Human Services Workers in Crisis 16

Burnout, Vicarious Traumatization, and Compassion Fatigue

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

1. Understand the dynamics of burnout.
2. Be aware of the myths surrounding burnout.
3. Recognize the host of behavioral, physical, attitudinal, and interpersonal symptoms that indicate burnout.
4. Know the levels of burnout.
5. Know the stages of burnout.
6. Understand the interrelationships and differences among secondary traumatic stress, vicarious traumatization, and compassion fatigue.
7. Understand that compassion satisfaction is a buffer against compassion fatigue and burnout.
8. Understand the role of organizations in perpetuating burnout.
9. Understand and know individual intervention strategies for burnout.
10. Understand both individual and organizational assessment devices for uncovering burnout.
11. Understand culture's influence on burnout.

Respond to the following questions with a yes or no.

1. Have you left parties early because the occasions offered you no opportunity to counsel?
2. Do you continue to counsel even though it interferes with your earning a living?
3. Do you sometimes have the "shakes" in the morning and find that this unpleasantness is relieved by counseling a little?
4. Do you repeat everything you hear? I mean, do you repeat or paraphrase everything you hear?

These questions are part of Adam's (1989) humorous, satirical test of counseling addiction. Yet the questions may not be too far off target when viewed in terms of another severe problem that strikes many professionals in the human services business—burnout—and its handmaidens, compassion fatigue and vicarious traumatization.

So you are a brand new human services worker with a diploma fresh off the presses and ready to go out and cure the world. You are full of vim and vigor and one salty dog! What's with burnout? That's just old dudes that are washed up! Apparently, since the last edition of this book went to press in 2012, 1,475 articles on burnout retrieved from the American Psychological Association (2015) search engine, Psychinfo, felt otherwise. They also seem to be talking about you, young grasshopper! Research indicates that if you are younger and female you are more likely to wind up in the burned out category of human services workers (Baum et al., 2014; de Figueiredo et al., 2014; Star, 2015; Volpe et al., 2014).

If you were a teacher from Ireland (Foley & Murphy, 2015), a Chinese civil servant (Hao et al., 2015), or a Peruvian correctional officer (Clemente et al., 2015), there was some concern you might be burning out. Indeed, it appears that about every country and occupation in the world is concerned about burnout, and it is far from humorous. Burnout is not just some pop psychology term designed to elicit sympathetic responses from one's coworkers or spouse. It is a complex individual-societal phenomenon that affects the welfare of not only millions of human services workers but also tens of millions of those workers' clients (Farber, 1983, pp. vii, 1). Put in economic terms, billions of dollars are lost each year because of workers in all fields who can no longer function adequately in their jobs. Signs and symptoms of burnout include turnover, absenteeism, lowered productivity, and psychological problems (Golembiewski, Munzenrider, &

Stevenson, 1986; Leiter & Maslach, 2005, pp. 3–9). Yet if burnout has been discussed in all occupations, why should it be endemic to the helping professions?

Helping Professionals: Prime Candidates

The bulk of writing and research that has been done on burnout has come from the helping professions because of its poorer job satisfaction and higher turnover and burnout compared to other occupations (Coates & Howe, 2014). The very nature of the job is to be intensely involved with people, and generally these are people who are not at the highest levels of self-actualized behavior (Maslach, 1982b, pp. 32–33). Burnout tends to afflict people who enter their professions highly motivated and idealistic and who expect their work to give their life a sense of meaning (Pines & Aronson, 1988, p. 11). When many of the clients get worse instead of better despite all of the workers' skill and effort, burnout becomes a high probability for these idealistic people.

Compounding the harsh realities of historically low success rates, the human services business is becoming more difficult. Human services workers are likely to intervene with people with severe psychological and physical traumatic problems connected with sexual and physical assault, murder, Alzheimer's disease, and AIDS. Because of managed care and restricted budgets, human services workers are expected to handle larger caseloads in shorter time periods. These traumatic problems call for tremendous amounts of the worker's energy, resilience, and hardiness. Day in and day out, the severity of these problems and their duration can wear down the optimism and motivation of any worker (McRaith, 1991).

AIDS counselors are an outstanding example of prime candidates for burnout. They must deal with concerns about safe working practices, fear of infection, intensity of counselor/client/significant other relationships over long periods of physical decline to death, the broad range of services needed, transcrisis events involving a variety of issues, increasing numbers of clients, lack of support by other organizations, and shunning by many health care providers (Miller, 1995; Oktay, 1992).

The foregoing problems are at the core of the helping professions, making them not just some of the most challenging but also some of the most stress-prone occupations. Thus, human services professionals must be able to tolerate a variety of complex problems that are generally couched in ambiguity, deal with conflict from both clients and institutions, and somehow meet a myriad of demands from the ecological framework in which they operate (Paine, 1982, p. 21).

For the crisis worker, this is true many times over. Crisis center work settings are notorious for long and erratic hours, low pay, poorly functioning clients, immediate deadlines, a lack of control over when clients will arrive or phone, few second chances, repeat callers with chronic problems, hostile and emotionally "raw" clients, and interagency red tape. These are only a few of the stressors that assault crisis workers, making them prime candidates for burnout (Distler, 1990). Because the crisis worker is exposed to a high incidence of trauma for extended periods of time, phrases such as "compassion fatigue" (Figley, 1995, 2002), "traumatic" or "event" countertransference (Dahlenberg, 2000, pp. 12–13), "vicarious traumatization" (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2002), and "traumatoid states" (Thomas & Wilson, 2004) have found their way into the literature to describe what happens when workers are faced over and over with unspeakable trauma.

However, a question arises about whether burnout and its newer derivatives are really dynamically identifiable. There is a lively ongoing discussion in the professional literature at this writing as to whether burnout is an identifiable, stand-alone malady or is really just clinical depression dressed up in work clothes and struggling through a workday (Bianchi & Laurent, 2015; Bianchi et al., 2015; Chiu et al., 2015). Indeed, Hafkenscheid (2005) proposes that the term *vicarious traumatization* is no more than a fancy term made up to excuse therapeutic failure. Paine (1982, p. 11) and Maslach (1982b, p. 29) report that critics propose that burnout is "part of the job," so if a human services professional "can't stand the heat then he or she ought to get out of the kitchen" because there "always has been stress on this job and always will be." Such cursory dismissal of burnout does not consider the major personal, social, and organizational costs that accrue when job stress turns into crisis (Paine, 1982, p. 11). Burnout is connected to loss of job productivity, impairment of inter- and intrapersonal relationships, and a variety of health problems (Golembiewski et al., 1992; Golembiewski & Munzenrider, 1993; Golembiewski, Munzenrider, & Stevenson, 1986). Indeed, there is ominous research accumulating that indicates people who manifest

burnout have significant changes in body chemistry that are biomarkers for cardiovascular disease (Grossi et al., 2005; Melamed et al., 2006; Toker et al., 2005). Burnout is not just part of the territory; it has major ramifications for both individuals and institutions (Maslach, 1982b, p. 39). It is a very real problem, with chronic occupational stress as the primary cause (Paine, 1982, p. 16; Tubesing & Tubesing, 1982, p. 156).

Dynamics of Burnout

LO1

A historical definition of burnout places it as a child of the 1970s. The term comes from the psychiatric concept of patients who were "burned out" physically, emotionally, spiritually, interpersonally, and behaviorally to the point of exhaustion (Paine, 1982, p. 16). It was first coined as a workplace term by Herbert Freudenberger to describe young, idealistic volunteers who were working with him in alternative health care settings and who started to look and act worse than many of their clients (Freudenberger, 1974, 1975). Yet defining burnout adequately is not simple.

A very broad definition depicts **burnout** as an internal psychological experience involving feelings, attitudes, motives, and expectations (Maslach, 1982b, p. 29). Being burned out means that the total psychic energy of the person has been consumed in trying to fuel the fires of existence. This energy crisis occurs because the psychic demand exceeds the supply (Tubesing & Tubesing, 1982, p. 156). It is experienced as a state of physical, mental, and emotional exhaustion caused by long-term involvement in emotionally demanding situations. It is accompanied by an array of symptoms including physical depletion, feelings of helplessness and hopelessness, disillusionment, negative self-concept, and negative attitudes toward work, people, and life itself. It represents a breaking point beyond which the ability to cope with the environment is severely hampered (Pines & Aronson, 1988, pp. 9–10) and the inability to work effectively (Stamm, 2010).

Put in plain language, burnout is lost energy. You are exhausted. A good night's sleep is out of the question and sleep aids (including alcohol) don't help much. Aborted attempts to get away don't help and you come back feeling worse than ever. Work is demanding beyond reason and exceeds the best you are able to do. Burnout is also lost enthusiasm. As Rhett Butler said to Scarlett O'Hara in *Gone with the Wind*, "Frankly my dear, I just don't give a damn!" Passion has been replaced by cynicism. You despise your bosses and the clients, and aren't overly thrilled with your coworkers either. All the zeal, energy, creativity, expertise, and enthusiasm you brought to the job are long gone. Going the extra mile has turned into wondering whether you can go the few yards to the break room. Finally, your confidence has gone out the window. The less effective you become, the more your self-worth shrinks. Why keep going (Leiter & Maslach, 2005, p. 2)? Indeed you are now a candidate for the long shopping list of maladies you'll soon see that come out of this thing called *burnout*!

