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Clinician Responses to Client Traumas: A Chronological Review of Constructs and Terminology

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Abstract

This paper presents a chronologically-organized review of various concepts and constructs in the literature describing professional burnout, compassion fatigue, secondary traumatic stress reactions, as well as other related terms and constructs that have been used to describe these experiences among clinical practitioners and other social service professionals. A timeline will provide a graphic illustration of the historical relationships between the concepts under examination. This paper begins with a review of practitioner-related stress that primarily results from interaction with clients, followed by an examination of professional burnout, which is thought to result largely from environmentally-related issues. Finally, the paper concludes with a discussion of posttraumatic growth and compassion satisfaction.

Keywords

vicarious trauma, PTSD, mental health and violence

Introduction

Professionals interested in helping others overcome mental health troubles have long been interested in the impact of professional practice on their own well-being. It is now understood that clinical providers can absorb some measure of the emotional pain their clients endure while listening to individuals, families, groups, or even entire communities describe their experiences of suffering. However, limits in the understanding of the relevant concepts and nomenclature in this area has hindered the ability to fully comprehend and measure the mechanisms by which this happens. This is particularly true for those treating clients who are survivors of primary trauma experiences (Courtois, 2002; Cunningham, 2004; Rothschild & Rand, 2006). In the last two decades, the therapeutic community has acknowledged the existence of these risks and the possibility that there may be underestimated occupational hazards for those providing clinical services (Pryce, Shackelford, & Pryce, 2007; Thomas & Wilson, 2004), but the emotional impact of receiving trauma material on clinical providers has historically been an overlooked issue in professional training programs (Cox & Steiner, 2013; Newell & MacNeil, 2010).

Although the professional community has become more aware of its professional and ethical obligations to participate in activities of professional self-care as a mechanism by which optimal services to others can be offered, the concepts, constructs, and labels for the phenomena are not commonly well understood by service providers (Newell & Nelson-Gardell, 2014). Indeed, while scholars continue to disagree on these labels and concepts, many of the terms have entered the lay vocabulary and are bandied about freely. For example, while "being depressed" is commonly used in the general public to describe a psychological state, the clinical criteria to satisfy the diagnosis for "depression" are quite specific; similarly, the common usage of terms such as "burnout" has created confusion in many professional ranks. Further, the common but incorrect consideration that terms related to this topic are synonyms complicates the discussion. Clarity and understanding of these constructs must be achieved in order for professionals to properly enact their professional and ethical responsibilities related to self-care (Cox & Steiner, 2013; Newell & Nelson-Gardell, 2014). A comprehensive presentation of the evolution of the concepts and nomenclature related to this topic has not been well articulated to date. This article attempts to fill this void by providing a chronologically organized review of concepts in the literature describing professional burnout, compassion fatigue, secondary traumatic stress reactions as well as other related terms and constructs that have been used to describe these experiences among clinical

