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The Unbearable Fatigue of Compassion: Notes from a Substance Abuse Counselor Who Dreams of Working at Starbuck's

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Abstract Current research has determined that a larger percent of social workers and other counselors are affected by PTSD types of symptoms when working with traumatized clients than the general population. While much of this research addresses workers in specific trauma areas like sexual assault centers or child welfare agencies, little specific thought has been given towards the special stress that working with Substance Abuse Disorders (SA) and trauma may present. This paper takes a brief look at the issues of vicarious trauma and compassion fatigue with SA practice and describes future investigation pathways toward this goal.

Keywords Compassion fatigue · Secondary trauma · Substance abuse

Introduction

> *I came to substance abuse work through the back door as a nurse. Like many current professionals, my Substance Abuse (SA) counseling career began in my thirties, leaving traditional hospital work to work in alcohol and other drug treatment. That was in 1988. I came without any substantial training in addictions. I had to hit the ground running. In the 1980's and 1990's treatment was easy. They came in and they did what we told them. We were in charge and we told them that they could only work on one problem at a time: their alcohol or drug problem. Everything that we did was based in the oral tradition of someone else's successful recovery. We felt successful because people got sober and became good AA members. The ones that weren't successful, well, they just left. We didn't see them so we didn't count them.*[1]

Experts agree that, in the coming century, there will be a growing need for a well-trained cohort of addictions counselors. Additionally, the need for adequate training of other counselors and primary health professionals in substance use, abuse and addictions is inevitable and imperative (Smith, Whitaker, & Weismuller, 2006). The National Association of Alcohol and Drug Abuse Counselors (NAADAC, 2007) estimates that many substance abuse (SA) workers come late to the field as a career change in their thirties and that over half of the current SA workforce is between the ages of 40 and 55. Demand far exceeds supply in all the behavioral health fields. A Maryland based firm hired to project future needs estimates that 5,000 new SA workers are needed each year to replace those leaving the field (Smith et al., 2006). "Our country is on the verge of a crisis: an inadequate supply of workers trained in Substance Abuse treatment... not unlike the nursing shortage addressed by congress in the last session" (NAADAC, 2007). Current labor statistics indicate that of 477,000 jobs in social work, 95,000 of these were classified as having a primary SA role (Smith et al., 2006). The unspoken question is why workers leave the field and part of the answer may lie with the stress and strain of empathic work with poor compensations.

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[1] Quotes in italics are derived from conversations with SA professionals in Georgia, California and New York.

In testimony before a federal policy panel, Cynthia Moreno Tuohy, the Executive director of NAADAC, noted that there is currently no career path that attracts talented new counselors from student to trainee to counselor to supervisor (Tuohy, 2006). Since many workers come in through the side door of their own recovery, they often have special training and self-care needs and may clash with more formally trained counselors. With blending of funding sources, administrators may or may not have training in substance related concerns. Lack of professional prestige and poor compensation add to this workforce crisis. Demographic data collected by the NASW in 2006 indicates that 71% of social workers report working with substance abuse and addicted (SA) clients although only 2% report this is their primary setting. A concerning statistic from this study is that 53% report having no SA specific training in the past 12 months (Smith et al., 2006). Lack of training and low wages make this work hard to stick with on a practical level. Poor working conditions combined with shifting philosophies and clients who seem to get tougher create a dilemma for the social workers, counselors and paraprofessionals who attempt to solve the nations substance related ills.

The lack of potential workers is one side of a rather large elephant of a problem. The demand for progressive multifaceted services is growing. The misuse of substances makes many of our social and health problems more complicated and costly. The effects are felt in every area of our society. The Robert Wood Johnson Foundation estimates that substance related deaths including tobacco are responsible for more deaths than any other preventable health condition. One study estimates that 80% of children in foster care are out of their parent's care because of alcohol or other drug problems in one or both parents. SAMSHA estimates that 18–26 million people need some type of substance treatment services and only about 3% are able to access services (Smith et al., 2006).

