Vicarious Trauma, Secondary Traumatic Stress, or Burnout?

Implications for Mental Health Professionals

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Welcome

* Introduction of presenters

* American author James Baldwin (1963) wrote, “One can give nothing whatever without giving oneself, that is to say risking oneself” (p.100).

Objectives

* Brief review of trauma and PTSD
* Define terms; vicarious trauma, secondary traumatic stress, and burnout
* Identify symptoms of these constructs including risk factors
* Explore organizational prevention of vicarious trauma
* Learn considerations for professionals within the mental health and judiciary system including those working with sexual offenders
* Discuss self-care strategies

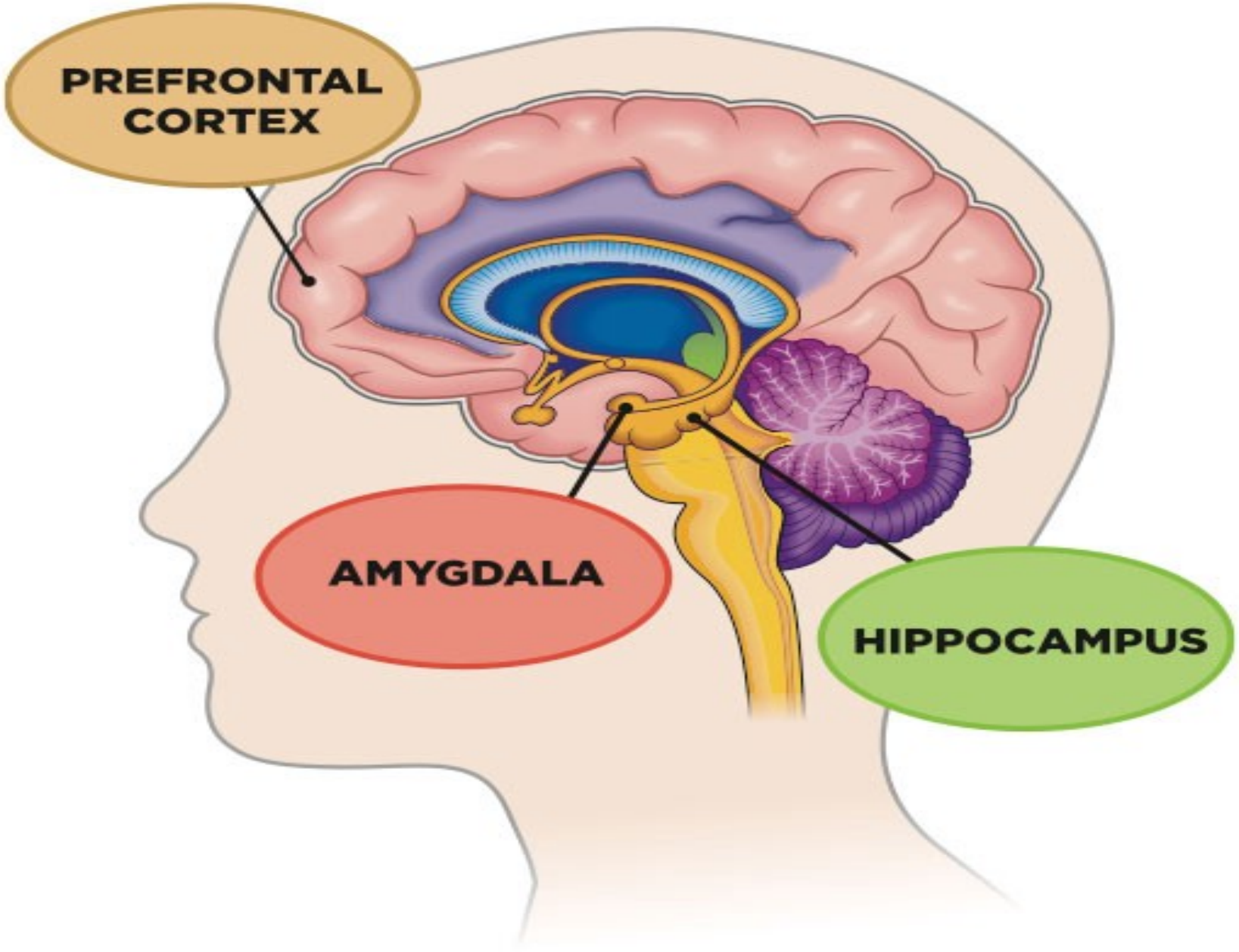

Intrusive memories
Hopelessness
Nightmares, Flashbacks
Startle response
Shame, self-hatred
Decreased concentration
Panic attacks
Insomnia
Numbing
Emotional overwhelm
Loss of interest
Trauma
Chronic pain, headaches
Irritability
Eating disorders
Depression
Substance abuse
Dissociation
Self-destructive behaviors
Little or no memories
Hypervigilance
Adapted from Janina Fisher

Trauma

* Deeply Disturbing or Distressing Experience
* Event that causes sense of horror and/or helplessness
* Threat to serious injury or death
* Sudden
* Unexpected
* Perceived as dangerous
* Diminishes our skills in coping

Trauma Cont.

* Single event
* Connected series of events
* Chronic lasting stress


PREFRONTAL CORTEX
AMYGDALA
HIPPOCAMPUS

Trauma and the Brain

* Adrenergic hyperactivity-Epi, NE, acetylcholine keep the stress response in play. Baseline often ramped up, and return to normal baseline levels is disrupted

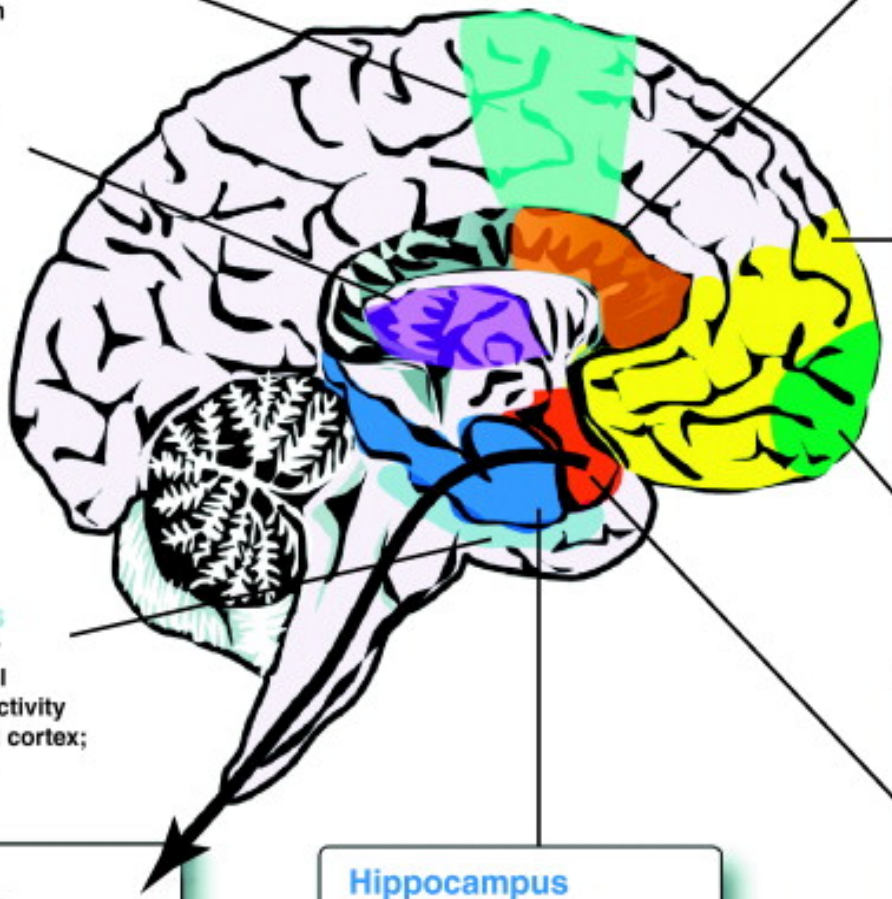
* Chronic cortisol dysregulation is unhealthy for many systems in the body (e.g. CV, GI, immune, adrenals)

Jackson, C. (2013). Recognizing and Preventing Vicarious Trauma: A Holistic Perspective. Penn Symposium.

Trauma and the Brain Cont.

* "Continuous activation of the SNS results in sustained autonomic arousal, and with repeated stressors, hyperactivity to subsequent stimuli" (Briere & Scott, 2013)
* Trauma changes brain structures + neural function. Limbic system (hippocampus and amygdala) and neurotransmitters e.g. serotonergic pathway function, lowered GABA levels [an inhibitory neurotransmitter that can reduce activation and excitability], thyroid hormone disruption

Jackson, C. (2013). Recognizing and Preventing Vicarious Trauma: A Holistic Perspective. Penn Symposium.



Sensorimotor cortex

Function: Coordination of sensory and motor functions
In PTSD: Symptom provocation results in increased activation

Thalamus

Function: Sensory relay station
In PTSD: Decreased cerebral blood flow

Parahippocampal gyrus

Function: Important for memory encoding and retrieval
In PTSD: Show stronger connectivity with medial prefrontal cortex; decreases in volume

Anterior cingulate cortex

Function: Autonomic functions, cognition
In PTSD: Reduced volume, higher resting metabolic activity

Prefrontal cortex

Function:
- Emotional
- Regulation

In PTSD:
- Decreased gray and white matter density
- Decreased responsiveness to trauma and emotional stimulia

Orbitofrontal cortex:

Function: Executive function
In PTSD: Decreases in volume

Amygdala

Function:
- Conditioned fear
- Associative learning

In PTSD:
- Increased responsiveness to traumatic and emotional

Fear response

Function:
- Evolutionary survival

In PTSD:
- Stress sensitivity
- Generalization of fear response
- Impaired extinction

Hippocampus

Function:
- Conditioned fear
- Associative learning

In PTSD:
- Increased responsiveness to traumatic and emotional stimuli


PTSD
flashbacks
post traumatic stress disorder
neuroendocrinology
numbing
disturbance
veterans
disorder
behavioural
drug addiction
falling
cognitive
fear
thinking
Feeling
detection
irritable
memories
criteria
avoidance
traumatic experience
mental health problems
distressing dreams
emotional
alternative
help
cortex
worse
survivors
thoughts
diagnose
risk
symptoms
severe
individuals
trauma
traumatic
psychological trauma
alcohol abuse
hypervigilance
anxiety
diagnostic
guilty
avoid
counselling
hippocampus
horror
accidents
death
anxious
psychological
trigger
treatments
arousal
acute
emotional numbing
intervention
loose

DSM-V
Posttraumatic Stress Disorder (PTSD)

* Criterion A. The person was exposed to; death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:
- 1. Direct exposure
- 2. Witnessing, in person
- 3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.

PTSD Cont.

* Criterion A cont.
- 4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures.

PTSD Cont.

* Criterion B. Intrusion (1/5 symptoms needed)
- 1. Recurrent, involuntary and intrusive recollections (children may express this symptom in repetitive play)
- 2. Traumatic nightmares

(children may have disturbing dreams without content related to trauma)

PTSD Cont.

* Criterion B (continued):
- 3. Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness (children may re-enact the event in play)
- 4. Intense or prolonged distress after exposure to traumatic reminders
- 5. Marked physiological reactivity after exposure to trauma-related stimuli

PTSD Cont.

* Criterion C. Persistent effortful avoidance of distressing trauma-related stimuli after the event (1/2 symptoms needed):
- 1. Trauma-related thoughts or feelings
- 2. Trauma-related external reminders (e.g. people, places, conversations, activities, objects or situations)

PTSD Cont.

* Criterion D. Negative alterations in cognitions and mood that began or worsened after the traumatic event
- 1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs)

PTSD Cont.

* Criterion D (continued):
- 2. Persistent (& often distorted) negative beliefs and expectations about oneself or the world (e.g. “I am bad,” “the world is completely dangerous”)
- 3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences

PTSD Cont.

* Criterion D (continued)
- 4. Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame)
- 5. Markedly diminished interest in (pre-traumatic) significant activities
- 6. Feeling alienated from others (e.g. detachment or estrangement)
- 7. Constricted affect: persistent inability to experience positive emotions

PTSD Cont.

* Criterion E. Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (2/6 symptoms needed)
- 1. Irritable or aggressive behavior
- 2. Self-destructive or reckless behavior

PTSD Cont.

* Criterion E (continued):
- 3. Hypervigilance
- 4. Exaggerated startle response
- 5. Problems in concentration
- 6. Sleep disturbance

History

* Effects of trauma exposure first observed late 1970s- in emergency and rescue workers who displayed symptoms similar to the trauma victims they helped
* Prompted investigation of individuals working with victims in various capacities; disaster relief workers, nurses and physicians, and crisis and hotline workers

(Alexander & Atcheson, 1998; Follette, Polusny, & Milbeck, 1994; Lyon, 1993)

History Cont.

* Important distinction arose-type of reaction depended on the nature of the exposure (Stamm, 1995)

- Primary trauma-direct exposure such as emergency and rescue workers

Cost of Caring (Figley)

* Secondary trauma-people working with or supporting those who had been traumatized such as therapists and family members (Mitchell, J.T., & Everly, 1995)
* Our Exposure
  - Clients, Stories, and Conditions that highlight; poverty, abuse, pain, loss, anger, etc.
  - Natural and Human-Made Disasters

History Cont.

