Secondary Traumatic Stress and the Trauma Volunteer in Victim Assistance Centers

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Introduction

Undertaking voluntary work is a relatively common activity in western countries such as the USA and UK (Payne, 2002). Within the broad definition of the term “volunteer work”, it is estimated that between 16% to 55% of Americans (Fischer et al., 1991) and almost 30% of Britons have given their time to volunteer work. It is now clear that the role of volunteers in supplementing health and social welfare services is important (Field & Johnson, 1993). Volunteers working with trauma victims are potentially subjected to “secondary traumatic stress” (STS). STS is the natural behavior and emotion resulting from knowing about a traumatizing event experienced by significant other, STS is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995). In this article we will review the literature regarding Secondary Traumatic Stress and discuss the special characteristic of the volunteer in regard to secondary traumatic stress prevention.

Secondary traumatic stress

There is a growing body of theoretical and empirical literature that recognizes that engaging in therapeutic work with trauma survivors can, and does, impact on the therapist. Initially, psychological theories, research and development of effective intervention techniques, methods and processes were patient focused. More recently, however, attention has turned to the caregiver as well (Johansen, 1993; Maslach, 1976; Maslach & Jackson, 1984; Singer & Luborsky, 1977). After an extensive review of the literature Stamm (1997) commented that “the great controversy about helping-induced trauma is not, can it happen, but what shall we call it?” She concluded that there is no consistently used term regarding the impact of being exposed to traumatic material as a consequence of being a therapist. Her review revealed that there were four terms, Compassion Fatigue (CF), countertransference,
Secondary Traumatic Stress (STS) and Vicarious Traumatization (VT), most commonly used to refer to this phenomenon.

Figley (1995) uses the terms compassion fatigue or secondary traumatic stress to describe the impact of empathic therapeutic engagement on therapists. His work on STS evolved in relation to Post Traumatic Stress Disorder (PTSD) and recognition that therapists were known to experience symptomatology similar to that experienced by their PTSD patients. He identified the mirroring or contagion effect of symptoms from patient to therapist and argued "those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress" (Figley, 1995, p.1).

Figley (1995) had conceptualized STS as a by-product of intensive caring, contact, and work with psychologically and physically traumatized people. Therapists are especially vulnerable to such secondary stress because of their empathic sensitivity, sense of personal integrity, and belief in humanity. These natural responses, values, and beliefs are shattered by over-exposure to hurting patients and lack of relief from the stress of compassionate resonance.

Therapists, as supporters and helpers, may become indirectly "traumatized as a result of their compassion for those in 'harm's way" (Figley, 1995). As a consequence, they may experience a range of psychologically dysfunctional reactions including emotionally distressful feelings (sadness or grief, anxiety, dread, fear, etc.); intrusive imagery of the patient's traumatic material (nightmares, flooding, etc.); numbing or avoidance of efforts to work with traumatic material; somatic complaints (difficulty sleeping, headaches, heart palpitations); addictive or compulsive behaviors; physiological arousal, and impairment of day-today functioning (isolation, missed appointments, etc.) (Dutton & Rubinstein, 1995). Many of the effects experienced by the therapist parallel those of the trauma survivor, but at sub-clinical levels (Pearlman & Saakvitne, 1995).

Pearlman & Saakvitne (1995) state that the therapists' self-protective beliefs about safety, control, predictability, and attachment are challenged through working with trauma survivors. Consequently the therapist may become anxious, and avoidant of situations they now perceive as potentially dangerous, such as being home alone,
driving at night, and walking through car parks (Resick & Schnicke, 1993). These and other effects, which can be disruptive and painful for the therapist, may occur as a short-term reaction to working with traumatized patients, or may persist for months or years after the completion of such work (McCann & Pearlman, 1990).

The concept of secondary traumatic stress contributes to an understanding of collusive resistance, in which therapists may collude with patients to avoid psychotherapeutic work, which needs to be done. Therapists receive little relief from the burden and responsibility ensuing from prolonged exposure of care for the traumatized and suffering patients. Ironically, their empathic ability makes them particularly susceptible to emotional contagion, experiencing feelings of the sufferer. Taken together with traumatic recollections, which are provoked by continual contact with the traumatized patient, therapists experience inordinate disruptions in their professional or personal life with inevitable and frequently negative consequences, such as collusive resistance, to their work with patients (Figley, 1995).

