Vicarious Traumatization and Burnout Survey Report

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THE CHALLENGE OF CARING:

The Voice of Caregivers in Maine

Do not believe that he who seeks
to comfort you
Lives untroubled among the simple
and quiet words
That sometimes do you good.
His life has much difficulty and sorrow.
Were it otherwise, he never would
have been
Able to find those words.

Ranier Marie Rilke

Maine Partners–in-Healing Committee Survey Report

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Preface

If you confront your problems
rather than avoid them,
you will be in a better position
to deal with them.

The Dalai Lama

Throughout history and across cultures, there has always been the suffering of those in need of care, and there has always been the compassion of those who willingly and generously cared for them. This, of course, is as true today as it ever was.

While choosing to care for the vulnerable attracts talented and dedicated people and offers great opportunities for emotional and spiritual gratification, it is also true that the demands of caring sometimes stretch a caregiver's skills and energy to a point where the caring itself becomes a problem. Knowing how to maintain a balance between effectively caring for another and appropriately caring for oneself is an essential ability. When the helper is part of a human service system or institution, it is also critical that the system itself be sensitive to the helper's need for support.

In *The Challenge of Caring* you will hear the voices of 355 caregivers in Maine who speak of what helps and what hinders them in doing the challenging work they have chosen to do. Included are employees of The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS),***** staff members of several community mental health agencies, and various private practitioners. In particular they are people who work directly with adult survivors of the trauma of interpersonal violence in the form of child sexual abuse, physical abuse, severe neglect, and/or the witnessing of violence or its effects on victims. With at least 1 in 4 women and 1 in 6 men sexually abused as children (Finkelhor, 1990), and with 74% of Maine's Augusta Mental Health Institute consent decree class members reporting histories of sexual and physical abuse (Maine DMHMRSAS, 1998), the statewide treatment needs of adults struggling to heal from that devastation are unmistakable.

By its very nature, working with traumatized people is an unusually intimate and intense process for both helper and client. It also holds the potential for exceptional rewards. Pearlman and Saakvitne, of the Traumatic Stress Institute in Connecticut, speak of the paradoxical reality of trauma work:

> Working as a therapist with sexual abuse survivors profoundly affects us as
> therapists and as human beings. While it is work we enter into by choice, and

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* While the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) was renamed in 2001 as the Department of Behavioral and Developmental Services (BDS), DMHMRSAS is being retained in this report to reflect the Department's title at the time.

continue because of commitment to our clients and because of the tremendous rewards we can experience, we must recognize that it affects us personally.This is not the responsibility of our clients, nor is it in any way an indictment of them. It is, rather, an occupational hazard that must be acknowledged and addressed. (Pearlman & Saakvitne, 1995b)

Anyone engaged with trauma survivors comes to understand the truth of these conflicting realities and feels the impact, both professionally and personally, on their lives. A study of 100 graduate level psychotherapists in Maryland and Virginia confirms the special benefits and awesome demands of this undertaking:

Undoubtedly, many [caregivers] find that working with survivors of trauma is meaningful and rewarding, and that they are truly privileged to witness clients' strength and resilience in the healing process. But the challenges of frequent exposure to human trauma are great. Steele (1991), in a moving essay about treating survivors of severe abuse, states that 'all the therapists I know who do this work have been blindsided at least once by the horror of it. Their own vulnerability, their helplessness in the face of such abuse is staggering.' (Kassam-Adams, 1995, Revised 1999a)

After reviewing considerable quantitative research evidence, Pearlman concurs. She remarks on the unique and personally transformative nature of trauma work.

Those who voluntarily engage empathically with survivors to help them resolve the aftermath of psychological trauma open themselves to a deep personal transformation. This transformation includes growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life. The darker side of the transformation includes changes in the self that parallel those experienced by survivors themselves. (Pearlman, 1995, Revised 1999a)

What does that mean – "changes in the self that parallel those experienced by survivors"? B. Hudnall Stamm's description is compelling.

There is a soul weariness that comes with caring. From daily doing business with the handiwork of fear. Sometimes it lives at the edges of one's life, brushing against hope and barely making its presence known. At other times, it comes crashing in, overtaking one with its vivid images of another's terror, and with its profound demands for attention: nightmares, strange fears, and generalized hopelessness. (Stamm, 1999b)

Maine's care providers are no exception. They, too, must face and manage the challenges of responding to people in enormous pain.

Sensitive to the potentially debilitating impact of working with traumatized clients and aware of the literature on professional burnout, The Office of Trauma Services (OTS) of DMHMRSAS initiated, in December, 1997, a confidential survey of providers on the unintended effects of their work on them. Surveying providers made eminent sense as a way to inform and

improve the service delivery system of the Department and other agencies and organizations. **The logic was simple: since care providers are at the heart of treatment, and since caring for trauma survivors presents unique and serious challenges, acknowledging and addressing the needs of caregivers is fundamental to effective service.**

The 355 respondents took the opportunity to open their hearts and minds and speak frankly of their experience working with clients. In *The Challenge of Caring* you will hear them reveal, with passion and intelligence, their needs, their concerns, their satisfactions, and their hopes for change, within themselves and within the system of care employing them. Sometimes they sound depressed -- overwhelmed, disheartened, exhausted. They speak of feeling helpless, of the heartbreak of feeling they can't do what they know needs to be done, of being stuck in a system and/or a situation that doesn't/can't support them. Sometimes what they say is critical, cynical, even angry. At the same time they speak of their devotion, creativity, and gratitude for the many times and ways they have felt effective and supported, for the gifts of the work. And finally, they willingly share what they have done to sustain themselves, offer their ideas of how workers can strengthen themselves, and make suggestions about what would improve the work environment and the system as a whole.

In the end, you will see that this report is not about finger pointing, "venting," or whining. It is about what dedicated and caring professionals say helps or does not help them do the demanding jobs they want to do. Their words are pleas for support and guidance, and for a systemic commitment to acknowledging trauma as the legitimate, treatable root of many of the conditions they are asked to address. They long for the climate they know they need to make their best effort. And they are not alone. National literature and widespread research on best practices, also included in this report, echo the feelings and recommendations articulated by Maine providers.

Saakvitne sums up: "Research and clinical experience have taught us that ignoring the impact of trauma work on providers jeopardizes the well-being of clients and treaters alike." (Saakvitne, et al, 1999) As one survey respondent urges: "Don't let this initiative [acknowledging the depth and nature of trauma's impact on everyone] develop in isolation from the rest of the Department."

At its heart, then, *The Challenge of Caring* is dedicated to all of us who care about the children of abuse, the adults they become, and the support caregivers need to be truly effective partners in their healing process. In turn, as the Dalai Lama counsels, it is up to us to pay attention to the problems aired and the suggestions offered, and then to find ways to do the right thing.

Introduction

No problem can be solved
from the same consciousness that created it.
We must learn to see the world anew.

Albert Einstein

Context for Caring

While research on the scope of child abuse* in the United States has burgeoned in recent years, childhood trauma still remains a serious and widespread problem. Tragically, clinical experience confirms that the impact of that trauma on its victims is often life-long and seriously disabling. An alarmingly high percentage of women, men and children in the mental health, mental retardation, substance abuse and correctional systems have been abused in childhood and/or as adults. As Judith Herman, M.D., points out in her seminal book on the subject, *Trauma and Recovery*:

> The mental health system is filled with survivors of prolonged, repeated childhood trauma.While a small minority of survivors, usually those with the most severe abuse histories, eventually become psychiatric patients, many or even most psychiatric patients are survivors of childhood abuse. The data on this point are beyond contention. On careful questioning, 50-60% of psychiatric inpatients and 40-60% of outpatients report childhood histories of physical or sexual abuse or both. Thus abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric help as an adult. (Herman, 1992)

Other related facts are sobering.

