CRISIS AND TRAUMA WORK AND THE IMPACTS ON FRONTLINE COUNSELLORS

Working with individuals in emotional pain is very challenging and has the potential to impact you as a frontline counsellor. It is important to understand the effects of caring and take steps to mitigate the stresses of your work. It is not a sign of weakness to experience intense emotions or to feel overwhelmed or to experience symptoms similar to those that our clients experience. Rather it is essential to know that the likelihood of being impacted as a result of your work is high. It is crucial that you develop an awareness of secondary trauma, burnout, countertransference and vicarious traumatization and take steps to lessen the potential impacts to you.

LEARNING OBJECTIVES:

- To become aware of the impacts of working in the area of domestic violence
- To develop a self-care plan in order to minimize these impacts

COUNTERTRANSFERENCE: Whenever counselling becomes intense, as in crisis work, the potential for countertransference increases. Countertransference is “the attributing to the client, by the crisis worker, traits and behaviours of past and present significant others or events in the crisis worker’s own life” (James, 2008, p. 538). Countertransference reactions can be positive or negative, verbal or nonverbal, conscious or unconscious. It is possible that the emotional characteristics of a client may disturb the counsellor's feelings, thoughts and behaviours that may be deeply buried within the counsellor. The worker may react in inappropriate ways and engage in behaviours that are intended to meet their own needs and not those of the client. It is essential that countertransference be recognized and then dealt with in a positive manner. Simply acknowledging that countertransference has occurred is usually enough to prevent the countertransference from interfering with the work with the client. If you find that you continue to struggle with your own issues arising as a result of the work with the clients it is important to seek out supervision to explore ways of managing the transference.

Pearlman and Saakvitne (1995) suggest that if crisis workers are to deal successfully and understand the pain of their clients in profoundly empathetic ways, then countertransference is inevitable and necessary. If in fact countertransference is inevitable it is necessary to acknowledge and be aware of its occurrence.

Example of countertransference:

Emily is a frontline counsellor in a small rural shelter. She has been working for almost a year and enjoys the challenge of her job. Emily experienced countertransference when she was completing an intake with a young nineteen year old mom of a 6 month old girl. When the young women shared she had been attending college when she met Bill. She said that she was immediately infatuated with Bill. He was charming, outgoing and a lot of fun. This was Wendy's first year away from home and she was often lonely and overwhelmed with the demands of college. Bill provided a welcome relief from the stresses of school. As Emily listened to Wendy recount her experiences with Bill, Emily was overcome with an ache in her stomach as she was reminded of her first year away from home when she attended University. She initially found herself focusing on her own feelings of loneliness and became distracted from Wendy’s story. Emily felt the pain that she had experienced when she too became involved with a fellow student much older than she was. Fairly quickly, Emily realized that she was distracted by her own unresolved issues and refocused herself so that she was able to hear Wendy’s story.

After the session, Emily sought out her supervisor and booked a supervision session for the following day.
Countertransference experiences are usually not pervasive and are often related to a specific interaction. If not dealt with, countertransference can have impacts on a counsellor's work.

**BURNOUT** is a debilitating psychological condition brought about by unrelieved work stress, resulting in:

- Depleted energy and emotional exhaustion
- Lowered resistance to illness
- Increased depersonalization in interpersonal relationships
- Increased dissatisfaction and pessimism
- Increased absenteeism and work inefficiency (Maslach, 1982).

Six systemic sources of burnout have been identified and explored by Leiter & Maslach (2005):
1. Work overload
2. Lack of control
3. Insufficient reward
4. Unfairness
5. Breakdown of a sense of community
6. Value conflict

Edelwich and Brodsky (1982) outline four stages that are typical of individuals going through burnout:

- **Stage 1: Enthusiasm:** a worker begins a job with high hopes and often unrealistic expectation. It is important that this idealism is influenced by orientation and training in order that the new worker gains a realistic picture of what she is able to accomplish.
- **Stage 2: Stagnation:** occurs when the worker begins to feel that her needs – financial, personal and career are not being met. If the worker does not receive both intrinsic and extrinsic rewards the worker will move onto the next stage, frustration.
- **Stage 3: Frustration:** this is an indication that the worker is in distress. The worker begins to question the effectiveness, value, and impact of her efforts as she appears to face ongoing obstacles. It is possible that one person’s frustration may impact others that she interacts with.
- **Stage 4: Apathy:** Apathy is burnout. It is a chronic indifference to the circumstance. The worker is in a state of disequilibrium

Although management has an important and necessary role to play to promote healthy work environments it is also essential that you as a crisis worker pay attention to how well you are doing, how positively you are feeling about your experience and how well you are regularly engaging in self-care activities.

