MOOC 2 – UNIT 3
Individual Training in Early Intervention Psychology,
as an Emergency Psychologist (EP)

Chapter 2
Recognition of Threatening and Protective
Factors in the Functioning of EP

Developed by Jan Kochanowski University (PL)

Chapter 2.
RECOGNITION OF THREATENING AND PROTECTIVE FACTORS IN THE FUNCTIONING OF EP

Introduction to the chapter

- The work of an emergency psychologist is burdensome,

- There are many factors that threaten one's own functioning, such as indirect traumatization or occupational burnout,

- In addition to the threatening factors, there are also protective factors,

- Being aware of the risk factors and resources allows you to better manage stress in the EP's work
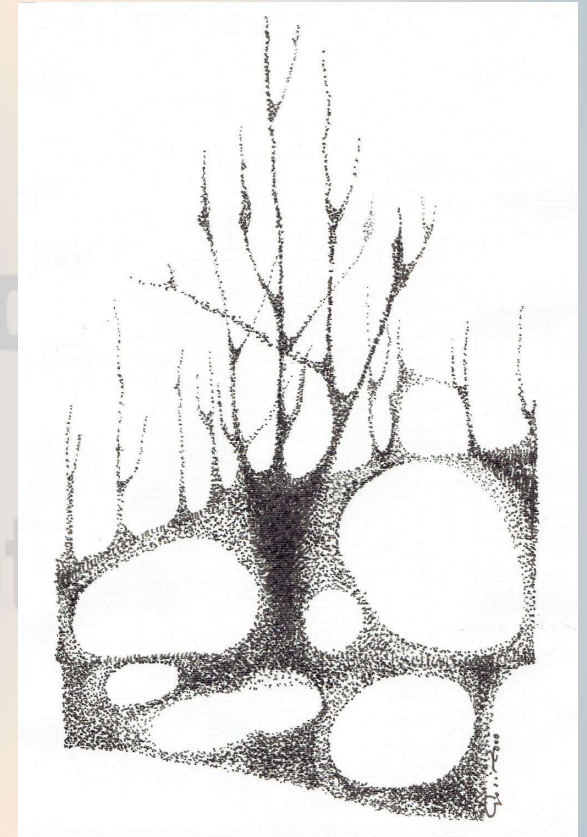
risk factors
- substitute traumatization
- burnout
- compassion fatigue

protective factors
- professional
- personal
- family and social

23
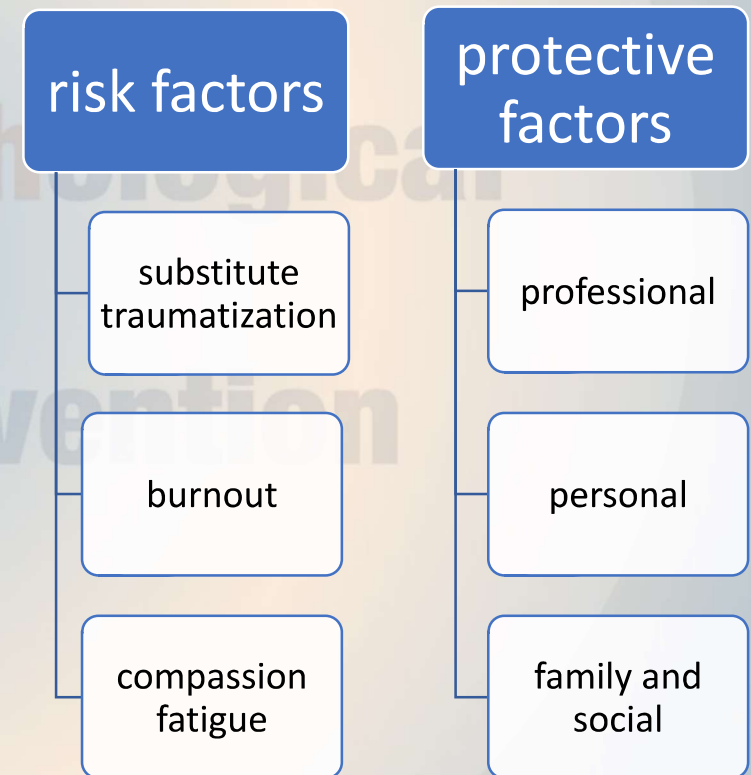
2.1. Risk Factors

A. **Indirect/replacement traumatization**

- EP constantly experiences confrontation with the experiences and relationships of people in crisis. This leaves traces of experience in the form of an impact on cognitive schemas (beliefs, expectations, assumptions about oneself and others) in helping people. This contributes to the emergence of a substitute trauma.

- The impact of a crisis event on the intervener's cognitive patterns depends on the level of satisfaction of his own needs.