* Stamm (1995)-published review of literature examining the impact on therapists of working with traumatized clients.

* She indicated that the issue was not whether such a phenomenon existed but what it would be called.

Vicarious Trauma, Secondary Traumatic Stress, and Burnout

Define the terms:

Introduction

Research has that shown those who help people that have been exposed to traumatic stressors are at risk for developing negative symptoms associated with burnout, depression, and posttraumatic stress disorder.

The positive feelings about people's ability to help are known as Compassion Satisfaction (CS). The negative, secondary outcomes have variously been identified as burnout, countertransference, Compassion Fatigue (CF), and Secondary Traumatic Stress (STS), and Vicarious Traumatization (VT).

Definitions

* Most common terms or labels; vicarious traumatization, compassion fatigue, traumatic countertransference, burnout, and secondary traumatic stress (Jenkins & Baird, 2002)
* All relate to the emotional and cognitive experiences of hearing stories that recount one or more traumatic events

(Cunningham, 2003; Figley, 2002; Moulden & Firestone, 2007)

Definitions Cont.

* Terms often used interchangeably, they each have a slightly different meaning (Severson & Pettus-Davis, 2011)

Vicarious Traumatization (VT)

* Coined by McCann and Pearlman (1990)
* Transformation in the therapist as a result of working with a client's traumatic experiences
* 3 Primary Characteristics
- Pervasive impact
- Cumulative effect
- Potentially permanent effects

(Moulden & Firestone (2007)

VT Cont.

* Repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects (McCann & Pearlman, 1990a).
* Primary symptoms of VT include disturbances in affect tolerance, cognitive frame of reference, interpersonal relationships, psychological needs, and identity (Moulden & Firestone,2007).

VT Cont.

* Some professionals (e.g. Beaton & Murphy, 1995) in the field contend that VT can result in physiological symptoms resembling posttraumatic stress reactions, which may manifest themselves either in the form of intrusive symptoms, such as flashbacks, nightmares, and obsessive thoughts, or in the form of constrictive symptoms, such as numbing and disassociation.
* May also result in disruptions to cognitive schemas

(McCann & Pearlman, 1990b;Pearlman & Saakvitne, 1995a, 1995b)

“COMPASSION IS BEING WITH THE HURT PERSON AND DOING THE RIGHT THING AS A RESULT. COMPASSION STRESS IS NOT BEING ABLE TO LET GO OF IT” -FIGLEY

VT and Constructivist Self-Development Theory

* Arose from constructivist self-development theory (CSDT)
* McCann and Pearlman in their seminal 1990 article on trauma therapy
* CSDT attempts to understand an individual's adaptation to trauma as an interaction between the following elements: personality, personal history, the traumatic event and its social and cultural context (Devilly, Wright, & Varker, 2009).

VT and CSDT

* These elements combine to redefine an individual's cognitive schema and therefore the process of constructing and interpreting their reality.
* In the application of CSDT to the study of trauma, McCann and Pearlman (1990) note seven psychological needs, which are cognitively manifested as schemas.
- 7 needs are; intimacy, esteem, power, dependency, trust/safety, independence, and frame of reference (attributions.

(Moulden & Firestone, 2007)

VT and CSDT

* ‘Meaning of the traumatic event is in the survivor’s experience of it’ (p.57), and that construction of meaning occurs and recurs as new information and experiences are incorporated into an individual’s beliefs and systems of meaning (Pearlman and Saakvitne, 1995).
- Fundamental to therapeutic change

(Devilly, Wright, & Varker, 2009)

VT and CSDT

- Pearlman and Saakvitne (1995) indicate that given this understanding of how trauma impacts on the individual, it is theoretically inevitable that, chronically exposed (vicariously) to patient's trauma and their struggle with it, therapists undergo a similar transformation over time.

(Devilly, Wright, & Varker, 2009)

Warning Signs (Overview)

* Cognitive shift in beliefs and thinking experienced by professionals as a result of [repeated] empathic engagement with trauma survivors. Disruptions to schema in 5 areas:
- Safety, Trust, Esteem, Intimacy, and Control

(McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995)

Warning Signs (Overview)

* VT often carries many of the same symptoms as PTSD.
* 3 Categories:
- Intrusions: flashbacks, nightmares, intrusive thoughts
- Avoidance of situations, people or places that trigger the intrusions
- Hyperarousal, including hypervigilance, sleeplessness, and increased startle response (“jumpiness”)

Warning Signs (Behavioral)

* Sleep disturbance
* Nightmares
* Appetite changes
* Hypervigilance
* “Jumpiness”
* Losing things
* Clumsiness
* Self-harm behaviors
* Negative coping-smoking, drinking, acting out

Warning Signs (Physical)

* Panic symptoms, swearing, rapid heartbeat, difficulty breathing, dizziness
* Aches and pains
* Weakened immune system

Warning Signs (Cognitive)

* Minimization
* Lowered self-esteem and increased self-doubt
* Trouble concentrating
* Confusion/disorientation
* Perfectionism
* Racing thoughts
* Loss of interest/pleasure in doing things
* Repetitive images of the trauma
* Thoughts of harming self or others
* Lack of meaning in life

Warning Signs: Emotional

* Helplessness and powerlessness
* Survivor guilt
* Numbness
* Oversensitivity
* Emotional unpredictability
* Fear
* Anxiety
* Sadness and/or depression
* Loneliness
* Irritability and intolerance
* Distrust

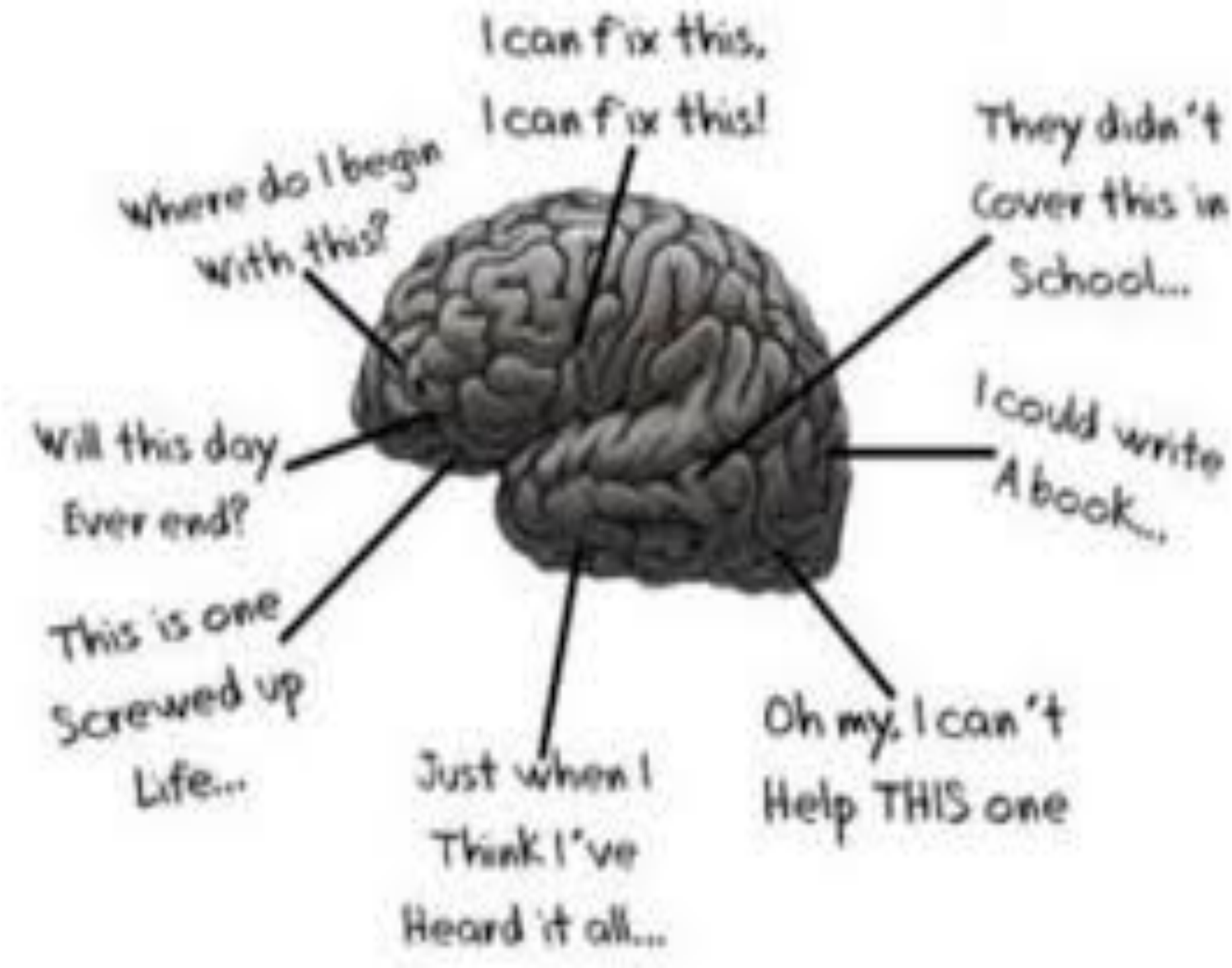
Warning Signs: Social

* Withdrawal and isolation
* Projection of blame and rage
* Decreased interest in intimacy
* Change in parenting style (e.g. becoming overprotective)

VT, Outcomes, and Final Thoughts

* Specific signs or symptoms such as reduced motivation, efficacy, empathy, self-esteem, self-perception, intimacy, safety, and trust (Baird & Kracen, 2006)
- Can lead to poorer quality of care given to clients (American Counseling Association, 2011)
- In comparison to Secondary Traumatic Stress, VT has been found to take longer to develop and is a result of the accumulation of exposure to clients' traumas

(Baird & Kracen, 2006; Stamm, 2010)


I can fix this,
I can fix this!
Where do I begin with this?
They didn't Cover this in School...
Will this day Ever end?
I could write A book...
This is one Screwed up Life...
Just when I Think I've Heard it all...
Oh my. I can't Help THIS one

Summary of VT

* Coined by Pearlman and Saakvitne (1995)
* Using CSDT, it is the permanent transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material.
- Main symptoms: disturbances in the therapist's cognitive frame of reference, identity, world view, spirituality, affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and physical presence in the world.

Secondary Traumatic Stress (STS)

* First defined by Figley in 1993: emotional distress experienced by clinicians working with trauma survivors, and is marked by symptoms almost identical to those common to PTSD

(Figley, 1995; Newell & MacNeil, 2010).

STS VS VT

* VT: negative changes in clinicians' cognitions that result from listening to clients' victimization over time (McCann & Pearlman, 1990).
* VT emphasizes cognitive responses and symptomology whereas STS refers to emotional and social reactions to disturbing sensory stimuli (Jenkins & Baird, 2002).
* STS has a more acute onset in comparison to other work related distress

STS VS. VT Cont.

* Some researchers say that STS is manifested more through changes in behavior than changes in cognition (Newell & MacNeil, 2010).
* However, others have conceptualized STS more expansively as pertaining to the emotional, cognitive, and physical consequences of providing professional services to clients who have experienced or perpetrated trauma (Figley, 2003; Salston & Figley, 2003)

STS Cont.

* Posited in the mid-late 1990s
- Revision to the DSM in 1994, altered the diagnostic criteria for PTSD
- Criterion A: definition of a 'traumatic event' was broadened to include witnessing or hearing about threatened death or serious injury occurring to another individual

(American Psychiatric Association, 1994)

STS Cont.

* Compassion fatigue (CF) signifies more progressed psychological disruptions
- CF used interchangeably with STS, considered less stigmatizing by Figley (1995).
* Proposed continuum of responses range from compassion satisfaction to compassion stress and ends with CF (Figley, 1995; Stamm, 2002b).

STS or CF?