Burnout does not necessarily mean that our view of the world has been damaged or that we have lost the ability to feel compassion for others. It is physical and emotional exhaustion that occurs when workers have low job satisfaction and feel powerless and overwhelmed at work.

**COMPASSION STRESS:** Charles Figley (1995) coined the term Compassion Stress as a “non-clinical, non-pathological” way to characterize the stress of helping or wanting to help a trauma survivor. Compassion stress is seen as a natural outcome of knowing about trauma experienced by a client. It can be of sudden onset and the symptoms include helplessness, confusion, isolation and secondary traumatic stress symptoms.
COMPASSION FATIGUE (Secondary Traumatic Stress Disorder): Compassion fatigue is considered a more severe example of cumulative compassion stress. It is defined as a “state of exhaustion and dysfunction, biologically, physiologically and emotionally, as a result of prolonged exposure to compassion stress” (Figley, 1995). The helper is vulnerable through his or her empathic openness to the emotional and spiritual impacts of vicarious traumatization. Compassion fatigue has been described as “cost of caring” for others in emotional pain (Figley, 1982). It can also be described as our decreased ability to respond to other’s emotions. It can be evident if we find ourselves becoming intolerant of others’ feelings. It may feel like there is nothing more to give. Our ability to be compassionate, empathetic and caring becomes strained and fatigued. Compassion fatigue is used interchangeably with secondary traumatic stress disorder and is similar and parallel to Post Traumatic Stress Disorder, except that the exposure is to the person relating the event and not the event itself. Figley (2002) states that compassion fatigue is “a more user friendly name” for Secondary Traumatic Stress Disorder (p. 6).

VICARIOUS TRAUMATIZATION: The term vicarious traumatization was first used by McCann and Pearlman in 1990 and is defined as “the transformation of the therapists’ or helpers’ inner experience as a result of empathetic engagement with survivor clients and their trauma material”. Vicarious traumatization “refers to the cumulative transformative effect on the helper working with the survivors of traumatic life events (Saakvitne and Pearlman, 1996). “When we open our hearts to hear someone’s story of devastation or betrayal, our cherished beliefs are challenged and we are changed” (Saakvitne & Pearlman, 1996. p. 25).

Vicarious traumatization is different than burnout, although there can be some overlap. Burnout usual refers to a response to a work situation which is too demanding, stressful and/or unrewarding. Vicarious traumatization has some elements in common with countertransference which generally refers to the activation of unconscious material in the therapist’s psyche, evoked by the client and his/her dynamics and issues. Vicarious traumatization is seen as a special form of countertransference stimulated by exposure to the client’s traumatic material. Vicarious trauma is the profound shift that workers experience in their world view when they work with clients who have experienced trauma. The fundamental beliefs that workers have of the world are altered and possibly damaged by being repeatedly exposed to traumatic material. Vicarious Trauma is different than compassion fatigue and occurs when we are traumatized by someone else’s stories.

VICARIOUS TRAUMATIZATION/COMPASSION FATIGUE AND SHELTER WORK

- The terms secondary traumatic stress, vicarious traumatization and compassion fatigue are often used interchangeably to describe what happens when the crisis worker-client relationship becomes unhealthy.

- Secondary Traumatic Stress Disorder and Compassion Fatigue are used interchangeably to describe what happens when helpers are unable to refuel and regenerate. Their ability to be empathetic has been eroded.

- Vicarious traumatization occurs when the worker’s view of the world is altered as a result of the work they do. The distinction between vicarious traumatization and compassion fatigue is not necessarily important to make. But what is important is to recognize the contributing
factors that can lead to the development of either. The more you know about the potential problems, the better you are to develop strategies to deal with the impacts of your work. There are very real, concrete negative impacts when workers have ongoing exposure to clients who are in crisis.

- James (2008) suggests that trauma work and crisis intervention are potentially addictive and at the same time potentially destructive. He states that “crisis workers feel the ‘adrenaline high’ of successful crisis intervention, and this can become highly addictive” (p. 537). He goes on to say that this constant exposure also means that the crisis worker is exposed to graphic and terrible situations.

- Counsellors can be directly impacted by the nature of a client’s trauma. The counsellor is expected to hear difficult stories while remaining psychologically available to the client. The effects of vicarious trauma are cumulative and are constructed upon memories obtained from listening to traumatic stories one after another. This can create a permanent, subtle or marked alternation in counsellors - politically, spiritually and professionally.

