

Distress in psychosocial workers and psychotherapists

The problems

DOCUMENT INTENDED FOR MENTAL HEALTH PROFESSIONALS

Evelyne Josse

2010

evelynejosse@gmail.com

<http://www.resilience-psy.com>

14 avenue Fond du Diable, 1310 La Hulpe, Belgique

Clinical psychologist. Ericksonian hypnosis, EMDR, brief therapy, TFT, EFT

Private practice psychotherapist, psychotherapist supervisor, humanitarian psychology consultant

Introduction.....	3
STRESS AND ITS DIFFERENT FORMS.....	4
1. Definition	4
2. The usefulness of stress	4
3. Normal phases of stress.....	4
4. Eustress and distress	6
5. The stress curve.....	7
6. The stressor and the stressed.....	8
7. The different forms of stress.....	9
7.1. Basic stress.....	10
7.2. Burn-in and burnout	10
7.2.1. Burn-in	11
7.2.2. Le burn-out.....	Erreur ! Signet non défini.
7.3. Le flame-out	Erreur ! Signet non défini.
7.4. La traumatisation directe : Le stress traumatique	Erreur ! Signet non défini.
7.5. La traumatisation indirecte (secondaire et tertiaire).....	Erreur ! Signet non défini.
7.5.1. La traumatisation secondaire : le Stress Traumatique Secondaire	Erreur ! Signet non défini.
7.5.2. La traumatisation tertiaire : le traumatisme vicariant et la fatigue de compassion	Erreur ! Signet non défini.
7.6. Le stress cumulatif	Erreur ! Signet non défini.
LES CONSÉQUENCES DU STRESS ET DES ÉVÉNEMENTS TRAUMATIQUES	24
1. Les conséquences du stress dépassé	Erreur ! Signet non défini.
1.1. Les signes d'alerte de stress dépassé	Erreur ! Signet non défini.
2.2. Les conséquences du stress chronique.....	25
2. Les conséquences d'un événement traumatique	27
2.1. Les réactions à l'événement traumatique.....	27
2.2. PTSD et syndrome psychotraumatique.....	28
2.3. Stress aigu et syndrome psychotraumatique	28
2.4. Les traumatismes de survenue différée.....	29
2.5. Les altérations de la personnalité.....	29
Cadre conceptuel du processus de traumatisation.....	30
LES RESSOURCES	31
1. Les ressources internes	31
2. Les ressources externes	32
2.1. Les ressources interpersonnelles.....	32
2.2. Les ressources organisationnelles	33
BIBLIOGRAPHIE.....	33

Introduction

When an individual is subjected to danger, his immediate response is a reaction known as “stress.”¹ Stress releases energy and provides the motivation needed to cope with difficult situations and challenges. It is a natural phenomenon that is normal and useful for survival.

Stress causes the appearance of certain characteristic physical and psychological reactions. On the somatic level, the heart rate increases, breathing becomes more rapid and muscles tense. The psychological effects result in alertness, euphoria, and feelings of distress or oppression. Generally, stress reactions persist for as long as the danger persists, and then gradually diminish. However, some people still exhibit signs of stress several days or even several months after the disappearance of the threat (but without showing traumatic symptoms of stress such as flashbacks or avoidance). If the problematic situation persists, stress can cause or exacerbate mental or physical illness.

Pleasurable and beneficial activities, such as a good night’s sleep, a healthy diet, relaxation, controlled breathing, massage, gentle gymnastics and physical exercise are ways to combat stress.²

¹ Canadian doctor Hans Selye is credited with introducing the term “stress” to the health field in 1936.

² This list is not exhaustive.

Stress and its different forms

1. Definition

According to H. Selye, stress is a unique and identifiable response by the organism to adapt to any demand (physical, psychological, emotional) of its environment.

L. Crocq defines normal stress as “the immediate biological, physiological and psychological reaction of alarm, to mobilize resources and defend the individual against aggression or threat.”

2. The usefulness of stress

Stress focuses attention on the threatening situation (vigilance, heightened attention); it mobilizes the energy needed for situational assessment and decision-making (increased powers of perception and analytical speed); and, it prepares for an appropriate action in response to the situation (fight, fight while retreating, flee, hide, stop³, call for help and also, adopt altruistic attitudes and behaviour toward people in trouble, etc.). The body's response is therefore a protective phenomenon, useful for survival and for coping effectively with difficult situations.

3. Normal phases of stress

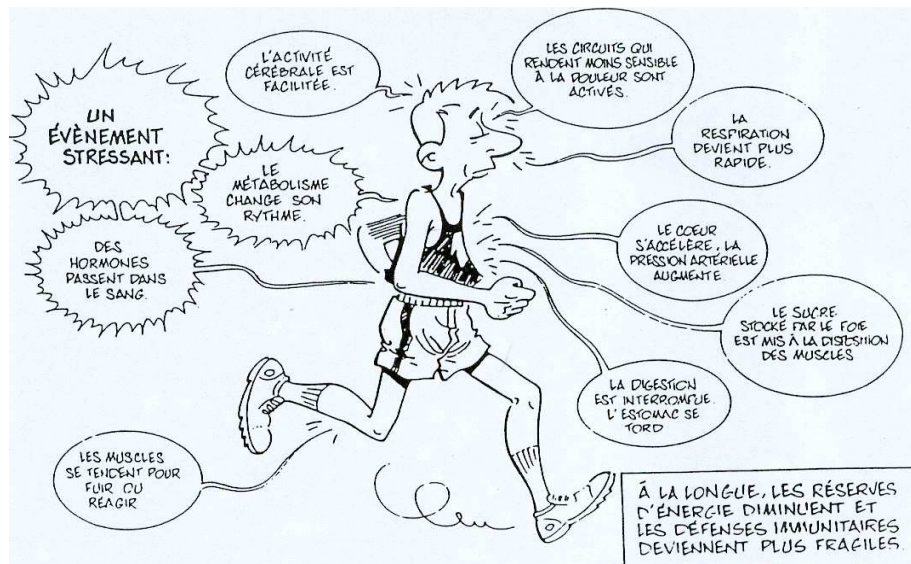


³ Stopping and calming oneself are often effective reactions to a danger.

The normal stress response occurs in 4 phases:

- ❑ **An alarm phase.** Defences are mobilized to respond quickly to the stressor⁴. Stress causes the appearance of certain characteristic physical and psychological reactions. On the somatic level, the heart rate increases, breathing becomes more rapid and muscles tense. The psychological effects result in alertness, euphoria, and feelings of distress or oppression.
- ❑ **A resistance phase.** If the stressor persists, the defence is maintained and the necessary energy reserves are replenished. The initial physical signs of the alarm reaction have disappeared. The body adapts and the resistance level rises above normal.
- ❑ **An exhaustion phase.** When exposure to the stressor continues for too long, the defences collapse. The person is no longer able to respond appropriately to stressful situations and characteristic symptoms appear.
- ❑ **A recovery phase.** When the stressor is controlled, tension levels drop, the person relaxes and little by little, the energy reserves are replenished.

The body's response in difficult situations is natural, normal and useful for survival. It puts the body on high alert and releases the energy resources that enable it to counter the stressor. The response is a phenomenon that is conducive to effectively coping with exceptional situations. This set of adaptive responses is called ***protective stress*** or more appropriately ***adaptive stress***.



⁴ A "stressor" can be considered any factor that is likely to initiate a stress response.

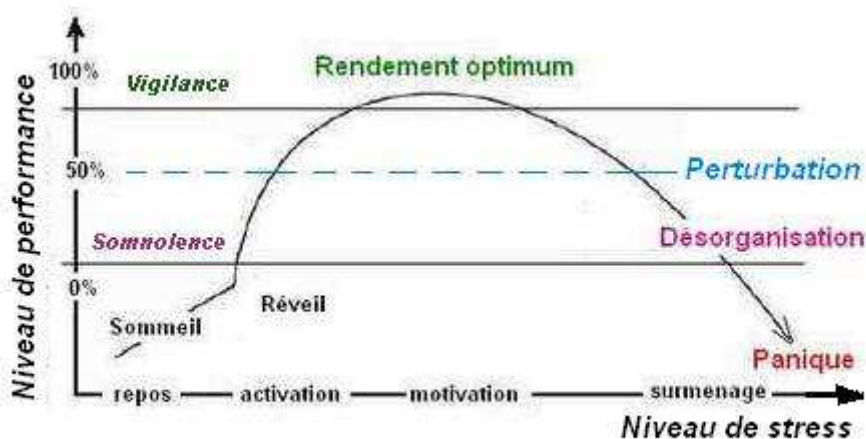
4. Eustress and distress

The generic term “stress” covers two categories of reaction: first, the normal adaptive reactions and second, other inadequate or inappropriate responses to extreme stress.

Humans need a minimum amount of stress in daily life. Achievable and challenging targets, realistic deadlines, desired changes, and interesting challenges aligned with one’s life, values, circumstances and personal capabilities provide this type of stress. Stress in this case is a positive energy necessary for the mobilization of resources, motivation, performance and, overall, the taste for life. This is called eustress.