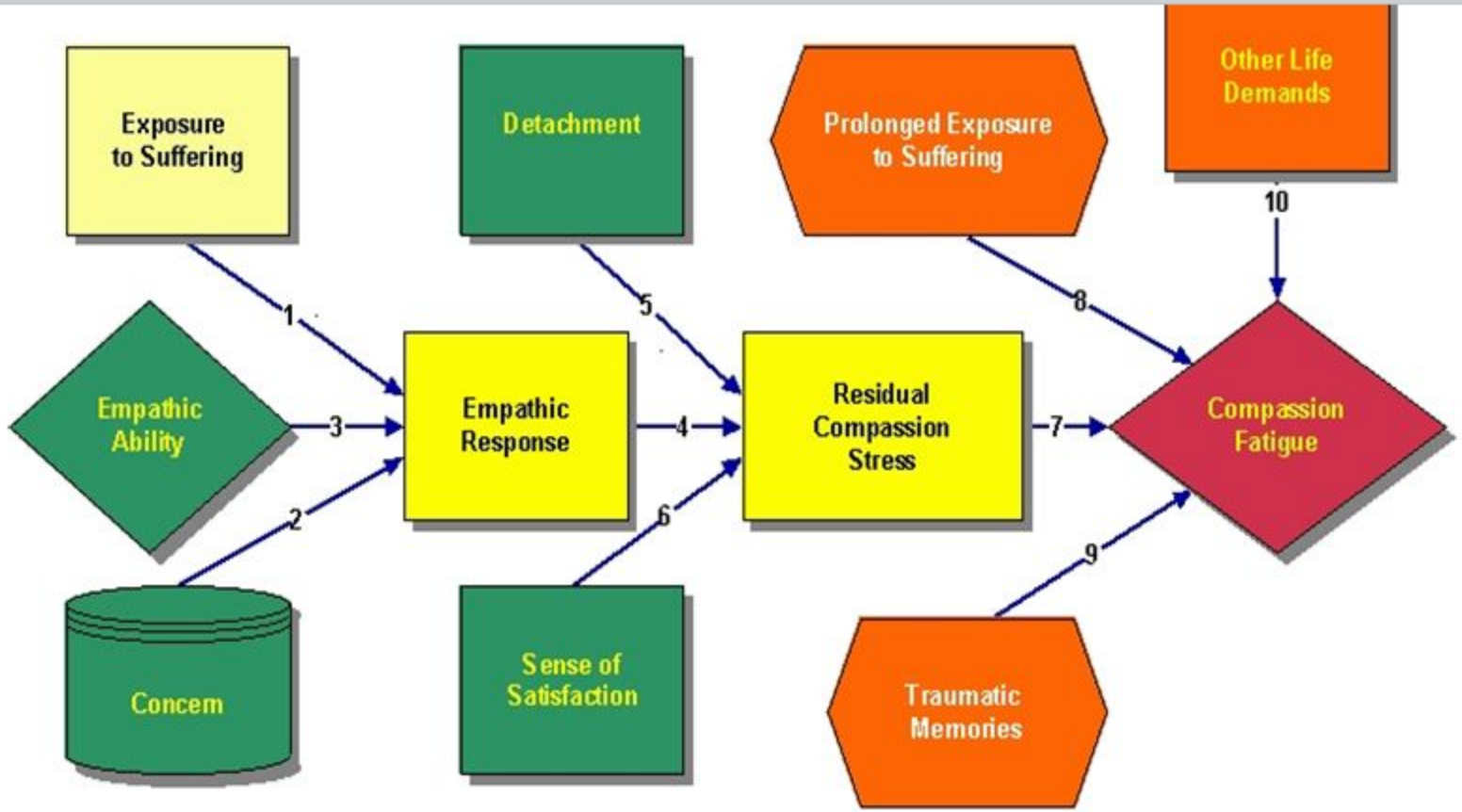
* Past term: ‘compassion fatigue’
* 1999: renamed by Figley
* Figley said ‘compassion fatigue’ is a more user friendly term for secondary traumatic stress disorder, which is nearly identical to PTSD
- Except it affects those emotionally affected by the trauma of another (usually a patient or a family member)

(American Psychiatric Association, 1994; Figley, 1995; Figley, 2002)

STS Cont.

* Figley's causal compassion stress and fatigue model (1995, 2002a, 2002b) points to the influence of nine variables implicated in the development of compassion fatigue, including those related to traumatic material exposure and clinicians' capacity for empathic engagement.
* (See figure on next slide)

Figley's model of Compassion Fatigue



The Compassion Fatigue Process (Figley, 2001)

STS Cont.

* Figley described two positive coping variables (sense of achievement and emotional disengagement), while prolonged exposure, traumatic recollections and life disruption exacerbate stress reactions and may lead to the development of compassion fatigue.

(Sprang, Clark & Whitt-Woosley, 2007)

Compassion Fatigue Trajectory

Adapted from Charles R. Figley

Which Phase describes where you are?

a) The Zealot Phase

b) The Irritability Phase

c) The Withdrawal Phase

d) The Zombie Phase

e) Pathology vs. Renewal/Maturation

*Make a note about which phase describes you as we discuss them. ARS later.

STS: Signs and Symptoms

* Excessive blaming
* Bottled up emotions
* Isolation
* Problems with intimacy and in personal relationships
* Substance abuse used to mask feelings
* Compulsive behaviors such as overspending, overeating, gambling, sexual addictions
* Legal problems, indebtedness
* Poor self-care (i.e. hygiene, appearance)
* Feeling trapped, overwhelmed, exhausted

STS: Signs and Symptoms

* Reoccurrence of nightmares and flashbacks to traumatic event
* Chronic physical ailments (e.g. gastrointestinal problems and recurrent colds)
* Apathy, sad, no longer finds activities pleasurable
* Anger and irritability
* Difficulty concentrating
* Preoccupied
* In denial about problems

STS: Signs and Symptoms

* Reduced ability to feel sympathy and empathy
* Dread of working with certain clients/patients
* Receives unusual amount of complaints from others
* Voices excessive complaints about administrative functions
* Absenteeism-missing work, taking many sick days
* Impaired ability to make decisions and care for clients/patients
* Difficulty separating work life from personal life
* Disruption to world view
* Diminished sense of enjoyment of career

Summary of STS

- Recollection, dreams, and sudden re-experiencing of the event, avoidance of thoughts, feelings, or activities; detachment or estrangement from others and activities; emotional difficulties or outbursts; concentration problems; physiological reactions (e.g. sleeping difficulties), and hypervigilance (Figley, 1995).

irritable
nightmares
trauma
post traumatic stress symptoms
withdrawn
fear
triggers
thinking
avoidance
emotional
anxious
sad
emotional numbing
friendship
depression
therapy
I need help
what helps?
there is help
and support
therapy

Summary of STS Cont.

* “Compassion fatigue is a state experienced by those helping people or animals in distress, it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create a secondary traumatic stress (or STSD) for the helper.” -Dr. Charles Figley

Burnout

* CF has been coined as a form of caregiver burnout

* Cieslack and colleagues (2014) found that STS had a strong association with burnout; this association was significantly larger using the PROQOL

(American Psychiatric Association, 1994; Figley, 1995; Figley, 2002)

“That which is to give light must endure burning”
- Viktor Frankl

Burnout

* First used in a psychological sense by German-born American psychologist Herbert J. Freudenberger in 1974
- He used the term to describe symptoms he was experiencing: "exhaustion, disillusionment, and withdrawal resulting from intense devotion to a cause that failed to produce the expected result."
- Publication: "Burnout: The High Cost of High Achievement."

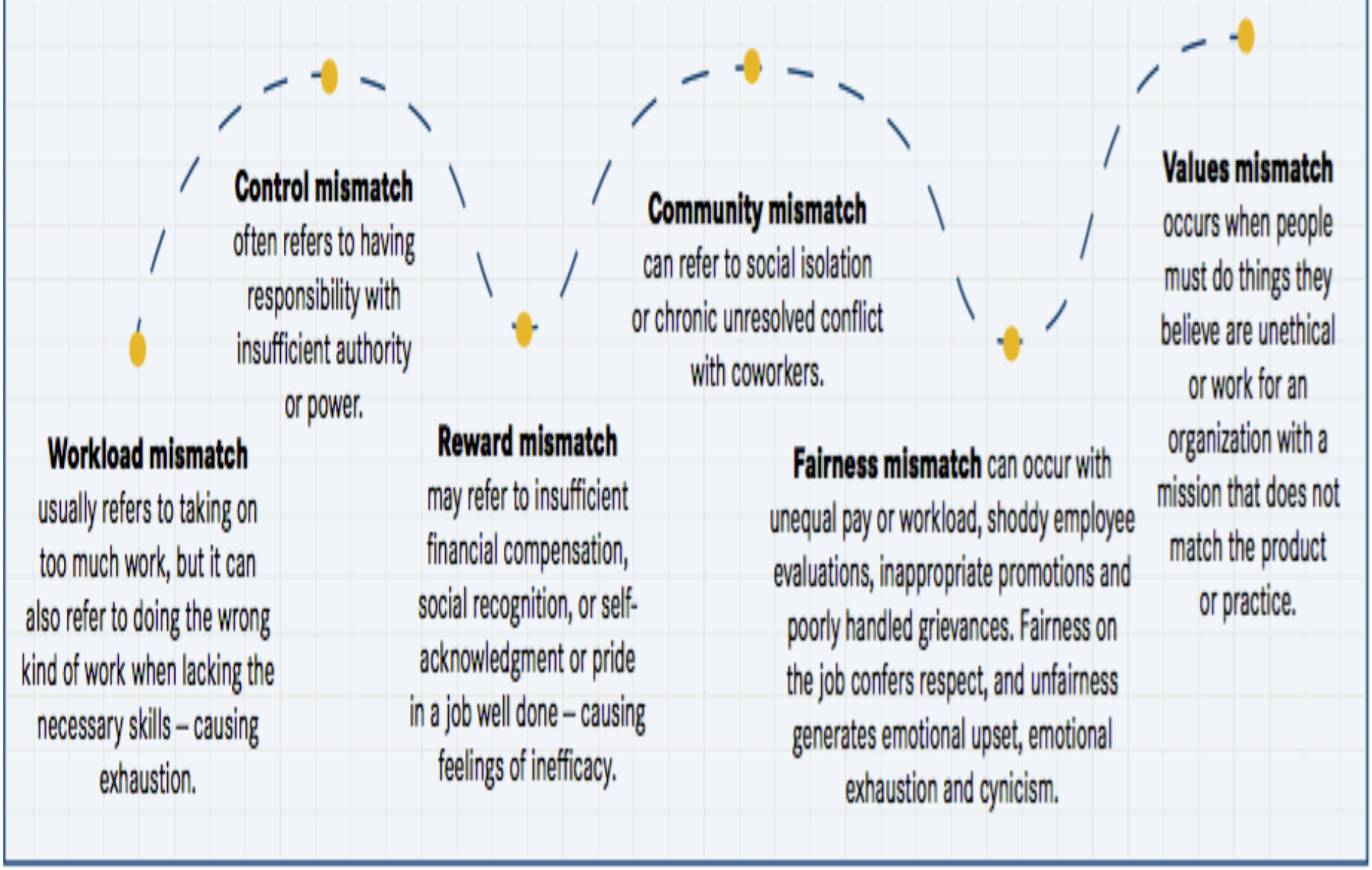
(Freudenberger & Richelson, 1980; Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1997; Maslach, Schaufeli, & Leiter, 2001)

Burnout

* Shortly afterwards, the Maslach Burnout Inventory (MBI) was constructed to measure the syndrome
- Designed to assess 3 components of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment.
* Maslach found that burnout was the result of mismatches in at least one of 6 areas (see following table)

(Freudenberger & Richelson, 1980; Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1997; Maslach, Schaufeli, & Leiter, 2001)

Figure 1. Burnout Mismatches According to Maslach[7]



12 Phases of Burnout

* The compulsion to prove oneself: excessive demonstration of worth and perfectionism
* Working harder: unable to “switch off” or delegate
* Neglecting physical and emotional needs: lack of social interaction
* Displacement of conflict: dismissive of problems, lack of sleep, missing appointments
* Revision of values: insensitive, emotionally blunt, sacrificing family, friends and hobbies
* Denial of emerging problems: performance suffers, intolerant, cynical and aggressive

12 Phases of Burnout Cont.

* Withdrawal: minimal or nonexistent social life, may turn to alcohol or drugs for relief
* Obvious behavior changes: apathetic and paranoid, evades work demands
* Depersonalization: no perception of own needs, automation, meaning of life is lost
* Inner emptiness: dejected, exhausted, fearful, may have panic attacks
* Depression: lost, unsure, self-destructive, suicidal
* Burnout syndrome: crisis with mental and/or physical collapse

Burnout

* Maslach (1982) defined burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment
- Characterized by cynicism, psychological distress, feelings of dissatisfaction, impaired interpersonal functioning, emotional numbing, and physiological problems (Fothergill, Edwards, & Burnard, 2004).
- Not significantly associated with worker countertransference or reactions to traumatic client material but with other workplace characteristics like caseload size and institutional stress (Stamm, 1997).

Burnout Cont.

* Currently viewed as a "psychological syndrome in response to chronic interpersonal stressors on the job.'
* Process rather than a condition or state
* 3 dimensions of the syndrome by Maslach et al. early factor analytic research has been retained over the years:

(Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Farber, 1985)

Burnout Cont.

* Dimensions cont.
- Overwhelming exhaustion or feeling depleted of one's emotional and physical resources (which is the central stress quality of burnout), feelings of cynicism or depersonalization (negative attitude towards clients) and detachment from the job or loss of ideals, and a sense of ineffectiveness and lack of accomplishment.

(Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Farber, 1985)

Burnout cont.

* Primary antecedents include:
- Work overload, limited support, role conflict and role ambiguity have been consistently associated with burnout ((Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Farber, 1985)
* Some of the numbing symptoms of vicarious trauma bear some resemblance to burnout and may result in burnout over time (Figley, 1995; Pearlman & Saakvitne, 1995a).

Burnout cont.

* Empirical studies of burnout revealed it as an especially prevalent condition among helping professionals, with mental health professionals demonstrating higher levels of burnout than primary health care workers (Imai, Nakao, Tsuchiya, Kuroda, & Katon, 2004).

Burnout Cont.