- The patterns associated with the least satisfied need (the so-called central need) will be the most exposed to change.

- Example: When EP has a low sense of security, working with victims of crimes, accidents, disasters will violate and trigger the intervener's beliefs about their personal safety.
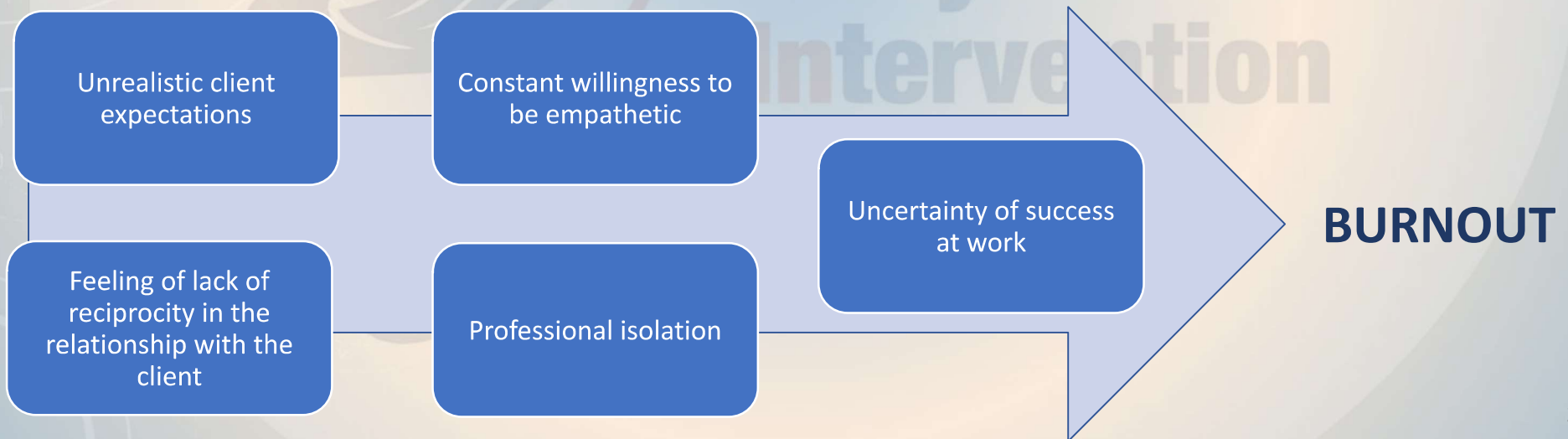
2.1. Risk Factors

B-1. Burnout

- The stress experienced at work requires countermeasures to maintain the mental and physical balance of the body.

- Incompetent coping with stress, accumulating stress, experiencing a difficult experience in professional practice (e.g. a patient's suicide) may take the form of a crisis. This chronic crisis is called **burnout syndrome.**

B-2. Burnout - risk factors

Unrealistic client expectations	Constant willingness to be empathetic	
Feeling of lack of reciprocity in the relationship with the client	Professional isolation	Uncertainty of success at work

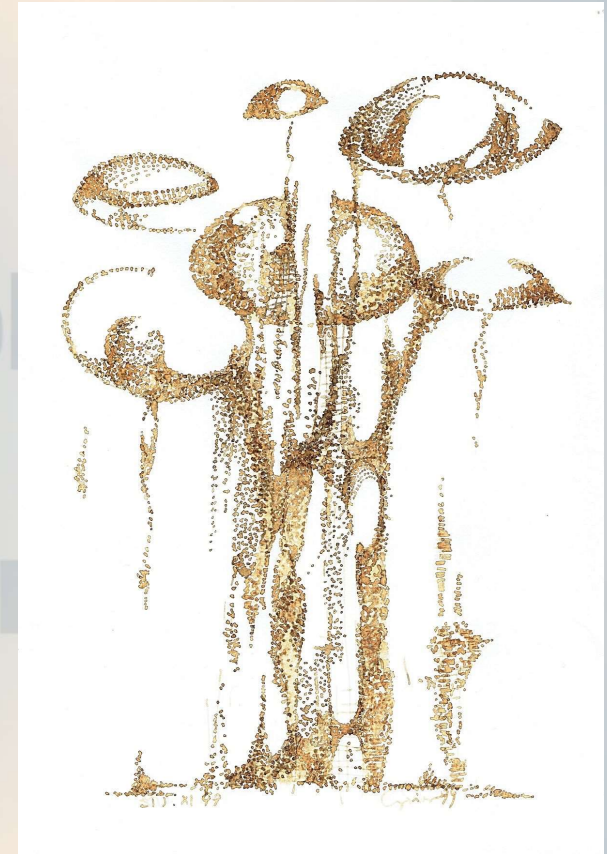**BURNOUT**

2.1. Risk Factors

B3. Burnout - phases:

a) **The phase of emotional exhaustion** - lack of satisfaction with the work performed, despite the successes achieved, and the accompanying somatic symptoms (chronic fatigue, headaches, insomnia, gastric disorders)

b) **Depersonalization phase** - the relationship with the client loses its current, subjective character, becomes impersonal (depersonalized). Intervener starts to avoid establishing contacts with clients, irritation, frustration, contempt and indifference appear. They blame the client for having suffered a difficult situation.

