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Beyond the Breaking Point: Examining the Pieces of Counselor Burnout, Compassion Fatigue, and Secondhand Depression

Steve T. Hunter

Hunter, Steve T., is professor of psychology and counseling and Hope for the Heart Chair of Biblical Counseling at Criswell College. As a professor, practitioner, and supervisor, he has dedicated his life to the counseling profession for over 20 years. His research interests are in the areas of depression, sexual addiction, and shame.

Abstract

The main purpose of this article is to introduce and define a new term: secondhand depression. Key aspects related to secondhand depression will be examined in order to distinguish it from other similar concepts (i.e., burnout and compassion fatigue). The article will also address how burnout and compassion fatigue contribute to secondhand depression. The final purpose of this article is to not only provide recommendations for counselors to be proactive in regard to self-care, but also suggest ways to move toward wholeness and health for those who have gone—beyond the breaking point.

Keywords: self-care, burnout, compassion fatigue, depression

An avalanche is a mass accumulation of snow, ice, and rocks descending rapidly down a mountainside. It can be triggered by such things as gravity, unsuspecting skiers, or hikers. The results can be devastating—even deadly. The same can be true in the life of a counselor. Counselors work with those who struggle with deep emotional challenges such as grief, anger, depression, abuse, and a myriad of other heartbreaking circumstances. At the same time, counselors cannot keep from taking on at least some of the pain of their clients in varying degrees. If left unchecked, this “accumulation of pain” can have unexpected and serious repercussions and the results can be catastrophic. It is similar to and as serious as the concept of secondhand smoke. It is similar to and as serious as the concept of secondary traumatic stress disorder (STSD).

The main purpose of this article is to introduce and define a new term: secondhand depression. Secondhand depression is beyond counselor burnout and compassion fatigue. Secondhand depression has all the characteristics and symptoms of clinical depression. It is the result of counseling, empathizing with, and walking alongside those with depression—perhaps the most emotionally draining issue in the counseling profession. A second purpose of the article is to examine and describe some

of the key aspects related to secondhand depression. The final purpose of the article is to provide recommendations for counselors in regard to self-care—to help keep their feet firmly planted on the mountainside, to help keep them from moving closer to the breaking point.

Moving Toward the Breaking Point

Burnout

In the beginning, there is burnout. Herbert Freudenberger (1974) originally coined the term *burnout*. He noticed this phenomenon in his own life and also in the lives of his coworkers who exhibited symptoms such as feelings of failure and exhaustion. He attributed the symptoms they were experiencing to the endless drain of energy as a result of direct contact with clients who were experiencing intense emotions due to devastating circumstances.

Pines and Aronson (1981) elaborated on this concept and defined burnout as a “physical, emotional and mental (i.e., attitudinal) exhaustion” (p. 202). According to Maslach and Jackson (1986), burnout is “a syndrome of emotional exhaustion, depersonalization, and reduced accomplishments that can occur among individuals who do ‘people work’ of some kind” (p. 1). No matter what the setting—private practice, schools, or agencies—counselors face emotionally draining demands with insufficient thanks or rewards in return. This is the very definition and primary cause of burnout over time—the sacrifice far outweighs the reward (Warnath & Shelton, 1976).

Burnout can erode a counselor’s confidence in self and others (Herman, 1997). If counselors have their identity wrapped up in their work, this could create the need for them to work even harder to feel competent and important, often at the sacrifice of self-care (Much, Swanson, & Jazazewski, 2005). This creates a vicious cycle as counselors run on an endless treadmill never really feeling that they are getting anywhere (Warnath & Shelton, 1976). Counselors are at great risk for burnout because of the very nature of the profession (Herman, 1997). However, one of the greatest contributors to counselor burnout is the inability of counselors to recognize the symptoms of burnout in themselves. They can recognize the warning signs in others, but not in themselves (Lawson, 2007). As a result, counselors have a greater potential to move closer to the breaking point—and beyond.