- Up to two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect. (US Dept. Health & Human Services, 2000)
- Adults who had experienced multiple types of abuse and violence in childhood, compared to those who had not, have a 2 – 4 fold increase in smoking, poor self-rated health, sexual partners, sexually transmitted disease, physical inactivity, and severe obesity. (Felitti, et al, 1998)
- As high as 81% of men and women in psychiatric hospitals, with a variety of major mental illness diagnoses, have experienced physical and/or sexual abuse. 67% of these men and women were abused as children. (Jacobson & Richardson, 1987)
- 70% of women on the streets or in shelters report abuse in childhood. (Goodman, 1991, Chesney-Lind & Shelden, 1998)

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* The terms "abuse" and "trauma," used interchangeably, are defined herein as: interpersonal violence in the form of sexual abuse, physical abuse, severe neglect, and/or the witnessing of violence or its effects on victims.

- More then 90% of people with developmental disabilities will experience sexual abuse; 49% will experience 10 or more incidents… Only 3% of those cases will ever be reported. (Valenti-Hein, & Schwartz, 1995)
- Twice as many women with a history of incest as women without such a history are victims of domestic abuse. (Russell, 1986)
- Numerous studies have documented that most violent criminals were physically and/or sexually abused as children. (Groth, 1979, Seghorn et al, 1987)

In spite of the pervasiveness of child abuse and its personal, financial, and societal costs, this shocking reality somehow has not penetrated our cultural consciousness in any major way. It has not yet motivated us to take concerted and effective action as a society, nor has it inspired the psychiatric profession, on the whole, to alter significantly its thinking about diagnosis and treatment. As prominent psychiatrist, Bessel van der Kolk, of Harvard Medical School observes: "In view of the horrendous life stories told by so many of our patients, the relative neglect by psychiatry of the issue of psychological trauma is almost as intriguing as the impact of trauma itself." (van der Kolk, 1987). Sadly, the extent of childhood trauma and its painful adult consequences remain denied or ignored, largely unchecked, and inadequately treated.

If background trauma is not recognized in those who do seek treatment, the results are both devastating and expensive. Patients can accumulate numerous mistaken diagnoses followed by numerous failed treatments "before finally discovering the source of their psychological problems in a history of severe childhood abuse. **The testimony of patients is eloquent on the point that recognition of the trauma is central to the recovery process."** [emphasis added] (Herman, 1992) It was only recently that a federal blue ribbon panel investigating substance abuse acknowledged that: "Clients often suspect that childhood abuse contributed to their substance abuse disorders and relapses… By addressing child abuse issues, the risk of relapse among clients who were abused as children might actually drop below that of their nonabused peers." (U.S. Dept. Health & Human Services, 2000)

How can our society have been so unaware and slow to respond? Listen to Alice Walker in Possessing the Secret of Joy: "They do not want to hear what their children suffer. They've made the telling of the suffering itself taboo." It would appear that accepting the truth of widespread interpersonal violence and child abuse is so disconcerting that for many people ignoring or marginalizing the issue has been more expedient than facing it. As Dr. Herman observes: "The ordinary response to atrocities is to banish them from consciousness…To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. It means bearing witness to horrible events… When the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator." This is as true for a society and its designated systems of care as it is for the individual caregiver listening to clients with trauma histories. "Denial, repression, and dissociation operate on a social level as well as an individual level." Yet Herman goes on to say that for those who are willing to accept and face the profoundly unsettling reality of human cruelty, it is "…morally impossible to remain neutral in this conflict. The bystander is forced to take sides." (Herman, 1992)

Maine's Response

In 1995, under the leadership of Melodie Peet, Commissioner the Department of Mental Health, Mental Retardation and Substance Abuse Services, (DMHMRSAS) the state of Maine chose not to stand by but to champion the cause of trauma survivors – a remarkably forward-looking, risky, and compassionate stance. Recognizing that trauma survivors are not a "special population," but are found in all categories and ages of people using DMHMRSAS services, the Department established an Office of Trauma Services (OTS) to provide leadership, education, and consultation on the subject of trauma and its treatment. Ann Jennings, PhD, was named to direct this new undertaking. OTS's first step was to examine the "status quo" of Maine's system of services, looking for clues as to what was working, what wasn't, and what needed to be done to improve the system's effectiveness.

Informed by several statewide needs assessments of consumers and professionals, the Department then explicitly identified trauma as a key public health issue, and Maine became first in the nation to develop a strategic plan to build capacity within the existing system to respond more effectively to the needs of consumers with trauma- related problems.

It soon became apparent that for all parties -- consumers, professionals, and administrators -- the process of change would be a serious test, a test of their "willingness to see the world anew," of their creativity in addressing the issues, and of their resolve to take bold and concerted action. A powerful and perhaps unexpected realization soon dawned: **working with trauma survivors requires not just specialized training, which it does, but also specialized supports for those providing the care.** Why? Because providers "experience their work with trauma survivors as distinctly different and, on the whole, more personally distressing than their work with non-traumatized individuals." (Saakvitne, et al, 1999) "The reality of loss and suffering, the knowledge that lives have been irrevocably altered, the awareness of our own limitations, that we can never undo what has been done, are painful." (Charney & Pearlman, 1998) "In our own searches for meaning, we are forced to integrate the realities of cruelty, indifference, and abuse that we have heard and to which we have been empathically and humanly connected." (Saakvitne, 1996) And in truth, there is no escaping the potent impact of this work if providers are to be authentically engaged partners with their clients.

Centrality of Relationship

Many professionals know that it is their courage, commitment, and connection with their clients that is at the very heart of an effective healing process. This is especially true of work with people recovering from trauma. "Because trauma occurs in an interpersonal, relational context, it is the interpersonal, relational context of the therapeutic relationship that provides the setting for holding and healing for the trauma survivor client." (Saakvitne, 1991) This is a key concept. The client must experience alternative and positive relationships in order to develop new beliefs, skills and hope for the future. The worker "must be trustworthy and provide a safe relational context that – in contrast to the client's past experience – presents a unique opportunity for healing." (U.S. Dept. Health & Human Services, 2000)

It is important to recognize that connection as a core value is not limited to the psychotherapy hour. It extends to **all** services clients choose. For instance;

[In crisis work]…all the skills in the repertoire of the [worker] may be required to meet the numerous and varied emotional responses of the impacted individuals. Most important, one brings one's self, one's essential humanity – an empathic, caring, and willing participant – to share in the sorrow, bear witness to the pain, shoulder the grief of those who need it, and psychologically 'carry' them until they can carry themselves. The work requires great finesse…(Charney & Pearlman, 1998)

It is also true that empathic relationship is central to successful psychotherapy. A notable example is found in a study by Bessel van der Kolk:

In our last study of patients with Borderline Personality Disorder, Judith Herman and I asked our self-mutilating subjects what had helped them most in over-coming the impact of their childhood traumas, including their self-mutilation. All subjects attributed their improvement to having found a safe therapeutic relationship in which they had been able to explore the realities of their childhood experiences and their reactions to them. All subjects reported that they had been able to markedly decrease a variety of repetitive behaviors, including habitual self-harm, after they established a relationship in which they felt safe to acknowledge the realities of both their past and their current lives. (van der Kolk, 1989)

All the above is to say that in addition to knowledge and skills, the caregiver's very humanness must be available in his or her relationship with the client. He or she must be open to empathic engagement with the client, for it is within the intimacy of connection that the transformation of recovery can occur. As explicitly expressed in Maine's clinical training curriculum, *Risking Connection*:

The alliance you form with a client is your major clinical tool. It is through this alliance that you create safety and trust, the two relationship factors that form the foundation for change with trauma survivor clients… In short, without an alliance, techniques will not work. (Saakvitne, et al, 1999)

Implications

There is another and crucial factor in the relationship story, however. While the helper's "capacity for empathy is an essential gift and tool, it is also a source of vulnerability…The cumulative effect of empathic engagement with traumatized clients and their material leads to profound and permanent changes in the self of the [provider]." (Saakvitne, 1996) Over the past 10-15 years, as the knowledge about traumatic stress has grown, so has an awareness of the high cost of caring. Time and again studies have shown that people working with those who have experienced highly stressful events are themselves vulnerable to becoming traumatized and to developing similar stress-related symptoms. (Kluft, 1989, Talbot, 1990, McCann & Pearlman, 1990, Pearlman & Saakvitne, 1995a & 1995b, Figley, 1995, and Stamm, 1995, Revised 1999) What strains these professionals is that hearing the "stories" and witnessing the physical, emotional, and social reactions of survivors to a variety of interpersonal traumas is a regular part of their everyday work life.

