Secondary Traumatic Stress Disorder, Vicarious Trauma, Compassion Fatigue and Burnout: Boundary Implications

An Independent Research Project by

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ABSTRACT

This study explored the incidence of Secondary Traumatization as it relates to career stressors, encompassing the phenomena of Compassion Fatigue, Burnout, Vicarious Traumatization, and Secondary Traumatic Stress Disorder. As will be discussed, Secondary Traumatization may affect any individual in the helping professions including, but not limited to, clinicians, caseworkers, teachers, doctors, firefighters, and first responders to disasters. Participants included those who responded to a self-constructed online, anonymous survey that explored choice of career, career stressors, and trauma associated with a career that may lead one to leave their chosen profession.
Previous studies focused on Secondary Traumatization that affected either clinicians or educators; this study focused, however, on trauma that may affect any individual in the helping professions, although the term “clinician” is used throughout to indicate the professional, regardless of focus of career. The hypothesis is presented as multifaceted: that prior trauma affects choice of career; that trauma on the job affects job performance and possibly the decision to leave the chosen profession; and that the professional’s unresolved trauma will negatively affect their clients. Admittedly, the sample size of respondents to the study is smaller than would be preferred for a more thorough evaluation of Secondary Traumatization in the helping professions. However, the results indicate that support for all those in the helping professions needs to be bolstered, not only for the professionals themselves, but also for those that they serve, to keep the professionals at their peak performance so that they may help their clients optimally.
Introduction

Just as the Eskimos have innumerable words for snow, so too do mental health clinicians and other mental health professionals have different terms for trauma, especially when it affects those amongst their ranks. Just like snow, too, trauma can vary widely from one type to another and affect the clinician in different ways. Clinicians should understand the different categories of trauma, not just to treat their clients, but also to be aware of trauma that may be affecting them directly. Career satisfaction, burnout, and more recently compassion fatigue have been identified in the research literature as issues influencing the cognitive, affective, social, spiritual, physical and behavioral experiences of helping professionals (Robinson, 2005 p.1). These constellations may negatively impact optimal levels of one’s functioning of symptoms. If these are the terms that will decide one’s happiness and satisfaction in their career, then it is imperative that those in the helping professions have greater awareness of their consequences. The research used in this research course offering was that of a questionnaire and online survey, and was anonymous.
Literature Review

Definition of Terms

Vicarious Traumatization

Vicarious Traumatization (VT) may be described as a “special form of counter transference stimulated by exposure to the client's traumatic material” (Courtois, 1993, p.2). Vicarious traumatization, then, is the incidence of a clinician becoming traumatized by treating clients who are almost or always victims (such as a first responder to a rape survivor, or one who counsels in a battered women’s shelter). For clinicians who are treating clients who are survivors of trauma, it makes sense that the clinician needs to be emotionally available and able to tolerate the story of the trauma—the clinician, in this case, is the mirror who reflects the trauma while the client can look at it from a safe distance and gain new perspective.

Over time, upon hearing countless incidences of clients’ trauma, the clinician’s boundaries may become permeable enough to let in the trauma that has been experienced by the client, at which point the clinician could become traumatized themselves. This
may manifest by a sense of fear, nightmares, and an inability to function properly at work. Vicarious traumatization, then, refers to a transformation in the therapist, resulting from empathic engagement with clients’ trauma material, leaving the clinician vulnerable to the emotional and psychological effects of that trauma. These effects are cumulative and permanent and evident in both a therapist’s professional and personal life (Pearlman & Saakvitne, 1995, p. 151). The therapist is most vulnerable to these stories of abuse, neglect, and trauma when they do not have the support necessary to remain objective.

Ahrens and Campbell (2000) acknowledge that “only recently… have the effects of violence on ‘secondary victims’—family, friends, social workers, researchers, and other helpers—been explored.” Vicarious traumatization “characterizes the cumulative effects of working with survivors of traumatic life events, such as rape, incest, child abuse, or domestic violence” (McCann & Pearlman, 1991). Nelson (2006) describes VT as “bearing witness to another’s trauma… As the client releases some of their pain, we take it in.” Mitchell (1985) reports that the clinician must “take care to avoid the repeated invasion of the trauma into our lives.” Campbell (2002) and Figley (2002) propose that “VT is a way of framing the emotional, physical, and spiritual transformations experienced by those work with traumatized populations.”

