WHAT WE KNOW (SO FAR) ABOUT THERAPIST SELF-CARE:

Myths of Individual Coping, Realities of Organizational Policy

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9/11 and its aftermath raised our collective consciousness about how traumatic events affect specific communities (e.g., "Ground Zero" in Manhattan, the Pentagon) and populations—fire fighters, police, service workers, military personnel, and their families. A few studies have examined the efficacy of service delivery to those hardest hit by the terrorist attacks. But a less studied phenomenon is the impact of extended exposure to traumatized populations on *helping professionals themselves*. This is an important area of investigation because healthy, psychologically present helping professionals are in a better position to offer assistance to trauma survivors than professionals suffering from primary and secondary traumatization. This article tackles the topic of what we know about self-care and resilience, and offers suggestions for how we can best maintain our health as we go about the challenging and rewarding work we do with trauma survivors.

Defining Terms: Compassion Fatigue, Compassion Satisfaction and Burnout

Charles Figley (1995) declared stress to be a "normal and natural byproduct of working with traumatized people" (p. 573). It makes sense that listening to traumatic material or "tough stuff" (such as that child sexual abuse case file making the rounds at your agency, a case of severe war trauma, or a survivor's detailed account of a sexual assault) for 30–40 hours a week (or longer for the workaholics out there—you know who you are) can lead to acute distress. In a process of secondary or vicarious traumatization, helping professionals begin to hurt, experiencing traumatic stress symptoms. In addition, our beliefs about our world and interpersonal relationships, such as our perception of safety and the ability to trust others, can become disrupted or contaminated via our empathic engagement with traumatic case material. Repeated and frequent exposure to persons suffering from symptoms of post-traumatic stress disorder (PTSD) can precipitate PTSD-like stress reactions in therapists. Vicarious or secondary trauma is also referred to as compassion fatigue. The positive opposite of this phenomenon is compassion satisfaction, the sense of reward, efficacy, and competence one feels in one's role as a helping professional. A last construct found in the literature is burnout, which is a condition characterized by emotional exhaustion and depersonalization. In the simplest terms, if one were to attribute affective domains to these three constructs, one could say that compassion fatigue dwells in the neighborhood of fear and anxiety, compassion satisfaction in pleasure or happiness, and burnout in emotional exhaustion and lack of self-efficacy.

Ever lost sleep over a particular case? Have you had intrusive thoughts about an awful experience that a client disclosed to you? Had difficulty concentrating, or had a panic attack, due to your workload or stress associated with some of your cases? These experiences represent indicators that your job is taking a toll on you. In fact, a qualitative study

of family therapists and social workers working with cases of child sexual abuse and domestic violence found that most of the research participants recognized stress associated with their jobs in symptoms of anxiety and panic, startle responses, fatigue, sleep disturbance, intrusive thoughts, and problems controlling anger. Interestingly, such bodily symptoms are diagnostic criteria for PTSD, and this is evidence that therapists working with severely traumatized clients do run the risk of developing secondary traumatic stress (Killian, 2006).

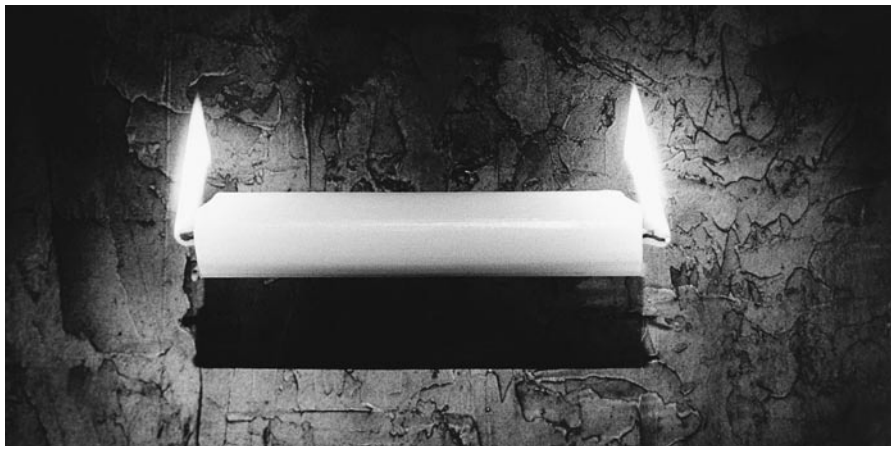
Therapists Heal Thy Selves? Self-Care Myth and Reality

Most of the research literature, and supervision and training talk, point us in the direction of further education and increased leisure time as ways of effectively dealing with the inevitable work stress associated with our roles as therapists. Many coping strategies come highly recommended by theorists, researchers, and trainers in the area of secondary or vicarious trauma, but I have yet to see a research project evaluating the effectiveness of these approaches on reducing stress (please e-mail me when you do). A recent study by Bober and Regehr (2006) found that social workers, psychologists, nurses and physicians "generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities, and supervision….However, there was no association between the belief that leisure and self-care were useful and time allotted to engage in these activities" (p. 7). This shouldn't be too surprising, for two reasons. First, there has always been a gap (okay, a chasm) between what we profess we believe and what we actually do. We are complicated creatures, and walking contradictions, often thinking and believing one way, and behaving in another. Such contradictions are the bread and butter of researchers and practitioners in the human sciences, and are a normal part of our daily existence. Second, it is safe to say that all of us have experienced how time flies in modern times, and how our schedules just couldn't get any more busy and hectic, and then, somehow, become even more so (see Fraenkel, 2000, 2001; Daly, 2001). So, it isn't too shocking to discover that the gap between our beliefs and behaviors extends into the domain of professional self-care practices.

