

Compassion Fatigue and Self-Care

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Patient Trauma

- Adverse Childhood Experiences (ACE) study suggests that 2/3 of the population has had at least one adverse childhood experience
- ACE scores are associated with both psychological and medical conditions
- Trauma symptoms are adaptive and a self-protective measure

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245-258. DOI: [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8).



Staff Trauma

- All staff are from the general population, thus many of us have experienced our own ACES
- Addressing the complex needs of individuals with numerous and serious behavioral and physical health difficulties increases staff risk of experiencing symptoms associated with burnout and compassion fatigue
- Staff can also be triggered by our patients' behaviors and stories
- Staff exposed to trauma may be reluctant to explore patient's trauma



Organizational Trauma

- Organizations are made up of people and so these too can be traumatized
- Work stress decreases innovation, creativity, morale and professional development
- It also can influence how present we are with our patients



Definitions

- According to the Mayo clinic, “Job burnout is a special type of job stress — a state of physical, emotional or mental exhaustion combined with doubts about your competence and the value of your work.”
<http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642>
- Christina Maslach, researcher in the field of work burnout, defines it as “feelings of exhaustion, a cynical attitude toward the job and people involved in the job and a reduced sense of personal accomplishment or work efficiency. Burnout can be thought of as “taking away a person’s spirit and will.”
- Compassion fatigue is often used synonymously with secondary trauma and vicarious trauma to describe the reaction of helpers to the trauma experienced by others.



Signs of Compassion Fatigue

- Reduced feelings of sympathy or empathy
- Dreading working for or taking care of another and [feeling guilty](#) as a result
- Feelings of irritability, [anger](#), or [anxiety](#)
- Depersonalization
- Hypersensitivity or complete insensitivity to emotional material
- Feelings of inequity toward the therapeutic or [caregiver](#) relationship
- Headaches
- Trouble sleeping
- Weight loss
- Impaired decision-making
- Problems in personal [relationships](#)
- Poor work-life balance
- Diminished sense of career fulfillment

<https://www.goodtherapy.org/blog/psychpedia/compassion-fatigue>



Compassion Fatigue vs. Compassion Satisfaction

Burnout or compassion fatigue may be a response to:

- Workload demands
- Poor organizational practices
- Intense time pressures
- Unsupportive relationships with supervisors and co-workers
- Lack of control across work environments

Compassion satisfaction associated with:

- Competence to do the work
- Confidence to do the work
- Support of supervisor
- Focus on staff wellness
- Empowered to use voice and choice



Measuring Compassion Satisfaction & Compassion Fatigue: The Professional Quality of Life Scale (ProQOL)

- The ProQOL is free and has been used for 15 years - <http://proqol.org/>
- A 30 item self report measure of the positive and negative aspects of caring
- The ProQOL measures Compassion Satisfaction and Compassion Fatigue
- Compassion Fatigue has two subscales
 - Burnout
 - Secondary Trauma



American Psychological Association

Resilience Building Strategies:

- Make connections
- Avoid seeing crises as insurmountable problems
- Accept that change is a part of living
- Move toward your goals
- Take decisive actions
- Look for opportunities for self-discovery
- Nurture a positive view of yourself
- Keep things in perspective
- Maintain a hopeful outlook
- Take care of yourself

<http://www.apa.org/helpcenter/road-resilience.aspx>



Staff Self-Care Tips

Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers

By Françoise Mathieu, M.Ed., CCC., Compassion Fatigue Specialist

1. Take stock of what's on your plate
2. Start a self-care idea collection
3. Find time for yourself every day – rebalance your workload
4. Delegate - learn to ask for help at home and at work
5. Have a transition from work to home
6. Learn to say no (or yes) more often
7. Assess your trauma input
8. Learn more about Compassion Fatigue and Vicarious Trauma
9. Consider joining a supervision/peer support group
10. Attend workshops/professional training regularly
11. Consider working part time (at this type of job)
12. Exercise