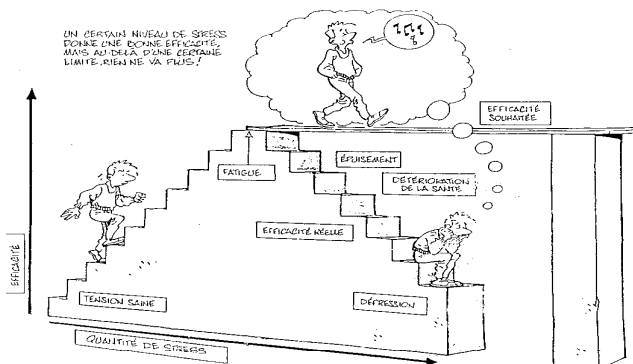
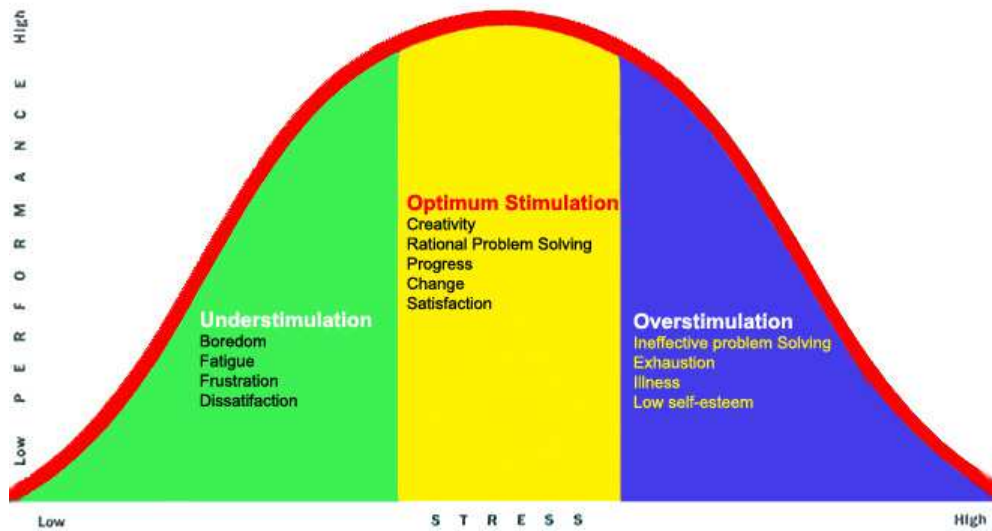
However, individuals are not only subjected to planned or sought after stress. Situations perceived as threatening, coercive or unpleasant, the feeling of not having the resources needed to respond, numerous requests from the environment either simultaneously or over a long period – all of these lead to distress. This negative stress induces a decrease in performance and leads to burnout. It is called ***distress or extreme stress***.

The absence of stress is harmful because our resources stop being mobilized and our performance becomes mediocre. Stress is therefore necessary, but only on the condition that the biological and psychological reactions are triggered appropriately and within acceptable limits. Stress can be compared to walking. Even without our noticing, when we walk we are alternately off balance from one foot to another. Similarly, we experience stress when a significant change occurs in what we consider to be our daily stability. At low doses, this stress is positive because without this small imbalance, we could not advance. But, if it becomes too intense or too repetitive, we may stumble, fall and hurt ourselves.



For some people, a trap lies in the excitement induced by protective stress. In fact, drugged by their own adrenaline, these individuals tend to want to prolong the stress, and advance to the distress phase without having seen the warning signs.

5. The stress curve



The relationship between the intensity of the stress response and our performance is not linear. Initially, the performance curve increases with the level of stress; then, beyond a specific and individually unique threshold, as stress continues to increase, performance drops. Between the two extremes of a lack of stimulation and a very high level of stress, there exists an optimal level that allows us to cope with situations without jeopardizing our physical and mental health.

For reasons that can result as much from the situation (external factors: violence, ongoing exposure to low intensity stress, etc.) as from the vulnerability of the person (internal factors⁵: anxiety, introversion or pre-existing mental disorders, tendency for avoidance, youth or inexperience⁶, recent experience of disruptive events), stress can be so severe that it leads to inappropriate responses, even pathological ones. Stress is no longer an adaptive process but a permanent condition. This is called extreme stress.

6. The stressor and the stressed

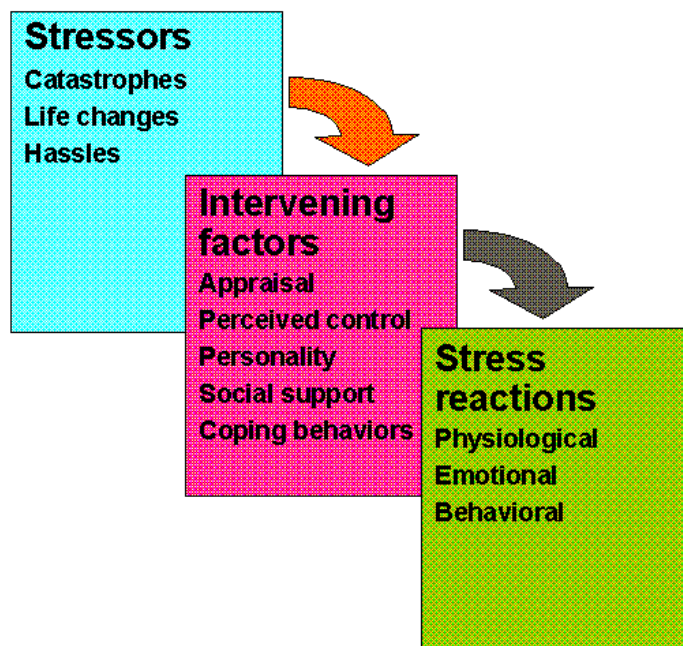
Stress is a subjective notion because the same external stimulation may affect each individual differently. Stress reactions can be compared to what happens on board a ship during a voyage on a stormy sea. Not all passengers will have the same reactions. Some suffer from seasickness and are very ill, others are less so and still others, not at all. Moreover, some waves, though not as high as others, may cause more nausea. In a similar way, the stressors that have the strongest effects are not necessarily the ones with the longest lasting effects.

Moreover, a person may react differently to the same stressful situation depending on when it occurs in his life. Thus, some people are affected by the turmoil of a rough sea when previously they had no reaction to similar circumstances. Conversely, others feel comfortable when they have previously suffered on rough seas. The significance attributed to stressors will also affect the experience of the situation. Thus, the passionate sailor will perceive the raging elements differently than the passenger forced to travel by sea.

Remember that stress is a process involving both a stressor and a person. It depends as much on the situation as on how it is perceived.

⁵ Stress is a subjective notion because the same external stimulation may affect different people in very different ways.

⁶ Young people or those with a lack of experience are more susceptible to developing inappropriate stress responses. To use a sailing metaphor, the young traveller is much more likely to experience seasickness than the older, seasoned sailor who already has his sea legs.



7. Different forms of stress

The stressors to which we are submitted as psychosocial workers and mental health professionals are many. Their accumulation may push us beyond our tolerance level. Depending on the type of factors leading to stress, we can talk about basic stress, burn-in, burnout (professional exhaustion), flameout, traumatic stress, secondary traumatisation, tertiary traumatisation (vicarious traumatisation and compassion fatigue), cumulative stress or chronic stress.

In this chapter we will discuss:

1. Basic stress
2. Burn-in and burnout
3. Flameout
4. Direct traumatisation: traumatic stress disorder (epicentre of the trauma)
5. Secondary traumatisation (1st shockwave)
6. Tertiary traumatisation: vicarious traumatisation and compassion fatigue (2nd shockwave)
7. Cumulative and chronic stress

It should be noted that basic stress, burn-in and burnout, flameout and cumulative and chronic stress are caused by stress alone, while traumatic stress disorder, secondary traumatisation and tertiary traumatisation are caused by a combination of stress and trauma.

Also note that basic stress is an appropriate and adaptive response, while the other forms cited are excessive stress reactions that are inadequate or inappropriate, or are traumatic symptoms.

7.1. Basic stress

Basic stress is the price we pay for the effort it takes to integrate and adapt to new situations. It is a normal and adaptive response, releasing energy and providing the motivation to cope with unknown situations and challenges. This type of stress is caused by any change in the everyday environment, lifestyle and/or habits. In one's personal life, it could include a new emotional relationship, a romantic break, or a move; in the workplace, it could be a new job, promotion, or many and sudden changes (turnover, computerization, new requirements, etc.). These are all situations where we face unfamiliar conditions to which we must adapt relatively quickly. After a possible period of euphoria and excitement akin to a "honeymoon", we may experience difficulties because our lifestyle has changed, because we have to assimilate a lot of information and because we need to implement new procedures. During this adjustment period, we may experience alternating moments of sadness and enthusiasm, showing a sense of detachment and emotional withdrawal, experiencing anxieties, disappointments and divers frustrations.

7.2 Burn-in and burn-out

For a long time, the adverse effect of work on health has been the subject of discussion⁷, but it was not until the second half of the 20th century that it became a genuine concern. The phenomenon experienced a real boom in the '70s. Clinicians and researchers focused on professional fatigue syndrome and began studying it in a clinical setting. Interest in this phenomenon emerged suddenly and occurred simultaneously on several continents. In the United States, Freudenberg, the first to describe it, called it "burnout." The name spread quickly and became popular in America and Europe. Recently, a preliminary phase of the burnout syndrome has been identified: burn-in.

Meanwhile, in Japan in 1969, the sudden death of a 29-year old employee drew attention to the evils of overwork. Occupational disability and the deaths of executives and clerical workers due to cardio-vascular diseases⁸ attributable to excessive workload or stress have raised significant and increasing interest. In 1982, three doctors, Hosokawa, Tajiri and Uehata, gave a detailed description of this syndrome they called "Karoshi"⁹ (death by work).