Burnout is not generally perceived as a crisis event because its onset is slow and insidious. There is no one point or incident that is readily identifiable as the instigating trauma. Rather, it is a slow and steady erosion of the spirit and energy as a result of the daily struggles and chronic stress typical of everyday life and work (Pines & Aronson, 1988, p. 11). Because of the difficulty in identifying burnout, it becomes much easier to chalk it up as a character deficit. A crisis appears only when people are so defeated and exhausted by the environment that they take extraordinary means to find relief, such as quitting a job or occupational field, developing a serious psychosomatic disease, becoming a substance abuser, or attempting suicide. What is even more problematic is that recovery from burnout is not always linear and tends toward chaos and crisis as the individual tries to come to grips with core issues of vocation, personality, and relationships (Kesler, 1990). As a result, the precipitating crisis of job burnout may move toward a more global, existential crisis wherein the person is in a state of crisis over living.

Occupationally, burnout occurs when past and present problems from the job continuously pile up. Leiter and Maslach (2005, pp. 14–19) propose that there are six major sources of burnout: **workload**, when the work is too complex, too much, too urgent, or just too awful; **control** issues from being micromanaged or having ineffective leaders or teams; lack of **reward** in the form of compensation, recognition, or pleasure; an **absence of community** that provides social support; lack of **fairness**, with little justice and lots of arbitrary and secretive decision making and favoritism; and **discordant values** that indicate you and the organization are severely at odds regarding your belief in the validity and worth of the organization and the organization's belief about your validity and worth. The foregoing problems may vary in

degree and kind, but the result is a continuous and grinding interface between the person and the work environment (Pines & Aronson, 1988, pp. 43–44; Riggar, 1985, p. xvi). From the worker's standpoint, no short- or long-term relief is forthcoming.

The body's nonspecific response to any demand is stress. Humans need some stress for optimal performance. However, there comes a point of maximal return for each person. That point is a function of genetic, biological, behavioral, and acquired physiological factors. Beyond that point, stress is harmful (Selye, 1974). Environmental events may either "cause" the activation of the stress response or, more often, set the stage for it through cognitive-affective processing (Everly, 1989, p. 45). The stress response itself involves enervation of neurological, neuroendocrine, and endocrine systems either singularly or in tandem with one another, which in turn activates various physiological mechanisms directed toward numerous target organs (p. 47). In Selye's (1956) **general adaptation syndrome (GAS)**, overstimulation and excessive wear of target organs lead to stress-related dysfunction and disease. If the stressor is persistent and there is a chronic drain on adaptive energy, eventual exhaustion of the target organ will occur. The end result physiologically may be as dramatic as a heart attack or as common as a headache. Indeed, where GAS is found burnout may not be far behind, and it has been linked to a wide range of both physical and mental illnesses (Maslach et al., 2001).

Stress occurs when there is a substantial imbalance (perceived or real) between environmental demands and the individual's response capability. Burnout occurs when the stress becomes unmediated and the person has no support systems or other buffers to ease the unrelenting pressure (Farber, 1983, p. 14). The outcome is a person affected in every dimension of life by unlimited combinations of symptoms. Such a description very adequately meets the crisis conditions of being in a state of disequilibrium and paralysis.

Cornerstones of Burnout

Let us now look at two human services professionals who are experientially and professionally different, but by almost any definition are in the process of burning out.

Mr. Templeton. Mr. Templeton has worked as a school counselor at Central Junior High School for 2 years. In that time he has instituted some sweeping changes in a guidance program that was, before he came, notorious for running attendance checks and not much more. Mr. Templeton's counseling approach changed all that. Formerly, the last place that students would have gone for help with personal problems would have been the counseling office. By getting out and explaining what his job was all about to students, faculty, parent groups, civic organizations, and anybody else who would listen, and indeed making good on his promises, Mr. Templeton has turned the guidance office into something akin to a land office during the California gold rush. His principal would now fight a circular saw to keep Mr. Templeton around.

What the principal does not know is that Mr. Templeton has fantasies about sending the entire ninth grade to an Outward Bound camp in the Sahara Desert. He has not had a new idea about how to improve the counseling program in 6 months and is wondering if maybe that stockbroker's job that he so capriciously turned down last year was not such a bad idea after all. As he considers all this, he wistfully looks at his wristwatch, then at the ninth grader sitting across from him, and wonders whether she is in his office because of grade problems or a problem at home. She has been talking for 30 minutes, and he cannot remember two sentences she has said.

Josh. Josh is a social worker at an outpatient clinic for a community mental health center. He has worked there for 5 years. His patient load resembles something on the order of bus traffic to Mecca. He has just received a memorandum from the director further increasing his caseload by 20%, along with a rather curt directive to move on some of those old cases and get them off the clinic rolls. Josh is sitting in his friendly local tavern quietly getting drunk and wondering how he is going to put 20 people out on the street with no support. He is also mulling over what response he will make to his wife, who just this morning asked for a separation. Among the complaints she voiced, his job was prominent: the lousy pay for somebody with a master's degree, the long hours with no compensatory time, the emergencies in the middle of the night, and particularly forgetting he is the father of their two children and a husband to her. Josh stares across the bar and orders another drink. While waiting for his order, he swallows an antacid tablet for the dull, burning pain slowly working its way outward from the pit of his stomach.

What do these two human services professionals have in common? They are alike in that they are empathic, sensitive, humane, idealistic, and people

oriented and have been highly committed and dedicated to their profession. However, like most other human services workers prone to burnout, they also tend to be overly anxious, obsessional, enthusiastic, a bit neurotic, extraverted, conscientious, and susceptible to identifying with their clients (Farber, 1983, p. 4; Piedmont, 1993). For both of them, one or more of the following foundation blocks of burnout have been laid (Borritz et al., 2005; Farber, 1983, p. 6; Hamois, 2015; Lee & Ashforth, 1993; Olivares-Faundez et al., 2014; Powell, 1994; Rupert, 2015).

1. *Role ambiguity.* They lack clarity concerning rights, responsibilities, methods, goals, status, and accountability to themselves or their institutions.
2. *Role conflict.* Demands placed on them are incompatible, inappropriate, and inconsistent with values and ethics.
3. *Role overload.* The quantity and quality of demands placed on them have become too great.
4. *Inconsequentiality.* They have a feeling that no matter how hard they work, the outcome means little in terms of recognition, accomplishment, appreciation, or success.
5. *Isolation.* They have little social support either in the institution or outside of it.
6. *Autonomy.* Their ability to make decisions as to what they will do and how they will deal with their clients is co-opted by the bureaucracy of their place of employment.

These foundation stones are not thrown down haphazardly. They are built up slowly but surely over time through a variety of dynamics.

Research on Burnout Dynamics

The following points have been supported to varying degrees by research on burnout (Baird & Jenkins, 2003; Bianchi et al., 2014; Borritz et al., 2005; Carroll & White, 1982; Decker, Bailey, & Westergaard, 2002; Golembiewski & Munzenrider, 1993; Golembiewski, Munzenrider, & Stevenson, 1986; Golembiewski et al., 1992; Grossi et al., 2005; Grouse, 1984; Hoeksma et al., 1993; Koeske, Kirk, & Koeske, 1993; Lee & Ashforth, 1993; Linley, Joseph, & Loumidis, 2005; Lyndall & Bicknell, 2001; Oerlamans & Bakker, 2014; Maslach, 1982a; Mather et al., 2014; Melamed et al., 2006; Piedmont, 1993; Pines & Aronson, 1988; Powell, 1994; Rupert et al., 2015; Salston & Figley, 2003; Toker et al., 2005).

1. All stressors are cumulative and can help lead to burnout.
2. Burnout is psychobiological.
3. Environmental factors other than work can be contributors.
4. A lack of effective interpersonal relationships contributes to burnout.
5. Signs of burnout will occur, but recognition of them depends on the observer's astuteness.
6. Symptoms sometimes appear quickly, but most usually occur over time.
7. Burnout is process oriented rather than event oriented.
8. Burnout varies in severity from mild energy loss to death.
9. Burnout also varies in duration.
10. Burnout and resulting crisis can occur more than once.
11. Awareness varies from complete denial to full consciousness of the problem.
12. Burnout is infectious in that it puts additional stress on other workers.
13. Burnout is greatest for beginning and long-term workers and least for midduration workers.
14. Those who are single experience the most burnout, whereas those with families experience the least. However, stressors that enter family life can exacerbate burnout.
15. Restorative and preventive measures have to be individually tailored because of the idiosyncratic nature of burnout.
16. Burnout has progressive phases that can be identified by the varying degrees of depersonalization, personal accomplishment (or lack thereof), and emotional exhaustion the individual exhibits.
17. Burnout is not a disease, and the medical model is not an appropriate analytical model.
18. Burnout should not be confused with malingering.
19. Progressive deterioration in physical and mental health occurs as burnout increases.
20. Job autonomy, sense of coherence, and social support buffers are critical to preventing, containing, and reducing burnout.
21. Making time for leisure and using it wisely are as important as any job variable.
22. Burnout can lead to personal and professional growth as well as to despair and trauma.
23. More education, training specific to trauma work, supervision, and institutional support are all related to lower burnout rates.
24. A personal history of trauma is a contributing factor.

Myths That Engender Burnout

LO2

Candidates for burnout believe a number of myths about themselves and how they must operate in their environment (Everly, 1989; Friedman & Rosenman, 1974; Kesler, 1990; Maslach, 1982a; Pines & Aronson, 1988; Rodesch, 1994). They tend to distort the reality of the situation in typical type A personality patterns (Friedman & Rosenman, 1974), generating a variety of irrational statements about themselves and their work. These statements are modeled after Albert Ellis's (Patterson, 1980, pp. 68–70) unhealthy thoughts people say to themselves about their predicaments.

