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*Diagnosis and Treatment of Helper Stresses, Traumas, and Illnesses**

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In the last two decades it has become accepted that people can be secondarily affected by the sufferings of others. The attunement and effort needed to help others in trouble may provide great rewards for helpers when they meet with success. But when they are strained, or worse, when they fail, helpers may be the next dominoes who follow primary victims in suffering themselves.

Although secondary stress and trauma have become widely recognized in traumatology, efforts to conceptualize them have taken place only recently. The purpose of this chapter is to overview these efforts and to extend some of my own recent conceptualizations of (primary) stress and trauma disorders (Valent, 1995, 1998a, 1998b) to secondary ones.

BACKGROUND

Soon after the recognition of traumatization and the need for early help for victims in the late 1970s and early 1980s, it became clear that helpers became

*I want to acknowledge Brunner-Routledge for allowing reproduction of Table 1.1 and Figures 1.1 and 1.2 from previous publications.

secondarily affected. For instance, Berah, Jones, and Valent (1984) noted that helpers in a disaster outreach team suffered shock, depression, sadness, fatigue, sleep disturbance, and dreams about helpers being victims in the disaster. They also suffered reminders of past traumas and a variety of physical symptoms, colds and flus, as well as minor accidents.

The Scope of the Problem: A Wide Variety of Symptoms

A great variety of symptoms was described over the years, and one may say came to parallel the similar great variety of symptoms in victims. For instance, a selection from the previous volume of *Compassion Fatigue* (Figley, 1995a) described a heterogeneity of physiological and physical symptoms, some extending to serious illnesses, and ultimately a higher mortality rate among helper professionals than among controls (Beaton & Murphy, 1995). A similar heterogeneity of psychological symptoms included sadness, grief, depression, anxiety, dread, horror, fear, rage, and shame; intrusive imagery in nightmares, flashbacks, and images; numbing and avoidance phenomena; cognitive shifts in viewing the world and oneself, such as suspiciousness, cynicism, and poor self-esteem; and guilt for survival and enjoying oneself (Dutton & Rubinstein, 1995). Social problems included drug abuse and relational problems (Beaton & Murphy, 1995). Figley (1988) noted early that families also become secondary victims.

To add to the complexity of symptoms, it has been pointed out that they appear differently in different disaster phases (Beaton & Murphy, 1995; Valent, 1984), and they range from reflex responses to moral and philosophical dilemmas (Herman, 1992), existential meanings, and spirituality (Lahad, 2000; Pearlman & Saakvitne, 1995a, 1995b).

A Wide Variety of Helper Treatments

In parallel to the wide variety of helper symptoms, a wide variety of treatments has been advocated for helpers. Yassen (1995) suggested that the following provide resistance against helper stress and trauma: management of vital functions, such as sleep, food, exercise, rest, and recreation; contact with nature; maintaining structures of work; and limiting exposure to traumatic situations. Others have suggested peer, institutional, and personal help and support (Dutton & Rubinstein, 1995), whereas Munroe et al. (1995) suggested a special team that provides outside perspective and mediates helpers' roles in the community. A number of workers emphasize the advantages of proper training, including helpers' ability to read and care for their own stress responses.

For helpers who have been involved in traumatic situations, a variety of

programs has been advocated. In order of proximity to the traumatic situation, they have included decompression, defusion, and a variety of debriefing programs ranging from single sessions to relatively ongoing care with peer support or professionals (McCammon & Allison, 1995). These programs vary in their educative, cognitive, emotional, and existential approaches.

Finally, some workers recommend supervision and personal therapy, especially for helpers who are involved in deep psychotherapy with clients with multiple early life traumas (e.g., Pearlman & Saakvitne, 1995a, 1995b).

Helper Stress and Trauma Conceptualizations

In order to make sense of the wide variety of symptoms and methods of treatment, some researchers have postulated phenomenological categorizations and mechanisms of symptom formation.

Regarding phenomenological categorizations, Figley (1995b) suggested that PTSD should be called *primary posttraumatic stress disorder*, whereas the same symptoms appearing secondarily to victim care in helpers should be called *secondary traumatic stress disorder* (STSD). The only difference between PTSD and STSD was that, in the latter, exposure was to the traumatized person(s) rather than to the traumatic event itself, and intrusion and avoidance symptoms related to the primary victim's experience, not to one's own. Figley (1995c) gave a special name, *compassion fatigue*, to the specific STSD resulting from deep involvement with a primarily traumatized person. Next, in parallel to the concept of (primary) stress, Figley delineated compassion stress (secondary traumatic stress, or STS). Here, helpers knew about, and were affected by, traumatizing events, but this did not reach traumatic STSD proportions.

However, just as for primary victims PTSD was insufficient to delineate and make sense of the wide variety of symptoms, so STSD did not heuristically delineate and make sense of the variety of symptoms described above. Figley (1995b) therefore distinguished two other commonly used terms that captured the significance of certain symptoms.

Burnout is a result of frustration, powerlessness, and inability to achieve work goals. It is characterized by some psychophysiological arousal symptoms, including sleep disturbance, headaches, irritability, and aggression, yet also physical and mental exhaustion. Other symptoms included callousness, pessimism, cynicism, problems in work relationships, and falling off of work performance. Burnout can result from the noxious nature of work stressors themselves or from hierarchical pressures, constraints, and lack of understanding.