Compassion Fatigue

Beyond burnout is compassion fatigue. Although there are some similar characteristics and symptoms between burnout and compassion fatigue, compassion fatigue is significantly different (Figley, 2002a). Compassion fatigue can be described as burnout plus the accumulation of stress resulting from empathizing with clients over time (Portney, 2011; Sabo, 2006). The greater the ability to empathize, the greater the potential for compassion fatigue (Adams, Boscarino, & Figley, 2006). Another difference is that compassion fatigue sometimes “emerges suddenly and with little warning, and it is usually more pervasive than burnout” (Portney, 2011, p. 48). According to Portney (2011),

In addition to regular burnout symptoms, a person experiencing compassion fatigue can feel a loss of meaning and hope and can have reactions associated

with Post Traumatic Stress Disorder (PTSD) such as strong feelings of anxiety, difficulty concentrating, being jumpy or easily startled, irritability, difficulty sleeping, excessive emotional numbing, intrusive images of another's traumatic material. Past traumas can also be activated. Long-term effects include reduced empathy, diminished sense of personal safety, reduced sense of control, hopelessness, increased involvement in escape activities and chronic overeating, drug or alcohol use. (p. 49)

Compassion fatigue is the price of empathy. In other words, "In our effort to view the world from the perspective of the suffering, we suffer" (Figley, 2002a, p. 1434).

By and large, counselors fail to recognize the impact of this "suffering" both personally and professionally (Keim, Olguin, Marley, & Thieman, 2008; Lawson, 2007). Figley (2002b) characterized this as a "chronic lack of self-care" among psychotherapists (p. 1433). One reason for this chronic neglect is a lack of awareness. Counselors not only lack awareness regarding their own need for self-care, they also lack awareness related to the negative effect this has on their clients (Lee et al., 2007). If signs of burnout and/or compassion fatigue are recognized, many times these signs are minimized, trivialized (Pope & Vasquez, 2005), or inaccurately assessed (Dunning, Heath, & Suls, 2004). Mental health professionals are much less likely to accurately self-assess when they are mentally and emotionally distressed (Bennett et al., 2006).

In addition to a lack of awareness, some counselors make false assumptions—as do others about them. It is assumed that counselors are experts at caring for themselves because of how caring they are with their clients, but this is usually not the case (Barnett & Hilliard, 2001). According to Cormier, Nurius, and Osborn (2013), "it is *because* you care for others that you are prone to not care for yourself adequately" (p. 10). Instead, mental health providers oftentimes substitute unhealthy ways of coping for healthy habits (e.g., drugs and alcohol; Barnett, Johnston, & Hillard, 2005) and working even harder in a futile attempt to boost self-esteem and self-importance (Much et al., 2005; Valente & Marotta, 2005). Perfectionistic standards, unrealistic expectations, boundary issues, and the inability to say "no" are among the many other reasons counselors either deny or ignore their need for self-care (Deutsch, 1984; Hill, 2004; Lawson & Venart, 2005; McLean, Wade, & Encel, 2003)—and, there is loneliness. Loneliness, resulting from the choice to suffer in silence, may very well be the number one hazard in the practice of psychotherapy (Guy, 1987; Lushington & Luscri, 2001). As a result, burnout, compassion fatigue, and the neglect of self-care, both personally and professionally, inch counselors closer and closer to the breaking point.

Secondhand Depression

The breaking point is the step just before the point of no return. It is the point of maximum stress. It is the crisis point. When counselors reach this point, there is the opportunity to take several steps back in order to recuperate and regain what was lost through appropriate self-care. However, there is also the danger for some clinicians to see that point through a rearview mirror (Barnett, 2008; Johnson, Barnett, Elman, Forrest, & Kaslow, 2013).

What lies ahead—beyond the breaking point—is secondhand depression, a concept created by the author. The author defines secondhand depression as clinical depression resulting from counseling the depressed over time. Once a counselor moves

beyond the breaking point, there is no short-term fix. There is no longer the opportunity to take several steps back in order to recuperate. Recovery requires much more. Based upon personal observations as a caregiver to caregivers and as someone who experienced secondhand depression firsthand, the author has identified seven variables or aspects associated with secondhand depression for consideration. Counselors with secondhand depression may experience some or all of the following characteristics.

First, secondhand depression entails burnout and everything associated with the everyday stress of just being in the counseling profession, including the counseling environment and the very nature of the work of a counselor. This is in addition to the counselor's own stress from daily living.

Second, it entails compassion fatigue and everything associated with a counselor accumulating a residue of intense and painful feelings from empathizing with clients. This is in addition to the counselor's own intense and painful feelings from the past and present, including intense and painful feelings triggered by specific clients and/or particular client issues.