In being present to this traumatic material, caregivers are confronted with the reality that the suffering of their clients results from conditions that exist in the very same world in which the helpers themselves live. The suffering cannot be explained by impersonal forces like biology or accident or acts of God. Rather it stems from widespread, frequent, usually intentional, and profoundly harmful violence perpetrated by people at all levels and in all segments of society. The caregiver, then,

> …must come face-to-face with the reality of trauma and the existence of terrible and traumatic events in the world. Acknowledgement of this reality interferes with the [their] adaptive assumptions of personal invulnerability, and of the world as meaningful and comprehensible… (Kassem-Adams, 1995, Revised 1999a)

Plainly these helpers face a unique set of demands. They must deal with their strong feelings and the natural inclination to defend against those feelings, with assaults on their idealism and hope, and with an erosion of confidence in their ability to make a difference. In short, they are challenged to find a way to understand and manage:

> …a host of feelings, often paralleling the experiences of the victims … Anger, and helplessness at the injustice of the situation; the extent of devastation, the awareness of danger to the self or others; …the pain and anguish. While the need to perform effectively may require that the [worker] hold the intense feelings associated with trauma and death in abeyance, ultimately, these feelings must be integrated into [a] sense of himself/herself as a person and a professional. (Charney & Pearlman, 1998)

And the ultimate significance is that failing to address these challenges not only affects the self and attitude of the caregiver but risks compromising the welfare of the client and the therapeutic process as well.

> If these feelings are not openly acknowledged and resolved, there is a risk that the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathic, and responsive stance with clients. (McCann & Pearlman, 1990)

Finally, it is important to understand that attending to the needs of the helper is in no way meant to "reduce the importance of being patient-centered but to acknowledge the importance of the mental health of the caregiver in his ability to give care and to live a productive life." (Monroe, 1995, Revised 1999a) **In short, from the relational perspective of trauma sensitive work, when the provider falters, the client suffers.**

Vicarious Traumatization

Various names have been given to caregivers' experience: empathic stress, traumatic countertransference, Secondary Traumatic Stress Disorder (STSD), compassion fatigue, compassion stress, and rape counselor syndrome. All are intended to describe the potential impact of working with traumatized people. In 1990, McCann and Pearlman developed a new term to describe the particular phenomenon they saw among care providers who work with

trauma survivors -- vicarious traumatization (VT).*****

> Vicarious traumatization is a process of change resulting from empathic engagement with trauma survivors. It can have an impact on the helper's sense of self, worldview, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory…. It is neither a reflection of inadequacy on the part of the [worker] nor of toxicity or badness on the part of the client. It is best conceptualized as a sort of occupational hazard…. (Pearlman, 1995, Revised 1999a)

Dr. Herman also spoke to the issue: "Trauma is contagious. In the role of witness to… atrocity, the [helper] at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, despair as the patient. This phenomenon is known as 'traumatic countertransference' or 'vicarious traumatization'." (Herman, 1992)

Or put another way:

> …[J]ust as Post Traumatic Stress Disorder (PTSD) is viewed as a normal reaction to an abnormal event, vicarious traumatization is a normal reaction to the stressful and sometimes traumatizing work with victims. … [T]his framework does not blame clients for traumatizing helpers, but rather, identifies an inevitable occupational hazard which may be mitigated. (Rosenbloom, et al, 1995, Revised 1999a)

Although the information in this document refers generally to mental health and substance abuse providers, it is noteworthy that "Anyone who engages empathically with trauma survivors is vulnerable to vicarious traumatization." (Pearlman, 1995, Revised 1999) Those numbers would include researchers, clergy, mental retardation workers, doctors, emergency room staff, attorneys, journalists, rescue workers, police, fire fighters, emergency medical technicians, dentists, nurses, family, friends, and all those connected to people who have endured psychological trauma. The conclusion is evident. **"You cannot engage in therapeutic relationships with victims of horrific life events and remain unchanged."** [emphasisi added] (Saakvitne, et al, 1999)

Work Environment

Wherever trauma work is happening, the setting itself is another critical variable. This is true for the professional as well as for the survivor, both of whom need to feel safe and supported within the work environment. For clients, as Judith Herman underscored in her authoritative book, *Trauma and Recovery,* the first and most fundamental requirement of successful trauma recovery is safety. (Herman, 1992) From the perspective of workers, it is also

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*Finding appropriate language to name the impact of trauma work on the helper is a very delicate process. The terminology, no matter how carefully framed, can imply a subtle blame of the trauma client for the experience of the provider. Such may be the case with the term we have been using: "vicarious traumatization." While in no way meaning to blame survivors for their providers' troubles, we find ourselves caught in the history of our own survey process. The questionnaire we distributed specifically named vicarious traumatization and burnout, so the responses we received addressed those issues. At the time we were unaware of the above concerns. We apologize for an offense and trust that our choice of language will not prevent readers from appreciating our intent, which is to improve the healing process for everyone concerned.

widely conceded that work settings "…have a powerful influence … on the therapeutic relationships that exist within the organization." (Pearlman & Saakvitne, 1995a) Without a safe and supportive climate in which to work, caregivers can be compromised and vulnerable to generalized work stress, fatigue, burnout, and VT. In short, the organizational context – the ways the organization "…supports, undermines, understands, or otherwise responds to the work" being done – is another potent factor in the life of those working with trauma survivors. (Rosenbloom, et al, 1995, Revised 1999a) To illustrate, "Norcross and Prochaska's informative study highlights the significant role of the work context in the [provider's] stress level," and concludes that often it is aspects of the work situation that are more distressing to workers than any client problem. (Norcross & Prochaska, 1986) Research on factors influencing burnout generally support this finding. (Edelwich, 1980)

Burnout

So while vicarious traumatization refers to a certain type of job stressor for providers, the more familiar term for the consequences of work-related strain is **burnout**. These two conditions are closely related, and yet they are distinctly different. **Vicarious traumatization** refers to unique connections with traumatized people. It emphasizes the inroads that a relational undertaking can make on the helper's sense of self, meaning, efficacy, and personal adaptation in the world. It is an inner experience, "a human consequence of knowing, caring and facing the reality of trauma." (Saakvitne & Pearlman, 1996) **Burnout**, on the other hand, can be experienced in numerous work settings, including, but not limited to, social service organizations. Unlike VT, which is based primarily on interpersonal relationships, burnout results from environmental conditions in the workplace and the nature of job expectations. In *The Truth About Burnout*, Maslach and Leiter, among the most widely respected authorities on this well-researched subject, share their conclusions:

> The conventional wisdom is that burnout is primarily a problem of the individual. That is, people burnout because of flaws in their characters, behavior, or productivity. According to this perspective, *people* are the problem, and the solution is to change them or get rid of them.
> But our research argues most emphatically otherwise. As a result of extensive study, we believe that burnout is not a problem of the people themselves but of the *social environment* in which people work.
> We argue that burnout in individual workers says more about the conditions of their job than it does about them. Contrary to popular opinion, it's not the individual but the organization that needs change….
> (Maslach & Leiter, 1997a)

What is it about the workplace that creates the conditions for burnout? Maslach and Leiter cite six "mismatches" between person and job.

1. *Work overload* is perhaps the most obvious indication of a mismatch between person and job. We have to do too much in too little time with too few resources. It is not a matter of stretching to meet new challenges but of going far beyond human limits… The pace increases further as people take on a second job or moonlight on the side in an attempt to meet financial pressures

and keep their job options open… The faster pace hurts quality, disrupts collegial relationships, kills innovation – and brings on burnout.