Supervisors Staff-Care Tips

- Walk around the office to check in on staff and ask how they are doing that day or if they need anything
- Suggest that staff take mini breaks throughout the day to get fresh air, have a snack, stretch
- Engage staff in team huddles, meetings to debrief and allow for support of each other
- Empower staff to start their own staff support group
- Ensure that staff has opportunities for learning inside and outside of the work setting - feeling competent to do own's work reduces stress
- Give staff the tools and resources they need to do their jobs
- Celebrate individual and collective successes



Resources

Bounce Back Project: <https://youtu.be/RB-4DYJbjd8>

- 3 Good Things
- Gratitude Letters or Gratitude Wall
- Random Acts of Kindness

Laura van Dernoot Lipsky:

- Ted Talk – Beyond the Cliff-www.youtube.com/watch?v=uOzDGrcvmus
- Book – Trauma Stewardship-<http://traumastewardship.com/laura-van-dernoot-lipsky/>

University of Buffalo School of SW Self-Care Starter Kit:

<file:///C:/Users/LindaL/Documents/Self-Care%20Starter%20Kit%20-%20University%20at%20Buffalo%20School%20of%20Social%20Work.htm>



SAMHSA-HRSA Center for Integrated Health Solutions

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The **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** is a national training and technical assistance center dedicated to the planning and development of **integration of primary and behavioral health care** for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider Settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America's healthcare organizations that deliver mental health and addictions treatment and services.



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Burnout and Secondary Traumatic Stress: Impact on Ethical Behaviour

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ABSTRACT

This article discusses the issue of counsellor burnout and secondary traumatic stress (STS) and its potential impact on ethical behaviour. Burnout and STS are common outcomes of providing counselling and psychotherapy and may lead to counsellor impairment. A diminished ability to function professionally may constitute a serious violation of the ethical principles and consequently place clients at risk. The commonalities between burnout and STS and the relationship between impaired practice and ethical behaviour are outlined. Preventative measures must be implemented to counteract the effects of burnout and STS. Three major avenues of prevention include self monitoring, obtaining supervision, and intervention and support of colleagues. Implications for practice and training are presented.

RÉSUMÉ

Cet article examine l'épuisement professionnel et le stress traumatique secondaire chez les conseillers et conseillères et leur impact éventuel sur le comportement éthique. Il arrive souvent que les personnes assurant les services de counseling et de psychothérapie souffrent d'épuisement professionnel ou de stress traumatique secondaire, qui peuvent mener à une diminution des capacités des conseillers et conseillères. Des capacités professionnelles réduites pourraient constituer une violation grave des principes déontologiques et par conséquent présenter des risques pour les clients. L'article décrit les liens entre l'épuisement professionnel et le stress traumatique secondaire ainsi que la relation entre la pratique du counseling par des personnes ayant des capacités détériorées et le comportement éthique. Il faut mettre en oeuvre des mesures préventives afin de neutraliser les effets de l'épuisement professionnel et du stress traumatique secondaire. Les trois moyens principaux de prévention sont l'autosurveillance, le recours à la supervision, et l'intervention et l'appui des collègues. Les implications pour la pratique et la formation sont présentées.

As professionals who are trained to care for others, we often overlook the need for personal self-care. Until recently, burnout and secondary traumatic stress (STS) were unrecognized as common consequences of practicing counselling (Corey, Corey, & Callanan, 1998; Iliffe & Steed, 2000; Miller, 1998; Sexton, 1999; Sherman, 1996). If we do not recognize the potential for burnout and STS in ourselves, we run the risk of engaging in unethical behaviour. The purpose of this article is to address the relationship between burnout, STS, and ethical behaviour. Following an exploration of these issues, implications for practice and training are presented.