Countertransference explains the mechanism of producing helper symptoms. It is described as the unconscious attunement to and absorption of victims' stresses and traumas. The latter are often expressed nonverbally, such as through gestures and enactments. These are vehicles of transferring especially emotional information not readily expressible in words. Such transfer-

ring of information is called *transference*. On the receiving side, empathy is the vehicle whereby helpers make themselves open to absorption of traumatic information. The absorption and subsequent impulse to respond may be life-saving in ongoing traumatic events. After the events, countertransference reads the relived transference information. This is done through one's own affective reactions, cognitive unfoldings, and impulses to action (Wilson & Lindy, 1994) and helps helpers to understand their clients' relived experiences and needs.

Such permeability to clients' traumatic events of necessity leads to stress, called *empathic strain* by Wilson, Lindy, and Raphael (1994), or to trauma, called *vicarious traumatization* by Pearlman and Saakvitne (1995a, 1995b).

Wilson et al. (1994) divided empathic strain into two categories approximately corresponding to intrusive and avoidance features of PTSD. Intrusive-type countertransference strain includes loss of boundaries, overinvolvement, reciprocal dependency, and pathological bonding. Avoidance-type countertransference strain includes withdrawal, numbness, intellectualization, and denial. On the other hand, vicarious traumatization includes disruptions of self-capacities, beliefs, relationships, world view, and spirituality (Black & Weinreich, 2000; Pearlman & Saakvitne, 1995a).

Finally, a number of workers have recognized that the intimate relationship between helpers and victims is a two-way affair. Helpers also bring unconscious current and past stresses and traumas into their interactions with clients (Figley, 1995b). For example, helpers may be attracted to clients who suffer similar traumas to the helpers' repressed ones. Helpers' unconscious transference of their problems onto clients may evoke countertransference in the latter, which may compound their traumas.

Current Dilemmas

STSD and compassion fatigue were diagnoses waiting to happen, and they provided meaningful and respectful labels for affected trauma workers. However, like PTSD, they do not categorize or heuristically make sense of the wide variety of manifestations and symptoms (e.g., Blair & Ramones, 1996) that are relived or avoided, or explain why they should be suffered. Although countertransference responses explain the means of transmission and reason for suffering, countertransference responses do not classify or provide reasons why particular symptoms should be transmitted at any particular time. Burnout seems to go some way toward providing a reason for a particular cluster of symptoms, but it does not explain why they should occur and not others and it does not explain symptoms outside its cluster.

Often implied reasons for the nature of symptoms lie in survival strategies such as fight and flight. However, these two strategies are insufficient to explain the variety of symptoms.

In the last volume, I suggested that eight survival strategies provide a more extensive framework for diagnosing, classifying, and making sense of the wide variety of STS phenomena. Which particular ones were experienced at any one time depended on specific identifications with, or responding in complementary fashions to, victims' needs and survival strategies (Valent, 1995).

In this chapter I intend to explain in greater detail how survival strategies provide a framework for the wide variety of STS and STSD manifestations and countertransference responses. It also will be suggested that two specific survival strategies (Rescue-Caretaking and Assertiveness-Goal Achievement) can heuristically delineate compassion fatigue and burnout, respectively.

A further tool, the triaxial framework, will be used to indicate how symptoms derived from survival strategies spread across the extensive field of traumatology, and how different treatments fit into its coordinates. Finally, treatment implications of the combined view of survival strategies and the triaxial framework (called the wholist perspective) will be examined.

SURVIVAL STRATEGIES AND CONCEPTUALIZATION OF SECONDARY STRESS AND TRAUMA RESPONSES

In this section survival strategies will be summarized and applied to STS and STSD, compassion strain and fatigue, burnout, and countertransference responses.

Survival Strategies

Survival strategies such as fight and flight are biopsychosocial templates that have evolved to enhance maximum survival within evolutionary social units. Their level of operation is in the "old mammalian" brain (MacLean, 1973), functionally between instincts and abstract functioning. In traumatic situations, they correspond to acute stress responses.

Although the arousal symptoms in PTSD imply that only fight and flight acute stress responses are relived and avoided, I suggest that they and six further such survival strategies contribute to reliving and avoidance responses. The eight survival strategies are Rescuing (Caretaking), Attaching, Asserting (Goal Achievement), Adapting (Goal Surrender), Fighting, Fleeing, Competing, and Cooperating. Further, it is their adaptive and maladaptive, biological, psychological, and social components that contribute to the wide variety of manifestations in traumatic stress. The survival strategies and their acute stress response manifestations are depicted in Table 1.1.

