Hazards of Practice in Helping Professions

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Abstract

Helping others with significant issues in their lives can be highly effective, satisfying, and meaningful. It can be great work. But to do this well, we must constantly attach and separate successfully, over and over again, with person after person. It can be difficult work. What is the nature of this difficult work? In this paper, we reviewed the difficult nature of the work in the high touch people fields---sometimes called the helping professions, the caring professions, or education, human services, and health occupations. The difficult nature often has to do with characteristics of clients, students, and patients we desire to help: they have an unsolvable problem that must be solved; they are not honors students; they have motivational conflicts; there is a readiness gap between them and us; they sometimes project negative feelings onto us; we cannot help sometimes because we are not good enough; and they have needs greater than the social service, health, or educational system can meet. The difficult nature of the work also has to do with major professional stressors of caring professions: our inability to say no, living in an ocean of stress emotions, ambiguous

professional loss, the covert nature of the work, constant interpersonal sensitivity and one-way caring, transference-countertransference data, elusive measures of success, normative failure, regulation oversight and control by external others, legal and ethical fears, vicarious traumatization, and primary trauma. With all these stressful qualities of the work, we must continually invest positively in others. How can we do it? It is the goal of portraying the difficult nature of the work in this paper to invite those in the caring professions to balance other-care and self-care on an ongoing basis.

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The capacity for compassion and empathy seems to be at the core of our ability to be wounded by the work (Stamm, 1995, p. ix).

Making a positive difference in human life it is the joy of practice, which results from the close connection to other people and the opportunity to help individuals in need. Successful helping can produce a sense of satisfaction and a joy of practice. It can be great work. But to do this well, we must constantly attach and separate successfully, over and over again, with person after person. It can be difficult work. Schelske & Romano (1994) reported the incidence of stress-related problems for teachers have been dramatic in studies that have investigated this phenomenon. Surveys have demonstrated that up to 90% of all teachers may suffer from job-related stress and 50% of all teachers indicated that stress is a serious problem for them (p.21). What is the nature of this difficult work? It often has to do with expectations-with our hope to make a difference, with the ability to tolerate so much ambiguity, with the distress we vicariously feel from those we attempt to assist.

In this paper, we review 19 hazards of practice in teaching, counseling, and healing, that are stressful qualities of the work. The first seven hazards relate with characteristics of clients, students, and patients. And the last twelve hazards relate with managing major professional stressors.

I. The Difficult Nature of the Work with Clients/Students/Patients

A. Hazard 1: They have an unsolvable problem that must be solved.

When people come in for counseling, they are often stuck, as in: Can't live with him, can't live without him. Neither approach nor avoidance works. When we are

stuck in life and unable to find a solution, the result is often a feeling of low self-efficacy and high despair. It is almost always difficult for helpers to have an impact on this condition, especially in a quick way. Examples here include the counselor working with the parent of a very rebellious teen. The parent will not abandon the teen but is unable to reach him to stop the angry, rebellious activity. A counselor can be effective here but not in the sense of finding an immediate, positive solution. A teacher of learning disabled children struggles to help them get up to grade level, a difficult task given the children's abilities. The possibility for improvement is limited. All of these practitioners are operating within a common arena, the unsolvable problem that must be solved.

B. Hazard 2: They are not "honors students."

Schoefield's (1974) term, YAVIS (the acronym for young, attractive, verbal, intelligent, and socially skilled), was a way to describe desirable psychotherapy clients; that is, those who could improve rapidly. As a helper, if one does not get in the way, one can take credit for the success. There is a natural tendency for practitioners in the helping fields to have clients/students/patients who have resources (e.g., motivation, ability, and limited problems) which will fuel the success of the helping efforts. This way, there is improvement, and the practitioner, feeling competent, can bask in the positive change. However, clients/students/patients in reality do not always have those resources.