* Research found that burnout tends to be more prevalent in younger 'helping professionals' than in those aged 30-40 years and over-a finding that is confounded by work experience and survival bias.
* Perceived social support has also been found to be a significant predictor of burnout.
* For therapists, caseload satisfaction, job stress, and support of supervisors and colleagues have been associated with burnout

(Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Farber, 1985; Kruger, Botman, & Goodenow, 1991; Kruger, Bernstein, & Botman, 1994; Raquepaw & Miller, 1989; Ross, Altmeier, & Russell, 1989)

Burnout VS CF

* Burnout tends to be chronic and generalized while CF is acute, associated with a particular relationship and centered around compassion and empathy

Overview: Signs and Symptoms of Burnout

* Cynicism and detachment
- Loss of enjoyment
- Pessimism
- Isolation
- Detachment

Overview: Signs and Symptoms of Burnout

* Signs of ineffectiveness and lack of accomplishment:
- Feelings of apathy and hopelessness
- Increased irritability
- Lack of productivity and poor performance

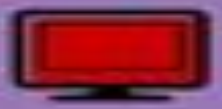
Overview: Signs and Symptoms of Burnout

* Physical and Emotional Exhaustion:
- Chronic fatigue
- Insomnia
- Forgetfulness/impaired concentration and attention
- Increased illness
- Loss of appetite
- Anxiety
- Depression
- Anger

Signs of Burnout

for social workers & therapists

- dread going to work
- always tired
- overwhelmed
- depression
- anxiety
- hopelessness
- apathy
- health problems (headaches, stomachaches, muscle aches)
- insomnia
- resentment
- irritability
- difficulty concentrating
- mistakes at work
- procrastination
- decreased productivity, missing deadlines
- boredom
- disillusionment
- No professional goals
- conflicts with colleagues or supervisors
- use of unhealthy coping (alcohol/drugs, food)



Burnout	Compassion Fatigue	Vicarious Traumatisation
Signs: • Fatigue • Anger • Frustration • Negative reactions towards others • Cynicism • Negativity • Withdrawal	**Signs:** • Sadness & Grief • Avoidance or dread of working with some patients • Reduced ability to feel empathy towards patients or families • Somatic complaints • Addiction • Nightmares • Frequent use of sick days • Increased psychological arousal • Changes in beliefs, expectations assumptions • Detachment • Decreased intimacy	**Signs:** • Anxiety • Sadness • Confusion • Apathy • Intrusive imagery • Loss of control, trust & independence • Somatic complaints • Relational disturbances
Symptoms • Physical • Psychological • Cognitive • Relational Disturbances	**Symptoms (mirror PTSD)** • Physical • Headaches • Digestive problems • Muscle tension • Fatigue • Psychological distress • Cognitive shifts • Relational Disturbances • Poor concentration, focus & judgement	**Symptoms (mirror PTSD)** • Physical • Psychological distress • Cognitive shifts • Relational Disturbances
Triggers • Personal characteristics • Work-related attributes • Work organisational characteristics	**Triggers** • Personal characteristics • Previous exposure to trauma • Empathy & emotional energy • Prolonged exposure to trauma material of clients • Response to stressor • Work environment • Work-related attitudes	**Triggers** • Personal characteristics • Previous exposure to trauma • Type of therapy • Organisational context • Resources • Re-enactment

Burnout	**Emotional exhaustion, feelings of cynicism and detachment from the job, a sense of ineffectiveness and lack of accomplishment**
Vicarious Trauma	Cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events, which specifically impact on the identity, world view, psychological needs, beliefs and memory system of the therapist
Secondary Traumatic Stress	A syndrome of symptoms nearly identical to those of PTSD, including symptoms of intrusion, avoidance and arousal, which is the natural consequence of caring between two people, one of whom has been initially traumatized and the other whom is affected by the first's traumatic experiences'

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Compassion satisfaction refers to the positive feelings dervied from competent performance as a trauma professionals. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the terms is not used to describe the effects of indirect trauma exposure specifically.

Figley (2002)

* “Caring people [sometimes] experience pain as a direct result of their exposure to another’s traumatic material…this situation-call it compassion fatigue, compassion stress or secondary traumatic stress-is the natural, predictable, treatable, and preventable unwanted consequence of working with suffering people”

STATS

* Emergency workers, police officers, sexual assault counselors, child protective service workers, and trauma therapists have all been documented as developing symptomology quite similar to acute and posttraumatic stress reactions as a result of their second-hand exposure to traumatic material (see references, pp..)

STATS

* 38% of social workers experience moderate to high levels of secondary traumatic stress (Cornille & Myers, 1999; Dalton, 2001).
* Research on STS symptomology in child protective service (CPS) workers suggest this type of work carries high risk for transmission of traumatic stress symptomology (Pryce, Shackelford, and Pryce, 2007).
- Cornille and Myers (1999) found 37% of participants exhibited clinically significant distress related to CPS work.

STATS

* A study of community mental health workers found that 17% met criteria for STSD and 18% exhibited significant but subclinical levels of psychopathology (Meldrum, King, & Spooner, 2002).
* Higher distress levels were found in studies of disaster response teams (Holtz, Salama, Cardozo, & Gotway, 2002).

STATS

* Following the Oklahoma City bombing, 64.7% of trauma workers reported significant traumatic stress (Wee & Myers, 2002).

* A study of responders to the 9/11 attacks found 27% at extremely high risk, 11.7% at high risk, and 15.4% at moderate risk for developing CF or STS (Roberts, Flannelly, Weaver, & Figley, 2003).

STATS

* In a survey of 148 counselors, Schauben and Frazier (1995), found that those who worked with a higher percentage of sexual violence survivors reported more symptoms of posttraumatic stress disorder and greater disruptions in their beliefs about themselves and others than did counselors seeing fewer survivors.

STATS

* Factors that are tied to these symptoms include:
- Hearing the trauma story and experiencing the pain of survivors was emotionally draining
- Counseling process more difficulty when working with trauma survivors, who tended to have more problems trusting and working in a therapeutic relationship than clients who were not traumatized
- Institutional barriers within the legal, and mental health systems (Schauben & Frazier, 1995).

STATS

* Johnson & Hunter, 1997: sexual assault counselors showed greater evidence of stress and their work stress also contributed to personal relationship difficulties at home.
* Sprang, Clark, & Whitt-Woosley (2007) implemented a study of 1121 mental health providers (psychologists, psychiatrists, social workers, marriage and family therapists, professional counselors, and drug and alcohol counselors) in a rural southern state:

STATS

- 13% of the provider population sampled is at high risk of CF and burnout
- Female gender enhanced the risk of suffering from CF and burnout, a finding consistent with studies by Kassam-Adams (1999) and Meyers and Cornille (2002).
- Specialized trauma training did enhance CS and reduce levels of CF and burnout

➢ Enhanced clinician self-efficacy through cultivation of more effective assessment and treatment skills

STATS

- Caseload percentage of PTSD clients that clinicians treated predicted their levels of CF and burnout

➢"caseload mix"

- Clinicians in this sample who were working in rural locations were more likely to suffer burnout than those in highly metropolitan locations.

STATS

- President's New Freedom Commission on Mental Health's (2003) analysis reported that rural areas endure "chronic shortages" of mental health professionals and rural residents tend to seek mental health services later in the course of their illnesses, with more persistent and disabling symptoms, and require more intensive treatment (p. 51).

STATS

- Limited resources, geographical isolation, few colleagues (limited peer support), and highly demanding caseloads create a "perfect storm" of burnout risk among rural clinicians.
- The general duties, burdens, and stressors of rural work appeared to generate burnout (but not CF), and might have prevented the development of empathy and engagement that was necessary to increase vulnerability to CF
- Burnout might have acted as a protective factors, interfering with the development of empathy and thereby interfering with the transmission of distress

STATS

- Psychiatrists in this study experienced higher levels of CF than other professionals
- General medical literature contains numerous studies regarding the high incidence of various conditions such as depression, substance misuse, posttraumatic stress, lethality, and interpersonal problems among physicians (Robinson, 2003; Sonneck & Wagner, 1996; Miller & McGowen, 2000).

STATS

* Many studies have explored the high levels of burnout reported by physicians and at least one supported a link between physicians' levels of work related stress and their higher mortality rates (Korkeila et al., 2003; Hawton et al., 2001).

* Another discovered that psychiatrists as a group have a higher risk for experiencing patient suicide than comparable group of mental health professionals (Chemtob, Bauer, Hamada, Pelowsk, & Muraoka, 1989).

STATS

* The finding of higher rates of CF among psychiatrists were likely to:
- Psychiatrists delivering intensive care to high numbers of traumatized patients in the context of a severe shortage of psychiatrists in the state where this survey was conducted.

- Resulted in higher patient caseloads and fewer medic*al* colleagues with whom to share the burden

STATS

* Slattery and Goodman (2009) study of 148 domestic violence workers:
- 54.4% reported having experienced one or more types of abuse (child sexual abuse, child witness to violence, intimate partner violence, rape/sexual assault, and child physical and emotional abuse or neglect).
- 47.3% met criteria for clinical levels of PTSD symptoms calculated according to DSM-IV criteria.

Risk Factors and Protective Factors

* The impact of the therapist's own history of abuse on current report of vicarious trauma are unclear.
- Pearlman and Mac Ian (1995) reported significant more vicarious trauma symptoms in 60% of the therapists they surveyed who reported a personal history of trauma.

Risk Factors and Protective Factors

* Increased time spent with traumatized clients seems to increase the risk of stress reactions in mental health professionals (Chrestman, 1995; Pearlman & Mac Ian, 1995).
- Spending time in other work activities decreases the risk
- Having a more diverse caseload with a greater variety of client problems and participating in research, education, and outreach also appear to mediate the effects of traumatic exposure

Risk Factors and Protective Factors

* Age and experience are inversely correlated with the development of vicarious trauma.
  - As age + Risk for STS, VT, and burnout – (Nelson-Gardell & Harris, 2003)
  - Younger and less experienced counselors exhibit the highest levels of distress (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995).
  - Possible reasons; less opportunity to integrate traumatic stories and experiences into their belief systems and to develop adaptive coping strategies

Risk Factors and Protective Factors

* Education mitigated burnout and years of professional experience were associated with a decreased potential for VT (Cunningham, 2003

* Some studies suggest that personal coping styles and the ability to construct meaning in the face of stressful experiences may be truer determinants of Professionals' emotional functioning (Ortlepp & Friedman, 2001).

Risk Factors and Protective Factors

* Researchers have also found that specialized training can serve a protective function for trauma counselors (Ortlepp & Friedman, 2002).
* According Creamer & Liddle (2005), type of profession (psychologists, social workers, counselors) was not a predictor of STS.
* Long hours, length of assignment and caseloads with high percentages of trauma patients have been associated with increased incidences of STS and CF (Boscarino, Figley, & Adams, 2004; Creamer & Liddle, 2005).

Risk Factors and Protective Factors

* Supportive work environment and adequate supervision noted to mitigate the incidence of STS and burnout (Boscarino et al., 2004).
* Autonomy and control seem to be mitigating factors for burnout (Abu-Bader, 2000)
- While access to sufficient resources mitigated both burnout and STS (Ortlepp & Friedman, 2001).

Risk Factors and Protective Factors

* Workers with high caseloads of trauma survivors of violent or human induced trauma (especially against children) seemed to be at greater risk for CF and STS (Creamer & Liddle, 2005).
* A study of mental health workers found that STS symptomology rates were higher for rural providers when compared to their urban counterparts (Meldrum et al., 2002).

Risk Factors and Protective Factors

* Females showed greater susceptibility for STS (Baum, 2016)
* An important aspect of the therapeutic relationship that may be linked to the development of VT is empathy (Figley, 1995a).
* Research has found CS has an inverse relationship with STS and burnout and may be a protective factor (Simon, Pryce, Roff, & Klemmack, 2006)

Risk Factors and Protective Factors

* In a meta-analysis of studies assessing interventions for burnout, it was reported that 80% led to a reduction in burnout…prevention programs focusing on increasing CS as a mean of reducing rates of burnout, STS, and VT should be considered (Awa, Plaumann, & Walter, 2010).
- Cummings, Singer, Hisaka, & Benuto (2018) findings suggested that individuals experiencing one form of psychological distress (burnout, VT, STS) are significantly more likely to experience at least one another.

Legal Profession

Lawyers

* A survey of attorneys working in family law, domestic violence, and legal aid criminal defense as well as mental health providers and social service providers working with those suffering from mental health issues found that attorneys had higher rates of secondary trauma than the other professionals surveyed (Levin & Greisberg, 2003).

Lawyers

* A 2010 study conducted of the lawyers and support staff of the Wisconsin State Public Defender Office showed that attorneys working with clients experiencing trauma and who worked long hours were at high risk of developing significant secondary trauma and burnout symptoms (Levin, Albert, Besser, and Smith et. al., 2011).

Judges

* STS: It is not uncommon for judges, especially those in family or criminal courts, to be exposed to cases involving traumatic events (Chamberlain & Miller, 2009).
* Safety concerns: Violence and threats of violence against judges and their families have become media topics in recent years.
- On June 28, 2006, a family court judge was shot and wounded in a Reno, Nevada courthouse, where he had presided over his attacker's divorce trial.

