Occupational Hazards

An informational & applied worksheet on mental health professionals' work-related stress experiences

Burnout

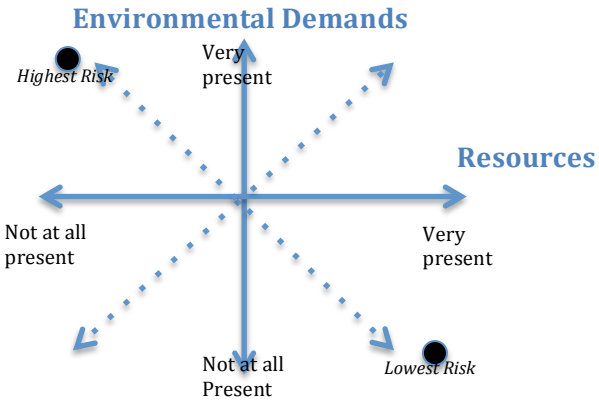
Burnout is an insidious process over time that largely stems from a person-environment mismatch of externally-imposed demands that tend to overwhelm one's resources and resilience factors. Classic/common symptoms of burnout include:

_____ (0-10) Emotional exhaustion (i.e., feeling increasing or chronic emotional overwhelm, exhaustion, fatigue, and self-declared "burn out")

_____ (0-10) Depersonalization (i.e., feeling increased sense of interpersonal detachment and callousness since working at your job)

_____ (0-10) Incompetence (i.e., feelings of professional inadequacy to do the job you are supposed to do)

Action Step: *Write in a number above (0-none <--> 10-extreme) for the degree of presence of each of those symptom clusters in your life right now.*



On the (left) diagram, mark an "E" on the vertical axis for the degree of workplace demands you have little control over (e.g., low pay, long hours, high productivity requirements, unending paperwork, long commute, etc).

Then mark an "R" on the horizontal axis for the degree of resources (healthy coping and resilience factors) in your life at this time (e.g., adequate sleep, satisfied personal life, in relatively good health, self-care strategies employed at work and home, good colleague support, etc.)

Find the point and in which quadrant where your E and R meet to assess your approximate risk of burnout now or in the near future.

The following checklists for prevention/intervention of occupational hazards are referencing ideas from stress.org/military/for-practitionersleaders/compassion-fatigue/

Burnout Prevention/Intervention

- ✓ Periodic mindful check-ins are essential. Ask yourself (and/or have trusted others ask):
  - ❑ if you feel psychologically safe/healthy in your current work environment
  - ❑ are you constantly working well beyond your capacity to be effective
  - ❑ are you at a time in your life right now during which your internal resources simply aren't at "optimal capacity" (ex., having small children, caring for ill parent, etc.)
  - ❑ if you feel like you have very little control over what you do at your current job
  - ❑ Connect to colleagues, other peers, and partners who know you and have your back
  - ❑ Evaluate the real degree of flexibility in your job. Is there more room for healthy change?
  - ❑ If emotional exhaustion, feeling interpersonally detached, and feeling like you just can't do good work is the norm for you, week after week, you might indeed be burning out. It is at this point that a very honest evaluation is warranted - of your circumstances, your resources, your unmet needs, and your desires/wishes/aspirations. Help from trusted colleagues and/or a therapist would be quite useful at that point in time.

Compassion Fatigue (CF)

CF is the "cost of constant caring" (C. Figley), and it largely stems from being exposed to a single client or multiple clients' experiences of deep suffering and trauma. In turn, from our empathy and unwitting absorption of clients' stresses, we experience the same feelings in ourselves. Per Figley (1995), we begin to lose our own spark, optimism, and humor. We tire easily, and we stop being our vital and unique selves. Although seemingly similar to burnout, CF can be thought of as a more relational-emotional process that may have a more rapid evolution.

Action Step:
If you work with clients with whom you have disproportionate difficulty maintaining boundaries, who are showing up with trauma and deep suffering, with whom you very easily feel upset, and with whom you tire easily after a session, you may be at higher risk of developing CF.

Check each symptom that is present in your work-personal life right now:

- ❑ markedly more upset than usual
- ❑ exhausted, especially after tough clients
- ❑ loss of sense of self
- ❑ increased irritability
- ❑ less optimistic about your work and the world
- ❑ less joy at work and home
- ❑ less enthusiasm about actually going to work

These are just symptoms that can be caused by multiple sources. But it's important to discern what is related to emotional-relational factors with your clients and what is from within your personal life that may be spilling over into work.

CF Prevention/Intervention

Seek and commit to supervision and peer consultation.

- ✓ Seek to find meaning in your clients' suffering and your work with them.
- ✓ Establish a gratitude practice for "what is" vs. only "what isn't".