Survival strategies and their components are parts of a dynamic process (Figure 1.1). They are evoked by appraisals of stressors with which they are to

TABLE 1.1
Survival Strategy Components

APPRAISAL OF MEANS OF SURVIVAL	SURVIVAL STRATEGIES	SUCCESSFUL / ADAPTIVE RESPONSES		
		BIOLOGICAL	PSYCHOLOGICAL	SOCIAL
MUST SAVE OTHERS	RESCUING PROTECT PROVIDE	↑ ESTROGEN ↑ OXYTOCIN ↑ OPIOIDS	CARE EMPATHY DEVOTION	RESPONSIBILITY NURTURE PRESERVATION
MUST BE SAVED BY OTHERS	ATTACHING PROTECTED PROVIDED	? ↑ OPIOIDS	HELD, CARED FOR NURTURED LOOKED AFTER	CLOSE SECURE CONTENT UNION
MUST ACHIEVE GOAL	ASSERTING COMBAT WORK	↑E, NE ↓ CORTISOL ↑ IMMUNOCOMP	STRENGTH CONTROL POTENCY	WILL HIGH MORALE SUCCESS
MUST SURRENDER GOAL	ADAPTING ACCEPT GRIEVE	PARASYMP AROUSAL ↑ CORTISOL	ACCEPTANCE SADNESS GRIEF HOPE	YIELDING MOURNING TURN TO NEW
MUST REMOVE DANGER	FIGHTING DEFEND RID	SYMP. AROUSAL ↑N, NE ↑BP	THREAT REVENGE FRIGHTEN	DETERRENCE WOUNDING RIDDANCE
MUST REMOVE ONSELF FROM DANGER	FLEEING RUN, HIDE SAVE ONSELF	SYMPATHETIC & PARASYMP AROUSAL	FEAR TERROR DELIVERANCE	RETREAT FLIGHT ESCAPE
MUST OBTAIN SCARCE ESSENTIALS	COMPETING POWER ACQUISITION	↑TESTOSTERONE SYMP. AROUSAL	WINNING STATUS DOMINANCE	CONTEST HIERARCHY POSSESSION
MUST CREATE MORE ESSENTIALS	COOPERATING TRUST MUTUAL GAIN	↑ OPIATES ↓BP, E, NE	MUTUALITY GENEROSITY LOVE	INTEGRATION RECIPROCITY CREATIVITY

Notes for Table 1.1. E = epinephrine. NE = norepinephrine. Immunocomp = immunocompetence. Parasymp = parasympathetic (nervous system). Symp = sympathetic

UNSUCCESSFUL / MALADAPTIVE RESPONSES			
BIOLOGICAL	PSYCHOLOGICAL	SOCIAL	TRAUMA RESPONSES
SYMPATHETIC & PARASYMP. AROUSAL	BURDEN DEPLETION SELF-CONCERN	RESENTMENT NEGLECT REJECTION	ANGUISH COMPASS FATIGUE CAUSED DEATH
↑ OPIOIDS	YEARNING NEED CRAVE ABANDONMENT	CRY INSECURE DEPRIVED SEPARATION	HELPLESSNESS CAST OUT LEFT TO DIE
↑↑ E, NE DEPLETION E, NE ↑ BP, ?CHD	FRUSTRATION LOSS OF CONTROL IMPOTENCE	WILLFULNESS LOW MORALE FAILURE	EXHAUSTION "BURN-OUT" POWERLESSNESS
↑ CORTISOL ↓ IMMUNOCOMP ↑ INFECTION, ?T CA	OVERWHELMED DEPRESSION DESPAIR	COLLAPSED WITHDRAWAL GIVING UP	DAMAGED GIVEN IN SUCCUMBING
↑↑SYMP AROUSAL ↓ CORTISOL	HATRED PERSECUTION KILLING	ATTACK ERADICATION DESTRUCTION	HORROR EVIL MURDER
NE DEPLETION ↑ E & CORTISOL	PHOBIA PARANOIA ENGULFMENT	AVOIDANCE PANIC ANNIHILATION	"INESCAPABLE SHOCK", BEING HUNTED, KILLED
↓ TESTOSTERONE ↓ FEMALE HORMS ↑ CORTISOL	DEFEATE GREED, ENVY EXPLOITATION	OPPRESSION STRUGGLE PLUNDER	TERRORIZATION MARGINALIZATION ELIMINATION
↓ OPIATES ?↑ PARASYMP AROUSAL	BETRAYAL SELFISHNESS ABUSE	DISCONNECTION CHEATING DISINTEGRATION	FRAGMENTATION ALIENATION DECAY

(nervous system). BP = blood pressure. CHD = coronary heart disease.

CA = cancer. Compass = compassion.

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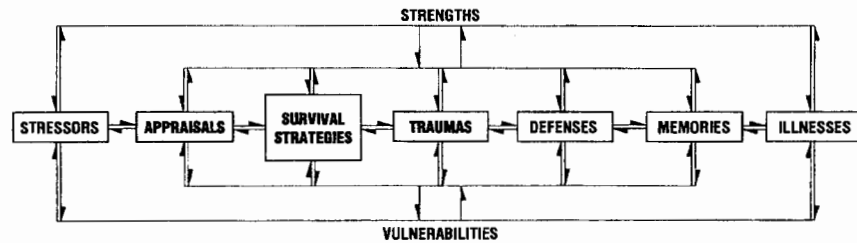


FIGURE 1.1. The place of Survival Strategies on the process axis.

deal. If they fail to do so, trauma and illnesses may result, although they may be mitigated by defenses and lack of memory for traumatic events. This process forms one axis of the triaxial framework (Figure 1.2), described below.