Third, secondhand depression entails the accumulation of the negative and distorted thinking of depressed clients over time. Although the phrase does not exist in the literature, the process can be called "counselor-client convergence." Counselors spend an inordinate amount of time with clients who share cynical, jaded, pessimistic, and negative thinking. This repeated interaction can result in a convergence of the counselor's own thinking with that of their clients—even to the point of depression.

Fourth, secondhand depression is severe. Secondhand depression is distinct from both burnout and compassion fatigue because of two important reasons: severity and length of recovery. The counselor who has moved beyond the breaking point into the depths of depression can no longer manage his or her own thinking or feelings, much less the negative thinking and painful feelings of clients entrusted to his or her care. Secondhand depression is clinical depression as a result of counseling, serving, empathizing with, and walking alongside multiple depressed clients over the course of multiple sessions. Wurtzel (1996) stated that:

Depression . . . involves a complete absence: absence of affect, absence of feeling, absence of response, absence of interest. The pain you feel in the course of a major clinical depression is an attempt on nature's part . . . to fill up the empty space. But for all intents and purposes, the deeply depressed are just the walking, waking dead. (p. 22)

Amen and Routh (2004) defined depression as:

Excessive activity in the brain's emotional center, the deep limbic system. This type is associated with primary depressive symptoms that range from chronic mild sadness (dysthymia) to the devastating illness of major depression. (p. 10)

According to the American Psychiatric Association (APA; 2013), regarding the diagnostic criteria for major depressive disorder, a person must experience five or more of the following symptoms for a continuous period of at least two weeks: feelings of sadness, hopelessness, depressed mood, loss of interest or pleasure in activities that used to be enjoyable, change in weight or appetite (either increase or decrease), change in activity either psychomotor agitation (being more active than usual) or psychomotor retardation (being less active than usual), insomnia or sleeping too much, feeling tired or

not having any energy, feelings of guilt or worthlessness, difficulties concentrating and paying attention, and/or thoughts of death or suicide. According to the APA (2013), five or more of these symptoms must be present daily or nearly every day with a significant disruption to daily life.

Fifth, a significant indication of the severity of secondhand depression is the thoughts, the desire, and/or the attempt on the part of the counselor to end his or her life. The number of deaths from self-harm worldwide were more than deaths as a result of war, natural disasters, and murder (Global Burden of Disease Study, 2010). It is important to note that the Global Burden of Disease Study (2010) attributed the rise in the suicide rate to one specific group of people—men and women ages 45 to 64. The suicide rate for this group of people has increased 30%. For men in this age group, the suicide rate has increased more than 50%. Suicide is a reality for people in all walks of life, including those in the mental health profession.

Joiner (2005) suggested three interacting factors contributing to suicide that also describe the life and work of a counselor. The first aspect is loneliness or isolation, what he calls “low belongingness.” It is the feelings of disconnection, detachment, or disengagement even when the person, or counselor, is inundated with people all day, every day. A second contributing factor is what he calls “burdensomeness.” It is the feeling on the part of the person, or the counselor, that he or she can no longer contribute, or contribute effectively and efficiently, according to personal expectations and/or the expectations of others (Joiner et al., 2002). Finally, there is the desire and the ability to take one’s own life—what he calls “fearlessness” (Joiner, 2005). He mentions specifically doctors, athletes, and the military—anyone who learns to hold in the pain—as being more prone to be in this category. This definitely includes mental health professionals who not only deal with their own pain, but also the pain of others. The “courage” to commit suicide becomes greater than the inability to cope with the pain (Joiner et al., 2002).

Sixth, there are personal crises or family crises at a time when the counselor is most vulnerable. The counselor suffering from secondhand depression has become so flooded and so overwhelmed that he or she is unable to manage his or her own personal thoughts and feelings and crises of life. Normally, the counselor would be able to manage these kinds of events. However, with all defenses down, a difficult and unexpected event or series of events is the catalyst that pushes the counselor beyond the breaking point.

Finally, secondhand depression requires intense, long-term care. The counselor must disengage from all counseling responsibilities and embark on a personal journey toward wholeness and healing. It is one of the most difficult battles a counselor will ever have to fight.