**Empathy in the context of secondary traumatic stress:**

One of the variables that are most likely to influence the therapists tendency to develop secondary traumatic stress is the amount of empathy the therapists have for their traumatized patient (Corcoran, 1989; Landry, 2001; Long, 1999; Walton, 1997 Wertz, 2001). It is not surprising given the fact that the root meaning of the word empathy is “feeling into”. Studies in the field of burn out and occupational stress add to this claim saying that empathy is a predisposition to the development of those syndromes (Gross, 1994; Miller, Stiff & Ellis, 1988; Miller, Birkholt, Scott & Stage, 1995). Together with that, empathy is one of the key concepts in the client-centered or person-centered approach (Rogers, 1957), and it had also received considerable attention from psychodynamic writers (Buie, 1981; Greenson, 1960; Margulies, 1989). It has been suggested that all psychotherapy must "include the therapist's capacity to empathize with what the patient cannot tolerate within himself" as well as intuitive awareness of the patient's central emotional experience (Kernberg, 1975). Becoming truly and deeply empathic, becoming transparent enough to perceive the patient’s world in a non-judgmental manner is a basic goal in therapy. A high degree of empathy in the therapeutic relationship is possibly the most potent factor in bringing about change in the patient’s life.
Together with that, it has been said that when therapists are unaware of their own internal responses, may over-identify with the patient, seeing the world too much from his or her perspective. Ultimately, this could harm the patient because the therapist is as emotionally hurt as the patient, and can not offer him the support he needs (Broke, 1971).

The special characteristics of the volunteers in victim assistance centers:
There is little evidence regarding the differences between professionals and volunteers when it comes to secondary traumatic stress. However, we can point out some characteristics that single out the nonprofessional volunteer:

1. Motivation for volunteering
People’s decision to give up some of their time to a specific volunteer work is not random. Usually it has to do with certain needs of the volunteer that the volunteer work can help fulfill, such as feeling needed, getting personal satisfaction, and enjoying the status of the volunteer (Cnaan & Goldberg, 1991). Most of the research on this topic is based upon self-report studies, and on the explanations and ideas of the volunteers themselves. The most commonly cited motivation for volunteering is a belief in the cause supported by the organization of the volunteer. Another common reason is the desire of the volunteers to use their skills and personal experience. Almost 70% of the volunteers in a Canadian survey said that they came to volunteer after being personally affected by the cause supported by the organization. In the same survey 57% of the volunteers wanted to explore their own strengths and abilities. Fewer volunteers said that they volunteer because their friends volunteer or in order to fulfill religious beliefs (Lasby, 2004). Cnaan and Goldberg (1991) claimed that volunteers operate under a collection of several motivations. This finding is equivalent with the theory presented by Titmus (1971) and Pinker (1979) claiming there is no such thing as “pure altruism” – people volunteer as long as it provides them with a rewarding experience. Furthermore, Zurcher (1978) viewed the volunteering experience as a compensating function, done in order to make up for missed opportunities or lack of social connections. Another study reported that as much as 90% of the volunteers had experienced a family trauma that affected their decision to volunteer (Wilkinson & Wilkinson, 1986).
Many volunteers use their volunteer work as a way to work through and deal with their own traumatic experience (Wilkinson & Wilkinson, 1986). It is not uncommon that women who had been raped or sexually assaulted will use volunteer work with rape victims as a way to fight their own fear of rape and to understand their own experience by helping victims understand their experience. These motivations for volunteering are as good as any other motivation, but are they constructive in the case of secondary traumatic stress? As mentioned before, empathy is one of the variables that are most likely to influence the therapist’s tendency to develop secondary traumatic stress. It is possible that the volunteers’ need to sort out their own personal trauma creates a strong identification between volunteers and victims; such identification will create empathy and potentially subject volunteers to secondary traumatic stress.

2. Training:
Another characteristic of volunteers is the training that nonprofessional volunteers get before counseling trauma victims. Volunteer training has become an integral part of the services offered by volunteer organizations in the past few years. Organizations such as “National Center for Victims of Crime” (USA) or “National Organization for Victim Assistance” (England) are committed not only to the operational aspects of the volunteer work, but also to the recruitment, training and ongoing supervision of the volunteers.

Basic methods of curriculum design and training postulates that the learning process of a role, or a new job consists of three elements: the first element is knowledge – the trainee must acquire the basic knowledge, theories, concepts and ideas regarding the specific role that is learned. In the field of treating trauma victims, basic knowledge is history and theories of victimization, theory and symptoms of Post Traumatic Stress Disorder, etc. The second element is skills – cognitive or manual skills that are included in the tasks of the job. These skills are based on knowledge, and it takes a lot of practice to master them. In the field of treating trauma victims basic skills are: interviewing techniques, debriefing protocols, etc. The third element in the role-learning process has to do with the personal thoughts, feelings and attitudes that the trainee has for the job. These personal conceptions about the job develop gradually and determine the amount of identification with the role the trainee will feel, the
amount of commitment to the job, and the set of ethical values she/he will embrace and choose to act upon (Piskurich, 1993).
Although volunteer training programs receive a great deal of attention, they are usually short in time, and attempt to cover a lot of learning material. Naturally the topics that take up most of the training time are subjects that have to do with the basic knowledge and techniques that are crucial to the work of the volunteer. The short training time, and the focus on knowledge and skills, usually does not leave enough room for integrating and conceptualizing a coherent role perception. It is important to note that most training programs have at least one session that deals with self-care during training. This is a new and welcomed approach, but it is certainly not enough, especially when the discussion of role perception does not always follow a period of time in which the new trainee can crystallize and embrace the relevant ethical values.
Another important fact is that most organizations have an ongoing support systems designed to help volunteer face personal problems such as secondary traumatic stress during their volunteer time.

