Burnout, Secondary Trauma and Compassion Fatigue in Social Work

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Abstract. Burnout is already a chronic social problem recognized in consumer societies. Secondary trauma among social workers employed to assist the traumatized persons is less known. Therefore social workers who work directly or indirectly with trauma do not access the necessary resources to prevent or overcome secondary traumatic stress. This study aims to work out a systematic review of the recent literature and a conceptual clarification of the terms which are well-known in the field of social work and mental health that describe chronic fatigue among social workers. To this end we analyzed the relevant academic works published between 2006-2015 which were selected on the following criteria: social work, burnout, compassion fatigue, trauma. In the discussions part the study calls for the development of self-care practices and strategies to cope with burnout and secondary trauma among students at social work faculties as a beginning of an advanced training on coping with trauma and a form of professional socializing since university. This study also calls for action research to explore the immediate and lasting effects of the potential advanced training programs on development the necessary skills to cope with burnout and secondary traumatic stress.

Keywords: helping relationship, burnout, compassion fatigue (CF), secondary traumatic stress (STS)/vicarious traumatization (VT), mental hygiene

Introduction

The burnout syndrome is usually found in persons with a high degree of enthusiasm in their efforts to help others, in professions such as social, psychological, medical, psychotherapeutical, educational, legal assistance etc. The established terms in the specialized literature for the chronic fatigue syndrome in helping relationships are: burnout & compassion fatigue. Burnout in helping relationships manifests itself through: chronic physical and emotional fatigue, the depletion of the empathic resources and of compassion, boredom, cynicism, diminution of enthusiasm, temporary distress and depression symptoms which do not satisfy the criteria for the clinical pictures as they are described in the statistical manuals of mental disorders (DSM IV, ICD 10).

Knowledge about and the applicative acquire of the basic terms in the field of health and mental hygiene, psychotherapy and counseling contribute to a more accurate evaluation and

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a more efficient intervention in the practice of social work. Person-centered psychotherapy contributes in the therapeutical relationship with the concepts of empathy, unconditional acceptance and congruence. Psychoanalysis contributes with the concepts of transfer, counter transfer and defense mechanisms of the ego. Cognitive and behaviorist therapies contribute with the concepts of identification and testing of cognitive distortions, cognitive restructuring, solutions focusing and tasksfocusing, relaxation training, systematic desensitization, assertive training etc. Systemic family therapies contribute with the terms of circular hypothesis vs. linear hypothesis in order to explain roles, rules, dysfunctional interactions and vicious communication circles in family relations.

The work concepts in the area of health and mental hygiene used in the practice of social work are necessary and useful both for understanding and supporting the persons who ask the social services for help, as well as for the purpose of self-knowledge. It is of importance that the professionals involved in helping relationships know their own abilities, attitudes, limitations, as well as their own personal and professional development potential especially when they face: 1. the request to solve very fast a large amount of cases, 2. prolonged exposure to the emotional and social suffering of the beneficiaries they work with, 3. an organizational and work environment far from supportive or toxic, dominated by cynicism, criticism and excessive negative remarks, aggressive competition for access to resources. Self-knowledge contributes both to making interventions in social work efficient, as well as to the prevention or at least limitation of the burnout syndrome.

Beside raising the number of qualified social workers with university degrees and newly employed in the area of social work, Florin Lazăr suggests ensuring professional supervision, not only in the sense of administrative control, but also in the sense of adopting a set of measures to support the persons working in the system at the present moment in order to be able to offer quality services, to cope better with stress and professional burnout situations (Lazăr, 2015, 36).

Purpose, methods and results

The present study intends to present an overview of the specialized literature and a number of concept clarifications regarding the terms which describe the burnout syndrome in the helping relationship and which are established in the field of social work, mental health and hygiene.

For this purpose we have analyzed relevant academic papers published in the last 9 years, in the period between 2006-2015, in specialized magazines indexed in the database Web of Knowledge, ProQuest and Scopus, made available for the academic environment in which I work through www.anelisplus.ro. The selection criteria of the academic papers were: social work, burnout, compassion fatigue, trauma.