In summary, the author describes secondhand depression as clinical depression with similar symptoms and characteristics. At the same time, there are significant differences between secondhand depression and clinical depression in at least three distinct categories: a specific etiology, a specific population at risk, and significant barriers to treatment. First of all, a specific and significant contributor to the etiology of secondhand depression is counseling those who are depressed. In essence, depression begets depression for a specific population—mental health providers—who are potentially at risk for depression. One survey reported that approximately 60% of psychologists continued to provide services even when exhausted or distressed at

potential risk to their clients (Pope, Tabachnick, & Keith-Spiegel, 1987). Epstein and Bower (1997) suggested the likelihood that 60% of therapists will experience depression at some point in their lives.

In addition to a specific etiology and population, a third difference between secondhand depression and clinical depression is in the category of significant barriers to treatment. One significant barrier to treatment is related to finances. In many instances, counselors are not only experiencing increased workloads, they are also being grossly underpaid (Lloyd, King, & Chenoweth, 2002; Trippany, Kress, & Wilcoxon, 2004). According to Lambie and Young (2007), a counselor required to see 35 clients a week in some agencies “faces stresses and work hours similar to a first year lawyer in a large firm, without the mitigating effects of financial compensation” (p. 101). Ironically, an hour of personal counseling for many counselors is an hour they simply cannot afford. Secondhand depression requires more intensive and long-term care. Stepping away from counseling responsibilities could potentially result in an end to a counselor’s livelihood; thus, creating a significant financial barrier to treatment.

Another significant barrier to treatment that differentiates secondhand depression from clinical depression is best described as a professional stigma, or a professional rejection, of colleagues who seek help. This distancing serves to perpetuate a “culture of silence” (Barnett, Doll, Younggren, & Rubin, 2007; Elman, 2007). Ironically, the counseling culture is an environment where clinicians do not typically share their struggles (Barnett & Hillard, 2001) and where fellow counselors do not usually reach out to help (Floyd & Myszka, 1998). O’Connor (2001) stated:

Public discussion of personal mistakes we commonly make in our craft is rare. Analytical discussion about psychological theory or psychotherapy cases may be more common. And this is the model we commonly provide our trainees, thereby ensuring an ongoing silence. (p. 347)

Changes are needed in the counseling culture to tear down these barriers of judgment and indifference (Handelsman, Gottlieb, & Knapp, 2005). This is especially true for “John.” His name has been changed, but his story of secondhand depression is real.

A Case Study

Dr. John Smith is a licensed psychologist. He has been a mental health provider for over 25 years. He is 57 years of age, in private practice. He also teaches adjunctively at a local college to try and make ends meet. He is married and has four children. The stress of two kids in college in addition to his other bills and a struggling private practice was taking its toll on his physical health and his marriage. He was counseling two seriously depressed clients who lost everything. They were unable to pay on a regular basis. He was counseling a suicidal client who attempted suicide and counseling another client with deep-seated issues of shame and mild depression. It got to the point where he could not manage his own negative thoughts or feelings and fears about the future. He often thought of suicide—almost daily. After a month of steady decline, John finally reached out for help. He was diagnosed with clinical depression. He told his counselor, “I went beyond the breaking point. My client’s depression became my depression. Their symptoms became my symptoms. My worries became just like their worries.” His counselor encouraged him to write down some of those worries during one of his many sleepless nights. The following are his words:

I would rather be sleeping but I can't let this go. My counselor asked me to write down my thoughts at night when I couldn't sleep. I really hate that guy. I wish my wife would hold me tight and tell me everything is going to be okay. I'm so afraid of losing everything. I have already lost my health. Will I ever be the same? Will I ever be able to work again? Am I going to lose my home? My practice?

My wife can't handle my moodiness. I am sick. I am depressed. I am so lonely. I feel so discouraged. I don't want to go on. I can't take this anymore.

Where is God in all of this? He has abandoned me as well. Church people tell me not to worry. Be strong. You shouldn't feel this way. God works all things for good. Just think positive. Just have faith. Take your eyes off of yourself. Stop being so selfish. You don't have anything to be sad or depressed about. Why don't you volunteer to help others? And a colleague who said, "You should have known better." It cut like a knife.