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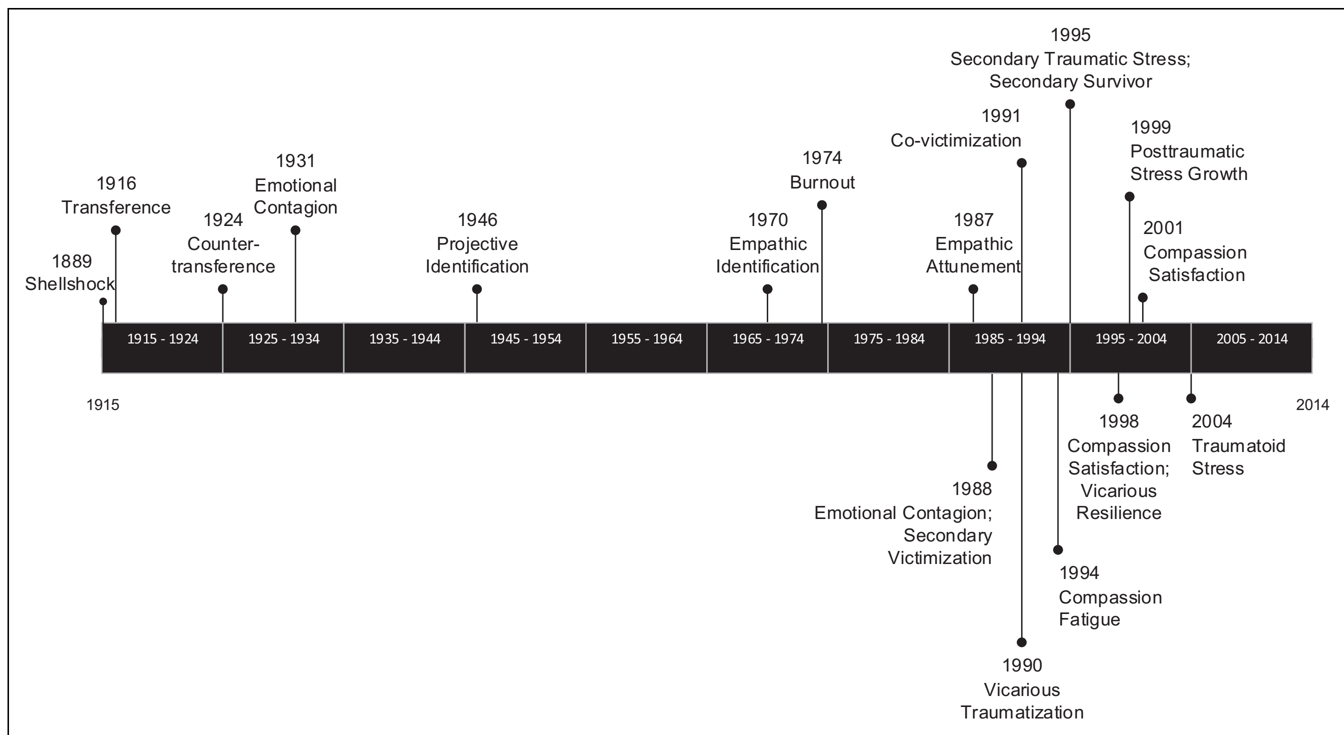

Figure 1. Terminology and Construct Timeline.

practitioners and other social service professionals. The intention for this work is to provide more than a review of literature but rather a conceptual description using contemporary and historical literature to explore the emergence of the various concepts and constructs used to describe how clinicians have viewed and responded to the difficult and traumatic experiences brought to them by clients for resolution. A timeline (see Figure 1) will provide a graphic illustration of the historical relationships between the concepts under examination forming the central focus of the article. For the sake of clarity and coherence, there is first a presentation of the evolution of terms used to describe practitioner-related stress that primarily results from interaction with clients, followed by an examination of professional burnout, which is thought to result largely from environmentally related issues. Finally, the article concludes with a discussion of posttraumatic growth (PTG) and compassion satisfaction.

Review of the Literature

While a thorough discussion of the history of posttraumatic stress disorder (PTSD) is beyond the scope of this article, in order to clearly understand any secondary or vicarious effects of client work on the therapist, one must first have a firm working knowledge of the primary effects of trauma on those clients who ultimately become involved with treatments for their stress reactions. The idea that neuroses could manifest based solely on life experiences outside of the biological mechanisms of the human brain and beyond the labyrinth of the unconscious mind was grounded in the examination of combat soldiers returning from war, particularly the First and Second World Wars (Birmes, Hatton, Brunet, & Schmitt, 2003; Figley & Nash, 2007; Van der Kolk, McFarlane & Weisaeth, 1996; van der Kolk, 1996). While this era marked the first formal examination of what is now referred to and understood as PTSD, references to the impact of combat stress on the mind and the soul of the soldier can be documented for as long as there have been written accounts of the tragedies associated with the acts of war (Birmes et al., 2003; Figley & Nash, 2007). Although the contemporary diagnostic terminology and the use of a "clustering of symptoms" classification system was not officially accepted into the Diagnostic and Statistical Manual for Mental Disorders–Third Edition (DSM III) until 1980, the impact of combat stress and trauma has been described historically using various descriptive terms such as *irritable heart*, *combat neuroses*, *war neuroses,* and *shell shock* (Figley & Nash, 2007; Gersons & Carlier, 1992; van der Kolk, McFarlane, & Weisaeth, 1996).

As the professional understandings of the fields of traumatology have developed over time, the various psychological responses to combat stress first observed in soldiers have been generalized to other traumatic events including natural disasters; fire or explosion; serious automobile or other moving vehicle accidents; exposure to a toxic substance; domestic violence and physical or sexual assault; rape; life-threatening illness; or bearing witness to severe human suffering, homicide; suicide; or sudden unexpected death or serious injury to a significant person or persons (American Psychiatric Association [APA], 2013; Figley, 2002). Thus, primary traumatization or posttraumatic stress reactions are understood as

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the consequential, complex, and problematic patterns of behavior that result from the impact of a traumatic incident or event involving an actual or perceived threat on the obvious victim or victims of that incident (APA, 2013; van der Kolk et al., 1996).

