Burnout, vicarious traumatization and its prevention

What is burnout, what is vicarious traumatization?

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Abstract

Previous studies on burnout and vicarious traumatization are reviewed and summarized with a list of signs and symptoms. From the author's own observations two histories of caregivers working with torture survivors are described which exemplify the risk, implications and consequences of secondary trauma. Contributing factors in the social and political framework in which caregivers operate are analyzed and possible means of prevention suggested, particularly focussing on the conflict of roles when providing evaluations on trauma victims for health and immigration authorities

Caregivers working with victims of violence carry a high risk of suffering from burnout and vicarious traumatization unless preventive factors are considered such as: self care, solid professional training in psychotherapy, therapeutic self-awareness, regular self-examination by collegial and external supervision, limiting caseload, continuing professional education and learning about new concepts in trauma, occasional research sabbaticals, keeping a balance between empathy and a proper professional distance to clients, protecting oneself against being mislead by clients with fictitious PTSD. An institutional setting should be provided in which the roles of therapists and evaluators are separated. Important factors for burnout and vicarious traumatization are the lack of social recognition for caregivers and the financial and legal outsider status of many centers. Therefore politicians and social insurance carriers should be urged to integrate facilities for traumatized refugees into the general health care system and centers should work on more alliances with the medical mainstream and academic medicine.

Key words: burnout, vicarious traumatization, care for caregivers

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Introduction

Symptoms of burnout include apathy, feelings of hopelessness, rapid exhaustion, disillusionment, melancholy, forgetfulness, irritability, experiencing work as a heavy burden,[1] an alienated, impersonal, uncaring and cynical attitude toward clients, a tendency to blame oneself coupled with a feeling of failure[2] (Table 1). Such phenomena are quite familiar from the normal health care system. Who has not experienced, as a patient or accompanying family member in a doctor's office or hospital, how impersonally and with what disinterest one is at times treated, and in what an insensitive and cynical tone doctors speak of suffering and illness!

A few years ago, a young doctor documented conversations between surgeons and OR nurses during operations in British hospitals and found distressing incidents

of contempt and obscenity. Beyond the indignation, the question arises of how this behavior can be explained. A certain amount of professional cynicism, and this is true of other professions as well, apparently serves to relieve tension and stress and helps deal with the accumulated misery and suffering with which personnel are confronted day after day in a medical environment. The line is crossed when cynicism turns into brutalization and contempt, which affects care and harms the patients. Helping has not only a noble and charitable side, but also an aggressive aspect. The following will discuss this in greater detail.

Johan Lansen has pointed out that people working with survivors of torture experience symptoms that go far beyond the usual burnout. In addition to burnout, such aid workers, like their clients, may develop symptoms of posttraumatic stress disorder (PTSD), with sleep disorders and threatening nightmares. This results in feelings of great vulnerability. Fears may arise in which less significant daily events are suddenly experienced as threatening. A growing feeling of alienation may set in, accompanied by withdrawal and isolation. The person no longer feels understood by friends and relatives and loses the confidence that good is still possible in the world; at home, they are quiet and withdrawn, cannot regain previous feelings of security, and are disillusioned by humanity. These manifestations are known as vicarious traumatization of members of healing professions.[3]

Based on their studies on incest survivors Laurie Anne Pearlman and Karen Saakvitne define vicarious traumatization as a transformation of the helper's inner experience, resulting from emphatic engagement with a client's trauma material.[4]

Table 1. *Signs and symptoms of burnout (Lansen, Fineman and Maslach).*

Apathy
Feeling of hopelessness
Rapid exhaustion
Disillusionment
Melancholy
Forgetfulness
Irritability
Experiencing work as a heavy burden
Alienated, impersonal, uncaring and cynical attitude towards clients
Tendency to blame oneself
Feeling of failure

Studies of vicarious traumatization

There have so far been few studies of burnout and vicarious traumatization among those who treat victims of extreme violence. McCann and Pearlman[5], who coined the phrase "vicarious traumatization," advocate the "infection model." The authors postulate that the patients' tormenting flood of memories, their nightmares, fears, despair and distrust, infect the therapist. As typical symptoms of vicarious traumatization, they see depression, cynicism, boredom, loss of sympathy and empathy, dejection. Danieli and Miller advocate a similar model, in the sense of "infectious trauma" or "emotional infection."[6] Figley[7] speaks of secondary traumatic stress reactions or "compassion fatigue" among therapists, manifested in feelings of faintness, confusion, and isolation from friends and relatives, which can create the same symptoms as PTSD and distinguishes this from chronic burnout syndrome, which can occur in all aid professionals (Table 2). Kleinman and Maeder call secondarily-traumatized therapists "wounded healers."[8] These are people who, through their own traumatic experiences, possess a greater capacity for empathy; however, their need to heal others helps them avoid contact with their own unprocessed traumas.

