Chapter 7

Contributing Factors: Understanding How Your Job Is Impacting You

> To combat compassion fatigue and burnout, agency administrators and therapists may also wish to ask themselves, "How many cases are too many?"[1]
>
> **—Kyle D. Killian**

In this chapter, you are invited to:

- Gain a better understanding of the factors that contribute to your compassion fatigue (CF) and vicarious traumatization (VT)
- Complete a self-assessment checklist to identify your primary contributing factors

Why Do We Get CF/VT? Contributing Factors[2]

As we discussed in earlier chapters, compassion fatigue exists on a continuum, meaning that at various times in our careers, we may be more immune to its damaging effects and at other times feel very depleted by it. Within an agency, there will be, at any one time, helpers who are feeling healthy and fulfilled in their work, a majority of people who are feeling some symptoms, and a few people feeling like there is no other answer available to them but to leave the profession. The main factors contributing to this continuum are your personal and current life factors and your work situation.[3]

Personal and Current Life Factors

Your current life circumstances, your childhood history, your way of coping with stress, and your personality all affect how compassion fatigue and vicarious trauma will impact you.[4] In addition to working in a challenging profession, most helpers have other life stressors to deal with. Many of us belong to the "sandwich generation," meaning that we take care of both young children and aging parents. Helpers are not immune to pain in their own lives, and in fact some studies show that we are more vulnerable to life changes such as divorce and difficulties such as addictions than people who do less emotionally stressful work.

Relationship to or Close Identification With Those Being Assisted[5]

For helpers who work in small communities, it can be hard to draw a clear line between work and home life. In the past few years, I have had the privilege of working with the Department of Justice Victim Service Division in the Yukon and Northwest Territories, where there are staggering rates of abuse and trauma. Some of the victim service workers are tasked with assisting victims in preparing a victim impact statement and accompanying them to court. This, in and of itself, can be challenging for helpers in terms of trauma exposure. But in remote communities, the offender *and* the victims *and* the support worker can often all be related to one another. This can place the worker in real ethical dilemmas, and they often get pitted against part of the community when advocating for a victim. In addition, resources are very scarce in small northern villages. The victim service worker can end up having to work extra-long hours, offering support that is often outside the scope of their training.

Working Conditions

Recent studies clearly show that the volume of work (a high caseload) and lack of control over the workload are directly related to lower compassion satisfaction.[6] Moreover, quality supervision is not always available to all helpers.

Clients and their stories are not always the main source of stress—it's also the paperwork, the new computerized system staff have to learn, and, let's not forget, the nth restructuring/merging with the agency next door/new executive director/best practice remodel that an agency is going through for the fourth time in 8 years. Helpers participating in my workshops often say, "I don't have any problems with my clients/patients; in fact, I love my clinical work. It's everything around it that is grinding me down." Moreover, helpers often do work that other people don't want to hear about, or spend their time caring for people who are not valued or understood in our society such as individuals who are homeless, abused, incarcerated, or chronically ill. The working environment is often stressful and fraught with workplace negativity as a result of individual compassion fatigue and unhappiness. We will discuss this further in the next chapter.

For mental health counselors, the push for the exclusive use of evidence-based practice (EBP) is presenting some additional challenges. EBP is the use of "manualized, empirically tested interventions that demonstrate evidence of ameliorating psychological symptoms."[7] The use of EBP comes from the medical field, where it makes sense to adopt a strict treatment protocol (I certainly would want that if I needed surgery—there is clearly research that demonstrates the best way to operate on my heart, for example, and I would hope the cardiology clinic I visit adheres to this.) This may sound like a great idea for psychology and counseling as well, but applying EBPs to mental health treatment is far more complicated than it sounds: Data show that in psychological counseling, there is no one-size-fits-all approach that works for every client. Research also shows that the best approaches are those that use the therapeutic techniques in the larger context of the relationship with the client. As Scott Miller recently said: "Is this relationship between this consumer and this provider, program, level of care, working for this individual at this time and place?"[8] No rigid, manualized treatment approach can guarantee that in mental health counseling. The moral distress caused by having to blindly adhere to EBPs can only make matters worse for the helping professional (and, I would suggest, for the client).

INTERESTED IN READING MORE ON EVIDENCE-BASED PRACTICE?

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I also recommend that you read:

Farley, A.J., et al. (2009). The challenges of implementing evidence based practice: Ethical considerations in practice, education, policy and research. *Social Work & Society*, (7) 2.

A HOSPITAL SOCIAL WORKER REFLECTS

Over my 23-year career I have learned the importance of self-care and work/life balance and pride myself on my ability to look after myself in the midst of doing very difficult trauma work. However, I was recently reminded of how quickly the tides can turn in the constant ebb and flow of compassion fatigue. In the midst of massive organizational change, I quickly learned how the balance can be toppled. I was shocked and embarrassed by my level of paranoia as my program was being bulldozed in the face of making improved

overall changes. For weeks I sat in my office literally shaking, waiting for management to come with the cardboard box and escort me out of the building. I started to clean out my office myself and bring important things home because I was so convinced that the knock on the door was coming. The stress of this was so overwhelming that I finally came to a place where I was fantasizing for it to occur already so that I could experience some relief and get on with my life. I have always found that I could function well doing the difficult work of trauma counseling as long as my team and organization were stable. When this stability was no longer there, I found I could not function in supporting my clients because I was feeling that I was the one in need of support. Ultimately the support of family, peers, and friends was the connection I needed to sustain me and be the voice of reason amidst all my exaggerated fears.