Out of 2,112 articles which comply to all mentioned criteria, I further selected articles based on the following criteria: whole text, scholarly-peer review, peer review and social welfare & social work. Thus, I found 212 articles relevant to social work. Among these I found 61 articles that operate only with the term burnout. After analyzing more summaries and articles with a whole text which deal with burnout in diverse professions, I noticed that focusing on burnout and MBI (Maslach Burnout Inventory) is especially preferred in work and health psychology, medicine, psychological assistance, business and education, as well as in comparative studies between different countries and professions, among which is included the social worker profession as well. The inspected comparative studies regard, without an elaborate conceptual analysis, differences that are statistically significant on the
axes: risk factors, coping strategies, consequences/symptoms: emotional fatigue, depersonalization symptoms, diminishing of professional satisfaction.

For Romania I found 2 studies which operate with the term burnout (Maslach) in which is included the social worker profession, on the axes: risk factors and solutions (Marc, Oşvat, 2013), respectively consequences, symptoms and professions: social workers, medical personnel, psychologists and educators (Runcan, 2013).

Among the articles relevant to social work I found 38 articles which operate with the terms: compassion fatigue, burnout, secondary trauma, social workers. Below I will summarize recent studies which approach these concepts and I will discuss a few terminology references, references of good practice and research and intervention directions for the future.

Theoretical references and concept clarifications

The burnout phenomenon has been studied worldwide in the last decades, however, secondary traumatic stress (STS) is a less familiar term in social work. Relatively new studies from Korea (Yoon, 2011) show that, out of the social workers who work with victims of violence, the ones who work in the area of child protection present higher scores on the scale of traumatic stress than the ones who work in the area of adult protection.

Usually stress is considered a reaction to negative experiences (distress), yet stress can also be a cause of positive experiences (eustress), for instance voluntary change of one’s home/work place, marriage, etc. Traumatic stress, a crisis situation of a traumatic type, is a form of acute stress which is the consequence of a traumatic incident or a disastrous event which disrupts some essential functions of individual or/and existing social institutions (plane crashes/car accidents, interpersonal violence, wars, terrorist attacks, floods, earthquakes etc.). According to DSM IV, the person may be exposed directly or indirectly to the traumatic incident. If the person was a witness without being directly exposed to the event or events which involved actual death, death threat or serious injury or the jeopardizing of the body integrity of his peers, then we are talking about secondary traumatization (ST). Family members who expect the verdict of the doctors in the waiting rooms of emergency units, doctors who work on ambulances, fire workers, policemen and social workers who work in emergency units are deeply affected due to indirect exposure to the traumatic event. Post-traumatic stress (PTS) represents the acute traumatic stress which persists after a traumatic stress. Only when PTS accumulates up to the level where it causes the symptoms described in DSM IV, especially a high level of daily disfunction, may the term of post-traumatic stress disorder be applied (PTSD). Although there are no statistics, according to Babette Rothschild (2013, 30), one can assume that there is a significant number of trauma survivors with PTS who are overlooked, who have not recovered from their traumas and who do not have yet the disability characteristic to PTSD (Rotschild, 2013, 30). The disturbance level characteristic to PTS is, for instance, avoidance of men/women in high positions by men who were sexually/physically abused by their fathers/mothers or by other important persons in their childhood, without the normal functioning in the rest of these men’s life being affected.

Secondary or indirect traumatization (ST), vicarious traumatization, is a term introduced by McCann and Pearlman in 1990 and developed by Pearlman and Saakvitne in 1995 (Bride, 2007, 155) to describe the deeply negative transformation of professionals in the area of cognitions and fundamental beliefs about the world when they involve themselves empathically repeatedly with clients who report traumatic experiences. Except for the fact that repeated exposure to traumatic experience is indirect and it is a consequence of the efforts to help or desire to help a person who suffers or is traumatized, according to Figley, mentioned by
Bride (2007, 156), secondary traumatic stress (STS) is almost identical with post-traumatic stress disorder (PTSD) or with the symptoms associated with PTSD. According to DSM IV, some of these symptoms are: intrusive images, persistent avoidance of stimuli/persons/activities associated with hyperexcitability, depersonalization/derealization/dissociative amnesia, faulty social and professional functioning etc. In order to describe the phenomena of secondary traumatic stress (STS), Figley introduced a friendlier term, compassion fatigue (Bride, 2007, 155).