Burn-in and burnout result from the exhaustion of the stress coping mechanisms suffered in the course of work. This exhaustion usually affects professionals involved in interpersonal

⁷ In the 18th century, Dr. Tissot devoted part of his research to the study of the mental pathology of occupational intellectuals and leaders. In the 19th century, Villermé focused on the effect of work on workers.

⁸Stroke, myocardial infarction or acute heart failure.

⁹ From the terms "Karo", meaning death, and "Shi", meaning fatigue at work.

relationships (particularly in aid relations), executives who are responsible for human resources and people pursuing elusive objectives¹⁰.

7.2.1. Burn-in

In English, in the field of art, “burn-in” means to overexpose parts of photographs. In computing, the term refers to the process of testing the strength of computer components at a voltage and a temperature above normal, before they are put into service.

Burn-in is the first phase of professional exhaustion and precedes the final step, burnout. It manifests itself mainly by “presenteeism.” This term appeared in 1994 and is attributed to psychologist Cary Cooper, professor in the department of organizational management at Manchester University. “Presenteeism” is the opposite of “absenteeism” and refers to an oppressive presence in the workplace leading to a pathological state of overwork. The worker suffering burn-in is at his desk despite physical or mental health issues that should keep him away (colds, flu, allergies, depression, fatigue, arthritis, back pain, headaches, gastro-intestinal issues, hypertension, major difficulties in his private life, etc.). He is physically present but unmotivated, tired, unproductive and suffers from various somatisations.

Insecurity (fear of job loss and/or loss of income), work overload, the need to be recognized by his colleagues or his superiors as well as the corporate culture that excessively rewards performance, resistance to stress, endurance, etc. are among the factors that lead to this phenomenon.

7.2.2 Burnout

The term ‘burnout’ means, for example, in the passive form, to be burnt out, destroyed by fire, burnt down to the wick (for a candle), extinguished, exhausted or blown (like a light bulb). The term is also used in aeronautics to describe when a rocket’s fuel runs out causing it to overheat, which risks destroying the engine.

Loretta Bradley, Professor and Coordinator of Counsellor Education at Texas Tech University, first described professional stress using the term burnout in 1969.

In 1974, Herbert J. Freudenberger, an American psychotherapist and psychiatrist, described this phenomenon in more detail. At the time he was director of a free clinic for drug addicts in New York. Freudenberger observed a recurring trend of, after about one year of working there, colleagues becoming demotivated, complaining of somatisations (fatigue, back pain, headaches, gastro-intestinal problems, colds etc.), mood swings (irritation, anger, withdrawal etc.) and were unable to deal with stress or new situations. He attributed these symptoms to the fact that the carers most affected were exhausted by seeing their help rejected by difficult patients¹¹; the energy they were using did not result in the desired therapeutic effects. Carers end up feeling dissatisfied and doubt the value of their work because they measure their results by an idealistic

¹⁰ This is also sometimes called “winner’s disease.”

¹¹ Drug addict patients are considered difficult because they frequently do not follow carers’ advice; they interrupt their treatment, relapse, don’t keep promises, lie, emotionally blackmail their carers, are aggressive etc.

standard or against those that they really want to obtain. They complain of continual fatigue and mental exhaustion, feel demotivated and incompetent, want to escape the unsatisfying professional situation, are irritable and suffer from psychosomatic problems. Freudenberger said that “people are sometimes, like buildings, victims of fire”. He defined burnout as **“a state of fatigue or frustration brought about by devotion to a cause, a way of life or a relationship which fails to produce the expected reward”** (1981). He attributes this phenomenon mainly to personal attributes. Individuals driven by a ‘calling’ (‘vocation’, desire to succeed etc.), who are dynamic and highly competent, link their self-esteem to professional performance and whose interests are limited to work are more at risk of developing this syndrome.

At the start of the 1980s, Christina Maslach, a social psychology researcher, made her contribution to formalising the concept of burnout. She carried out research into medical and mental health professionals and then extended this to lawyers and other professionals. She confirmed that the phenomenon was widespread among those individuals engaged in interpersonal relationships, for all professions. Maslach defined burnout as “a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occurs in individuals who work with other people in some capacity”. Freudenberger emphasises the personal factors in the appearance of burnout while Maslach mainly attributes it to the professional environment and working conditions (workload, lack of control, lack of recognition, difficulties with interpersonal skills, unequal treatment of workers, differences between personal values and those of the employer). In 1981 she established the MBI or Maslach Burnout Inventory; a test for measuring professional exhaustion.

ANALYSIS OF DEFINITIONS

There are many different definitions of burnout. In 1982, the first literature review dedicated to this topic (studies of teachers, educators, care and health professionals) found 48 definitions!

To return to Freudenberger’s definition:

“a state of fatigue or frustration brought about by devotion to a cause, a way of life or a relationship which fails to produce the expected reward”
and Maslach’s:

“a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occurs in individuals who work with other people in some capacity.”

From these we can draw the following general definition:

“a state of exhaustion (mental, emotional and physical) in which coping mechanisms are exhausted due to the effects of stress experienced at work.”

THE THREE DIMENSIONS OF BURNOUT

According to Christina Maslach and Susan Jackson's three-dimensional model, the dimensions of burnout are:

- ❑ **Professional exhaustion.** Exhaustion appears as a loss of energy, asthenia¹², mental exhaustion, demotivation, frustration etc.
- ❑ **Depersonalisation**¹³. This is the interpersonal dimension of burnout. It is marked by a loss of empathy towards others: a negative attitude towards patients and/or colleagues (impatience, irritability, blaming, pathologisation¹⁴, moralising, cynicism, reification¹⁵, belittling patients' problems etc.), detachment, emotional coldness, John Wayne syndrome¹⁶ (the person is capable of dealing with any problem, deals with only their own problems, is impassive, does not show emotion and is insensitive to others emotions), etc. Depersonalisation can also translate into mistrust and pessimism. In the most severe cases it can lead to the dehumanisation of relationships with others (attacks on the individual's dignity, physical, psychological and social well-being, rejection, mistreatment, cruelty etc.).
- ❑ **Reduction in 'personal accomplishment'**, subsequently altered to 'professional efficiency' by Michael Leiter and Christina Maslach. This is the self-assessment dimension of the syndrome. It appears as devaluing work itself (work is uninteresting, pointless, not enough to solve the root of the problem etc.), questioning its professional value, a feeling of incompetence, self deprecation, a decrease in self esteem, feelings of guilt etc.

Initially, stress provokes either a decrease in personal accomplishment or emotional exhaustion, which in turn leads to depersonalisation and results in a reduction of personal accomplishment (see diagram below).

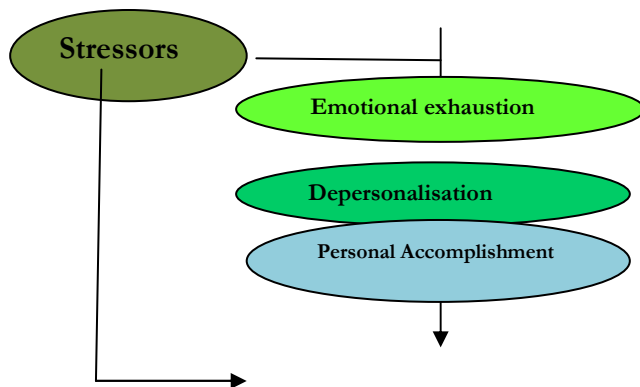
¹² Morbid fatigue that does not go away even after resting.

¹³ We have used the author's term 'depersonalisation' although it is poorly chosen and can cause confusion. Here, depersonalisation does not mean a dissociative problem where the person feels alien to themselves but rather a disruption in interpersonal relations. The term 'dehumanisation' is sometimes used instead but is too strong to be used for the majority of reactions that appear in professionals.

¹⁴ Pathologisation here means belittling other people by applying an unjustified diagnosis (mad, sick, weak etc.).

¹⁵ The patient is no longer seen as a subject but as an object (e.g. calling the patient in room 23 'number 23' or saying 'the heart patient can go into the operating theatre now' instead of 'Mr X can go into the operating theatre now').

¹⁶ There are different interpretations of this term. Richard Slotkin, English professor and director of American Studies at Wesleyan University applies it to Vietnam veterans to describe the feelings of soldiers (a mix of fear and bravery, excessive feelings of guilt and shame, emotions linked to bereavement etc.). For more on this see Slotkin, R. (1992), 'Gunfighter Nation: The Myth of the Frontier in Twentieth Century America', University of Oklahoma Press, Norman.



THE STAGES OF BURNOUT

The process leading to burnout is relatively slow and insidious. It evolves in successive stages: enthusiasm, stagnation, frustration, apathy and finally, hopelessness.

- ❑ Enthusiasm. This is the honeymoon period. The professional cultivates his hopes and unrealistic expectations towards work. He is enthusiastic, excessively motivated and overflows with energy. He overinvests himself and works long hours six or seven days a week, taking work tasks home at the expense of free time. He identifies with the victims he helps which leads to him confusing his needs with theirs. Completely over taken by his professional cause, he neglects his private life and personal needs.
- ❑ Stagnation. The worker realises, either slowly or suddenly, that work will not fulfil all his needs. He wants, for example to have more time to spend with family and friends, to dedicate time to a hobby, be paid at a level commensurate to his efforts, etc. The satisfaction that he gains from work gradually decreases and the first signs of fatigue start to show.
- ❑ Frustration. The professional realises that he is frustrated by his inability to change the system (bureaucracy, lack of or too much responsibility, insufficient scope to make decisions, etc.), to free patients from their problems, ease their suffering, convince them to follow treatment etc. Fatigue, dissatisfaction and bad moods become chronic. The worker becomes irritable, withdraws into himself, doubts his competence, experiences a feeling of personal failure, and complains of various physical problems. Some quit their job, others fight to improve their situation (make demands of their superiors, request help and training, team support, audit etc.); others slide into apathy.
- ❑ Apathy. The professional becomes less and less interested in work and emotionally detaches himself from patients. He protects himself by avoiding conflict and challenge, and puts in the minimum effort possible. He is no longer preoccupied with his own physical and mental health. Some people resign while

others cling on to their jobs, usually because it is well paid or because it offers them immediate or eventual financial security (for example, someone at the end of their career aiming for a full retirement pension). This period of apathy can last for a long time.