Definitions of deviance and criminality, changes in treatment services accessibility and delivery and gaps in resources created by welfare reform and the health insurance crisis all contribute to feelings of instability within the field. In addition to these issues are the complexities of cultural norms that are shifting. Funding for SA treatment is currently more likely to come via the criminal justice system with advent of formal and informal collaborations. Substance abuse treatment has shifted from a largely voluntary, insured and mildly coerced population to a mandated one. Time frames for care are shorter and stakes are higher as community entities like drug courts (who more and more control funding, access and staffing of treatment) demand positive outcomes...or else. (Clients may be terminated from treatment or jailed for relapse and or poor progress.) Sometimes these expectations for the most diagnostically and environmentally complex and underserved clients are unattainable and set up counselors with impossible expectations. SA counselors barely have time to get their documentation complete let alone take a time out for evaluative thinking.

Counselors have a difficult dilemma as they straddle the high wire of therapeutic relationship, behavior monitor and reporter to the judge. This shift may already be attracting persons with different attitudes, talents and skills than those who came to SA counseling out of an empathic appreciation for what addiction counseling could do.

> *I got involved with treatment courts and, at first, it felt like a real collaboration. Then, more and more, it felt like probation wanted me to use my counselor tricks to catch the clients. One time we had a guy open up in group about an incest issue. It just bubbled up. We weren't expecting it. I made an individual appointment with him for the next week but he didn't come. His urine test had come back positive and he had been picked up and incarcerated that morning. I felt really frustrated about that. I wondered if we were helping him. A return to old behavior to cope was predictable but our system had no way to circle the wagons around him. I thought we had a pretty good relationship but when he came back the momentum was gone and we had to try and find it again. We watched him cycle around about using until the judge removed him from the program. Within a year, I found another job. I don't want to work with the courts anymore.*

Another factor in SA work that is evolving with breakthroughs in neurobiology is a deeper understanding of comorbid factors and the dangerous intersection they can present to SA treatment. Of these, trauma and post-trauma response, has special importance when considering SA work. Alterations that occur in the neurobiology of a person suffering from PTSD are thought to be similar to or enhancing at the neurotransmitter level to those created by substance disorders (Triffleman, Marmar, Delucchi, & Ronfeldt, 1995). PTSD complicates the course of treatment and also predicts poor short term and long term outcomes (Brown, Stout, & Mueller, 1996, 1999; Oumiette, Ahrens, & Moos, 1997, 1998).

As early as 1990, researchers identified lifetime exposure to trauma in a range of 40–81%; many of these without lasting effects (Kulka et al., 1990). According to Kulka et al. (1990), 75% of combat veterans who met criteria for PTSD, also suffered from and SA related condition. Estimates of co-occurring SA with PTSD in civilian population is placed at 21.6–43.0% with substance users 4–10 times more likely to suffer PTSD (Cottler, Compton, Mager, Spitznagel, & Janca, 1992). Trauma exposure with

symptoms is even more prevalent in clinical treatment settings. One study reports up to 56.2% of inpatient clients with a lifetime history of trauma and up to 42.5% reporting active PTSD while in treatment (Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995).

Current thinking accepts the incidence of exposure to trauma in persons seeking treatment as 60–90% and the identification of those meeting PTSD criteria as within the 30–50% range, according to Bride (2007). There has been some investigation into the relationship of secondary trauma on workers involved in many special populations of clients like child welfare, HIV, sexual assault and those in prison but little attention has been paid to the special needs that SA clients and staff have regarding post trauma support. With the demand for more competent SA workers, it is becoming increasingly important to understand is the meaning of trauma experience in an individual vulnerable to SA its concurrent effect on SA workers; many of whom are also in recovery.