1. "My job is my life." This means long hours, no leisure time, and difficulty delegating authority. Anxiety, defensiveness, anger, and frustration are the result when things do not go perfectly.
2. "I must be totally competent, knowledgeable, and able to help everyone." Unrealistic expectations of performance, a need to prove oneself, lack of confidence, and overriding guilt occur when one is not perfect.
3. "To accomplish my job and maintain my own sense of self-worth, I must be liked and approved of by everyone with whom I work." Such workers cannot assert themselves, set limits, say no, disagree with others, or give negative feedback. Therefore, they get manipulated by others in the work setting—including by clients. Self-doubt, passive hostility, insecurity, and subsequent depression are the reward.
4. "Other people are hardheaded and difficult to deal with, do not understand the real value of my work, and should be more supportive." Stereotyping and generalizing about specific problems and people occur, and lack of creativity, wasted energy, and decreased motivation result. The person has a defeatist attitude and a passive acceptance of the status quo.
5. "Any negative feedback indicates there is something wrong with what I do." The person cannot evaluate his or her work realistically and make constructive changes. There is a great deal of anger with critics, which may manifest itself in either passive or aggressive hostility, depending on the person toward whom the anger is directed. Frustration and immobilization are the outcomes.
6. "Because of past blunders and failures by others, things will not work the way they must." Old programs are not carried to fruition, nor are new ones created. Stagnation and decay in the work setting are the result.
7. "Things have to work out the way I want." The person's behavior is thus characterized by working extra hours and checking up on staff members' work, an inability to compromise or delegate, over attention to detail, repetition of tasks, impatience with others, and an authoritarian style.
8. "I must be omniscient and infallible." The person can never be wrong. The very act of doing therapy with humans in all their infinite ways of behaving means fallibility for the worker, particularly when the client is in crisis.

These dynamics lead to a wide array of symptoms.

Symptoms of Burnout

LO3

Burnout is a multidimensional phenomenon, consisting of behavioral, physical, interpersonal, and attitudinal components. Table 16.1 is a ready reference. While the list is lengthy, it is undoubtedly not all-encompassing. Certainly not all human services workers in crisis manifest all the symptoms listed. Yet for the watchful observer, many will become noticeable, particularly if one looks back in time and notes any pronounced changes in the worker.

Levels of Burnout

LO4

Burnout can be categorized as occurring at one of three levels: *trait*, *state*, and *activity* (Forney, Wallace-Schutzman, & Wiggers, 1982). At a trait level, it is all-pervasive, encompassing every facet of the worker's life. The worker is completely nonfunctional in regard to person, place, and time. The trait level of burnout is extremely serious and calls for immediate intervention in the worker's life. At a state level, burnout may be periodic or situational. A classic example is what occurs during the period of full moon at a crisis line center. At such times it seems as if every crisis-prone person in town takes a signal from a lunar clock to go berserk. Although problematic, such crisis situations are relieved when the moon wanes, and the crisis line worker returns to some semblance of normalcy. However, over the long term, such state events contribute mightily to anticipatory anxiety, which if not dealt with can precipitate total burnout.

Finally, burnout may be activity based. Any activity that is performed over and over at an intense level, as in encounter group counseling of substance abusers or serving as a chaplain to the grief stricken in a trauma center, will invariably wear the armor off the most

TABLE 16.1 Symptoms of Burnout

Behavioral	Physical	Interpersonal	Attitudinal
Reduced quantity or efficiency of work	Chronic fatigue and exhaustion	Withdrawal from family	Depression
Use and abuse of alcohol and illicit drugs	Lower resistance	Compulsion to do all and be all at home	Feeling of emptiness, meaninglessness
Increase in absenteeism	Maladies occurring at organ weak points: ulcers, migraines, gastrointestinal upset, facial tics, etc.	No mature interactions—keeping hidden agendas	Ranging from omnipotence to incompetence
Increase in risk taking	Colds and viral infections	Keeping everyone subservient	Cynicism
Increase in medication	Poor coordination	Feeling drawn to people who are less secure	Paranoia
Clock watching	Insomnia, nightmares, and excessive sleeping	Reduction of significant others to status of clients	Compulsiveness and obsessiveness
Complaining	Muscular tension	Breaking up of long-lasting relationships	Callousness
Changing or quitting the job	Addiction to alcohol and/or drugs	Becoming therapeutically minded and overreacting to comments of friends	Guilt
Inability to cope with minor problems	Increased use of tobacco and caffeine	No separation of professional and social life	Boredom
Lack of creativity	Over- or undereating	Allowing clients to abuse privacy of home by calls or visits at any time	Helplessness and/or hopelessness Suicidal/homicidal ideation
Loss of enjoyment	Hyperactivity	No opportunity for or enjoyment in just being oneself	Terrifying and paralyzing feelings and thoughts
Loss of control	Sudden weight gain or loss	Loneliness, trust issues	Stereotyping
Tardiness	Flare-ups in preexisting medical conditions: high blood pressure, ulcers, asthma, diabetes, etc.	Loss of authenticity	Depersonalizing
Dread of work	Injury from high-risk behavior	Loss of ability to relate to friends, family, or clients	Pessimism
Vacillation between extremes of overinvolvement and detachment	Missed menstrual cycle	Avoidance of close interpersonal contact	Air of righteousness
Mechanistic responding	Increased premenstrual tension	Switch from open and accepting to closed and denying	Grandiosity
Accident proneness	Injury from accident	Inability to cope with minor interpersonal problems	Sick humor, particularly aimed at clients
Change in or cessation of religious affiliation	Rapid heartbeat	Isolation from or overbonding with staff	Distrust of management, supervisors, and peers
Errors in setting therapeutic boundaries	Breathing difficulties	Increased expression of anger and mistrust	Hypercritical attitude toward institution and coworkers
Errors in judgment and strategy in and outside therapy	Anxiety and panic attacks	Increased vigilance and safety issues for self and loved ones	

TABLE 16.1 *(continued)*

Behavioral	Physical	Interpersonal	Attitudinal
PTSD-like symptoms of intrusive thoughts, numbing of affect, sleep disturbance, nightmares, and hypervigilance	Dizziness	Overprotection as a parent	Entrapment in job and relations
Regression	Impaired immune system	Decreased interest in intimacy or sex	Free-floating feelings of inadequacy, inferiority, incompetence, and survivor guilt
Impatient and irritable			Self-criticism and perfectionism
Withdrawn			Rapid mood swings
Losing things			Loss of faith, meaning, purpose
Suicide attempts			Change in religious beliefs
Homicide attempts			Sense of grounding, inner balance lost Increased sense of vulnerability to world at large

emotionally bulletproof crisis worker. A simple way of decreasing chances of burnout when the stressor is activity based is to change the routine. However, such change is not always easily accomplished or even recognized as needed.

Stages of Burnout

LO5

Another way of characterizing the road to burnout is by stages. Edelwich and Brodsky (1982, pp. 135–136) delineated four stages through which the typical candidate for burnout goes.

Stage 1: Enthusiasm. The worker enters the job with high hopes and unrealistic expectations. If such idealism is not tempered by orientation and training programs that define what the worker can reasonably expect to accomplish, such a rose-colored view of human services work will inevitably lead to the stage of stagnation.

Stage 2: Stagnation. Stagnation occurs when the worker starts to feel that personal, financial, and career needs are not being met. Awareness may come from seeing people perceived as less able moving up the career ladder faster, pressures from home to meet increased financial obligations, and lack of personal intrinsic reinforcement for doing the job well. Astute management policy will head off stagnation by providing a variety of incentives that clearly say to the worker, "You're doing a good job here, and we appreciate it." If intrinsic and extrinsic reinforcement does not occur, the worker will move into the next stage, frustration.

Stage 3: Frustration. Frustration clearly indicates that the worker is in trouble. The worker starts questioning the effectiveness, value, and impact of his or her efforts in the face of ever-mounting obstacles. Because the effects of burnout are highly contagious in the organizational setting, one person's frustration is likely to have a domino effect on others. One appropriate way of meeting frustration is to confront the problem head on by arranging workshops or support groups to increase awareness of the burnout syndrome, and generate problem solving as a group to bring about changes within both the institution and the individual. Catching the problem at this stage may well lead back to a more tempered stage of enthusiasm. If the problem is not resolved, then the final stage, apathy, is reached.

Stage 4: Apathy. Apathy is burnout. It is a chronic indifference to the situation and defies most efforts at intervention. Apathy is truly a crisis stage: The person is in a state of disequilibrium and immobility. Further compounding this stage are denial and little objective understanding of what is occurring. At this point psychotherapy is almost mandatory for reversal to take place.

Worker–Client Relationships

LO6

As crisis intervention has spread to more and more areas of psychological trauma, interest in what happens to the workers who deal with these clients has led to the concept of **secondary traumatic stress disorder (STSD)**. STSD is a consequence for

health care professionals who are frequently exposed to the stress and trauma of others in the course of treating them (Hensel et al., 2015) or what McCann and Pearlman (1990) call **vicarious traumatization (VT)**. **Compassion fatigue (CF)** is manifested in the continuous negative aspects of care provision for tough cases and customers in a demanding work environment that generally revolve around some type of trauma (Stamm, 2010). These terms are often used interchangeably to describe what is going on when the crisis worker–client relationship becomes pathological. These are the very real, concrete negative effects that occur when human services workers have prolonged exposure to traumatized clients who are in crisis.

Research does indicate that health services workers experience more negative effects from crisis work than other types of health services workers (Arvay & Uhlemann, 1996; Blanchard & Jones, 1997; Charney & Pearlman, 1998; Johnson & Hunter, 1997; Smart et al., 2014). The potential for STSD is even more pronounced in crisis workers who work with long-term disasters. Wee and Myers (2002) conducted a study of mental health workers who did long-term follow-up in the Murrah Federal Building bombing in Oklahoma City, and found that about half of the respondents reported being more stressed than doing normal mental health work and being at high risk for both compassion fatigue and burnout. Why is this so?