- Despair. Despair is the final phase of burnout. The professional loses all hope of seeing the situation resolve itself positively and loses confidence in the future. Some abandon their profession while others behave as if they are in perfect control of the situation and as if everything is ok.

Recovering from burnout is a slow process. Prevention is better than cure!

CONTRIBUTING FACTORS TO BURNOUT

Situations which make burnout more likely are those where people:

- are mentally and emotionally in much demand.
- take on management and human resources responsibilities.
- are confronted with unrealistic objectives and a disparity between professional tasks and the means that are available to carry them out, both from a personal point of view (lack of personal resources such as positive self esteem, feeling of efficiency and control, resistance to stress etc.), and an organisational point of view (overloaded with work, insufficient scope to make decisions, lack of supervision, insufficient training, budget etc.).
- perceive an ambiguity and/or conflict between their role and that of colleagues.
- encounter difficulty in communicating with colleagues or superiors (for example, in teams with strict hierarchies).
- experience a feeling of lack of control in the work environment.
- perceive the work carried out to be incoherent, ineffective or pointless. For example, someone who works with female victims of domestic violence might, in some countries, think that the problems should be resolved at a different level, i.e. the macro-social level (amendments to laws discriminating against women and which are against human rights).
- observe a gap between their hopes, expectations, intentions, efforts, ideals and the results actually obtained.
- receive little support and/or supervision from superiors.
- are overloaded with work.

- feels (rightly or wrongly) that they are not paid enough.
- is surrounded by a business culture which places excessive value on performance, resistance to stress, endurance and courage.

If resistance and reaction to burnout are dependent on individual factors, it would however be wrong to attribute the problem wholly to the individual. Professional exhaustion is also directly linked to political, organisational and/or institutional constraints.

Today burnout is seen as the result of complex, multi-factoral, accumulative and interactive interactions between the individual and the environment as they continually influence each other.

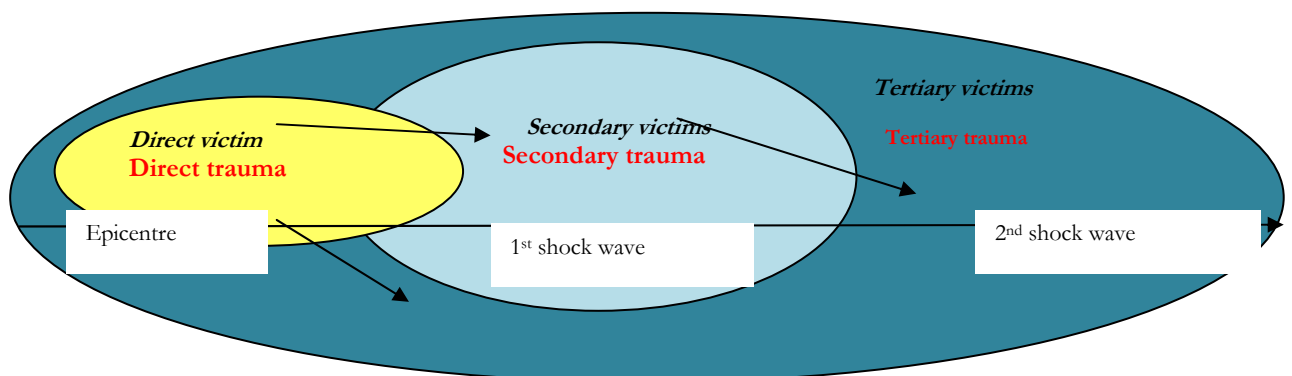
7.3 Flameout

In aeronautics the term ‘flameout’ is used for the breakdown of a jet engine when the flame in the combustion chamber is extinguished (due to lack of fuel or a combustion fault).

When professional exhaustion appears suddenly, particularly after a period of not enough sleep, rest or poor nutrition, it is called ‘flameout’. Contrary to burn-in and burnout, flameout can improve after a period of rest (holiday, long weekend).

7.4 Direct trauma: traumatic stress

Trauma can be described as like an earthquake where the critical incident is at the epicentre. The shock waves spread out in concentric circles from the traumatic event and decrease in intensity the further out they spread. The direct victim is at the heart of the earthquake and the shock waves progressively affect their family, friends, neighbours and colleagues as well as the carers encountered during and after the crisis.



Traumatic stress can occur when a person has experienced a ***traumatic event***, also called a ***critical incident***. Such an event threatens a person or group of peoples' lives, and physical and/or mental wellbeing. Being confronted with actual or possible death produces intense fear, a feeling of powerlessness, and/or horror and leads them to question the basic values of existence such as safety, peace, kindness, solidarity, justice, morals, life, the meaning of things, etc.

An event is said to be traumatic if it exceeds the coping abilities of the majority of people. However it must be noted that an event could be traumatic for one person and not for another or be traumatic for someone today when it wouldn't have been yesterday.

In carrying out a care profession, we can become direct victims (as subjects or witnesses) of trauma. Here are some of the traumatising factors to which we might be exposed as a subject: physical violence (from a patient or someone close to them), verbal abuse (insults, threats, bullying from a patient or someone close to them), or be held hostage (e.g. humanitarian organisation staff). As a witness we can find ourselves confronted with people who are seriously injured or in pain, mutilated bodies and cadavers (emergency services at the scene of a tragedy, hospital staff), an apocalyptic scene of massive destruction (for example after a natural disaster or an explosion etc.). These situations are both sensory and emotional experiences for professionals.

It should also be noted that contact with victims can cause professionals to relive traumatic events that they have experienced before, in either their professional or private lives.

Type of victim	Traumatisation process	Professionals affected
Primary victim	Direct trauma (professionals who are victims of a critical incident as a subject or witness).	Emergency service staff (fire fighters, law enforcement, emergency medical outreach and resuscitation teams) Psychosocial professionals (social workers, field psychologists, youth workers etc.) Journalists

7.5 Indirect Trauma (secondary and tertiary)

Indirect trauma is a problem specific to professionals in contact with direct and secondary victims. It follows contact with a person or group of people who are traumatised and is the result of intense emotions experienced due to the work carried out. Burn-in, burnout and flameout affect many different workers of all professions while indirect trauma specifically affects professionals working with traumatised people. There are two levels of intervention with victims:

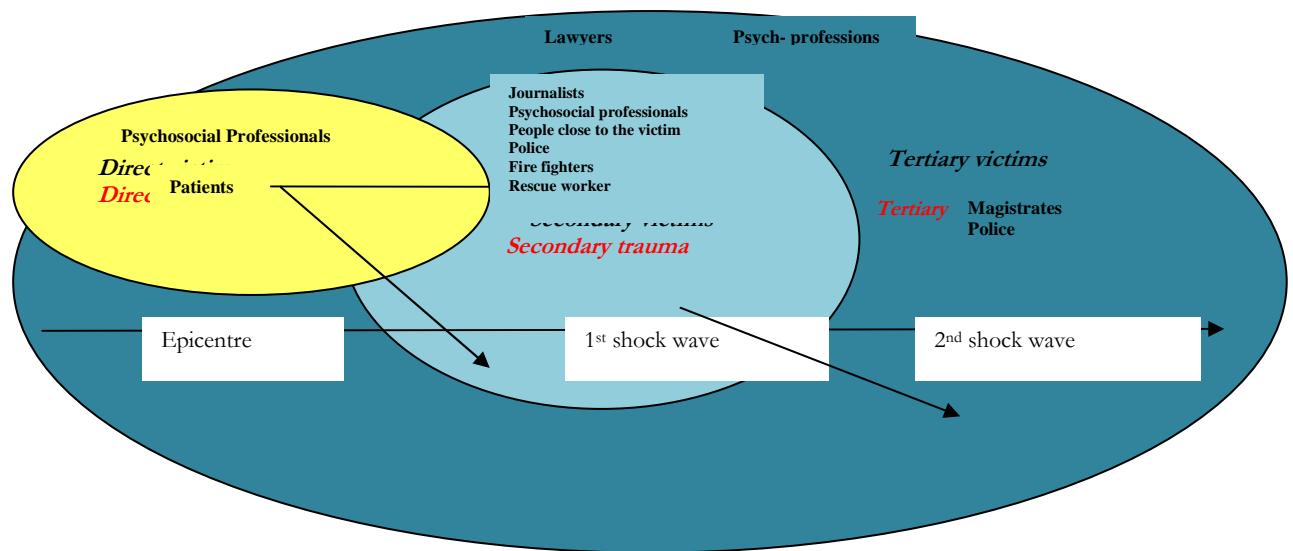
- ⇒ **Front line:** carers are in direct contact with victims of the crisis situation. This affects psychosocial professionals (social workers, field psychologists, youth

workers etc.), emergency service staff (fire fighters, law enforcement and emergency medical outreach and resuscitation teams), field journalists, staff from hospital emergency rooms and coroners etc.