The reader is referred to more detailed descriptions of survival strategies and the triaxial framework, and clinical application of the wholist perspective to treatment in Valent (1998a and 1998b, respectively).

Application of Survival Strategies to Conceptualizing Helper Stresses and Traumas

In this part it will be shown that secondary traumatic stress and secondary traumatic stress disorder are the results of countertransference identification

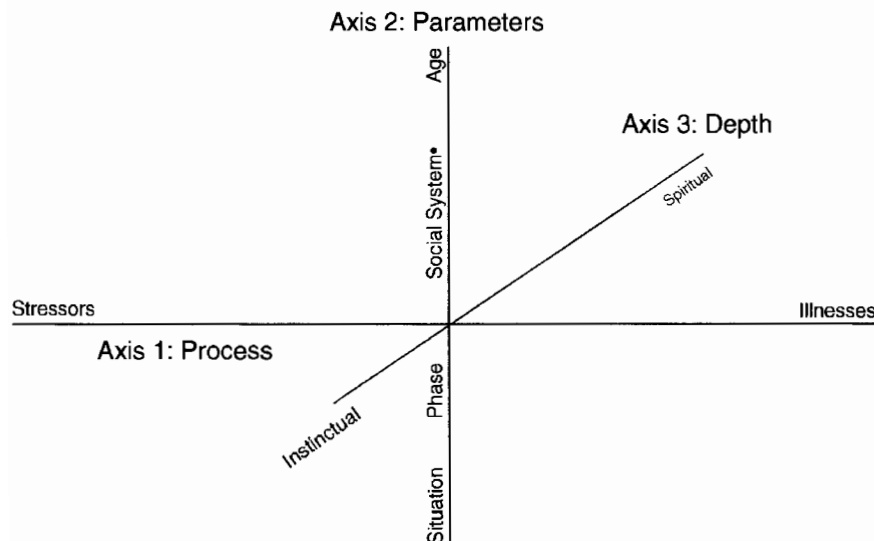


FIGURE 1.2. Triaxial view of traumatic stress.

with victims' maladaptive and traumatic aspects of helpers' survival strategies, respectively, and/or one's own complementary survival strategies being insufficient to various degrees. It will be shown that compassion fatigue and burnout are specific failed Rescue-Caretaking and Assertiveness-Goal Achievement survival strategy responses. They are salient in helpers because they are commonly complementary to victim needs.

Secondary Traumatic Stress and Countertransference Responses

Secondary traumatic stress responses are the maladaptive (stress) responses in Table 1.1. As mentioned above, they may be evoked in helpers through identification with victim survival strategies and/or complementing victim survival strategies with their own. In identification, the helper is in attunement and reverberates with client signals and needs. By reading the reverberations in themselves, helpers understand client experiences better. This is called countertransference.

The purpose of such reverberation in helpers is to evoke in them adaptive survival strategies that fortify insufficient victims. For instance, a person in panic (maladaptive Flight) may be offered escape and deliverance (adaptive Flight); defeated people (maladaptive Competition) may be empowered and offered status (adaptive Competition); abandoned, needy people (maladaptive Attachment) may be offered care and nurture (adaptive Rescue-Caretaking); inability to grieve (Adaptation-Goal Surrender) may be helped by hope and a shoulder to cry on. Helpers' survival strategies often are the adaptive equivalents of victims' maladaptive ones, or the adaptive equivalents of adjacent reciprocal survival strategies (the other of the pair delineated by double lines in Table 1.1), or adaptive aspects of wider ranging survival strategies.

A number of points follow from the above:

- Although countertransference usually is recognized in long-term psychotherapy, its mechanisms can be intense in acute situations, as well.
- When helpers' survival strategies are insufficient to resolve victim stresses, helpers become secondarily stressed by carrying both maladaptive victim survival strategies with which they identify and their own maladaptive complementary survival strategies, which become insufficient.
- Because in traumatic situations all survival strategies may be attempted, helper reverberations and evocation of complementary survival strategies (even if not acted on) may mean that all survival strategies are experienced to some degree.
- Both victims and (more so) helpers experience adaptive survival strategies as well as maladaptive ones. In other words, helpers are not only stressed but also fulfilled.

Secondary Traumatic Stress Disorder

Secondary traumatic stress disorder in this schema arises in parallel to sec-

ondary traumatic stress. In other words, helpers may identify with the trauma responses of victims (see Table 1.1), or their own failed complementary efforts may reach traumatic proportions. For instance, a rescuer may respond to a trapped woman's cries but not be able to save her. The rescuer's PTSD may include both the identification with inescapable shock and terror of imminent annihilation (trauma of Flight) of the victim, and his own compassion fatigue (trauma of Rescue).

Compassion Strain and Fatigue

Appreciation of the survival strategy Rescue-Caretaking allows a heuristic separation of compassion stress and compassion fatigue from the more generic STS and PTSD.

Referral to Table 1.1 shows that the appraisal in helpers that they must save or help others evokes adaptive Rescue-Caretaking responses. The psychological and social components of these responses are care; empathy and devotion; and responsibility, nurture, and preservation, respectively. Together, these responses are the components of compassion.