Clemans et al (1999) give examples of the transformative process of working with traumatized clients, including “persistent feelings of fear and vulnerability to assault, difficulty trusting others, intrusive thoughts of violence, hopelessness to make a difference in their clients’ lives, and a cynical view of the world.” Campbell (2002) notes that clinicians and clients “often experience parallel reactions,” and although this is painful, it is preventable.
Early research on VT focused on psychologists in private practice treating adult survivors of incest, but later research has included a wide range of helping professionals who routinely—because of their jobs—experience the impact of violence, such as workers in rape crisis (Clemans, 1999), child welfare workers (Dane, 2000), child sexual abuse therapists (Cunningham, 1999), and researchers (Campbell, 2002).

**Secondary Traumatic Stress Disorder**

Secondary traumatic stress disorder (STSD) is considered to be exposure to another’s trauma, in the case of secondary trauma, is relative—while a counselor may be removed from a client’s war-torn home, their client’s abusive childhood, or a tragedy such as the September 11 terrorist attacks, the emotional proximity to their client’s trauma is what is most relevant.

Such secondary trauma, as it is called in research done by Bride, et al (2003); Catherall (n.d.); Chrestram (1999); Cornille, et al (1999); Dane (2000); Figley (1995-2003); Jenkins, et al (2002); Kassam-Adams (1999); Pinto (2003); Salston, et al (2003); and Stamm (1999), strikes not only counselors and mental health clinicians but anyone who makes themselves vulnerable to another’s’ trauma by way of teaching and helping.

Secondary Traumatic Stress Disorder (STSD) is analogous to VT in that the clinician’s boundaries have become permeable enough to let in their clients’ experience to such a way that they are not just holding the trauma but experiencing it. In this way, the trauma is affecting those who experience it indirectly, when the clinician works with those people who have experienced a specific trauma.
Symptoms of STSD may include: depression, increased somatic complaints, and hopelessness. Especially for those in the helping professions, the individual may feel grief similar to the client’s. Whitmer (2006) notes “it is not uncommon for seasoned therapists, advocates, or caregivers to experience a sudden feeling of incompetence and hopelessness when dealing with a traumatized patient” (p.141). Feelings of incompetence, of course, would not then give the clinician the urge to get up in the morning and look forward to their caseload.

Compassion Fatigue

The concept of the Compassion Fatigue (CF) has only been around since 1992 when Joinson used the term in a nursing magazine to describe nurses who were worn out due to the amount of care and compassion they were expected to, and did, provide. The dictionary meaning of compassion is a “feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause” (Webster, 1989, p. 229).

Compassion fatigue is similar to both VT and STSD, but with a twist. Figley (2002b) describes CF as “a state of tension and preoccupation with the individual or cumulative trauma of clients” (p. 125). Compassion fatigue may also be defined as “the reduced capacity or interest in being empathic” due to the trauma of hearing clients’ stories of victimization (Boscarino et al, 2004, p.2). In this case, the clinician has given so much that they literally have no more to give; they are unable and perhaps unwilling to give anymore of themselves. This blocking of empathy is a way for the clinician to protect themselves from further trauma, to firm up their boundaries before going back out into the line of fire.
As opposed to burnout (see below) which generally builds over time, CF may have a sudden onset and “also may be the result of cumulative events reaching a critical threshold” (Robinson, p.29). Figley (2003) discusses the important of compassion in the therapeutic relationship; indeed, it is compassion itself that provides the basis of the therapeutic relationship and allows for the trust that is necessary to effect change in the client (p.1). However, “…practitioners must understand their limitations in helping alleviate the pain suffered by their clients” (Figley, 2003, p.1). In contrast to how CF evolves, burnout encapsulates a condition whereby the helping professional experiences the triad of traumatic sequelae of intrusive thoughts, avoidant behaviors, and systemic arousal due to indirect exposure to another’s trauma. Also possible is restimulation of one’s own traumatic experiences. It may be conceived of the cost of caring as helping professionals share in the aftermath of traumatic events in their clients’ lives. Morrisette (2001) offered the following definition of compassion fatigue: “Compassion Fatigue has been defined as a state of tension and preoccupation with individual or cumulative trauma of clients as manifested in one or more ways including (a) reexperiencing the traumatic event, (b) avoidance or numbing of reminders of the event, and (c) persistent arousal” (p.140).