THE NATURE OF BURNOUT AND SECONDARY TRAUMATIC STRESS

Burnout and secondary traumatic stress (STS) are common outcomes of providing counselling and psychotherapy (Arvay, 2001; Figley, 1995; Mahoney, 1997). In fact, Kottler (1993) states that it is not a question of who will experience burnout, but how long the next episode of it will last. Pearlman and Saakvitne (1995) contend that traumatization is an occupational hazard that will affect all trauma therapists at least to some extent at some point in their career. A key difference between burnout and STS lies in the cause of the symptoms.

Definitions of burnout vary from "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who 'do people work' of some kind" (Ackerley, Burnell, Holder, & Kurdek, 1988, p. 73) to a condition of physical, emotional, and mental exhaustion brought on by involvement with emotionally demanding situations over prolonged periods (Pines & Aronson, 1988). Although there are various definitions of burnout, a common thread between definitions is that it is a negative internal psychological state (Emerson & Markos, 1996; Kottler, 1993; Mahoney, 1997; Norcross, 2000; Sheffield, 1998). Burnout includes psychological exhaustion (Maslach, 1982), over-involvement with clients and overwork (Maslach, 1982; Meiselman, 1990), emotional distress (Swearingen, 1990), and potential exploitation of clients (Norcross, 2000). It is a response to the emotional strain of working with others who are troubled and thus can be considered a job stress that arises from the social interaction between helper and recipient, personal frustration, and inadequate or impaired coping skills.

The resulting feelings can include helplessness, hopelessness, and a sense of entrapment that manifests itself in negative attitudes toward self, work, and life itself. Additional symptoms include anger, boredom, cynicism, loss of confidence, impatience, irritability, a sense of omnipotence, paranoia, denial of feelings, rigidity of perception, and sometimes increased physical ailments (Swearingen, 1990). Perhaps the most significant effects in terms of counsellor impairment are the reluctance to admit that a problem exists and a reluctance to look for causes or remedies (Corey et al., 1998; Kottler, 1993).

Secondary traumatic stress has been differentiated from burnout as being the result of the accumulation of experiences across many situations specifically related to dealing with clients' trauma (Figley, 1995; O'Halloran & Linton, 2000; Pfifferling & Gilley, 2000). Pearlman and Saakvitne (1995) and Figley (1995) define STS as the cumulative transformation in the inner experience of the therapist that comes about from the empathic engagement with clients' traumatic material. O'Halloran and Linton (2000) indicate that STS can include the rapid onset of post traumatic stress disorder-like (PTSD) symptoms in addition to the symptoms of burnout. Symptoms include re-experiencing the traumatic events in recollections or dreams, avoidance or numbing of reminders of the event such as efforts to avoid thoughts, feelings, and activities related to the situation, diminished affect, and loss of interest in significant activities, persistent arousal

such as having difficulty sleeping and concentrating, hypervigilance, and exaggerated startle response. While STS is the direct result of hearing emotionally shocking material from clients, burnout can result from work with any client group (Iliffe & Steed, 2000).

Although burnout and STS are defined differently, there are common impacts, symptoms, and themes between these two states. Both may result in depression, insomnia, or loss of intimacy with friends and family, and both are cumulative (Arvey & Uhlemann, 1996). The effects of burnout and STS may emerge in a counselling session as loss of empathy, respect, and positive feelings for the client (Skorupa & Agresti, 1993). Depersonalization (Ackerley et al., 1988) may also contribute to negative counsellor behaviour including responding to the client in a derogatory way, negating the client as a person, and being unresponsive to client needs. While burnout and STS have been identified as distinct constructs in the research literature (Arvey, 2001), the impact on the delivery of services is similar from the client's perspective. Counsellors who do not adequately deal with STS and burnout are more likely to experience disruptions of their empathic abilities resulting in therapeutic impasses and more frequent incomplete treatments. They are also more likely to have difficulty maintaining a therapeutic stance and to engage in boundary violations (Newmann & Gamble, 1995; Pearlman & Saakvitne, 1995).