Compassion stress can be seen in the unsuccessful, maladaptive psychological and social stress responses of Rescue-Caretaking. They are a sense of burden; depletion and self-concern; and resentment, neglect, and rejection, respectively. In helpers these feelings gather into strain, stress, and distress.

Compassion stress can be aggravated by specific negative psychosocial feedback judgments (such as "irresponsible" in the Judgments column of Table 1.1) and by nascent meanings about one's poor role, failed expectations, and existential shortcoming.

In the traumatic situation where victims could not be saved or properly cared for, compassion strain reaches traumatic proportions and may be called compassion fatigue. It includes maladaptive compassion strain, but in addition includes severe anguish and intense guilt associated with the meaning of not having prevented, or even having caused, harm or death. The distress and trauma of not having done enough to avert suffering or death is a common secondary stress and secondary trauma response in helpers.

The word *compassion* also could be applied to deep sympathy and sorrow for those afflicted by suffering and misfortune (Figley, 1995c). However, it may be better to use the words *sympathy* and *sorrow* as specific responses to those in grief (Adaptation-Goal Surrender). Other specific words that fall under a generic term of compassion can also be honed as specific survival strategy responses. Examples are *pity* for refugees (Flight), *support* for the helpless (Attachment), and *tenderness* for the abused (Cooperation).

Burnout

Burnout relates to the survival strategy of Assertiveness-Goal Achievement. Like the hunters and warriors for whose goals this survival strategy evolved in particular, helpers also have life and death goals that may contain hazards,

whose execution requires training and effort and often requires group coordination.

When goals are being attained, helpers feel that they are executing their will, they feel strong, in control, and potent. They have high morale, and feel successful (see Table 1.1).

Inability to achieve goals is accompanied by frustration, a sense of loss of control and impotence, increased willful efforts, diminishing morale, and failure to achieve goals. Many symptoms described for burnout—such as poor work performance, irritability, and inability to concentrate—are secondary to the stress symptoms listed above. As well, work effort and frustration elevate sympathetic nervous system arousal, which then produces common burnout symptoms such as sleep difficulties, muscle tensions and pains, and may contribute to hypertension, coronary heart disease, and stroke (Valent, 1998a). These are the illnesses that were seen to contribute to higher helper mortality rates.

Traumatic intensities of Assertiveness contain earlier burnout stress symptoms as well as intense exhaustion and powerlessness. Burnout exhaustion may be the civilian equivalent of combat exhaustion, which was the definitive military trauma diagnosis of World War II (Bartemeier, Kubie, Menninger, Romano, & Whitehorn, 1946). The exhaustion may be severe, but it is not associated with ability to rest and sleep. Rather, it is accompanied by sleeplessness, anger, and rumination about one's ineffectiveness. The sense of powerlessness is one in which one senses that no amount of one's exertions and efforts can achieve important life goals.

Associated negative judgments include being weak, incompetent, inadequate, a failure, and associated meanings include not being able to make it, not being a man, and being a weakling in life.

In summary, maladaptive and traumatic survival strategy responses account for and explain the wide variety of helper stress and trauma responses to victims. Compassion stress and fatigue, and burnout stress and fatigue are stress and trauma responses in two specific survival strategies: Rescue-Caretaking and Assertiveness-Goal Achievement.

DIAGNOSIS OF HELPER DYSFUNCTIONS

Helper dysfunctions appear in different forms at different points in the process between stressors and illnesses, as depicted in Figure 1.1. Thus insufficient, overdetermined, or inappropriate survival strategies may stem from faulty appraisals. Symptoms of stress stem from unsuccessful or maladaptive survival strategies, whereas traumas stem from failed survival strategies (see Table 1.1). In each case, stress and trauma symptoms may be classified or diagnosed as biological, psychological, and social aspects of specific survival strategies. They in turn may be traced to identificatory or complementary survival strategies in specific victim-helper interactions.

Case 1. A nurse who had intensively looked after a severely ill young man who eventually died felt extreme exhaustion, irritability with other patients, headaches, tremors, and an unexplained chest pain. She had an inordinate fear that she would die of a heart attack.

In this nurse's case, the initial STS group of symptoms was traced to incipient burnout due to the extensive effort that failed to achieve its goal (Assertiveness stress). The latter symptom was an identification of being annihilated (Flight) by the same enemy as the young man, who died of a heart problem.

In parallel with the reliving and avoiding features of PTSD, helpers may experience intrusive STS and STSD symptoms, or they may manifest defenses to avoid and mitigate traumatic states, judgments of guilt and shame, and shattered meanings. In such cases their memories of the original helping situations may be incomplete or absent. Symptoms and illnesses are a vector result of relived and avoided biological, psychological, and social secondary stress and trauma symptoms. Survival strategies add the content, the flesh and blood to what is relived and avoided, and the sense of why. Their specific features facilitate tracing a wide variety of symptom and illness fragments and clusters back to their sources and contexts in traumatic events and victim relationships.