Wilson and Lindy[9] see these occurrences

as lapses in the patient-therapist relationship with a summation of negative or positive countertransference reactions. On the one hand, this can manifest itself in too much detachment on the part of the therapist, who no longer shows empathy and withdraws into an intellectualizing, apparently neutral posture. On the other hand, it can be expressed in the therapist's undistanced overidentification with the patient, which leads him or her to act in concert with the patient, a disabling exaggeration of care that results in mutual dependence.

Hoppe's study of this dynamic focused on the relationship between evaluators and test subjects based on his experience as an evaluator of concentration camp survivors in the 1950s and 1960s. He distinguished four typical attitudinal patterns on the part of evaluators:

1) Total denial. The evaluator identifies with the aggressor and fends off his own fear, shame and guilt by denying or downplaying the victim's sufferings.

2) Rationalization. The evaluator's attitude seems open and well-meaning, but he then finds no connection between the persecution and the suffering from a scientific standpoint. His lip service of understanding to the suffering helps to relieve his feelings of guilt, while the "objective" conclusions guarantee recognition as a reasonable, unbiased evaluator by the German authorities and German colleagues. Victims would associate this type of evaluator with the "nice SS man" who offered them a cigarette during interrogation.

3) Overidentification with the victim. The evaluator ties the victim to him and thus satisfies his own narcissistic and omnipotent needs. Because of his subjective and polemic statements, his evaluations are generally not recognized by the reparations offices, and thus this type of evaluator disappoints the high hopes that he raises in the victims. Hidden behind his sympathy and exaggerated empathy with the survivors is a hatred of the Nazis, who destroyed his own hopes, as well as anger at himself for not fulfilling these hopes.

4) Controlled identification. This position represents the ideal evaluator, who withholds his own judgment, sees the unbelievable experiences of concentration camp survivors as possible and credible, does not shut himself off from the unbearable terror of which he is told, feels empathy, but also observes himself critically and perceives countertransference phenomena and his own defense mechanisms.[10]

Table 2. *Signs and symptoms of vicarious traumatization (Lansen, Pearlman and Saakvitne, Wilson and Lindy, Hoppe).*

Symptoms of posttraumatic stress disorder: – nightmares, sleeplessness, intrusions, avoidance behaviour, irritability
Denial of client's trauma
Overidentification with client
No time and energy for oneself
Feelings of great vulnerability
Insignificant daily events are experienced as threatening
Feelings of alienation
Social withdrawal
Disconnection from loved ones
Loss of confidence that good is still possible in the world
Generalized despair and hopelessness
Loss of feeling secure
Increased sensitivity to violence
Cynicism
Feeling disillusioned by humanity
Disrupted frame of reference
Changes in identity, world view, spirituality
Diminished self capacities
Impaired ego resources
Alterations in sensory experiences (intrusive imagery, dissociation, depersonalization)

Studies on helper personalities and burnout

Studies by Hawkins and Shohet,[11] Rioch, et al., and Guggenbühl-Graig[12] on helper

personalities make possible an even more far-reaching understanding of the causes of burnout. They postulate that no one acts for purely altruistic reasons in entering a helping profession, and show that it is the dark sides of the personality that can lead to early burnout, if suppressed and left unprocessed. They include in this dark side a hidden urge for power on the part of the helper, as the "healthy" one superior to the "sick and helpless" client. Power over the client helps the helper to conceal and avoid his or her own feelings of helplessness and incapacity. Thus, for example, a helper will attempt to overcome his or her own feelings of helplessness by devoting hectic activity to clients, fighting for them with the authorities, and, in his or her role as the omnipotent rescuer, essentially reducing them to the role of a child. Such altruistic care of a cancer patient can help ward off fear of one's own death. A helper who takes on too many clients, groaning under a too-great workload and refusing to accept the support and help of colleagues, is trying through addictive overactivity to defend against his or her own neediness. Another dark side of the "selfless" helper is narcissistic lust for glory and honor, for idolization by thankful clients. A final aspect, which is particularly taboo, is a person's own violent side. A helper who has taken on the care of violent psychotics, suicides and drug addicts may have done this because, out of unconscious motives, he acts out and controls his dark side with the help of his patients: his hidden murderous impulses, paranoid fears, confusion and despair.