At first sight the phenomenon of compassion fatigue (CF) is similar to the burnout syndrome. Both have in common the deep emotional and physical fatigue that social workers and other professionals can develop in helping relationships, as well as the persons who take care of other persons in their life even if their occupation is not professionalized (e.g. biological or adoptive parents, children taking care of their traumatized siblings or parents, life partners, friends etc). We are talking about a progressive fatigue of the empathy, of compassion, and hope both for others and for themselves.

Compassion fatigue was described as being the “cost of caring”; the ones who suffer from compassion fatigue start seeing deeply negative changes in their personal and professional lives: they might become distressed and very staunch at their work place; they might contribute to a toxic work environment (criticism, negative remarks); they might be predisposed to clinical errors; they might trespass the client’s limits and lose the respectful attitude towards clients; they might become irascible towards their dear ones and constantly feel guilt at the repeated requests of the loved ones with regard to private time etc. (Bride et al 2007; Stamm, 2010; Mathieu, 2012; Rothschild, 2013).

Although it has many aspects in common with the fatigue described by Maslach, compassion fatigue, declares Mathieu (2012, 8-14), is not identical with the burnout syndrome: Burnout is a term which has been largely used in order to describe the physical and emotional fatigue that professionals can go through when they have low professional satisfaction and they feel helpless and overwhelmed at their work place. Many professionals involved in helping relationships present, as well, a high degree of burnout, fatigue because they work in difficult work environments with a large amount of work, low salaries, little control of the work program, unreal requests, faulty management and inexistente or inefficient supervision, yet this can happen in any line of work. Burnout can make us more vulnerable to compassion fatigue (CF), secondary traumatic stress (STS) or secondary traumatization (ST); a non-supportive work environment can be a fertile soil for cynicism and fatigue. In spite of all this, fatigue in itself can be solved quite easily: changing the work place can offer immediate relief to someone suffering from burnout. However, this is not valid for compassion fatigue (CF), secondary traumatic stress (STS)/secondary traumatization (TS).

Mathieu (2012) states that ST is the result of more STS events, while Beth Stamm (2010) considers that compassion fatigue results from the cummulated effect of fatigue/burnout and secondary traumatic stress/secondary trauma. For more information regarding the similarities and differences between the discussed concepts we invite the readers to explore comparatively the scales burnout BMI\(^2\), compassion fatigue CF\(^3\) and the DSM IV criteria for post-traumatic stress.

**Self-care and coping strategies**

Building a solid base for the practice of social work requires the creation of a conceptual and practical frame for self-care among practitioners, supervisors, students and teachers (Lee, Miller, 2013). Most social work graduates, even though they will not work in crisis intervention
centers specialized in violence and mental health issues, will frequently meet persons who present symptoms of traumatic stress, of adaptation or behavior, addictions, symptoms of burnout and depression as a response to different traumatic life events. Apart from the theoretical knowledge and the training of the specific work skills it is important that, especially when they work with traumatized persons, students learn to take care of themselves. For this purpose it becomes necessary that they find out, in Aglias’s (2012) opinion, about the adverse reactions of fatigue and secondary traumatic stress they might be confronted with as practitioners and to prepare in due time in order to cope with them, especially if they suffered because of violence or they already dealt with symptoms of primary or secondary traumatic stress in their childhood.

Shannon and others (2014) explore the practice of self-care among social work students during advanced courses of trauma therapy. The interviewed students report that in their practice of self-care some strategies functioned more efficiently and that it was important to explore previously more strategies before choosing the most suitable ones for them as current practices.

Out of these we enumerate: physical or behavioral strategies (jogging, dancing, yoga, hiking in the mountains, diverse sports, simple relaxation exercises and deep breathing learnt during workshops); relational strategies (expressing feelings in the relations with friends, colleagues, partners, supervisors, mentors or therapists, spending time with pets, as well as doing activities together with the dear ones: cooking, eating, exercises etc.); cognitive strategies (deliberate distraction of attention: film, music, internet surfing, avoidance of trauma exposure outside of the work hours, avoidance of reading about trauma under conditions of overwork, limitation of exposure to details regarding traumatic experiences, limitation of the work time with trauma, daily prayers, work diary/marking the experience in writing as a strategy of thought processing, focusing on the clients’ strong points etc.). The difficulties in the practice of self-care reported by the interviewed students were: stressful school program, lack of time, lack of motivation and mutual support for this kind of practice, a degree of difficulty of some relaxation strategies that is too high etc. (Shannon et al., 2014, 444-445).

