Chapter 72

CARING FOR THE CARETAKER

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INTRODUCTION

After ten years of work with victims of child abuse, I found myself in a deep clinical depression. I lost interest in food, found no pleasure in gardening, dreaded going to work, and was irritable with family and friends. I thought about quitting the work I had once loved. I realized that if I (considered one of the strongest people in our program, a person whose natural state is joy, curiosity and anticipation) left the work without discovering what was wrong and how to treat it, I would be leaving my best friends and coworkers to face the same problem, but without my support and without a remedy. As a doctor, I needed to know if this disease had a name, a cause and a cure. I began to read.

Professionals who work with child maltreatment encounter aspects of human suffering that most people never encounter and do not wish to acknowledge exist. Daily encounters with new and horrifying ways people can be cruel to children can take its mental, physical and spiritual toll. Every job has its occupational hazards. Child abuse work is no exception. Four syndromes affecting those who work closely with human suffering have been described. There is a growing body of literature and research detailing their incidence, etiology, signs, symptoms and treatment. These four are burnout, post traumatic stress disorder (PTSD), secondary trauma, and compassion fatigue.

OCCUPATIONAL HAZARDS OF CHILD PROTECTION WORK

Burnout

When I first began this work, there were only a few physicians in the state who would evaluate abused children. Calls began pouring in. I answered these calls myself, made appointments, interviewed the families, examined an interviewed children, typed my own reports and did my own billing. Parents and caseworkers pled that every case was urgent. "You're the only one."

Burnout is "... a process in which a previously committed professional disengages from his or her work in response to stress on the job."[1] Symptoms include physical, mental and emotional exhaustion, depersonalization, a loss of enthusiasm and sense of mission with decreased motivation and effectiveness on the job. Signs of burnout include fatigue, irritability, anger over small issues, indifference, a decline in efficiency or overall work performance, rigidity, paranoia and depression.[2,3] Burnout is common and, untreated, its cost can be high. In one survey of Canadian hospital-based child protection professionals over one third exhibited burnout on a standard burnout inventory, and two thirds had seriously considered changing their work situation.[4]

Burnout is attributed to progressive and prolonged job stress[1] related to a person's attempts to meet unrealistically high expectations. The origin of these expectations can be internal or external.[2] Burnout occurs when we set our goals too high and cannot change them when people try to give us feedback. We begin the transformation from saints into martyrs.

Azar[2] points out that unconscious assumptions held by professionals and professionals may serve as the source of unrealistic internal expectations. Here are examples:

- Family problems can always be solved and we have the tools to be helpful.
- Parents and children want my help and will be grateful for my efforts.
- Because of my role as a helper I will be safe (e.g. I should be able to tolerate client verbal abuse and visiting unsafe neighborhoods).
- I will do no harm.
- I will approach my clients with a clear idea of my biases and have ways to keep them out of my work.
- I will always be available when someone needs my help.
- I will always be empathic, with my child and adolescent patients, their families, and even the perpetrator.
- I am on the side of truth and justice and thus the court will always agree with my point of view.
- I will be treated fairly by clients, lawyers, judges, all members of multi-disciplinary teams and by the news media.

In describing strategies in supervision to prevent burnout in child abuse workers, Azar writes that uncovering these hidden assumptions, beliefs and expectations is key. She also warns that they may be deeply held and that changing them requires skill and patience, as it is akin to changing a person's religion.

Unrealistic external expectations often come from the public, the media or from government officials with superficial knowledge of the difficulties inherent in attempting to intervene in the dynamics of abuse. A state legislator who angrily criticizes state agencies for failing to protect a child from abuse may also vote to cut funding for hiring and training new child protection workers or law enforcement officers.

Post Traumatic Stress Disorder

After attending an autopsy on a child who was raped and tortured I find myself sitting and staring out the window, emotionally and mentally numb. This is a blessed protection against letting the feelings of horror come up, against my mind's attempts to imagine the child's last hours. This protective effect becomes disabling when "going unconscious" renders me unable to respond to my own child's distress over a skinned knee or indifferent to a coworker complaining about a difficult client.

Post traumatic stress disorder (PTSD) can occur in first responders who witness traumatic events as they unfold. Emergency response personnel rate certain events as the most stressful aspects of their occupation: death of a child, injury to a child, a personally life-threatening event, and grotesque sights and sounds, outside the usual range of human experience. Any professional evaluating and treating child victims is also likely to encounter these types of events and thus be susceptible to PTSD. Even reviewing photos or videos of child pornography can be stressful.