2. *Lack of control* over one's work…. People want the opportunity to make choices and decisions, use their ability to think and solve problems, and have some input in the process of achieving the outcomes for which they will be held accountable. There is a world of difference between being accountable and being constrained by rigid policies and tight monitoring. [The latter] sends the message that 'you can't be trusted, we don't respect your judgment, you aren't very smart, you are incapable of doing this by yourself.'

3. *Lack of reward* for contributions on the job…. When we don't get recognition, both the work we do and we ourselves as workers are devalued. Although everyone knows that rewards are important, this knowledge does not necessarily translate into action. Most devastating for workers, however, is the loss of the internal reward that comes when a person [can take] pride in doing something of importance and value to others, and doing that job well.

4. *Lack of community* … results when people lose a positive connection with others in the workplace. People thrive in community, and they function best when praise, comfort, happiness, and humor are shared with others they like and respect… Sometimes the job has a chilling effect on what people can say or do because of explicit or implicit prohibitions…However, what is most destructive to a sense of community is chronic and unresolved conflict. It tears apart the fabric of social support, making it less likely that people will help each other out when things get tough.

5. *Lack of fairness.* Fairness in the workplace means that people are shown respect and their self-worth is confirmed… Unfairness is most evident during the evaluation and promotion process. But day-to-day interactions may also be unfair – when people get blamed for things they didn't do, for example. Lack of fairness is also evident when there is inequity of workload or pay, or when people bend the rules or cheat in order to get ahead… [O]rganizational policies that send the message that money takes precedence over employees cause mutual respect and shared values to erode.

6. *A value conflict* occurs when there is a mismatch between the requirements of the job and personal principles… People do their best when they believe in what they are doing and when they can maintain their pride, integrity, and self-respect. (Maslach & Leiter, 1997a)

Burnout can take a terrible toll on workers. In 1988 Kahill made a comprehensive review of the empirical research on burnout and identified five categories of symptoms:

1. Physical symptoms (fatigue and physical depletion/exhaustion, sleep difficulties, specific somatic problems such as headaches, gastrointestinal disturbances, colds, and flu).

2. Emotional symptoms (e.g., irritability, anxiety, depression, guilt, sense of helplessness).

3. Behavioral symptoms (e.g., aggression, callousness, pessimism, defensiveness, cynicism, substance abuse).

4. Work-related symptoms (e.g., quitting the job, poor work performance, absenteeism, tardiness, misuse of work breaks, thefts).

5. Interpersonal symptoms (e.g., perfunctory communication with, inability to concentrate/focus on, withdrawal from clients/coworkers, and then dehumanizing, intellectualizing clients). (Kahill, cited in Figley, 1995b)

Perhaps the most deeply troubling result of burnout is a form of "soul erosion," not unlike some of the impacts of VT. "In addition to depersonalization, burnout has been associated with a reduced sense of personal accomplishment and discouragement as an employee." (Figley, 1995b)

> It can be detrimental to your health, your ability to cope, and your personal lifestyle. It can lead to a serious deterioration in your job performance. And these costs are not just yours alone – they are felt by everyone who is affected by you, both on the job and at home. (Maslach & Leiter, 1997a)

The Compounding Effect

In fact, the dual perils of **VT** and **burnout** are hard to separate. Often the signs and symptoms of the two conditions are similar, as is the language describing them. These debilitating and costly consequences of working with traumatized people can act synergistically, reinforcing and exacerbating one another. To begin with, mental health work is highly stressful.

> In a report issued by the National Institute of Occupational Safety and Health (NIOCSH), researchers studied 22,000 workers in 130 different occupations. The results demonstrated that one of the most stressful occupations is the health care professional, including social work. (Daleo, 1986)

Furthermore, "The stress and 'burnout' that may result from working with [these] clients can even produce symptoms similar to those of posttraumatic stress disorder (PTSD)," also known as Secondary Traumatic Stress (STS) or vicarious traumatization. (U.S. Dept. Health & Human Services, 2000) Finally, **"Unaddressed VT is a likely precursor to burnout."** [emphasis added] (Neuman & Gamble, 1995 quoted in Saakvitne, et al, 1999)

 What happens when people are experiencing VT and/or are burning out?   Researchers reporting in *The Truth About Burnout* speak frankly of professional and practical matters:

> One final result of burnout's negative downward spiral is that, as they become more stressed and receive less support in their personal lives, people become even less capable of dealing with problems on the job. People who are burning out are likely to withdraw from the job, both psychologically and physically. They invest less time and energy in their work, do only what is absolutely necessary, and are absent more often. In addition to doing less, they do their work less well.
> (Maslach & Leiter, 1997a)

The result "is not just a trivial matter of people feeling cranky or having bad days – burnout [like VT] costs money. And this economic bottom line can only be controlled by paying attention to the human bottom line." (Maslach & Leiter, 1997a)

Addressing the Challenges

It seems apparent that to ignore, minimize or fail to address the above issues is to risk the quality of service provision, the health and well-being of the helper, and the viability of the provider organization. As stated succinctly in the trauma training curriculum used in Maine, *Risking Connection*: **"The single most important factor in the success or failure of trauma work is the attention paid to the experience and needs of the helper."** [Emphasis added] (Saakvitne, et al, 1999)

> We have an obligation to our clients – as well as to ourselves, our colleagues, and our loved ones – not to be damaged by the work we do. Specifically, many traumatized clients live with the fear that they will harm others through their needs or feelings… It is our responsibility to take care of ourselves… (Saakvitne & Pearlman, 1996)

In Maine, both survivor and provider respondents to the 1996 needs assessment surveys conducted by the Office of Trauma Services expressed this same imperative. In the resulting document, *In Their Own Words*, one survivor put it this way: "We need professionals who have the ability to take care of themselves, be centered, and not take on what comes out of me – not be hurt by what I say – sit, be calm and centered, and not personally take on my issues." While caregivers surveyed recognized the same need for themselves, they went on to add: "There needs to be organizational awareness of the effects of secondary trauma. Help must be built into the organization – including ready access to a staff support group, individual counseling and trauma sensitive supervision." (Jennings & Ralph, 1997) The Traumatic Stress Institute professionals concur:

> It is essential to have organizational recognition of the reality of VT. Every helping professional can and (we hope) *will* make a personal commitment to address their own VT. This effort, alone, however, is not enough. The organization and agencies that employ helping professionals and offer clinical services to survivors of trauma and abuse also must incorporate an awareness of the costs of trauma work on staff, and the toll of VT on organizations or agencies. (Saakvitne, et al, 1999)

The U.S. Department of Health and Human Services adds that providers "can be expected to function well and provide effective treatment only if their agency's leadership gives them appropriate support. Such support includes recognition for and appreciation of the role of the [worker] and the stresses it entails." Based on ethics guidelines of the American Psychological Society, Monroe concludes that "…it does not seem ethically justifiable to assume any [provider] has immunity from secondary effects" of working with people recovering from traumatic histories. (Monroe, 1995, Revised 1999a)

Maine's Survey

In November of 1996, in remarks to survivors at the first state-sponsored Survivor Forum, Commissioner Melodie Peet said: "professionals are out there struggling as individuals as well, often not getting the kind of reinforcement they need." (Jennings & Ralph, 1997) Recognizing the profound challenges facing the providers working within Maine's emerging

system of trauma sensitive services, and the obvious implications for training, supervision and the provision of services, Peet asked OTS to initiate and oversee a process for determining the effects of trauma work and ascertaining ways to ameliorate those effects. **Specifically the Commissioner's request was for recommendations for possible services, policies, and procedures that would address the issues of VT and burnout.**

The Office of Trauma Services contracted a part-time consultant (designated The Provider Support Consultant) to carry out the Commissioner's mandate. The investigation began with a daylong brainstorming meeting in February of 1998 for professionals interested in the subjects of VT and burnout. That initial meeting produced a plethora of original and practical ideas and energized a group of volunteers willing to work with the Provider Support Consultant on the enterprise**. They came to call themselves and the project: Partners in Healing: Care for Caregivers.**

Interestingly, of the thirty-five (35) professionals at the meeting, only a few worked full time in the public sector. The Partners' committee soon recognized that to make truly viable recommendations, they would need input from a broader cross-section of people, suggesting, therefore, a much larger endeavor than originally envisioned.

