

The Personal Cost of Care

By Karl LaRowe, MA, LCSW

“Modern man has developed a social and economic structure and a sense of time urgency which subject him to more and greater stresses than have been experienced at any other time in human history, and the effect of often devastating.”

— Kenneth R. Pelletier, “Mind as Healer, Mind as Slayer.”

Top Ten Signs You’re Suffering from Burnout

10. You’re so tired you now answer the phone "Hell." 9. Your friends call to ask how you’ve been, and you immediately scream, “Get off my back!” 8. Your garbage can IS your “in” box. 7. You wake up to discover your bed is on fire, but go back to sleep because you just don’t care. 6. You have so much on your mind you’ve forgotten how to pee. 5. Visions of the upcoming weekend help you make it through Monday. 4. You sleep more at work than at home. 3. You leave for a party and instinctively bring your briefcase. 2. Your Day-Timer exploded a week ago. 1. You think about how relaxing it would be if you were in jail right now.

The Personal Cost

The cost of providing care is staggering. The cost of not providing care, especially for care providers is even more staggering. Job stress is estimated to cost American Industry 200 - 300 billion dollars annually as assessed by absenteeism, diminished productivity, employee turnover, accidents, direct medical, legal and insurance fees, workman’s compensation awards, etc.

The personal cost of providing care is more difficult to estimate. How do you place a price tag on the emotional experience of secondary trauma, burnout and depression?

As we discovered in “The Care Giving Personality,” care providers are unique people with an ability to connect with others that is both our greatest gift and our greatest challenge.

We also discovered that 19% of Masters level and above therapists have been victims of Childhood Sexual Assault or CSA which is just one kind of trauma. When we consider physical and emotional abuse, neglect, abandonment and other less identified and defined trauma, 19% may not represent the actual percentage. And what about the millions of professional and non-professional care providers who do not have a Master’s degree? I personally believe the percentage is much higher.

Our own past experience with trauma is both our greatest resource as a care provider and our greatest limitation.

As a resource, our experience of learning to live with trauma with self-honesty, personal responsibility and self-expression has developed an internal “sanctuary” of calm and safety and

provided us tools to help our clients discover and develop their own.

As a limitation, the past personal experience of trauma can also render us more vulnerable to creating a sympathetic response with our clients that can result in our experiencing secondary trauma and the development of counter-transference reactions, triggering our own “need-desire,” that can lead to burnout and depression.

The Role of Trauma

The experience of trauma is possibly one of the least identified and most under-treated underlying causes of human suffering today. From “Listening to High Utilizers of Mental Health Services” (Blackshaw, Levy, & Perciano, 1999) it is estimated that in the general population approximately 10% of women and 5% of men are likely to suffer Post Traumatic Stress Disorder (PTSD) during their lifetime. Those who are most vulnerable are those with inadequate social support and survivors of childhood sexual abuse (CSA).

When community and hospital public mental health consumers were asked about their lifetime exposure to severely traumatic events, 98% of the 275 asked, acknowledged exposure and the clinical researchers determined that 43% of them were suffering from PTSD. When the charts were examined, only 2% of these PTSD sufferers had this condition diagnosed. An earlier study reported that 34% of recently admitted psychiatric patients to a state hospital were suffering from PTSD secondary to CSA.

With public mental health consumers, the model of a single incident trauma rarely applies; violent victimization by intimates and strangers is an almost normative experience, especially for mentally ill female clients without adequate supports or skills. Around one quarter to one third of people who experience extreme stressors are likely to develop PTSD, much of which is frequently unreported and untreated. Among public mental health consumers, CSA is one of the strongest predictors of PTSD. It is the most frequently occurring type of traumatic event related to PTSD that overlaps both male and female consumers. People who develop PTSD after interpersonal trauma (as adults) reveal many more symptoms if they have been victims of CSA. Adult survivors of CSA are four times more likely to have a psychiatric disorder and three times more likely to abuse alcohol or drugs.