—Hospital social worker

Risk of Personal Injury

As discussed in Chapter 4, a large number of helping professionals are assaulted or threatened in the line of duty.

Insufficient Training

Work overload means that helpers are often asked to do work that is outside of their scope of practice. We are sometimes asked to run a program after having had barely enough training ourselves to feel confident with the material.[9]

Working in Isolation

More helpers are being asked to work with ever-decreasing resources in smaller and less well organized teams. Kyle Killian found that social support at work was "the most significant factor associated with compassion satisfaction."[10] This

HOW DID YOU LEARN ABOUT SELF-CARE?

In his study of trauma counselors and compassion fatigue, Kyle Killian found that "most of the therapists interviewed observed that they had not had any courses or specific training on professional self-care, and this was an important but neglected area in training."[11] He recommends that self-awareness and self-care become integral parts of the curriculum for all helping professionals.

finding is both encouraging and concerning as we know that compassion fatigue erodes what we most need: our connection with others. Burnout, compassion fatigue, and vicarious trauma can contribute to poor workplace morale and bitterness. The more embittered we are, the less likely we are to turn to our colleagues for support (or for *constructive* support—we may spend a lot of time bitching to them about the work, but is this productive and healthy?). Killian strongly recommends that we create structured group meetings to offer one another regular support.

Let's Stop Blaming the Helpers

Killian and others before him found that individual self-care strategies were only moderately effective in reducing CF and VT in helpers. Killian is concerned that by focusing only on individual self-care, we risk falling into the pitfall of blaming the helpers for developing CF and VT: "This focus implies that helping professionals who are hurting are somehow at fault—they are not balancing work and life."[12] Far more effective were organizational changes that offered helpers better working conditions, more control over their schedule, good-quality supervision, and reduced exposure to trauma.

Killian believes that our industry as a whole has to make a "paradigm shift" where we see the solution to CF and VT in a larger (organizational, political, societal) context rather than focusing solely on individual helpers' responsibility to self-care: "As trainers, educators, and supervisors, we want to protect therapists from compassion fatigue, enhance their resilience, and help professionals deliver quality mental health interventions, but to achieve these goals, we may need to shift paradigms, moving our focus away from individualistic efforts at education and training and toward a more systemic approach of advocacy for healthier working conditions."[13]

MAKING IT PERSONAL HOMEWORK: ASSESS YOUR CONTRIBUTING FACTORS

In their book *Transforming the Pain*, Saakvitne and Pearlman offer a conceptual way to assess contributing factors. They divide them up in the following manner:

Nature of the Work
Nature of the Clientele
Nature of the Helper

Within Nature of the Work, the authors ask helpers to assess elements such as:

- Do you have control over your schedule?
- Are you satisfied with your current schedule?
- Do you have a healthy workplace?
- Do you like your work?
- Do you feel supported in your workplace?
- Do you have support from colleagues at work, or within your profession?
- Are you getting enough helpful supervision?

Within Nature of the Clientele, the authors ask helpers to assess elements such as:

- Does your work with clients feel fulfilling?
- Do you get to see clients improve?
- Do you feel well suited for this work?
- Do you feel well trained to do your job?
- Is there balance and variety in your workday?
- Do you have clients you enjoy working with?

Within Nature of the Helper, the authors ask helpers to assess elements such as:

- Do you have a fulfilling social life?
- Are you able to make time for yourself?
- Do you have non-work-related hobbies/activities?
- Do you have healthy coping strategies?
- Are you aware of your own family history/past traumas and how this may impact your work and your own well-being?

Question: What are your thoughts about your current job and how it contributes to your compassion fatigue? Take your journal or a separate sheet of paper to answer these questions. If you are working with a group, consider sharing some of findings with one another.

Adapted from Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton. pp. 53–55.

RECOMMENDED READING

Killian, K.D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, (14) 2.

www.headington-institute.com. The Headington Institute is an organization that offers Web-based and in-person training and support to humanitarian relief and aid workers across the world. They provide excellent free resources for all helping professionals, regardless of whether you are an aid worker or not. I highly recommend you visit their Web site.

Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton, pp. 32–44.

Endnotes

1. Killian, K.D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 41.
2. This section is adapted from an article entitled, "Running on Empty," originally published in the Spring 2007 issue of *Rehab & Community Care Medicine*.
3. Saakvitne, K.W., Pearlman, L.A., & the staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton, pp. 53–59.
4. Saakvitne, K.W., Pearlman, L.A., & staff. (1996).
5. The Headington Institute, "Understanding and Addressing Vicarious Trauma Self-Study Course." http://www.headington-institute.org/Default.aspx?tabid=2649
6. Killian, K.D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 32–44.
7. Craig, C.D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping*, *23*(3), 322.
8. Miller, S.D. (2011). Transforming public behavioral health care: Improving outcome and efficiency with consumer-driven, outcome-informed service delivery. Presented at the Canadian Counseling and Psychotherapy Association's annual conference, Ottawa, May 2011.
9. Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
10. Killian, K.D. (2008), p. 40.
11. Killian, K.D. (2008), p. 42.
12. Killian, K.D. (2008), p. 42.
13. Killian, K.D. (2008), p. 43.