While there are differing descriptions of these numbers in various populations, most workers will tell you that these numbers don't accurately reflect the current state of practice and that these statistics should be higher. Most SA workers believe that stabilization of SA actually brings up more symptoms if the substance was used to numb PTSD symptoms. Abstinence may actually exacerbate symptoms and create another kind of coping crises.

Secondary trauma stress has gathering effect over time and is a hazard of empathic work with traumatized clients (Collins & Long, 2003). Poor understanding of the counselor effects that come from working with complex trauma without adequate supports create a gap in the field. Research is needed to inform policy makers and stakeholders about these effects so that appropriate prevention, intervention and protective systemic policies are developed that improve retention and resilience of these valuable workers.

From Burnout to Compassion Fatigue

> *In the 90's we called it "burnout" and we wore it like a badge because it meant that we were working hard and we really cared. The clients got harder. We saw more drug alcohol combinations and less compatibility with 12 step support. We saw the same clients over and over. We called them "frequent flyers" and rolled our eyes. When they died, we called them "sacrifice flies" while our own eyes stayed dry and tired. We saw more and more who had never had a stretch of functionality. Homelessness and poverty created the background noise of hopelessness.*
>
> *At night we came home bone tired and zombified watching television or drinking while our families clamored around us. We were exhausted by client need and shifts created by managed care and clients who would not do what we suggested. Some of us escaped by developing our own condition: disordered substance use, chronic illness, or depression. Some of us left to get more education. Some of us stayed and became more and more rigid with the unmet expectations of our work.*

The way that we think about substance abuse is changing and one size doesn't fit all anymore. There is a need to differentiate between conditions of secondary trauma stress and compassionate fatigue in workers and not rely on the overall descriptor of burnout. Burnout has been a catch all term since 1978 when it was identified by Pines and Maslach (Collins & Long, 2003). Burnout quickly resonated with alcohol and other drug treatment providers and became part of the national jargon along with a host of other self help language. Figley (1995) points out that burnout it is actually a gradual process rather than a set condition and that it increases over time (Collins & Long, 2003). Burnout, as a concept, involves exhaustion on a variety of levels. One definition of burnout states "exhaustion of a practitioner's mental and physical resources attributed to his or her prolonged and unsuccessful striving toward unrealistic expectations (internally or externally derived)", (definition by Farber 1979, 1983 and Freudenberger, 1975 as cited by (Azar, 2000, p. 645). Burnout was shorthand and covered all the employee problems that the substance abuse field experienced. Absenteeism, physical health ailments, cynicism and low hope or morale had workers labeling and diagnosing each other (Collins & Long, 2003). Burnout is not a precise enough term to research or assist policy makers and clinical directors in creating prevention for it. Further, burnout can have a blaming component to it almost as relapse does for the addict. The unspoken message is if you are burned out its already too late. Compassionate Fatigue (CF), as identified by Figley (1995), is a more useful solution focused term and encourages workers and supervisors to dialogue about solutions to the hazards of empathic work.

By the late 1990's, the global culture as well as the culture of helpers demanded more discerning constructs for trauma once or twice removed (Azar, 2000). Mass media images of school shootings and random violence were an add-in to the explosive images of terrorism the war and natural disasters and suddenly everyone had a visceral connection to trauma. The last quarter century of research in trauma work has offered a boon of differential definitions as well as more intricate understanding of the cost benefit analysis of working with traumatized clients. Secondary trauma

stress, vicarious trauma and compassion fatigue identify the constellations of exhaustion, PTSD and social effects that trauma workers may encounter with clients (Azar, 2000; Bride, 2007; Collins & Long, 2003; Figley, 1995; McCann & Pearlman, 1990). Descriptions of Secondary trauma stress and CF are often used interchangeably, however, it should be noted that trauma stress is focused on symptoms that parallel PTSD, while CF may encompass philosophical and policy work stressor that devalue workers as a whole. Secondary trauma stress as a condition and compassionate fatigue as a process are the best fit from a clinical perspective as most accurately describing what happens to unsupported workers over time (Bride and Walls, in press).