c) **The phase of lack of achievements at work** - there is a decrease in the quality of work. The employee tries to counteract this by increasing the time and intensity of work or by avoiding duties. More and more difficult emotions appear (hostility, uncontrolled outbursts of anger, increased number of conflicts with co-workers. Difficulty in seeing the relationship between one's mental state and poor performance at work. , sadness, aversion to the environment, helplessness may lead to depression, increased frequency of reaching for alcohol or other stimulants, gastrointestinal diseases / cardiovascular diseases and greater susceptibility to infections.

2.1. Risk Factors

C. Compassion fatigue

- Constant exposure to contact with people who experience traumatic events may result in the correction of one's own beliefs about the meaning of life, suffering, sense of justice, attitudes towards people and the world.

- Interveners are at risk of experiencing feelings and symptoms similar to the problems experienced by clients.

- Then a state of tension and concentration on the client and their experience begins to emerge.

- It manifests itself in the form of re-experiencing a traumatic event, which is accompanied by paralyzing action, nightmares, avoiding remembering the event. Meeting the client, which causes these symptoms, acquires an emotional significance for the intervener, which begins to reduce the distance to what the assisted person is experiencing.
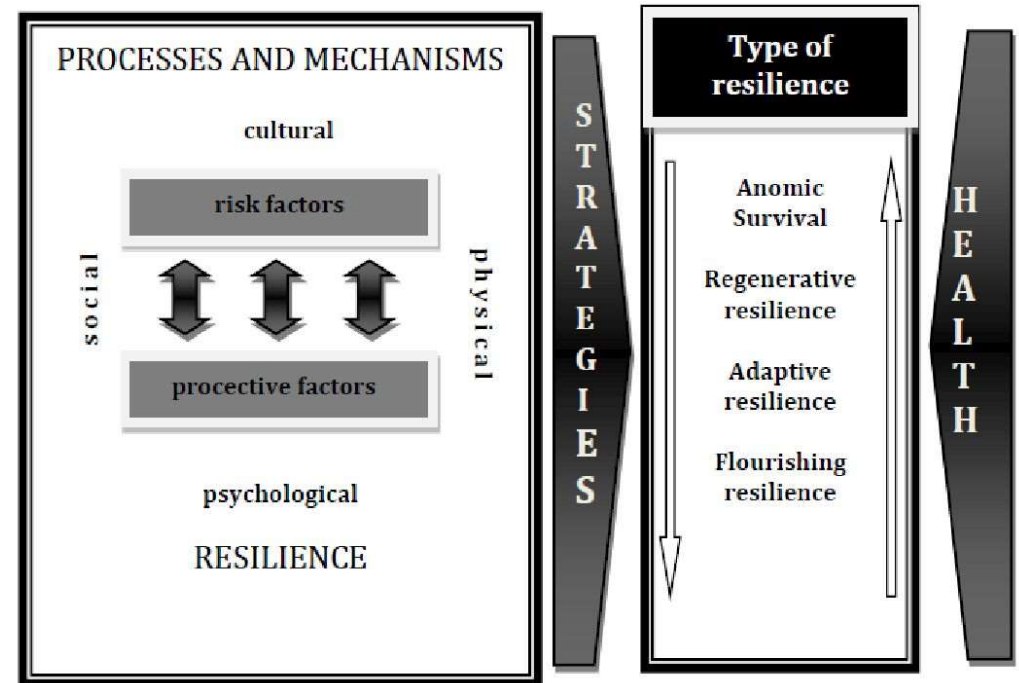
2.2. Protective Factors