The next 10 months was spent creating two survey questionnaires: one for direct service staff and one for management. Information about the project and survey questionnaire drafts were distributed widely, and feedback was sought from a range of interested parties. It was thought that the broader the participation in developing the survey instrument's content and design, the stronger the reliability of the outcome. Accordingly, the following people and groups were consulted, and their suggestons informed the development and content of the questionnaires.

- DMHMRSAS Commissioner
- DMHMRSAS Office of Trauma Services personnel
- DMHMRSAS Director of Internal Operations
- All DMHMRSAS Regional Directors and several Mental Health Team Leaders
- DMHMRSAS Director of Human Resources
- DMHMRSAS Employee Union staff
- Maine Information Services
- Community Mental Health Agency representatives
- Laurie Pearlman, of The Traumatic Stress Institute, who coined the term Vicarious Traumatization and has researched the subject extensively.

Because the "Partners" committee felt that confidentiality was critical to receiving honest, authentic, and useful information, it was decided that the final staff survey packet (Appendix A) would be mailed to individual workers, rather than to agencies or programs. The mailing went out in January of 1999 to:

1315	DMHMRSAS employees: including all administrative, professional and support staff workers.
972	Professional employees of fourteen (14) contract agencies.
113	Other practitioners who had expressed an interest in the subject.
2400	Total

The packet included: 1) a cover letter, 2) an invitation to join the "Partners" working committee, and 3) the questionnaire itself: after a page of specific questions about VT and burnout a second page asked for narrative responses to the following questions:

1. **What comes up for you, affects you, or concerns you in responding to trauma in your job? (e.g. trauma in the client's past, client's current trauma, or trauma you feel)**

2. **What have you been able to do and/or what conditions in your environment have worked in the service of <u>preventing</u> Vicarious Traumatization or burnout?**

3. **How could the Department or your employer be more supportive of you and your efforts? What changes or resources would help you to avoid Vicarious Traumatization or burnout?**

4. **If we didn't ask the right questions, please add any comments you think might be useful for us to know.**

There was a 14.79% response rate. Three hundred and fifty-five (355) people voluntarily took the time to reply. They not only completed the "check-the-box" questions, but they wrote careful, extensive, and heartfelt answers to the narrative sections. Additionally, ninety-seven (97) people indicated an interest in joining the "Partners" project.

The management questionnaire (Appendix B) was sent to each of the Department's Regional Directors and their Mental Health Team Leaders, asking them to distribute copies to appropriate personnel, and to CEO's of five (5) contract agencies, requesting that their management teams participate. We received eight (8) responses.

While the confidentiality factor precluded pin-pointing the comments as coming from one or another of the three (3) groups surveyed,***** this shared voice of caregivers from all across the state of Maine was definitely worthy of conscientious attention. Remembering that at least 75% of those served by DMHMRSAS (now BDS) report histories of childhood trauma, the vast majority of Department employees must deal with that issue and its consequences for them. They, perhaps even more than the so-called "experts" (the researchers and clinical theorists), are Maine's own experts. They are the ones "in the trenches" doing the daily work of empathic relating – listening and comforting, of teaching, supporting, and holding out hope to those who suffer from trauma's painful effects. **Just as many professions, including medicine, law, and mental health, have traditionally relied on the analysis of case studies for teaching and training purposes, Maine workers' narrative/anecdotal descriptions of their experiences lend an effective immediacy and reliability to their feedback.** So while not technically a scientific or quantitative study, the survey responses provide thoroughly credible material.

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*1) All DMHMRSAS employees (including administrators, supervisors, case managers, crisis workers, community support workers, mental retardation personnel, substance abuse specialists, hospital and residence personnel, therapists, and support staff), 2) contract agencies' professionals, and 3) private practitioners.

Recording into a database what was written, examining the data for both thematic and specific observations, and cataloging the recommendations was the next task. The Provider Support Consultant began by sharing the raw data with representatives from the now enlarged "Partners" committee in each of DMHMRSAS's Regions. They were asked for their impressions of the material: did it generally match their experience, were there areas that deserved particular emphasis, did they have ideas about how a report might be organized and distributed? They were enthusiastic about the richness of the data and touched by the honesty and creativity of the responses. Their recommendation was that the final report take the form of a book that would serve as a companion piece to *In Their Own Words,* a widely acclaimed account, by trauma survivors and providers, of what helps and what hurts in Maine's system of care.

In the summer of 1999 the Commissioner reviewed the raw data and reiterated her mandate. However, a few months later, she had resigned her position. OTS continued the project, and over the winter and spring of '99-2000, the narrative data was analyzed and differentiated into eight (8) discernible issues and supporting themes.

After the new Commissioner, Lynn Duby, was apprised of the project's status, the suggestion was made that the report's effectiveness would be enhanced by including information from the literature on trauma and best treatment practices, along with Maine's field data. An in-depth literature search was initiated and continued to the spring of 2001, when the process of articulating the final report began.

About This Report

What follows in this document, then, is an inclusive and thorough review of both what Maine's front-line providers and their managers say about the effects of working with trauma survivors and what the researchers, theoreticians *and* educators have found to be true on the subject. The goal has been to provide information and recommendations on the subjects of vicarious traumatization and burnout in enough depth and clarity to be useful to interested people at all levels: personal, professional, organizational, legislative and societal.

The three major parts of the report correlate with the survey structure, and in each part, material from the trauma literature also is included:

- Part One focuses on caregivers' and managers' narrative responses to four open-ended questions (Appendices A & B) and includes eight chapters organized around the themes that emerged from the material.
- Part Two covers an analysis of the quantitative data – responses to 33 specific questions (Appendix C) about the effects of vicarious traumatization and burnout on providers.
- In Part Three, recommendations for improvements to the system are offered.

Because of the length of time between the distribution of the survey (1999) and this report (2001), it could be asked whether these survey results are dated and stale. To test that possibility, a draft of the report was distributed to the 114 providers who volunteered to be part of the Partners-in-Healing Planning Group. They were invited to respond to a brief survey with questions pointing directly at this document's recommendations and asking to what extent the report and its recommendations are appropriate and important. Those responses are included in Appendix D, and their message is integrated into the docment's final version.

Part One

Maine Caregivers' Words
and
Related Recovery Literature

1

Recognizing Vicarious Traumatization and Burnout: What They Are and What Would Help

The Big Picture

Overview of Vicarious Traumatization

From the Literature

People are traumatized either directly or indirectly. According to the DSM-IV diagnosis of PTSD (APA, 1994), …people can be traumatized without actually being physically harmed or threatened with harm. Simply <u>learning about</u> *the traumatic event(s) carries traumatic potential. (Figley, 1995, Revised 1999a)*

The general signs and symptoms of vicarious traumatization are decreased energy, no time for yourself, increasing disconnection from loved ones, social withdrawal, increased sensitivity to violence, threat, or fear, or the opposite – decreased sensitivity, cynicism, generalized despair and hopelessness. These are the endpoints of a gradual erosion of one's beliefs and at times of dramatic shifts in beliefs… (Saakvitne, 1995)

For a detailed accounting of the personal and professional effects of Secondary Traumatic Stress, another term for vicarious traumatization, see tables 1 and 2 at the end of this chapter, pp. 25a-25b (Yassen, 1995)

From Maine Caregivers

"Trauma can feel like a heavy burden sometimes."…"The amount of energy required to truly be present for the client can be a monumental challenge."…"I feel I've been drained for too many years. There's no more to give. There are days I'm not sure there's even enough left for me to care for myself."… "Offering support to trauma survivors is <u>extremely</u> draining. It requires an immense amount of energy."… "High anxiety and extreme emotional distress triggers anxiety responses in me which are difficult to manage and slow to resolve."