Two examples

Case history 1

In his last years of practice, an expert on the evaluation of concentration camp survivors underwent an about-face in his evaluation practice. Until then, he had pled for a finding of persecution harms even in doubtful cases, but now, even in obvious cases of survivor syndrome, he would conclude that they involved early-childhood psychological damage in the form of neurotic disturbance, which had simply been worsened temporarily by persecution. His evaluations came to public attention and an organization of concentration camp survivors complained to the reparations offices about what they considered his tendentious evaluations. His colleagues reported that in recent years he had withdrawn more and more from clinical work, isolated himself, and refused inquiries from colleagues and invitations to professional lectures. The tone of his evaluations was covertly aggressive towards the applicants. A colleague who was relatively close to him believed he detected depression. Thus, he said, the doctor in question had frequently expressed doubts about the results of his work as a psychiatrist and downplayed the unquestioned success of his reforms in the anachronistic German system of psychiatric care. After his retirement he brusquely burnt all bridges to his colleagues and died shortly thereafter. It must also be mentioned that this man had been a pioneer in his field; he had played an important role in the heated debates and scientific battles over so-called concentration camp syndrome in the 1960s and 1970s and had taken on the big names in German psychiatry, infected as they were by the racial-hygiene spirit of Nazism. How could one explain this about-face in his later years? My remarks are hypothetical, but there is much evidence that this colleague suffered from burnout. He had given his all in a grueling debate fought with no punches pulled, both professionally and on a political and legal level. He and other pioneers of the psychopathology of persecution were publicly defamed as unreliable evaluators who gave out positive evaluations as fa-

vors.[13] He may have come to a point where he was tired of being an outsider and hoped finally to be accepted by the academic mainstream. Perhaps he had also been manipulated by some of his clients. A small number of faked instances of persecution harms may have triggered a backlash, and from then on he received each applicant with great mistrust.

Case history 2

A psychologist who had made a name evaluating traumatized refugees and fighting with the authorities became, over the years, more and more the addressee for refugees who had problems with residency permits. In the country she came from, she herself had been subject to political persecution, but she spoke with evident disdain of her countrymen and claimed that the majority of them exaggerated and had not experienced particularly grave persecution. She took no patients from her homeland, only particularly difficult cases from other countries. Her office was packed during office hours. She would go through fire for her clients and for many took on the role of mother and friend. She took more applications for statements and evaluations than she could handle. Her very careful, convincing evaluations helped many people gain residency permits. For some clients, she functioned as both therapist and evaluator, which led to unresolvable conflicts of roles and loyalties. Like a typical workaholic, she worked to the brink of exhaustion. Her big-heartedness and eagerness to help were exploited, and she even gave material assistance to those in particularly great need. When she refused to give further help to an especially insistent client, he attempted to pressure her with threats of suicide. A few times, appearing as an expert witness, she felt compromised by her clients when, during proceedings before the administrative court, they suddenly gave different stories about their persecution that were completely contrary to their previous medical histories. She had difficulty explaining this, and the plausibility of her evaluations, and thus her professionalism in general, were called into question. Her initial zest ebbed, and more and more frequently she lost her temper, was aggressive to colleagues and clients, and ultimately suffered a long illness.[14]

The studies by Lansen, Hoppe and Shohet help us to better understand the traps illustrated by these two cases. The psychologist who denies her own persecution attempts through her altruistic dedication to other refugees to deal with her own trauma. She fends off her own needy impulses by driving herself to the brink of exhaustion for her clients. At the same time, she gains a narcissistic benefit: she is revered by her grateful clients like a cult figure and in this way satisfies her need for love and friendship. The fact that her evaluations help many clients to achieve residency status in court gives her a feeling of power and fantasies of being an omnipotent rescuer. In turn, this raises the expectations of her clients, and word gets around that she is a life preserver for hopeless cases. She is overwhelmed with clients. When her clients lead her astray and she is exposed and exploited in court, she is forced to the painful realization that this cannot end well, that it will all fall apart sooner or later, and that the clients are not her friends. Eventually she reaches her limit, her altruistic attitude changes, she is aggressive towards clients and colleagues and escapes into illness. Additionally, her over-identification and over-involvement with the victims was accompanied, as in Hoppe, by anger at herself for not doing enough against violence and its consequences.