It is so because trauma work and crisis intervention are so potentially addictive and at the same time so potentially destructive! Much like the "rush" that police officers, paramedics, and other emergency workers experience from being in the middle of traumatic events, crisis workers feel the "adrenaline high" of successful crisis intervention, and this can become highly addictive. As an example, psychologists who worked the aftermath of 9/11 in New York City reported more positive than negative feelings regarding their work (Eidelson, D'Alessio, & Eidelson, 2003). Yet the constant exposure to the "highs" that come with dealing with traumatic events also means that the crisis worker is exposed to a constant barrage of some of the most graphic and horrible physical and psychological ramifications that nature or humankind can visit on people. Two psychological concepts are hallmarks of dealing with crisis clients and, if not understood and dealt with, have the potential to infect the crisis worker and lead to burnout. Those two concepts are countertransference and secondary traumatic stress or vicarious traumatization/compassion fatigue.

Countertransference

Whenever therapy becomes intense, as in crisis work, the potential for countertransference rises dramatically. **Countertransference** is the attributing to the client, by the crisis worker, of traits and behaviors of past and present significant others or events in the crisis worker's own life. Countertransference responses may be positive or negative, spoken or unspoken, conscious or unconscious. They may include physical, psychological, social, gender, racial, moral, spiritual, cultural, or ecological factors that have impacted the worker through past experiences and are manifested in the "here and now" of therapy by the client. At times, emotional aspects of the client may agitate feelings, thoughts, and behaviors that are deeply buried within the worker's own personality.

When confronted with their own shortcomings, fears, faults, prejudices, and stereotypes as mirrored by the client, human services workers may begin behaving in inappropriate ways. Workers may act in ways designed to meet their own needs and not the clients'. The result is that clients are made to fit neatly into the workers' preconceived patterns for the way things "ought to be," and not necessarily in reference to the client but how they "ought to be" for the crisis worker (Freudenberger, 1977).

The general axiom of psychoanalytic therapy is that countertransference needs to be guarded against, and the therapist's refusal to recognize it and deal with it can, at the least, inhibit the therapist's effectiveness, and at the most, be destructive to the relationship (Dahlenberg, 2000, pp. 1–6). If the phenomenon of countertransference is not recognized and dealt with in positive ways, the human services worker ends up feeling guilty about having negative feelings toward the client and is not even sure why those feelings are occurring. Such feelings are antithetical to what the worker has been taught and believes and can significantly compound the occupational stresses that lead to burnout.

However, Pearlman and Saakvitne (1995a, pp. 22–24) propose that if crisis workers are to deal successfully and understand the pain of their clients in deeply empathic ways, then countertransference is inevitable and necessary. Particularly emotion-laden issues such as physical and sexual abuse of children, terminal illnesses, and chronic suicidal ideation are prime examples of content that may be exceedingly

stressful to the worker because of strong feelings and experiences the worker may have about the problem (Dahlenberg, 2000; Fox & Cooper, 1998; Pearlman & Saakvitne, 1995a). The pluses and minuses of countertransference as it applies to trauma appear to balance precariously on a very thin psychological high wire. Main's (2008) study of sexual offender treatment providers found that while they manifested disruptions in cognitions, emotions, and behaviors consistent with those that characterize compassion fatigue and vicarious traumatization, they also possessed many of the components for **compassion satisfaction** (the positive feelings and intrinsic rewards one feels from helping others who have experienced a traumatic event) (Stamm, 2010) and reported that their child sexual abuse histories were an advantage in the treatment of sex offenders. As such, one of the critical components to handling countertransference effectively would appear to be close and competent supervision.

Secondary Traumatic Stress/Vicarious Traumatization/Compassion Fatigue

STS/VT and CF are different from the phenomenon of countertransference. As these terms have evolved, they have taken on somewhat different, more discrete meanings. **Secondary traumatic stress/vicarious traumatization** is the transformation that occurs when an individual begins to change in a manner that mimics a client's trauma-related symptoms. It is a constructivist model in which the individual's experience and worldview are changed as a direct result of secondary exposure to trauma through crisis work (Pearlman & Mac Ian, 1995). As an example, in a study conducted by Alexander and associates (1989), researchers who were deeply involved in reading and reviewing rape cases and not actually talking to the victims started to manifest victim pathology. The bottom line is that all of these terms apply to a worker who has been affected by long-term, intense involvement of some type with very traumatized clients.

STS/VT and CF occur as a result of an accumulation of experiences across therapies and clients and are felt far beyond the transference–countertransference issues of a specific client–therapist relationship. Whereas countertransference is temporary, STS/VT and CF have the potential to permanently change the psychological constructs of workers who engage in intense and long-term trauma and are an inevitable occupational hazard of trauma work (Saakvitne & Pearlman, 1996, p. 31). In summary, a worker who has a full-blown case of STS/VT doesn't look and act very much different than the PTSD clients they are treating.

The end result of VT and CF is their generalizing effects on countertransference issues. As VT is multiplied and generalized over clients, countertransference reactions become stronger through the human services worker acting them out against the client or submerging them even deeper from awareness (Saakvitne & Pearlman, 1996, p. 48). For human services workers in general, and crisis workers in particular, VT/STS and CF are major mediating factors that lead to burnout. In fact, Cieslak and associates (2014) conducted a meta-analysis that examined the relationship between STS/VT and burnout and found a substantial overlap between the two particularly if measured in the framework of compassion fatigue.

Worker Vulnerability. Maslach (1982b, pp. 36–37) states that the only human services workers who burn out are the ones who are on fire. For such workers, Saakvitne and Pearlman (1996, pp. 26, 49) and Figley (1995) believe that the deep empathy needed to deal with the heart-wrenching situations that often accompany crises makes workers vulnerable to intense and overwhelming feelings and profound disruptions in their beliefs, and assaults the very core of their hope and idealism. Over time, such assaults lead to compassion fatigue (Figley, 1995), wherein the crisis workers' energy is literally wrung out by the incidence and amplitude of dealing with the horrific problems that trauma clients face.

Between a very real dedicatory ethic and at times an insatiable need to assist everyone with any type of problem, the idealistic human services worker sees his or her job as a calling. In an imperfect world, such an idealistic outlook can lead to over involvement and identification with the client—often to the worker's detriment (Koeske & Kelly, 1995). As the human services worker becomes more deeply enmeshed in the helping relationship, the worker's strong need to be accepted and liked makes it harder and harder to say no to the client's demands. At this point, the worker has started to take on responsibility for the client.

The worker's over involvement with the client may be manifested in a variety of ways. Some of the many indicators that the worker is not paying attention to his or her own needs, or frankly to the client's, include extending the session beyond its usual time limit, taking and responding to phone calls at home at all hours of the night, experiencing hurt feelings

over client failures, attempting dramatic cures on impossible cases, becoming panic stricken when well-laid plans go awry, refusing to withdraw from the case when it is clearly beyond the worker's purview, becoming angry, sarcastic, or bored with clients, changing the subject and avoiding the topic, providing pat answers, discounting the client's problems and minimizing distress, not believing clients, fearing what the client will say, silencing client trauma talk, wishing or suggesting the client would "just get over it," feeling numb or avoidant, not being able to pay attention, being constantly reminded of one's own personal trauma events, hoping the client won't show up, becoming frustrated over lack of progress, and losing one's sense of humor over the human dilemma (Baranowsky, 2002; Dahlenberg, 2000; Van Auken, 1979). The foregoing are all indicators that unresolved countertransference and vicarious trauma/compassion fatigue issues are flourishing.

Under these circumstances, the worker comes to see the helping relationship as a chore, and the client may regress and act out as a way of announcing the client's awareness of the worker's apathetic attitude. As this psychological vortex continues to swirl and the worker becomes even more overwrought and discouraged, the client is likely to terminate the therapeutic relationship (Dahlenberg, 2000; Watkins, 1983). Such negative reinforcement does little to mollify the worker's already bruised ego and may lead to a further downward spiral into burnout. Whether exposure to these occupational hazards has negative or positive outcomes depends a great deal on how both the individual worker and the human services institution deal with them in proactive ways (Dahlenberg, 2000; Deiter & Pearlman, 1998; Figley, 1995; Pearlman & Saakvitne, 1995a; Saakvitne & Pearlman, 1996).

Compassion Satisfaction

LO7

Stamm (2005) describes compassion satisfaction as simply the pleasure you derive from being able to do your work well. The reason compassion satisfaction as a construct has gained notoriety is that it appears to be an extremely effective buffer against burnout. Human services workers who are satisfied with the effect they have on clients consistently show low levels of vicarious traumatization and burnout (Conrad & Keller-Guenther, 2006; Eastwood, 2007; Killian, 2008; LaFauci Schutt, 2009; Lawson & Myers, 2011; Ling et al., 2014; Ringenbach, 2009; Sullivan, 2004). Therefore, it would seem reasonable that organizations do everything in their power to tell their workers that they are doing a good job and further to get direct feedback from clients that they are satisfied with the care they have been given and the concern they have been shown by the crisis worker.

The Culpability of Organizations

LO8

Much of the responsibility for burnout rests with the employing agency and its inability to either recognize or do anything about organizational problems that lead to burnout (de Figueiredo et al., 2014; Everly, 1989, pp. 295–297; Kulkami et al., 2013; Pines & Aronson, 1988, pp. 97–111; Shinn & Mørch, 1983, p. 238). Savicki and Cooley (1987) compared degree of burnout with work environment and found that those workers who scored highest on burnout indexes felt that they had little impact on procedural and policy issues, lacked autonomy within the guidelines of the job structure, were unclear about agency objectives, had a high intensity of work assignments over extended periods of time, were highly restricted in how they could deal with clients, and felt generally unappreciated by their coworkers or supervisors. One example is handling client verbal and physical aggression as a major mediating factor in burnout (Gascon et al., 2013; Hensel et al., 2012; Yung, 2013; Ho et al., 2013). Although personal safety is a major concern, when workers feel their safety concerns are not responded to by management then threat level goes up (Evans & Petter, 2012) along with the potential for burnout with it.