(Coen & Heinzmann, 2005; Associated Press: NBC)

Judges

- Created a tangible source of stress
- Violence aimed at judges is likely to create a sense of vulnerability and insecurity.
- Concerns about safety may extend to family, as violence against family members of some judges has occurred in recent years.
- A survey of Pennsylvania judges revealed that 52% had received one or more threatening messages.
- 77% of the judges who received threats stated that they occurred inside the courtroom, while 44% reported threats occurring outside the courthouse.

(Coen & Heinzmann, 2005; Harris, Kirschner, Rozek, and et al., 2001).

Judges

* Work-related Burnout: long hours, consistent heavy workload, unprepared lawyers, uncooperative defendants, and conflicts with others judges are some examples of job-related stressors.
- Make decisions that will have a major impact on the lives of the parties involved in the case

(Eells & Showalter, 1994; Maslach & Leiter, 1997)

Judges

* Burnout may result from workplace conflict, an overload of responsibilities, and the perception of inequity or inadequate rewards.
- Judges are routinely given responsibilities that carry important consequences and are commonly exposed to the trauma of others. Workplace conflict is also a prominent aspect of the judicial occupation, given the nature of adversarial system and the subsequent threats of violence that many judges receive.

(Eells & Showalter, 1994; Maslach & Leiter, 1997)

Judges

* Chamberlain & Miller (2009): study showed judges were at risk of STS
- 96% of researchers agreed- signs of stress due to safety concerns
- Judge-vulnerable to burnout (94% intercoder reliability)

Judges

* From a sample of 105 judges, 63 percent reported symptoms of work-related VT

(Jaffe, et. al., 2003)

Probation Officers

* To answer the question as to whether probation practitioners experience vicarious traumatization is difficult. This is due to a lack of empirical research which explores the impact of engagement with client trauma stories within probation supervision practices.

Probation Officers Cont.

* This is despite the prevalence of trauma experiences of the client group (Browne et al., 1999; NOMS, 2015), the need for practitioners to engage with these trauma accounts (Digard, 2014) and the employment of empathy as a tool in desistance-focused work (Bonta et al., 2008).

* The impact of engaging with clients' trauma stories: Personal and organizational strategies to manage probation practitioners' risk of developing vicarious traumatization by Rosie Lee National Probation Service, UK. 2017

VT, Burnout, and STS: Therapists who Work with Sexual Offenders (SO)

SO

* Countertransference-commonly proposed explanation for VT
* involves the therapist's experience of responses to the client within the psychotherapeutic relationship whereas VT is related to changes taking place in the therapist's life.
* Both have the following involved; decreased self-awareness, increased defenses, and challenges to identity and beliefs

(Pearlman & Saakvitne, 1995)

SO

* Mitchell and Melikian (1995) identified multiple countertransference issues specific to sexual offenders
- Sadistic and aggressive fantasy
- Polarization of the client (victim vs. offender)
- Barriers to empathic engagement with the client (e.g. focusing on the offense or the offender's denial).

SO

* Farrenkopft (1992) proposed a model describing the cumulative impact of working with this challenging population.

* 4 phases of impact:
- Shock-therapists experience shock, fear, and a greater sense of threat and vulnerability
- Mission-therapist's adaption and desire to help while at the same repressing emotions and reactions to the sexual offenses

SO

❖Phases continued:

- Anger-therapists exhibit a confrontational style and intolerance of criminal attitudes
- Erosion-continuation and amplification of phase 3, where therapists feel resentful, depressed, and a sense of futility

SO

* In a recent survey of trauma in therapists, the authors concluded that more than 50% of sexual offender and survivor therapists reported symptoms of trauma reactions in the clinical range as measured by the Impact of Event Scale-Revised (IES-R; Way, VanDeusen, Martin, Applegate, & Jandle, 2004)

SO

* In a study (Steed & Bicknell, 2001) examining 67 male and female sexual offender therapists, participants were asked to complete the IES-R.
- 46% reported a moderate or high risk of developing CF
- 38% moderate to high risk of developing burnout (which has been purported to be a predictor or sign of untreated VT)

(Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 1995)

SO

* Steed and Bicknell (2001) also found therapists were experiencing the following:
- Mild disruptions in intrusive (15.4%), avoidant (12.4%), and hyperarousal (8%) symptoms
* Many studies have shown that therapists who work with victims and perpetrators experience a variety of trauma-related symptoms
- Approximately 1/3 of SO therapists described symptoms of hypervigilance pertaining to their own safety and their own interpersonal behavior (Bengis, 1997; Farrenkopf, 1992).

SO

* SO therapists also described feeling mistrustful of others in general, but particularly of those who have regular access to children either through work, family/friends, or volunteering.
* Therapists have described attributing malevolent motivations to seemingly innocent interactions.
- Hypervigilance regarding one's own and others' behavior exemplifies the schematic shift described as a hallmark of VT (McCann & Pearlman, 1990)

SO

* Some suggestion that male therapists tend to over identify with offenders and describe the experience of a collective guilt (Edmunds, 1997).
* Some theorists have suggested that male therapists feel shame on behalf of the male sex and engage in hypercritical analysis of their own sexual behavior and their way of interacting and showing affection to children (Farrenkopf, 1992).

SO

* Steed and Bicknell (2002) found a trend toward an interaction between therapist symptom severity and years of experience based on responses to the IES-R and the Compassion Fatigue Scale (Figley, 1995a).
- Results: newest to the field (< 2 years) and those working with sexual offenders for the longest (9 to 12 years) were most at risk for developing symptoms of VT, including intrusive, avoidant, and hyperarousal symptoms as well as burnout.
➢ Those working with sexual offenders between 2 and 4 years were least vulnerable to symptoms of VT.

SO

* Additional finding of Steed and Bicknell (2001)-previous work as a therapist with general populations had no relationship to the experience of VT, suggesting may be a product of delivering SO therapy specifically

SO

* Research found a relationship between trauma history and VT symptoms (Sabin-Farrell & Turpin, 2003).
* Kassam-Adams (1995), based on multiple regression analyses, concluded that three variables together accounted for the most variance in the prediction of VT symptoms in victim therapists: female, personal trauma history, and number of traumatized clients therapists had worked with over the course of their career.

SO

* In a study of therapists who treat victims and perpetrators, 75% of respondents reported an undefined history of childhood abuse, including sexual, physical, and emotional victimization, with no differences between the groups (victim or perpetrator therapists) on trauma history or IES scores (Way et al., 2004).

SO

* Edmunds (1997), in her descriptive study of sexual offender therapists, found that 54% of respondents reported lifetime psychological (22%), physical (11%), and sexual (21%) victimization. Females represented a larger proportion of therapists who had been victimized (27% of females, 16% of males).
* One study drawing from the same ATSA sample found only 25% of respondents identified themselves as survivors of trauma (Ennis & Horne, 2003).

SO

* The impact of personal/professional support:
- In the ATSA conference of 1993, Ellerby and his colleagues reported approximately 70% of the sexual offender therapists reported they felt uncomfortable and needed to justify their own work when asked
- Approximately 90% described a negative reaction from others when they described their occupation.

SO

* Gratification if ever takes years

- Measuring competency through the offender's progress

➢ May lead to feelings of helplessness, guilt, and questions of competency (Farrenkopt, 1992; Kearns, 1995).

SO

* Ellerby (1998) in his studies on the impact of working with sexual offenders, reported that both male and female sexual offender therapists have felt threatened or endangered by a client (63 and 79 percent respectively)
- Females described violations of personal boundaries by clients (84 %) and being sexualized by clients (42%).
- More than 50% of therapist have been verbally or physically attacked by a client (Jackson et al., 1997).

Organizational Prevention

Organizational Culture

* Organizations that serve trauma survivors, whether rape crisis centers, shelters for battered women, or programs that work with veterans, acknowledge the impact of trauma on the individual worker and the organization (Bell, Kulkarni, & Dalton, 2003).
* Rosenbloom, Pratt, and Pearlman (1995) stated of their work at the Traumatic Stress Institute, “we work together to develop an atmosphere in which it is considered inevitable to be affected by the work” (p.77).

Organizational Culture Cont.

* A supportive organization is one that allows for vacations, creates opportunities for professionals to vary their caseload and work activities; take time off for illness, participate in continuing education, and make time for other self-care activities.
- Administrators might also monitor staff vacation time and encourage staff with too much accrued time to take time off.
- Self care should be addressed in staff meetings

(Bell, Kulkarni, & Dalton, 2003)

Correlations between Organization and Burnout

* Organizations can either promote job satisfaction or contribute to burnout (Soderfeldt, Soderfeldt, & Warg, 1995).
- Unsupportive administration, lack of professional challenge, low salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Arches, 1991; Beck, 1987; Himle, Jayaratne, & Thyness, 1986).

Workload

* Research has shown that having a more diverse caseload is associated with decreased vicarious trauma (Chrestman, 1995).

- Agencies could develop intake procedures that attempt to distribute clients among staff in a way that pays attention to the risk of vicarious trauma certain clients might present to workers (Bell, Kulkarni, & Dalton, 2003)

- Trauma cases should be distributed among those who have the necessary skills (Dutton & Rubinstein, 1995; Regehr & Cadell, 1999; Wade et al., 1996).

Workload Cont.

* Those providing direct services to traumatized people may benefit from opportunities to participate in social change activities (Regehr & Cadell, 1999).
- e.g. community education and outreach or working to influence policy
- Such activities can provide a sense of hope and empowerment that can be energizing and can neutralize some of the negative effects of trauma work.

(Bell, Kulkarni, & Dalton, 2003)

Workload Cont.

* Organizations maintain "attitude of respect"
- Acknowledge that work with trauma survivors often involves multiple, long-term services.
* Important for organizations to develop or link client with adjunct services-self-help groups, experienced medical professionals for medication, in and out patient hospitalization, and resources for paying for these services
- Can support clients and decrease workload for staff
- Collaborative relationships among agencies in trauma work can provide material support and prevent a sense of isolation and frustration at having to "go it alone."

(Pearlman & Saakvitne, 1995b)

Work Environment

* A safe, comfortable, and private work environment is crucial for those[ ] in settings that may expose them to violence (Pearlman & Saakvitne, 1995b; Yassen, 1995).
* In a sample of 210 licensed social workers, Dalton (2001) found that 57.6% had been threatened by a client or member of a client's family, and 16.6% had been physically or sexually assaulted by a client or member of a client's family.
- Being threatened was strongly correlated with compassion fatigue or STS.

Work Environment Cont.

* Pearlman and Saakvitne (1995) suggested that trauma workers need to have personally meaningful items in their workplace.
- E.g. places workers have visited, scenes or quotes that can help them remember who they are and they do this work
- Agency administrators can facilitate the above by placing inspiring posters or pictures of scenic environments (rather than agency rules and regulations) in the waiting rooms, staff meeting rooms, and break rooms.

(Bell, Kulkarni, & Dalton, 2003)

Work Environment Cont.

- Agency can model the importance of the personal in the professional
* Workers also need places for rest at the job site, such as a break room that is separate from clients (Yassen, 1995) or work space.
- Organization in this space could address the self-care needs of staff by providing a coffee maker, soft music, and comfortable furniture, to give a few examples.

(Bell, Kulkarni, & Dalton, 2003)

Education

* Trauma-specific education also diminishes the potential of vicarious trauma (Pearlman & Saakvitne, 1995b).
* Efforts to educate staff about vicarious trauma can begin in the job interview (Urquiza, Wyatt, & Goodlin-Jones, 1997).
- Agencies have duty to warn applicants of the potential risks of trauma work and to assess new workers' resilience (Pearlman & Saakvitne, 1995b).

Education Cont.

* New employees can be educated about the risks and effects associated with trauma, as new and inexperienced are likely to experience the most impact (Chrestman, 1995; Neuman & Gamble, 1995).
* Ongoing education about trauma theory and the effects of vicarious trauma can be included in staff training (Regehr & Cadell, 1999; Urquiza et al., 1997) and discussed on an ongoing basis as part of staff meetings.

Education Cont.

* Agencies can send staff to workshops on vicarious trauma or send a representative and have him/her present the information.
- This outlet can help those working in trauma to feel more competent and have more realistic expectations about what they can accomplish in their professional role.

(Bell, Kulkarni, & Dalton, 2003)

Education Cont.

* Preparation for a stressful event, when possible, protects individuals from the adverse effects of stress (Chemtob et al., 1990).
* Learning new ways to address clients' trauma may also help to prevent vicarious trauma (Bell, Kulkarni, & Dalton, 2003)

Group Support

* Both literature on burnout and vicarious trauma emphasize the importance of social support within the organization (Catheral, 1995; Munroe et al., Rosenbloom et al., 1995).

Supervision

* Essential component of the prevention and healing of vicarious trauma.
- to create safe place for professional to express fears, concerns, and/or limitations.
- Teach about vicarious trauma in a way that is supportive, respectful, and sensitive to its effects.

(Pearlman & Saakvitne, 1995b; Regehr & Caldwell, 1999; Rosenbloom et al., 1995; Urquiza et al., 1997; Bell, Kulkarni, & Dalton, 2003).

Overview: Organization Prevention

* 3 of the most important workplace contributors to psychological well-being in trauma: social support, clinical supervision, and access to power.
- Kanter (1993) states power is synonymous with autonomy and freedom to act.
- In a empowering organization, individuals are able to participate in decision making processes, and have the ability to obtain the support, information, resources, and opportunities that they need to meet their goals.