Enrichment of Diagnoses Through the Triaxial Framework

The triaxial framework (Valent, 1998a) sees the stressor → illness process as one of three axes: the process axis (Figure 1.1), the parameter axis, and the depth axis (Figure 1.2).

The parameter axis takes into account the nature of the stressor, the phase of disasters, social systems of helpers, and their maturity, knowledge, and experience. The nature of stressors includes their severity (such as whether they include deaths and mutilations), duration, identification with victims through relationship or similar age, and place of the event in relation to other traumatic events. For instance, it is possible that a traumatic event reverberates with past or subsequent traumatic events, evoking untoward major symptoms or defenses and blind spots.

The phase of disasters includes time in relation to the event. Social system includes the helper's peers, institutions, family, and community. Sometimes institutional, career, and family conflicts are as stressful as the helping itself.

The depth axis takes into account external and internal judgments, morality, meanings, principles, ideals, ethics, status, dignity, identity, beliefs, spiritual aspirations, and life's purpose. All of these may be stressed and traumatized through reverberations with victims and through one's own perceived failures to respond.

I believe that each survival strategy manifests itself in all three axes. This extends and enriches both victim and helper diagnoses. For instance, in the case of the nurse, her stresses influenced her behavior with her family, fiancée, subsequent patients, and colleagues, and had negative influence on her self-views, identity as a nurse, and sense of purpose in saving lives.

Influence of Secondary Stresses and Traumas on Clients

One specific social parameter interaction deserves special examination—the helper–client social system. This is because client–helper relationships are two-way, and helper stresses and traumas have at least as large secondary effects on clients as client stresses and traumas have on helpers.

Whether through current stresses with victims or through blind spots from previous traumas, helpers themselves emit survival strategy signals with which clients reverberate and to which they respond countertransferentially. Detrimental interactions may be diagnosed in helpers, clients, and their interactions.

Helper stresses and traumas may be reflected in nonrecognition, denial of client traumas, fragmented attention, lack of empathy, intellectualization, dehumanization of victims as cases or research subjects, and partial and foreclosed diagnoses and treatments. Occasionally helpers may manifest a paradoxically overenthusiastic (even if short-lived) involvement with client traumas.

Reciprocally, clients may see their helpers as naive, ignorant, limited, patronizing, denigratory, unsympathetic, lacking understanding and compassion, and at worst more traumatic than the original trauma. Often clients and patients of necessity deny helper problems and accommodate to them.

Negative interactions may manifest as patient distress, acting out, intensification of symptoms, decompensation, and premature termination of treatment. Excessive accommodations can lead to treatment enmeshments, such as ever-grateful patients who gratify insecure therapists. In extreme cases, enmeshments may lead to clients absorbing helper problems, such as their depressions. They may act them out, even through suicidal acts. The following case is mild by comparison, though more common.

Case 2. The daughter of a traumatized and depressed mother became a psychologist. She felt compelled to “reach out” to those bereaved in a local calamity. However, talking to bereaved victims evoked depression in her, and she left the scene after some days. The only help she had been able to offer was intellectual explanations of responses and conventional wisdoms, which seemed to distress victims.

Diagnosis of helper symptoms and blind spots can be enriched in extent and accuracy using the triaxial framework and survival strategies. In this case,

the helper was blind to grief (Adaptation), which was transmitted to her by her mother. Her career was a transference of her role of being mother's caregiver (Rescue-Caretaking).

TREATMENT OF HELPER DYSFUNCTIONS

Just as the wide variety of helper symptoms can be orientated and specified with the help of the wholist perspective (that is, the triaxial framework and survival strategies), so can the wholist perspective orientate and specify a wide variety of helper treatments. In addition, the wholist perspective can add to the enrichment, rationalization, and tailoring of treatment of helper stresses and traumas.

Orientation and Specifications of Current Treatments

Although most treatments span various axes and survival strategies, it may help conceptualization of treatments to see where they mainly fit in the wholist perspective.

Thus, on the *process axis* a variety of treatments are aimed at ameliorating stresses—that is, maladaptive survival strategies. Some programs are mainly educational (e.g., Zimmerman & Weber, 2000). Others include stress management treatments, which limit the intensity of exposure to stressors through rest, recreation, meditation, and communion with nature (Yassen, 1995). De-compressions, defusings, and debriefings emphasize understanding stress symptoms as normal survival strategy responses to abnormal situations. Different types of debriefings emphasize understanding different combinations of biological, cognitive, emotional, and social stress symptoms. Entrenched traumas and illnesses require more extensive help, such as through cognitive behavior or psychodynamic psychotherapy. Many workers emphasize training as preparation to enhance adaptive and diminish maladaptive responses.

Treatment *parameters* may include different times of initiation and frequency and duration of different treatments. They include individual, group, or institutional treatment targets. Further, therapists of helpers may also be individuals, cotherapists, or treatment teams.

Depth axis involvement may involve deeper debriefings over longer times. They take into account emotions, moralities, meanings, and existential issues (e.g., Lahad, 2000). Deeper vicarious traumatization or role-, identity-, spiritual-, and existential-level disruptions as well as helper blind spots and earlier traumas (Black & Weinreich, 2000) may require long-term supervision and treatment (Pearlman & Saakvitne, 1995a, 1995b).