Above all, the organization's inability to clearly define job roles and functions causes role conflict and role ambiguity, and these are two of the best predictors of the workplace's contribution to burnout (Barber & Iwai, 1996). These findings should not be construed as representing "gripes" of the respondents. Numerous other studies (Burke & Greenglass, 1995; de Figueiredo et al., 2014; Duquette et al., 1994; Jayaratne, Vinokur-Kaplan, & Chess, 1995; Lee & Ashforth, 1993) have substantiated findings that agencies that do not take pains to communicate clearly with and support their staff have high burnout rates.

One of the critical support mechanisms for crisis workers is easy access to consultation, support, and supervision (de Figueiredo et al., 2014; Handran, 2014; Ling et al., 2014; Salloum et al., 2015). Crisis intervention should never be done in isolation, and the case example presented in this chapter is

an excellent example of why that is so. Yet, as Pearlman and Saakvitne (1995a, p. 359) report, unsupervised trauma therapy seems all too common. Pearlman and Mac Ian (1995) found that less than two-thirds of trauma therapists they interviewed reported getting any kind of supervision, although more than 80% of those who did receive supervision and consultation found it helpful.

In contrast, those agencies that do allow input into the mission of the organization, are flexible in providing instrumental and emotional support to workers, generate support groups, provide consultation, have job clarity, promote managers with social leadership styles, retain realistic expectations for the progress of their clients, and furnish supervision to help workers solve problems associated with the high stress of their jobs report workers with lower indexes of burnout (Everly, 1989, pp. 299–309; Kahn, 2005; Melchior et al., 1997; Pines & Aronson, 1988, pp. 107–111; Savicki & Cooley, 1987).

Self-Recognition of Burnout

Whatever the degree of burnout, human services workers and their organizations have a notorious blind spot. What they can detect in others and change by therapeutic intervention, they are generally unaware of in themselves. Furthermore, they have extreme difficulty maintaining both the personal and professional objectivity to self-diagnose burnout or muster the discipline and devote the energy to integrate effective intervention strategies into their own lives (Spicuzza & Devoe, 1982).

When they finally are confronted with the fact that something is terribly wrong in their professional lives, their initial maladaptive response is likely to be "What's wrong with me?" rather than "What can I do to change the situation?" Their typical operating mode is not to change the situation but rather to increase the amount of effort and consequently increase the original problem (Pines & Aronson, 1988, pp. 5–9).

Before delving into intervention, your authors want to be very clear that they agree with Watkins (1983) that no one—and we would go a step further and state that *absolutely* no one—who practices in the human services professions is immune to burnout. Furthermore, it has been our experience that human services workers who, like some of you who are reading this passage, think "It'll never happen to me" are invariably the kinds of fellow professionals we end up treating; or, in the absence of treatment, become those who can no longer stand to ply the trade and quit; or, at the extreme, become substance abusers or suicidal or homicidal. In these circumstances, the outcomes range from bad to worse: bad for the profession and worse for you, the professional.

Intervention Strategies

LO9

While there is a great deal of literature on self-care and balancing other life experiences against work as a buffer against burnout (Ling et al., 2014; Oerlemans & Bakker, 2014), there have been few protocol and hard data studies to identify specific treatments that work with those who are experiencing STS and are burned out (Bercier & Maynard, 2015).

Practitioners on the road to burnout typically are perfectionistic workaholics (Falco et al., 2014) who push relentlessly toward emotional exhaustion, becoming more inefficient and unhappy as they do so. Note the "aholic" component because our experience is that burning up professionals are much the same as alcoholics in their vehement denial that things are going badly awry until a severe crisis of their own is created such that it finally gets their attention. Thus, when we consider individual crisis intervention with an impaired fellow professional, emphasis in applying the crisis task model in this book will usually focus on the directive end of the continuum because of the depth of the crisis and an "I know more than you do, and I'm not nuts" fellow worker. The crisis interventionist who helps a burned-out human services worker typically must proceed in a very directive manner while confronting the client's irrational beliefs, proposing definite alternatives, and getting the client to commit to specific action steps that will get the person out of the state of immobility. Put in simple terms, fellow human services workers are some of the most stubborn and denial-prone clients there are when they have reached the later stages of burnout.

Intervention for the human services worker suffering from burnout may best be considered in three distinct dimensions: intervention through training, intervention with the organization, and intervention with the individual. Triage assessment of the level of burnout is important in determining the type of intervention to be used. At a trait level, individual therapeutic intervention will clearly be warranted. At a state or activity level, training or organizational intervention may be sufficient. When the organization itself becomes a client, triage assessment would

clearly include the administering of both burnout and work-setting instruments to all members of the organization and following up that administration with individual interviews.

Assessment

LO10

Three types of instruments are important in determining burnout and compassion fatigue.

Burnout. The first type has to do with determining the degree of burnout in the individual. The most widely used instrument is the Maslach Burnout Inventory–Human Services Survey (MBI-HSS; Maslach & Jackson, 1981a), which is a valid cross-occupational and cross-cultural (Bakker, Demerouti, & Schaufeli, 2002; Gorter et al., 1999) instrument that measures three symptom patterns associated with burnout. The Emotional Exhaustion scale assesses feelings of being emotionally worn out by work. The Personal Accomplishment scale measures feelings of competence and achievement with work. The Depersonalization scale measures unfeeling and impersonal responses toward clients. The scales can also be combined to produce a total frequency and intensity score for burnout. A variation of the scale for professional burnout in general (MBI-GS; Maslach, Jackson, & Leiter, 1996) measures exhaustion, cynicism, and reduced personal efficiency, three components that parallel the original MBI-HSS. There is also a Maslach Burnout Inventory for educators (MBI-ES; Maslach, Jackson, & Leiter, 1996), which uses the foregoing components to measure degree of burnout in educators.

Golembiewski, Munzenrider, and Stevenson (1986) used the Maslach Burnout Inventory's three domains to develop a progressive phase model of burnout. In their model, depersonalization is seen as the least potent and initial burnout phase. It must occur prior to any substantial reduction in feelings of personal accomplishment, which they see as a secondary response and more potent level of burnout. Emotional exhaustion, the third and most potent indicator of burnout (Lee & Ashforth, 1996; Wright & Bonett, 1997), would follow heightening of the prior two stages.

Lee and associates (2007) have developed the Counselor Burnout Inventory. This instrument measures five burnout dimensions: Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration of Personal Life. This instrument attempts to integrate both personal and organizational components of potential burnout factors and determine how much workplace factors contribute to overall burnout. They have attempted to determine what particular patterns of these scales best classify levels of burnout and pattern clusters (Lee et al., 2010). Their research, which sampled counselors who worked in a variety of settings, identified three sets of counselor profiles. A cluster they called "Well-Adjusted Counselors" (WACs) had low scores and flat profiles across all the scales. WACs also reported high job satisfaction, good self-esteem, and decent pay. Their MBI scores correlated with their CBI profiles, with low scores on Emotional Exhaustion and Depersonalization and high scores on Personal Accomplishment.

Lee and his associates (2010) found a second cluster they called "Disconnected Counselors" (DCs), who had medium-level scores on Exhaustion, Negative Work Environment, and Deterioration in Personal Life with high Incompetence and Devaluing Client scores. DCs' scores on the MBI paralleled their CBI scores, with a very high Depersonalization score, low Personal Accomplishment, and midrange Emotional Exhaustion scores. They reported low job satisfaction, poor self-esteem, and low pay.

A third cluster, which the researcher named "Persevering Counselors" (PCs), was characterized by high Exhaustion, Negative Work Environment, and Deterioration in Personal Life, but low scores on the Incompetence and Devaluing Client scales. Of the three groups, the PCs scored far higher on the MBI Emotional Exhaustion scale, in the midrange on Depersonalization, and high on sense of Personal Accomplishment. They reported the most counseling experience, highest positive self-esteem, and highest pay of the three groups, even though they reported the most dissatisfaction with their jobs. The PC cluster is interesting in that they are still performing well, but all the indicators are there for burnout. As such, it would appear that this instrument could identify not only workers who were functioning well as opposed to those who were burning or burned out, but those who were moving in that direction.

Compassion Fatigue and Compassion Satisfaction. Newer tests that specifically target different facets of secondary stress include the Compassion Fatigue Self-Test (Figley, 1995). From Wee and Myers's (2003) preliminary work with this test, it appears that satisfaction with doing crisis intervention work is indeed a counterbalance to compassion fatigue. What they found was that although approximately half the

workers sampled had high compassion fatigue scores, almost 90% had high satisfaction scores and low burnout scores. The belief is that compassion satisfaction can act as a protective buffer against compassion fatigue and burnout (Collins & Long, 2003).

The Professional Quality of Life Scale (ProQOL; Stamm, 2002, 2005, 2010) measures compassion satisfaction, compassion fatigue, and burnout. It is a test for workers in the human services field but is particularly designed for first responders such as police, EMTs, firefighters, and ER personnel. The Compassion Satisfaction and Fatigue Test is of particular interest because it factors in the worker's satisfaction and therapeutic fatigue with clients. Certainly not all crisis workers manifest STSD; many workers are resilient, hardy, and continuously involved in crisis work over long terms with no ill effects. Stamm (2002) hypothesizes that it is because their satisfaction with doing the job counterweights and compensates for the heavy fatigue factors they experience. Therefore, this test gives scores for compassion satisfaction (CS), compassion fatigue (CF), and burnout (BO). Research indicates that indeed compassion satisfaction is an ameliorating factor in both compassion fatigue and burnout.