(Slattery & Goodman, 2009)

Agencies and Self-Care Resources

* Workers having health insurance that provides mental health coverage
* Agencies providing opportunities for structured and stress management and physical activities

(Wade et al., 1996)

Trauma-Informed System

- "A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (SAMHSA, 2014)

Trauma Informed Care Model

* Awareness of environment (physical as well as subtleties)
* Starts immediately upon hiring
* Non-harassment Policies & anti-violence training – Effective and accountable
* Empower staff (empower oneself)
* Training
* Ongoing Support (1:1 as well as group)

1. Lead and communicate about being trauma-informed

2. Engage patients in organizing and planning

3. Train both clinical and non-clinical staff

4. Create a safe physical and emotional environment

5. Prevent secondary traumatic stress in staff

6. Build a trauma-informed workforce

7. Involve patients in the treatment process

8. Screen for trauma

9. Train staff in trauma-specific treatments

10. Engage referral source and partner organizations

Self-Care: Identification of the Problem

Assessments

Assessments

* Professional Quality of Life Scale: a common measurement of compassion fatigue and burnout, the PROQOL describes compassion fatigue as comprising burnout and secondary trauma
- 30 question, five point Likert scale assessment developed by Beth Hudnall Stamm, PhD gives scores for compassion satisfaction, burnout, and secondary traumatic stress.
- Free to use and available on ProQOL and AVMA websites

(Stamm, 2016; Stamm, 2012)

Assessments cont.

- Helps to answer the question: “Do I have compassion fatigue, burnout or something else?”
- Score can show how much compassion satisfaction your job brings you and help you differentiate between burnout and secondary trauma-the latter of which is roughly equivalent to CF

(Stamm, 2016; Stamm, 2012)

Assessments cont.

* MindTools website for burnout self-test (see Table 1)
* Compassion Fatigue Scale (see Table 2)
- a less extensive investigation of compassion fatigue; like the ProQOL, scores for secondary traumatic stress and burnout components of compassion fatigue

(Gentry, Baranowsky, & Dunning, 2002)

Assessments cont.

* Secondary Traumatic Stress Scale
- 17 items based on PTSD symptoms described in the DSM-IV (see Table 3)
  - Intrusion statements: 2, 3, 6, 10, 13
  - Avoidance statements: 1, 5, 7, 9, 12, 14, 17
  - Arousal statements: 4, 8, 11, 15, 16

(Bride, Robinson, Yegidis, & Figley, 2004; American Psychiatric Association, 2000)

Table 1. Checking Yourself for Burnout

0 = Never	1 = Rarely	2 = Sometimes	3 = Often	4 = Very Often
___ 1. I feel run down and drained of physical or emotional energy.				
___ 2. I have negative thoughts about my job.				
___ 3. I am harder and less sympathetic with people than perhaps they deserve.				
___ 4. I am easily irritated by small problems, or by my coworkers and team.				
___ 5. I feel misunderstood or unappreciated by my coworkers.				
___ 6. I feel that I have no one to talk to.				
___ 7. I feel that I am achieving less than I should.				
___ 8. I feel under an unpleasant level of pressure to succeed.				
___ 9. I feel that I am not getting what I want out of my job.				
___ 10. I feel that I am in the wrong organization or the wrong profession.				
___ 11. I am frustrated with parts of my job.				
___ 12. I feel that organizational politics or bureaucracy frustrate my ability to do a good job.				
___ 13. I feel that there is more work to do than I practically have the ability to do.				
___ 14. I feel that I do not have time to do many of the things that are important to doing a good quality job.				
___ 15. I find that I do not have time to plan as much as I would like to.				

Score	Assessment
5	Little sign of burnout, unless some factors are particularly severe
18	Be careful — you may be at risk for burnout, particularly if several statements are true very often
35	Severe risk for burnout — do something about this urgently
45	Very severe risk for burnout — do something about this urgently

Table 2. Compassion Fatigue Scale

Consider the following statements about your work/life situation. Check the box that best reflects your experiences using the rating scale 1 through 10.

	Never/Rarely									Very Often
	1	2	3	4	5	6	7	8	9	10
a. I have felt trapped by my work.										
b. I have thoughts that I am not succeeding in achieving my life goals.										
c. I have had flashbacks connected to my clients.										
d. I feel that I am a "failure" in my work.										
e. I experience troubling dreams similar to those of a client of mine.										
f. I have felt a sense of hopelessness associated with working with clients/patients.										
g. I have frequently felt weak, tired or rundown as a result of my work.										
h. I have experienced intrusive thoughts after working with an especially difficult client/patient.										
i. I have felt depressed as a result of my work.										
j. I have suddenly and involuntarily recalled a frightening experience while working with a client/patient.										
k. I feel I am unsuccessful at separating work from my personal life.										
l. I am losing sleep over a client's traumatic experiences.										
m. I have a sense of worthlessness, disillusionment or resentment associated with my work.										

NOTE: Secondary trauma items (c, e, h, j and l); job burnout items (a, b, d, f, g, i, k and m)

Table 3. Secondary Traumatic Stress Scale

The following is a list of statements made by persons who have been affected by their work with traumatized clients. Read each statement, then indicate how frequently the statement was true for you in the past *seven days*.

	Never	Rarely	Occasionally	Often	Very Often
	1	2	3	4	5
1. I felt emotionally numb.					
2. My heart started pounding when I thought about my work with clients.					
3. It seemed as if I was reliving the trauma experienced by my client.					
4. I had trouble sleeping.					
5. I felt discouraged about the future.					
6. Reminders of my work with clients upset me.					
7. I had little interest in being around others.					
8. I felt jumpy.					
9. I was less active than usual.					
10. I thought about my work with clients when I didn't intend to.					
11. I had trouble concentrating.					
12. I avoided people, places or things that reminded me of my work with clients.					
13. I had disturbing dreams about my work with clients.					
14. I wanted to avoid working with some clients.					
15. I was easily annoyed.					
16. I expected something bad to happen.					
17. I noticed gaps in my memory about client sessions.					

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work, such as consumer, patient, recipient and so forth.

Assessments: Provider Resilience

* Provider Resilience: mobile phone app to assess your resilience.
- Developed to help health care providers guard against burnout and compassion fatigue when helping veterans, but has many features that are useful for any health care professional

(Provider Resilience [app]. National Center for Telehealth and Technology website)

Resilience

Resilience is the strength of spirit to recover from adversity. When we experience disappointment, loss, or tragedy, we find the hope and courage to carry on. Humor lightens the load when it seems too heavy. We overcome obstacles by tapping into a deep well of faith and endurance. At times of loss, we come together for comfort. We grieve and then move on. We create new memories. We discern the learning that can come from hardship. We don't cower in the face of challenge. We engage fully in the dance of life.

Assessments: Provider Resilience

* The main screen is a dashboard with a Resilience Rating gauge. The value is based on the data you input via:
  - Vacation clock
  - Resilience builders/killers quiz (recommended daily)
  - Burnout toggle chart (recommended weekly)
  - ProQOL assessment (recommended monthly)

Assessments: Provider Resilience

- There are cartoon jokes to add humor, simple physical exercises that can be done in the office and alphabetically sorted “value cards” for contemplation or use as a daily devotional.

Provider Resilience

PROFESSIONAL QUALITY OF LIFE

It's been 18 days since your last update.

Update ProQOL

COMPASSION SATISFACTION

High Score

You've scored in the high range of Compassion Satisfaction which is higher than 75% of individuals completing this scale. This suggest that you are experiencing considerable satisfaction with your work and that your daily activities tend to bring you pleasure through a sense of competence and accomplishment.

BURNOUT

Low Score

Your score associated with Burnout is in a range that is lower than approximately 75% of the scores of those who have taken this scale. This low score suggests that you are energetic, like what you are doing and feel like you are making a difference in the work that you do.

SECONDARY TRAUMATIC STRESS

Low Score

Your score associated with Secondary Traumatic Stress is in a range that is lower than approximately 75% of the scores of those who have taken this scale. You may not be working with individuals who are reporting and describing traumatic events or if you are, you are doing a good job creating necessary emotional boundaries.

Burnout Survey

How would you describe yourself as you approach your work today?

Happy

Not at All — Very Much So

Trapped

Not at All — Very Much So

Satisfied

Not at All — Very Much So

Preoccupied

Not at All — Very Much So

Connected

Not at All — Very Much So

Worn Out

Not at All — Very Much So

Assessments Cont.

* Important to know whether it is burnout or compassion fatigue or both-because action plans addressing these problems differ.
- Treatment of burnout focuses on identifying and addressing areas of mismatch by changing the individual and/or the organization.
- Compassion satisfaction helps increase resilience by improving empathic ability and empathic response. Focus is on improving self-care, maintaining appropriate detachment and increasing support and a sense of satisfaction.

(Ludick & Figley, 2016; Maslach & Leiter, 1997; Figley & Roop, 2006)

Self-Care

* The Dalai Lama on Self Care

‘In dealing with those who are undergoing great suffering, if you feel “burnout” setting in, if you feel demoralized and exhausted, it is best, for the sake of everyone, to withdraw and restore yourself. The point is to have a long-term perspective.’

Obstacles

- Most days, the amount of energy devoted to others' needs far exceeds any energy directed to own well-being.
- Finance
- Demands of work and family (time-too many responsibilities)
- Lack of awareness or knowledge
- Perfectionism
- Believe shouldn't need support or overall lack support
- Prolonged ignoring leads to greater risk for Vicarious Trauma

Impact of our Childhood

* LOOKING AT OURSELVES….
  - What was our "template"? –The Core Story –How Brains are Built
  - Understanding ACES

“Wounded Healer”-Carl Jung

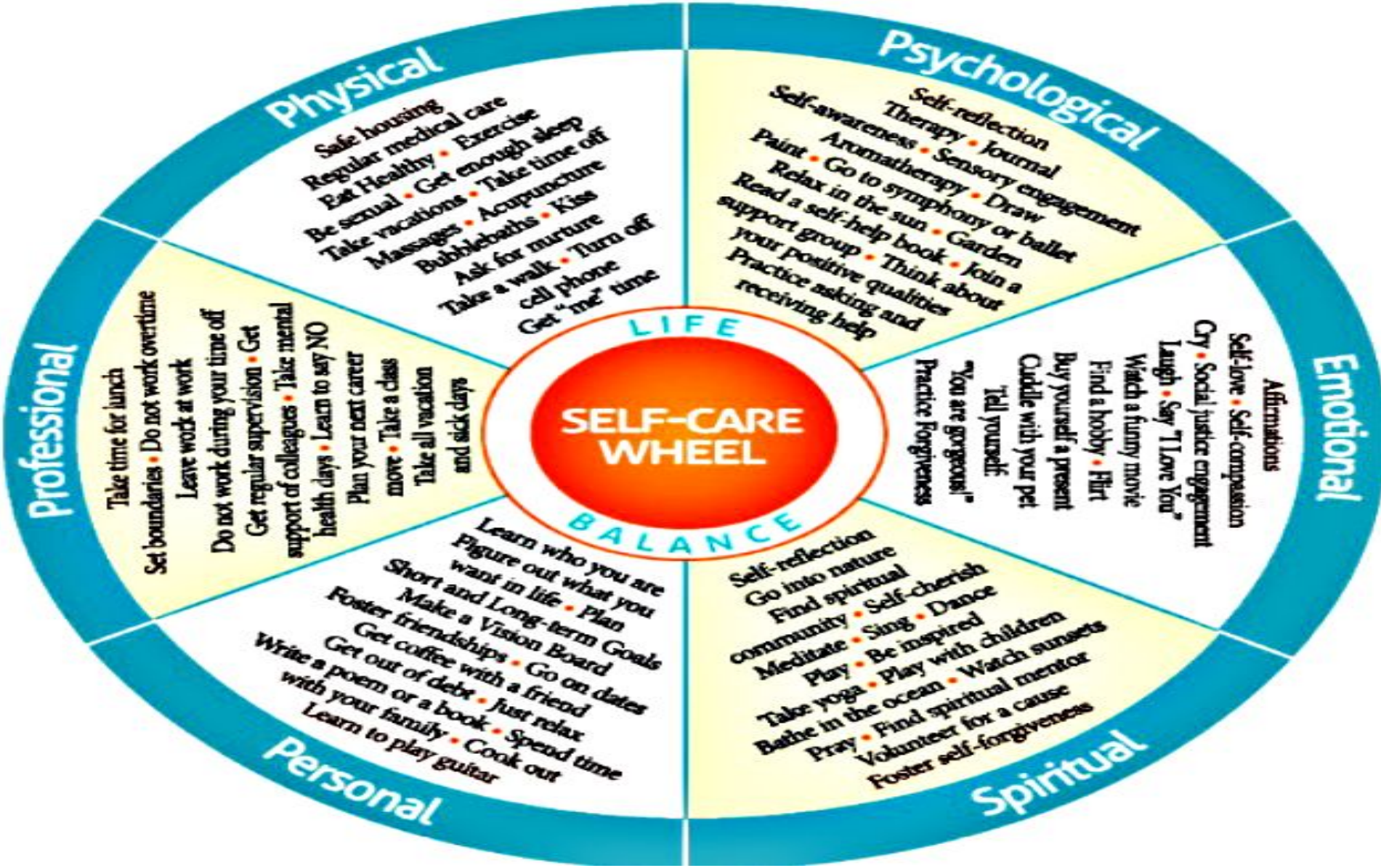
* The “analyst”/helper is compelled to treat patients because s/he is “wounded” himself/herself.
* Research (Barr, 2006) has shown that approximately 74% of counselors and therapists have experienced one or more wounding experiences, often leading to career choice
* Important to understand Transference and Countertransference Principles as well as catharsis

A, B, C'S of Self-Care

Awareness Balance Connection

- Know your tolerance levels, boundaries, needs, feelings, resources, body sensations
- Know when your needs/ emotions/ sensations change
- Balance (harmonize) work and life
- Prioritize
- Re-evaluate
- Theory of thirds: **1/3 work 1/3 play 1/3 rest**
- Connect to LIFEGIVING individuals
- Connect to bigger purpose or meaning
- Allow for at least one deep emotional connections with an individual who can be 100% there for you, to support and reflect your image back to you

SELF-CARE WHEEL



Strategies

* Know the signs of burnout, STS, and VT
* Exercise: run, dance, garden, do yoga
* Increase self-awareness
* Go for therapy
* Get support from peers and others…e.g. supervision, peer support groups, positive mentoring relationships, routine de-briefing
* Personal growth: increase your repertoire of therapeutic techniques. You will feel more effective and less helpless or frustrated.
* Feed your creativity
* Pursue your spiritual/religious practice
* Pursue interests that have nothing to do with work or even helping others

Strategies Cont.