Sometimes specific helper survival strategies are targets for treatment. For instance, helpers may be facilitated to grieve their losses (Adaptation) or man-

age anger and work frustrations (Assertiveness) or their helper anguish (Rescue-Caretaking).

Thus, the wholist perspective can help to orientate the different foci of various treatments and to provide a view of the strengths and boundaries of those treatments.

Ubiquitous Treatment Principles

Trauma therapies include one or more of four ubiquitous principles (Valent, 1998b): recognition, nonspecific, symptomatic, and specific treatment approaches. *Recognition* here includes helper stresses and traumas and their wholist diagnoses. *Nonspecific treatment* includes countertrauma environments in which helpers are intuitively provided with adaptive antidotes to their maladaptive survival strategies. *Symptomatic treatment* deals with specific biological, psychological, or social survival strategies at particular triaxial framework points.

Specific therapy includes remembering and specifying symptoms and understanding them according to their traumatic sources. Through dual focus of attention on the traumatic source and current perspectives of that situation in the present, stressful and traumatic responses and significances are readjusted to a nonstressful meaningful story, which subsumes past and current realities.

Application of the Wholist Perspective to Treatment Principles in Helpers

In order to provide as wide and rich yet specific treatment to helpers, the aim of wholist therapy is to apply the wholist perspective to each treatment principle. The following general approach will be applied specifically to compassion fatigue and burnout. Finally, a unified yet potentially specific tailored approach across disaster phases will be presented.

Recognition

According to the first treatment principle, it is recognized that helpers are living or reliving stress and trauma survival strategy responses. Their specific biological, psychological, and social features give clues to the specific survival strategy involved and the type of appraisal that evoked it in the traumatic event. Recognition thus includes specific reconstruction of traumatic events and helpers' responses to them. This includes recognition of responses as reverberations in unison with victims, responding to victims' needs, or survival strategies of one's own, irrespective of victims.

This recognition is fed back to helpers. It includes the understanding that their responses were normal reactions in abnormal situations, but it also speci-

fies the evolutionary and specific contexts of a wide range of survival strategies in which victims and helpers participated in the situations.

Nonspecific Therapy

The intuitive placing of boundaries between helpers and victims allows the latter to safely concentrate on and express solely their own survival strategy responses.

Further, each adaptive survival strategy is intuitively enhanced. The bounded place of therapy away from demanding situations provides a sanctuary (Flight). The respect accorded ensures status and dignity (Competition). The goal of therapy is greater control in one's work (Assertiveness) and gaining weapons to defeat trauma in the future (Fight). A safe place to cry for losses facilitates grief and hope (Adaptation). The therapeutic relationship encourages a sense of support and being cared for (Attachment), and identification with the care and empathy of the therapists facilitates Rescue-Caretaking. Mutuality of sharing enhances a sense of love and creativity (Cooperation).

Symptomatic Therapy

As mentioned, symptomatic therapy alleviates specific biological, psychological, or social symptoms at specific triaxial points. For instance, headaches are managed with analgesics, anxiety with anxiety management, powerlessness with empowerment, and so on.

Specific Therapy

In this case, helpers' specific stress and trauma survival strategy responses, whose sense and sources have already been recognized, are contrasted with past and present realities. This may need to be done for each component of each survival strategy. Compassion fatigue and burnout will be used as examples.

Compassion fatigue. Helpers may present with any of the stress and trauma symptoms of Rescue-Caretaking (Table 1.1), such as feeling burdened, rejecting victims, anguish for not having prevented damage or death, not having done enough, having neglected their responsibilities, and so on. Helpers may also complain of reverberating still with the cries of the helpless, those they abandoned—that is, the maladaptive and trauma symptoms of Attachment of those they were to help.

In a sympathetic environment each of these and related symptoms is traced back through adaptive Rescue-Caretaking responses that helpers also had but which were insufficient for the situation, to the situation itself. It may become clear that the causes of the damage were the insurmountable situations, impossible choices, and too few resources—not the helpers themselves. Each stress and trauma response may need to be reworked in terms of those realities and current and future possibilities. What was done, could be done and may be done, better in the future become part of a coherent and meaningful story of caring.

Burnout. In this case helpers may suffer a range of Assertiveness stress and trauma responses such as exhaustion, impotence, sense of failure, tension, arousal, and so on. They may also reverberate with victims' losses, which they failed to avert.

Helpers may be given rest, recreation, exercises to manage anger, and tasks in which they succeed. In addition, it is necessary once again for the symptoms to be recognized and traced back via adaptive efforts that were insufficient to specific traumatic stressor contexts. It may be understood how strength, morale, and all the will in the world were insufficient to achieve success in the situation. It may be realized that the task was too great for the resources, that institutions and community provided too little support, or that one was thrown into situations with too little training. This may be contrasted with realistic expectations and current and future resources and possibilities. The event then becomes part of a learning process of experience, knowing what is possible and what could be improved.

Extension of Treatment Across the Triaxial Framework

Principles of treatment for survival strategy stress and trauma responses apply for their ramifications across the triaxial framework. For instance, on the depth axis each survival strategy may be associated with specific anxieties and strained or shattered moral judgments, meanings, principles, ideals, and existential beliefs. Each of these may require application of all treatment ingredients.