- ⇒ **Second line:** Professionals are confronted with emotional accounts given by victims. These include mental health professionals (psychotherapists, psychologists, psychiatrists) whether at a practice or within institutions, lawyers, magistrates, editorial journalists, police based within police stations etc.

Secondary trauma, the first trauma shock wave, affects front line professionals; tertiary trauma is the second shock wave and mainly affects second line professionals.

Type of victim	Traumatisation process	Professionals affected
Secondary victim	Secondary trauma – professionals in direct contact with victims in a crisis situation, colleagues of a primary victim	Emergency service staff (fire fighters, law enforcement, emergency medical outreach and resuscitation teams) Psychosocial professionals (social workers, field psychologists, youth workers, etc.) Mental health professionals (psychotherapists, psychologists, psychiatrists) Hospital emergency staff Coroners Journalists
Tertiary victim	Tertiary trauma (care professional confronted with emotional accounts given by traumatised victims)	Psychosocial professionals (social workers, field psychologists, youth worker, etc.) Mental health professionals (psychotherapists, psychologists, psychiatrists) Magistrates Lawyers Police Journalists



7.5.1 Secondary Trauma: Secondary Traumatic Stress

Secondary trauma is the first trauma shock wave. It affects front line professionals in direct contact with the crisis victim, i.e. emergency services staff (emergency medical outreach and resuscitation teams, fire fighters, law enforcement) and psychosocial professionals (social workers, field psychologists, youth workers, etc.) but also in some cases, second line professionals (for example, when they are confronted with the death of a patient).

When coming into contact with victims, professionals may present a psychosomatic condition known as Secondary Traumatic Stress. This means that contact with the traumatised person or people is in itself a traumatic event. Even today and although numerous authors refer to it, there is still no agreed definition for Secondary Traumatic Stress syndrome nor is it recognised in official nosographies. Figley et al define it as the result of stress caused by the act of helping or wanting to help a traumatised or suffering person, particularly if this person is held dear or close. The condition presents essentially with post-traumatic type symptoms: repetitive and overwhelming memories of the 'rescued' person, reliving the traumatic event as seen or imagined by that person, avoiding things that remind them of the victim and/or the particular incident, and neurovegetative hyperactivity. It is also marked by feelings of powerlessness and by a breakdown of beliefs in the basic values of existence as safety, peace, goodness, solidarity, justice, morals, life, the meaning of things etc.). The symptoms of Secondary Traumatic Stress can appear very suddenly, for example from first contact with a direct victim.

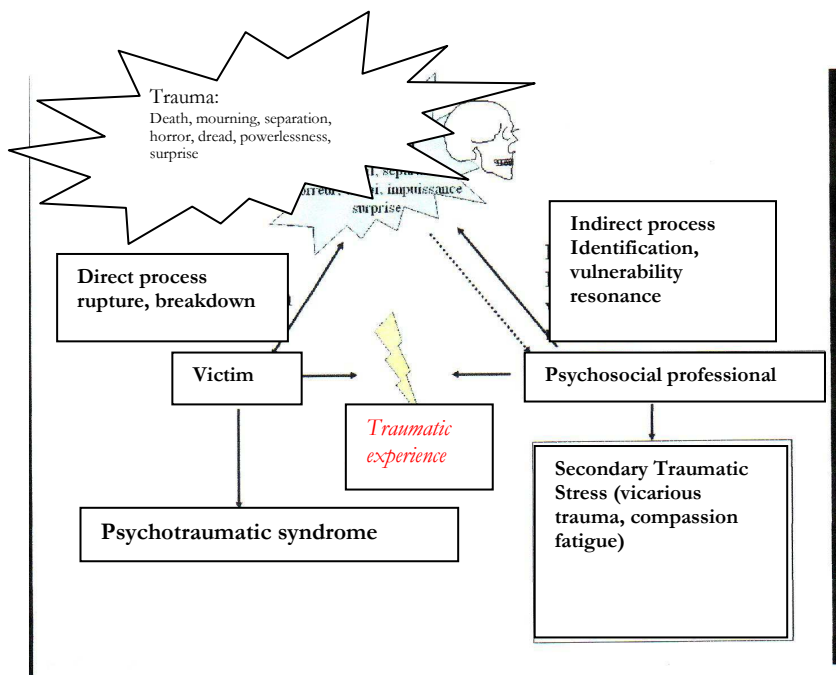
FACTORS OF SECONDARY TRAUMA

Contributing factors to secondary trauma:

- repeated contact with persons in crisis situations and those close to them.
- recurring confrontation with the different consequences of critical incidents (for example, destruction, chaos etc.).
- having to help several victims at the same time.
- powerlessness to satisfy the demands and needs of victims ('helpless witness trauma') or to comfort them (for example, informing them when one is not informed oneself, reassuring them about the prognosis of an injured person who is in a critical condition etc.).
- being frequently called upon to announce bad news (death, serious injury, disappearance etc.).
- lack of control in the field of work.

THE SECONDARY TRAUMA PROCESS

Confronted repeatedly by death, with the fragility of life, and with tragic and brutal shocks, carers become aware of their own vulnerability and that of the people they hold dear. Recurring confrontation with suffering and damage caused, sustained and exacerbated deliberately by ill-meaning third parties provokes people to question human nature and call fundamental human values into question. In addition, when in contact with victims who are in a state of shock (incapable of speech, confused, disorientated etc.), agitated, panicked, hopeless, crying, shouting, in denial of the reality of the drama, refusing all help, aggressive towards the emergency services, threatening to kill themselves etc, the carers can experience strong emotional reactions (e.g. anger when a victim hinders the efforts of or is aggressive towards the emergency services for no logical reason; distress when someone attempts to kill themselves after the death of someone close to them), contagion (anxiety, psychological tension etc are 'contagious') and empathetic or sympathetic identification ('this could happen to me or someone close to me'). Secondary Traumatic Stress can also result from the particular meaning that a situation has for someone at a particular time in their lives (e.g. intervention with a seriously injured child when the carer has recently become a parent).



7.5.2. Tertiary trauma: vicarious trauma and compassion fatigue

Tertiary trauma is the second trauma shock wave. It affects second-line professionals working with direct and secondary victims, mental health professionals (psychotherapists, psychologists, psychiatrists) working in a practice or within institutions, lawyers, magistrates, editorial journalists, police based within police stations, etc.

VICARIOUS TRAUMA

The term ‘vicarious’ comes from the Latin ‘vicarius’, taking the place of another, meaning a body or post which takes on the role of another deficient body or other post. Vicarious trauma is the result of emotional overload. This can happen to those who engage with people in distress (ill, injured, outcasts, victims of violence, etc.) and, when hearing their emotional account, are confronted with situations which lead them to experience intense emotions. These confrontations with the suffering of others can sooner or later be the cause of greater or lesser psychological suffering, called vicarious trauma. The effects of vicarious trauma accumulate over time and can lead to a state of compassion fatigue.

COMPASSION FATIGUE

Compassion is a feeling which leads us to perceive or feel the suffering of others and attempt to remedy it. It is the final form of vicarious trauma. Vicarious trauma and compassion fatigue have a major effect in changing perception of the self and the world (loss of a feeling of safety and confidence, loss of the capacity to connect to others, hopelessness, cynicism, disillusionment, loss of self-esteem, negativity at work, tendency to blame, identification with the victim).

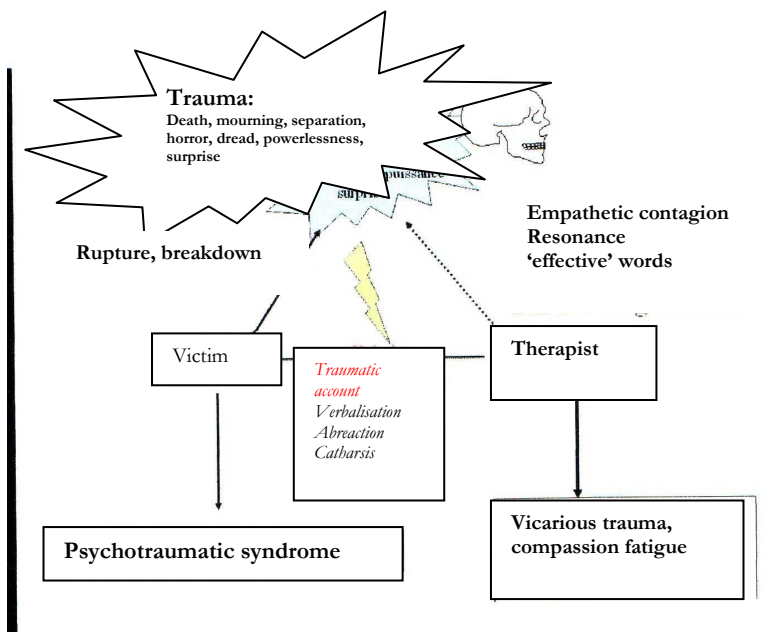
THE VICARIOUS PROCESS

To create trust, care professionals need to show empathy and compassion towards the victims. They become in tune with the victim's experiences.

Emotional accounts of traumatic events use 'active' and 'effective' words which have the potential to traumatise. These accounts are capable of transmitting to their audience such strong emotions as fear, anxiety, helplessness, anger and guilt. These are memorised with their emotional charge (interior film, visualisations) and form memories for the therapist who ends up sharing the victim's insecurity.