The Influence of Psychoanalytic Theory

As illustrated by the timeline, we suggest that the first formal discussion in the professional literature describing the process by which the emotions of a client can be absorbed or ''transferred'' to the therapist was introduced in the early 1900s as part of the advent of Freudian theory and the practice of psychoanalysis (Clarkson & Nuttall, 2000; Freud, 1923/1964; Hayes, Gelso, & Hummel, 2011; Orr, 1988). The Freudian view of transference represents the client's unconscious projection of thoughts, feelings, and emotions based on past experiences onto the therapist or other individuals involved with the client, such as spouses, friends, or other persons of significance (Freud, 1923/1964; Jones, 2004). However, Freud later observed that it would be impossible for the analyst to completely block all conscious and unconscious thoughts and feelings about the patient and described ''transference neurosis'' as being a complimentary pathway between the analyst and the client (Hayes et al., 2011). This process, by which client information and material presented to the analyst during psychoanalysis activates the analyst's own unconscious and unresolved childhood conflict, was referred to as ''countertransference neurosis,'' later referred to simply as countertransference (Freud, 1923/1964; Hacker, 1957). In the process of classical or Freudian psychoanalysis, the phenomenon of transference neurosis from the client to the analyst was generally described as positive as it allowed for the analyst to learn more about the client's neuroses (Jones, 2004). Ideally, the mind of the analyst would be like a ''blank slate,'' allowing the patient to project his or her neurotic feelings onto the analyst for interpretation uncomplicated by the analyst's own interpersonal conflicts and neuroses (Appignanesi & Zarate, 1979; Freud, 1923/1964). Consequently, the phenomenon of countertransference was not viewed as a positive or helpful part of the psychoanalytic process but rather as potentially harmful or even destructive to the analyst's ability to objectively analyze and interpret clients' information and situations (Clarkson & Nuttall, 2000).

As with other concepts discussed in this article, there is wide variation in the literature regarding what specifically constitutes a countertransference reaction between a therapist and a patient. The process of countertransference has been described in two different ways: first, as the collective unconscious response a therapist has to his or her client, the client's clinical material, transference, and reenactments based on the therapists past life events; and second, as the therapist's conscious and unconscious defenses against the presentation of information and material by the client, including reactions such as avoidance, detachment, and overidentification with the client and his or her situation (Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). This distinction between the two types of countertransference reactions has also been referred to as Type I and Type II countertransference (Wilson & Lindy, 1994).

Freud's identification of the countertransference relationship between the client and the therapist also influenced later, similar developments in psychoanalytic theory and process in concepts such as projective identification. Projective identification (Klein, 1946) is said to occur when a therapist experiences emotions or feelings similar to that of the client due to the client's projection of these feelings onto the therapist (i.e., while in the process of therapy, the client states ''you feel disgusted,'' when in fact the client feels disgusted and the therapist does not feel disgusted), and the occurrence of projection identification has been described as an antecedent behavior to countertransference (Greatrex, 2002; Rothschild & Rand, 2006).

Secondary Trauma Effects: A New Dimension

Following the increased awareness of work-related stress brought about by research on professional burnout in the 1980s and early 1990s (see following section), there was increased interest in the idea that clinical (micro) practice, particularly work with people experiencing emotional reaction to traumatic events, could have a negative impact on the worker beyond the macro-oriented conceptualization of professional burnout. This idea suggested that there was potential for maladaptive emotional reactions with associated behaviors to occur in the helping professional due to chronic exposure to clients' trauma material and information that were not countertransference reactions and that were not the result of professional burnout. The review of the literature in this area reveals there are three central terms used to describe the negative psychological reactions mental health professionals may experience when working with traumatized clients: vicarious traumatization, secondary traumatic stress, and compassion fatigue. However, other terms, such as co-victimization, secondary survivor, emotional contagion, secondary victimization, and traumatoid stress, were also cited in the literature less frequently but used in similar connotations.