Everyone is disappointed in me. I can't take the disappointment anymore. My wife is disappointed in me. My parents are disappointed in me. My kids are disappointed in me. And my clients. I can't stop worrying about them. Are they okay? Will I ever counsel anybody again? I'm such a failure.

I am alone and unloved. I work myself to death to meet the needs of others and they are never satisfied. I work so hard and I fail so often even though I try so hard. Good enough is never good enough. I hear it every day. I experience the rejection and neglect and disappointment every day.

No one ever asks if I need help. No one ever asks for my opinion. I talk and no one listens. No one responds. I am completely ignored as if I don't exist. No one asks about my dreams and goals and desires. Not ever. I am only of use when I help meet the needs and the agendas of others. Good enough is never good enough—ever.

I don't have anything left to give. I have dreams and goals. I want to be loved and accepted and hugged. I wish someone would hug me and tell me that everything is going to be okay. Anyone. I feel so alone. The world would be a better place without me. I just wish the pain would end. I don't want to live anymore. God, please don't let me wake up.

After losing his practice, selling his home, having a mild heart attack, and being two years on the road to recovery, Dr. Smith still has not gotten back to the point where he can see clients again, but he is close. He is a real unsung hero. After going beyond the breaking point, he has dedicated himself to wholeness and health and putting the pieces of his life back together. He has said more than once, "this has been the most difficult time in my entire life—no other time in my life even comes close." His first step toward healing was to recognize the signs.

Moving Toward Wholeness and Health

Recognizing the Signs

It is necessary for counselors to recognize the signs and symptoms of burnout, compassion fatigue, and depression in their own lives—not just in the lives of their clients. In an excellent article in *Counseling Today*, Shallcross (2011) interviewed Leslie Kooyman, Assistant Professor of Counseling and Educational Leadership Department at Montclair State University. Kooyman stated that feelings of resentment toward certain clients or feeling burdened by certain clients can be warning signs of burnout or fatigue. Other warning signs might include such things as: becoming sloppy with administrative details, neglecting case notes, starting sessions late and ending late, and/or missing appointments. Other warning signs include such things as: exhaustion, problems at home, and losing your sense of humor (Shallcross, 2011). In the case study above, Dr. Smith recognized the warning signs. Unfortunately, it was too little too late. Once the signs and symptoms are recognized and acknowledged, it is probably unrealistic to expect that many counselors will get the help they need, and in a timely fashion—just like in the case with John. Hence, it is crucial that counselors are members of communities where they can be transparent, receive empathy, and be held accountable in order to move toward wholeness and healing.

Community

In all forms of psychotherapy, whether individual, marital, family, or group therapy, there is power and healing in simply acknowledging the existence of a problem. Transparency, the act of admitting struggles and challenges, has significant psychological and physical benefits (Pennebaker, 1990). More often than not, however, counselors feel lonely, isolated, and disconnected. According to Warnath and Shelton (1976):

During their education and training, counselors learn the value and absolute necessity of quality relationships in the therapeutic process. However, counselors find themselves isolated from others in their educational institutions and in their agencies. They are psychologically distanced from faculty in their previous academic settings. They are distanced from their administrators. They are distanced from the population they serve because of the potential for dual relationships and the importance of remaining professional in the services they provide. They are distanced from their fellow counselors because of a fear to be vulnerable and the possibility of being incompetent or inadequate. (p. 173)

Counselors may also feel distant, isolated, and disconnected in their relationships at home because they simply have no emotional energy left to give the significant others in their lives. Figley (2002a) stated, “It is vital to increase the therapist’s support system in both numbers and variety of relationships so that she or he is viewed apart from the therapist persona” (p. 1439). Counselors need assistance from time to time, and emotional support—just like everyone else (Maslach & Leiter, 1997; Skovholt, 2001). Counselors empathize as a precious gift; they also need the precious gift of empathy.

In my own personal journey of self-care, it took at least a month to reconnect with my thoughts and feelings and begin to share those openly in a depression recovery group. The same was true for John. His head and heart were filled with fear and anxiety. The rewards for sharing openly with others were far greater than the risks—for both of us.

Community provides support, encouragement, empathy, accountability, and awareness (Johnson et al., 2013). Community also helps promote mindfulness—the next self-care recommendation.