* Stay in contact with important people in your life
* Treat yourself kindly (supportive inner dialogue or self-talk)
* Recognize the proud moments
* Reread favorite books, review favorite movies or music
* Identify and seek out comforting activities, objects, people, relationships, and places
* Find the humor
* Express emotions (e.g. anger) in a constructive way

Put on your own oxygen mask before helping others around you.

Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers By Françoise Mathieu, M.Ed., CCC., Compassion Fatigue Specialist

* **1. Take stock of what's on your plate**
* **2. Start a self-care idea collection**
* **3. Find time for yourself every day – Rebalance your workload**
* **4. Delegate - learn to ask for help at home and at work**
* **5. Have a transition from work to home**
* **6. Learn to say no (or yes) more often**
* **7. Assess your trauma inputs**
* **8. Learn more about Compassion Fatigue and Vicarious Trauma**
* **9. Consider joining a supervision/peer support group**
* **10. Attend workshops/professional training regularly**
* **11. Consider working part time (at this type of job)**
* **12. Exercise**

Mindfulness

* “The awareness that arises through paying attention, in the present moment on purpose without judgement.” – Jon Kabot-Zinn
* Being present can interrupt the negative consequences of trauma exposure.
* When we are numb, it is more difficult to understand or see when we are doing harm.


"Mindfulness is a pause --
the space between stimulus
and response: that's where
choice lies."
--Tara Brach

Mindfulness Cont.

* It is often not the mood or feeling state that is problematic, but our judgment or reactions to them.

* Decreasing reaction to emotions and letting go of expectations calms down the amygdala.

* The Science Behind Mindfulness Meditation

www.youtube.com/watch?v=VTAOj8FfCvs

Benefits of Mindfulness

* Studies have shown mindfulness has:
- Positively effects brain patterns
- Calms down overactive amygdala
- Improves physical effects of stress
- Increases immunity
- Prevents depression

Mindfulness Apps

* Headspace
* Calm
* 10 percent happier
* The Mindfulness App by MindApp
* Mindbell
* Centering Prayer

Compassion and kindness towards oneself are intrinsically woven into mindfulness.

Jon Kabat-Zinn

Happiness and Life Satisfaction

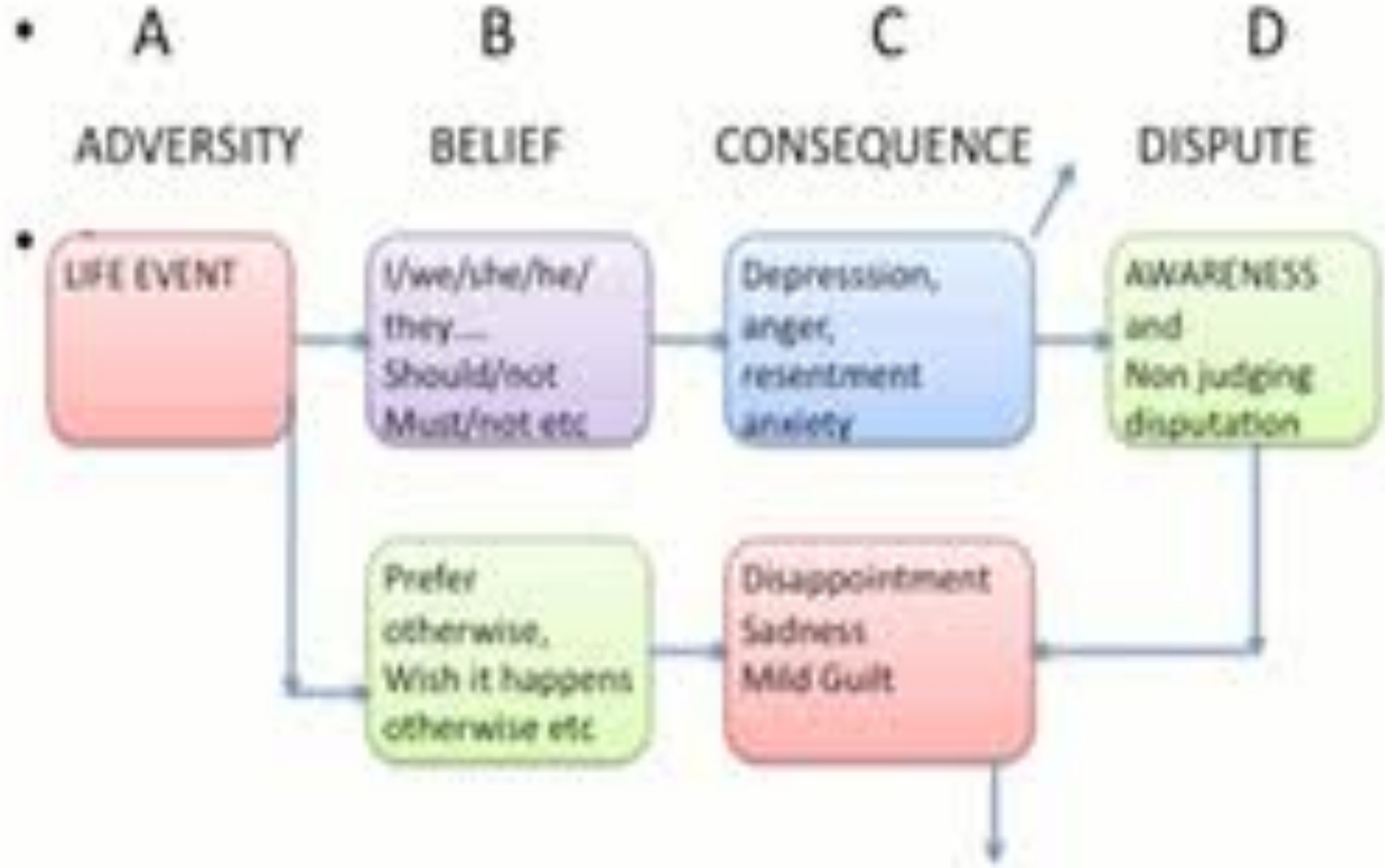
* **Studies have demonstrated significant improvements in optimism and life satisfaction by engaging in one of these activities every day for 3 weeks:**
- **Write down 3 things for which you are grateful**
- **Meditate for 3-minutes**
- **Describe in a journal a meaningful experience of the day**
- **Perform a random act of kindness**
- **Research suggests the brain can rewire, creating alternate pathways as new habits develop**

(Achor, 2010)

Lao Tzu (6th Century BC, Chinese Philosopher)

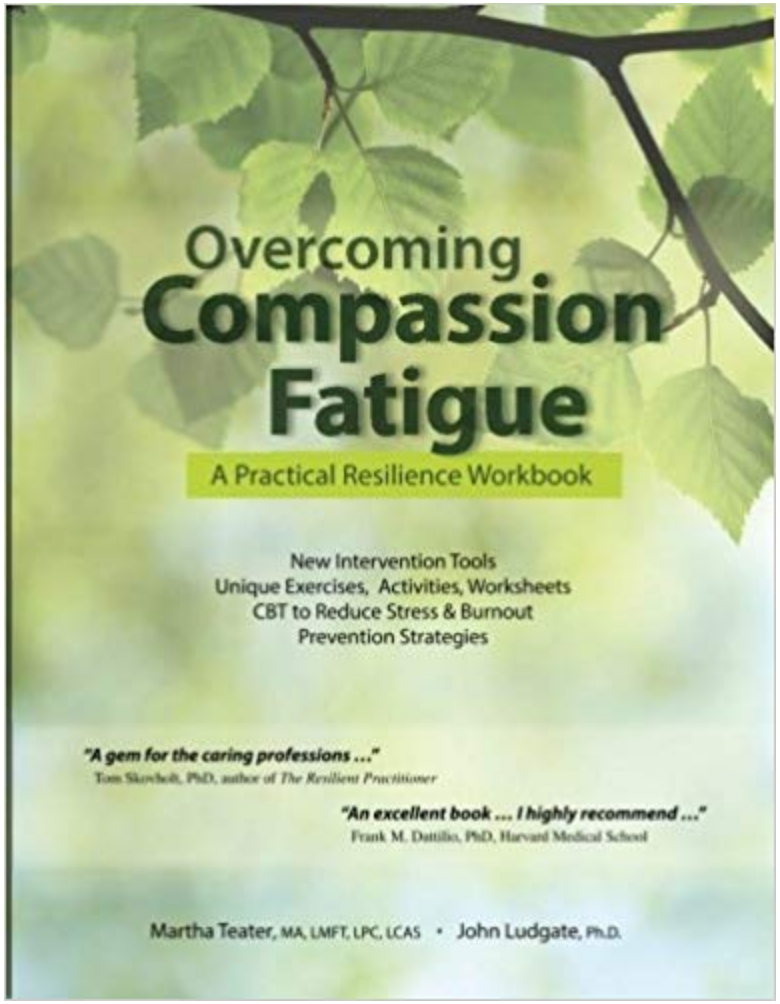
“ If you are depressed, you are living in the Past. If you are anxious, living in the Future. If you are at peace, you are living in the moment.”