But before we say, "Alright, I'll just make more time for these coping strategies, and my resilience is ensured," Bober and Regehr discovered something else: There was no association between time actually devoted to leisure, self-care, continuing education, or supervision and helping professionals' traumatic stress scores. That is, they found *no evidence that using suggested coping strategies protects professionals from symptoms of traumatic stress*. My own research corroborates their findings (Killian, in preparation): I found no significant correlations between the use of various coping strategies and reported levels of compassion satisfaction, compassion fatigue, and burnout in family therapists working with trauma survivors. In my study, clinicians' coping styles, while related to overall work stress, did not directly influence their resilience (i.e., compassion satisfaction) or symptoms of compassion fatigue in the high stress job of working with trauma survivors.

However, four factors do seem to make a difference. A primary predictor of higher traumatic stress scores (Bober & Regehr, 2006) and lower scores on compassion satisfaction (Killian, in preparation) is *higher number of hours per week* spent working with traumatized people. And, in my research, two other factors are associated with higher compassion satisfaction: higher reported social support and higher internal locus of control at the workplace. Finally, lower scores on work morale were a significant predictor of symptoms of burnout. What does this all mean? It means that working with trauma survivors all day and all week is hard work, and doing *less of it per week* may help us do more of it *in the long term*. It suggests that other working conditions play a role in our health as helping professionals. In addition, it indicates that we should stop expecting helping professionals to "pull themselves up by their bootstraps" by reducing their stress with standard individual coping strategies of leisure and continuing education, which are clearly not all that effective. This may require a change in our ways of thinking about self-care, a recalibration of our theoretical lenses, if you will.

Family therapists are known as big fans of the systemic paradigm, seeing the value in looking at, understanding, and treating individuals and their presenting problems within a larger couple and family context. The move away from the atomistic, reductionist, anticontextual framework so much a part of the Western dominant discourse was certainly a watershed event within the helping professions, but in the past decade, some



therapists have called for another paradigmatic shift, one that asks us to look at couple and family systems in larger *sociopolitical* structures and contexts (e.g., Killian, 2001), using a framework that includes clients' social locations on axes of power and privilege (race, gender, class, culture, etc.) relative to one another, relative to their therapist, etc.

I propose a parallel paradigmatic shift in our understanding of therapists and professional self-care, where we look at professionals' stress and coping in structural, political, and organizational contexts. Agencies and organizations could begin to move from focusing on individual workers and their coping strategies, because this focus implies that helping professionals who are hurting are somehow at fault—they aren't balancing work and life (i.e., "just take some leisure time"), or they are failing to make use of opportunities for supervision, or educational seminars that focus on individual coping responses. In a "shout out" to agency administrators and supervisors, I suggest that organizations take on the task of figuring out ways of distributing workload so that traumatic exposure of any one worker can be limited. In addition, organizations could institute policy changes to help make the workplace a space where therapists feel a sense of collegiality and support, and where they feel they have a sense of control (e.g., having some say about administrative policies, experiencing a degree of predictability in their workload, etc.). Borrill et al. (2000) reported that individuals in the helping professions who worked in clearly defined teams were found to suffer less psychological strain, had great job satisfaction, and reported greater organizational commitment. Since social support is an important ingredient in our fight against compassion fatigue, then forging connections to broader community movements, like participating in political advocacy for trauma survivors, might help to us resist the debilitating effects of alienation, isolation, helplessness, and cynicism. To combat compassion fatigue and burnout, agency administrators and therapists may also wish to ask themselves, "How many cases are too many?" Answering that question, and then establishing an upward limit on case workload, could nip stress in the bud before we become overwhelmed or exhausted, and before compassion fatigue begins to interfere with our abilities to concentrate, to remember relevant information about our cases, and to hold the hope for our clients until such time that they can do so for themselves.

In conclusion, we want to protect therapists from compassion fatigue, enhance their resilience, and help professionals deliver quality mental health interventions, but to achieve these goals, we may need to shift paradigms, moving our focus away from individualistic efforts at education and toward a more systemic approach of advocacy for healthier working conditions. Put in narrative terms, bureaucracy, paperwork, workaholism, the court system, etc., are allies to the externalized problem of compassion fatigue. Let's work together to figure out what, or who, will be our allies in combating compassion fatigue's influence on our lives so we can get back to the work that we love. ❍

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