Although state laws provide a measure of legal protection for mandated reporters, they do not provide protection from stressful consequences of their work. Flaherty [5] surveyed 56 physicians who specialize in child abuse and found that 77% had experienced at least one negative consequence of their practice. Half had been verbally or physically threatened, an average of 2.7 times, and in 5% of cases a weapon had been displayed. Half had a formal complaint filed with their employer by parents or families. One quarter had been subjected to adverse local or national media attention as a result of their work. One in six had been sued for malpractice (1 to 3 times), and one in eight had been reported to their professional licensing agency.

Johnson [6] found that pediatricians and emergency room physicians rated court appearances as the most stressful aspect of child abuse work. Law and medicine have different rules and assumptions; law is inherently adversarial, and medicine inherently cooperative. It is acutely uncomfortable to feel pulled by both sides in what we consider an impersonal finding of facts, to be forced to reduce the complexities of human interactions and biology to yes or no answers, to be attacked for doing humanitarian work, or to feel that one word misspoken could set a dangerous criminal free.

Secondary trauma

Secondary trauma (also called secondary victimization, vicarious trauma and secondary trauma syndrome, or STS) is a group of signs and symptoms that develop through close contact with victims of "actual or threatened death, serious injury or threats to the physical integrity of self or others" and "hearing shocking material from clients."[2,3] Interviewers often describe visualizing traumatic events as they are recounted, witnessing them through the eyes of their patients and clients.

Burnout is described as a process, while secondary trauma can emerge after a single exposure or incident such as working with victims of a mass disaster or terrorist bombing. Burnout can occur in any occupation but secondary trauma is specific to those who work with victims of trauma and violence. Several authors[2,3,7,-9] describe symptoms attributed to secondary trauma in child abuse work. Many of these symptoms are identical to those of post traumatic stress disorder (PTSD). The compiled list is long, but the most distinctive features are re-experiencing the traumatic event described by the patient through intrusive thoughts, dreams or visual imagery, emotional numbing, and persistent arousal which leads to difficulty concentrating and hypervigilance.

Pearlman and Saakvitne[10] discuss six basic human psychological needs that are sensitive to disruption by actual or vicarious trauma. They are:

Safety: Working with victims heightens the sense of personal vulnerability and the fragility of life. Symptoms include preoccupation with safety, not letting anyone babysit one's children, and hypervigilance.

Trust: Through exposure to the many cruel ways people deceive, betray, or violate the trust of others, we become overly suspicious. Symptoms include cynicism, isolation, and not trusting co-workers or one's own instincts.

Esteem: Esteem is defined as the need to perceive others as benevolent and worthy of respect. Encountering so much human cruelty can shatter our world view. Symptoms occur such as pessimism and anger at individuals or the fate of mankind in general.

Intimacy: A sense of alienation emerges from exposure to horrific imagery that cannot be shared with others, because of their distress or confidentiality requirements. This is particularly painful if your

spouse cannot bear to hear what you are doing in life or what is worrying you. Symptoms are emotional numbing and withdrawal from social life and personal intimacy.
Power or control: Realizing the fragility of life and encountering clients' powerlessness, we may try to increase our sense of power in the world, by taking self-defense classes or becoming domineering. Symptoms include restricted personal freedom through fears of safety and despair about the uncontrollable forces of nature and the human world.
Frame of reference: We try to figure out the motive of the perpetrator or what the victim did wrong. How did this happen? Symptoms can be pervasive unease or loss of religious faith.

Compassion Fatigue

I believe that the most profound effect of this work is on our spiritual well being. When we remove children from abusive families and they are subjected to worse cruelty in foster homes, what have we accomplished? When people we know, ministers, police officers, protective service workers and even pediatricians abuse children, who is the enemy? It breaks through our denial. It becomes harder to hold the larger framework, the higher purpose that gives our life a sense of direction and meaning.

Compassion fatigue is the newest term. Some authors equate compassion fatigue with secondary trauma syndrome; some include both as aspects of burn out. Workers with compassion fatigue keep trying to be open-hearted and sympathetic when they feel that the inner well of empathy and kindness has run dry. They fall into cynicism ("*What else can you expect from that judge?"*), suspicion (*"I never believe what parents tell me anymore."*) despair (*"The system is too broken to fix."),* and depression (*"Nothing I've done in all these years has changed things for the better."*)[11] Compassion fatigue has also become a more general term, used, for example, to explain why people who are overexposed to media depiction of disasters and victims become cynical and cease donating to charities or why soldiers become inured to death.

PREVENTION AND TREATMENT

Preventing vicarious trauma is an active process. First, realize that anyone is susceptible to burnout, post traumatic stress, secondary trauma and compassion fatigue. This is true no matter how many years one has been working in the field. At some point the container of human suffering may become full and begin to overflow. This is more likely to happen when stressful events in our personal life, such as illness or death in the family, concerns over the difficulties of a parent or child, or financial or marital problems, compound the strain of working with the distress of our clients.