Mindfulness

There is growing research and evidence to support a method of self-care that involves greater self-awareness. This practice is called mindfulness (Wenzlaff, 2005). The process of mindfulness is “keeping one’s consciousness alive to the present reality” (Hanh, 1976, p. 11). One strategic and effective way to be more mindful is to focus on breathing and breathing techniques.

Thompson (2015) expanded on this self-awareness technique by describing the “4-7-8 Breathing Exercise.” The initial steps involve sitting up straight and placing the tongue just behind the upper front teeth. It is important to keep the tongue in that spot throughout the exercise. The next steps are as follows:

- Exhale completely through the mouth, making a whoosh sound.
- As the mouth is closed, inhale quietly through the nose to a mental count of four.
- Hold in that breath for a count of seven.
- Exhale completely through the mouth, making a whoosh sound to a count of eight.
- This is one breath. Now inhale again and repeat the cycle three more times for a total of four breaths.

The time spent on each phase is not important; the ratio of 4:7:8 is important. With practice, the process can be slowed down in order to inhale and exhale more and more deeply.

How important is this simple exercise? Dr. Fred Luskin and Dr. Kenneth Pelletier (2005), Senior Consultants in Health Promotion at Stanford University, agree that this simple practice is one of great importance when it comes to self-care, self-awareness, and relieving stress. This breathing technique helps to release the “fight or flight” impulses when experiencing feelings of anxiety (Luskin & Pelletier, 2005). In Dr. Smith’s case, he wanted out—permanently. The combination of deep breathing with an “attitude of gratitude” is a simple, effective, mindful exercise. For John, this technique was literally a lifesaver. In addition to deep breathing, self-care also requires “getting off the couch” to maintain and/or move toward wholeness and health.

Diet, Exercise, and Sleep

Proper diet, exercise, and sleep are major weapons in the battle against depression. When it comes to diet, a good place to start is with caffeine and sugar. According to a review of literature conducted by Dr. Pamela Broderick, a member of the Oklahoma State Medical Association, “Caffeine is a widely used psychoactive substance that has the potential to contribute to many psychiatric symptoms,” including symptoms of depression (Broderick & Benjamin, 2004, p. 538). Sugar intake has been linked to depression as well. In a national study by Westover and Marangell (2002), the national rate of sugar consumption was shown to directly affect the prevalence of major depression.

In addition to changes in diet, exercise has been shown to contribute to a number of beneficial physiological effects that help in treating depression. Studies have shown

that exercise increases levels of serotonin, dopamine, and norepinephrine (Caperuto, Mello, & Costa Rosa, 2009). Physical activity should last at least 20 minutes a day for at least 10 weeks in order to help improve psychological well-being. Studies have shown that regular exercise—aerobic, strength, or flexibility training can reduce the symptoms of mild-to-moderate depression. Exercise has also been shown to reduce the symptoms of major depression. Some studies even suggest that exercise may work as well as psychotherapy for people with mild-to-moderate depression (Babyak, Blumenthal, & Herman, 2000). It may be that diet and exercise are among the most important “pills” in treating depression; especially, when taken with a third “pill”—sleep.

At least 90% of people with depression have disturbed sleep patterns (i.e., insomnia or hypersomnia; Tsuno, Besset, & Ritchie, 2005). Dr. Colleen Carney is an Associate Professor at Louisiana State University and conducts research examining the relationship between sleep and depression at the Ryerson Sleep and Depression Laboratory. Carney and Manber (2009) discovered that approximately 87% of patients who were able to cure their insomnia saw their depression symptoms disappear after 8 weeks of treatment. In John’s case, he mentioned that he not only worried about his clients, he worried like his clients. As a result, insomnia became one of the greatest contributors to his depression. He simply could not break free from his negative thoughts and feelings; at least, not until he followed through with the next recommendation for moving toward health and wholeness—professional counseling.