Rudolph, Stamm, and Stamm (1997) described compassion fatigue as presence of PTSD symptoms that generally are related to clients traumatic event and blended with the helper’s life experiences. The good news is that recovery from fatigue compassion is held to be faster than recuperation from burnout if appropriate interventions are implanted (Sexton, 1999).
Working with victims of trauma can change helpers’ worldwide views due to assumptions about the predictability of an orderly world, invulnerability, fairness, and personal efficacy being shattered (Janoff-Bulman, 1992; Matsakis, 1996). As is the case with primary victims of trauma professionals dealing with compassion fatigue experience alterations in their sense of safety, trust esteem and intimacy control.

**Burnout**

First coined in 1974 by Freudenberger to describe the condition of physical and emotional exhaustion witnessed in employees of healthcare institutions, burnout is the term that is probably the most commonly used in this category, as it continues to affect scores of clinicians and others in the helping professions (Berg, 1994; Wearne, 1991; James & Gilliland, 2001; Salston & Figley, 2003; Williams & Davis, 2002). As with the risk factors for CF, Freudenberg suggested that overcommitment and overdedication would predispose helping professionals to burnout (Dane, 2000).

Burnout is segregated from the other terms of secondary traumatization as it is the only concept that results in *disengagement* from the work of therapy, rather than overengagement (Kotler, 1993). The stress management movement of the 1980s and 1990s was a preventative response to concerns about burnout in the workplace (Gibson & Mitchell, 1999).

Maslach’s (1982) definition of burnout has become the most widely cited, encompassing emotional exhaustion, depersonalization of the client, and a feeling of reduced personal accomplishment or failure (in Lee, 1990). Girdin et al. (1996) described burnout as a state of mental and/or physical exhaustion due an overload of stress. Blair and Ramones (1996) defined burnout as a psychological response occurring from
frequent interaction with people in need. Pines and Aronson (1988) described burnout as a complex state of exhaustion resulting from emotionally taxing interactions. It should be noted here that burnout is a process rather than a distinct event, which Kottler (1999) refers to as an “insidious and progressive condition”.

Factors contributing to professional burnout may include: high stress, unrealistic expectations, constant pressure to produce or perform, unrewarding tasks, intrusive interference and interruptions while working, lack of support, and an imbalance between professional and personal life (Gibson & Mitchell, 1999). Maslach (1982) proposed that burnout evolves from the convergence of emotional exhaustion, depersonalization, and a reduced sense of accomplishment, although Jenkins and Baird (2002) specify that these may actually be symptoms of burnout rather than causes.

Symptoms of burnout include exhaustion, detachment from work and clients, cynicism, and feelings of ineffectiveness. Symptoms may also include absenteeism, apathy, and decreased productivity (Gibson & Mitchell, 1999). Like with CF, the detachment is a way for the clinician to separate from the trauma for a time in order to store up reserves of energy, so that they may be renewed for their work and their clients.
The DSM-IV criteria for the kinds of traumatization under discussion would fall under Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder. Acute Stress Disorder (308.3) is defined by the DSM-IV TR as follows:

Acute Stress Disorder is an anxiety disorder that
develops within one month after a severe traumatic event or experience. Distressing dissociative symptoms are common in the person with Acute Stress Disorder, including depersonalization, derealization, or dissociative amnesia.

These symptoms can affect any sex or age group. Anxiety, irritability, and depression are also common in people who have Acute Stress Disorder. People with Acute Stress Disorder have a diminished ability to experience pleasure. There may be problems falling or staying asleep. A person with Acute Stress Disorder will avoid any reminders of the trauma but re-experiencing the event in dreams, nightmares, or painful memories.

**PTSD (309.81)** is defined as follows:

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that develops after a severe traumatic event or experience. Several distressing symptoms are common in the person with PTSD, including Psychic numbing, emotion anesthesia, increased arousal, or unwanted re-experiencing of the trauma. These symptoms can affect any sex or age group. Anxiety, irritability, and depression are also common in people who have PTSD.

People with PTSD have a diminished ability to experience emotion, including tenderness or intimacy. There may be problems falling or staying asleep. A person with PTSD will avoid any reminders of the trauma but re-experiencing the event in dreams, nightmares, or painful memories are common. Some people will turn to drugs or alcohol to escape the pain of PTSD, while others may become suicidal or self-defeating.