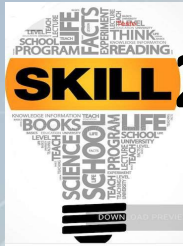| Professional	Personal	Family	Social
Participation in clinical supervision and team meetings	Awareness of what can happen to me when I help others	A family that supports and understands the specificity of the work performed	Having a reference group that encounters similar problems (colleagues, supervisory group)
Balancing the burden of contacts with the client with other professional activities, e.g. research work	Knowing your own psychophysical capacity, adjusting to your own needs		
Ability to set adequate work goals	Developing the skills of self-observation and analysis of one's own experiences		
Noticing the positive values of your own work, enjoying small successes	Knowledge of own coping strategies in difficult situations.		
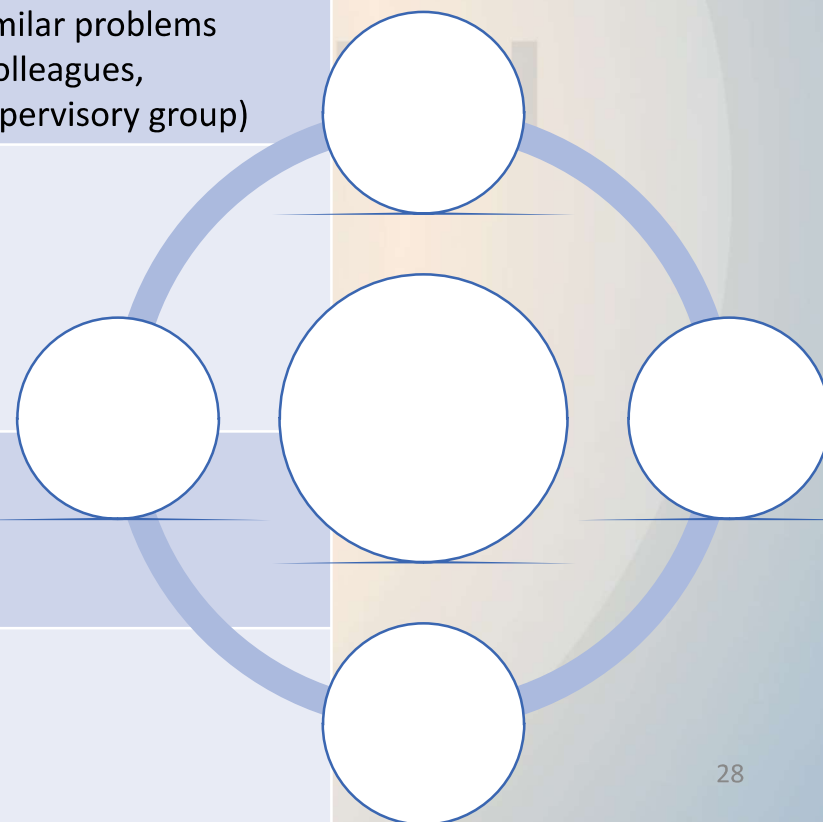
2.2. Protective Factors – Resilience 1

- The work of EP is burdened with severe stress and traumatization.

- The most important factor in protecting is resilience.

- Resilience is a variety of skills, strategies and competences related to dealing with trauma and adversities.

- Resilience is a personality trait. It is also a series of processes thanks to which an individual, family or community is able to cope with adversity.

read more: Southwick, SM, Bonanno, GA, Masten, AS, Panter-Brick, C, and Yehuda, R, (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives. European Journal of Psychotraumatology, 5: 25338 - http://dx.doi.org/10.3402/ejpt.v5.25338

2.2. Protective Factors –Resilience 2: Types of Resilience

Type of resilience	Major Life Areas			
	Homeostasis (Disruption and Balance)	Coping Strategies (Development and Internalization)	Relationship to Environment (Distancing and Accessing)	Use of Energy
Anomic survival	Constant state of crisis and disruption Continued need for repair	Little or no use of constructive coping strategies Consistent use of dysfunctional coping behaviors	Destructive cognitions and behaviors Diminished access to personal and environmental resources	Energy directed to survival and safety Little or no coherence or predictability to life
Regenerative resilience	Periods of some stability Crisis and disruption frequent Limited repair achieved	Formative development of constructive coping strategies Little integration and internalization	Sporadic constructive cognitions and behaviors Initiation of access to personal and environmental resources	Exceeding survival and safety needs frees energy for learning and integration Insight into self
Adaptive resilience	Sustained periods of stability and balance Some disruption, reassembly for growth	Regular use of competencies and coping strategies Some skills building needed Some integration and internalization	Regular use of competencies results in reciprocity between personal and environmental resources for growth and change	Reciprocity provides continual flow of energy to sustain birth of philosophical self
Flourishing resilience	Extended periods of stability and balance Sustained growth	Sustained use of effective cognitive and behavioral coping strategies Skills integrated and internalized	Enduring reciprocity and confidence between self and environment Flow of energy	Sense of coherence in life, enduring philosophical self Energy maximized

(4) TiP 2.2. Drill: vignette about a real case (Eve).

Source: Palmer, N. (1997). Resilience in Adult Children of Alcoholics: A nonpathological approach to social work practice. Health & Social Work, 22(3): 201-209