"If I'm immediately exposed to family/friends after work time I find myself transferring work experiences to life experiences."… "If I'm not careful to separate work from life, I will sometimes attribute (falsely) negative aspects of my job to the people in my life. For, example, I will be suspicious of my husband after working with women in domestic violence situations. I also carry a hypersensitive awareness and concern for children about sexual abuse. I find myself closely examining all the relationships children in my life have with other people and feeling suspicion for some"… "Emotionally I have noticed periods of explosiveness

at home. I have experienced periods of depression. And I have had to declare bankruptcy due to trauma from the workplace."… "I have intrusive thoughts, such as when I am meditating or practicing yoga. It's hard to disconnect from the stories."

Overview of Burnout

From the Literature

There are three predominant aspects [of burnout]: emotional exhaustion (e.g., 'I feel emotionally drained from my work.'); depersonalization (e.g., 'I worry that the job is hardening me emotionally.'); and reduced personal accomplishment (e.g., 'I feel I'm not positively influencing other people's lives in my work.') (Figley, 1999)

From Maine Caregivers

"I am aware of the level of numbness I feel as client after client reveals a horrific trauma history."… "What affects me is the possibility of our remaining 'indifferent,' if you will, to the plight of our clients' lives."… "I have had to request removel from direct service care for a time due to the frequency of physical and verbal assaults I was experiencing. I found I was becoming so fearful of these attacks that I was uable to relate to patients in a therapeutic manner, nor did I have the desire to."

"I was having extreme difficulty finding any value or reward to my work."… "I feel a level of helplessness at assisting clients who have only meds, who are not well connected in therapy or don't have the resources to afford therapy."… "Feelings of inadequacy to impact change. Frustration. Fear. Overwhelmed with <u>never ending stress</u>, keeping up with 'units' (service hours) while maintaining quality."

Impact on Professional Life

Emotional Consequences

From the Literature

Vicarious traumatization is a process not an event. It includes our strong feelings and our defenses against those feelings. Thus vicarious traumatization is our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people's pain and loss and are forced to recognize human potential for cruelty and indifference, <u>and</u> it is our numbing, our protective shell, and our wish not to know, which follow those reactions. These two alternating states of numbness and overwhelming feelings parallel the experience of PTSD. (Saakvitne, 1996)

From Maine Caregivers

"What affects me is the pain and suffering of the client."… "I feel a sadness that they had to experience what they have."… "Anger that no one helped before trauma happened, when

it could have been prevented."… "It's hard to hold what I hear sometimes – I would rather not know that such things happen in the world, especially to kids."

"Defenses arise that can interfere with compassion and helpfulness."… "What bothers me most is that I feel little now when a client discloses horrific trauma."… "It's hard to listen over and over to trauma and stay empathic in a <u>real</u> way."… " Since I learn about so much trauma, I fear I don't respond adequately to clients' stories. That is, I'm desensitized, so the stories don't hold the power they once did. The client then does not get adequate empathy from me, as 'I've heard it all before'." …"An outcome of working with trauma survivors is the development of pejorative and negative attitudes toward the person who is s trauma survivor because of the impact that person's behavior has on how the providers feel."

From the Literature

Through their work with survivors, [workers] may also experience intrusive imagery, often images of those scenes that survivor clients have described vividly which connect in some way with the therapist's own psychology. (Pearlman, 1995, Revised 1999a)

From Maine Caregivers

"I have difficulty hearing of the tremendous atrocities experienced by my clients and it brings up personal issues."… "It is the images connected to my clients' childhood abuse, which can affect me, especially if I do not have a balanced caseload and many individuals who are trauma survivors."… " Clients' very vivid accounts of abuse sometimes are difficult to stop thinking about."… "In the two cases I handled that resulted in the definition of 'vicarious trauma,' the energy kept coming back up in my mind like a flashback."… "As a clinician, almost everyone I see has trauma of some sort in the background and it is difficult, if not impossible, to not be affected by the stories I hear."

From the Literature

Perhaps the most insidious impact of vicarious traumatization over time is its assault on our hope and idealism… However, both as a direct result of vicarious traumatization and in defense against vicarious traumatization, it is all too easy to give in to cynicism and pessimism. (Saakvitne, 1996)

From Maine Caregivers

"Numerous clients have such extensive trauma experiences and so few supports that I feel helpless and wonder if it is accurate to say they can heal."… "I find that my work with persons with complex PTSD is often stuck at the stabilizing stage with no hope of getting to the issues that keep them stuck and suicidal."… "It is hard to help trauma survivors see that they have worth, importance and deserve a better life."… "I work with MR (mental retardation) consumers in crisis. The most frustrating part of that for me is their apparent inability to move forward. Their situations are the most static. It's hard to feel like I'm <u>doing</u> anything."

"Being exposed to the trauma of others sometimes sours me into a more fatalistic view of life."… "An overwhelming sense of despair and sadness about the state of society as evidenced by the way we treat others. I have definitely become more cynical and less willing to trust others."… "How do I cope? Withdrawal and cynicism."

Diminished Sense of Efficacy

From the Literature

…[W]e see that [providers] reported more stress with trauma clients in terms of feeling unable to help … and feeling like a helpless witness. (Gamble, et al, 1995)

It is not uncommon for experienced [caregivers] to feel suddenly incompetent and hopeless in the face of a traumatized patient. (Herman, 1992)

From Maine Caregivers

"I worry after work about clients. I feel responsible for their well-being. I question my abilities. I'm afraid to make a mistake because it could mean someone's life."… "The work for me is so exhausting that I can't always do it. I feel as though my clients miss out and that I can not do my best work under these circumstances."… "I wonder whether I have the skills to handle the situation, my level of energy has been diminishing of late. My interest is not what it once was."… "At times not feeling effective. Occasionally a patient's issues are so overpowering that progress is difficult."

From the Literature

Trauma workers are further challenged with dealing simultaneously with the aftermath of prior traumatic events and the threat of continuing tragedy, in the case of domestic violence, childhood sexual abuse or physical abuse, or hate-crime violence. [Suicidality and self harm issues, as well.] (Dutton & Rubinstein, 1995)

From Maine Caregivers

"Current trauma in a client's life is my main concern and knowing how to help alleviate damage being done. When past trauma comes up, I tend to refer to therapy." …"I'm afraid that I will miss something when a client talks about suicidal ideation and that an actual suicide will result."… "What comes up for me is the chronic suicidal ideation and self-mutilation with the majority of clients I see, and the fact that I have to do on-call crisis work when I am not trained to do so."… "What I notice is my fear that the symptoms of my client's trauma can become so overwhelming, in whatever form it takes (i.e. depression, suicidal ideation, self-mutilation, alters acting out, mood swings, OCD, eating disorders), that nothing I/we/agency can do to help, really help, before it's too late and the person goes over the edge."…"Having clients who self abuse to deal with pain is very hard, too"

From the Literature

Helper's own reactions to the material they hear, if unexamined or unprocessed, may lead to a range of reactions; helpers may feel unable to hear additional trauma material, thereby discouraging clients from fully exploring feelings because the helper does not feel able to tolerate more affect. Our ability to guide clients in examining other aspects of themselves,

their lives, or their traumatic experiences(s) may also be compromised. (Rosenbloom, et al, 1995, Revised 1999a)
<u>From Maine Caregivers</u>

"I find myself not going after the story (my client's) because I just can't hear them."… "Secretly, I have at times agreed in myself that suicide is the only way some people can have any peace because of their daily tortures and night terrors. This attitude frightens me and thankfully doesn't come up very often, but I have to fight to not sink down with some of my severest traumatized clients."… "My reactions are a sense of frustration and helplessness – clients' real and perceived lack of choices can be contagious."… "I am affected when I see so little improvement."… " It is extremely difficult to know how to help maintain healthy, sustainable boundaries and relationships with survivors of trauma <u>and</u> to invest enough of myself to allow the individual to trust me."