The term vicarious traumatization was first introduced into the literature in the early 1990s. The development of this concept was largely influenced by the work of Laurie Anne Pearlman with survivors of sexual abuse and incest. Pearlman described the effects of trauma as ''vicarious,'' meaning therapists treating trauma victims could actually indirectly experience the client's emotional traumatic reactions (or other psychological reactions) themselves in the process of treatment as a result of chronic empathic engagement (McCann & Pearlman, 1990; Pearlman & MacIan, 1995). Based on the theory of constructivist self-development, vicarious trauma represented the potential cognitive changes in the therapist's collective frame of reference both intrinsically and extrinsically, such as the therapist's sense of self; worldviews regarding issues such as safety, intimacy, and trust; and spirituality as a result of chronic exposure to and the treatment of trauma-related disorders (McCann & Pearlman, 1990; Pearlman,

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1998; Pearlman & Saakvitne, 1995). If left untreated or unacknowledged, it has been suggested that vicarious traumatization could result in a complete disruption in the therapist's ability to provide care for both himself or herself and the client, essentially depleting psychological resources and abilities for client and self-care (Pearlman & Saakvitne, 1995; Rothschild & Rand, 2006; Stamm, 1999).

During this same time period in the early to mid-1990s, the term secondary traumatic stress was introduced into the literature largely by the work of Charles Figley who grounded this concept in his early works examining the psychiatric symptoms associated with PTSD (Figley, 1995). Questioning whether clinical interaction with clients suffering from primary trauma–associated disorders could have secondary effects on the provider, Figley referred to this phenomenon in his early work as catastrophic stress reaction and also traumatization by concern (Figley, 1995). He later defined what is now referred to as secondary traumatic stress as the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). Similar to the work of Pearlman and the concept of vicarious traumatization, it was suggested that secondary traumatic stress reactions may also result from engaging in an empathic relationship with a client or other close associate suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that particular person's trauma (Figley, 1995). However, rather than focusing on the cognitive shifts in thinking that could potentially occur when treating trauma disorders, Figley's early conceptualization of secondary traumatic stress suggested that the clinician could actually mirror the symptoms of PTSD in the client to a lesser degree (Figley, 1995). Therefore, the manifestation of a secondary traumatic stress reaction could potentially include a full range of PTSD symptoms, including intrusive thoughts, traumatic memories, nightmares associated with client traumas, insomnia, chronic irritability or angry outbursts, fatigue, difficulty concentrating, avoidance of clients and client situations, and hypervigilant or startled reactions toward stimuli or reminders of client trauma (Figley, 1995).

The symptoms associated with exposure to a traumatic event include intrusive memories and reexperiencing of the traumatic event, avoidance of trigger stimuli associated with the traumatic event, and increased arousal upon exposure to reexperiencing symptoms or trigger stimuli (APA, 2013). In addition to direct exposure to a traumatic event or events as described above, recent versions of the DSM stipulate that the diagnostic criteria for PTSD also indicates that trauma reactions can occur based on "learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (APA, 1994, p. 424) and "Experiencing repeated or extreme exposure to aversive details of the traumatic events(s)" (APA, 2013, p. 271). In other words, these parts of the diagnostic criteria suggest that traumatic reactions may occur as a result of hearing or experiencing trauma indirectly through the suffering of someone else, as in the case of social service professionals or family members who are responsible for providing care to the individual who is suffering. However, it was not until recent history that the indirect form of posttraumatic stress was identified as a separate issue of concern.

Perhaps the most recently used term regarding clinician's psychological reactions to their clients is compassion fatigue, which evolved from earlier work on various trauma and secondary traumatic stress. Compassion fatigue has been cited in the literature and frequently used interchangeably (although we contend, incorrectly) with both vicarious trauma and secondary traumatic stress (Newell & MacNeil, 2010). Compassion fatigue has been both described and measured as a component of overall professional quality of life and as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout (Figley, 1995; Stamm, 1999, 2005). Compassion fatigue is a more general, and perhaps more user-friendly term that describes the overall experience of emotional and psychological fatigue that mental health professionals experience due to the chronic use of empathy when treating individuals who are suffering in some way (Figley, 1995; Stamm, 2005). The concept of compassion fatigue suggests that clinicians who treat victims of trauma may experience a significant level of stress associated with trauma work but may or may not experience a secondary traumatic stress reaction. Others have wondered about the interrelationships of these terms. For example, Sabo (2011) posed the question as to whether compassion fatigue might be an antecedent behavior to vicarious traumatization.

