Too Many Sad Stories: Clinician Stress and Coping

Samantha Marriage, BSc[1] and Keith Marriage, MD[2]

ABSTRACT

Introduction: Mental health clinicians make their careers working with patients and families who have experienced extremes of stress and trauma. **Methods:** The psychological effects on the caregiver of prolonged therapeutic work with traumatized patients have previously been studied within the theoretical frameworks of Burnout, Secondary Post Traumatic Stress and Vicarious Traumatization. **Results:** We report a qualitative study of experienced clinicians' responses to the stressors inherent in such therapeutic work, and the coping strategies they developed. **Conclusion:** We found that some degree of vicarious traumatization was the main result of engaging in such work.

Key Words: secondary traumatic stress, vicarious trauma, compassion fatigue, burnout, counter-transference.

RÉSUMÉ

Introduction: Les cliniciens travaillant en santé mentale sont exposés leur vie durant à des patients et à des familles qui souffrent de stress et de trauma très sévères. Méthodologie : Les effets psychologiques de ces situations sur le soignant l'ont généralement été via l'épuisement professionnel, le syndrome de stress post-traumatique secondaire et le trauma par association. **Résultats:** Nous faisons état d'observations qualitatives, effectuées sur un groupe de cliniciens chevronnés ayant été exposés à ces stresseurs en cours d'emploi, et des stratégies élaborées par ceux-ci pour faire face à la situation. **Conclusion:** Nous concluons qu'en bout de piste ces cliniciens présentent un certain degré de trauma par association.

Mots clefs: stress traumatique secondaire, trauma par association, épuisement professionnel, contre-transférence.

INTRODUCTION

Mental health clinicians make their careers working with patients and families who have experienced extremes of stress and trauma. Many of those we seek to help have been battered by events and circumstances beyond their control, while others struggle with the consequences of their own actions that they did not anticipate. Some of our patients we are able to assist, others we cannot.

How do clinicians respond to continued work with such patients and families? In what ways do they manage the impact of this material on their functioning as professionals, and as empathic individuals?

The literature addressing these questions draws on a number of different but overlapping concepts:

- Counter-transference
- Burnout
- Secondary Post Traumatic Stress / Compassion Fatigue
- Vicarious Traumatization

COUNTER-TRANSFERENCE

A psychodynamic concept that relates to the past experiences and psychological defences of the therapist, who then responds to a particular patient, in a conscious and unconscious manner, determined by these processes. This view emphasizes the importance of the clinician being aware of these feelings, and employing this awareness diagnostically and therapeutically. Specific to a particular patient therapist dyad, it does not address the cumulative effect of working with many patients.

BURNOUT

"A syndrome of emotional exhaustion, depersonalization and feelings of reduced personal accomplishment that occurs in response to the chronic emotional strain of dealing extensively with human beings, particularly where they are troubled and having problems" (Maslach 1982). Burnout has been found to be closely related to organizational structures and job role factors, such as job pressures, role overload, role conflict, and ambiguity that in turn lead to lack of job satisfaction.

Indicators of the costs of such stressors include: impaired job performance, impact on mental and physical health, chemical dependency, marital breakdown and early retirement (summarized in Moore et al, 1996).

SECONDARY POST TRAUMATIC STRESS

"The emotional duress experienced by persons having close contact with a trauma survivor – a natural response to the survivor's traumatic material with which helpers may identify and empathize" (Figley 1983a). The symptoms are similar to those of primary Post Traumatic Stress Disorder i.e. experiencing primary survivor's event, avoidance of reminders / numbing of response, persistent arousal.

This construct has since been renamed "Compassion Fatigue" and broadened to include a burnout aspect (Figley 1995b). It could, in theory, follow exposure to a single traumatized person.

VICARIOUS TRAUMATIZATION

"The permanent transformation of the inner experience of the therapist that comes about as the result of empathic engagement with a client's traumatic material" (Pearlman et al, 1995). This concept relates to permanent changes in the clinician's cognitive frame of reference, including identity, world view, spirituality, affect tolerance, deeply held beliefs about self and others, and interpersonal relationships.