Due to the fact that 30% of the students, according to the studies cited by Shannon and others (2014, 450), were exposed to trauma before starting university and the effect of secondary traumatic stress is cumulative in time, it is important, as Shannon states, that the development of the self-care practices start as a form of professional socializing already at university, before they get involved in the practice of the social work profession.

Most recommended strategies of coping with the adverse reactions of fatigue and secondary traumatic stress are: training the abilities to be completely present in one’s body and the abilities of stress reduction (simple and systematic exercises of progressive relaxation, yoga, qigong, taichi etc.); empathical communication, debriefing for the verbalization and processing of the secondary traumatic stress experience and mutual social support in the intervision sessions; mentoring programs for social support offered to newcomers in social work (Mathieu, 2012; Babin et al., 2012).

The supervision of counselors who are motivated by their own experiences of primary traumatization through sexual and/or domestic violence to work with trauma is important to facilitate both the processing of the personal trauma, of the transfer and countertransfer reactions in current and professional relations, as well as the learning, growth and development process in and from the helping relation with the beneficiaries they work with (Gibbons et al., 2010; Jenkins et al., 2011). The ones who say that they learnt from the helping relation report less symptoms of fatigue and secondary traumatization (Jenkins et al., 2011).
Discussions and conclusions

Most of the explored studies agree on the risk factors, implicitly on the remedies, with regard to the burnout syndrome: large amount of work, time pressure/management, conflicting work climate, ethical/moral dilemmas, discrepancies between professional desires and the structural/organizational/legislative context etc. The burnout syndrome is already a chronic social problem recognized in consumer societies which value aggressive competition for access to resources and devalues therapeutical strategies and holistic development which focus on a healthy lifestyle, deep respect towards nature, recognizing the therapeutical potential of spiritual resources, time and quality relations in family and community life etc.

On the other hand, secondary traumatization among the social workers involved in the work of caring for others is little known, minimalized or not recognized as a social problem and thus it does not benefit from access to the necessary resources for prevention, remedy and specific and long-term professional training.

Consequently, we propose the following directions of research and intervention:

– the conceptual and predictive validation of the scales Maslach Burnout Inventory and Compassion Fatigue among social workers, especially among those who work currently with crisis and trauma situations: emergency units, domestic violence and family violence, pediatric oncology, care in terminal phase, homeless people without a temporary shelter during winter, etc.

– the training of the relaxation and meditation abilities for stress reduction, body awareness and maturization of self-consciousness in order to be completely present and authentic in interpersonal relations; of identification and testing one’s own anxious and depressive cognitions and myths; of emphatic and assertive communication between peers, peer counseling, with the purpose of mental hygiene, in order to cope and contribute to the debriefing meetings of intervision, at the moment when social workers face transfer and countertransfer reactions and they do not have the time and money necessary for post graduate psychotherapeutical education and classical supervision\(^4\). These interventions, initiated before graduation, as a form of professional socializing during free seminars, can be followed by research sequences, action research, to explore the immediate and the long-term effects of the training programs of the abilities needed in order to cope with the symptoms of fatigue, burnout and secondary traumatization.

Notes

1. These terms are discussed in university courses which focus on: the social work relationship and the specifics of communication in social work, these are studied in depth later on during the courses focused on mental health, therapies, counseling and crisis intervention.


4. The current salaries of the social workers which are very low and the sometimes very high costs of psychotherapeutical education in Romania diminish the access of the social workers to postgraduate trainings which can facilitate their personal and professional development. However, those who can cover these costs for a while are included in the vicious circle that one of the present psychotherapy schools is already facing: practicing very high tariffs and the rush after recovering the highly expensive training investments and to survive, fact which risks to finally
sabotage the very purpose and mission of psychotherapeutic assistance. Thus, the ones who are in need of social work and psychotherapeutic care risk to be excluded from or left out from the care system.

References