An inability to care responsibly is another common symptom of burnout and STS. Kottler (1993) describes the symptoms as including an unwillingness to engage in social and family circles, a reluctance to check for messages or return calls, and "an unseemly delight" in a cancelled appointment. The counsellor may come to agree with the many clients who complain about hopelessness, frustration, or pessimism, and begin to doubt the efficacy of counselling. Daydreaming and escape fantasies occupy the counsellor's thoughts, while a reluctance to start the day pervades. Cynicism, loss of spontaneity and enthusiasm, procrastination, physical fatigue, and lack of family or social involvement plague the counsellor. When the counsellor reaches this point, he or she needs to be asking, "Am I doing my work as well as I might? Should I search for ways of becoming more effective?" (Pawlovich, 2000, p. 46). Surveys of practitioners have reported that anxiety, depression, substance abuse, and relationship problems are common responses (Deutsch, 1984; Thoreson, Miller, & Krauskopf, 1989).

Unremedied, burnout and STS can be expected to escalate to more severe impairments, although it is often difficult to see the outward signs of stress. Nonetheless, the longer the professional is in distress, the more likely that symptoms will be revealed. Colleagues may begin to see signs of boredom, fatigue, loss of interest in work, or a decreased ability to complete tasks. The impaired professional may fail to meet deadlines, forget appointments, dramatically change work habits, or become extremely critical and abrasive (Emerson & Markos, 1996). Clients may also notice symptoms when the professional's behaviour begins to affect them. Symptoms may include such inappropriate behaviours as being late for appointments, cancelling appointments, and being unresponsive to client

needs. Counsellors may protect themselves by their own denial. They may believe that drinking or using drugs is not the problem and tend to zealously protect their privacy by working alone and limiting professional contacts (Thoreson et al., 1989).

RELATIONSHIP BETWEEN BURNOUT, STS, AND ETHICAL PRACTICE

Clinical work is demanding and challenging, although the stressful nature of the work is not immediately apparent. Impaired practitioners, suffering from burnout and STS, are at risk of violating several of the ethical principles identified in the CCA Code of Ethics (1999) and CPA Code of Ethics (2000). The most notable areas of violation are identified to occur within (a) integrity in relationships (CPA, Principle 3; CCA, Principle C) and (b) responsible caring (CPA, Principle 2; CCA, Principle D). While these codes identify the necessity of being mindful of the aspirations of the ethical principles, clinicians require additional articulation of the mechanisms needed to apply them to practice.

Integrity In Relationships

The relationships formed by psychologists in the course of their work embody explicit and implicit mutual expectations of integrity that are vital to the advancement of scientific knowledge and to the maintenance of public confidence in the discipline of psychology. These expectations include: accuracy and honesty; straightforwardness and openness; the maximization of objectivity and minimization of bias; and, avoidance of conflicts of interest. (CPA, 2000, p. 73)

Whereas ethical codes delineate guidelines for integrity in relationships, little direction is given on how to manage this in practice. In the counselling relationship, the counsellor needs to be cognizant of the intimacy of the counselling relationship and consequently avoid behaviour that denigrates the needs of the client (Schulz, 1994). For example, some individuals harbour excessively high self-expectations regarding their counselling performance and abilities that violate the expectations of accuracy, honesty, and objectivity. They tend to expect themselves to work well with every client, serve as a perfect model of mental health, be on call 24 hours a day, place clients' needs before their own, be the most important person in every client's life, assume personal responsibility for clients' behaviour, and have the ability to control clients' lives (Meiselman, 1990). It is difficult to accept the limitations inherent in the role of counsellor if there is a personal need on the part of the counsellor to assume full responsibility and control in the lives of clients (Norcross, 2000). When they are unable to meet these unrealistic expectations, stress-related disorders are the probable outcome (Leiter & Maslach, 2001).

