

Managing Vicarious Trauma and Compassion Fatigue

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I used to believe the world was basically fair and that people were basically good. Now I think fate is fickle and I don't trust anyone.

—Saakvitne & Pearlman, *Transforming the Pain*

The practice of counseling is an intense, personal relationship, and it is often emotional.

Successful counseling demands that mental health professionals be empathically engaged in the pain of the person they are helping. Despite mental health professionals being trained to maintain a certain degree of professional distance, this typically refers to the personal and professional boundaries necessary for ethical practice. Maintaining “professional distance” does not insulate the practitioner from the effects of intense emotional content. As a result, practitioners can be affected by exposure to the powerful and at times trauma-based experiences of their clients, which at times result in vicarious trauma or compassion fatigue.

While exposure to traumatic material can affect mental health practitioners across therapeutic modalities and theories, play therapists especially have greater exposure to traumatic material. Rather than listening to recollections of traumatic events as in traditional talk therapy, play therapists witness traumatic experiences unfold through the play of the child. Witnessing traumatic events through play, or experiencing the traumatic event through the eyes of the child, may increase the susceptibility of the play therapists to experiencing vicarious trauma or compassion fatigue.

Defining Vicarious Trauma and Compassion Fatigue

Vicarious trauma and compassion fatigue are unique phenomena, though they are terms that are often used interchangeably. Vicarious trauma is defined as “a transformation of the helper’s inner experience, resulting from empathic engagement with clients’ trauma material” (Saakvitne & Pearlman, 1996, p. 40). When therapists experience vicarious traumas, their inner experiences and their views of the world are affected. Though one client story can elicit traumatic responses in a therapist, repeated exposure to traumatic material across time and across clients can lead to vicarious traumatization. Compassion fatigue is defined by the specific behaviors and emotions exhibited by therapists in response to a client’s traumatic content. Specifically, compassion fatigue consists of the manifestation of post-traumatic stress disorder (PTSD) symptoms in the therapist. The primary difference between PTSD and compassion fatigue is the experience of the traumatic event. The therapist experiences the event second hand (listening to or witnessing the experience, as in play therapy) rather than directly. Unlike vicarious trauma, compassion fatigue can occur from work with a single client (Figley, 1995). While a complete discussion of both compassion fatigue and vicarious trauma are outside the focus of this article, it is important to understand the distinction between the two. A more detailed description of vicarious trauma is the focus of the remainder of this article.

Constructivist Self-Development Theory

The concept of vicarious traumatization is based on the constructivist self-development theory (CSDT) (Saakvitne & Pearlman, 1996). Understanding the concept of CSDT can assist the practitioner in identifying the experience and manifestation of vicarious trauma. CSDT describes how exposure to traumatic material affects the self; in this case, the self of the therapist. CSDT asserts that individuals construct their realities based on their perceptions and schemas

(Trippany, White Kress, & Wilcoxon, 2004). In this context, therapists cope with traumatic material based on their current circumstances and their early experiences (Saakvitne & Pearlman, 1996); specifically, their interpersonal, intrapsychic, familial, cultural, and social experiences. Through the CSDT lens, symptoms resulting from traumatic events are seen as adaptations to the events. When individuals are exposed to events that do not fit within their current perceptions of reality, irrational or distorted beliefs protect the individuals and their meaning system from the harm caused by the trauma. From the perspective of this theory, vicarious traumatic responses are adaptive responses to hearing clients describe their traumatic experiences. For example, a therapist who works with rape victims may begin to see the world as an unsafe place. By maintaining this assumption, the therapist can engage in behaviors and feelings consistent with an unsafe world in an attempt to protect herself from harm.

CDST also asserts that the changes in the therapist's belief system and cognitive schemas, while adaptive, are both pervasive and cumulative (Trippany et al., 2004). Changes are pervasive in that they have the potential to touch nearly every aspect of a therapist's life, and cumulative in that each encounter with a traumatized client reinforces beliefs and schemas. According to this theory, there are five components of self, each of which can be potentially affected by exposure to traumatic material. The five components are frame of reference; self-capacities; ego resources; psychological needs and cognitive schemas; and memory and perception (Saakvitne & Pearlman, 1996).