Although there are differences in analysis, most current researchers agree that global effects from empathic work with trauma survivors share some common features. These can include, but are not limited to, intrusive thoughts, avoidance behaviors, emotional numbing, hyper arousal and hyper vigilance (McCann & Pearlman, 1990; Figley, 1995, 1999). There are excellent literature reviews that place all these theories in context with their development of the last 25 years (Collins & Long, 2003; Bride, 2004). Still, though anecdotally understood wisdom about the risk and need for systemic supports has not yet filtered down into the everyday lives of workers and created policy change that affects policy (Bride, 2007).

> *How many of my clients have trauma? How about try all of 'em. I've heard its 80% but I think that it's higher. It's definitely higher in the women. I did a women's group once with nine women and all of them had had at least one rape that they remembered. Compassion Fatigue - I don't know what that is but I know I got it. These clients are so needy. Services are being cut and residential beds are evaporating. Sometimes I come home from my job and I just sit and stare. I tell my kids "Mommy can't talk for a while"*

Addiction treatment may have unique working conditions that may actually manifest trauma stress in clients and expose SA workers to secondary trauma stress more often because of the special nature of the work and the potential chronicity of some clients. SA counseling is at its heart a storied empathic brand of counseling. Clients often bond and connect with staff in programs as they begin the relational healing that happens with treatment. In small towns, clients are well known and sometimes SA counselors treat generations of clients from a single family.

> *We make all the clients write their autobiography and read it out loud... we wouldn't let her graduate until she dealt with her abuse... She told us how he pulled her legs open to see if she had had sex with someone else and I felt nauseous for her...she left treatment after we role played angry partners and how to deal with them. She just wasn't serious, she hasn't hit her bottom. I remember when her mama was here, she was just seven then. She didn't ever get it together either.*

Researchers agree that trauma creates an additional risk factor for development of a substance disorder and also that a large number of seekers of treatment services have some trauma history, however, clients are not assessed for trauma as a standard of care (Ford & Russo, 2006). Even if addictions workers reason that all their clients have had some trauma, discerning the effects and potential effects of trauma is an important part of treatment planning. Substance abuse treatment historically has a foundation of ritualized practice that is based on truth telling along the lines of a religious confession. Many programs use some autobiographical tool and thus create a high potential to elicit trauma material. This often occurs within the context of a group (since many publicly funded programs have cut staff, adhere to the old dogma that group therapy is the only effective therapy for alcohol and other drug problems and eliminated individual therapy) and may not be in the presence of a licensed individual. Since some studies have shown a relationship to secondary trauma stress and new workers, this is of special concern as we see workers leave the field before achieving competence. Additionally, some veteran workers may be suffering with the worst effects of secondary trauma stress because, as in the case of this writer, most of the past 20 years was spent without awareness of this risk and without empirically derived interventions guiding practice (Azar, 2000).

Evidenced based practices in SA treatment are an emerging standard. Substance abuse counselors, like other kinds of clinicians in the trenches, are often poor consumers of current research. Innovations are slow to percolate down into the general treatment culture. Substance abuse providers, as a group have been slow to utilize empirical research and evidence-based practices to improve systems policies and overall retention of experienced workers, perhaps partly because of funding shifts and changes in public perceptions of substance use disorders.

> *I woke up every night for a week after I found out about a client's abuse as a child. It was my weekly three a.m. appointment with her memory. The thought wouldn't linger, it would just be the vivid picture that woke me up all agitated so that I couldn't fall back to sleep. I would move into my own worries and fears for my daughter asleep in her little footie pajamas. I never even realized how much it affected me until about two years later when I came across a*

secondary traumatic stress reference. I almost didn't have to read the article I knew it from the inside out.