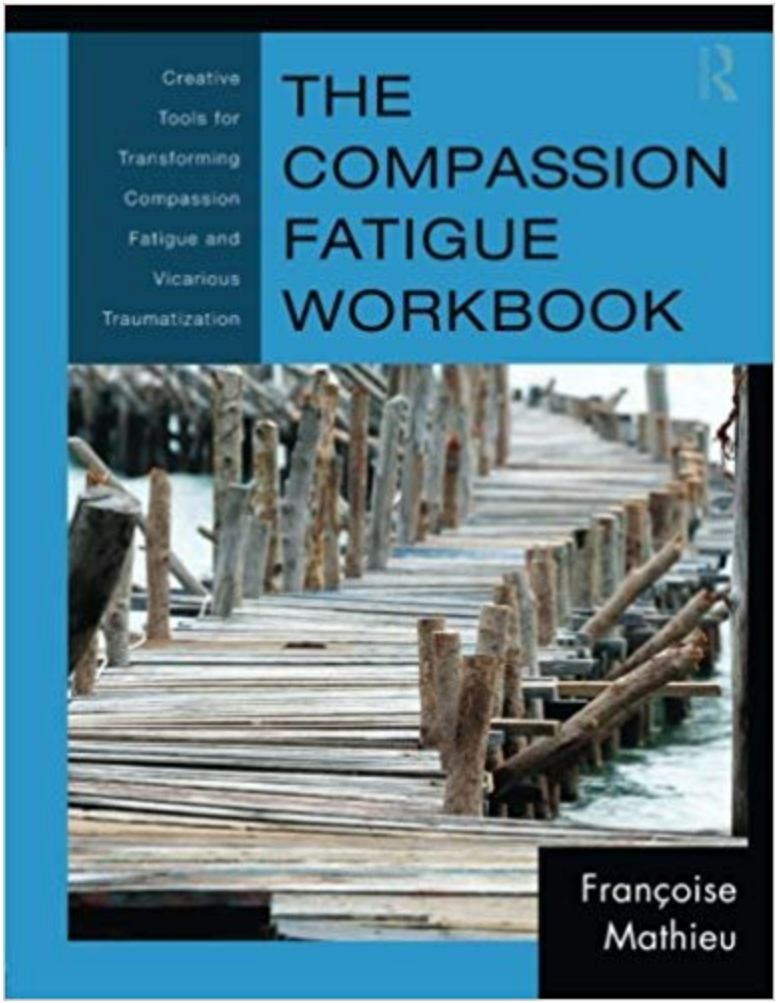
The REBT Model…

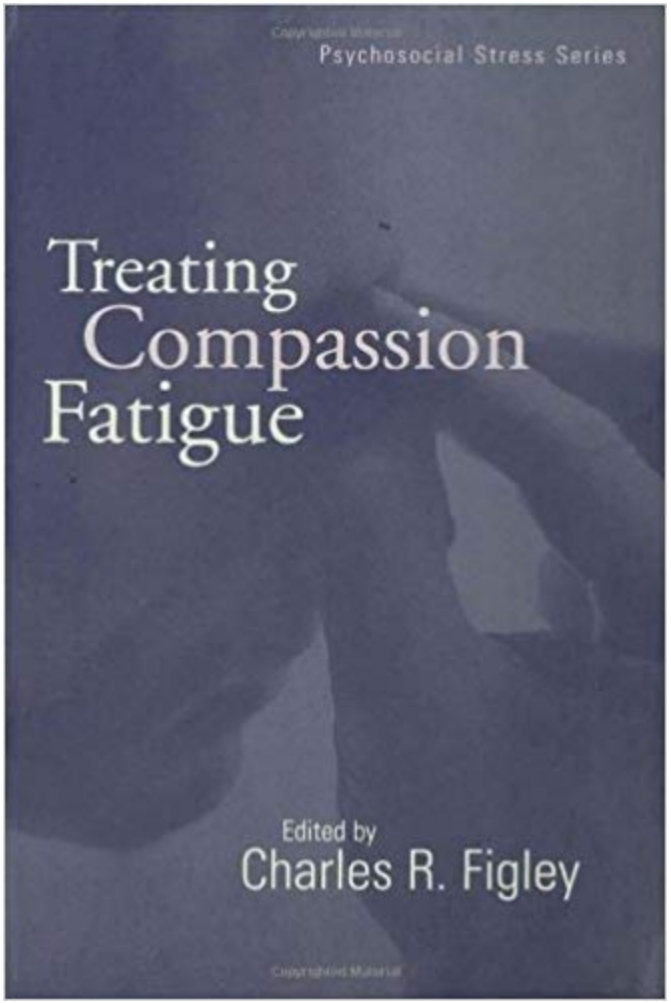


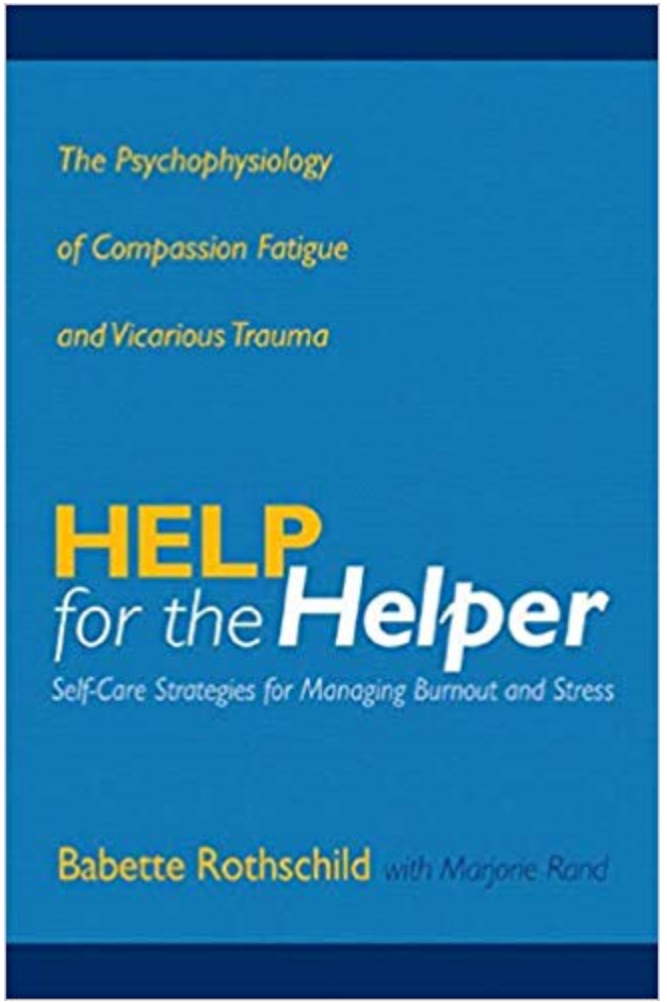
Web and Book Resources

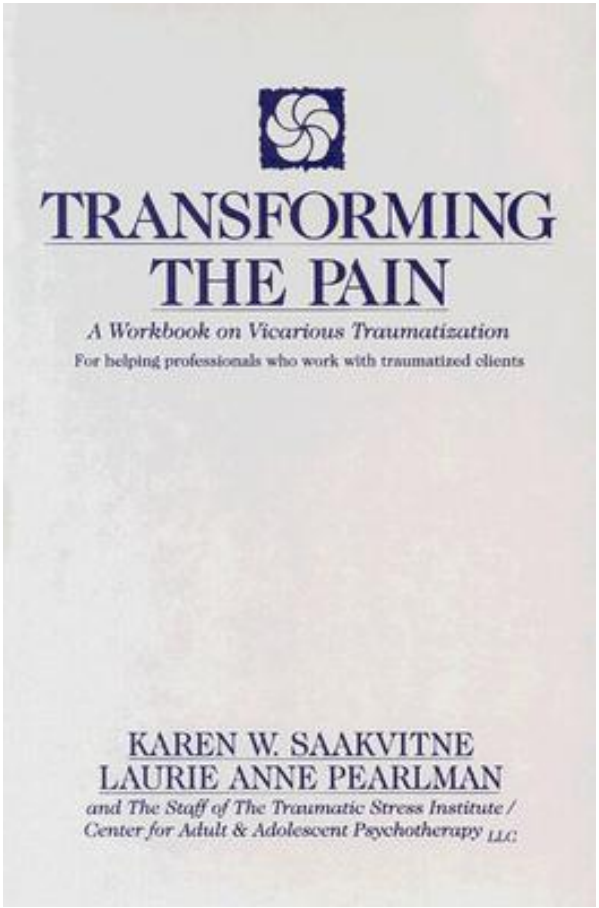
* www.intentionalpeersupport.com
* www.proqol.org

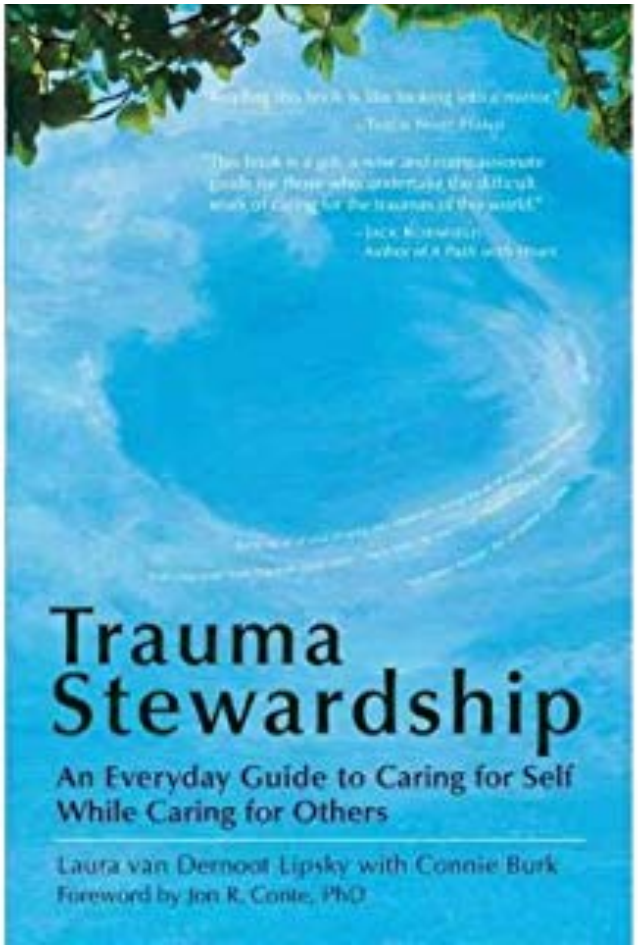

Overcoming
Compassion
Fatigue
A Practical Resilience Workbook
New Intervention Tools
Unique Exercises, Activities, Worksheets
CBT to Reduce Stress & Burnout
Prevention Strategies
"A gem for the caring professions ..."
Tom Skovholt, PhD, author of The Resilient Practitioner
"An excellent book ... I highly recommend ..."
Frank M. Dattilio, PhD, Harvard Medical School
Martha Teater, MA, LMFT, LPC, LCAS • John Ludgate, Ph.D.


Creative
Tools for
Transforming
Compassion
Fatigue and
Vicarious
Traumatization
THE
COMPASSION
FATIGUE
WORKBOOK
Françoise
Mathieu


Psychosocial Stress Series
Treating Compassion Fatigue
Edited by
Charles R. Figley


The Psychophysiology
of Compassion Fatigue
and Vicarious Trauma
HELP for the Helper
Self-Care Strategies for Managing Burnout and Stress
Babette Rothschild with Marjorie Rand


TRANSFORMING
THE PAIN
A Workbook on Vicarious Traumatization
For helping professionals who work with traumatized clients
KAREN W. SAAKVITNE
LAURIE ANNE PEARLMAN
and The Staff of The Traumatic Stress Institute /
Center for Adult & Adolescent Psychotherapy LLC


Trauma
Stewardship
An Everyday Guide to Caring for Self
While Caring for Others
Laura van Dernoot Lipsky with Connie Burk
Foreword by Jon R. Conte, PhD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Баярлалаа
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তোমাকে ধন্যবাদ
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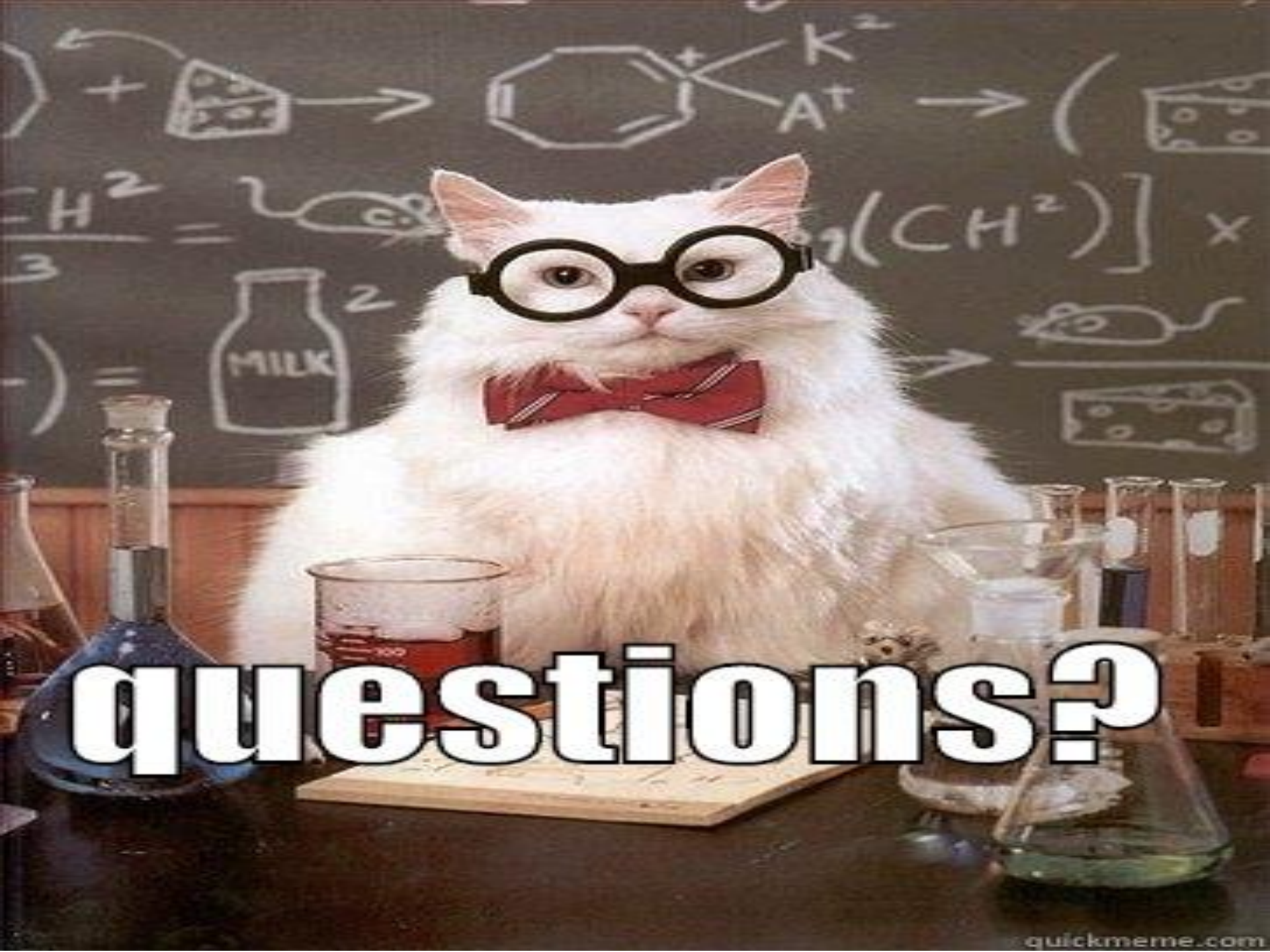
MILK
questions?
quickmeme.com

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