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Recognizing Risks of Secondary Trauma

Ensuring client outcomes by supporting therapists

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Introduction

A good psychotherapist is someone who is trained to identify and diagnose various types of behavioral or emotional problems and then interact with a client in an appropriately warm and supportive manner to help him overcome or cope with those problems.

The training includes:

- Learning techniques for careful listening to what a client says,
- Analytical thinking about the meaning of what a client says, and
- Thoughtful selection of words to make a client feel understood and encouraged to engage in the difficult process of change.

Psychotherapy is an effective mechanism for change when such techniques are employed in a respectful, empathetic manner, thus credibly reassuring the client that there is a sincere appreciation for his suffering and a strong belief in the prospect of relief from that suffering. In short, the psychotherapist has to communicate a genuine sense of caring for the client and a belief that he can get better.

Successful therapists connect

Successful therapists connect with clients and establish a shared sense of humanity and emotional reality. Although a therapist learns techniques to facilitate the connection, it should be stressed that the connection cannot be faked over an extended period. Therapists are generally encouraged not to engage in extensive disclosure about their personal lives to clients. Still, by virtue of how the therapist expresses herself and how she responds to the client's remarks, she can impart a sense of keen interest and concern about the client's life. The point is that in order for the therapeutic relationship to take root and progress, the connection must be real, with the prospect of dramatically affecting the lives of both the client and the therapist.

Children's treatment poses challenges

The requirement of authenticity between the client and the therapist poses special challenges for the therapist who specializes in treatment of child or adolescent victims of trauma. In this context, *trauma* is defined as a catastrophic or injurious event in which a child or adolescent experiences intense horror, fear, or pain, along with a sense of helplessness. The youth may either have been directly victimized during the event or have been a witness to its occurrence.

Clinical practice and research has identified the phenomenon of secondary trauma. It is the cumulative emotional impact incurred by a counselor or psychotherapist in response to repeated, prolonged exposure to his/her clients' reports of traumatic experiences, specifically, emotional pain or scarring resulting from prolonged engagement in empathetic sharing in their

clients' painful experiences. Understanding the implications of such an occupational hazard for the therapist is important, as failure to safeguard against it could have serious ramifications for the therapist and the client.

Many therapists choose not to work with children precisely because the sense of responsibility they feel for them as minors has a different quality than that they would feel toward adults. Generally, therapists work to maintain conditions in the treatment relationship with adult clients that discourage excessive dependence on the therapist.

Although the therapist strives to encourage trust and disclosure, he takes care both to reinforce the adult client's sense of autonomy and to impart a fundamental belief in his capacity for self-care and basic problem-solving. However, in practically all modern cultures, children are readily permitted to develop dependent relationships with adults; in fact, to varying degrees, such dependency is even encouraged to ensure the safety and appropriate nurturing and guidance of children within families or communities.

Thus, the enterprise of conducting psychotherapy with children is complicated by the legitimate, culturally sanctioned dependency that is considered normative in relationships between adults and children.

Arguably, the dynamic changes the quality of the connectedness that the therapist experiences with the client, likely due to a strong cultural or psychological imperative to protect children from harm. As a result, the prospect of receiving the client's painful accounts of victimization — always a demanding undertaking in the development of a strong therapeutic alliance with any client — may be fraught with even greater difficulty when the client is a minor.

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Signs of discouragement surface

Children are more readily perceived as vulnerable, defenseless and undeserving of cruelty and suffering than are adults; thus, deeply engrained feelings of horror, despair and moral outrage, along with fantasies of selfless devotion and heroism (among many other possible complex psychological reactions), may be aroused in the therapist by reports of injury.

Research on the impact that providing clinical services to victims of trauma has on psychotherapists over an extended period reveals damaging and disruptive effects that are often insidious in their onset. The therapist generally starts out filled with passion, idealism and zeal, but within two years, starts to show early signs of discouragement associated with coming to grips with limitations in his or her role. It should be emphasized that such a reaction is born not only because of the horrific nature of the trauma reported to them and the seemingly intractable conditions that support it (e.g. poverty, parental substance abuse, etc.), but also from the exigent demands and inadequacies that characterize the systems in which therapists deliver services (e.g. tight budgets, heavy caseloads, voluminous paperwork, etc.).

Burnout signs begin to show

By the fifth year of practice, a therapist's behavior is likely to reflect signs of chronic frustration and exhaustion, ranging in manifestation from frequent complaining to increased absence

from work to exhibition of erratic behavior toward co-workers and clients. Typically, the buildup of such negative effects is gradual and may be masked or dismissed by sharing "war stories" with similarly disgruntled fellow staff. In the extreme, the therapist's functioning during this phase (commonly referred to as "burnout") can be characterized by:

- •Illness (perhaps chronic insomnia, vague physical complaints, depression)
- •Self-harm (maybe substance abuse, suicidal ideation), or
- •Development of inappropriate relationships with clients (for instance, enmeshment, reinforcement of sense of helplessness and pessimism, sexual acting out).