C. Hazard 3: They have motivational conflict.

Motivational conflicts in the helping professions have historically been discussed under the concept of "secondary gains." In some government programs, when one gets better, he or she may lose benefits. For clients who received monthly disability payments because of a mental health diagnosis, losing the diagnosis means losing the payments. One research study found that advanced undergraduates who are unable to decide on a college major are often frozen in the decision-making process not by simply issues such as lack of information or a lack of decision-making skills. Rather, these individuals are experiencing a highly complex set of conflicts that are difficult to resolve (Hagstrom, Skovholt, & Rivers, 1997).

Motivational conflict also refers to begin being sent by others, like parents or the court system. The motivation is outside. One of the classic red flags predicting limited success in human services is external, not internal, motivation for seeking help.

D. Hazard 4: There is often a readiness gap between them and us.

In the helping professions, readiness is about matching our commitment and readiness to work at change with the client/student/patient's commitment and readiness. This "readiness dance," which in its best form closely matches the helper's efforts to that of the helpee, is especially difficult for the novice, who is trying to judge "dose" and "timing" without much practice. Like firefighters ready to fight a fire, we often misread smoke for fire. This happens more with beginners in the helping professions (Skovholt & Ronnestad, 1995). A classic problem in helping, teaching, and healing is in offering programs to people who are not ready. Prochaska, DiClemente, and Norcross (1992) developed a five-stage model of change. The five stages are precontemplation (no plans to change), contemplation (awareness of problem but no decision to change), preparation (awareness of problem and some attempts to be different), action (actively engaged in changing processes), and maintenance (work to maintain changes made). And they suggests Probably the most obvious and direct implications of our research is the need to assess the stage of a client's readiness for change and to tailor interventions accordingly(p. 1110). We can easily be more ready than the client, student, or patient. This is a natural occupational hazard.

Readiness is also a matter of cognitive complexity-when the client/student/patient can understand in a broader, deeper, less egocentric way. Readiness is critical, and sometimes we have little power to affect it. After all, you can lead a horse to water, but you can't make it drink, and the teacher will appear when the student is ready. Until then, you, the helper, are *invisible, unrecognizable*, and *inaudible*: I can't hear a word you are saying, only the echo of my mind. We can't all be lucky enough to have the attention and commitment of the airplane passenger listening to instructions on the use of oxygen in the midst of intense turbulence and cabin depressurization. This is exactly why the work can be difficult. Helpers, teachers, and healers want to feel that they make a difference in human life, but sometimes they do not. At times, we feel ineffective; that is why the work is difficult. The key is that, in time, the helper/teacher/healer, like the veteran athlete, learns when to expend energy and when to preserve energy for the helping, teaching, or healing attachment process.

E. Hazard 5: Sometimes they project negative feeling onto us.

Our clients/students/patients can bring intense transference reactions to us with their past pain, hurt, anger, and fear related to helper and authority figures. We get their unrecognized stubbornness, resentment, anger, and lack of cooperation. Teachers often experience angry, disappointed, distressed parents and personalize the parental reaction. It can be difficult to relate to the transference element and not be personally hurt. The mark of an expert at attachment and connection may be the ability to do this well even when the client/student/patient brings "excess baggage,"

a term which connotes that the student brings extra painful feelings from interactions with adults in the past.

F. Hazard 6: We cannot help sometimes because we are not good enough.

Their needs and our competence as practitioners may not fit. The demographic variables may be wrong. We may not have the right experiential background or the specific competence needed. Maslow's famous quote, "If the only tool you have is a hammer, [you tend] to treat everything as if it were a nail" (cited by Goldfried, 1980, p994), symbolizes the effect of limited competence. Practitioners in time experience a "series of humiliations" when their wrong demographics, wrong life experience, or wrong competence level meets with the needs of the client/student/patient. This is often difficult for the practitioner because of a basic occupational need to feel one is making a positive difference in human life.

