

Secondary Trauma Issues for Psychiatrists

Identifying Vicarious Trauma and Job Burnout

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Psychiatrists face growing challenges both as health practitioners and as sources of reassurance and empathy for their patients. But what if the effort to understand and help patients itself becomes a burden? The purpose of this article is to provide a brief overview of what we know about secondary trauma—frequently called compassion fatigue or vicarious trauma.

Studies related to the effects of exposure to psychosocial stressors on individuals have primarily focused on the effects on nonprofessionals who provide social support.^{1,2} Until recently, there has been far less concern about the impact of social support provisions on professionals working with traumatized patients.^{3,4} Secondary traumatization also affects other health care professionals, including those who work with patients with AIDS or cancer or who are involved in critical care or hospice care.⁵

Generally, those who work in psychotherapeutic professions attempt to alter the cognitive status, emotional state, or the behavior of patients by providing cognitive-therapeutic interventions as well as empathy and strategies for coping with stress.⁶ Within this context, it has been suggested that providing therapy to patients who have experienced a traumatic event can be especially emotionally difficult.⁴ Specifically, therapists who work with traumatized patients often show signs of psychological distress, including symptoms of posttraumatic stress disorder (PTSD), which appears to result from “vicarious” traumatization.^{4,7-9} Thus, it appears that providing psychotherapy to traumatized patients puts therapists at risk for mental health problems.^{4,5}

Despite findings that suggest that many therapists experience symptoms of vicarious traumatization, research has been limited.¹⁰ One problem has been a lack of conceptual clarity.¹¹ For example, the adverse consequences of working with traumatized patients have been variously described as vicarious trauma, sec-

ondary traumatic stress, and compassion fatigue, and also in other terms.¹⁰ Moreover, different scales used in the past have used different conceptualizations.⁵ We briefly review a study that attempted to address these problems and, on the basis of this research, we offer brief assessment tools to screen for both vicarious trauma and job burnout in clinical practice.

Vicarious trauma and compassion fatigue

Our work suggests that vicarious trauma and job burnout are separate phenomena and that both syndromes are related to working with traumatized patients.⁵ Our recent conceptu-

of traumatized individuals and who had an empathic orientation to their patients.^{4,13,14}

Thus, the therapist who reports symptoms related to reexperiencing the client’s traumatic event, who wishes to avoid both the client and reminders of the client’s trauma, and who experiences persistent arousal from knowledge of the client’s traumatic experiences may be suffering from vicarious trauma—a component of compassion fatigue.^{4,9,10,13} Compassion fatigue has been clinically defined as the formal caregiver’s reduced capacity or interest in being empathic or “bearing the suffering of clients” and is the behavioral and emotional state that results

trauma is not the same as job burnout, and each seems to have a unique effect on well-being.^{10,17,20} Job burnout is often defined as a response to prolonged exposure to demanding interpersonal situations and is characterized by “emotional exhaustion, depersonalization, and reduced sense of personal accomplishment.”²¹ High emotional involvement without adequate social support or feelings of personal work accomplishments (ie, job satisfaction) may leave the health care professional vulnerable to job burnout.⁵

Stress-process model

We conceptualized vicarious trauma and job burnout within a stress-process framework.^{1,2} This framework contends that challenging environmental stressors typically require individuals to respond both physiologically, through alterations in neuroendocrine and hormonal systems, and psychologically, usually through changes in cognitive functioning.^{2,22}

Studies suggest that other aspects of the caregiver’s environment can influence the development of compassion fatigue, vicarious trauma, and job burnout.² This means that professionals exposed to similar stressors are not equally vulnerable to the negative consequences of occupation-related stress.⁵ Stress research indicates that individuals from historically disadvantaged groups are more vulnerable to stress exposures.^{1,2} A history of psychological trauma also increases the likelihood of developing compassion fatigue.^{4,8} Furthermore, positive coping and social support can reduce or moderate the influence of stressful events on well-being.^{1,2} Finally, psychological qualities such as self-esteem and a “sense of mastery” can reduce the adverse impact of psychosocial stressors.¹

Social support is usually provided by significant others in the form of emotional, informational, or instrumental support. Individuals who have few social support resources are more vulnerable to stressors and tend to suffer greater physical and psychological health problems.²³ Among mental health professionals, social support can come from friends, family members, or signifi-