- ✓ Engage in a loving-kindness practice of directing your warmth and goodwill to yourself and to your clients. (see *Sharon Salzberg's* work).
- ✓ Practice balancing your goals for the client with the client's own goals. If you feel you are working harder than the client, you likely are at higher risk for compassion fatigue.
- ✓ Practice the art of "not being a therapist or a helper."
- ✓ Practice acknowledging grief, loss, and hopelessness. If you have a personal history of these elements, you may be at higher risk of compassion fatigue.
- ✓ Connect with others in multiple ways. Keep a watchful eye on feelings of social numbness and isolation.

Secondary Traumatic Stress (STS)

STS is essentially post-traumatic stress (PTS) but experienced by the therapist when treating a client with highly traumatic material being shared. It is (personally and ethically) imperative that you be on the lookout for more classic symptom categories of PTS within yourself as a direct result of working with traumatized individuals.

STS differs from CF (and Burnout) in that the PTS symptoms that the client presents with become, in effect, the therapist's symptoms. There is more of a 1 to 1 transmission of PTS(D) from client to therapist just by virtue of being so present and proximal to the traumatic material.

Action Step:
Check off which symptom clusters you currently may be experiencing as a *direct result* of working with a traumatized client who shared their own traumatic material with you.

- **Re-experiencing** of the traumatic material (e.g., nightmares, flashbacks, intrusive thoughts, etc) - You, as the therapist, are now re-experiencing someone else's traumatic experience as if it were your own.
- **Avoidance** of traumatic material, affect, associated thoughts (i.e., not wanting to think about your traumatized client, hold a session with him/her, avoidance of treatment planning, etc.)
- **Negative ideation, affect, behavior** that initiates or worsens after the traumatic exposure to a client's trauma (e.g., feeling isolated, (self)blaming, anhedonia, overly negative thoughts of self/world)
- **Hyper-arousal** and/or reactivity related to the trauma that began or worsened after being exposed to your client's traumatic material and affect (e.g., hypervigilence, short fuse, heightened startle response, etc.)

STS Prevention/Intervention

- ✓ If the aforementioned symptoms are distressing, lasting for more than a few weeks, and are beginning to influence your personal life and/or professional composure, engagement, confidence, feelings of competence, etc., these would be clear signs that you would benefit from seeking out therapeutic
- ✓ support from a trauma specialist or clinician well-versed in trauma-related recovery.
- ✓ As always, seeking peer consultation as you work with highly traumatized clients is a wise prevention strategy and can support you in meaning making as you are assisting that client with his/her trauma.

Vicarious Traumatization (VT)

VT is much less discussed in the helping professions, at least as a relatively distinct construct from STS. We (as do others) define VT as the more cognitive and meaning-oriented experience of working with traumatized individuals or groups.

In other words, therapists experiencing VT may begin to take on and embody the hopelessness and spiritual meaninglessness of their traumatized (or deeply suffering)
clients. This is not the more "symptom-based" PTS(D) we are familiar with. Rather, a therapist with VT may see his own children, for example, as inevitably at risk for the trauma that was described by a child client. The therapist's meta-level view of the world may shift in meaningful ways.

Action Step: Rate the extent to which the following scenario resonates with you in your recent history _____ (0 none - 10 completely). Even if your particular cognitions are different, the process of absorbing a client's mindset and outlook may be similar. So, please reflect on how much the *process* (rather than the content) overlaps with your experience.

VT Example: You have become quite emphatic that '"life is just plain hard and then you die." This has not always been your philosophy. But the last several months of working with one of your favorite clients who happens to also be the victim of horrible childhood abuse has apparently taken its toll. Your client maintains that life is really not worth living and that she doesn't really deserve anything good for herself. You have unwittingly absorbed this person-worldview and now find it hard to live with joy and fulfillment as you once did. You also find it increasingly hard to believe that people are basically good, decent human beings.

VT Prevention/Intervention

- ✓ It is important to have trusted others (life partners, colleagues, peer consultation groups, friends, etc.) who know us well and who can suggest to us that our worldview has shifted in unhealthy ways.
- ✓ Identifying the source of our VT can be very useful so that we pinpoint from where and with whom our newfound sense of hopelessness, helplessness, or feelings of danger in the world are stemming. Once that is done, we can begin to work on cognitively, affectively, and in meaning-oriented ways separating our experience from our client's. This is imperative if we are to move forward with our own lives and if we are to be of optimal assistance to all others, not just that client from whom we have absorbed such traumatic ideation.
- ✓ Seeking your own therapy for such matters is again one of the best ways to help yourself through this experience.