In terms of DSM-IV criteria for VT, STSD, CF, or burnout—there isn’t one. That would mean that we as clinicians would have to start diagnosing ourselves! But there are plenty of diagnostic criteria provided by other researchers. One “burnout quiz” is
provided by the Search and Rescue Society of British Columbia (their tagline: “So that others may live). Clinicians and others in the helping professions should be encouraged to seek out professional resources and treatment, include their agency’s EAP, personal psychotherapy, or individual or group supervision. Even taking a self-test on burnout, just for kicks, may clue you in that there is something simmering under the surface that you may need to take a closer look at.

Etiology of Secondary Traumatization

Secondary traumatization can strike anyone in the helping professions, not being limited to just counselors and clinicians: ER and other medical trauma personnel, medical personnel working with patients with terminal illness, hospice workers, police and firefighters, DYS and DSS case managers whose clients are most likely abused and neglected, and even overlooked caregivers like adult children caring for ailing parents. One hard-hitting story is one that is well known. The rescue worker Robert O’Donnell who extracted Baby Jessica (the 18-month-old toddler who fell down a drainpipe in 1987 and was finally rescued 58 hours later) and who was the first to hold and comfort her, suicides eight years later due to unresolved trauma. It almost seems unnecessary to discuss the first responders to the World Trade Center on 9/11. The trauma and grief these workers suffer everyday is to be expected, as is survivor guilt of the employees who made it out of the WTC alive, when so many of their colleagues perished.

Focusing, however, on counselors and clinicians in the mental health field can bring into focus substantially the minutiae of clients’ lives: their childhood traumas—
abandonment, neglect, sexual/physical/emotional abuse; their adult traumas—unresolved

grief and loss issues; and the loss of their childhood for which they probably have never

mourned, chronic mental health and substance abuse issues. The list, undoubtedly, goes

on.

Another aspect of the clinician-client relationship that frequently goes ignored is

the concept of expectation—both what the clinician expects from their client, and what
the client expects from their therapist. The clinician undoubtedly expects growth from
their client; otherwise, devoid of hope for their clients’ improvement, burnout would

come much more quickly. They may expect this growth to occur rapidly, or even just

within a specific timeframe. They may expect their client to follow their suggestions and
they become frustrated if, and more likely when, the client does not do their homework,
misses sessions, or acts in a way that they feel is not in their clients’ best interest and

harmful to their growth and recovery. The clinician may believe that they know what is
best for the client, and even that they are the only one who can save them from

themselves. The pain, frustration, and betrayal they feel when they receive a release of
information from another therapist whom their client is now seeing leaves them

questioning, vulnerable, and feeling as though they have failed (Kotler, 1993, p.101).

As part of the clinician’s expectations, furthermore, they need to go into the work
understanding that the work itself will have an effect. Nelson (2006) cautions,

“Recognizing that it is ‘normal’ to be affected by this type of work is the most important

coping skill that you can give to yourself. You’re not alone. It’s okay to feel outraged,
horrified, shocked, saddened, or vulnerable.” Nelson also notes that first responders and

crisis counselors, along with clinicians doing longer-term work, will be affected. To
protect themselves, even before the experience of listening to another’s trauma, they need to understand that they are vulnerable to the trauma, and thereby will protect themselves from the shock of its impact.

Ellis (1984), meanwhile, believes that it is irrational to believe that a therapist can be successful with all clients, when considering that the success (or failure) in therapy is largely based on the relationship between therapist and client. Just as, as a human being outside of the realm of work, people do not trust or connect with everyone they meet, so too should therapists not expect to connect with every client who walks through their door. The assumption that a therapist can help everyone, because of their gentle nature, their depth of experience, and the thoroughness of their training, is deceiving—the client may not want to change; some are not ready to change, even if they themselves believe they are; some move too slowly for the therapist’s pace; and some may just not connect with the therapist, as the therapist may not connect with them (Kotler, 1993, p.101).

The therapist may actually delude themselves into believing that a client is progressing even when all signs point toward the opposite. They may tell themselves that the client who does not return is cured; that the client keeps returning because she must be receiving something from therapy; that the client is really improving and just will not admit it; that the client is beyond help, no matter what the therapist does, so it cannot be their fault; or that the clinician just needs to “sit and wait” for the client to take charge of their own life, so forward movement is impossible until that point (Kotler and Blau, 1989, p. 109).