Similarly, each principle of treatment for each survival strategy is adapted to disaster phases, social system levels, type of disaster, helper experience, and previous traumas.

A Rationale for Tailored Application of Wholist Helper Treatment

Ideally all maladaptive and traumatic survival strategy responses are treated with all treatment ingredients across the whole triaxial framework. While this is seldom possible, education, planning, and checking throughout treatments highlights what is being treated and what is not.

Each lack in wholist treatment carries potential costs. For instance, biological, psychological, or social responses may be unattended; one or another survival strategy may be ignored; treatment possibilities in different disaster phases may not be utilized; individuals, teams, or institutions may be forgotten; and humanist treatment potentials may be ignored.

The following takes disaster phases as a pragmatic central point for checking and tailoring helper treatments. In different circumstances other points may be taken as central. For instance, one may check that all survival strategies are covered in a debriefing. Alternately, a single survival strategy, such as Assertiveness, may be taken as the focus in order to make sure that burnout is

prevented or treated in all circumstances.

Preimpact

At different social levels, education and training includes preemption of stressors. Failing that, preparation is made to facilitate all adaptive survival strategies and to prevent maladaptive ones. Helpers are educated in the wholist framework, especially compassion fatigue and burnout. Structures are put in place to prepare for helping helpers in each subsequent disaster phase. Helpers are given tasks within their capacities and available resources.

During Traumatic Events

All is done to facilitate adaptive survival strategies at all social system levels. Helpers have themselves access to helpers who understand and support them (Rescue–Caretaking); provide resources and coordinate services and hierarchies (Assertiveness); help through cutting of losses (Adaptation); are allies (Fight); maintain authority (Competition); provide relief (Flight), tea, and sympathy (Attachment); and provide trust and generosity, and facilitate creativity (Cooperation). They preempt burnout and compassion fatigue by tailoring tasks, providing rosters, relieving burdens, and taking responsibility for prioritizations and necessary choices. They explain expected survival strategy responses and place them quickly in context. Helper ethics, values, ideals, and self-views are protected. Negative client–helper relationships are identified and treated, or alternate helpers are provided.

After Traumatic Events

In decompressions and defusions, especially problematic survival strategies are given space for expression and put in current realistic perspective. In debriefings in a safe countertrauma environment, all survival strategy responses are covered, including all their adaptive and maladaptive, biological, psychological, and social components. Each response is explained, understood in context, and readjusted to realistic perspectives. The same is done for negative judgments and meanings, as well as for shattered principles, self-views, and deeper meanings. This is done for individuals, groups, and institutions. New adaptive ways of dealing with future events are facilitated at all levels.

Over the next period, defensive responses and emerging illnesses are identified. Vulnerabilities and blind spots associated with other current or past traumas are identified or treated. The same treatment principles are applied, perhaps over a longer period, to clear multiple defenses and maladaptive survival strategy ramifications.

Long-Term Problems

Involvement in traumatic events may reverberate with and uncover long-term traumatic events and their sequelae. Helpers may require long-term su-

pervision and therapy, in which entrenched and defended maladaptive and traumatic survival strategy responses and their ramifications are readjusted across the triaxial framework.

This chapter does not evaluate specific treatments, but points to where research may be fruitfully directed. For instance, particular treatments may be most efficacious at particular parameter axis points, such as of time (e.g., Campfield & Hills, 2001). Treatments must also be judged according to what they measure and what they do not (e.g., Deahl, Srinivasan, Jones, Neblett, & Jolly, 2001).

SUMMARY

In summary, the wholist perspective, with its concepts of survival strategies and the triaxial framework, may help conceptualization of the wide variety of helper symptoms and treatments.

Eight survival strategies and their components are the basis for explaining the great variety of lived and relived stress and trauma symptoms in helpers. The mechanism for evoking survival strategies in helpers is through reverberation with victims' survival strategies in an attempt to understand their needs and/or responding to them with complementary helper survival strategies in order to execute the needs. These early countertransference phenomena were the basis of subsequent sequelae, which formed the wide range of helper stress and trauma phenomena.

This wide range of maladaptive survival strategy manifestations forms what has been called STS. In the same vein, secondary traumatic survival strategy responses account for a variety of STSDs. Two commonly used helper survival strategies, Rescue–Caretaking and Assertiveness–Goal Achievement, account for two common specifically delineated syndromes: compassion fatigue and burnout, respectively. Although the term compassion fatigue has been used generically for helper traumas, the current suggestion limits it to Rescue–Caretaking trauma, while the general term remains STSD.

Survival strategies are represented triaxially on the process, parameter, and depth axes of traumatic stress. Using them as coordinates for survival strategies allowed a wholist perspective that is both a unifying and a specifying view of helper symptoms, diagnoses, and treatments.

Finally, the wholist perspective can be usefully applied to recognition, non-specific, symptomatic, and specific components of trauma therapy. An example was given of its application to helper treatment across disaster phases.

This view needs verification, working through, and adjusting. However, it may have applications in other secondarily affected populations, such as in families, including across generations.

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