted, momentary snapshot of the pervasive pain the client experiences constantly. He pointed out that as clinicians; we serve as our own healing instruments. The ability to truly listen, attend, and empathize with someone who is suffering is a powerful therapeutic tool; but it comes at a price. It can often mean pain and discomfort for the caregiver. It can mean that we feel lost. In those instances, we have to give ourselves "permission not to know."

Prevention and Treatment

Having remarked that many of the symptoms of secondary traumatic stress mirror those of PTSD, we at the Bellevue/NYU Program for Survivors of Torture have found that the core therapeutic principles of safety and empowerment are also effective in helping caregivers to tolerate the challenging nature of their work.

In terms of safety, we strive to create an environment where colleagues feel free to share concerns, insights, and most importantly, feelings about the work we are doing. Writers on this subject are basically unanimous in espousing the importance of open communication among work colleagues (i.e. Figley, 1995a; Hesse, 2002; Kinzie, 1994; Smith, 2003; Spahn-Nelson, 1996; Trippany et al., 2004).

Multidisciplinary case conferences and/or staff meetings occur weekly, and serve as vehicles for the exchange of information and ideas across professions. Although traumatic case material is often exchanged

during these meetings, the supportive cross-discipline relationships they facilitate help to decrease feelings of professional isolation. Weekly supervision sessions include individual, group, and peer supervision formats. Informal case consultations and planning meetings are encouraged. In essence, we try to avoid any collusion of silence, in which we assume everyone is maintaining a healthy equilibrium in the work.

When caregivers express feelings of anger, discomfort, fatigue, or frustration, that may indicate secondary stress, they are listened to in a supportive, non-judgmental or stigmatized way. Attempts are made to facilitate understanding of the feelings in the context of the difficult nature of the work we are engaged in. Many authors in the field focus on the need to acknowledge and normalize countertransference and secondary stress reactions (Figley, 1995a; Figley & Kleber, 1995; Hesse, 2002; Kinzie, 1995; Spahn-Nelson, 1996; Trippany et al., 2004; Wilson & Lindy, 1994).

Another important element in combating secondary traumatic stress and burnout is to find positive outlets for one's energy and feelings. Smith (2003) has written that it is crucial to "be a conduit, not a container" in doing this work (p. 314). It is important to make time and space for the things you love to do in life. Sublimating the traumatic case material can be facilitated by engaging in creative pursuits, such as writing poetry or playing music, exercising and doing fun physical activities, or engaging in relaxation techniques, such as meditating and deep breathing exercises. Listening to music, hanging out with friends, and finding occasions to laugh, are other potentially therapeutic activities that can protect from the long-term effects of burnout.

Of course, basic ideas like eating well-balanced meals, getting enough rest, avoiding use of alcohol or drugs, and avoiding excessive use of

stimulants like sugar and caffeine are recommended. Work related issues, like rotating through different types of work activity, or having intermittent work-free periods, if possible, can reduce the negative impact of working with traumatic material (Trippany et al., 2004). Some clinicians have encouraged the sharing of painful clinical material with significant life partners (while respecting ethical guidelines), so that the clinician will not be so isolated in terms of family or social functioning (Figley, 1995a).

One of the important factors for preventing compassion fatigue is that caregivers set realistic expectations of themselves in doing this work (Hesse, 2002). Clinicians should resist the desire to "fix" everything for the survivor, and realize that we are not able to fully erase the trauma from someone's mind. These are key factors in staving off compassion fatigue and secondary trauma. Victories need to be measured in small steps, and the gradual process of recovery needs to be respected and tolerated. A program clinician remembered his first day of work as a junior counselor as such:

> *A more experienced counselor pulled me aside and said that he could tell it was my first day by my wide-eyed expression. He told me that I needed to get the "Robin Hood Complex" out of my head. I immediately asked him what that was. He responded that I had to realize that I couldn't save everybody. When I acknowledged his statement and started to walk away, he stopped me.*
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> *He said, "Not only can you not save everybody; you can't save anybody. All you can do is help to put people in a context where they can save themselves." Once again, I started to walk away, but he added, "You seem to be reasonably intelligent, so you may learn this*

pretty quickly up here," he said as he pointed to his head. "But it will probably take you a lifetime, or at least your career to learn it here," as he pointed to his heart.

These words turned out to be prophetic for the young therapist in question. The emotional learning that the senior counselor was alluding to continues to be a major component of the continued growth - both as a clinician and a person - for that therapist, who has become one of the senior clinicians in our program. Engaging in work with this population of survivors of torture and refugee trauma helps to take this emotional learning to a whole new level.

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