The incidence of CSA among adult female psychiatric in-patients has been reported to be around 50%, and around half that rate for adult male in-patients. CSA is associated with subsequent dissociation, affect dysregulation, substance abuse, suicidal and self-harming behaviors.

What Is Trauma?

Trauma is most commonly associated with people who suffer from PTSD precipitating multiple problems that interfere with normal brain functioning that can result in: “...an enduring vigilance for, and hypersensitivity to, environmental threat,” (Blackshaw, Levy, & Perciano, 1999).

Is the experience of trauma limited to those who have experienced CSA and PTSD? Dr. Goleman in his book "Emotional Intelligence" believes not. He states: "Fortunately, the catastrophic moments in which traumatic memories are emblazoned are rare during the course of life for most of us. But the same circuitry that can be seen so boldly imprinting traumatic memories is presumably at work in life's quieter moments, too."

The more ordinary travails of childhood, such as being chronically ignored and deprived of attention or tenderness by one's parents, abandonment or loss, or social rejections may never reach the fever pitch of trauma, but they surely leave their imprint on the emotional brain, creating distortions - and tears and rages - in intimate relationships later in life."

Horror Frozen in Memory

Dr. Goleman has coined the term "Horror Frozen in Memory" in his chapter "Trauma and Emotional Relearning" in "Emotional Intelligence," and states: "...the more brutal, shocking, and horrendous the events that trigger the amygdala hijacking, the more indelible the memory. The neural basis for these memories appears to be a sweeping alteration in the chemistry of the brain set in motion by a single instance of overwhelming terror. While the PTSD findings are typically based on the impact of a single episode, similar results can come from cruelties inflicted over a period of years, as is the case with children who are sexually, physically, or emotionally abused."

What research is discovering with the aid of some very sophisticated technology is, our experiences in life can actually leave a mark on our brain; the more traumatizing the experience, the "deeper" the mark.

Dr. Goleman explains: "Some of the key changes are in the locus called catecholamines: adrenaline and noradrenaline. These neurochemicals mobilize the body for an emergency; the same catecholamine surge stamps memories with special strength. In PTSD this system becomes hyperreactive, secreting extra-large doses of these brain chemicals in response to situations that hold little or no threat but are reminders of the original trauma..."

As we will discover later, this same neurochemical process underlies an "emotional hijacking" that is often precipitated by secondary trauma that can result in our experiencing distraction, (hyper)-sensitivity, overload and misperception in our communication and relationships with self and others.

One of the results of the neurochemical stamps that are imprinted with traumatic experience is physiological arousal.

From "Listening to High Utilizers" (Blackshaw, Levy, & Perciano, 1999) it is noted that people with PTSD have profound and persistent alterations in physiologic reactivity and stress hormone secretion. A variety of triggers may come to precipitate extreme reactions, including both specific stimuli (related to the trauma itself) and neutral stimuli. To compensate for their chronic hyper- arousal, traumatized people may withdraw, shut down, or become emotionally

numb and thus attempt to avoid the chronic noxious stimuli.

Sounds, images, or thoughts related to traumatic incidents result in significant increases in heart rate, skin conductance (sweating), and blood pressure in people with PTSD, illustrating the intensity of timelessness with which these memories continue to affect current experience.

Traumatized people thus have difficulty evaluating sensory stimuli, mobilizing appropriate levels of physiologic arousal, and neutralizing stimuli in their environment in order to attend to relevant tasks.

Chronic physiologic arousal (with the resulting failure to regulate autonomic reactions to internal and external stimuli) impairs people's capacity to utilize emotions as warning signals to take adaptive action. Emotional arousal and goal directed behaviors become dissociated, and they tend to go directly from stimulus to response without being able to analyze the meaning of the stimuli.

Secondary Trauma

The concept of "secondary trauma" is key to understanding care provider burnout. What is secondary trauma? From "Listening to High Utilizers" (Blackshaw, Levy, & Perciano J, 1999), "A mental health professional's empathy for a trauma survivor is a crucial variable in helping, but it can cause the helper to become more vulnerable to secondary traumatization or burnout. Staff as well as consumers need dependable support."