The process resulting from a reaction:

- ⇒ to the victim: identification and empathetic contagion ('cognitive', 'imaginative' contagion), even sympathetic ('emotional' contagion) of their experience.
- ⇒ to the facts themselves as a human (values, beliefs, philosophical foundations), citizen and/or social actor.
- ⇒ to trauma: fascination.



7.6 Cumulative Stress

Stress can be compared to a calculator because it adds everything up: the small everyday problems, professional pressure, risky situations, life events, etc.

Cumulative stress is a result of:

- ⇒ either prolonged exposure to often minor stress, which is foreseeable and repetitive. This is called **chronic stress**. Similar to the drops of water which slowly wear away and cut into a stone on which they are falling, the

multiplication of small worries can push even the most resistant people to the edge.

⇒ or the accumulation of a series of difficult events (in the professional and/or private spheres).

This form of stress develops slowly but accelerates if there are not enough opportunities for recovery (lack of sleep, holidays, rest periods, hobbies, etc.) and if the person presents personal vulnerability factors (previous highly stressful or traumatic experiences which have not been assimilated, emotional or family difficulties, etc.).

Increasing vulnerability versus increasing resistance

Some people believe that persons who repeatedly undergo highly stressful or even traumatic events become more able to deal with similar situations later. They are proponents of ‘increasing resistance’. Others, on the contrary, believe that each traumatic event increases the individual’s vulnerability and therefore the risk that they will develop a psychotraumatic syndrome. They are the advocates of ‘increasing vulnerability’.

So where are we? Who is right?

It seems that, to a certain extent, a gradual resistance to stress can be built up. Emotional reactions provoked by stressful events are mastered when the stressful events are repeated, and decrease as the events are repeated. To return to the metaphor of the sea, the young ship boy is more likely to suffer from sea sickness than an experienced sailor with ‘sea legs’. This encourages adaptation and strengthens the person, enabling him/her to deal with other situations later. Rescue workers, coroners, police, fire fighters, mental health professionals working in a crisis situation and humanitarian staff without experience are also at greater risk of becoming distressed than their more experienced and better trained colleagues.

It seems however that this desensitisation is strongly linked to the intensity and the frequency of such situations. The more intense and/or frequent the events which are intense or threatening, the less they constitute a positive apprenticeship for future adaptability to similar situations, they reinforce fear and the individuals increase the risk of developing a psychotraumatic syndrome. The weaker the danger stimuli and the more frequent they are, the more the individual can get used to them (e.g. fire fighters confronted from time to time with a fire that is not very serious do not get used to it). If however there is the risk of destruction and death, but the person is not directly confronted with it (e.g. bombing in which the individual, nor any buildings or people close to them are affected), emotional adaptation can only happen if the incidence of events is relatively low (if the town is crushed, no adaptation).

The degree of danger is directly linked to the degree of exposure. Having escaped death, been injured, been present at someone’s death, lost a loved one, the closer it is.

Resistance can affect fear

Excessive intensity of stimulations

What should we conclude?

Resistant or not, on the contrary they become more vulnerable.

Increasing resistance suggests that repeated exposure

The consequences of stress and traumatic events

1. The consequences of distress

Just as a useful medicine can become harmful beyond a certain dose, stress reactions that are too intense, too frequent, too prolonged and poorly managed can produce negative effects. These can be expressed in the relational, professional, behavioural, somatic and affective spheres. Distress will appear mainly as relational difficulties, professional counter-productivity, mood changes, behavioural problems and somatic complaints. These reactions will have repercussions on the family and professional entourages. In fact, like yawning, stress is contagious. It is transmitted, leading to true “epidemics” of conflicts, depressions, break-ups and abdications difficult to master.

1.1. Warning signs of distress

How can one tell when a person is in a state of distress?

- On the relational level, we notice the appearance of attitudes that are uncharacteristic for the person: (irritability, tendency to cry, unjustified lack of trust, negative or pessimistic attitude, etc.), dehumanisation of interpersonal relations (coldness, cynicism, inappropriate humour, sexism, racism, intolerance, critical judgments, aggressiveness), placing greater emotional demands on family, friends and colleagues (continuous need to talk and be listened to, be taken care of, etc.), apathy, avoidance of family and/or friends and /or social and/or professional relations and withdrawal into oneself.

- ❑ **On the professional level**, we may notice a progressive deterioration of professional performance (difficulty concentrating, withdrawal or unproductive hyperactivity, rigid thinking, excessive resistance to change, etc.) as well as a loss of objectivity about one’s own performances, abilities or skills, and those of others (overestimation or underestimation).
- ❑ **On the behavioural level**, the person frequently develops sleep disorders (insomnia, agitated sleep, nocturnal or premature awakening), eating disorders (bulimia or anorexia), a tendency to resort to psychoactive substances (alcohol, psychotropic medications, drugs) irritability and behaviour that places the concerned person or others at risk (reckless driving, provocative behaviour, unprotected sex, etc.)
- ❑ **On the somatic level**, signs may be excessive fatigue, the appearance of minor health problems (headache and backache, gastrointestinal disorders, recurrent or prolonged colds and flu, dermatological problems, palpitations, dizziness, sleep disorders, etc.), exacerbation of an existing health problem and excessive complaining about minor health problems.
- ❑ **On the emotional level**, the main repercussions are changes of self image and views of the world and others (negative attitude towards oneself, one’s spouse or partner, work, life, colleagues, etc.), mood disorders (significant mood swings, heightened sensitivity, crying jags and anger, depressive state, anxieties, etc.)

2.2. The consequences of chronic stress

What happens when a person is subjected to stress factors over long periods?

If the stress persists, it may lead to or exacerbate physical or mental disease.

Stress has known effects on the organism. It may be at the origin of, or intensify the development of a somatic disease such as hypertension, myocardial infarction, asthma, ulcers, colitis, eczema, psoriasis, diabetes, thyroid disorders, etc.

On the psychological level, stress triggers three main types of emotion: anxiety (perception of a danger places the individual in a state of alert), aggressiveness (it produces the strength and motivation to attack or destroy the danger) and depression (the individual cannot or can no longer counteract the sources of stress; he/she endures without reacting). A person subjected to the permanent activation of one of these emotions risks developing an anxiety, behavioural or depressive disorder.

Types of Victims	Traumatisation Process	Professionals concerned	Specific consequences

Secondary victim	Secondary traumatisation (involved persons are in direct contact with victims in a crisis situation, colleagues of a primary victim)	<p>Members of first response services (fire-fighters, forces of order, mobile urgent medical care and resuscitation teams)</p> <p>Psychosocial actors (field social workers and psychologists, neighbourhood organisers, etc.)</p> <p>Mental health professionals (psychotherapists, psychologists, psychiatrists)</p> <p>Personnel of hospital emergency departments</p> <p>Forensic scientists</p> <p>Journalists</p>	Secondary Traumatic Stress Disorder Traumatic bereavement
Tertiary victim	Tertiary traumatisation (involved persons confronted with the poignant testimony of traumatised victims)	<p>Psychosocial actors (field social workers and psychologists, neighbourhood organisers, etc.)</p> <p>Mental health professionals (psychotherapists, psychologists, psychiatrists)</p> <p>Judges</p> <p>Lawyers</p> <p>Police officers</p> <p>Journalists</p>	Vicarious traumatisation Compassion fatigue

2. The consequences of a traumatic event

2.1. Reactions to the traumatic event

In the hours and days following a critical incident, the affected person may show a set of physical, emotional, cognitive and behavioural reactions. Most of these reactions are considered normal in view of what the person has had to face, even if these reactions may seem “inappropriate” or “abnormal” to the entourage. However, the fact that these reactions are common does not mean that they are easy to deal with for either the victims or the entourage.

Among commonly observed reactions are the following:

- ❑ **On the somatic level:** permanent fatigue, startle reactions, gastrointestinal disorders (nausea, vomiting, diarrhoea or constipation, abdominal pain), muscle pains (back and neck aches), headaches, dizziness, trembling, sweating, palpitations, etc.
- ❑ **On the emotional level:** fear, worry, anxiety, apathy, worry and anxiety, a feeling of powerlessness, sadness, guilt, anger, emotional numbing, loss of confidence in people, God and the world order (which is generally considered just and logical), etc.
- ❑ **On the cognitive level:** disorientation, confusion, dissociative phenomena (impression of unreality), inability to remember an important aspect of the traumatic event, concentration difficulties, etc.
- ❑ **On the behavioural level:** irritability, aggressiveness directed against oneself (suicidal tendencies, self-destructive behaviours such as alcoholism) or against others (physical and/or verbal violence), agitation, a slow-down or on the contrary, hyperactivity, absenteeism or on the contrary, “presenteeism” at work, modification of sexual behaviour, sleep disorders (insomnia, nocturnal or premature awakenings), etc.

These reactions are stress-related. They are not specific to a critical incident and may appear in response to other situations and events. Certain effects are on the other hand, specific to trauma:

- ❑ **Re-experiencing:** this is a phenomenon in which the person has the impression of reliving the traumatising scenes (recurrent memories, flashback, nightmares, impression that the event is going to re-occur, distress upon exposure to reminders of an aspect of the traumatic event).
- ❑ **Avoidance:** the person avoids all reminders of the traumatic event (places, people, conversations, feelings, activities, etc.).
- ❑ **Hyperarousal:** the person experiences hyperawareness, startling at the slightest sound, and disturbed sleep. He/she complains of cardiac palpitations, chest pains, nausea or diarrhoea, feels constriction of the throat or a weight on the chest and breathes with difficulty. He/she perspires, trembles and shivers, and feels tingling in the limbs as well as muscle cramps and tension.

