

SO WHAT ABOUT US?

SANDRA L. BLOOM, M.D.

E-MAIL FROM AMERICA. *THE PSYCHOTHERAPY REVIEW* 1(4): 8-164-165. SEPTEMBER, 1999

Have you ever gone home after a long day of therapy sessions feeling exhausted, depressed, overwhelmingly angry? Have you ever listened to a particularly disturbing story during a session and then had similarly disturbing dreams later that night? Do you ever find yourself suddenly being hypervigilant, jumpy, frightened, even though there is no danger, no apparent threat? Certainly, therapists can suffer from a number of countertransference problems related to their own unresolved issues, but if you are suffering from some of these symptoms, it may be worthwhile considering some other, although related, sources of distress.

People, who are repeatedly exposed to the effects of violence, even though only secondarily, can be traumatized themselves and even experience symptoms similar to victims of post-traumatic stress. This phenomenon has been frequently observed in friends, family members, colleagues, police and fire workers, emergency workers, medical providers and others. Secondary traumatic stress - also called compassion fatigue, vicarious traumatization (McCann & Pearlman 1990) and co-victimization (Hartsough & Myers 1985) - is the stress resulting from helping or wanting to help a suffering person (Figley 1995a, b). It is somewhat different from "burnout" which is a state of physical, emotional, and mental exhaustion caused by the long-term involvement in very emotionally draining situations (Pines and Arnsion 1988). Burnout emerges gradually while secondary traumatic stress can emerge suddenly and without much warning. It is often accompanied by a sense of confusion and helplessness (Figley 1995).

In such cases, exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person. One of the mechanisms behind this phenomenon is empathy. Empathy is absolutely necessary to the healing process and is a major resource for all people who work with traumatized people. Yet it is empathy that is a key factor in the spread of traumatic experience from one person to another. Our ability to "feel with" another leaves us vulnerable to feeling what they feel about the traumatic experiences as well. Repeated exposure to man-made violence can impact on our willingness and ability to relate to others, on how we make sense of a frightening world. The hallmark of vicarious traumatization is a disrupted frame

of reference. Our sense of identity, worldview, and spirituality together constitute a frame of reference. As a result of exposure to victims of violence, helpers may experience disruptions in their sense of identity, world view, and spirituality (Pearlman 1995).

This sense of threat and burden of stress is compounded by the added stress implicit in medical practice today. Demands to carry increasing caseloads with an attendant increase in paperwork combined with decreases in staffing have made many health care settings “pressure-cooker” environments. Under such conditions, it is increasingly difficult for many providers to find the time or psychic energy to provide the level of compassion that victims of violence require if they are to take the first steps in recovery. In this way one vital component of the ability to promote healing becomes increasingly compromised as health care professionals succumb to both physical fatigue and compassion fatigue.

What can be done? Mental health workers specializing in the field of traumatic stress studies have begun to study the effects of vicarious traumatization and compassion fatigue among professionals and have looked at various successful strategies to overcome the effects of this stress. Socializing, exercising, and spending time with family members ranked highly as strategies that were useful in coping with the demands of working with traumatized patients. Only slightly lower in ranking were activities like engaging in social justice actions and getting a massage. Others included seeking consultation for difficult cases, reading relevant professional literature, taking vacations and breaks as well as engaging in a variety of leisure time and creative activities (Pearlman 1995).

Figley has identified a number of variables that go into determining a healing environment for family members who have been affected by traumatic stress and these ideas are also being tried out for other organizational settings as well. An environment that is most likely to facilitate the recovery from traumatic stress are those in which: 1) the stressors are accepted as real and legitimate; 2) the problem is viewed as a problem for the entire group and is not seen as a problem limited to a specific individual; 3) the general approach to the problem is to seek solutions, not to assign blame; 4) there is a high tolerance level for individual idiosyncracies; 5) support is expressed clearly, directly, and abundantly in the form of praise, commitment, and affection; 6) communication is open and effective; there are few sanctions against what can be said, the quality of communication is good and messages are clear and direct; 7) the group is highly cohesive and there is considerable flexibility of roles within the group; 8) resources – material, social, and institutional – are utilized efficiently; 9) there is no subculture of violence and no substance abuse (Catherall 1995).

REFERENCES

- Bloom, S. L. 1995. The germ theory of trauma: The impossibility of ethical neutrality. In *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators* edited by B. H. Stamm. Lutherville, MD: Sidran. pp. 257-276.
- Catherall, D. R. 1995. Coping with secondary traumatic stress: the importance of the therapist's professional peer group. In *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators* edited by B. H. Stamm. Lutherville, MD: Sidran. pp .80-92.
- Demos, E.V. 1989. Resiliency in infancy. In T. F. Dugan & R. Coles (Eds), *The Child In Our Times: Studies in the Development of Resiliency*. New York: Brunner/Mazel.
- Figley, C. R. 1995a. Compassion Fatigue: Toward a New Understanding of the Costs of Caring. In *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators* edited by B. H. Stamm. Lutherville, MD: Sidran. Pp.3-28
- Figley, C. R. 1995b. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.
- Hartsough, D. and D. Myers, 1985. Disaster work and mental health: Prevention and control of stress among workers. Washington, D.C.: National Institute of Mental Health, Center for Mental Health Studies of Emergencies.
- McCann, I. L. & Pearlman, L. A. 1990. Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3,131-147.
- Pearlman, L. A. 1995. Self Care for Trauma Therapists: Ameliorating Vicarious Traumatization. In *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators* edited by B. H. Stamm Lutherville, MD: Sidran. pp. 51-64.
- Pines, A. M. and E. Arenson. 1988. *Career Burnout: Causes and Cures*. New York: Free Press.