In one of the big rallies in the mid 1990s against xenophobic and racist Neonazi

violence in Germany a slogan was carried saying: „Dear foreigners please protect us against *these* Germans!" Many caregivers of the postwar generation in Germany are driven by the wish to make up for the crimes of the Nazi parent generation. The slogan can be read as an appeal to foreign immigrants to absolve Germans from the sins of their Nazi parents.[15]

It is frequently observed that beginners in the field of psychotraumatology are in danger of starting off with highly inflated expectations. They are full of illusions that this work can help them battle the causes of violence in general or that their clients can be completely healed. This makes their disappointment all the greater when these expectations are not fulfilled and it turns out instead that the labour is often Sisyphean, marked by frequent setbacks, and that the criteria for success must be set very low.[16]

Social aspects

I would like to add something that is lacking in the studies mentioned here: One cause of burnout in helpers who work with traumatized people is their low level of social recognition, especially in the professional establishment. Such recognition, expressed in things as profane as titles, positions and salaries, nevertheless plays a major role in the psychological health of the helper. To return to the first case history: the doctors who dealt with the suffering of concentration camp survivors in the years immediately following the war were a small minority, unrecognized by the medical academic mainstream. They pursued their studies on their own, without institutional support. The subject was taboo in society, and it did not further one's career. Only much later did a few of them receive academic honors. The same is true today for colleagues who deal with torture victims and traumatized refugees. Their outsider position is apparent in the very fact that their institutions exist in a gray area outside of the normal health care system and the universities, and are understaffed and very modestly financed. Thus the people who work there feel like hamsters on a wheel. They work very hard, possess an enormous amount of knowledge and experience for which they are not well paid, and earn neither the interest nor the recognition of the professional world. They have little possibility of professional advancement. On the contrary: the subject of psychotraumatology is controlled by others who make careers with client populations that are easier to sell, such as victims of crime and traffic accidents. The issue is power and influence in society: who determines the prevailing scholarly views, who has the authority to interpret in the field of psychotraumatology? Colleagues from facilities for traumatized refugees often find their evaluations nullified by colleagues who have much less experience with these specific clients, but are considered more credible by courts and agencies merely because of their academic titles or important positions in the profession.

On the other hand, this outsider existence also has its fascinations. Torture is a taboo subject that is given a wide berth by normal people and society. They delegate the responsibility for doing something about it to institutions like centers for torture victims. There is something heroic, pioneering, missionary about the work. One is admired for this, but also dismissed as an exotic idealist. This is seductive, and it promotes narcissistic overestimation of the self. The danger exists of losing sight of reality; an elite team spirit develops in which the outside world is seen as hostile, or flatly separated into good and evil. This exaggerated self-image inevitably breeds disappointment that can be expressed in conflicts among col-

leagues. In principle, a treatment center for torture victims is a socio-medical service like any other, like child protection centers, addiction clinics, pain clinics, etc. If such centers became part of the normal health and welfare systems, this would reduce the idealistic overload and exaggerated expectations and would ease the pressure on the staff. In the Netherlands, treatment of traumatized refugees was integrated years ago into the general health care system. This form of social recognition and integration has led to noticeable relief and increased professionalization.

The overburdening of the evaluator role in the residency process

The terrible stories that confront therapists and evaluators of torture survivors create spontaneous feelings of sympathy and a strong impulse to help. One is tempted to do anything possible to ease the persons' suffering and guarantee them a secure life in exile. The risk of losing professional detachment is great. In the eyes of the subjects, the evaluator has enormous power, which can mean life or death in a residency procedure: residency means life, deportation means death. This puts massive pressure on the doctor or psychologist and, from the subject's point of view, shifts onto him a responsibility that is not his. I believe that the high risk of burnout for evaluators of the traumatized is also a result of this extreme tension, of the excessive demands that follow from the role of omnipotent judge and savior that is thrust upon him. Yet it is not his job to judge the subject's credibility or the plausibility of his story of persecution, like a criminologist. The final decision is made by the judge. The authority of the doctor or psychologist, as a clinical evaluator, consists exclusively in recognizing illness, diagnosing it, and assessing causation based on patient history and clinical and psychological test results. Especially in psychology and psychosomatics, one finds oneself here in the realm of probabilities. Like the reparations offices for Nazi persecutees in the past, however, the agencies – state foreigners' offices, the federal office for recognition of foreign refugees, and the pension offices (for former East German political persecutes)– require so-called "objective" information and findings.