"Encourage each therapist to reflect on which levels best support satisfaction and happiness."

Although such extreme outcomes are generally rare, the more subtle career arc toward disenchantment, bewilderment and resignation is reliable enough as a phenomenon to warrant careful observation and management.

The Detroit-Wayne County-Community Mental Health Authority, via consultation with **Dr. James Henry** and **Connie Black-Pond,** MA, LMSW of Western Michigan University's Children's Trauma Assessment Center, has acknowledged the problems associated with secondary trauma and is raising consciousness among its network of providers by training executive and supervisory staff. The initiative is intended to create a culture within the provider agencies that understands the stressors faced by psychotherapists and develops a formal structure for easing them.

While clinical supervision has been a longstanding practice in DWC-CMH agencies, the new emphasis on dealing with the unique pressures from treating youth victims of trauma is intended to bolster the traditional mechanism with more specific, active clinical supervision. The traditional "open door" approach to addressing job-related stress ("You know my door is always open if we need to talk.") is being supplemented

by mandatory scheduled supervision sessions that feature a psycho-educational component explaining secondary trauma. The approach is especially important for new therapists who, given their enthusiasm and eagerness to demonstrate their competence, may misconstrue perfectly natural or expected reactions to case material as signs of weakness and choose not to discuss the issues with a supervisor. Such reluctance may intensify if the traumatic case material has stirred up personal issues for the therapist, or awakened painful and/or overwhelming memories from his own past.

The therapist will seek badly needed counsel under such circumstances only if the groundwork for a safe, non-judgmental clinical supervisory environment already has been laid. Such groundwork includes a clear accounting of the challenges a therapist should expect to face providing trauma-focused treatment. By creating an environment that affirms the therapist's competence and reflects concern for his emotional well-being, the clinical supervision has supported the therapist both personally and professionally.

Secondary trauma not inevitable

While it is unrealistic (perhaps even undesirable) for budding psychotherapists to think they can successfully conduct trauma-focused treatment without being affected emotionally, secondary trauma is not an inevitable consequence of their occupation. As human services agencies become more supportive and proactive in addressing the phenomenon, therapists can be taught to engage in ongoing self-monitoring and self-care to lessen its negative impact.

Clinical supervisors can help therapists monitor

their own level of pursuit of:

- Hobbies
- Physical exercise
- Contact with supportive family and friends
- Participation in spiritual worship and fellowship
- Pursuit of intellectual stimulation, and
- Attendance of (or even participation in) cultural and community events.

"There is no higher purpose than to provide guidance and care for suffering children."

All items on the list may not be relevant for each therapist and their relative significance will differ for each. The important point is to encourage each therapist to reflect on which levels best support satisfaction and happiness or, alternatively, which areas can no longer be neglected given the job's stresses.

New therapists should be taught to construe the aforementioned list as their emotional support and to find ways of sustaining it at optimal levels. They should be encouraged not to dismiss the task, saying, "I'm swamped; I'll get around to it/them when I have time." Regarding emotional support, clinical supervisors should encourage therapists to pursue a protocol of maintenance rather than one exclusively of respite or rescue. Metaphorically speaking, a steady diet of emotional support, rather than binge-eating during crises, is the course to follow.

War stories can reinforce negativity

A more delicate undertaking for clinical supervisors is to provide guidance for trauma-focused psychotherapists regarding habits or practices that should be abandoned or avoided. Therapists should be encouraged to re-evaluate recreational use of alcohol and other drugs to make sure they are not engaging in emotional numbing, isolated escapism or self-medication. The prospect for addiction is real and should not be regarded as something that happens just to other people. The informal practice of trading "war stories" also can lead to or reinforce negativity. Eagerness to feign sophistication in an effort to establish camaraderie with more experienced clinicians can lead to development of an unhealthy perspective about clients and their trauma. Cynicism and pessimism should be considered viral and parasitic; the therapist striving to nurture hope and optimism in her traumatized clients cannot host such infection.

Therapists deserve enduring respect, care

In conclusion, there is no higher purpose than to provide guidance and care for suffering children. Psychotherapists devoted to the demanding mission of treating traumatized youth deserve our enduring admiration, respect, care and nurturing as a valued resource. Appropriately supported, their accumulation of knowledge and experience in a difficult clinical specialty will strengthen our system of care immeasurably, creating a culture of compassion and effective intervention that greatly benefits our community. As leaders within the system of care, ours is the responsibility of affirming them through guidance in the crucial practice of "replenishing the well" — routine engagement in the restorative practice of self-monitoring and self-care.

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