I would add here, that it is more our sympathetic response to our clients that can cause the helper to become more vulnerable to secondary traumatization or burnout.

From the previous chapter: The Care Giving Personality, empathy is defined in the Oxford American Dictionary as: "1. The ability to identify oneself mentally with a person or things and so understand his feelings or its meaning. 2. Do not confuse empathy with sympathy.

Sympathy is defined as: "1. Sharing or the ability to share another person's emotions or sensations. 2. A feeling of pity or tenderness toward one suffering pain or grief or trouble. 3. Liking for each other produced in people who have similar opinions or tastes. 4. Approval of an opinion or desire."

The concept of sharing another person's emotions is central to our next chapter on Parallel Process as well as understanding secondary trauma.

When we form a sympathetic response with our clients we are more vulnerable to unconsciously absorbing and internalizing their emotions. We are more vulnerable to experiencing secondary trauma. This can occur as a result of cumulative stress, emotional hijackings and/or low stress tolerance.

Cumulative Stress

As with the experience of trauma, secondary trauma may be experienced in care providers either acutely, by co-experiencing a traumatic memory your client is re-living or cumulatively, over time as the result of absorbing and internalizing the emotions of our clients. Even those care providers who have not experienced trauma directly in their lives can become vulnerable to secondary trauma as a result of cumulative stress.

From Texmed.org stress is seen as a continuum: Cumulative stress is insidious. It is the psychological equivalent of hypertension - "the silent killer". As stress lays down "emotional cholesterol" - over a period of time it becomes hardened and encrusted in our anger and cynicism toward the profession and eventually our clients. We will eventually reach a trigger point and become vulnerable to experiencing "emotional hijackings" in our communication and relationships with clients and co-workers that can be both the result of and precipitate secondary trauma.

Secondary Trauma and Emotional Hijacking

Have you ever had the experience (who hasn't?) of being suddenly overwhelmed with such strong emotions that you felt out of control as though your mind did not belong to you? It most often happens to me when I am under stress or feeling burned out and something I am particularly vulnerable to suddenly triggers my emotions and I can become enraged, depressed and/or "lost in space."

The excellent work by Daniel Goleman Ph.D. in his bestselling book "Emotional Intelligence," lays the foundation for understanding how our minds do not seem belong to us at times, particularly when under acute and/or prolonged stress or trauma. He states: "Such emotional explosions are neural hijackings. At those moments, evidence suggests, a center in the limbic brain proclaims an emergency, recruiting the rest of the brain to its urgent agenda. The hijacking occurs in an instant, triggering this reaction crucial moments before the neocortex, the thinking brain, has had a chance to glimpse fully what is happening, let alone decide if it is a good idea. The hallmark of such a hijack is that once the moment passes, those so possessed have the sense of not knowing what came over them.

Emotional hijackings are a neural-chemical process built into our brains that in some instances are outdated. Dr. Goleman states: "In terms of biological design for the basic neural circuitry of emotion, what we are born with is what worked best for the last 50,000 human generations, not the last 500 generations - and certainly not the last five...For better or for worse, our appraisal of every personal encounter and our responses to it are shaped not just by our rational judgments or our personal history, but also by our distant past."

When we are faced with what we personally experience as a threat, whether it actually is or not, our brains are wired to bypass our rational mind and immediately react. This appears to be the working of the part of our brain called the Amygdala. Dr. Goleman again states: "Some emotional reactions and emotional memories can be formed without any conscious, cognitive

participation at all. The amygdala can house memories and responses repertoires that we enact without quite realizing why we do so because the shortcut from thalamus to amygdala completely bypasses the neocortex.”

As care providers we are continually exposed to the trauma of our clients that can result in secondary trauma, cumulative stress and emotional hijackings. We may also have a condition Dr. Steven Burns in his web site: www.teachhealth.com calls low stress tolerance.

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