The clinician's verbal exposure to traumatic material theoretically changes cognitive schemas in five key areas: trust, safety, control, esteem and intimacy. Intrusive imagery and other

[1]Undergraduate, Faculty of Medicine, University of Melbourne, Australia
[2]Children's & Women's Health Centre of British Columbia, Vancouver, British Columbia
kmarriage@cw.bc.ca

Table One: Comparison of three different caregiver responses to the traumatic histories of their patients.

	Symptoms	Susceptible Population	Risk Factors
Burnout	• Exhaustion • Feelings of inadequacy • Mental and physical health problems • Substance abuse	Human service personnel of all types	Job / role factors limiting autonomy, work overload, low satisfaction
Secondary Traumatic Stress	• Rapid onset of re-experiencing client's trauma • Avoidance and numbing • Persistent arousal	• Victim's significant others • Emergency personnel • Care providers to victim	Personal trauma in history of care provider
Vicarious Traumatization	Gradual change in inner experience / world view of therapist, +/- PTSD symptoms	Mental health professionals working with victims over time	Better training / education of provider a protective factor

(Maslach 1982, Figley 1983a, 1995b, McCann et al 1990, Baird & Jenkins, 2003)

PTSD symptoms may appear as disruptions to the therapist's imagery system of memory (McCann et al, 1990).

A recent study highlighted the similarities and differences between the constructs of Secondary Traumatic Stress (STS), Vicarious Traumatization (VT) and Burnout (B), and used questionnaires specific to each concept to examine their relationship to each other (Jenkins et al, 1999).

Using questionnaires developed specifically by the original authors for Burnout, STS and VT, Jenkins & Baird showed "adequate evidence that neither of these measures (STS and VT) is reducible to the other, and that neither the STS nor VT scales captures the construct of Burnout."

Conversely, because of concerns that these terms can imply criticism of the clinician or the patient, Arledge and Wolfson (2001) have advocated including them all under the rubric of "Impact of Trauma Work".

Although a number of authors e.g. (Rabin et al, 1999; Arvay et al, 1996) have discussed institutional factors and interactions that may protect clinicians from the stress of working with traumatized patients, relatively little has been written about the strategies employed by the therapists themselves. We were prompted to conduct a qualitative study of experienced clinicians in a Child & Family Psychiatry Clinic, asking about their work experiences, responses, and coping methods. We chose the semi-structured interview format to allow more spontaneity and variation in responses, rather than restricting replies to rating scales. We also discussed these issues with psychiatric residents commencing their experiential journey as psychotherapists.

METHOD

We conducted a semi-structured interview with 7 clinicians in the Department of Psychiatry, BC Children's Hospital. We selected from 25 clinicians the most experienced, i.e. those with 10-25 years therapeutic work with children, adolescents and families. All respondents were in full time practice in a university teaching hospital, and were psychiatrists (3), psychologists (2) or psychiatric social workers (2). Age range was 40-60 years.

Four specific questions were used to open key areas of discussion, allowing the clinicians to respond in their own way, with additional questions as necessary to probe for B, STS, and VT. Interviews were videotaped, and answers abstracted.

RESULTS

Clinicians' Responses

Opening Question One:

In the course of your work as a clinician, you encounter many children and families struggling with the consequences of traumatic lives…

Could you describe one or two patient situations you found particularly poignant?

Examples of Responses:

"…a 14 year old boy who was becoming aggressive and oppositional in school. His mother had been given a diagnosis of terminal breast cancer 2 years previously, and had been undergoing continuous chemotherapy. The family was falling apart, and the boy was angry, rough and tough, under which he was terrified. He could not show his anger to his mother, so took it all out on his father, and the school. It was hard to see the whole family struggling, not coping…and, what would 'coping well under the circumstances' look like?" (female social worker).

"…a 5 year old girl who had the experience of raising her three younger siblings. Her father had died of a heroine overdose, her mother was in and out of overdosing, in the home there was neglect, violence, sexual abuse. It seems incredible that a child could go through that, but the child is in front of you, in a safe place, and you have the privilege of containing some of that experience" (female psychiatrist).

"…a patient I worked with for a year, a teenager from Taiwan who had cancer, and she eventually succumbed. We worked very intensively, and the experience had a huge impact on me" (male psychologist).