Maintain a positive framework. Secondary trauma is not considered abnormal but rather a natural consequence of caring for another person and listening to them empathically, the very qualities that characterize a skilled professional who works with abused children. Know your risk factors. Research indicates a higher risk of secondary trauma in those who themselves have a history of abuse or neglect, as painful emotions and memories may be re-activated.[3,9] To balance this, a history of abuse in their own childhood can provide workers with a greater sense of meaning and accomplishment in the work.[7] Actively discuss and nurture what Conrad terms "compassion satisfaction",[1] the positive benefits of meaningful work, the sense of fulfillment from helping those in distress, and involvment in supportive collegial relationships. High levels of job satisfaction seem to

be protective against burnout.[4] We can create ways to celebrate our work, and, when appropriate, to honor our clients' accomplishments.

A combination of realism and optimism is key.[7] Acknowledge that real change is difficult and slow. An historical perspective is important, especially for young workers. The first article identifying injuries due to abuse appeared in the medical literature just 46 years ago and many doctors greeted it with disbelief.[12] We have come a long way! And, there is still along way to go.

Openly acknowledge the potential side effects of sustained work with human suffering, and provide education from the start, both when hiring and training new employees, and also as part of continuing education. A ctively monitor oneself and colleagues for hidden assumptions that create unrealistically high expectations or reveal negative coping strategies. (*"I shouldn't have lost that case in court".)* Support from supervisors and colleagues is key in encouraging consultation on the job and informal, relaxed gatherings off the job. Institutional support is essential. An invaluable benefit institutions can provide is the services of lawyers and public relations staff to shield line workers from the stress of media harassment and threatened law suits.

Provide education about using positive coping strategies and avoiding negative ones.[9] When we ruminate over past mistakes or fall prey to anxiety and dread over future possibilities, we are incubating our own distress. Positive coping strategies focus on the present moment and restore our capacity for hope, love, intimacy, laughter and creativity. They include exercise, time with healthy children and pets, hobbies, the arts, and travel. Activities that provide spiritual renewal are particularly important in restoring a sense of perspective. These include attending church or temple, yoga, meditation, or just being in nature. Negative strategies include complaining, isolating, blaming, or addictive behavior with drugs, alcohol, food, shopping, pornography or gambling.

Suggested areas for routine maintenance and repair include :

Environmental: Balance a clinical case load with teaching and research. Limit exposure by balancing victim and non-victim work. Set boundaries--limit weekend and night work. Make sure days off are *really* off. Find a way to work for social change.

Interpersonal: Don't work alone. Seek support from professional colleagues. Seek supervision and consultation. Develop support groups where feelings can be discussed, separate from work time.

Personal: Find healthy ways to mentally leave the past behind, remain in the present moment, and not obsess about future problems and eventualities. Understand that vicarious victimization is a normal response. Use it for growth. Use individual therapy to work on areas that are particular problems. Seek balance between personal and professional life. Make time for non-victim related activities that renew a sense of optimism and hope. The most common are exercise, rest, gardening, music, dance, art work, pets, time with healthy children, travel, being in nature, and doing nothing!

Spiritual: Attend to empathy. Stay anchored in the present. Develop a sense of connection to something larger than oneself. Seek spiritual renewal.

Research on the secondary effects of working with victims of trauma is relatively new and sparse. Hopefully future studies will help us understand who is relatively immune to secondary trauma and whether their immunity rests on personal differences or upon characteristics of the profession. Physicians seem to be more immune to burn out than social workers, for example.[4] Is this due to more rigorous selection of candidates, longer and more grueling training, higher pay, appreciation and status, or because their intervention is short and they have less long-term contact with troubled families? We

also need to clarify what measures work, for individuals and cohorts of workers, to lessen the trauma of working with trauma.

If child abuse professionals are to remain healthy and effective in their work, they need to be aware of the potential side effects of working with victims in order to recognize and prevent these side effects, or to apply appropriate antidotes at the earliest signs of distress. It is one time that physicians *must* treat themselves. A good physician adjusts the dose of medicine to the strength of the dis-ease. Remember, the more stress arises at work, the more time needs to be set aside as an antidote that stress. If we take good care of ourselves we will be able to take better care of the children we serve.

Over ten years have passed since I burned and almost crashed. I still work in child abuse, part time, and healthier for it. I am happy that my skills and experience are still useful. The work is difficult at times, but difficult work can be done well with the help of good people, and it is continuously gratifying to find that child abuse professionals worldwide are the finest people with whom I have ever worked.

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