Valuing of SA work and workers with research that offers them real on the ground job improvements could improve counselor willingness to adapt innovations. Listening to addiction counselors and workers may be an important direction for researchers interested in exploring compassion fatigue and associated conditions. Counselors, both past and present, can well articulate the numbing, avoidance, flooding or blocking of emotional symptoms that come from working with others trauma material. However, many often don't identify their own vulnerability. Azar (2000) notes that emotional numbing may cause workers to take on more risks, such as going to unsafe neighborhoods with the belief that they can rescue the client or underestimating their own ability to help. More difficult to elicit are the cognitive shifts that may evolve out of this kind of work. This changed view of the world can engender hopelessness and cynicism (Bober, Regeher, & Zhou, 2006). SA treatment systems would benefit from creating protective factors that control the dosage of trauma by assessing trauma in the client and reducing caseloads and, also, by assisting workers to identify and negotiate around their own trauma needs.

Treatment Models May Help Prevent Compassion Fatigue

I had to change in my work so I wouldn't go crazy. I thought I wouldn't do it anymore. I couldn't work in treatment any more. It felt like we were just losing people. Then I learned Motivational Interviewing and started in a clinical consultation group that supported harm reduction practices. I really felt born again in my work. I didn't have to control for the outcome anymore. I had to change some other things too...like get a life and live it. There was no guide for this. I just put it together as I went. Now, I think that we need to help new workers and veterans with more skills, coaching and techniques to work with trauma so they are not working blind like I was... and excuse me but we have to pay more and create more stability around jobs. Most counselors I know are afraid that the money is drying up and that they are one breath away from becoming the homeless bag lady in their nightmares.

Most experts agree that an integrated model of trauma and SA treatment is best (Najavits, 2002). The push to create evidence-based best practices in all areas of mental health and substance abuse care may offer the best solution to an overstressed workforce. Two manualized modules offered by many gender-specific treatment programs may offer treatment providers clues on how to manage their own trauma needs as they deliver the model to clients. Seeking Safety, developed by Lisa Najavits (2002), offers twenty five topics with handouts and support for treatment providers and clients own self help. Another similar approach is the Trauma Recovery and Empowerment Model (TREM) which creates a similar 33 session group intervention that uses cognitive education and skill building along with self soothing and development of healthy supports and coping (Fallot & Harris, 2004, 2002). It stands to reason that if there is vicarious trauma then there is also vicarious healing.

Both of these models support the belief that trauma creates long term adaptive response that affects all domains of life. Neither supports delving into trauma material as a specific intervention. Although these programs have gained a kind of brand recognition, there are still many programs that use them in combination with autobiographic techniques that may not be the most helpful for clients or staff (personal communication Stout, 2007). Counselor effects from these types of interventions should be studied. We can no longer sacrifice the health and wellness of our workers for interventions that are not helpful to the client.

Other interventions that may be helpful when working with SA and trauma are interventions that assist workers attain a more naturally healthy stance with their clients. Three that warrant more study for their counselor effects are Harm Reduction (HR), Motivational Interviewing (MI) and Narrative Therapy (NT). All three have a philosophical framework that creates an egalitarian relationship with the client. Although a complete discussion of these is beyond the scope of this article, all three share certain features that may have benefit to counselors dealing with trauma and the complexities of active substance use. All use a client-centered approach that holds the belief that clients' will act in their own best interest and with a desire to improve their situation. All believe in a rearrangement of power within the therapeutic relationship so that the client retains as much self efficacy and control as possible. HR is controversial because it holds the belief that it is possible to work therapeutically with clients while they may continue to use drugs. HR practitioners believe that the primary goal of a worker is to assist the client to reduce harm. This often means supporting practices like clean needle exchange or discussing the benefits of continued use with a client's safety in mind. These may feel strange to those trained in abstinence-based treatment, however many workers report that this frees up the dialogue to really hear what the client is saying (Denning, 2002; Harm reduction. org, 2007). Harm reduction may make counselor expectations more manageable and client-centered. This, in itself, may offer some increased relief for counselors. Client-centered

approaches may also increase protective factors because they encourage the client to set the pace and drive the nature of the work.

