

Secondary Traumatic Stress, Compassion Fatigue and Counselor Spirituality: Implications for Counselors Working with Trauma

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As a career, counseling is recognized as emotionally demanding. Therapists are called upon to be empathic, understanding, and giving, yet they must control their own emotional needs and responsiveness in dealing with their clients. When engaging empathically with an adult or child who has been traumatized, clinicians are at risk of experiencing a state of emotional, mental, and physical exhaustion (Figley, 1995; McCann & Pearlman, 1990; McCann & Saakvitne, 1995; & Pearlman & MacIain, 1995).

Empirical studies support the theory that counselors who work with the trauma of others have an increased likelihood of experiencing a change in their own psychological functioning (Chrestman, 1995). Reactions may include avoidance of the trauma, feelings of horror, guilt, rage, grief, detachment, or dread, and may possibly lead to burnout and countertransference. Additionally, these responses can impact the counseling relationship. If counselors are unaware of this stress response, they may implicitly

convey a message to clients that they are unwilling to hear the details of the client's trauma, or be less likely to ask questions to facilitate dialogue related to the event. This can result in a revictimization of individuals who often have limited environments in which telling their story is safe and acceptable (McCann & Perlman, 1990).

The effects of post traumatic stress disorder to the primary victims of trauma are well established. Of key importance to counseling practitioners is the examination of the effects that working with the primary victims of trauma can have on the psychological well-being of the counseling professionals. These ancillary effects, frequently experienced by those not directly traumatized are often defined as secondary trauma or compassion fatigue.

CF is defined as “a state of exhaustion and dysfunction – biologically, psychologically, and socially – as a result of prolonged exposure to compassion stress” (Figley, 1995, p. 253). CF is “identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD” (Figley, 1995, p. xv). Within professional literature, compassion fatigue is also known as secondary traumatization, secondary traumatic stress disorder, or vicarious traumatization (Figley, 1995; McCann & Saakvitne, 1995). Researchers in this area may differ in their focus or what term they use to describe the phenomenon, but one common theme emerges; work that is focused on the relief of clients' emotional suffering typically results in the absorption of information about human suffering (Figley, 1995). Individuals differ in their responses to stressors; some are able to tolerate exposure to stressors without negative manifestations while others are not. Differences in coping techniques to handle stressors can play an important role in compassion fatigue.

Research has identified a counselor's psychological well being as a contributing factor in the avoidance of compassion fatigue symptoms (Figley, 1995). When considering what makes up psychological well being, the issue of spirituality is of key interest. Graham, Furr, Flowers, and Burke (2001) reported on a survey conducted by the American Counseling Association that indicates counselors view spirituality as an important component of mental health. These authors conducted additional research that examined the relationship between religion and spirituality in coping with stress and found a positive correlation between spiritual health and immunity to stressful situations (Graham et al., 2001).

Spirituality and Wellness

Religion and spirituality has been increasingly supported as relevant to both physical and mental health. When spiritual and religious involvements have been measured, they have consistently been found to be positively related to health and inversely related to physical disorders, mental disorders, and substance use disorders (Cooper, 2003). Theologians and researchers alike agree upon one thing; spirituality is not the same thing as religion. Although they share common ground, they are distinctly separate. Spirituality is fundamental to understanding the ways in which a person finds purpose in life. It is thus a unique, personally meaningful experience, which is positively related to religiosity but is not reliant on any given form of religion.

A growing body of research has investigated the relationship of various spiritual principles to multiple aspects of health. According to Simpson (2005), cumulative reviews of studies have concluded that there is a protective factor of spirituality to health. Similar results have been found relative to mental health as spirituality has been associated with higher self-esteem and lower depression (Koenig, 1998). According to Ellison and Pargment, as reported by Simpson (2005), an increasing number of studies indicate that those who are more spiritual experience a greater sense of well-being and life satisfaction, cope better with stress, and are less likely to commit suicide.

Ryan (1995) theorized that individuals that lack spiritual beliefs are at risk to experience excruciating pain and feelings of rejection as they search for meaning in the world. Thus, it can be suggested that spirituality is a source of hope, meaning and purpose, particularly during difficult times. Research exploring the relationship between counselors' sense of spirituality and the development of symptoms of secondary traumatic stress is limited. Pearlman and Saakvitne (1995) suggested that the development of vicarious traumatization may be linked to the counselor's sense of spirituality. Through their research, they suggest that counselors with a "larger sense of meaning and connection" are less likely to experience symptoms of vicarious traumatization (p. 161).