"…little boy, not yet 5…the parents were separated…his mother was dying of cancer. The mother's way of coping, and the father's also, was not to tell the boy about it. The boy was having some behavioural disturbances, but the father, who brought the boy in, insisted we could not mention the mother's illness. In

his sandbox play, the boy buried a cobra in the sand – it could strike out any time, could not be controlled, or predicted, and was unseen. You knew the current situation would not work well for the patient, but the father could not bring himself to discuss it with the boy, so neither could I" (female social worker).

Therapists' Responses To The Clinical Experiences

Opening Question Two:

Could you describe some of your personal responses to situations like these?

Examples of Responses:

"Each patient's experience is individual, and you enter into it. Many of us read Victor Frankel's book, *The Search for Meaning*. If this suffering, these atrocities, these hurts, are such a universal part of human experience, then what is human experience about? If clinicians don't ask these questions, they may cave in under the magnitude of the trauma, or become deadened as a defence mechanism."

"The patients in a therapeutic relationship will want to please you, they will be aware of what we can handle, and may protect us by not giving us too much, just as they may have protected their parents. In order to keep yourself open to hearing what they bring, you have to monitor what is happening in yourself" (female psychiatrist).

"Working with dying patients gives me a perspective on what is important in life. At the end of the journey, most focus on relationships, rather than fame or fortune. And the experience humbles you…we are not always successful in saving patients. And then there is frustration and guilt – why do patients have to go through this?" (male psychologist).

"When you listen to these stories, it's as if the repetitive nature, the persistent abuse, the chronic neglect, the substance use by the parents, the poor quality of community resources, it's as if you come to expect it, and the stories should just bounce off. But there are some that stick to whatever part of you. They are often the ones that resonate with something – in your own life – the patient may be the same age as your own child, and you reflect on your relationships with your child" (male psychologist).

"When I've done everything I can, and the patient is not getting better. I work with depressed adolescents and if depression gets worse there may be cutting, and the risk of suicide. The adolescent will come in with evidence of fresh cutting, and I worry that maybe I am missing something" (female psychiatrist).

Comment: The clinicians' responses to our first two questions, as illustrated by the examples here, gave evidence of the considerable stress inherent in working with this traumatized population.

Risk factors associated with Burnout e.g. frustration with the non-availability of adequate community support resources, awareness of the limits of what our own institution could provide, were reported by most respondents. Although some symptoms of burnout were disclosed by several clinicians e.g. feeling of being therapeutically ineffectual, none reported the full syndrome. Though all were aware of the impact of traumatic material on their emotions, none identified suffering full Secondary Post Traumatic Stress.

Effect On The Clinician

Opening Question Three:

Do you feel that dealing with these issues has affected the way you see the world?

Examples of Responses:

"Over time, I have tended to become complacent with very scary, very traumatic stories, so that I almost come to expect it. I think we should all be required to spend time with normal kids, to remind us how normal teenagers can be, what is the rule, what is the exception" (male psychologist).

Every case sets up a reaction, reinforces biases that I have, makes me more protective of my family, to the extent that I only have babysitters who are registered nurses. It disturbs me that we become so complacent about trauma that we come to expect it" (male psychologist).

"It touches you; you see the intimate parts of people's lives. You realize there are more layers, gives you a different perspective – it is harder to be certain – things are not always what they seem. Your perspective changes as you learn more. You learn it is not just using countertransference; you must be emotionally available to be effective. So, you must keep a balance, while still being self protective" (female social worker).

Comment: If the essence of the concept of Vicarious Traumatization is a change in inner experience/cognitive frame of reference, then all our respondents reported this, to some degree, and in different ways.

Coping Strategies

Opening Question Four:

As you gained experience as a clinician, what are some of the ways you have developed of dealing with these encounters?

Examples of Responses:

"My number one resource tends to be humour – I am a strong advocate of humour, both therapeutically and to support myself. The second would be the support of people around me, my family, my wife – not to share the details, but the themes and the emotions these stories engender" (male psychologist).

"Debriefing with colleagues, peer support. I may use up so much of my emotional energy at work and be taking on other people's emotions, when I go home I could be demanding – it takes a lot to live with a psychologist. Pets and music can also be therapeutic. Fortunately my spouse can be very understanding" (male psychologist).

"Accepting the limits of what you can do. I feel sad, I talk to colleagues if I need to, I divert myself, I have hobbies. There are a lot of things in life which are hard" (female social worker).