A serious relational breach of the ethical guidelines may be the exploitation of clients through boundary violations, dual roles, or role reversal to meet personal needs. "It is vital for counsellors to give some attention to their own level of stress and to become aware of the danger signs within themselves that signal...a

potential breakdown of the professional and ethical boundaries of the case” (Meiselman, 1990, p. 267). A counsellor who has not learned to meet his or her personal needs appropriately may become more and more deeply enmeshed with his or her clients. It is at this point that ethical violations occur and often result in overt, although unintentional, harm to clients. Over-involvement with a client blurs boundaries and can lead to confusion over ethical separation of personal and professional roles. Signs of over-involvement include being obsessed about the client and/or the client’s problem, withdrawing from involvement with other clients and family, deviating from professional behaviour, and wishing that the case would terminate. The over-involvement may or may not be sexual in nature and constitutes a serious breach of professional ethical codes (CCA, 1999; CPA, 2000). Therapists who are likely to become enmeshed are those who may be overly idealistic and dedicated. Such individuals are likely to sacrifice personal needs and concerns in an attempt to benefit others even when the result is physical or emotional harm to him/herself. It is not commitment that is the problem here; it is over-commitment and inappropriate levels of dedication that increase the chances of emotional difficulties.

Responsible Caring

Professionals are directed to maintain high standards of competence and ethical behaviour and recognize the need for continuing education and personal care in order to meet this responsibility (CCA, 1999; CPA, 2000). Since responsible caring requires professionals to actively demonstrate a concern for the welfare of individuals, the practitioner’s diminished ability to function as a result of burnout or STS may constitute a serious violation of a fundamental principle of ethical practice. Providing incompetent services may place the client at risk of harm (CCA, Principle B).

The signs of burnout and STS include a constellation of internal and relational indicators (Pfifferling & Gilley, 2000) that often overlap and interact. When the helping professional negates the client as a person and struggles to maintain a sense of empathy and respect for the client, a warning signal is being emitted. Since a demonstration of responsible caring requires the professional to be actively involved in the well-being of their client, these behaviours are the warning signs of the clinician failing to engage in responsible caring (CCA, 1999). Additionally, the professional may engage in minimizing the personal experience and pain of the client.

To keep a focus on both the costs and the benefits of engaging in practice is important in maintaining a firm grounding of self care. In fact, when reviewing both the CCA (1999) and CPA (2000) Codes of Ethics, reference is made to practitioners maintaining their level of competence (CCA, Ethical Principle A1, p. 3) and providing responsible caring (CCA, Ethical Principle D, p. 3). In order to comply with our own codes of behaviour, it is essential for counsellors to engage in self care and to monitor their professional functioning with the caveat that burnout and STS are consequences of professional practice. There is an

important differentiation that must be made between distress and impairment (Corey et al., 1998). Despite being identified as a guiding principle, however, these current Codes of Ethics do not describe or discuss the manner in which responsible caring is defined, leaving practitioners to make their own interpretations. The codes strongly emphasize our responsibilities as helping professionals to our clients but provide very little information on our own self care responsibilities.

Potential situations that create risk for mental health providers include lack of control of clientele, too many traumatized or high-risk clients, and unresolved personal issues (Arvay, 2001; Vredenburg, Carlozzi, & Stein, 1999). Typically, the chronically suicidal, trauma survivors, child welfare cases, clients with addictions, and multiple issue clients often comprise high-risk situations for both clinicians and clients. A lack of training to deal with these issues contributes to the potential of burnout and STS when the required services go beyond the counsellor's expertise. Out of an ethic of caring, the counsellor may feel compelled to attempt to provide service. This would be particularly relevant in regions where service provision is limited. The demand for service and attempt to provide it without adequate training places the professional in an untenable position. Therefore, not only is the client or issue difficult to deal with, but there is an added element of struggling to provide competent service. Additionally, many professionals working within agencies have little control over the type of clientele to whom they provide service or the size of their client load (Ackerley et al., 1988; Dupree & Day, 1995) and consequently report lower levels of satisfaction and higher levels of burnout and STS. Therefore, difficulty may result from a mismatch between the therapist and type of client that the agency serves.