- Vicarious traumatization and compassion fatigue occur as a result of an accumulation of experiences and are far beyond the transference-countertransference issues of a specific crisis worker-client relationship. Countertransference is temporary while vicarious traumatization and compassion fatigue have the potential to permanently change the “psychological constructs of workers” who work in the area of trauma for an extended period of time (Saakvitne and Pearlman, 1996, p. 31).

- Compassion fatigue and vicarious traumatization can contribute to burnout.

- As a shelter worker, you are vulnerable to the impacts of vicarious traumatization. You listen to the stories of women impacted by domestic violence and have only brief involvement with them before they move out of the shelter. You have few opportunities to get feedback about how your helping may have assisted the women. You are not often a part of their ongoing healing process. As counsellors “our capacity for empathy is an essential gift and tool, yet our empathy is also a source of our vulnerability to vicarious traumatization” (Saakvitne & Pearlman (1996, p. 46). In a parallel process to the clients that you work with, you may have your view of yourself and the world altered and in this way experience vicariously the trauma that your clients have experienced.

- Researchers have discovered that helpers may begin to show symptoms very similar to their traumatized clients: difficulty concentrating, intrusive imagery, feeling discouraged about the world, hopelessness, exhaustion, irritability, high attrition, and negative outcomes (cynical workers remaining in the field, boundary violations many of which affect the work environment and have the potential to create a “toxic work environment.”

**Signs and Symptoms of Vicarious Trauma** (Saakvitne & Pearlman, 1996)

**General Changes:**

- No time or energy for oneself
- Disconnection from loves ones
- Social withdrawal
- Increased sensitivity to violence
- Cynicism
- Generalized despair and hopelessness
### Specific changes:
- Nightmares
- Disrupted frame of reference
- Changes in identity, world view, spirituality
- Diminished self capacities
- Impaired ego resources
- Disrupted psychological needs and cognitive schemas
- Alterations in sensory experiences (intrusive imagery, dissociation, depersonalization)

Yassen (1995) outlines the impact of secondary traumatic stress (vicarious traumatization) on professional functioning:

<table>
<thead>
<tr>
<th>Performance of job tasks</th>
<th>Morale</th>
<th>Interpersonal</th>
<th>Behavioral</th>
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<tbody>
<tr>
<td>Decrease in quality</td>
<td>Decrease in confidence</td>
<td>Withdrawal from colleagues</td>
<td>Absenteeism</td>
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<td>Decrease in quantity</td>
<td>Loss of interest</td>
<td>Impatience</td>
<td>Exhaustion</td>
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<td>Low motivation</td>
<td>Dissatisfaction</td>
<td>Decrease in quality of relationships</td>
<td>Faulty judgment</td>
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<td>Avoidance of job tasks</td>
<td>Negative attitude</td>
<td>Poor communication</td>
<td>Irritability</td>
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<td>Increase in mistakes</td>
<td>Apathy</td>
<td>Subsume own needs</td>
<td>Tardiness</td>
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<tr>
<td>Setting perfectionist standards</td>
<td>Lack of appreciation</td>
<td>Staff conflicts</td>
<td>Irresponsibility</td>
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<td>Obsession with detail</td>
<td>Detachment</td>
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Yassen also outlines the impact of secondary traumatic stress on workers on a personal level:

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<th>Cognitive</th>
<th>Emotional</th>
<th>Behavioural</th>
<th>Spiritual</th>
<th>Interpersonal</th>
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<tr>
<td>Diminished concentration</td>
<td>Powerlessness</td>
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<td>Confusion</td>
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<td>Spaciness</td>
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<td>Lack of self-satisfaction</td>
<td>Mistrust</td>
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<td>Loss of meaning</td>
<td>Shutdown</td>
<td>Moody</td>
<td>Pervasive hopelessness</td>
<td>Isolation from friends</td>
<td>Breathing difficulties</td>
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<td>Decreased self-esteem</td>
<td>Numbness</td>
<td>Regression</td>
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<td>Impact on parenting</td>
<td>Somatic reactions</td>
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<td>Preoccupation with trauma</td>
<td>Fear</td>
<td>Sleep disturbance</td>
<td>Anger at god</td>
<td>Projection of anger or blame</td>
<td>Aches and pains</td>
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<td>Trauma imagery</td>
<td>Helplessness</td>
<td>Appetite changes</td>
<td>Questioning of prior</td>
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<td>Rigidity</td>
<td>Depression</td>
<td>Hypervigilance</td>
<td>Impaired immune system</td>
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### TO THINK ABOUT

**COPING WITH VICARIOUS TRAUMATIZATION**

Immunization against vicarious traumatization involves education about trauma symptoms and their treatment, the normalizing of responses, the recognition of the impact of the information on oneself and an opportunity to debrief in a supportive setting. Prevention and management involve setting boundaries between personal and professional activities and including variety in each area of one’s life.