CHECK POINTS

- ✓ **It can be emotionally difficult to provide therapy to patients who have experienced a traumatic event; therapists who work with traumatized patients often show signs of psychological distress, including symptoms of posttraumatic stress disorder, which may be a result of “vicarious” traumatization.**
- ✓ **Professionals exposed to similar stressors are not equally vulnerable to the negative consequences of occupation-related stress: individuals from historically disadvantaged groups and those who have a history of psychological trauma are more vulnerable to stress exposures.**
- ✓ **Recently developed burnout and vicarious trauma scales seem to be appropriate assessment tools for identifying professionals at risk for compassion fatigue and other psychological difficulties.**

alization of vicarious trauma was developed from analytical models that incorporate the broader conceptualization of compassion fatigue in the clinical literature.⁴ For this project, we assessed a random sample of senior-level social workers in New York City following the 9/11 attacks.^{5,11,12}

With the inclusion of PTSD in DSM-III, stress response symptoms related to psychological trauma have been defined as a psychiatric disorder. The concept of compassion fatigue emerged when clinicians noted the occupational effects among mental health workers who work with traumatized patients. In essence, some professionals appeared to experience the effects of their client’s trauma vicariously.⁴ It seemed that vicarious trauma was a risk factor for mental health professionals who were exposed to significant numbers

from knowing about a traumatizing event experienced by another person.⁴ Our work suggests that compassion fatigue is a hazard associated with many clinical settings and has at least 2 components—vicarious trauma and job burnout.^{5,11,12}

From a behavioral point of view, the general psychological mechanisms for the patient-to-therapist transmission of this condition can be understood in terms of cognitive-behavioral conditioning.^{6,15,16} More complex mechanisms have also been suggested to explain this phenomenon, such as “countertransference,” but we prefer a cognitive-behavioral framework because of its parsimony and direct therapeutic implications.^{17,18}

The current evidence also suggests that vicarious trauma and job burnout tend to overlap.^{4,8,10,13,14,19} However, vicarious, or secondary,

cant others outside the work environment or from coworkers and supervisors within the work environment. Generally, the evidence suggests that coworker support is very important to the mental health professional.

Recent research

To address limitations in previous research related to vicarious trauma and job burnout (ie, compassion fatigue), we undertook a study among a random sample of senior social workers with a Masters in Social Work (or higher) in clinical practice affected by the September 11 terrorist attacks. We chose to study social workers, because their professional work environment—high case loads, direct contact with patients, poor so-

cial support, and limited resources—potentially offers little protection from compassion fatigue and vicarious trauma.¹¹

We assessed a number of factors among these social workers that could have increased vicarious trauma and job burnout, and we examined their association with psychological distress. From this research, we developed 2 reliable, validated scales.^{11,12} Using the scales, we tested the hypothesis that vicarious trauma was different from burnout. Our data analyses supported our hypothesis.^{5,11,12} We found the two scales tended to measure different aspects of the more general phenomenon of compassion fatigue.^{4,17,19}

Selected results from this study

are shown in **Table 1**. As can be seen, vicarious trauma tends to be associated with other negative life events, greater disaster recovery involvement, a lower sense of mastery, and worse mental health; it is also associated with job burnout. Job burnout tends to be associated with being single, negative life events, greater lifetime trauma exposure, a lower sense of mastery, and worse mental health status; it is also associated with vicarious trauma. Additional multivariate analyses suggested that exposure to traumatized patients increased vicarious trauma, but not job burnout. In turn, both vicarious trauma and job burnout were related to experiencing psychological problems. These associations held even

after we took into account (ie, adjusted for) demographic and other factors (eg, personal history of trauma) that could place the therapist at greater risk for reasons outside of his or her work life.

The results of our analyses support our contention that the scales used were valid.⁵ Therefore, the burnout and vicarious trauma scales seem to be appropriate assessment tools for identifying professionals at risk for compassion fatigue and other psychological difficulties. In summary, using these scales, we showed that working with traumatized patients is related to vicarious trauma, but not job burnout, and that both vi-