Professional Burnout

In the 1960s and early 1970s, with the growth of the helping professions, a macro-oriented conceptualization of the stress of human service work that included the social service agency and the community was cited in the research literature (Freudenberger, 1974; Maslach & Schaufeli, 1993). With the proliferation of community-based social service helping agencies, there was also a subsequent increase in the number of career human service professionals entering the workforce. This era marked the first time social service workers became responsible for large numbers of cases, and when the phenomenon of becoming "burned out" with professional responsibilities was first introduced (Freudenberger, 1974). One of the first qualitative descriptions of professional burnout depicted professional social workers as:

> idealistic young men and women who, while working harder and harder, were sacrificing their own health in the process of meeting ideals larger than themselves, and reaping few rewards for their efforts. Despite all their energetic and enthusiastic labor for the larger good, the human service worker often failed to make a difference in the lives of their clients. (Freudenberger, 1974, p. 160)

The concept of professional burnout actually introduced a new orientation to the influence of the stress associated with

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working difficult clients, one that accounted for both the interpersonal relationship between the human service professional and the client and also the relationship between the professional and the social service agency (Maslach, 2001). The breadth and applicability of the concept of professional burnout has reached far beyond the confines of psychoanalysis or psychotherapy and even the human social services field and has been researched in fields such as management, technology, education, and within military populations (Maslach, 2001). In fact, the term burnout has now been absorbed into the lay vocabulary in a manner similar to terms associated with psychoanalysis did earlier in history.

Professional burnout can be defined as a state of physical, emotional, psychological, and spiritual exhaustion resulting from chronic exposure to (or practice with) populations who are vulnerable or suffering (Pines & Aronson, 1988). The actual process of *burning out* is best described as a progressive state occurring cumulatively over time, with contributing factors related to the individual, the populations served, and the organization (Maslach, 2001, 2003). Burnout is best conceptualized as a multidimensional or meta-construct, with three distinct domains: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment (Maslach, 1982, 2001; Maslach & Jackson, 1981; Maslach & Leiter, 1997). A multidimensional approach to burnout provides a holistic conceptualization of this otherwise complex phenomenon (Lee & Ashworth, 1996; Maslach, 1998). Emotional exhaustion is a state that occurs when a practitioner's emotional resources become depleted by the chronic needs, demands, and expectations of their clients, supervisors, and organizations (Maslach, 1998, 2001). Depersonalization (also referred to as cynicism) refers to the negative, cynical, or excessively detached responses to coworkers or clients and their situations (Maslach, 1998, 2001). This domain is a representation of the change in interpersonal thoughts and feelings regarding practice with clients that may occur in the process of professional burnout. Reduction in one's sense of personal accomplishment occurs when professional helpers feel inadequate when clients do not respond to intervention, despite efforts to help them. This domain of the burnout phenomenon may also occur in response to bureaucratic constraints and administrative demands that often accompany social service practice, such as dictating client records or completing required administrative documentation.

Factors contributing to professional burnout may occur at the individual, organizational, or client levels (or in combination). The single largest risk factor for developing professional burnout in human service work occurs at the organizational level due to chronically inadequate funding and professional resources coupled with the overwhelming level of need of many consumers and their families. The emotional expectations involved with human service work, such as requirements to either repress or display emotions routinely as well as the chronic use of empathy, are strongly associated with the experience of professional burnout (Maslach, 2001; Maslach & Leiter, 1997). As many direct practitioners work within bureaucratic social service agencies, the organization plays a key role in the professional burnout process. Organizational factors shown to contribute to professional burnout include excessively high caseloads, lack of control or influence over agency policies and procedures, unfairness in organization structure and discipline, low peer and supervisory support, and poor agency and on-the-job training (Barak, Nissly, & Levin, 2001: Maslach & Leiter, 1997). Organizational behaviors such as frequent absenteeism, chronic tardiness, chronic fatigue, evidence of poor client care, and low completion rates of clinical and administrative duties should be considered warning signs for burnout (Barak et al., 2001; Lloyd, King, & Chenoweth, 2002). At the individual level, factors such as conflicting relationships with coworkers, individual personality and coping styles and difficulty interacting with and understanding clients and their situations may also contribute to the experience of professional burnout (Barak et al., 2001; Lloyd et al., 2002; Thorton, 1992).