In the months following the event, the stress remains acute, but it should subside little by little. The person begins to integrate the experience and most of the reactions diminish in intensity and eventually disappear. Beyond this time frame, the persistence of reactions, possibly with the appearance of additional or more intense signs, is cause for concern about the development of true psychological trauma and evolution towards a chronic state.

2.2. PTSD and the Psychotraumatic Syndrome

PTSD comprises only part of the symptoms that may emerge in people suffering in the wake of a traumatic event.

PTSD is the acronym of the English term Post-Traumatic Stress Disorder. In French the term is «Etat de Stress Post Traumatique» or ESPT. The designations PTSD and ESPT are both restrictive and include only the phenomena of re-experiencing, avoidance and hyperarousal that we have just described above. Some people however, will not present these types of symptoms, but will suffer from depression, anxiety disorders, psychosomatic conditions or behaviour disorders (alcohol or other substance abuse, suicidal or aggressive behaviour).

Psychotraumatic suffering thus covers a vast range of conditions varying from mild to severe cases. Their seriousness will be evaluated as much by the number of symptoms as by their intensity. In fact, a person may present many signs that are not very bothersome, or show few, but very debilitating reactions.

2.3. Acute stress and psychotraumatic syndrome

At what point exactly can one say that a person is truly traumatised?

When people are exposed to a highly stressful or potentially traumatic event, some will react immediately in an appropriate way(while perhaps showing temporarily disturbing reactions such as numbness, confusion, feelings of unreality, agitation, etc.); others will show reactions of acute traumatic stress (feeling of detachment, lack of emotional reaction, mental paralysis, derealisation, flashback and recurrent images of the event, the impression of reliving the experience, distress on exposure to any possible reminders of traumatic events, avoidance). Some fragile and predisposed individuals may even develop pathological behaviour (paralysis, mutism, or blindness without organic cause, tics, obsessive-compulsive disorders, convulsions, brief reactive psychosis, etc.). These initial reactions are not however, predictive of evolution. In fact, as of the first days and weeks, some individuals (whether or not they have reacted normally), find their symptoms diminishing and disappearing spontaneously, Others, on the contrary (and again, irrespective of whether they showed a normal reaction or distress/ traumatic stress reactions, or pathological reactions) begin to suffer from psychotraumatic symptoms (particularly re-experiencing and nightmares), and develop a psychotraumatic syndrome, which may be temporary or become chronic. Only the future will reveal, retroactively, which individuals experienced the event as manageable and which experienced it as traumatising.

Thus, the traumatic impact cannot be assessed until after *a latency period* of at least one month, and which may last up to three months. During this three-month interval, reactions may be considered normal and within the bounds of acute stress reactions. Beyond three months, they are classified as comprising *“chronic psychological trauma”*.

2.4. Delayed onset psychological trauma

The effects of a traumatic experience may occur long after the event. Some people react in an altogether appropriate way to a critical incident and no longer feel affected after a few days or weeks. If symptoms only begin to appear at least 6 months after the traumatic event, the term “**delayed onset**” is used. The trauma may in fact re-emerge at a later time when the person undergoes major stress or is exposed to one or more events that act as direct or symbolic reminders of the original traumatising event (previous trauma, mourning, and break-up).

2.5. Personality changes

At the time of the traumatic impact and in the following days, victims easily attribute their reactions to the ordeal they have just lived through. On the other hand when symptoms appear more than 6 months after the critical incident, they generally do not make the connection. When the psychological trauma is not taken into account, it ends up by changing the personality. Such personality change is usually characterised by altered interest in others (attitude of dependence in affective relations with others or, on the contrary, an exaggerated independence, refusal to establish lasting emotional relationships, brusqueness in dealing with others, impression of emotional anaesthesia) and in the external world (loss of curiosity about activities, reduction of activities, loss of motivation, perception of the external world as artificial or unreal, future seen as devoid of prospects), as well by an attitude of hypervigilance and alert.

Types of Victims	Traumatisation process	Groups concerned	Specific consequences	Treatment framework
Primary Victim	Direct traumatisation (involved persons are victims of a critical incident, directly or as witnesses)	Members of first response services (fire-fighters, forces of order, mobile urgent medical care and resuscitation teams) Psychosocial actors (field social workers and psychologists, neighborhood organisers, etc.) Journalists	Acute Stress Disorder Post-traumatic Stress Disorder	Ego rupture, intrusion

Conceptual framework for the traumatisation process

Types of Victims	Traumatisation process	Groups concerned	Specific consequences	Treatment framework
Primary victim	Direct traumatisation (involved persons are victims of a critical incident, directly or as witnesses)	Members of first response services (fire-fighters, forces of order, mobile urgent medical care and resuscitation teams) Psychosocial actors (field social workers and psychologists, neighborhood organisers, etc.) Journalists	Acute Stress Disorder Post-traumatic Stress Disorder	Ego rupture, intrusion
Secondary victim	Secondary traumatisation (involved persons are in direct contact with victims in a crisis situation, colleagues of a primary victim)	Members of first response services (fire-fighters, forces of order, mobile urgent medical care and resuscitation teams) Psychosocial actors (field social workers and psychologists, neighbourhood organisers, etc.) Mental health professionals (psychotherapists, psychologists, psychiatrists) Personnel of hospital emergency departments Forensic scientists Journalists	Secondary Traumatic Stress Disorder Traumatic bereavement	Framework undefined and fluctuating
Tertiary victim	Tertiary traumatisation (involved persons are confronted with the poignant testimony of traumatised victims)	Psychosocial actors (field social workers and psychologists, neighborhood organisers, etc.) Mental health professionals (psychotherapists, psychologists, psychiatrists) Judges Lawyers	Vicarious traumatisation Compassion fatigue	Treatment framework

		Police officers Journalists		
--	--	--------------------------------	--	--

According to Serniclaes O., Psychologist- March 2000

Resources

As we have seen, the stress factors to which psychosocial personnel and mental health professionals are subjected may have negative repercussions in different areas of their lives. However, these same factors may also contribute to their development. Being tested, the ability to deal with emotionally intense situations and the sense of participating in a useful action all contribute to the satisfaction of humanitarian workers. Their commitment enhances their self image (new personal possibilities, sense of worth and self-esteem), revitalises basic human values and interpersonal relations (openness, empathy) and invigorates the spiritual dimension (appreciation of life).

This ability to function well despite stress, adversity and unfavourable conditions is called “resilience”¹⁷. Even a traumatising event may have positive consequences and be at the origin of what is termed “post-traumatic growth”.

The ability to rebound after a difficult event depends not only on personal characteristics (internal resources), but also on interaction with the environment (external resources). Resilience and post-traumatic growth are not built up from personal resources alone, or solely from social resources (private and professional), but from their being tightly meshed together. It is these resources that need to be mobilised.

The resources acting as factors in resilience and post-traumatic growth may be divided into two categories:

- ⇒ Resources internal to the individual
- ⇒ Resources external to the individual
 - Interpersonal resources
 - Organisational resources

1. Internal resources

The factors listed below are individual characteristics that contribute to the person’s capacity to overcome stressful, even traumatising situations.

¹⁷ This term is borrowed from physics, where it defines the resistance of materials to stress.

- Social skills
 - Being sociable
 - Being able to establish good-quality communication
 - Having a sense of humour
 - Being able to feel and show empathy
 - Being able to put things into perspective
 - Willing to seek support and accept help when needed
- Sense of autonomy
 - Being capable of acting independently
 - Having a deeply anchored sense of self-identity
 - Having self-esteem
 - Being able to set boundaries between oneself and others
- Problem-solving skills
 - Being capable of abstract thinking
 - Being observant and able to think analytically
 - Being capable of introspection
 - Being capable of pragmatism
 - Being capable of flexibility in thinking
 - Being able to find alternative solutions
 - Being able to take part in a process of continuous learning
- The ability to formulate life projects and have the determination to achieve them
 - Being able to identify one's own needs and expectations
 - Being able to envision the future and anticipate
 - Being able to set personal goals
 - Having the feeling of being useful and capable
 - Being capable of perseverance
 - Showing an optimistic attitude

2. External resources

2.1. Interpersonal resources

There is no resilience without a social network. The surrounding support mechanisms act as a buffer and provide a reservoir of resources allowing the individual to cope effectively with stress.

These factors are:

- family support and affection
- significant and satisfying friendships
- positive relationships with colleagues

- solidarity and support provided by colleagues
- integration in a professional network allowing the exchange and sharing of experiences

2.2. Organisational resources

The structure and procedures of an organisation may also play a role in the conditions affecting the resilience and post-traumatic growth of individuals confronting difficult situations.