Work Environment. The third type of instrument measures the work setting. Typical of this type of assessment device is the Work Environment Scale (Moos, 1981), which measures 10 different dimensions of an organizational component named "social climate." These dimensions are job commitment, support from coworkers, management support, independence in decision making, efficient and planful approaches to tasks, performance pressure, role clarity, degree of control by management, variety and change in job, and physical comfort. Taken together, these various instruments provide a way of examining the degree of burnout in relation to environmental factors within the organization, yield a fairly comprehensive picture of how burned out the worker is, and indicate the degree of intervention necessary (Savicki & Cooley, 1987).

Intervention Through Training

Early in a human services worker's training, and on an ongoing basis when in practice, emphasis needs to be placed on correcting worker attitudes that lead to over involvement (Koeske & Kelly, 1995). Although Saakvitne and Pearlman (1996, pp. 25–26) argue that the deep empathy needed for trauma work inevitably begets countertransference and the possibility of vicarious traumatization, at least a part of training should focus on increasing therapeutic detachment and moderating idealism (Warnath & Shelton, 1976). A delicate balance exists between providing empathy and manifesting sympathy for a client. To that end, trauma-informed worker development training has been found to be a strong predictor against burnout (Handran, 2014; Salloum et al., 2015).

Beginning human services practitioners need to have their rose-colored glasses gently removed, so they can see that their good intentions are doing neither themselves nor their clients much good (Pines & Aronson, 1988, p. 194). Most particularly, students need to examine their limited insight into their own unresolved issues and conflicts and how those interact with those of their clients, particularly when they are dealing with the often horrific material that is a hallmark of crisis intervention and trauma work (Dahlenberg, 2000; Pearlman & Saakvitne, 1995a, pp. 359–380; Watkins, 1983).

Not all students in the human services field are psychologically equipped to go into crisis work. Although this work is absolutely some of the most gratifying and reinforcing there is in the human services field, it is also some of the most gut-wrenching and heartbreaking. Students who are not exposed to realistic field experiences and good supervision may go blindly into one of the most stressful occupational fields known.

Intervention with the Organization

Much of the literature shows burnout to be situation based (Barber & Iwai, 1996; Kesler, 1990; Melchior et al., 1997; Schaufeli, 2006). Thus, the organization can also be considered as client. When an organization is in danger of burnout, all those who work in the organization should be involved in restructuring working conditions. Indeed, one of the major criticisms of burnout intervention has been the lack of change in the total system (Carroll & White, 1982, p. 56). What makes the major difference in obtaining peak performance from workers as opposed to having them burn out is whether the work environment is supportive or stressful (Pines & Aronson, 1988, p. 48).

Lack of positive reinforcement by the institution is not at all uncommon and fits neatly into an aversive management policy: "There is no such thing as burnout, only staff who don't work and have malicious motives toward the organization." As staff become increasingly burned out, they tend to fulfill

management's negative predictions about them (Carroll & White, 1982, pp. 53–54). Although much is mentioned in the burnout literature about eradicating the negative aspects of the work environment, research indicates that a lack of positive features is significantly correlated with burnout independent of the presence of negative work features (Pines & Aronson, 1988, p. 48).

Human services organizations are notorious for having to live continuously on the edge of financial exigency. Lack of physical, human, and financial resources militates against comprehensive service provision and long-term planning. Organizations that face crises such as funding and human resource cutbacks often cope with problems by unwittingly adopting crisis characteristics and operating in a state of disequilibrium and immobility. Just letting the crisis "run its course" is no more appropriate for organizations than for individuals in crisis (Devine, 1984).

Therefore, from an ecological standpoint, the organization needs to move away from piecemeal interventions and apply techniques that have general inputs to the total organization rather than just inputs focused on individuals (Paine, 1982, p. 25). Ideally, interventions should be multifaceted and take into consideration both individual and environmental issues in a balanced and sensitive fashion (Carroll & White, 1982, p. 53). As a start, the administration can take the time to articulate clearly the organization's mission. Cherniss and Krantz (1983) found that organizations that have a clear ideology of purpose have reduced burnout in staff because they minimize ambiguity and doubt about what kind of action is to be taken. Time should be devoted both to establishing positive coworker and supervisory relationships and to reducing the rules, regulations, and paperwork that line staff face as they attempt to provide service to their clients (Savicki & Cooley, 1987). Improved job design, flexible hours, continuous supervision and training, intrinsic and extrinsic reinforcement, and emotional support are a few of many changes that will go a long way toward reducing burnout (Shinn & Mørch, 1983, p. 238).

Most attempts to deal with the organization by people who are burned out are typified by passively hostile actions that include physical, emotional, and mental withdrawal from problems the organization faces (Pines & Aronson, 1988, pp. 91–93). However, effective organizational change rarely is generated solely by the administration or by the individual. Both parties must decide that stopping burnout in its tracks is a good thing to do. To effect change in the organization, each individual must recognize that there is an institutional problem and be responsible for doing something about it. Likewise, administrators and boards of directors must be constantly vigilant and not deny these kinds of problems exist in the organization. Beginning to take responsibility for effecting change in a difficult situation is therapeutic in and of itself simply because it reduces the debilitating effects of the feeling of helplessness.

Yet workers who believe that everything about an organization is wrong and should be changed are the most likely to be burnouts, and administrators and boards of directors who believe the same about their workers are likely to go out of business. Some aspects of the bureaucracy cannot be changed short of destroying it. Thus workers need to develop the ability to distinguish between those aspects of the organization that can be changed and those that cannot (Pines & Aronson, 1988, p. 29).

Burnout-Proofing an Agency. Probably one of the very best organizations at preventing burnout your authors are aware of is the Exchange Club–Carl Perkins Center for the Prevention of Child Abuse in Jackson, Tennessee, which is used as an example of an exemplary child abuse treatment program in Chapter 9, Sexual Assault. One of the reasons for Carl Perkins Center's excellence is that its directors attempt, to the best of their ability, to burnout-proof the agency and the people in it. As described by East, James, and Keim (2001), they use several strategies to prevent burnout, STS/VT, and CF that are recommended by many of the researchers in this chapter. They are:

1. Nobody works more than a 40-hour week. Although emergencies may arise, workers will immediately take comp time off after the emergency has passed. Nobody works through lunch. Lunch is downtime and is expected to be taken.
2. The center takes quality time to promote inservice education as a way of continuously updating staff on the most effective and innovative practices available in the field. Quarterly inservices combine staff development, organizational issues, and fun events on skill building.
3. Supervision is continuous and supportive. The supervisor-to-worker ratio is 1:6. Each worker has a weekly session with a supervisor. The role of the supervisor is to listen, provide empathic support, consult, and plan cases.

4. The center expedites logistical problems. Work areas are clean, well lit, with cheerfully decorated offices and meeting rooms. Therapy rooms have brightly colored carpets and colorful children's murals on the walls. There is a well-stocked resource center with videos, instructional programs, reference books, and a complete, full-sized, Kids on the Block puppet set. There is adequate office and clerical help for all workers, so they do not drown in paperwork. Supplies are adequate and readily available.
5. Case staffings are carefully constructed in a comprehensive manner with team inputs. A clear treatment plan is laid out. There is little confusion about what mission goals are. There is a definite feeling of "we" between the administration and the staff. All supervisors have worked their way up through the organization, so they are acutely aware of the problems and issues staff face.
6. There is a clear delineation between work and home. Home and family are an overriding priority, and the directors of the center are adamant that families come first and work comes second.
7. Faith-based renewal and spiritual growth are encouraged. As one worker stated, "I can't do this alone. I have to give it over to God." This approach is encouraged without regard to denomination. Prayer is a powerful tool for these people, and they use it. There is a saying in war that there are few atheists in foxholes. A parallel can be made to the trauma and crisis business. Finding a sacrosanct spiritual center that one can believe in and retreat to is paramount, given the often heinous nature of crisis work (Collins, 2005; Kennedy, 2006). Because Jackson, Tennessee, is in the "Bible Belt" you may suppose that the staff's deep reliance on faith is a southern cultural artifact. You would be wrong. A good deal of research (Harrison & Westwood, 2009; Lawson & Myers, 2011; Reese, 2009; Simpson, 2006) demonstrates that spirituality is a key component in keeping the nastiness in this chapter out of your life. Short of proselytizing, your authors believe that anybody in this business needs to find some spiritual rock to anchor them. Go to a church, synagogue, mosque. Hug a cypress tree if you are green. Meditate, read theology, worship the Great Spirit, Buddha, God, but get a spiritual foundation in your life. You'll need it if you do this work.
8. Debriefing is used continuously. Whenever a tragedy occurs, such as a child's death or other traumatic event, workers are debriefed, and it is done as expeditiously as possible.
9. The center does not work on an assembly-line basis with repetitious, day-in-day-out work assignments that grind staff down. Workers are expected to schedule variety into their days.
10. The center provides technical support. All of the staff have offices, computers, cell phones, VCRs, and other equipment necessary for optimal performance.
11. The center is well maintained. It is a pleasant place to work with bright colors, nice furniture, individual spacious offices, and conference and therapy rooms that are well lit with good AV and IT facilities and equipment.
12. Workers use a team approach. No one is above getting her or his hands "dirty," and everyone pitches in when something needs to be done. It is not frowned upon to ask for assistance. The center does not deify go-it-alone, heroic martyrs.
13. Safety is the most important product of the center, for both its clients and staff. Clear-cut safety procedures are constantly taught and reinforced to ensure the workers' well-being both at the center and during home visits.
14. The workload is "doable." Over the years, the center has lightened workers' caseloads. As the total number of caseloads rises, more workers are hired. The center has been able to increase staff because its administration is very adept at convincing its constituency that it is doing a great job and should be given the financial support to continue to do so. The administration works very closely with its board and continuously educates it regarding the financial and staffing needs of the center.
15. The center does an excellent job of networking. It serves a large geographic area and therefore has established relationships with other social services agencies (such as schools, police departments, and state welfare agencies) in outlying counties. The center also goes out of its way to provide support for other agencies within its service area. This not only increases the center's credibility with the agencies and institutions, but it also allows for reciprocal perquisites: center employees can utilize office space and the support of staff in other agencies when the employees are far away from their home office.
16. The administration is very thorough in its hiring selection. Candidates are carefully screened to determine how well they will fit into the overall scheme of things.