The client, for their part, seeks a particular therapist for any number of reasons: one who is of the same race, gender, religion, etc.; one who is very gentle so as not to
push them toward forward movement; one who is “take charge”, so that it is the therapist and not the client who is actually doing the work. The client may expect that the therapist is going to solve their problems, and they become enraged when the therapist puts the onus back on them to work through the issues. The client may expect a personal connection, instead of what the therapist is offering themselves to be: a guide or a partner on a journey towards healing. Furthermore, they may expect their therapist to be “a mentor, a guru, a doctor, a friend, or a wizard” (May, 1983).

The question clinicians need to ask themselves is: What is the impact of clients’ traumas on us as their caregivers? Caregivers may think that they are holding together well; but once they notice the deficiencies in their own well-being, it may be too late. At this point, they need to focus primarily on self-care practices before secondary trauma becomes full-blown VT, STSD, or burnout.

**Impact of Secondary Traumatization, or The Impaired Therapist**

There is a theory in the field of psychotherapy that the therapist is the therapy (Fierman, 1997). This can be viewed in multiple ways—the therapist can feel very competent and powerful because they do not have to find the particular tool that will work with any particular client, because we are the tool. In this way the therapist can feel quite validated in their knowledge (Kottler, 1993, p. 16). Alternately, the therapist can begin to feel powerless, inadequate and helpless (much like their clients) because they may feel that they cannot possibly understand their clients’ traumas, they are unable to help them get well, and eventually become unwilling to open themselves to their clients because of these feelings of inadequacy.
There are risks for therapists in being both too emotionally involved and emotionally distant from their work. Those who are too involved will tend to experience long, draining days, private time, and interpersonal relationships of their own. However, those who are not willing or able to become emotionally involved with their clients will likely end up distanced from their clients and also “risk emotional sterility in other relationships” (Kottler, 1993, p. 69).

Part of the problem occurs very early on in a therapist’s career, while they are still in school, and being told mostly what they cannot do in session with a client instead of being told what is helpful and effective. This may grow out of fear of retaliation or, worse, a client’s suicide due to the therapist’s mistake. The therapist them, may go headlong into their career without the proper tools of the trade, although they know exactly what not to do.

At the heart of therapy, the clinician waits for clients to walk through their door, drop their nightmares in their lap, and wait for them to figure it out for themselves. In terms of their interpersonal relationships with clients, the clinician may even notice a depletion in their ability to care for their clients, and continue treating them, not considering the need to regroup and seek counsel for themselves. When this occurs, boundaries may deteriorate. Clients may become aware that we are in pain; we further their pain by not being able to care for them in the way that we have promised; we may care for them too much and experience harmful counter-transference; we may back away quickly due to our helplessness, hopelessness, and feelings of inadequacy. Any and all of these actions harm treaters, their clients, and the therapeutic relationship.
It is important for the therapist to realize that not all of their processing is unhealthy or points to impairment. Some clinicians may need to take a client’s story, mull over it through the week, and return the following session with improved insight. The clinician, then, ultimately needs to know themselves well enough to know when they are involved in a client’s care appropriately and when they are overly and inappropriately involved.

**The Impaired Therapist: Substance Abuse and Recovery**

A significant concern the clinician needs to be aware of is their own relationship to alcohol and drugs. If the clinician has a previous history of substance abuse or addiction, they should be obviously clean and sober, receiving adequate counseling and support to be sure that the stress of their clients’ trauma and addictions do not impact them in such a way that they themselves begin using again or jeopardize their recovery. Clinical supervision is important for professional concerns, support, and problem-solving; and personal support such as AA and NA should be considered for ongoing awareness of the individual’s relationship to substances.

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**The Impaired Therapist: Family History of Mental Illness**

As has been discussed above, many clinicians enter the helping profession due to the influence of mental illness in their family or their own traumas, depression, and related illness. The clinician is able to do their job well because of their deep empathy and urge to care for others, but this skill can also be a trap door that can lead the therapist
back to their own depression and anxiety. The therapist should be receiving proper supervision and support in order to monitor their counter transference with clients, and they should be engaging in activities that are healthy and stress-relieving for their own well-being.

**The Impaired Therapist: History of Trauma**

Although the clinician’s own history of trauma was discussed briefly, it does differ from mental illness such as depression in significant ways. A clinician with a history of trauma needs to be acutely aware of their own history in relation to their clients’ trauma materials. The therapist is at risk of becoming secondarily traumatized by others’ trauma material, and they should be engaged in their own counseling to work on their own trauma history.