F. Hazard 7: They have needs greater than the social service, health, or educational system can meet.

All practitioners have examples of how they could be successful if there were enough resources. Difficult clients can be those who fail because the system does not provide enough resources for success. In contrast, easy clients/students/patients are those who quickly succeed at the task. They have the motivation, skills, and resources to get better, and we as practitioners can bask in their success and be nourished by successfully helping another human being. But of course, the world is not that way.

II. Major Professional Stressors of Caring Professions

A. Hazard 8: Our inability to say no.

The dilemma of all of us in human services concerns the tension between the two elements: good intentions/heroic strivings and the "no" of turning one's back on human need. These two pulls on the heart and mind of the helper are extremely difficult to reconcile.

The difficulty of reconciliation is especially true for the novice helper, teacher, or healer who is often confused about how hard to try in the helping role. Practicum, clerkship, practice teaching, and internship sites often receive excessive services from students in training whose strong intentions and heroic striving naturally lead to overextension. How does one learn to say "no" yet avoid indifference and apathy? For many, the proper point of tension only occurs after becoming overextended and exhausted. This process inspired the first work on

burnout by Freudenberger (1974) and the subsequent work by many others, including a book with a poignant title, <u>Burnout: The Cost of Caring</u>, by Maslach (1982).

B. Hazard 9: Living in an ocean of stress emotions.

Practitioners often work with others who are experiencing some kind of difficulty. It may be physical, academic, or emotional problems. Often a component of the need is emotional distress: confusion, frustration, discouragement, anxiety, and anger are common. Unable to solve his/her own problems, the helpee often experiences a strong dose of the distress we could call Demoralized Hopelessness. Frank (1974) states that it is the job of the professional helper to work with demoralization. Hopelessness is a strong predictive sign of suicidal ideation. The term "Demoralized Hopelessness" is used to communicate the level of human distress we are often asked to address.

The job of the helper, teacher, and healer often involves attaching and being wired emotionally to the other. That is the essence of empathy-wired as if one's battery is connected to the other's battery in order to jumpstart it. The wiring often involves the negative emotions, meaning the emotions of stress. This results in the practitioner living in an "ocean of stress emotions." Practitioners learn in time how to be both "wired" to these distress emotions and separate from them; learning this skill is complex and takes time.

The intensity and scope of human distress that comes to practitioners should not be underemphasized. Human beings are an extremely intelligent, able, and creative species and have the capacity to solve many complex problems (D'Zurilla & Nezu, 1982). All of us are very skilled at problem solving. Often people seek out helpers only when they can't solve their problems by themselves; that is, when they have unsolvable problems that have to be solved. It is the combination of "unsolvable" and "have to be solved" that leads people to experience demoralized hopelessness.

C. Hazard 10: Ambiguous Professional Loss: Ending before ending.

In studies with families of MIA soldiers or Alzheimer patients, Boss et al. described ambiguous loss as producing extreme stress (Boss, Caron, & Horbal, 1988; Boss Caron, Horbal, & Mortimer, 1990). The family member is missing but not gone, present but not present. This can be extremely stressful. Ambiguous Professional Loss is a modified term to describe the constant lack of concrete results and closure for those in the helping, teaching, and healing professions.

Reflecting on Ambiguous Professional Loss, Hage (1994), a counselor in campus ministry, said;

Perhaps here lies one of the most difficult personal challenges of being a counselor. We most likely will never know the fruits of our work. We are very often the sowers or the waters of a harvest we will never see. (p. 3)

The constant demand for helping professionals to attach, be involved, and then separate over and over means that this process must be done in a way that is energizing to the individual. Ambiguous Professional Loss produces the opposite result: it drains the practitioner.

D. Hazard 11: The covert nature of the work.

Practitioners in the counseling, teaching, and health professions can't talk about their work. For example, the psychotherapist may have achieved an incredible breakthrough with a client, which is life changing; yet, the practitioner must return home and remain quiet about the day's success. Confidentiality is an important and valuable aspect of these professions and is a catalyst for the work to occur, especially at the end of the helping professions, such as with psychotherapy where the client reveals very personal information.