Another practice gaining recognition for SA counseling is Narrative Therapy (Dulwich Centre, 2007; White & Epston, 1990; Winslade & Smith, 1997). Developed in Australia, for work primarily with children, NT offers an alternative mode for working with a number of issues in a culturally sensitive mode. At its core, NT involves a radical realignment of the authoritarian stance that most substance abuse counselors are taught (White & Epston, 1990). Narrative therapists help locate the problem as something that is external to the client himself. As White and Epston state "The person is not the problem. Rather the problem is the problem becomes the problem, and then the person's relationship with the problem becomes the real problem" (1990, p. 40). This language shift also creates a shared exploration of the coping strengths that a client already possesses. This method frees up the counselor to join with the client so that they may uncover their own solution to their issues. Narrative trauma work involves retelling the story with an eye towards expanding the focus on the clients' success in surviving the trauma. Often a history of trauma creates a rigid narrow space that that memory dominates (White & Epston, 1990; Winslade & Smith, 1997). As a storied therapy, NT fits well with many aspects of traditional therapy and study of counselor response to using it with trauma and SUD would be valuable. It could also be interesting to investigate levels of vicarious trauma in its practitioners perhaps as a comparison to other interventions.

Motivational Interviewing (MI) is a third client-centered intervention that holds great potential to change not only the client but the therapist who practices it (Miller & Rollnick, 2002). MI stands alone as a true evidenced based practice that repeatedly demonstrates its efficacy and is currently being adapted for many health behavior change issues such as diabetes, heart disease and obesity among others (W. R. Miller, personal communication). MI is set of strategies combined with a philosophy of client-centered principles including accurate empathy, rolling with resistance and timing interventions based on client cues. It may be one of the first empirically based practices that are derived from practice itself rather than coming out of a theory (Miller, 2006). MI is also noteworthy because it demonstrates efficacy in a variety of behavior change areas. Although the skills, mostly based in reflective listening, are simple, they are not easy. Miller and others are interested in how it works, why it works, when it works and how to train others so that it will work as it has in over 180 evidence-based trials (Miller, 2007). MI has several interesting features that could make it useful for developing resilience in addiction treatment workers. One is that MI spends a great deal of time teaching accurate empathy. Accurate empathy or understanding offers a client more space to find their own solution. MI research is exciting because researchers not only study what works but why it works and how to train so that it works. Research indicates that training alone does not build the practice. MI requires consultation and coaching to improve skill acquisition and as an evidenced based practice gaining momentum may naturally develop and support more supervision than SUD workers currently receive (Baer et al., 2004; Miller, Yahne, & Moyers, 2004). Also, MI may be an excellent way to investigate how the therapist changes with an intervention. All three of these styles of counseling focus on the therapeutic interaction. More research needs to assess paired client and counselor outcomes as a fuller picture of what works.

Conclusion

Substance abuse counselors have neglected their need for adequate supervision and visioning around workforce issues. Many current providers entered the field without formal training and a foundation in evidence-based practice. Assessment for PTSD and secondary trauma stress in workers should be standard in all programs. Research must shape practice with PTSD and SA presentations that create safety for both the client and the worker. Identification of compassion fatigue and secondary trauma stress should be a regular part of supervision and counselor wellness programs. Creation of compassionate work practices, supervision and coaching and, perhaps sabbaticals within the field that encourage exploration and transformation of the stressful ecology of the work could be developed. Adequate compensation and basic quality of life issues must be addressed. Current counselors and their descendants must begin to explore and investigate their own solutions as well as find support for the hazards of empathic work with others. Like survivors of trauma they must begin their own empirically supported interventions for supervision, training and wellness programs that assist healing and resilience in its workforce.

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