The temptation to take an overly biased position in favor of the subject lies precisely in this overburdening of the evaluators' role. It also lies perhaps in latent feelings of guilt for being confronted from a secure position of privilege in a rich country of refuge with a person who has lost everything, partly because of actions by the country of refuge (weapons sales, economic assistance, restrictive asylum laws). Evaluators are under heavy moral pressure and fear the envy and aggressive reaction of the subject in case of a negative judgment. They may also fear being seen as heartless and being blamed for the subject's deportation and delivery to his tormentors. Negative transference where the therapist finds himself in the role of the perpetrator are particularly hard on therapists working with trauma victims. Not infrequently, colleagues who, in the process of an evaluation, reach a result other than the one desired by their subjects are berated and morally pressured by them. One refugee rejected by the treatment center took over the waiting room for days, slept by the entrance, repeatedly forced his way into the colleagues' office to show his scars, and complained to the director of the center that he was being treated like an animal.

As with treatment, there are also too few facilities and experts to evaluate reactive psychological trauma results. All facilities are overbooked and have long waiting lists. This is partly because refugees who have given up

everything in their home countries and find themselves here in exile at the lowest end of the poverty scale are confronted with an asylum process that requires detailed, consistent and coherent biographical histories of persecution. Often, because of their psychological disorders, they are unable to deliver this. The result is a pull in the direction of institutions that deal explicitly with torture. Lawyers and charitable organizations send their clients to centers for traumatized refugees as a last hope, because, supposedly, only an attestation or statement from such a center can help. Doctors and psychologists are utilized for work that lawyers and refugee counselors should actually be doing. But most clients cannot afford a lawyer, and therefore turn to psychosocial facilities that will advise them for free.

Preventing burnout and vicarious traumatization

The most important means of preventing burnout and vicarious traumatization in the field of psychotrauma is therapeutic self-awareness through a therapy training course.

Table 3. *Factors of prevention.*

Self Care – avoid workoholism, time for hobbies, leisure, family and friends
Solid professional training in diagnosis and (psycho)therapy
Therapeutic self-awareness
Regular self-examination by collegial and external supervision
Limiting caseload
Continuing professional education and learning about new concepts in trauma
Opportunities for research and training sabbaticals
Keeping a balance between empathy and a proper professional distance to clients Protecting caregivers against being mislead by clients with fictitious PTSD
Institutional setting in which the roles of therapists and evaluators are separated
Social recognition for caregivers
Overcoming financial and legal outsider status of centers
Integration of centers into the general health care system
Alliance with medical mainstream and academic medicine

(Table 3). If this is lacking, it should at least be provided on the job; otherwise, early burnout is inevitable. Regular self-examination with the help of collegial and external supervision is essential for both evaluations and treatment, in order to confront helpers, in a controlled environment, with their dark side. This would aid in determining whether they have become overidentified with their clients and risk losing professional detachment, or whether they have maneuvered themselves into detached avoidance or denial of the trauma. But despite common misperceptions, supervision cannot replace training and self-awareness!

To prevent clients from exploiting and deceiving helpers, limits and proper professional distance must be maintained. The patients' information should be supplemented by third party information, by comparisons with prior statements to agencies, and the knowledge of human rights organizations about methods of persecution and torture and prison conditions, including data on countries of origin. Several detailed interviews should be held before writing a statement or evaluation, including inquiry into the incidents described from various perspectives, keeping in mind that faked histories generally cannot be maintained consistently over a long period.

A further protection against burnout consists of the institutional and personal separation of therapist and evaluator, which has not been done to a sufficient degree in many facilities due to lack of financial and staff resources. It should be demanded from funders and the responsible authorities. In Berlin, this step has already been taken: the Center for the Treatment of Torture Victims, together with other facilities and the responsible professional associations, conducts a curriculum for diagnosis and treatment of PTSD for doctors and psychologists, at the

end of which the participants receive certification. Over the long term, this will increase the hitherto very small number of evaluation experts operating in the state of Berlin, to the point where it will be possible to separate the two functions.

As a further means of prevention, it is important that individuals not be solely involved with evaluating or treating traumatized patients. Many colleagues at centers for traumatized refugees, out of a healthy instinct for self-preservation, have reduced their hours in recent years and set up offices in which they also treat less-ill patients with neurotic disorders. Politicians and social insurance carriers should be urged to integrate facilities for traumatized refugees into the general health care system, as this would in the long run avoid the expensive follow-up costs of in-patient psychiatric care in chronic cases, free the work from its ideological burdens and its niche as an exotic charity, and offer more opportunities for continuing education in other areas. Not infrequently, apathy and disinterest appear in helpers in the midst of their professional careers if they cease to continue their professional education, and instead fall into the familiar rut of routine. This is a further cause of burnout that has rarely been mentioned in the literature.[17] Thus a work environment must be created that encourages flexibility and creativity and promotes continuing education and qualification, for example in the form of sabbaticals for research projects and publications.

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