Although confidentiality is a very positive aspect of the work overall, it binds practitioners to not talk about the work, hence the covert nature of the work. Therapists and CIA agents share a common bond: a secret life they cannot reveal. The negative side of this is that a person in these fields is unable to share the successes, the failures, the frustrations, and the confusion of the work outside of the professional context. Therefore, the value of social support, connection, and understanding as ways to reduce work stress gets greatly compromised in these fields.

E. Hazard 12: Constant interpersonal sensitivity and one-way caring.

Individuals in the "high touch," vs. "high tech," occupations are successful only because they can do "high touch"-relate to others via expert people skills. Yet this work takes effort; the practitioner must concentrate, be involved, and work at it until depletion-not total depletion but relative depletion.

Interpersonal sensitivity demands that the practitioner understand the complexity of human relationships, including concepts such as projection and transference, which describe the feelings another projects-like in a movie-onto the practitioner.

F. Hazard 13: Transference-countertransference data.

The psychoanalytic-psychodynamic tradition has been most useful in illuminating transference-countertransference concepts (Corsini & Wedding, 1989). Maintaining a clear awareness of transference/ countertransference issues is not always easy for

helpers, teachers, and healers trying to establish positive human relationships with individuals they attempt to assist. Mitchell and Anderson (1983) describe the stress of the transference reaction in the professional lives of an allied helping field, the clergy. They write:

"At the best of times, people project on their pastor their fears of judgement, their anger at God, and many other feelings. In moments of severe stress, the tendency to misperceive the pastor is even stronger" (p. 118).

With countertransference, which is our own distorted reactions to the other (Sexton & Whiston, 1994), we must work to understand the wide array of perceptual filters we bring to the helping relationship-our own personal history; our own major demographic variables; our own family of origin genogram and its biases; our own trauma and pain; and our own cultural encapsulation with geographic and national boundaries. Understanding all of these perceptual filters and their impact on our reaction to the other is hard, hard work.

Thus, although transference and countertransference provide rich data for the helper of others, making use of this data means swimming against the current. The temptation is always to turn around and go with the current, with the lay reaction of just being human. This is both a primary stressor and hard work.

G. Hazard 14: Elusive measure of success.

In complex, ambiguous caring for others, it is difficult to gauge success. If the professional impulse is to help, teach, or heal, then success must relate to the amount of helping, teaching, or healing. Or does it relate more to the amount of improvement by the client, student, or patient? Or is it some combination of these qualities-effort by the practitioner multiplied times improvement by the recipient? Then is it the effort or the quality? Is it improvement by the recipient compared to self or to the general population? If the person in need is significantly impaired, do we expect less? If he or she is highly functional, do we expect more? For example, should the doctor of terminally ill cancer patient judge success or failure by whether the patient stays alive? If not this criteria, what? Professional stress comes in part from the elusiveness of concrete results and the difficulty in measuring success. In the ambiguous and murky world of helping and teaching, who is responsible for improvement?

Perhaps success is related not to results but rather to skilled effort. In other words, the counselor of an acting out, angry adolescent can measure success by how much an adolescent client becomes more cooperative, social, and achieving, or the counselor can measure success by how much he or she practices professional skills to a maximum level.

Even if we decide that "realism" rather than "idealism" should be a goal, how do

we move in that direction? This question often emerges for practitioners from the older dilemma of realizing that one's professional efforts are not enough. This realization usually occurs through a "series of professional humiliations" which occur when one's best efforts produced only failure (Skovholt & Ronnestad, 1995).

H. Hazard 15: Normative failure.

One of the most distressing part of being a practitioner in helping, teaching, and healing is searching for concrete standards of success versus failure. The personal threat is often severe, and one's career search and occupational identity are at stake. Also, there is often a sense of ambiguous but pervasive anxiety related to this question. One element of this dis-ease is the need to differentiate normative failure from excessive failure. Resolving this question is very important for the novice practitioner, and increased experience often brings more clarity to the distinction.

A second element here regards the term Normative Failure. It is a startling term. Helpers most often enter the helping professions, teaching, and the healing arts with an intense desire to make a significant impact in the lives of others-to heal, educate, reduce hurt, stop pain, increase competence, provide insights. Accompanying this desire, there is often an only partially understood sense of using powerful method of change, a feeling of one's own potence in helping others make positive changes. Related to this, there can also be an urgent attempt to rescue the other.

We may know at one level that the patient of expert doctors sometimes die, but this profound understanding of the reality of professional success and failure doesn't penetrate our own professional self-concept. Somehow, we believe we will succeed in our own healing of others, and our clients will change and get better. With further experience and a clearer reality, the practitioner must realize that he/she is like the doctor whose patient die. All our will, all our work, all our competence will sometimes not be enough. This means that, in time, the practitioner must develop the capacity to accept lack of success-Normative-Failure-as a component of the work.

I. Hazard 16: Regulation oversight and control by external-often unknown-others.

The layer of administration between the practitioner and the client/student/patient in human services, education, and health care has a positive goal-to reduce excessive costs and increase quality of care. However, from the practitioner's point of view, the main result is often increased stress: less control but increased responsibility by the practitioner, more detailed paperwork without pay for the additional work, contradictory messages to increase and decrease services at the

same time.

J. Hazard 17: Legal and ethical fears.

It is important to start by noting that legal and ethical complaints have been nurtured by illegal and unethical behavior of practitioners in the helping, teaching, and healing fields. Misuse of power to meet one's own needs, general incompetence, and other unethical behavior are not to be tolerated. But here we are talking about the wider arena of potential legal and ethical complaints and instances where the practitioner is wrongly accused.

K. Hazard 18: Vicarious traumatization.

Vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Maclan, 1995) and secondary trauma (Cerney, 1985) describe how we hear about, visualize, and experience the events that bring people to helping professionals. This construct overlaps the earlier described ocean of distress emotions, but it goes beyond that to experiencing the reality of difficult events in the lives of our clients, students, and patients. Over the years of practitioner's career, many of these events and others are heard and described. Often history taking and diagnosis purposes, the therapist/counselor, nurse, or teacher must hear the details of the experience. Later in therapy/counseling, for example, the desensitization elements of the work may entail countless times of recalling the experience in order to help the client reduce the traumatic elements of it. The therapeutic process for the client, over time, produces a vicarious traumatization/secondary trauma experience for the therapist/counselor.

L. Hazard 19: Primary trauma.

The most frightening form of primary trauma for psychotherapists is direct attack by clients. In research on this topic, Guy and his colleagues (Guy, Brown, & Poelsra, 1990; 1992) discovered that 40% of the sample group of 750 predominantly full-time practitioners had been physically attacked by clients during their careers, and 49% had received serious verbal threats against their health and safety. These kinds of traumatic events led to many different concerns about safety. For example, 28% often or sometimes concerned about the verbal threats toward their physical safety, 17% were often or sometimes concerned about physical attacks on their loved ones, and 7% were often or sometimes concerned about being murdered. This in turn led to a variety of protective measures against clients. For example, this sample group frequently refused to treat certain clients (50%), discussed safety issues with loved ones (30%), installed a home security alarm system (13%), or kept a weapon at home to protect themselves against present or former clients (5%). The

study provides sobering data regarding this issue of therapist/counselor primary trauma.

Primary emotional trauma, although less threatening, occurs more often. For example, there is the angry reaction of a parent to a teacher at a parent-teacher conference, the intense affect liability of a teenage client to a youth counselor, or the hostile behavior of a patient to a nurse. This negative reaction from those we try to help can be quite stressful because it can hit the "soft side of the turtle" part of us with which we attach and negates our primary occupational need of being helpful.

III. Implications of the Hazards of Practice for Helping Professions

The intent of this article is to describe work difficulties so that practitioners will realize the hazards of people work. Sometimes practitioners have a high expectation that they will always make a positive influence on people they serve. However, it can be an unrealistic expectation because of all these hazards of practice. Then, how should practitioners deal with these hazards of practice? When practitioners cannot realize and deal with the hazards of practice successfully, they might be burn-out with all their energy used up for others. And therefore, in order to avoid burnout, practitioners must actively engage in self-care while involved in other-care. When practitioners can restore energy through self-care, they can continually invest positively in others. Balance between self-care and other-care can be suggested as a way of managing professional stresses of helping professions.

References

Boss, P., Caron, W., & Horbal, J., & Mortimer, J. (1990). Predictors of depression in caregivers of dementia patients: Boundary ambiguity and mastery. Family Process, 29, 245-254.

Boss, P., Caron, W., & Horbal, J. (1988). Alzheimer's disease and ambiguous loss. In C. Chilman, E. Nunally, & F. Cox (Eds.), Chronic illness and disability: Families in trouble series, Vol. II. Beverly Hills, CA: Sage Publications.

Cerney, M. S. (1985). Traumatized by traumatized: The experience of secondary trauma. In C. Figley (Ed.), Trauma and its wake. New York: Brunner/Mazel.

Corsini, R. J., & Wedding, D. (1989). Current psychotherapies. Itaska, IL: F. E. Peacock.

D'Zurilla, T. J., & Nezu, A. (1982). Social problem solving in adults. In P. C. Kendall (Ed.), Advances in cognitive-behavioral research and therapy, Vol. 1

Frank, J. D. (1974). Psychotherapy: The restoration of morale. American Journal of Psychiatry, 131, 271-274.

Freudenberger, H. (1974). Staff burnout. Journal of Social Work, 30, 159-165.

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principle. American Psychologist, 35, 991-999.

Guy, J., Brown, K., & Poestra, P. (1990). Who gets attacked? A national survey of patient violence directed at psychologists in clinical practice. Professional Psychology: Research and Practice, 21, 493-495.

Guy, J., Brown, K., & Poelstra, P. (1992). Safety concerns and protective measures used by psychotherapists. Professional Psychology: Research and Practice, 23, 421-423.

Hage, S. (1994). Reaction to the practitioner of data base. Unpublished paper, University of Minnesota, Minneapolis.

Hagstrom, S., Skovholt, T. M., & Rivers, D. (1997). Portraits of academic advising by chronically undecided undergraduates. NACADA Journal.

Maslach, C. (1982). Burnout: The cost caring. Englewood Cliffs, NJ: Prentice-Hall.

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

Mitchell, K. R., & Anderson, H. (1983). All our losses, all our griefs: Resources for pastoral care. Louisville, KY: Westminster, John Knox.

Pearlman, L. A., & Maclan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Professional Psychology: Research and Practice, 26, 558-565.

Prochaska, K. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behavior. American Psychologist, 47(9), 1102-1114.

Schelske, M. T., & Romano, J. L. (1994). Coping skills and classroom management training for student teachers. The Teacher Educator, 29, 21-33.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. The Counseling Psychologist, 22(1), 6-78.

Schoefield, W. (1974). Psychotherapy: The purchase of friendship. Englewood Cliffs, NJ: Prentice-Hall.

Skovholt, T. M. & Ronnestad, M. H. (1995). The evolving professional self: Stages and themes in therapist and counselor development. New York: John Wiley and Sons.

Stamm, B. H. (1995). Preface. In B. H. Stamm (Ed.), Secondary traumatic stress (pp. ix-xii). Lutherville, MD: Sidran Press.