While there is an existing body of literature available in the separate areas of spirituality in counseling practice and prevention of compassion fatigue among counseling professionals, there is virtually no literature, conceptually or empirically linking the two areas. External issues such as caseload limits and supervision have been investigated, yet the counselor's internal coping mechanisms have been largely ignored. In an effort to examine the relationship between counselor's level of spirituality and development of compassion fatigue symptoms, Simpson (2005) conducted a study composed of

counselor's from regional mental health centers, residential care facilities, private practitioners and schools throughout a southern state. Volunteers' eligibility for participation in the study was dependent on current, active employment as a counseling professional. Additional demographic information was collected to allow comparison of the groups. Of the participants ($n = 223$), the majority of the respondents were female ($n = 190$), white ($n = 167$) and employed as school counselors ($n = 144$). Scores on the Spiritual Involvements and Beliefs Scale – Revised (SIBS-R) were utilized as the predictor variable. Scores for the respondent group ($M = 131.35$; $SD = 15.70$) were slightly higher than norms for the norm referenced group ($M = 113.1$; $SD = 20.9$). The Compassion Satisfaction/ Fatigue Self-Test for Helpers (CFST), a measure of compassion fatigue served as the criterion variable. Participants scores ($M = 27.95$; $SD = 11.92$) were comparable to the norm referenced scores ($M = 28.78$, $SD = 13.4$).

The variables of SIBS-R score and number of trauma victims on a counselor's caseload were found to have a significant predictive relationship with the potential for development of compassion fatigue symptoms in this sample. Level of spirituality and the potential for the development of compassion fatigue correlated negatively implying an inverse relationship: as spirituality decreases the likelihood of compassion fatigue increases. The variables of age, race, gender, years of experience, and occupation had no significant predictive relationship with the potential for development of CF symptoms.

As there is no current consensus on a profile that suggests risk for symptom development, exploration of how counseling professionals cope with the stressors of working with traumatized clients has been largely limited to external behavioral responses such as supervision and caseload limits. Exploration of the internal coping mechanisms of counselors in response to working with trauma victims has been virtually overlooked in existing research. "A greater awareness now exists in education and health services that if a person's spiritual needs fail to be addressed, a person's emotional well-being is put at risk" (Morgan, 2004, p. 8).

The results of Simpson's (2005) study suggest that counselors' internal coping resources have the potential to play a significant role in protecting clinicians from debilitating secondary traumatic stress responses. It seems that one key to assisting counseling professionals in the avoidance of and coping with CF symptoms may be education on the concepts of secondary traumatic stress. Additionally, encouraging counselors to maintain acute self awareness of responses to trauma clients and educating practitioners on resources available to assist in the treatment of symptom development may minimize the proportion of

clinicians experiencing CF symptoms. One speculation is that different coping skills may be needed to combat stressful situations than the skills used to prevent stressful situations. Thus, it is critical that counselor education programs expose students to these concepts during the training of counselors. Additionally, it is postulated that if it is true that counselor experience is inconsequential to the development of secondary distress symptoms in counselors, then educational programming and advanced training could be of vital importance to all counseling professionals at all levels of experience.

If counselors are taught to understand that CF symptoms sometimes result from counseling traumatized individuals, they will be more likely to prepare themselves for prevention of its symptoms. This may be particularly true for more seasoned counselors who may feel immune to the effects of secondary distress due to their experience level. If aware of the possible development of CF symptoms, therapists will not be easily overwhelmed or become shocked if symptoms development should occur.

Additionally, if counselors are able to assess the development of compassion fatigue, they will be more apt to seek assistance and collaborate with peers and supervisors when in distress. This research does support the existence of a relationship between a counselor's level of spirituality and the potential for development of CF symptoms. It supports the need for an inclusion of a spirituality course in counseling curricula to help counseling students become aware of their own spiritual development and its effect on the counseling relationship.

Counselors who are unaware of the potential hazards of their work may simply leave the field due to its difficult nature and their difficulty coping. If aware of the challenging nature of the work and the resultant naturally occurring potential for CF, new therapists may be more willing to process upsetting material and seek assistance from others. In particular, counselors trained to pay attention to their own reactions to clients may be able to identify their own CF symptoms. Consequently, quality of care is enhanced and the traumatized client population is protected when mental health professionals obtain educational training in this area.

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