**The Impaired Therapist: Healing Unresolved Issues**

Although, again, many clinicians enter the helping professions in order to give others the care they felt themselves lacking, and moreover to heal themselves, the clinician needs to understand that their clients’ therapy is not their therapy. Though the clinician may, and certainly should, derive deep satisfaction from their work of helping others, it is not appropriate for the clinician to use their clients’ time or material to work on their own unresolved issues. The therapist’s material should be discussed with their private counselor and never with clients.

**The Impaired Therapist: Questioning Sexuality**

The therapist who is LGBT (lesbian, gay, bi-sexual, or transgendered) or questioning is probably already aware of the vast differences that exist in sexual orientation, practices, and identity. Those therapists who do not have experience with
these issues should be engaged in continuing education to learn more about this topic so that they feel comfortable with bringing up issues of sexuality with their client, as this may be a significant issue for some.

**The Impaired Therapist: Imposing Personal Values**

Just as it is possible for clinicians who identify as heterosexual to assume that all of their clients are heterosexual, it is important for the clinician to be aware of the differences that exist in worldviews. Culture should always be assessed and considered to be a factor in defining a client’s world—this includes ethnicity, sexuality, age and generation, educational and social class, and religion, to name just a few.

The following tables outline the intrapersonal and interpersonal effects of secondary traumatization:

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Emotional</th>
<th>Behavioral</th>
<th>Spiritual</th>
<th>Interpersonal</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>* diminished</td>
<td>powerlessness</td>
<td>clingy</td>
<td>questioning meaning</td>
<td>withdrawn</td>
<td>shock</td>
</tr>
<tr>
<td>concentration</td>
<td></td>
<td></td>
<td>of life</td>
<td>decreased interest</td>
<td>sweating</td>
</tr>
<tr>
<td>* confusion</td>
<td>anxiety</td>
<td>impatient</td>
<td>loss of purpose</td>
<td>in intimacy or sex</td>
<td>rapid heartbeat</td>
</tr>
<tr>
<td>* spaciness</td>
<td>guilt</td>
<td>irritable</td>
<td>lack of self-satisfaction</td>
<td>mistrust</td>
<td>breathing</td>
</tr>
<tr>
<td>* loss of meaning</td>
<td>survivor guilt</td>
<td>withdrawn</td>
<td>pervasive hopelessness</td>
<td>isolation from friends</td>
<td>difficulty</td>
</tr>
<tr>
<td>* decreased self esteem</td>
<td>shutdown</td>
<td>moody</td>
<td>ennui</td>
<td>impact on parenting</td>
<td>somatic reactions</td>
</tr>
</tbody>
</table>
**Secondary Traumatization 22**

<table>
<thead>
<tr>
<th>* preoccupation with trauma</th>
<th>* numtness regression anger at god (protectiveness, concern) aches/pains</th>
<th>* projection of anger dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>* trauma imagery fear</td>
<td>sleep disturbance questioning prior or blame impaired immune sys.</td>
<td></td>
</tr>
<tr>
<td>* apathy</td>
<td>religious beliefs intolerance</td>
<td></td>
</tr>
<tr>
<td>* rigidity helplessness</td>
<td>appetite changes loneliness</td>
<td></td>
</tr>
<tr>
<td>* disorientation sadness</td>
<td>nightmares</td>
<td></td>
</tr>
<tr>
<td>* whirling thoughts depression</td>
<td>hypervigilance</td>
<td></td>
</tr>
<tr>
<td>* thoughts of self harm, hypersensitivity</td>
<td>elevated startle response</td>
<td></td>
</tr>
<tr>
<td>or harm to others emotional-</td>
<td>use of negative coping</td>
<td></td>
</tr>
<tr>
<td>* self doubt rollercoaster</td>
<td>(smoking, alcohol, substance abuse)</td>
<td></td>
</tr>
<tr>
<td>* perfectionism</td>
<td>subsume own needs</td>
<td></td>
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<tr>
<td>* minimization overwhelmed</td>
<td>accident-proneness</td>
<td></td>
</tr>
<tr>
<td>depleted</td>
<td>losing things self-harm bxs</td>
<td></td>
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</tbody>
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(Yassen, 1995)