Environmental Factors

<u>From the Literature</u>

The context of our work -- organizational, professional, and social – influences our resilience or vulnerability to the effects of vicarious traumatization. (Pearlman & Saakvitne, 1995a)

<u>From Maine Caregivers</u>

"There is not a lot of support, either professionally or from the public, for trauma work."…"What comes up for me is an awareness of society's lack of commitment to trauma healing."… "My concerns are for the lack of community resources, especially in the PM hours and on weekends, for the children of abuse victims."… "It's hard to break the cycle of abuse when we can't change the poverty, lack of meaningful employment, and lack of hope these families live with."

<u>From the Literature</u>

A person's behavior in the workplace can only be understood when it is examined within the social context of the workplace, [and of the society at large.] (Maslach & Leiter, 1997b)

<u>From Maine Caregivers</u>

"The system needs to be healthy for me to be healthy. Stresses are both political (intra-office) and human (clients). To expect more than is humanly possible is traumatizing and a betrayal."… "What triggers burnout for me? Too high a case load with non-supportive supervisor, non-supportive superior, no pay increases, not taking sick time so I get edgy, voice mail with 43 messages, dealing with four clients per day (hospital setting) and a day that has two deaths, one birth and one loss of job."… "The more subtle issues of burnout and VT get overlooked – I begin to somatize (headaches, blank affect, zoning out), and then I have to help myself outside of the agency. I'm getting better at 'catching' it earlier, but the sad part is, it's without help from the agency. It's by myself."

"I feel a lack of control to change the situation and make it a safe place to work."… "Violence on the job, on an on-going basis, is a constant source of stress. This takes a toll both professionally and personally. This long-term stress has and does extend beyond the workplace."

From the Literature

The idea of the workplace as an efficient machine is returning to undermine the <u>ideal</u> of the workplace as a safe and healthy setting in which people may fulfill their potential through intrinsically rewarding work and for which they are given fair compensation. (Maslach & Leiter, 1997a)

From Maine Caregivers

"We work in an environment that supports 'quantity' not 'quality.' This gives one the feeling of assembly line clinical work."… "Department paperwork, regulations, lack of resources, the large caseloads of agency therapists, pressure for direct service hour quotas, etc. do more to cause burnout than listening to cult abuse clients share their stories"… "Reduced funding has a tremendous impact on clients and clinicians. Increased bureaucratic paperwork with no funding and collateral support makes the job harder."… " I often feel that I am on 'overload.' Paperwork is tremendous and often more challenging than dealing with client issues."

Impact on Personal Life

From the Literature

Working with trauma survivors reminds us daily of our vulnerability to traumatic events, the dangerousness of the world we live in, and how the things that matter the most to us (for example, our loved ones, our health, our sense of meaning and purpose) can be suddenly ripped away and seemingly lost forever. If we care and feel deeply, if we risk connection rather than wall ourselves off or numb ourselves out – then we are at risk for the pain of loss...constantly aware of our vulnerability. (Saakvitne et al, 1999)

From Maine Caregivers

"What gets me is the reality of the lack of safety in the world. Makes it hard sometimes to help people take risks when the newspapers speak to the world's being unsafe – e.g. there are extra things to deal with when you are a victim of domestic violence and you've just read about two domestic violence related incidents in Maine in one week."… "I have been affected by the stress in an emotional, sexual and financial manner."… "The death of a patient has upset me from the time of her death in 1996."

"My concern is for the children of abuse victims, which results in a concern for my own children. I get scared, overprotective."… "I notice I stay away from TV, movies, books that contain violence, even minimally."… "I have tension in my neck and shoulders and headaches at times."

TABLE 1

The Personal Impact of Secondary Traumatic Stress

Cognitive	Emotional	Behavioral	Spiritual	Interpersonal	Physical
• Diminished concentration • Confusion • Spaciness • Loss of meaning • Decressed self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm toward others • Self-doubt • Perfectionism • Minimization	• Powerlessnss • Anxiety • Guilt • Anger/rage • Survivor guilt • Shutdown • Numbness • Fear • Helplessness • Sadness • Depression • Hypersensitivity • Emotional roller coaster • Overwhelmed • Depleted	• Clingy • Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hypervigilance • Elevated startle response • Use of negative coping (smoking; alcohol or other substance misue) • Accident proneness • Losing things • Self-harm behaviors	• Questioning the meaning of life • Loss of purpose • Lack of self-satisfaction • Pervasive hopelessness • Ennui • Anger at God • Questioning of prior religious beliefs	• Withdrawn • Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact on parenting (protectiveness, concern abut aggression) • Projection of anger or blame • Intolerance • Loneliness	• Shock • Sweating • Rapid heartbeat • Breathing difficulties • Somatic reactions • Aches and pains • Dizziness • Impaired immune system

TABLE 2

Impact of Secondary Traumatic Stress o Professional Functioning

Performance of Job Tasks	Morale	Interpersonal	Behavorial
• Decrease in quality • Decrease in quantity • Low motivation • Avoidance of Job tasks • Increase in mistakes • Setting perfectionist standards • Obsession about details	• Decrease in confidence • Loss of interest • Dissatisfaction • Negative attitude • Apathy • Demoralization • Lack of appreciation • Detachment • Feelings of incompleteness	• Withdrawal from colleagues • Impatience • Decrease in quality of relationship • Poor communication • Subsume own needs • Staff conflicts	• Absenteeism • Exhaustion • Faulty judgment • Irritability • Tardiness • Irresponsibility • Overwork • Frequent job changes

2

Necessary Resources:
The Importance to Caregivers

The Big Picture

From the Literature

Factors that contribute to vicarious traumatization:
> *Our Clients –*
> - *Their multiple problems and limited resources*
>
> *Our Context --*
> - *A social context that denies or underrates trauma and its after effects*
> - *A political context that underfunds psychological treatment for trauma*
> - *A cultural context that blames the victim and glorifies violence and victimization as entertainment*
> - *An organizational context that fails to provide staff with resources necessary to do the work they believe they can do on behalf of clients (Saakvitne & Pearlman, 1996)*

From Maine Caregivers

"What affects me is not having adequate resources to deal with the issues that present themselves. Issues are overlooked, ignored, or not dealt with."… " I think mental health clients are stigmatized quite often by the system designed to help them. Watching these abuses happen traumatizes the worker, too."… "Sometimes a client's trauma is exacerbated by our backlogged, underfunded support services. Being on a waiting list can cause stress, feelings of frustration, anger and a sense of marginalization."… "I'm aware of the cumulative effects of attempting to find resources for consumers when those resources are not available to them."

"Acknowledging the limited resources available to address the real issues is a challenge: that would require providing effective intervention and prevention of the causes of trauma rather than simply managing the effect and its symptoms."… "There are multiple factors that are currently impacting the clients' mental state – economic, support, isolation. It seems that their environment counteracts our efforts. I get a kind of frustrated, overwhelmed feeling"… "Are we as a system providing sufficient resources to ensure that clients have the same opportunities as everyone else? Are clients treated in the same way by health care providers as the general population would be? Current answer is NO."

Unmet Needs

Insurance and Funding Gaps

From the Literature:

A lack of funds for treatment beleaguers many survivors, and can leave [caregivers] struggling with conflicting needs and ideals. (Pearlman & Saakvitne, 1995a)

Survivors who rely on health insurance (or who have no health insurance) to pay for their [recovery] may only have resources for limited treatment. Unfortunately, recovery from childhood sexual abuse is long-term work…. Short-term work with incest survivors, increasingly mandated by managed care and other social systems which seek to limit costs and therefore treatment, sets the [caregiver] up for vicarious traumatization. (Pearlman & Saakvitne, 1995a)

From Maine Caregivers

"People enter the hospital with rampant self destructive feelings and actions related to the increased emergence of past trauma, and near impossible changes are expected to happen in a very inadequate amount of time."… "I am concerned about the brief treatment push of the 90's. It is contraindicated for many of my trauma clients, but payers don't seem to care."… "I feel frustration and helplessness with the 6-8 week limitation on services. The clients' real and perceived lack of choices can be contagious. This is a set up for failure for everyone!"… "We need more support groups in this area to which we can refer the great number of people who have no insurance or ability to pay for services. Community Mental Health Centers cannot provide for all these needs. The Sexual Assault Center does a great job in this regard."