"Academically, I've set up a supervision group with psychiatric and psychologist colleagues; we consult together monthly about difficult cases, and this keeps me grounded. I don't have to feel alone with these dilemmas. Personally, I have developed a ritual of letting go when I leave work. At home, I work in my garden" (female psychiatrist).

"Like any other anxiety, learn to let it go, to compartmentalize. Go home and do joyful things, see movies, read books. Reading research about trauma leads to another defense, the understanding of what we are dealing with."

"Sharing the story with a colleague, reflecting on what it is like to sit with enormous trauma, can be part of an empathic exchange, a mentoring process. Realizing that times of sharing the worst stories are also times of potential growth for the patient. With longer experience, as you see people work through these things, it becomes easier to nurture a thread of hope for each client" (female psychiatrist).

Comment: The support of friends and family, together with personally meaningful endeavours outside the clinical field, were as important to our respondents as the coping mechanism provided within the professions by peer consultation and interaction. Continuing personal education in the field of trauma theory and therapy may have also enhance the resilience noted in better trained staff (Baird and Jenkins, 2003).

TRAINEE RESPONSES

An abstract of the videotaped interviews made with these experienced clinicians was shown to a group of seven PGY-3 residents who were currently receiving their mandatory six months training in Child Psychiatry. The following themes emerged from the group discussion:

All reported stressful experiences including: patient's suicides and attempts, encounters with verbally and physically aggressive individuals, therapeutic failures, patients presenting in a decompensated state.

Many residents worried about their patients when off duty. As the residency progressed, the gradual assumption of increasing responsibility for individual patient's care led to heightened levels of stress.

Residents developed supportive networks first within their peer groups, then with supervisors and other mental health staff. They believed that the discipline of psychiatry was more open than others to considering the clinician's feelings generated by encounters with patients, "we are taught to recognize feelings and ask for help."

Comment: These trainees, being early in their clinical experience, did not disclose specific symptoms of B, STS or VT, but all reflected, as above, on the stresses of the therapeutic work. Their coping strategies focused more on peer and supervisor support, and less outside the work environment, on family and friends. This may reflect the intensity of the intra-group dynamic as they progressed together through training.

CONCLUSION

Though none of our consultants reported the syndromes of Burnout or Secondary Post-Traumatic Stress, an element of altered world view, i.e. Vicarious Traumatization was present in the accounts of all.

These experienced therapists managed stress by self-monitoring their emotional responses, continuing professional education, the employment of collegial support networks, formal and informal, interests outside of the work environment, and the support of significant others.

We recommend addressing these issues as a formal part of training, acquainting students with the expectation that they will encounter these feelings, the permission to express them, and the strategies employed successfully by their seniors to manage them.

REFERENCES

Arledge, E. and Wolfson, R. (2001). Care of the clinician. *New Directions for Mental Health Services*, 89, Spring: 91-98.

Arvay, M. J. and Uhlemann, M. R. (1996). Counsellor stress and impairment in the field of trauma. *The Canadian Journal of Counselling,* 30(3): 193-210.

Baird, S. and Jenkins, S. R. (2003). Vicarious Traumatization, Secondary Traumatic Stress and Burnout in Sexual Assault and Domestic Violence Agency Staff. *Violence and Victims*, 18(1) 71-86.

Figley, C. R. (1983a). Catastrophes: An overview of family reactions. In: *Stress and the Family: Vol.2 Coping with Catastrophe.* Figley, C. R. and McCubbin, H. I. (eds.), Brunner Mazel, New York: 3-20.

Figley, C. R. (1995b). Compassion fatigue as secondary Traumatic Stress Disorder: An overview. In: *Compassion Fatigue – Coping with Secondary Post Traumatic Stress Disorder in those Who Treat the Traumatized.* Figley, C. R. (ed.), Brunner Mazel, New York: 1-20.

Jenkins, S. R. and Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15(5): 423-432.

Maslach, C. (1982). *Burn-out – The Cost of Caring.* Prentice Hall, Englewood, Cliffs, NJ.

McCann, L. and Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3: 131-149.

Pearlmanm, L. A. and Saakvitne, K. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.* WWV Norton, New York.

Rabin, S., Feldman, D. and Kaplan, Z. (1999). Stress and intervention strategies in mental health professionals. *British Journal of Medical Psychology*, 72: 159-169.