Professional Counseling

Burnout, compassion fatigue, and secondhand depression are serious. It is important for counselors to reach out for professional help when needed. For example, cognitive behavioral therapy (CBT) is a counseling process that helps to correct negative core-beliefs and negative thinking. Counselors identify, address, and help to reframe self-defeating and self-destructive attitudes and behaviors contributing to depression (Rupke, Blesko, & Refro, 2006). As a result of this process, CBT has also been shown to reduce relapse rates with those suffering from depression (Teasdale et al., 2001). In John’s case, one of the first homework assignments he was given by his therapist was to begin to identify his negative thoughts and feelings by putting them down in writing. He not only began to recognize how his clients’ negative thoughts and feelings, worries, and fears were contributing to his depression, he also began to recognize how his own unresolved pain was contributing to his depression. This is a critical part of the process of substituting healthy thoughts for negative thoughts to improve the depressed person’s mood, self-concept, and associated behaviors and attitudes. Medication can also be a helpful supplement to this counseling process. The combination of counseling and medication has been shown to significantly impact the treatment of severe or chronic depression (Rupke et al., 2006). This leads to the next important recommendation to move toward wholeness and health.

Medication

Whenever there is the diagnosis of depression, there is the need for a thorough medical checkup and the possibility of medication. Whenever there is the need for medication, there is always the need for a doctor’s supervision. The most common form of medication to treat depression is antidepressants. They work by bringing back the

chemicals in the brain to the right levels in order to relieve symptoms. Antidepressants primarily work on neurotransmitters in the brain, especially serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine (Cassano & Fava, 2002). Some of the newer and more popular antidepressants are called selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs). SNRIs tend to have fewer side effects than older antidepressants, but they sometimes can cause headaches, nausea, jitters, or insomnia when people first start to take them. These symptoms tend to fade with time. Some people also experience sexual problems with SSRIs or SNRIs, which may be helped by adjusting the dosage or switching to another medication (Wheeler-Vega, Mortimer, & Tyson, 2003). Though Monoamine Oxidase Inhibitors (MAOIs) are the oldest class of antidepressant medications, they can sometimes be very helpful for people with treatment-resistant depression, or certain forms of depression with anxious feelings or panic and other specific symptoms (Rush et al., 2006).

All antidepressants must be taken for at least four to six weeks before they have a full effect. Some medications need to be gradually stopped to give the body time to adjust. Although antidepressants are not habit-forming or addictive, suddenly getting off an antidepressant can cause withdrawal symptoms or lead to a relapse of depression. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely even after they start feeling better (Trivedi et al., 2006). In other words, when it comes to medication, there is no magic pill or quick fix. Even with a combination of medication and counseling—the best of both worlds—there is no instant cure for depression. It takes time, which leads to the last recommendation to move toward wholeness and healing.

Time

The last suggestion for counselors battling burnout, compassion fatigue, and/or secondhand depression is to give it time. How long does it take to dig out of the depths of depression? In John's case, it has been over two years, and counting. Most of the time, it takes more time, energy, and effort than those moving toward wholeness and healing want to give. It takes more time, energy, and effort than family, friends, and employers want to give. According to Lockley (2002),

It usually takes many months, and in some cases even years, to recover. Patience is essential, because, by the nature of the illness, the depressed person is likely to go over the same ground time and again, needing the same reassurance that was given a day, a week or a month ago. (p. 338)

Progress can often be one step forward and three steps back. Progress can be undetectable by those suffering with depression and their caregivers. Progress takes the support and encouragement of a caring community. It takes the help of trusted and competent professionals. It takes the willingness to change—but most of all, progress on the road to wholeness and healing takes time.

Conclusion

Flight attendants remind their passengers to put on their own oxygen masks before helping children, the disabled, or persons requiring assistance. These are words of

wisdom for counselors as well. It is important for counselors to address their own personal needs for health and well-being before addressing the needs of others. This article addressed the progression from counselor burnout, to compassion fatigue, and ultimately, to secondhand depression—from the serious to the severe. Secondhand depression was defined, described, and distinguished from other similar concepts. The article also provided recommendations for how counselors could move toward deeper levels of wholeness and health.

Counselors do a masterful job of giving the world what it so desperately needs—care, empathy, support, encouragement, and gentle guidance. At the same time, counselors can serve, empathize, and walk alongside the hurting at the sacrifice of their own personal health and well-being. It sounds noble—even biblical. The reality is that the neglect of self-care has the potential to be one of the greatest disservices counselors can do—to themselves, to their loved ones, and to those they serve. If we are not careful, our profession can be the cause of debilitating stress that not only impacts our own personal health and well-being, but also the health and well-being of our closest relationships. However, an amazing and beautiful truth is that our profession can also be the cure—especially, if we find ourselves beyond the breaking point.

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