An individual's frame of reference includes his/her sense of identity and his/her views of self, the world, and relationships. Self-capacities refer to an individual's ability to manage strong emotions and feel worthy of loving and being loved. A person possessing ego resources has the capacity for empathy and self-awareness. The person with ego resources has good interpersonal

skills and maintains good personal boundaries. Psychological needs and cognitive schemas are an individual's personal needs for safety, esteem, trust, control, and intimacy. The cognitive schemas around these needs are reflected in an individual's belief about self and others. Finally, memory and perception are often affected by a traumatic event. Memories can become fragmented and disjointed, or recalled without emotion. It is within these components of CDST that vicarious traumatic reactions occur.

Symptoms of Vicarious Trauma

While the symptoms of vicarious trauma can differ according to the individual's life experiences and perceptions about the traumatic event, there are several common signs and symptoms of vicarious trauma that often occur in the mental health practitioner. The dimensions of symptoms are across emotion, cognitive, physical, and behavioral realms (Morrisette, 2004; Saakvitne & Pearlman, 1996). Mental health practitioners who are experiencing the emotional symptoms of vicarious trauma often feel overwhelmed, anxious, unable to experience pleasure, emotional numbness, despair, resentment, and emotional exhaustion, and are flooded by personal reminders of their own trauma. Based on the cognitive domain, they may think they are unworthy of love or that they are currently unloved. They may question the right to be alive and happy while experiencing self-loathing. This could affect their ability to make decisions or trust others. Finally, they are often cynical about people and about the world, and experience intrusive imagery. Other types of imagery experienced by those with vicarious traumatization are visual, auditory, sensory, and olfactory. Overall, they feel unsafe and therefore withdraw socially and from those they love. They may demonstrate moments of intense rage, crying, and intolerance,

and they may have nightmares. It is common that they will avoid looking at the traumatic event itself.

Though largely theoretical and anecdotal, it is clear that through deep empathic engagement, practitioners are at risk of experiencing vicarious traumatization. CSDT guides us in understanding how traumatic material is processed in an effort to make meaning of material that challenges one's belief of the world and of others in the world. While there is no way of knowing just how prevalent vicarious trauma is, all mental health practitioners are at risk. Therefore, identification and intervention are essential steps. Because mental health practitioners rely on their own mental well-being as the instrument of their craft, the deleterious effects of vicarious trauma can severely influence the work they do with clients. Skovholt (2001) conceptualizes the process through which practitioners progress with clients to provide an understanding of why mental health professionals are vulnerable to vicarious trauma.

The Cost of Caring

Skovholt (2001) writes about the caring cycle; this is the cycle in which practitioners engage with their clients to facilitate healing. The three elements of this cycle are empathic attachment, active involvement, and felt separation. "In many ways, in counseling, therapy, teaching, and healing, we constantly must first feel for the other, be involved, then separate—being able to feel for, be involved with, and then separate from person after person in a highly effective, competent, useful way" (Skovholt, 2001, p. 13). This process is the essence of the helping process, and it requires that the practitioner be skilled in each phase of the process.

Empathic attachment, as it implies, is the connection practitioners have with their clients.

Attachment between the therapist and the client often occurs during the most vulnerable time, and with the most vulnerable aspects of a client's life. It requires emotional involvement, which is often the sole responsibility of the practitioner given the emotional state of the client and the many mechanisms the client has developed to protect himself/herself. Skovholt (2001) writes that "practitioners spend hours trying to learn the attachment skills of attending, intense listening, emotional sensitivity, and nonverbal understanding" (p. 16). The skills of empathic attachment require that the practitioner attempt to fully understand the life of the client by feeling the client's feelings. Empathic attachment is the first stage of the caring cycle and is necessary for the process to be effective. This process can be particularly intense for play therapists who attach themselves to a vulnerable population for whom attachment issues are common.