The most difficult situation, however, likely involves dealing with clients that trigger the professional's personal issues (Corey et al., 1998). Examples of these concerns include a family history of alcoholism, abuse, or violence. The client may be dealing with issues that are related to the therapist's own unresolved problems (Danieli, 1994). Pearlman and MacIan (1995) found that those therapists experiencing burnout or STS who had a personal experience of trauma in their lives reported greater levels of vicarious traumatization than those without a personal trauma history.

IMPLICATIONS FOR ETHICAL PRACTICE

Preventative measures need to be implemented to counteract the effects of burnout or STS. Not only is it a matter of personal health and welfare, but it is an ethical obligation to maintain the provision of service to the highest standard possible. Three strategies are suggested in this article: (a) self monitoring, (b) obtaining supervision, and (c) intervention and support of colleagues. The principles mandate that attention to client need be paramount in service provision. As an initial step, it is our responsibility as professionals, therefore, to broaden our understanding of how impairment has the potential to impact ethical

behaviour and to develop a repertoire of practices to ameliorate the impact of conducting psychotherapy. Norcross (2000) indicates that the Socratic dicta of “know thyself” and “heal thyself” should be taken to heart by all practitioners and that psychological principles, methods, and research should be brought to bear on therapists themselves. Mahoney (1997) and Norcross agree that this is an ethical imperative in order to protect both clients and therapists.

Self monitoring is an ethical responsibility of all counsellors. Pearlman and Saakvitne (1995) contend that the effects of traumatization can be modified and ameliorated if they are made conscious and addressed proactively, as they believe that counsellors need to identify and accept traumatization in themselves as a normal response before they are free to develop strategies and seek support to counteract its effects. Norcross (2000) discusses the results of a study in which both program directors and professional psychologists identified “self-awareness/self-monitoring” as the top-ranked contributor to optimal functioning among psychologists. As Herlihy and Corey (1996) state

Because competence is so difficult to define and assess, careful self monitoring may be the most effective method to ensure that they are providing the highest quality of services. Counsellors are ethically obligated to monitor their effectiveness as professionals and take steps to improve as necessary. (p. 220)

Self monitoring signifies a commitment to replenishment both personally and professionally. Personal replenishment can involve a diversity of activities. Mahoney (1997) reported a large majority of therapists surveyed (87.7%) had been in personal psychotherapy. Other personal self care activities included practicing meditation or prayer (50%), engaging in regular physical exercise (75%), and pleasure reading, hobbies, and artistic enjoyments (80%). Engaging in creative endeavours, exercise, and social activities have also been recommended (Pearlman & Saakvitne, 1995). Maintaining a fulfilling personal life helps to keep clear boundaries.

Obtaining supervision and maintaining a professional support system (Norcross, 2000) are additional components of practicing ethically. Professional replenishment can include supervision and debriefing, monitoring caseloads, and focussing on client resilience and strengths (Iliffe & Steed, 2000). When used for prevention, such methods can assist counsellors in maintaining their psychological and physical health while dealing with highly distressing individuals. Developing and maintaining a network of people who can offer support and with whom trauma-related work can be shared also seems to be important (Pearlman & Saakvitne, 1995).

Organizations can ensure that adequate resources are made available to help practitioners process disturbing clinical material (Figley, 1995). This can be done by including clinical supervision or consultation, case conferences, peer process groups, personal psychotherapy, trauma therapy training, professional development, and regular organizational team meetings (Neumann & Gamble, 1995). Obtaining regular supervision is an important element in maintaining professional

accountability regardless of the level of experience. This work is too demanding to do without supervision and should be understood as an ethical responsibility to maintain competence (Pearlman & Saakvitne, 1995; Yassen, 1995).