Posttraumatic Growth and Compassion Satisfaction

A recent shift in the professional literature in this area presents a stronger focus on defining and measuring the positive aspects and experiences that occur in trauma practice, rather than focusing solely on the negative and sometimes consequential implications of clinical work with those who are vulnerable and suffering. Our review of the literature reveals one common denominator in this area, which is the use of empathy and compassion as the driving force to do this work. This is illustrated in the literature by early references to terms such as empathic identification and empathic attunement. To work with those who are vulnerable and suffering, particularly trauma populations, inherently requires clinicians to be actively ready to use their own personal psychological resources in the form of empathy and compassion on a daily basis. While this may seem obvious to those of us in the profession, we maintain that this "requirement of the job" is quite unique in comparison to other professional disciplines. In other words, the emotional requirements of clinical practice, specifically the chronic use of empathy and compassion, are simply not required as part of the essential skill set in other professions. However, the recent shift in focus to the positive aspects of trauma work suggests that while the chronic use of compassion and empathy within the context of practice can be a great source of stress, there is also potential for this to be a great source of strength and fulfillment (Radey & Figley, 2007; Stamm, 1998). It has been suggested that learning to regulate empathy as one interacts with clients and their experiences can actually promote the growth of practice wisdom and expertise (Linley, 2003).

The timeline illustrates that many of the concepts discussed in this article emerged in response to developments on primary trauma. We have found that this is also true of the literature on positive adaptation. Grounded in the research and literature on PTSD, the term posttraumatic was first cited in the late 1980s but became a more researched and measured construct in the 1990s. Much of the early work in this area was conducted by

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Tedeschi and Calhoun, who suggested that personal growth can occur even in the most challenging of life situations such as physical and sexual assault, major medical illness, natural disaster, and combat stress (Tedeschi & Calhoun, 1996, 2004). Much like the review of the literature on the other terms and constructs in this article, the review on PTG revealed other terms such as *stress-related growth* and *transformational coping* that have been used interchangeably with PTG (Linley, 2003).

The literature on PTG and related terms focuses solely on the ability of the trauma survivor to move beyond the traumatic experience and to grow as a result, but it applies itself only to the trauma survivor and not to the practitioners treating the trauma material (Engstrom, Hernandez, & Gangsei, 2008). Later terms such as vicarious resilience (Hernandez, Gangsei, & Engstrom, 2007) were introduced into the literature, suggesting that the process of trauma recovery has the potential to foster resilience and growth not only in the client but in the clinician as well. One commonly used term in this area is *compassion satisfaction*, which refers to those aspects of work that are rewarding and fulfilling to the human service professional (Conrad & Keller-Guenther, 2006; Stamm, 2005). Elements of compassion satisfaction may include positive interactions with clients, colleagues, the human service organization, or the helping community in general (Stamm, 2005). Vicarious resilience describes the positive psychological transformations that can occur in the clinician during the process of trauma recovery due to the direct exposure and contribution to client growth and recovery (Hernandez et al., 2007). Again, with empathy as the driving force behind compassion satisfaction and vicarious resilience, both of these terms suggest that witnessing and interacting with clients as they overcome adversity and heal despite hardships and suffering allows the clinician to experience professional and spiritual satisfaction in a unique way (Engstrom et al., 2008). This type of personal and professional growth can, and should, be considered both a unique reward of clinical practice and an opportunity to truly appreciate the importance and value of this work.

Conclusion

The aim of this article is to provide a historical perspective on the various constructs in the professional literature describing the consequential responses clinicians may have to clients and their problems, particularly for clinicians involved in trauma practice. The intention of this work was to provide an exploration of conceptual knowledge and application of the various concepts and constructs used to describe how clinicians have viewed and responded to the difficult and traumatic experiences brought to them by clients. In order to highlight the issues facing the field, we have attempted to illustrate the complex evolution of trauma practice and how it affects practitioners. The review and corresponding timeline illustrates the many terms cited in the literature, describing these phenomena, terms that are used interchangeably, to describe very similar phenomenon.

We began our work on this article with the metaphor of a family tree in mind. This metaphor allowed for the consideration and development of various "branches" simultaneously, but eventually it was decided that the best way to provide a clear representation of the evolution was through a timeline. This "genealogical narrative" allowed for the partial unraveling of the conceptual conundrum presented by a variety of constructs currently in use to express professionals' concerns with the influence of client trauma on clinicians' emotions, thinking, and behavior. One of the positive implications of investigating the history of these constructs is that the literature revealed a movement in human services, particularly in trauma practice, toward realizing the importance of professional self-care. In fact, one could hypothesize for future research that the chronic lack of professional self-care among clinical providers may be more important in the burnout or compassion fatigue process than either the clients' material or the organizational context. Another important finding was the evidence that compassion satisfaction and vicarious resilience are also important components of practice with vulnerable populations. Research investigating the "buffering" effects of these phenomena on burnout and compassion fatigue would fill a substantial gap in the research literature.

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