**Ethical values**

Ethics are standards of conduct that prescribe how one should act or behave based on moral obligations. Ethics are concerned with examining human conduct and the rules and principles that ought to govern that conduct. Values are core beliefs or desires, which guide or motivate attitudes and actions. The values one holds affect one's ethical positioning which in turn affect responses in situations where ethics come into play.

Professional code of ethics is much more than a set of rules, it represents profound understandings about the role of the professional, and it includes modes of thinking and norms of behavior that have proven themselves to be effective over the years.

Most of the victim’s assistance organizations have codes of ethics that obligate all of their workers and volunteers. But values, being an abstract notion, are not easily enforced and evaluated. The real embracement of ethical values by both professionals and non-professionals is somewhat voluntary – even if trauma workers are acting upon the code of ethics it does not ensure that they really believe in them, or accept them as part of their own set of personal values. Some ethical conduct are easy to detect (volunteers should not speak openly about a victims while mentioning their name), but most of the ethical values influence the treatment indirectly so that it is
almost impossible to single out their impact. There is a difference between acting ethically, and embracing the overall spirit of the code of ethics – making it part of the therapist’s role perception.

The role of Ethical values in treating trauma victims

As mentioned before, one of the basic assumptions in field of psychotherapy is that empathy is crucial in the therapeutic relationship on one hand, and that efficient treatment cannot occur when the therapist is over identified with the patient on the other hand. Terms such as boundaries and differentiation are often used to describe the way in which the therapist should navigate the empathic process in therapy – meaning that therapist should be empathic, but together with that he should feel differentiated from the patient. Differentiation is the ability to distinct between the self and the other, and the ability to distinct between cognitive and emotional reactions within the self. Bowen (1978) referred to differentiation as the ability to be in a relationship without being swallowed into symbiosis. Differentiation in the empathic process is the ability to distinct between the experiences of the patient to the experience of the therapist, so that the therapist could empathize with the patient, without feeling that the patient’s experience had happened to him.

The assumption regarding the importance of differentiation in therapeutic processes is deeply rooted in the codes of ethics of the helping professions. This need for differentiation between therapists and patients manifests itself in the code of ethics through rules and regulations that keep the boundaries between care taker and patient, and set the standard for quality care. The therapist’s obligation to the patient, and the true commitment to a high standard of care, underlies an inherent agreement to keep a clear differentiation between therapists and patients. In other word, therapists who are obligated to ethical values are actually obligated to boundary keeping because boundary keeping is an integral part of ethical values.

Therapists that have embraced ethical values such as: being responsible for the patient’s well being, putting the patient’s needs in front of theirs during the session, the commitment to being effective in the session, etc., will naturally create the differentiation between themselves and their patients even unconsciously, simply because they are professionally obligated to do so. A stable and coherent set of professional values can become a part of the therapists’ personal narrative, through which they will navigate themselves in the course of the therapeutic relationship.
Ethical values as “differentiation rituals”
Ethical values that have become part of the therapists’ inner voice can help them to deal with stressful situations such as treating a trauma victim. It has been found that therapists that have a weak ethical value system are potentially subjected to secondary traumatic stress in comparison with therapists who have a strong perception of professional ethical values (Williams & Sommer, 1999). It is not easy for therapists to keep the boundaries between them and the patient, doctors have their white coats and stethoscopes as a symbolic boundary setting tool; police men have their gun and badge, and but therapists have only the knowledge of their profession to help them set the fine line between them and the victims. Lahad (2000) mentions the term “differentiation ritual”. This is a symbolic ritual that defines the boundaries between the therapist and the patient. Lahad notes that in therapeutic situations that are not related to the immediate care of trauma victims therapists have some more differentiating rituals such as setting the time and the date of the meeting, or having an intake meeting. Volunteers who tend to trauma survivors usually do not have the opportunity to create such differentiation rituals, so that they are left with no actual tool that will to help them create boundaries between them and the patient. The code of ethics serves in this sense as a differentiation ritual for them. The belief in some ethical values functions as an inner shield, keeping the volunteer focused on the patient’s needs that include keeping a clear differentiation between therapist and patient (as noted earlier: the empathic process in therapy in not helpful when the therapist “goes down” with his patient instead of “pulling him out”). Volunteers who do not get enough training time that deals with the subjects of values and ethics, and do not have the needed personal capacities to work through their own thoughts and feelings about their ethical beliefs, are left without this important and ultimate differentiating ritual.

Conclusion
Volunteers are taking an important role in the trauma victim’s support systems. In some cases they even replace the professional trauma counselor or therapist. All people working with trauma victims are at risk of getting Secondary Traumatic Stress, but the special characteristics of the volunteers puts them in the front line, potentially risking themselves more then the professional therapist. The focus of the training program and the motivation of the volunteers usually do not allow them to develop
the right tools for boundary maintenance, especially in the beginning of the volunteering work. The issue of differentiation in the therapeutic process did not receive much attention in research of professional therapy, much less in the world of volunteer work. The growing usage of volunteer in trauma cases calls for a more careful examination of volunteer self-care needs and Secondary Traumatic Stress prevention issues.

**Bibliography**