<table>
<thead>
<tr>
<th><strong>Performance of job tasks</strong></th>
<th><strong>Morale</strong></th>
<th><strong>Interpersonal</strong></th>
<th><strong>Behavioral</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>* decrease in quality</td>
<td>* decrease in confidence</td>
<td>* withdrawal from colleagues</td>
<td>* absenteeism</td>
</tr>
<tr>
<td>* decrease in quantity</td>
<td>* loss of interest</td>
<td>* impatient</td>
<td>* exhaustion</td>
</tr>
<tr>
<td>* low motivation</td>
<td>* dissatisfaction</td>
<td>* decrease in quality of relationships</td>
<td>* faulty judgment</td>
</tr>
<tr>
<td>* avoidance of job tasks</td>
<td>* negative attitude</td>
<td>* apathy</td>
<td>* irritability</td>
</tr>
<tr>
<td>* increase in mistakes</td>
<td>* apathy</td>
<td>* poor communication</td>
<td>* tardiness</td>
</tr>
<tr>
<td>* setting perfectionist standards</td>
<td>* demoralization</td>
<td>* subsume own needs</td>
<td>* irresponsibility</td>
</tr>
<tr>
<td>* obsession about detail</td>
<td>* lack of appreciation</td>
<td>* staff conflicts</td>
<td>* overwork</td>
</tr>
<tr>
<td>* detachment</td>
<td></td>
<td></td>
<td>* frequent job changes</td>
</tr>
</tbody>
</table>
Sometimes the rift is indelible; and sometimes, after seeking supervision and renewal, clinicians may return to their clients with boundaries intact, once again ready to process their clients’ traumas without letting them cross the protective boundaries that have been newly reconstructed.

All of these warnings may lead a clinician to believe that secondary traumatization is something that cannot be avoided, but can only be fixed or patched-up once it is recognized. Secondary traumatization, though, is not inevitable. With focus on self-care, positive professional relationships, continued education, supervision, personal psychotherapy, and other activities (such as reading, traveling, time spent with loved ones), clinicians may actually be able to avoid the huge and painful pitfall of secondary traumatization. They need to keep their eyes open and clinical senses aware, not only for their clients, and not only for themselves, but for their colleagues as well. Indeed, caregivers are each others’ strongest allies.

**Treatment and Intervention strategies**

For the clinician who is already impacted by secondary traumatization, the focus needs to be on treatment and intervention. There is an extensive array of treatment options, and what follows is just a small portion of the possibilities for intervention.

One option for the therapist is to develop their own self-care plan. Included in this are: spending enough quiet time alone; recharging daily; and holding one focused and meaningful conversation each day, especially with family and close friends (Pfifferling...
and Gilley, 2006). Because CF and its related stressors can impair the clinician’s functioning, it may be helping to think in terms of “don’ts”: making big decisions, blaming others, spending time complaining, trying a quick fix. Just as the trauma may have taken time to set in, so does treatment and healing take time.

Alternately, thinking in terms of “do’s” is important as well: find someone to talk to; understand that the feelings of pain are normal; exercise and eat properly; get enough sleep; take some time off; develop interests outside of the field of work; identify what’s most important and work on incorporating that more fully (Pfifferling and Gilley, 2006).

For those with burnout, the following may be helpful: find time to play by getting away from the workplace and doing something enjoyable; get physical and exercise; set realistic objectives and don’t strive for perfection; keep options open within the company and consider what else may be enjoyable and fulfilling; leave if there is no indication a negative situation will change (adapted from www.applesforhealth.com).

For all kinds of secondary trauma, the clinician can incorporate a stress management plan to focus on reducing the mental and physical symptoms of stress. This may include breathing, exercise, good nutrition, positive attitude, good time management, appreciating one’s uniqueness and value, relaxation, involvement in professional associations, laughter to relieve tension (BE NATURAL), and taking responsibilities for one’s own actions, which also includes knowing which actions are not one’s responsibility (Yalom, 1995). Of course, these techniques can be used to reduce stress as a normal part of daily living.

Journaling is an important method for a variety of reasons. The act of writing out one’s thoughts “is a way to supervise oneself” and attempt to work through difficult cases
and issues; it is a method of self-analysis; it is a way to record and develop ideas; and it acts as a record of significant events (Kottler, 1993). Jung “used the journal as a vehicle for a heroic journey into the sea of unconsciousness” but also theorized that it is important to integrate dreams and dream images with the reality of one’s existence (Kottler, 1993).

When the clinician is unable to deal with the impact of secondary traumatization by themselves, it may be necessary to involve other professionals for support. Seek out support groups of other professionals, and find a professionally trained counselor whom is trustworthy and shares the clinician’s worldview.