17. Staff are positively reinforced both intrinsically and extrinsically on a consistent basis. Workers are told they are doing a good job in specific behavioral terms, and they are told often. After a particularly horrific incident in which three sexually abused children all died in a house fire at a foster home, the associate director went to the field office and picked up the workers who had been engaged nonstop in dealing with this tragedy. She piled them into her van and, without a word, took them to a local spa, where they spent the day getting makeovers, massages, aromatherapy, yoga lessons, and a nice lunch. While a day trip to a spa can in no way assuage the grief and stress these workers felt, it does say very clearly, "We care about you!" and that message comes across loud and clear to all of the staff.

The Carl Perkins Center sees its workers as its most important asset and understands the perils of the kind of work it does. The outcomes are proof positive that a proactive program to prevent burnout works. The attrition rate is extremely low. Because this is a fairly young and rapidly expanding agency, many of the workers are young. Research indicates (Meyers & Cornille, 2002) that the demographics and job role of this group would cause them to be at high risk for burnout or STSD. They are not!

The following tests were administered to the Carl Perkins staff: the Los Angeles Symptom Checklist (LASC; King et al., 1995) to measure PTSD symptoms, the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) to measure subjective perceptions of stress experienced by human services workers as a result of working with their clients, and the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981a) to measure burnout. While the IES indicated that traumatic events have had a high impact on workers, the LASC and MBI scores were very low, indicating that these workers do not have PTSD symptoms and they are not burned out. Particularly noteworthy were their extremely high "personal accomplishment" scores on the MBI (East, James, & Keim, 2001).

In conclusion, the administrative staff at Carl Perkins understand the effects that vicarious traumatization, compassion fatigue, and burnout can have on their organization and set aside time and resources to deal with it. In providing support to staff, the Carl Perkins Center follows very closely the six points proposed by Pines (1983), listed and described in the next section. It would thus appear that even in one of the most stressful of all types of crisis agencies—one that works with traumatized children (Meyers & Cornille, 2002)—the institution can stop burnout dead in its tracks if it has the will to do so.

Social Support Systems. Social support systems act as buffers for the individual and help maintain psychological and physical well-being over time (Ling et al., 2014; Oerlemans & Bakker, 2014; Pines, 1983, p. 157). They are just as critical to avoiding burnout, whether at home or in the workplace (Distler, 1990; Greenglass, Fiksenbaum, & Burke, 1996; Halbesleben, 2006; Kesler, 1990; Pines & Aronson, 1988; Sullivan, 2004). Family systems are major sources of support (Killian, 2008; Lawson & Myers, 2011; Sullivan, 2004) and can help insulate workers against burnout (Bakker, Demerouti, & Schaufeli, 2005; Halbesleben, 2006; Maslach & Jackson, 1981b). However, it is impossible for one's spouse, partner, family, or friends to fulfill all the support tasks a crisis worker who engages specifically in trauma work will need (Pines, 1983, p. 172). Clearly, the worker needs to have functioning support systems at the job site (Handran, 2014; Li et al., 2014). How, then, might this occur if it does not happen spontaneously?

In that regard, Golembiewski, Munzenrider, and Stevenson (1986) propose that both instrumental support to achieve an end, such as material assistance, and expressive support to provide a sense of belonging and caring are needed in the workplace (p. 52). They found that employee concern and commitment to the job, peer friendliness and support for one another, and management's support and encouragement of employees all characterized low-burnout groups (p. 189).

Social support systems have six basic functions: listening, technical support, technical challenge, emotional support, emotional challenge, and sharing social reality (Pines, 1983).

1. *Listening.* Periodically, all workers need someone to listen actively to them in an empathic manner without giving advice or making judgments (p. 158).
2. *Technical support.* When confronted with complex client problems, all workers need someone who can affirm confidence in their endeavors. Such a person must have the expertise to understand the complexities of the job and be able to give the worker honest feedback (p. 158).
3. *Technical challenge.* If workers are not intellectually challenged, they will stagnate. Intellectual contact

with significant others stretches the worker in a positive way. Such challenges can come only from people who do not intend to humiliate or gain an advantage and who have professional expertise equivalent to that of the worker (p. 158).

4. *Emotional support.* Workers need someone to be on their side in difficult situations, even if the significant others do not necessarily agree totally with the workers. Professional expertise is not necessary for this function (pp. 158–159).
5. *Emotional challenge.* It is comforting for workers to believe that they have explored all avenues in attempting to resolve their problems. Support persons serve a valuable function when they question such assumptions and confront the worker's excuses. This function should be used sparingly; otherwise it may be construed as nagging (p. 159).
6. *Sharing social reality.* When workers become unsure of the reliability of their own perceptions about the reality of the situation, they need external validation. This function is especially important when workers feel that they are losing the ability to evaluate what is happening with their clients and with the organization (p. 159).

Support Groups. Within the organizational structure, time should be set aside for formal, structured support groups. Structurally, a support group resembles a problem-solving discussion group. The goal of such a group is to build a sense of competence and help workers feel that they can deal with the stresses they encounter in their work situation. A support group is a safe place for workers to disagree and challenge feelings of helplessness.

The group serves as a cathartic agent for releasing pent-up emotions related to the job. Once catharsis occurs, members can realistically examine feelings associated with job stressors. By providing feedback, the support group validates for members that they are not alone in their feelings and reassures them that they are not abnormal in their response to the situation (Sculley, 1983, pp. 188–191).

To do this effectively, a support group not only needs the support of the administration but also must have a consultant/facilitator who is sensitive to the issues involved and can walk a tightwire between allowing the group to vent feelings and keeping the group in a problem-solving model. The buffering effect of a third party consultant/facilitator can help reduce conflict stressors (Giebels & Janssen, 2005). The consultant/facilitator also needs to be in a position to provide the administration with information from the group that will allow for effective organizational change without becoming a "snitch" in the process (Sculley, 1983, pp. 193–194).

Finally, for those members suffering from vicarious traumatization, compassion fatigue, and the later stages of burnout, referring them for personal counseling should be done with the understanding that these outcomes are indeed occupational hazards no different from carpal tunnel syndrome for keyboard operators or arthritis for concrete finishers. In that regard, organizations must be careful not to secondarily victimize such people as being of weak character or lacking in the "right stuff."

The Individual and the Organization. Vocationally, there are four major maladaptive responses to the onset of burnout. As the level of burnout increases, so does escape avoidance behavior (Thornton, 1992). Workers may attempt horizontal job mobility. They continuously look for the "right" boss or organization when it is the job they are in that is causing their unhappiness.

Others tire of the constant interaction with clients and decide to move vertically up the job ladder into administrative positions. What they fail to realize is that their cynical and jaundiced view of the system will not be left behind but will be carried with them into a whole new set of stresses. It is an understatement to say that these people do not make very good bosses.

There are also people who become what Pines and Aronson (1988, p. 18) call "deadwood." These people have long ago decided that their best bet is to not "rock the boat" so they can make it to retirement. If you have ever read the comic strip *Dilbert*, Wally best represents these individuals. When asked to do something, they politely indicate they are too busy, or agree with every idea put forth but venture none of their own, or contribute only what is minimally necessary to escape notice or censure, or turn the tables and cast incompetence on others to cover up their own failings.

Finally, some people quit their job and the vocation, and in some instances this may be the wisest choice of all.

At this stage of frustration, choices may seem to be limited to job change or job stagnation, but the individual does have other options. First, clearly defining one's role within the organization is a high priority (Kesler, 1990). The worker should conduct a

job analysis and determine which tasks are necessary, which are self-imposed, and which contribute to role overload (Pines & Aronson, 1988, p. 109). Through assertive negotiation with the administration, the worker needs to define a reasonable work level and commensurate financial or other rewards for the work performed. Clients should be clearly apprised of the limits of service in regard to time as well as the amount and kind of service to be provided. Although service to clients needs to be a high priority, other tasks should be clearly prioritized. If chores that do not have a high priority cannot be delegated, then serious consideration should be given to dropping them (Leiter & Maslach, 2005).

Finally, if it is apparent that the organization is so entrenched and regressive that little change in policies and programs can be effected, it is probably time to look for greener occupational pastures. It would behoove a worker who is in the frustration stage to consider what a near-future job change entails and start planning for it before reaching the apathy stage. Knowing company severance policies and state unemployment benefits, updating a resume, saving money, and commencing a job search are examples of prudent measures workers may take before they are so mentally, physically, and emotionally exhausted that there is little energy left for a major shift in one's life.

Self-Care

As we have said, burnout is a two-way street with both individual and organizational culpability. There are literally volumes of research that find self-care as *the* critical ingredient for the crisis worker (Alkema, Linton, & Davies, 2008; Eastwood, 2007; Harrison & Westwood, 2009; Killian, 2008; Lawson, 2009; Lawson & Myers, 2011; Ling et al., 2014; Morkides, 2009; Oerlemans & Bakker, 2014; Rupert et al., 2015; Ringenbach, 2009; Thomas, 2007). We have already spoken to the significance of support systems and spirituality. What follows sounds a lot like what your mother lectured you on: eating right, sleeping right, getting exercise, taking care of your general hygiene, and after all of those things are done, not forgetting to have fun! One of the toughest parts of this business is doing that.

