

Chapter from: *Treating the lifetime health effects of childhood victimization: A guide for mental health, medical and social service professionals*. New York: Civic Research Institute, 2003

## **Clinician Self-Care When Working with Adult Survivors**

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Self-care is critical when you work with traumatized patients. The sheer needs of these patients can become overwhelming, and burnout rates are high. You might also be dealing with your own history of abuse, and working with adult survivors makes these memories more salient. There are two specific occupational hazards in working with trauma survivors: vicarious traumatization and countertransference. These are described below.

### **Vicarious Traumatization**

The phenomenon of vicarious traumatization is well-documented in children of Holocaust survivors (Levav, Kohn, & Schwartz, 1998; Yehuda, Schmeidler, Giller, Siever, & Binder-Brynes, 1998) and children of American Indians (Brave Heart & DeBruyn, 1998). These children often develop PTSD by simply hearing about the experiences of their parents.

Vicarious traumatization can also happen to clinicians who work with adult survivors. When patients recount the circumstances leading to their trauma, it's not unusual for you to experience intense emotions. You may feel guilt that you have not been through the horrific events your patients describe (Friedman, 2001). You may also feel a sense of powerlessness that you were unable to protect your patient, even when you rationally know that you could never have done that (e.g., the event took place long before you knew your patient).

While it natural to feel bad for what your patients have gone through, it gets to be a problem when you begin to have symptoms of PTSD yourself. For example, you might start experiencing intrusive thoughts, you might have nightmares about their experiences, or you might experience emotional numbing. All of these experiences can cloud your professional judgment to such an extent that you try to "rescue" your patients, or you try to avoid the patients' references to their traumas. This can lead to severe personal distress (DeAngelis, 2002; Friedman, 2001).

Vicarious traumatization appears to be relatively common among those who work with abuse survivors. In a national study of 1,000 women psychotherapists, those with the highest levels of exposure to sexual abuse material had the highest levels of trauma symptoms. However, spirituality offered some protection. When the subjects had a spiritual life, they seemed to do well even when exposed to abuse histories of their

patients. The clinicians that saw the highest numbers of abuse survivors, also reported the highest levels of spiritual well-being (Brady, Guy, Poelstra, & Brokaw, 1999).

### **Countertransference**

Countertransference is a psychoanalytic term that has relevance to trauma work. It happens when a patient's story triggers memories of abuse in the clinician. Vicarious traumatization can occur in the absence of previous trauma, whereas countertransference draws upon a clinician's traumatic past. Countertransference is more likely to occur when patients reveal histories that are similar to the clinician's own story (Friedman, 2001).

Abuse histories are fairly common in both mental health and medical providers, and are often found in those who work with either victims or perpetrators of abuse. For example, in a survey of 645 professionals who conduct sexual abuse evaluations, 17% reported a history of sexual abuse, and 7% reported a history of physical abuse (Nuttal & Jackson, 1994).

In another study of 501 clinicians, Little and Hamby (1996) found that 32% reported a history of child sexual abuse. Therapists who had been sexually abused reported more difficulties with countertransference and boundary issues. However, gender differences were a stronger source of variance than past abuse. Female clinicians were more likely to report that sexual abuse was more difficult to treat, that they screened regularly for sexual abuse in their patients, and that they used more coping strategies in their work than male clinicians.

In a sample of 150 clinicians working with sex offenders, 37% of females and 27% of males had a history of child sexual abuse (Hilton, Jennings, Drugge, & Stephens, 1995). Interestingly, those clinicians with a history of sexual abuse reported that it had either no impact on their work, or that its effects were positive. The authors offered one possible explanation for their finding: the overall abuse experiences of most of their subjects were relatively mild.

Finally, a study of 323 nurses revealed that 13% had a history of child sexual abuse. In comparing the work of abused and non-abused nurses, there were no significant differences between the two groups on whether they thought patients should be screened for past abuse (most thought nurses should screen), and whether they thought patients would be upset if they asked about the patients about past abuse (slightly over half thought that these questions would upset patients). Past history did seem to influence the nurses' level of comfort in talking about abuse with patients. Twenty-three percent of the abused nurses and 34% of the non-abused nurses felt "extremely comfortable" listening to patients' stories of abuse. On the other end, 9.5% of abused nurses and 3.6% of non-abused nurses reported that they would be "extremely uncomfortable" talking to patients about abuse. For the nurses who were moderately comfortable, there were no differences between the abused and non-abused groups. The nurses who thought that all patients should be screened offered the following caveats: the

nurse needs to be skilled in knowing how to ask, and they must have the resources in place to respond to any needs that should arise (Gallop, McKeever, Toner, Lancee, & Lueck, 1995).