In addition to self monitoring and supervision, we have a professional and ethical responsibility to address concerns that arise when observing colleagues who are demonstrating signs of impairment. Sensitivity to colleagues' distress and a willingness to discuss these concerns with the colleague, even when the immediate reaction may be expected to be defensive, hostile, or rejecting, is challenging and sometimes feels threatening (Good, Thoreson, & Shaughnessy, 1995). Not only is it an ethical responsibility to provide feedback, but each practitioner needs to maintain a position of being open to receiving feedback from colleagues.

We may hold a double standard as healing professionals. Those who heal may think of themselves as not requiring healing, as it may be seen as a negative reflection of personal and professional competence. This perception may hinder the decision to identify the need for assistance and make the decision to obtain it. Good et al. (1995) indicate in their study that despite knowledge of colleagues' impairment, few were willing to confront the colleague directly or report the impairment to the licensing body. To compound this issue, a survey completed by Barnett and Hillard (2001) indicates that there are few assistance programs provided by professional associations. They concluded that while helping professionals are ready, willing, and able to assist others, there is a failure to "assess and acknowledge personal feelings of distress" (p. 206) within the profession. Intervening with caring concern, even when rejected, may be an important step toward addressing the distress that is being perceived by other colleagues. Licensing boards across the country operate with the mandate to protect the public but unless members of the profession are sensitive to and act to ameliorate symptoms of burnout and STS in themselves and in their colleagues, ethics boards are rendered ineffective.

IMPLICATIONS FOR PRACTITIONER TRAINING

Until recently, counsellor educators have not included training for students about the occupational hazards of burnout and STS. There are emotional costs of being involved in a profession based upon an ethic of caring. Trainees need to be prepared for the impact on their personal health and well-being of working in demanding settings, with large case loads, and with challenging client issues. It is important for graduate training programs to establish a culture that stresses the importance of self care strategies from the onset of the training program. The benefit of practitioners maintaining a range of supportive professional relationships with whom they can process their personal reactions and arising issues needs to be stressed through all aspects of counsellor training.

Not only is it important to have a culture that fosters self care, but there needs to be didactic training in ethical and personal care issues in both practica and theoretical courses. Ethics training needs to both teach the delivery of service to

clients and address the issues of self care and impairment. Heretofore, training programs have focussed on ethical behaviour in relationship to delivery of client services, but rarely have they focused on the responsibilities of the professional to maintain their own well-being. The emerging literature suggests that this is an important aspect that needs to be addressed within our program delivery (Corey et al., 1998).

While most practitioners in training may understand burnout and STS from an academic perspective, the challenge is to help students make the transition to a personal understanding that no one is immune. It is important that therapists take time to reflect on their experiences and to develop self awareness of their reactions to the work. The impact upon therapists is unavoidable but can be ameliorated by proactive strategies that include developing trauma training programs and creating a culture that acknowledges and normalizes personal reactions. Finally, a crucial element of the therapist's self care and ethical responsibility is to arrange regular supervision or consultation, regardless of his or her level of training or experience, establish a professional support network, and engage in systematic self monitoring.

CONCLUSION

In addition to the increasing body of research attesting to the negative personal toll exacted by a career in counselling and psychotherapy, there is growing recognition of the need for professionals to engage in preventative measures that maintain personal well-being. The literature points to internal and relationship difficulties as the common residue of immersing ourselves in the inner worlds of distressed people. Helping professionals need to acknowledge that the nature of their work makes them susceptible to and likely to experience burnout or STS unless regular corrective action is taken to circumvent it. Perhaps a significant benefit to be achieved from acknowledging the strains of counselling is the realization that virtually all mental health professionals experience similar kinds of pressure. Corrective action can be facilitated by appreciating the universality and inevitable personal distress associated with providing psychotherapy.

Competent practice requires that counsellors constantly monitor their personal attitudes toward their clients and toward their work. It is an ethical imperative to deal with personal issues in order to maintain a high standard of practice and adhere to the principles of responsible caring and integrity of relationships. The challenge is to incorporate the practice of continual self reflection and corrective action with the aim of maintaining personal mental health to ensure that the highest possible level of service is provided.

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