Organisation-related factors having a protective effect are:

- ❑ visible and consistent operating rules
- ❑ effective communication between peers as well as with the administrative hierarchy
- ❑ opportunities to express opinions, needs and expectations
- ❑ the existence of conflict-resolution mechanisms
- ❑ function, status and position that are clearly defined and recognised (job description, role, duties, objectives)
- ❑ availability of means appropriate to the defined duties and objectives
- ❑ opportunities for positive social contacts
- ❑ opportunities for continuous learning

Bibliographie

Abaakouk Z. (2005), «Guide gestion émotionnelle et intervention après un incident critique », Médecins Sans Frontières-Espagne

Amloot L. (2005), «You are stressed?», Humanitarian operations courses, Handicap International-Belgique

Antares Foundation (2005), «Managing stress in humanitarian workers», <http://www.antaresfoundation.org/download/Managing%20Stress%20in%20Humanitarian%20Aid%20Workers%20-%20Guidelines%20for%20Good%20Practice.pdf>

Attorney-General's Department (2003), «Preparing for the unexpected», Emergency Management Australia (EMA), <http://www.ema.gov.au/agd/ema/emaInternet.nsf/0/C7AF0EEDB2B58615CA256CC200CF078?OpenDocument>

Bierens de Haan B. (2005), « Sauveteurs de l'impossible. Un engagement à haut risque », Belin

Bierens de Haan B. (1997), "Providing support for Red Cross volunteers and other humanitarian workers following a security incident or a disaster", International Review of the Red Cross, no 318, p. 311-323

Bierens de Haan B. (1998), «Le débriefing émotionnel collectif des intervenants humanitaires : l'expérience du CICR», Archives suisses de neurologie et de psychiatrie, 1998 ;149 :218-28

Bierens de Haan B., Van Beerendonk H., Michel N. et Mulli J.-C. (2002), « Le programme de soutien psychologique des intervenants humanitaires du Comité International de la Croix-Rouge (CICR), La Revue Française de Psychiatrie et de Psychologie Médicale, Février 2002, Tome VI, N° 53

Bryce P. C. (2001), "Insights into the concept of stress", Emergency Preparedness and Disaster Relief Coordination Program, Pan American Health Organization, World Health Organization, Washington D.C., <http://www.paho.org/English/DD/PED/stressin.htm>

CARE Aceh (2005), "Natural disaster safety guidelines", EPO Office, Alexandre_carle@hotmail.com

Cottraux, J. (1993), « Ces pensées qui nous emprisonnent », Psychologies, Numéro 111, Juillet 1993, http://www.acsm-ca.qc.ca/mieux_v/images/DD01/DI-188.pdf

Crocq L. (1999), « Les traumatismes psychiques de guerre », Paris, Editions Odile Jacob

De Soir E. (2004), « Marqué au cœur », Antwerpen-Appeldoorn, Garant.

De Soir E. (2003) , « Cadre conceptuel pour l'aide psychosociale en situations d'exception traumatogènes : la prévention primaire, secondaire et tertiaire de traumatismes psychiques », Année 1, Numéro 2, Janvier 2003, JIDV. COM, [http://www.jidv.com/EDITO%20-%20JIDV%202003%201%20\(2\).htm](http://www.jidv.com/EDITO%20-%20JIDV%202003%201%20(2).htm)

De Soir E., Fils J-F. (2004), « Le débriefing psychologique est-il dangereux ? », Année 2, Numéro 3, Juillet 2004, JIDV.COM N°7, [http://www.jidv.com/DE_SOIR,E-JIDV2004_2\(3\).htm](http://www.jidv.com/DE_SOIR,E-JIDV2004_2(3).htm)

De Soir E., Vermeiren E. (2002), "Les débriefings psychologiques en question...", Antwerpen-Appeldoorn, Garant.

Ehrenreich J. H. (2005), "The humanitarian companion". A guide for International Aid, Development and Human Rights Workers", Great Britain, ITDG Publishing

Emory University (2005), "Safety and Security Handbook", Rollins School of Public Health, Atlanta, <http://www.sph.emory.edu/gh/Safety%20&%20Security%20Handbook%5B1%5D%5B1%5D.doc>

Fédération Internationale des Sociétés de la Croix Rouge et du Croissant Rouge (2001), "Gérer son stress sur le terrain", <http://www.ifcr.org/pubilcat/catalog/autogen/4773.asp>, <http://www.ifcr.org/what/health/psycholog/stress.asp>

Figley C.R., Kleber R.J. (1995), "Beyond Trauma: Cultural and Societal Dynamics", Plenum Press, New York

Fillot A. (2005), « L'urgence de prévoir », Médecins Sans Frontières-Belgique

Fillot A. (2005), « Critical incident intervention. Step by step. For SMS team leaving », Médecins Sans Frontières-Belgique

Giroux A. (2006), « Le prélude au burn-out : le burn-in! », <http://www.latoiledesrecruteurs.com/newsletter/prelude-au-burn-out-le-burn-in-ou-le-presenteisme-au-travail-l-fr-i-436.html>

Human Resources Branch (1997), "Resources Guide for Critical Incident stress and Debriefing in Human Service Agencies", Department of Human Services, Melbourne, <http://www.health.vic.gov.au/archive/archive2004/96ma124/downloads/96ma124.pdf>

International Federation of Red Cross and Red Crescent (2001), "Managing stress in the field", <http://www.ifrc.org/what/health/psycholog/stress.asp>

Johannes M. (1993), "Helping the helpers", Kansas State University, Kansas, <http://www.oznet.ksu.edu/library/hlsaf2/mf1140.pdf>

Josse E., (2004), "Le trauma. Guide de prise en charge psychosociale », Médecins Sans Frontières- Belgique, document interne.

Josse E. (2004), "Le traumatisme psychique. Théorie », Médecins Sans Frontières-Belgique, document interne.

Josse E., sur <http://www.resilience-psy.com> :

- Le stress, c'est quoi ? Première partie : Le stress, c'est quoi exactement ?
- Le stress, c'est quoi ? Deuxième partie : Existe-t-il différentes formes de stress ?
- Le stress, c'est quoi ? Troisième partie : Quelles sont les conséquences du stress dépassé ?
- Le stress, c'est quoi ? Quatrième partie : Le stress traumatique, c'est quoi ?
- Le stress. Quelques repères notionnels
- Les expatriés dans la tourmente. Le stress humanitaire
- Les expatriés à l'épreuve des séismes
- Comment faire? Le débriefing psychologique des expatriés affectés par un incident critique
- Comment gérer le stress dépassé lié à l'expatriation ?
- Comment gérer le stress traumatique survenant dans le cadre d'une expatriation ?
- Le défusing du personnel expatrié affecté par un incident critique
- Le débriefing psychologique dans un cadre professionnel
- Le soutien immédiat et post-immédiat des expatriés affectés par un incident critique
- Le soutien psychosocial des équipes humanitaires. De l'incident critique à la prise de décision

Légeron P. (2001), « Le stress au travail », Paris, Editions Odile Jacob

Maquéda F. (1997), « Le vécu du traumatisme chez des « soignants » (volontaires) en situation d'intervention « humanitaire » », in « Les traumatismes dans le psychisme et la culture », sous la dir. De Doray B. et Louzoun C., Ramonville Saint-Agne, France, Editions Erès

Munro L. (2007), "Absenteeism and presenteeism: possible causes and solutions", APRIL 2007 volume 45 number 1, "The south african radiographer", <http://www.sar.org.za/index.php/sar/article/viewFile/76/82>

Ouss-Ryngaert L., Dixméras J.-P. (2003), « Que vivent les équipes dans les situations extrêmes ? » in « Soigner malgré tout », Baubet T., Le Roch K., Bitar D., Moro M.R, France, Editions La Pensée Sauvage.

Peace Corps (1999), "Crisis Management handbook", http://www.globaled.us/peacecorps/crisis_h.html

People In Aid (2005), "Managing people under pressure. On day symposium. Report"

People In Aid (002), « Supporting aid's psychological casualties », <http://www.peopleinaid.org/download/French%20translations%20January2002.pdf>

People In Aid (2002), "Debriefing to support aid workers after trauma" <http://www.peopleinaid.org/download/French%20translations%20January2002.pdf>

Reuters Foundation (2002), « Managers must help aid staff cope with stress », <http://www.alertnet.org/thefacts/reliefresources/392006.htm>

Santé Canada (2004), « Se préparer et intervenir face à un incident traumatique au travail : Guide électronique pour gestionnaires », Bureau des Services d'aide aux employés (SAE), http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/empl/trauma/e_guide-man_gest/index_f.html

Santé Canada (2004), « Se préparer et intervenir face à un incident traumatique au travail : livret pour gestionnaires », Bureau des Services d'aide aux employés (SAE), http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/empl/trauma/man_hand-livret_gest/index_f.html

Slotkin R. (1992), « Gunfighter Nation : The Myth of the Frontier in Twentieth-Century America », University of Oklahoma Press, Norman

United Nations, Office of Human Resources Management (1998), « Mission readiness and stress management », NY, <http://www.un.org/Depts/OHRM/stress.htm>

United Nations Department of Peace-keeping Operations (1995), "Stress management booklet", NY, http://www.the-ecentre.net/resources/e_library/doc/UN%20Stress%20Management%20Booklet.pdf

UNHCR (2001), "Managing the stress of humanitarian emergencies", Staff Welfare Unit, Career and Staff Support Services, Geneva, [http://www.reliefweb.int/rw/lib.nsf/db900SID/LGEL-5G8JQH/\\$FILE/unhcr-stress-jul01.pdf?OpenElement](http://www.reliefweb.int/rw/lib.nsf/db900SID/LGEL-5G8JQH/$FILE/unhcr-stress-jul01.pdf?OpenElement)

Groupe URD Urgence Réhabilitation Développement, "Gérer stress et santé", <http://www.urd.org/rech/securite/stress.htm>

Webmaster (2005), « Faire face au stress sur le terrain », <http://www.secourisme.net/article184.htm>

Wikipédia, «Syndrome d'épuisement professionnel», http://fr.wikipedia.org/wiki/Syndrome_d'%C3%A9puisement_professionnel#cite_note-5