### **Some Warning Signs of Possible Burnout**

Some signs that may indicate that you are overinvolved with others include fatigue, resentment, strained relationships with others, irritability, feeling coerced or obligated to help, or feeling self-important (i.e., that you're the *only* one who can help with this problem, this patient, or this type of patient).

### **Pay Attention to Your Beliefs about Helping**

The research of Helgeson and Fritz (1998), which I described in Chapter 6, has relevance to professional burnout. Of particular interest, is the construct of unmitigated communion (UC). People with this interpersonal style tend not to have reciprocal relationships, and are too involved in the needs of others. Now in many caretaking situations, it is appropriate for you to be the one giving. However, it is concerning when *all* of your relationships are this way. If you are the one at work, in your family, and in your circle of friends that takes care of everyone's needs, you may be at risk for burning out. Here are some beliefs that might be problematic for you. These are the characteristics of the unmitigated-communion style.

- **Attachments.** If you have a hard time connecting with others, you fear abandonment, and don't feel sure that people love you.
- **Relationships.** If you have a negative view of yourself or others, feel that others perceive you negatively, or don't enjoy helping people, but feel coerced into it.
- **Social Support.** If you lack of genuine support, are always the one to give support and never receive it, or you like the sense of control you have by being the "support provider."
- **Motivations for Helping.** If you are motivated to help others so that people will think well of you rather than because you have a genuine concern for the wellbeing of others.

While most practitioners experience these thoughts from time to time, they become problematic when they are the predominant beliefs. You may not even be aware that you are thinking this way, but it can be damaging nonetheless both in your professional and personal lives. Adult survivors may be especially prone to these beliefs. But once you recognize them, they can be addressed.

## **Professional Self-Care**

Given the inherent difficulties in working with abuse survivors, taking care of yourself is absolutely essential. Without self-care, you, your patients, and your family all suffer. Vicarious traumatization and countertransference can impair both your professional judgment and your personal mental health. Friedman (2001) describes how clinicians may find themselves trapped in a vicious cycle of increasing symptoms, and increasing ineffectiveness with clients, which leads them to plunge themselves into their work further. Some specific suggestions for breaking this cycle are described below.

### **Recognize the Occupational Hazards**

The first step to breaking the vicious cycle is to recognize that there are unique hazards associated with working with adult survivors and other traumatized patients. This may also involve recognizing your own vulnerability, and acknowledging, perhaps for the first time, your own history of childhood abuse. This history can eventually make you more effective in your work. But it also brings with it an increased vulnerability.

### **Take Steps to Counter Vicarious Traumatization and Countertransference**

Once you recognize your vulnerability, the next step is to take specific steps to counter it. Here are some specific ideas to help (DeAngelis, 2002; Friedman, 2001).

**Don't Go It Alone.** Clinical work is often a solitary activity, even when you share office space with others. Acknowledge that some patients require the care of more than one clinician. This can include having regular supervision if you are in training. Peer support is also important as you work with challenging patients. And a team approach also works well in this regard. Make relationships with family and friends a priority, and nurture these relationships. And if a patient's story is stirring up some memories in you, don't be afraid to seek counseling yourself.

**Limit Your Involvement.** An important type of self-care is learning not to carry your patients' concerns once you leave the office. Keep firm boundaries between your work and home life. For example, you may resolve to leave your brief case in your office, or to not think about clients once you are on your way home. This way you can continue to be connected and caring in the office, while minimizing the emotional toll of this type of caring. Another strategy is to limit the number of trauma cases that you see. Try to balance out your caseload with less severely affected patients.

**Take Care of Your Body.** This final strategy applies to anyone doing stressful work, but it is especially important for you—take care of your body. This means getting enough sleep, eating nutritious foods, exercising, connecting with others, and maintaining a spiritual life. Taking care of your body might mean taking a walk in the middle of the day, getting a massage, or making a date with a friend. If you want your patients to live balanced lives, you are going to have to model that for them.

## Summary

There are some unique aspects to working with traumatized patients that make it easy to get overwhelmed. It is important that you don't isolate yourself that you connect with others, and make time for activities away from work. If you are going to be available to your patients, you must take time to refresh, refuel, and restore your balance. In this way, you can continue to be a healthy helper.

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