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Table 1	Selected findings from the Compassion Fatigue Study showing key associations for vicarious trauma and job burnout ^{5,12}				
Sample characteristics	Sample % (N)	Vicarious trauma		Job burnout	
		Low % (n)	High % (n)	Low % (n)	High % (n)
Marital status					
Single	42.3 (99)	40.6 (80)	51.4 (19)	39.2 (78)	60.0 (21) ^a
Married	57.7 (135)	59.4 (117)	48.6 (18)	60.8 (121)	40.0 (14)
Negative life events past year					
Low (0 - 1 event)	69.1 (163)	72.5 (144)	51.4 (19) ^a	72.6 (146)	48.6 (17) ^b
High (2+ events)	30.9 (73)	27.6 (55)	48.6 (18)	27.4 (55)	51.4 (18)
Lifetime traumatic events					
Low (0 - 2 events)	65.7 (155)	66.8 (133)	59.5 (22)	68.7 (138)	48.6 (17) ^a
High (3+ events)	34.3 (81)	33.2 (66)	40.5 (15)	31.3 (63)	51.4 (18)
Disaster recovery involvement					
Low (< 4 activities)	80.9 (191)	84.9 (169)	59.5 (22) ^c	81.1 (163)	80.0 (28)
High (4+ activities)	19.1 (45)	15.1 (30)	40.5 (15)	18.9 (38)	20.0 (7)
Sense of mastery (self-esteem)					
Low	42.1 (98)	38.4 (76)	62.9 (22) ^b	35.2 (70)	82.4 (28) ^c
High	57.9 (135)	61.6 (122)	37.1 (13)	64.8 (129)	17.6 (6)
General Health Questionnaire (GHQ)					
Good health (< 4)	80.1 (189)	84.9 (169)	54.1 (20) ^c	85.1 (171)	51.4 (18) ^c
Poor health (4+)	19.9 (47)	15.1 (30)	45.9 (17)	14.9 (30)	48.6 (17)
Vicarious trauma score					
Low (< 15)	84.3 (199)	—	—	90.5 (182)	48.6 (17) ^c
High (15+)	15.7 (37)	—	—	9.5 (19)	51.4 (18)
Job burnout score					
Low (< 30)	85.2 (301)	91.5 (182)	51.4 (19) ^c	—	—
High (30+)	14.8 (35)	8.5 (17)	48.6 (18)	—	—
^a <i>P</i> < .05, chi-square test. ^b <i>P</i> < .01, chi-square test. ^c <i>P</i> < .001, chi-square test.					

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carious trauma and job burnout (compassion fatigue) are associated with psychological problems. More important, these outcomes will likely result in problems with service delivery and higher job turnover and will produce serious issues for continuity as well as quality of care provided by mental health professionals.⁷

Application and conclusion

The following several strategies can reduce professionals' chances of developing compassion fatigue^{4,24}:

- Increased resiliency skills
- Use of self-care strategies
- Improved social support from others, including coworkers
- Development of caregiving skills
- Use of conflict resolution

From a stress-process perspective, resiliency skills and self-care strategies are essentially coping skills. The main theme of these strategies includes both social and orga-

nizational functions for reducing compassion fatigue and vicarious trauma. Organizationally, social service agencies need to recognize the workplace hazard of compassion fatigue and offer training in self-care and other strategies to reduce this problem. Increased social support from coworkers and supervisors can also reduce this work hazard.¹²

Our work may help clarify the conceptual differences between vicarious trauma, job burnout, and compassion fatigue.¹⁰ Among therapists, compassion fatigue contains at least 2 components: vicarious trauma and job burnout. Developing a valid and reliable instrument to detect compassion fatigue is a prelude to devising intervention strategies to mitigate its negative effects on practitioners. In **Table 2**, we show the scales developed from our study. Although additional research is required, findings from the study suggest that professionals who score a 15 or higher on the vicarious trauma scale and/or 30 or higher on the job burnout scale may require clinical at-

tention or further clinical evaluation for these syndromes.

Clearly, compassion fatigue demands concern and resonates among mental health professionals. Psychiatrists are drawn to work with those who are mentally ill, because they value providing care to others and often overlook their own needs. The characteristics that bring people into the caring professions are, ironically, the very factors that make them vulnerable to vicarious trauma and job burnout. It is our responsibility to ensure that these adverse outcomes are minimized among those who have chosen such a career.

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Table 2

Short Compassion Fatigue Scale^{5,12}

Consider the following items about your work/life situation. Write the number that best reflects your experiences using the following rating scale, 1 through 10:

Never/Rarely		Sometimes						Very Often	
1	2	3	4	5	6	7	8	9	10
___ a. I have felt trapped by my work.									
___ b. I have thoughts that I am not succeeding in achieving my life goals.									
___ c. I have had flashbacks connected to my patients.									
___ d. I feel that I am a "failure" in my work.									
___ e. I experience troubling dreams similar to those of a client of mine.									
___ f. I have felt a sense of hopelessness associated with working with clients/patients.									
___ g. I have frequently felt weak, tired, or rundown as a result of my work as a caregiver.									
___ h. I have experienced intrusive thoughts after working with especially difficult clients/patients.									
___ i. I have felt depressed as a result of my work.									
___ j. I have suddenly and involuntarily recalled a frightening experience while working with a client/patient.									
___ k. I feel I am unsuccessful at separating work from my personal life.									
___ l. I am losing sleep over a client's traumatic experiences.									
___ m. I have a sense of worthlessness, disillusionment, or resentment associated with my work.									

Vicarious Trauma = c, e, h, j, l^a; Job Burnout = a, b, d, f, g, i, k, m^b

^a A score of 15+ suggests that vicarious trauma may be present.

^b A score of 30+ suggests that job burnout may be present.

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