

# Becoming a More "Self"ish Caregiver: No Really!!

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Nothing can be more rewarding nor more taxing on our personal resources than providing solid, consistent, nurturing, supportive care to another human being. This can be true whether that person is a client or a family member, or whether you are responding to a crisis or a more chronic situation. During the course of their work most professionals have encountered the phrase "vicarious traumatization," and heard the importance of self-care. Family caregivers may or may not ever have been reminded to take time for self and rejuvenation. Most of us know that without attention to ourselves, it becomes untenable to provide constant care to another. So why come to another "self-care" workshop? Why hear yet again that you should place the oxygen mask over your own nose and mouth before you help someone else? The focus of this workshop is to examine the reasons why it is so difficult to utilize this information, and the obstacles that stand in our way of putting self-care into practice.

As a refresher: We know from the ecological model of psychological trauma (Harvey, 1996) that traumatic events have a great impact on immediate survivors as well those around them. A traumatic event acts like a stone thrown into water. Immediate survivors are at the center of impact. Partners, families, friends, caregivers and communities and social institutions comprise the rings around the center. Those who make up the rings closest to the survivor(s) are susceptible to secondary traumatic stress disorder or vicarious traumatization (Yassen, 1995.)

People are affected by traumatic and/or violent events in a variety of ways, depending on the individual. The most common post-trauma reactions can be grouped into six different realms of functioning: cognitive, psychological/emotional, physical, behavioral, spiritual/world view, and relational (Community Crisis Response Team pamphlet, 1999). Caregivers who experience vicarious traumatization may also experience reactions within those same six realms. Vicarious traumatization that is not addressed can lead to impaired personal and professional functioning. Caregivers' symptoms and reactions must be alleviated in order for them to be able to continue to provide their critical services.

What do we, as caregivers tell our clients about managing their post-trauma, post-crisis symptoms and reactions? We encourage them to activate their self-care skills, those they have used in the past and new skills they work to develop. This is the advice that we must also follow in managing our reactions to vicarious trauma. The repertoire employed is most beneficial when it includes self-care activities aimed at each of the six realms of

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functioning that can be impacted. For example, peer supervision/support groups can address the relational reaction of withdrawing from and difficulty trusting others. Exercise can address the physical reaction of fatigue, and behavioral strategies can help manage our fears and anxieties.

So why can we not take this not only well-intentioned but essential advice and run with it? There are a host of obstacles that make taking care of oneself in the face of clients or family members who are suffering feel almost impossible. These obstacles could be classified as 1) personal or psychological, 2) professional or role driven, and 3) environmental, societal or institutional. Of course these categories are not completely discreet and overlap to some degree.

In the personal domain: First of all, it is sometimes difficult to prevent vicarious traumatization symptoms because they insidiously ensnare the caregiver before s/he is aware. The precipitant of a caregiver's reactions may not be obvious. As helpers we are invested in our roles, in being needed, and in being important in those roles. We may have difficulties asking for help, acknowledging our own needs, or relinquishing the control and responsibility that seeking help may connote. Of course there are a panoply of ways our own personalities can shape our ability to see ourselves as worthy (or not) of self-care.

In the professional or role driven domain: The literature suggests that persons high in empathy may find it difficult to be sympathetic to their own needs, always putting others' needs first (Rubenstein, 1998). In the same vein, the role of mother or caregiver has become synonymous with self-sacrifice. Caregivers see themselves as not entitled to be selfish and not entitled to have the same kinds of needs our clients or charges have. This leads to the psychological and professional need to maintain a sense of separateness from our clients. This serves as a way to maintain professional distance, and to keep from perceiving ourselves as in the same circumstances as our clients. It also allows us not to minimize the other's circumstances by saying "me too." Professionally, we may never have had models of people who have taken adequate care of themselves. Finally, individuals who are drawn to this work and these roles, may in fact have done so as a means to work at and master the world of emotion. Our desire to understand, to control, to master our responses and reactions, may make it difficult to acknowledge our vulnerability to vicarious traumatization.

Finally in the Environmental/Institutional domain: Here we deal with things such as gender roles. For example, it may be difficult for women to put themselves first, in order to take self-care measures. There are a host of forces encouraging mental health professionals and other caregivers not to put any energy into their own well-being. Our clients and charges are often undervalued or marginalized in the society. Thus the venues in which we care for them (agencies, homes) are undervalued and under-resourced. The limited resources always place the caregiver in the dilemma of doing more with less.

Combined with all the reasons listed above, self-care may not even make it onto the priority list.

Sources:

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