The second phase in the caring cycle involves active involvement. Skovholt (2001) likens this phase to the initial attachment phase of parenting that follows the birth of the baby. This phase can be a long one, and it draws on the practitioner's expertise to help the client do the work that will assist his/her healing. During this phase the benefits of successful attachment are seen. The length of this phase depends on many factors, including the presenting problems, the limits of managed health care and insurance, and the readiness of the client. Despite the variability in the length of this phase, it does involve some level of post-attachment involvement and caring. It is important to note that while a long active involvement phase may increase the challenges of separation, the length of this involvement does not correlate with increased *or* decreased risk of vicarious trauma. A single session during which attachment and involvement occur and traumatic material is presented can influence the therapist significantly. As mentioned previously, vicarious trauma results from ongoing exposure to traumatic material.

The final phase of the caring cycle is the separation phase. “We know almost nothing about professional separations,” according to Skovholt (2001, p. 21). However, a therapist knows the effects of a client terminating without explanation, a client terminating at the end of his/her work, and the termination of many clients when a change occurs in the therapist’s life. Skovholt (2001) asserts that the ability to separate well may be a necessary element in maintaining professional vitality. This phase in the cycle is often not attended to in the manner necessary to prevent potentially deleterious effects. Successfully maneuvering this phase in the process can prevent the practitioner from attaching again. Regardless of the process a practitioner applies, it is essential that the practitioner is intentional about how he/she manages the separation phase.

The caring cycle refers to the process of caring across helping professions and does not suggest that those who are engaged in this cycle will develop vicarious trauma. However, it does show how caring deeply, while hearing the intense material of those having experienced a traumatic event, can shape the practitioner’s experience of the helping process. It also demonstrates how important it is for practitioners, if they are struggling with vicarious trauma, to assess whether they are negotiating each phase appropriately and, if not, to seek support, supervision, or consultation. The cycle is discussed here to emphasize the unique process of helping that can create vulnerability in practitioners who are exposed to the traumatic experiences of their clients.

Prevention and Intervention

Prevention and intervention of vicarious trauma requires intentional and comprehensive efforts. While not every practitioner who works with traumatized clients will develop vicarious traumatization, all are potentially at risk. As mentioned at the beginning of this article, play

therapists may be at greater risk. Through the process of play, play therapists often witness the client's trauma when the client uses toys to re-enact the experience. Therefore, while prevention and intervention are no less important for practitioners of any modality, play therapists may wish to pay specific attention to prevention efforts.

Prevention and intervention efforts should occur across four dimensions: wellness, organizational, supervision, and education. While there are many definitions of wellness in the professional literature, it is essentially one that practitioners define for themselves. Wellness is a personal process. Dimensions of wellness include the physical, psychological, interpersonal/relational, behavioral, and spiritual. Prevention and intervention should occur at the organizational level as well. Agency dynamics can greatly influence the level of support practitioners' receive. At the agency level, it is important to consider whether the culture allows practitioners to seek support and assistance when they are struggling. If the culture punishes practitioners for expressing their struggles, the practitioners are at an increased risk of impairment. Other aspects of the organizational culture are workload, the makeup of the client caseload, training support and opportunities, and resources for self-care. The final two prevention and intervention dimensions are supervision and education. Ongoing supervision is essential to prevent vicarious trauma from occurring and for intervening once it does occur. Finally, education about vicarious trauma can make identifying it easier and timelier.

Conclusion

Vicarious trauma can affect any practitioner who works with traumatized clients. Based on the consequences this trauma can have on the self of the therapist and subsequently how this affects client care, it is essential to understand the signs and symptoms of vicarious trauma. While the

scope of this article is limited given that the information about vicarious trauma is much broader than what is covered here, it does provide a brief overview of the topic. Despite the degree of passion practitioners have for the work they do, it is important that they remain vigilant about caring for their own well-being.

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