In William Glasser's reality therapy/control theory (1985), one of the central axes on which his theory revolves is engaging in positive addicting behaviors, and central to those positive addicting behaviors is having fun. The whole notion of Glasser's theory is that when you engage in these positive addicting behaviors your personal world grows much larger, and so does your social world as you interact with it.

Nobody can make you get out of your rut, and it is extremely easy to stay in it, as in the case of one of your authors who right now has been word processing 12 days in a row on this $!%#@$%#! book and not getting his workouts in and feeling very guilty and even physically edgy about missing his positive addiction. The word *recreate* makes a lot more sense when you break it down into *re-create*. So meditate, play rugby, work up your fantasy football team, make a quilt, run a marathon, shoot some pool, play bridge or poker, kill all the video game aliens, go fishing, see a ballgame, weed your flower garden—any of those will do as long as you are having fun, enjoying it, and it has absolutely nothing to do with anything in this book. Hey! You cannot use that as an excuse to your professor that you needed to go recreate and didn't finish this chapter so flunked the exam because you were afraid of burning out!

Private Practitioners and Burnout

The occupational dream of many of our students is to start their own private practice. They fantasize that they could do the kind of therapy they wanted with the clients they selected, be rid of overbearing supervisors and be their own boss, not be bothered with bureaucratic hassles and avalanches of paperwork, set their own hours, and make lots of money! Yet the private practitioner has the potential for even greater problems.

Generally, private practitioners are type A personalities who tend to invest a great deal of time in the job as a means of finding a sense of fulfillment and identity. Competition and achievement serve as guiding values that correlate highly with the need to be seen as worthy and capable (Everly, 1989, p. 105; Pines & Aronson, 1988, pp. 6–9). In a word, they are "driven" workaholics (Falco et al., 2014).

Although the aloneness that pervades a private practice is not the same as the isolation that agency workers sometimes impose on themselves when placed in high-stress situations, it can be more complete. Fenced off from other professionals by ethical and ecological boundaries, the private practitioner has few others with whom to discuss client problems. More important, there are few other individuals with whom they can discuss their own personal problems.

Private practice is clearly a business. As such, it promotes the continuing fear that there will be no

clients or that there will never be enough no matter how successfully the business is going (Mitchell, 1977, pp. 145–146). Every client termination raises questions: "Will there be someone to take her place?" "Will he pass the word along that I did him some good?" The private practitioner who is moving toward crisis invariably answers these questions negatively and redoubles his or her efforts to increase client loads and effect cures.

Starting and maintaining a private practice also call for maintaining a public presence. Whether such a presence involves making speeches to the Rotary Club on stress and the businessperson, consulting with the oncology staff on death and dying at the local hospital, or giving a workshop on discipline for Parents Without Partners, the continuous pressure of needing to be seen as active, abreast of current developments, and visible is part of a sales program that must constantly be maintained and upgraded.

Although the private practitioner is his or her own boss, being an independent businessperson also means being completely responsible for maintaining the practice. Long hours and difficult work periods are the rule rather than the exception. Because most clients work regular hours, private practitioners devote many evenings and weekends to their work. Usually there is no one to pick up caseloads, so vacations or even short respites are few and far between. Certainly not all private practitioners suffer from burnout. However, when burnout does occur with human services workers who are in private practice, it is accelerated by the foregoing problems and issues.

Intervention with the Individual: A Case Study

Direct action, in which the worker tries to master the environmental stressors, and palliative action, in which the worker tries to reduce disturbances when unable to manage the environment, are the two positive ways to cope with stress (Pines & Aronson, 1988, p. 144). Direct action is applied externally to the situational stressor in the environment, whereas palliative action is applied internally to one's cognitions and emotions about the stressor. Social support groups, workshops, assertiveness training, flextime, taking time off, salary increase, and role shifts are all examples of direct action. Meditation, relaxation techniques, biofeedback, physical exercise with no ego involvement, adopting positive cognitions, engaging in leisure-time pursuits, adopting better eating habits, reducing addictive substance intake, and adding more humor and joy to one's life are all palliative "decompensation activities" that allow the worker to put stressors aside (Hoeksma et al., 1993; Melamed, Meir, & Samson, 1995; Oerlemans & Bakker, 2014; Pines & Aronson, 1988, p. 152; Rupert et al., 2015; Saakvitne & Pearlman, 1996, pp. 78–87; Stark, 1994).

Whereas workers who are at the frustration stage may well be helped by being involved in self-initiated directive and palliative actions, those at the more serious stage of apathy will not be (Edelwich & Brodsky, 1982, p. 137). In such cases, individual counseling is more appropriate (Baron & Cohen, 1982). Kesler (1990) proposed using Arnold Lazarus's (1976) BASIC ID (behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology) paradigm as a treatment approach to burnout. To this formulation Kesler adds an *S* for setting. Given the interactive effects of burnout across multiple facets of the individual, the BASIC IDS approach seems valid for attacking burnout in a comprehensive way.

The following case illustrates the crisis worker using combinations of direct and palliative actions in an abbreviated BASIC IDS approach. It should be clearly understood that neither symptoms nor intervention procedures are all-inclusive. For example, Tubesing and Tubesing (1982, p. 161) listed 36 possible intervention strategies that cover physical, intellectual, social, emotional, spiritual, and environmental components of burnout, and those are not comprehensive by any means. If the client is identified as having more compassion fatigue or vicarious traumatization, a more specific program that focuses on STSD symptoms may be used, such as the Accelerated Recovery Program (ARP; Gentry, Baranowsky, & Dunning, 2002). The case presented is that of a professional with a doctorate and many years of experience, but neophytes should understand that Dr. Jane Lee is genotypical of any human services worker. Her case clearly points out that no worker is immune to burnout, no matter how much experience or expertise that worker may have.

The Client. Dr. Jane Lee is a striking, raven-haired, 43-year-old woman with aquiline features, a low, melodious voice, aquamarine eyes that twinkle, and a smile that could serve as a toothpaste commercial. She is extremely witty and incisive of intellect, is widely read, and can talk as easily with truck drivers as she can with lawyers. At any social function people gravitate toward her. She seems to have been born

with the natural empathy and easy familiarity that many people consciously work their whole lives for, yet never quite attain. Divorced for 10 years, Jane has raised her only son while carrying on an exceedingly successful professional life.

Jane has a thriving practice in marriage and family therapy. She has a heavy client load and is clearing approximately $150,000 a year. She is seen by her peers as extremely capable, and her clients speak highly of her. Jane has been in private practice for 8 years. Prior to entering private practice she worked in a community mental health facility. She was so skillful at therapy there that she rose to the directorship of the clinical program.

Jane graduated from a major university with a doctorate in counseling psychology and completed her internship in a VA hospital. She then successfully completed an American Association of Marriage and Family Therapists internship at a private clinic. She has written and published many articles on therapy for anorexics and the families of individuals suffering from catastrophic illnesses. She has also given many inservice programs and presentations at national human services conferences.

By any criteria imaginable, Jane appears to be a highly competent, successful therapist and an exceptionally endowed woman overall. Her ability and demeanor have made her a role model that many in her community aspire to emulate. As Jane sits down with the crisis worker, she is seriously considering drinking a good deal of wine, closing her garage door, climbing into her new Lexus, turning on the ignition, and killing herself.

Jane: I came here today because of what you said to me the other night when we were having a drink. You pretty much have me pegged. I'm burned out even more than what you think, more than what I like to admit. Today I had a decision to make, whether to kill myself or come here. I came here, but I'm not sure it's the right decision. If I killed myself, it seems like it would just be over and done with. I've taken care of everything concerning Bobby, my son. He's practically through with college, and even though we're very close, I really think it'd be better for him if I were gone.

He wouldn't have to put up with my lousy behavior, and believe me, it's lousy right now. There's enough insurance to get him finished up in school, and he could sell the house. He's the only one that really matters besides my clients, and right now I'm not doing worth a damn with them. I'm probably hurting more than I help, and I'm just not up to it anymore. So much pain and so damn little I can do about it. The only thing I can think about now when I go into a cancer ward is how bad the patients smell. Whoever said "You don't have to smell them. All you gotta do is help them!" sure wasn't in this end of the business. I'm also starting to behave like those screwed-up anorexics I work with too. It's starting to seem pretty reasonable to me that they aren't eating. Why the hell should they? Why the hell should *I*? Just sort of fade away and look thin while you're doing it. At least I'd make a great-looking corpse. Anyway, the main reason I came over today was to see if you'd be willing to take my clients. I've thought this over, and you've got what it takes. I think you could help them, and if you agree, I'll start talking to them about coming over to your practice.

CW: What you just said scares the living hell out of me. There's a part of me that wants to run right out of here, because what you're saying is really hitting home with the way I feel at times. There's another part of me that wants to tie you up in log chains until you come to your senses. Finally, there's another part of me that cares for you so much that I'm angry that you've let yourself get into this predicament. Most of all, though, I'm glad I made that reflection the other night and that it finally sank in. I've seen you going downhill for quite a while now. My guess is that you didn't even know it was happening or just laid another piece of armor plate over yourself and said something like "I've got to gut this through" or some of that other irrational garbage I hear you unload on yourself. First of all, I won't even consider what you said about the clients until we agree on one thing, and that is you don't do any harm to yourself until we talk this through. So I want an agreement both as your therapist and as your friend that we shake on that before anything else happens. I won't take no for an answer. If that's not acceptable, we'll negotiate it. No matter what, we're now in this together.

Ethical Issues. The crisis worker is in a difficult position as the client's friend, fellow professional, and now as a therapist dealing with another human being in crisis. When a human services professional who is a colleague becomes impaired, it is the ethical duty of the fellow professional to do something to prevent harm to clients (Harrison & Westwood, 2009;