Pearlman and Saakvitne (1996) state that there are four areas that are important to the prevention of secondary traumatization including:

1. Professional strategies such as balancing caseloads and adequate supervision
2. Organizational strategies such as sufficient “down” time and a safe physical space
3. Personal strategies such as respecting one’s own limits and maintaining time for self-care activities
4. General coping strategies such as self-nurturing and seeking connection

Saakvitne & Pearlman (1996) outline the ABCs of addressing Vicarious Trauma:

- **Awareness**: Being attuned to one’s needs, limits, emotions and resources. It is important to pay attention to all levels of awareness and sources of information – cognitive, intuitive and somatic. It is helpful to practice mindfulness and acceptance.
- **Balance**: It is vital to maintain balance among activities, especially work, play and rest. Inner balance allows for attention to all aspects on oneself.
- **Connection**: Connections to oneself, to others and to something larger than oneself are critical for maintaining emotional health. Communication is part of connection and helps to break the silence of unacknowledged pain. Connecting with others offsets isolation and increases validation and hope.
Saakvitne & Pearlman (1996) stress that it is important to be mindful of the above three strategies – Professionally, Organizationally and Personally. As a frontline worker you are encouraged to implement some strategies for yourselves professionally and personally. If you feel that there are organizational changes that may be helpful to counter the impacts of vicarious trauma it is suggested that you speak with your supervisor.

- **Professionally**, it makes a profound impact simply to acknowledge vicarious traumatization. When you accept your responses as normal, you are more likely to address them in a constructive manner. **Awareness** permits you to make responsible choices in order to limit your exposure to traumatic information and to work towards creating balance in your work life.

- **Balance** in your professional life means balance with the various tasks you are expected to perform. As a frontline counsellor, there are few opportunities for down time – the demands are constant. If possible work out a schedule with your supervisor that allows for a break in your day and then make sure that you take it. Leave the office. Sit in another room and do something that is not work related; go for a walk if possible; listen to music; visit with a co-worker.

- **Connection** is also important professionally. Connection is about nurturing relationships. It is about having an opportunity to share how you are doing, to talk about your challenges and frustrations. Supervision and consultation are necessary. It is also essential to have a personal life if you are going to be able to continue to work with individuals that have been traumatized.

- You need time to play and not have responsibilities. It is important to be **aware** of the roles that you play at work and in your personal life and to add variety to those roles. It is not healthy to always be in a role of caregiver. Take time for you to enjoy activities that bring joy to you.

- Your personal life also needs **balance**. It is essential to balance the various parts of you and your life including the spiritual, physical, emotional, relational, psychological, creative and sensual parts of you. Rest and play are essentials.

- It is also important to find meaning in life and to nurture the **connections** that you have with others in your world- family and friends.

The following are ways that organizations can have an impact on vicarious traumatization: encouraging support among team members, facilitating forums to address vicarious traumatization, providing adequate supervision, creating a respectful work environment, and ensuring that there are adequate resources for you as a frontline worker including health benefits, adequate time to do your work and a safe, nurturing environment.

**SELF-CARE ASSESSMENT SCALE**

The following is a Self-Care Assessment Scale developed by Saakvitne and Pearlman (1996). It is designed as a tool to assess how well a counsellor is dealing with her own needs. Once you have completed the assessment, look for patterns in your responses. Are you doing more in one area of self-care than others? Are there areas that you feel it would be important to do more in? It is helpful to use this assessment on a regular basis. **Rate the following areas in frequency**

5 = frequently 4 = occasionally 3=rarely 2=never 1=it never occurred to me

**Physical self-care**

- Eat regularly
- Eat healthily
- Exercise
- Get regular medical care for prevention
Get medical care when needed
Take time off when sick
Get massages
Do physical exercise that is fun
Take time to be sexual
Get enough sleep
Wear clothes you like
Take vacations
Take day trips or mini-vacations
Make time away from telephones
Other:

Psychological Self-Care
- Make time for self-reflection
- Have your own personal therapy
- Write in a journal
- Read literature that is unrelated to work
- Do something that you are not expert or in charge
- Decrease stress in your life
- Notice your inner experience – listen to your thoughts, feelings, judgments, attitudes, and beliefs
- Let others know different aspects of you
- Engage your intelligence in a new area – go to a museum, sports event, theatre
- Practice receiving from others
- Be curious
- Say no to extra responsibilities sometimes
- Other

Emotional Self-Care
- Spend time with others whose company you enjoy
- Stay in contact with important people in your life
- Give yourself affirmations, praise yourself
- Love yourself
- Reread favourite books see favourite movies
- Identify comforting activities, people, relationships, objects and seek them out
- Allow yourself to cry
- Find things that make you laugh
- Express your outrage in social action, letters, donations, marches, protests
- Play with children
- Other

Spiritual Self-Care
- Make time for reflection
- Spend time with nature
- Find a spiritual connection or community
- Be open to inspiration
- Cherish your optimism and hope
- Be aware of nonmaterial aspects of life
- Try at times not to be in charge or the expert
- Be open to not knowing
- Identify what is meaningful to you and notice its place in your life
- Meditate
- Pray
- Spend time with children
- Have experiences of awe
Contribute to causes in which you believe
Read inspirational literature (talks, music, etc)
Other

Workplace or Professional Self-Care

Take a break during the workday
Take time to chat with co-workers
Make a quiet time to complete tasks
Identify projects or tasks that are exciting and rewarding
Set limits with clients and colleagues
Balance your caseload so no one day or part of a day is “too much”
Arrange your work space so it is comfortable and comforting
Get regular supervision or consultation
Negotiate for your needs
Have a peer support group
Develop a non-trauma area of professional interest
Other

Balance

Strive for balance within your work-life and workday
Strive for balance among work, family, relationships, play and rest

COMPASSION SATISFACTION/FATIGUE SELF-TEST

Dr. Figley has developed a Compassion Satisfaction/Fatigue Self-Test for Helpers. Dr. Figley recommends that the scale and the scores be used as a guide only. He states that the cut points are theoretically derived and should be used with caution. By using this self-test on a regular basis it may be a useful tool to assist frontline workers to gauge how well they are managing in very stressful working conditions. (SEE APPENDIX A).

The Professional Quality of Life Scale – Compassion Satisfaction and Fatigue Subscales – Revision IV is a shortened scale developed by B. Hudnall Stamm. Stamm stresses that this scale is not a substitute for medical advice and is not to be used to diagnose or treat a health problem. The scores may indicate that it is advisable to seek support. (SEE APPENDIX B)

EXAMPLE:

Carol had been working as a frontline counsellor for about three years. She was dedicated and consistently worked diligently to support the women in the shelter. On one particular day, Carol had met with 6 individual women each telling Carol about the abuses that had resulted in their shelter stay. At 8 pm Carol met with her last client of the day. Lynn had been in the shelter previously after leaving a very abusive relationship. Lynn and her two children had moved into the community in subsidized housing and had been doing very well. Recently, Lynn’s apartment was broken into during the day. Lynn’s children were in school and Lynn was having a nap as she often did in the afternoon. Lynn has Multiple Sclerosis and tires easily. Lynn proceeded to tell Carol what had happened when the three men broke into her apartment. She stated that they tied her to her bed and sexually assaulted her.

She gave a very detailed account of the incident and then began to sob uncontrollably when she told Carol that her children found her tied to the bed when they came home from school. Carol was able to remain calm during Lynn’s disclosure and provided emotional support for Lynn. After the session, Carol found herself feeling physically ill. When she got home that night after work, she found that
she could not stop thinking about the horrific assault on Lynn. She was not able to sleep that night. The next day at work, she found herself avoiding certain women as she did not feel that she could listen to any more painful stories.

Carol made an appointment to see her supervisor the following day. When she met with her supervisor they discussed strategies that Carol might have used to have minimized the impact of listening to Lynn’s distressing situation. Carol could have asked to debrief with one of her co-workers. Carol could have taken a break after the difficult session and gone to the staff room and taken some time for herself. Carol acknowledged that she rarely took her breaks during the day and often felt overwhelmed. Carol’s supervisor assisted her to look at a plan of self-care and Carol made a commitment to herself to develop a ritual that would assist her to leave her work at work and be able to transition to her home life. Carol identified some activities that she finds nurturing and made a commitment to engage in at least one or two of these activities on a weekly basis.

ADDITIONAL RESOURCES:


REFERENCES:


