

PROFESSIONAL RISKS OF VOLUNTEER PSYCHOLOGISTS / PSYCHOTHERAPISTS WORKING WITH TRAUMA PATIENTS

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Abstract

In conditions of today's Ukraine, even experienced psychotherapists note quite serious and exhausting overload in their professional activities. The study of adverse conditions experienced by professionals has been based on the classification by B. H. Stamm, according to which the professional quality of life of a psychologist / psychotherapist is made up of the satisfaction from empathy and compassion fatigue. Compassion fatigue includes the secondary traumatic stress and emotional burnout. The development of negative conditions associated with compassion fatigue is recognized as a major professional risk of the professionals working with the traumatized. There are general emotional, cognitive and behavioral indicators of compassion fatigue that are considered universal for professionals working with different age groups and categories of clients. On the basis of Western and our own research findings, we identified the stressors that significantly increase the risks of development of various symptoms of compassion fatigue. Diagnosis of conditions associated with compassion fatigue (secondary traumatic stress, emotional burnout symptoms) can be done via the assessment of professional quality of life using the appropriate questionnaire and other special instruments described in the article. Recent studies show that understanding of the negative psychological consequences of working with traumatized clients increases psychologists / psychotherapists' awareness of their emotional states, whereas psychologists / psychotherapists' continuing education and retraining as well supervisory group visits are reliable compassion fatigue prevention measures.

Keywords: negative emotional states, professional risk, compassion fatigue, secondary traumatic stress, burnout, diagnostic method, stress factors, prevention.

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1. Introduction

Professional activities of psychologists / psychotherapists and other “helping” professionals involve risks due to the nature of contacts with traumatized clients. These risks increase significantly in times of societal crises when the number of victims in need of psychological help significantly increases and an intensive and free of charge psychological assistance is provided on a large scale. In modern conditions, even experienced psychologists / psychotherapists who have seen a lot of human sufferings and losses, note quite serious and exhausting overload in their daily work. Poor attention to the risks in the psychologists / therapists' work with victims can lead to psychologists / therapists' developing negative emotional conditions. The development of indirect traumatization conditions is regarded the main risk for the professionals working with traumatized people.

Therefore, it is important to study the emotional states of psychologists / psychotherapists especially of those who have been working as volunteers for several years in a row in order to create effective negative emotional conditions prevention and psychosocial support programs.

2. Results of the theoretical analysis of the problem

The problem of negative emotional reactions and conditions manifested by psychologists / psychotherapists and their possible consequences has been widely covered in Western publications. There is a lot of research on this problem in the countries that have experienced crises and traumatic events in their recent history (e.g., Georgia, Croatia, Israel, United States). According to J. Herman, negative emotional reactions occur in 70 % of psychotherapists due to victims' descrip-

tions of tortures and sufferings [1]. The experience of Croatian therapists (during the breakup of Yugoslavia) showed that due to the fact that psychotherapeutic work took place in conditions of total war and danger as well as during the post-war restoration, the psychotherapists and their clients were equally traumatized. Research by D. Meichenbaum-indicates that 50 % of professionals who work with trauma patients report feeling distressed; 30 % of trauma psychotherapists report experiencing "extreme distress". Such distress is exacerbated by the fact that some 30 % of psychotherapists have experienced trauma during their own childhood [2].

As it is noted by a group of American scientists (Laura Ting et al.), research on the effects of secondary traumatic stress has been growing. Past research has shown that secondary traumatic stress or compassion fatigue appears to be prevalent among mental health professionals [3]. Specific estimates of trauma therapists experiencing post-traumatic symptoms are currently unknown; however, in the general population, the prevalence of post-traumatic stress disorder (PTSD) has been reported to be as high as 30 % or more in observers and rescuers after serious accidents and disasters [3, 4]. E. Gentry, A. Baranowsky and C. Dunning note that all professional caregivers will at some point in their professional lives be forced to confront secondary traumatic stress and burnout [5]. Working with traumatized clients indisputably has negative effects upon the mental health professionals, including social workers.

The objective of the article is the theoretical and methodological analysis of negative emotional states experienced by psychologists and psychotherapists who work with different categories of victims of crises and / or traumatic events in Ukraine.

3. Results and discussion

The relevant literature has a lot of classifications of adverse conditions experienced by helping professionals in their work with trauma clients. In our study, we rely on the classification suggested by American trauma-therapists (B.H. Stamm [6]) who consider the professional quality of life as a reference point (Fig. 1). It should be noted that the model is based on the idea that the ability for empathy, being the psychologists' main work tool, has both positive and negative aspects. We speak of the positive aspect when the individuals' responsiveness leads to active actions to help people, and we speak of the negative aspect when too sensitive individuals develop the so-called empathic stress reactions [6].

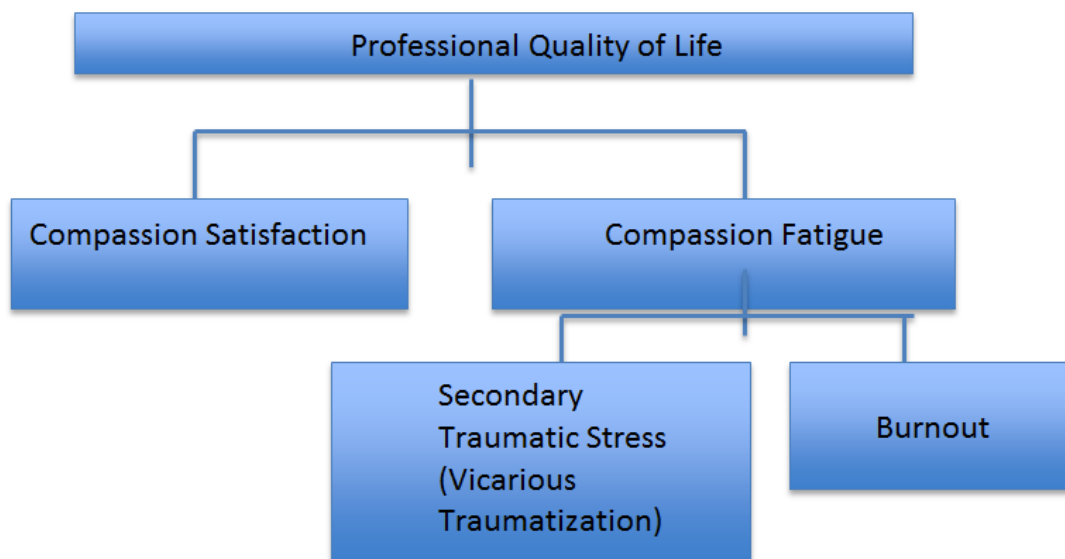


Fig. 1. Emotional reactions model – the elements of professional quality of life of caregiving professionals (B.H. Stamm, 2009)

Now let's consider the basic concepts illustrating them with the examples from work of specialists in the Ukrainian realities.

Professional quality of life is the integral conception which fully reflects the level and de-

gree of social and spiritual development of an individual through their activities and which makes it possible to examine their health condition [7].

Compassion Satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues and the conviction that one's work makes a meaningful contribution to clients and society. When the tragic events in Ukraine began, many psychologists and psychotherapists joined the active work with all groups of victims. According to those who have worked with traumatized children, the most important positive changes in their professional lives included: return to the profession of children's psychotherapist / psychologist (many of the respondents stayed out of this profession for some time); acquisition of a new specialty (e.g. trauma therapist); development of new work skills, improvement of trauma-work skills (through the participations in trauma-work seminars); joining the associations of children's trauma therapists, creation of psychological and rehabilitation centers; experience and achievements sharing (through the participations in various professional events in Ukraine and abroad, writing practical recommendations, etc.).

Compassion Fatigue is the term that most often denotes the whole range of negative emotional reactions of trauma professionals to their indirect involvement in traumatic experiences of their clients. It should be noted that compassion fatigue is one of the terms that are widely used in the literature and often replaced by a number of synonyms (existential suffering, fatal availability, indirect trauma, secondary victimization, soul pain, vicarious trauma, wounded healer ext.) although poorly defined (e.g. many experts believe this term identical to the secondary traumatic stress and vicarious trauma [8–10]). Thus, according to S. Figley, compassion fatigue develops as a result of psychotherapists' empathy towards the traumatized clients in addition to their own traumatic experiences [8].

The first results of our research suggest that Ukrainian psychologists / psychotherapists who work with different categories of crisis victims generally note the following signs of compassion fatigue: the fear of victims (e.g., children who lost their parents, hid in bomb shelters, etc.; prisoners of war, both military and civilian, who were subjected to tortures, etc.); emotional numbness; depressive episodes; disgust and anger; psychosomatic symptoms (headaches, digestive problems, loss of appetite, impaired sleep, etc.); desire to accuse the parents of children clients, playing the role of the 'savior' or 'best mother' for the victims; self- or work depreciation; difficulties in switching from working with the traumatized to work with other clients; changes in relationships with their own children and / or other family members (desire to care for them, communicate with them, refrain from excesses, asceticism in everyday life, etc.).

Secondary Traumatic Stress (STS), being a component of compassion fatigue, develops when psychologists / psychotherapists indirectly (second-handedly) re-experience the trauma suffered by clients.

Secondary traumatic stress (STS) can exacerbate the negative reactions of counter-transference, lead to the use of coping strategies of avoidance or excessive identification with the client or their parents (in case of children) [3]. As S. Figley noted, STS manifestations could be amplified by raw traumatic experience of psychologists / therapists [8, 9]. The symptoms of STS, which usually occur suddenly and are associated with a specific event, can include anxiety, sleep problems, negative flashbacks and / or avoidance of things that remind of the traumatic events [3, 6].

A striking example of the STS manifestation is the story of a volunteer psychologist who from the first days joined the work with children refugees. A child psychotherapist (the psychotherapist is a mother of two children) was addressed by a family of Donbass refugees due to emotional problems in their son. The six-year-old boy spent five days in the basement with total strangers sheltering from bombardments. After the attacks stopped and the boy was found by his parents, the family decided to move to a safer place. Immediately after these events, the boy developed severe symptoms of partial mutism (he stopped talking only occasionally speaking to his mother), which led his parents to seek help. The psychotherapist works with the child three times a week for free (voluntarily). Despite the fact that the boy does not speak out his feelings and fears and does not tell his story, he plays it all in the sand and pictures. As the therapist recalls, almost from the first meeting she emotionally got attached to the boy, but at the same time she began experiencing physical problems such as headaches, lack of appetite, and bad sleep. Despite the fact that the therapist works with many children refugees, it is that boy who makes her feel intense emotions (compassion, love). After the meetings, she finds it very difficult to switch over to other children clients. As the therapist notes, common themes and needs of customers began to provoke her strong resistance and irritation, increasingly making her refuse to work with children with

'normal' symptoms (class-mate relationships, children-parents problems, school problems, etc.) and putting less effort into work with traumatized children. The therapist also notes a change in relationships with her own children: she feels a strong need to communicate with them at home, hugging them and caring about them.

Among the distinctive symptoms of secondary traumatic stress, the therapist has, one can note the images related to the boy's story that visioned after the sessions with him and a constantly repeating night-dream. The therapist who had similar tragic experiences in early childhood often dreams of being a little girl. Every night this girl in utter darkness looks for someone extremely intimate, probably her mother. The girl neither cries, nor fears, but keeps looking for her until she is completely exhausted.

Vicarious traumatization is about the changes in the therapists' inner experience due to their empathic involvement in the traumatic material of clients. The relevant literature uses this term mainly for various types of indirect trauma. The focus of scientists' attention is drawn to cognitive and behavioral changes brought about by accumulated emotions from the work with trauma material, rather than to trauma symptoms [2, 7].

US scientists list a number of features of vicarious trauma which distinguish it from different conditions of secondary traumatic stress:

1) vicarious trauma is a cumulative transformation in the inner experience of the therapist as a result of his / her empathic involvement in clients' traumatic material, as opposed to secondary trauma whose symptoms are usually sudden at the onset and associated with a specific event;

2) vicarious trauma involves permanent rather than temporary stress reactions (as is the case with secondary traumatic stress) [2, 11].

Burnout is a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when the helper feels overwhelmed and unable to meet constant demands. As the stress continues, psychologists begin to lose the interest or motivation that led them to take a professional mission – help the victims [6].

According to our data, Ukrainian trauma specialists develop the feeling of energy exhaustion after about six months' work with traumatized children. Currently, we have collected a lot of evidence from specialists who started working with children from displaced families from the late March 2014. The main symptoms named by the respondents included the loss of a sense of joy, distancing from friends, avoidance of celebration parties and deliberate asceticism. Due to the fact that a lot of specialists consider their work ineffective, they start spending their money on buying goodies (candies, clothing, etc.) for children clients. Not infrequent are the stories about women therapists who spend all their money to help children from refugee families, depriving their own children of gifts, sweets and other pleasures. At the same time, they try to spend as much time with their children as possible. Some therapists who lack professional experience, after having difficult emotions (up to manifestations of depersonalization) and chronic work overload have decided to quit the profession and currently are undergoing psychological rehabilitation.

In our opinion, it is very necessary for the next treatment to distinguish compassion fatigue from burnout. Let's see the characteristics that can differentiate these two processes (**Table 1**) [12].

Table 1

Characteristics Differentiating Burnout from Compassion Fatigue [12]

Variable	Compassion Fatigue	Burnout
Etiology	<u>Relational</u> : consequences of caring for those who are suffering (i.e., inability to change course of painful scenario or trajectory)	<u>Reactional</u> : response to work or environmental stressors (i.e., staffing, workload, managerial decision making, inadequate supplies or resources)
Chronology	Sudden, acute onset	Gradual, over time
Outcomes	Continued endurance or 'giving' results in an imbalance of empathy and objectivity; may ultimately leave position	Decreased empathic responses, withdrawal; may leave position or transfer

Risk factors for Compassion Fatigue. Based on the findings of Western scientists and our own previous scientific research, we have identified the stressors that significantly increase the

risks of development of various symptoms of compassion fatigue [2, 4, 7]. Here are some of them. At risk are volunteer psychologists / psychotherapists who:

- have a large number of clients who have suffered from human cruelty;
- have a high percentage of clients (children) who are suffering from PTSD;
- use scientific methods in rendering assistance;

Have the following personal qualities:

• lack coping skills, make unreasonable demands on themselves and / or others and / or work settings;

- are stress-out (have difficulties in their personal life);
- lack professional experience;
- have unacted-out traumas;
- have low levels of subjective personal achievements, low goals achievement (therapists need to set attainable goals in each session, in each case and for each client);
- have unrealistic expectations regarding clients' recovery / restoration;
- lack of protective factors and mechanisms that contribute to the restoration of spiritual energy, including high self-esteem, creativity, desire and ability to help others, as well as the faith in and abilities for meaningful actions and activities;

- have critical cultural and value differences a child / parents of the child;
- have structural and personal deformations, work overload;

Organization-relevant characteristics:

- social and organizational isolation;
- lack of collegial support and supervision;
- lack of clinical / personal support in the workplace;
- problems with salary (usually unpaid volunteer work);
- interagency inconsistencies and legal uncertainty about the possible consequences for volunteer psychologists associated with various aspects of the work (especially if the volunteer psychologists, who work in public institutions, have no official status and assume responsibility for child psychotherapy, keeping documentation, writing out statements etc.);

- difficulties that prevent volunteer psychologists from seeking help due to confidentiality.

Preliminary research results demonstrate that volunteer psychologists who know about the risks of trauma work and their consequences and do not realize that counter-transference can be both a work tool and a cause of psycho-emotional problems, are more prone to compassion fatigue than those who are aware of their emotional states and the consequences and self-develop [7, 13].

Available instruments that measure the presence of compassion fatigue are limited in scope and appropriateness for use with psychotherapists and psychologists. Their domains fail to capture unique aspects of the caregivers' role and target only select populations (e.g., trauma). To date, the following three tools have been used most frequently to measure compassion fatigue [12]:

- The Compassion Fatigue Scale (Adams et al., 2006; Adams, Figley, & Boscarino, 2008)
- The Secondary Traumatic Stress Scale (Bride, 2007; Bride, Robinson, Yegidis, & Figley, 2004; Dominquez-Gomez & Rutledge, 2009; Ting, Jacobson, Sanders, Bride, & Harrington, 2005)
- The Professional Quality of Life Scale (Stamm, 2009; Stamm, 2002)
- To diagnose the extent and characteristics of emotional burnout in volunteers, we have used the V. Boyko questionnaire [14].

The investigations done by western scientists have shown that psychologists / psychotherapists' understanding of the negative psychological consequences of working with the traumatized clients increase their awareness of emotional states, while psychologists / psychotherapists' continuing training and refresher training, as well as supervisory group visits are good measures to prevent their development of conditions associated with compassion fatigue [11].

Latest western studies show that the most effective compassion fatigue preventing technique are the triad made up of self-awareness – continuous professional development – supervision [5]. Using specially organized procedures, volunteer psychologists / therapists who work with victims should periodically examine themselves, raising awareness of their feelings and experiences, use different strategies to safeguard themselves against various conditions associated with compassion fatigue, improve their own psychological resistance to the aftereffects of trauma work. It is also noteworthy that, as latest research shows, a comprehensive approach to the prevention of conditions associated with compassion fatigue (secondary traumatic stress, burnout) among spe-

cialists who work with traumatized children, should be based on individual, organizational and supervisory policies [11].

4. Conclusion

The professions of psychologist or psychotherapist, as well as other helping professions, have a broad range of professional risks associated with the professionals' main work tool – the ability for empathy. Neglect of these risks may lead to the professionals' developing negative emotional states. Based on Western and our own research findings, we described the emotional states experienced by psychologists / psychotherapists as well as identified the stressors that cause their compassion fatigue. Our follow-up research may focus on the development of the theoretical and methodological model of work with the negative emotional states of the psychologists / psychotherapists who work with trauma patients, as well as on the negative emotional states diagnosis and the creation of relevant preventive and mental hygiene techniques.

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