"Not having adequate resources to help people/clients is extremely frustrating."… "The demands placed on staff are well beyond the available resources to support them."… "I'm stressed by 'crisis intervention' that is not helpful – poorly organized. I have to do the crisis work. I'm upset by the fact that I have to do on-call crisis work when I am not trained to do so and also carry a full caseload."

"Too often I see the patient's hopes and happiness dashed by one agency or another backing out from lack of funding."… "The lack of quality services for poor consumers and the stipulations put on by managed care companies limits treatment."… "I am affected by my client's current trauma. Example: decayed teeth, mouth pain, unable to eat, and I'm not able to get client a dentist."

"Working with Social Security, Medicaid/food stamps, and Section 8 Housing can be extremely stressful, not only to clients but to case managers, too."… "I'm affected when an adult in a family receives the attention and the children are ignored."

Lack of Referral Resources

<u>**From the Literature**</u>

Trauma [workers] can feel more strain and a sense of isolation when there are few trauma-sensitive individuals or programs to whom to refer survivor clients for adjunctive treatments, including medication evaluation, self-help groups, group therapy, body therapies, expressive therapies, inpatient treatment, partial hospital programs, outpatient therapists, and substance abuse treatment programs that specialize in treating survivors. (Pearlman & Saakvitne, 1995a)

<u>**From Maine Caregivers**</u>

"I don't always feel like I have the right tools to help me help my clients."… "Substance abuse is never addressed within the class member genre. No funding to address this issue. People are allowed to flounder."… "We need resources to address the trauma experienced by the clients with mental retardation served by this office and to actually make these resources available to our consumers. We need access to professionals who are experienced and willing to work with people with MR."… "More resources for people with Axis II diagnosis would help." "Increase resources in rural areas."… "Trauma respite facilities are greatly needed."

"**I have had patients who needed substance abuse, incest survivor support and co-dependent services that were not met because the hospital had a problem with an outside agency that occurred years ago."**… "I feel frustration directly as a result of there not being enough inexpensive community resources to refer clients with trauma histories to."… "What affects me is the role different systems play in re-traumatizing folks. I watch state agencies, community agencies run people in circles who are hoping to receive assistance."… " There is no Safe House in our region to send clients to. There is no state trauma treatment center to refer clients to."

"There is a lack of community resources: transportation, supports for working parents, emergency funding for housing, food, heat, or for single working parents"… "Limited resources: psychiatrists, money, and respite providers who are trained in psychiatric issues."… "There are insufficient community resources: e.g. group homes, residential treatment for youth, etc."… "I see a lack of available crisis and hospitalization services and in-home support and/or respite (childcare) services."… "We need greater resources devoted to client needs such as dentistry, psychiatry, food, housing, etc."… "Far too often families appear disconnected from the respective (residential) client. There are no resources for educating/helping the family."

Prevention of VT and Burnout

<u>**From the Literature**</u>

Van der Kolk (1989) points out that traumatization occurs when ones' combined internal and external resources are insufficient to cope… (Bloom, 1995, Revised 1999a)

Stress is the state of discomfort that arises when our problems exceed our resources to cope with them. Stress is present until the problem is solved, and illness may follow if the problem remains unremedied for too long. (Flannery, 1994)

Social support has been shown to be an effective moderator of both general stress (Cobb, 1976) and traumatic stress (Flannery, 1990). Institutional personnel can be supportive by providing resources. Resources refer to such tangible aid as financial aid, increased flexibility in the work schedule or time off from the job, changes in duty assignments, and generally staying abreast of the needs of traumatized workers. (Catherall, 1995)

From Maine Caregivers

"Refocusing on the primary mission of community agencies, i.e. providing services to the disenfranchised, even though this means funding and creating means other than the currently available reimbursement funding."… "Advocating for system changes regarding funding and services."… "Better funding would provide me with a computer, an ergonomically correct workplace, more appropriate office space, informational literature, outreach supplies (information boards, pamphlets, brochures, educational booklets, etc.) and coverage for my mental health time off."… "Everyone should have a computer and applications to reduce paperwork."… "The Department could help by providing 1) the resources needed, including enough case managers for the number of referrals, 2) supervision, 3) community resources for families to access."

"I have often thought that if one person could put together a computer program that encompasses every resource known to social work it would be a time-saving device for many caseworkers. It would include financial, housing, special services needed for special circumstances, medical, dental (those that take Medicaid), and recreational resources. This resource could be for both professionals and clients."… "The Department could sponsor a newsletter connecting clinicians to reduce isolation."… "Create a consistent 24 hour telephone number for providers to call and ask for information/resources/data/advice regarding the complex issues of working with people in various stages of crisis or impending crisis."… "Provide a warmline for providers (800 number)."

"It's important to ask the down-line people and the ones 'in the trenches' about how to structure a process to facilitate support."… "How is policy made? There's no worker input." …"Reconsider how many severe trauma survivors one clinician can see."… "Vacation is essential too. At least 4 weeks."… "We need to be able to say no, to know and have our limits respected, as the best way for us to take care of ourselves."… "We need to be able to take time off to attend trainings or for team building."… "Develop ways to support and relieve 24 hour crisis work."… "I have benefited from the employee exercise program at AMHI gym – low impact/step aerobic classes."

"Providing proper resources for those of us in rural areas would drastically and dramatically reduce stress and burnout for rural care providers."… "Knowing that there were resources being allocated toward prevention of these kinds of problems (VT and burnout) in the future would help my feelings of 'shoveling s____ against the tide'."

3

Vulnerabilities in the System:
The Significance of Supportive Conditions

The Big Picture

From the Literature

The social context for … therapy can either support or drain the [worker]. The way victims and victimization are viewed in the community will affect the support the [worker] feels for his work. (Pearlman & Saakvitne, 1995a)

From Maine Caregivers

"I find myself feeling angry about the denial that exists in our culture about the abuse and neglect of children."… " I feel anger toward adult perpetrators and abusers."… "There is a sense of helplessness on the part of caregivers; frustration that trauma is a social problem and can't be remedied on an individual basis alone." …"I'm concerned about the prevalence of trauma. I'm concerned about the dual impacts of trauma and poverty on my clients."… " I wonder if there is any safety for children and women in our society. This comes after almost 20 years of doing this work."… "The most influential impact of working with trauma survivors is recognizing the lack of acknowledgement of trauma – survivors are not believed. Those of us attempting to help are being targeted in many cases – most directly by FMS (False Memory Syndrome) advocates and the insurance companies who resist payment."

From the Literature

The agency's leadership should strive to impart a sense of vision to staff members that communicates how important their work is as part of the larger effort to break the cycle of abuse and neglect and their impact on society. (U.S. Dept. of Health & Human Services, 2000)

For an organization to have a sense of vision and mission also makes a difference for the individual [caregiver]. It helps one stay grounded in the bigger picture, to remember the social, political, and professional context and impact of the work. This vision helps address and alleviate the sense of randomness and despair that can emerge over time in the field. (Saakvitne, 1995)

From Maine Caregivers

"I feel frustration at the missing resources and management's continuous lack of common theme, communication, and understanding around the same issues."… "I fear the worst. I fear for the client. The 'system' seems to respond so slowly and appears so indifferent." …"I'm frustrated by the system's inability to make a coordinated and cohesive presentation of interventions."… "Leadership should encourage more collaboration between Department and treatment providers. Recognize everybody's efforts in some way and avoid a 'them-us' mentality

between Department, providers, and consumers."… "It all comes down to money, and of course, the value society puts on the work. Low salaries and high productivity expectations tell me what I do is of little value."

"I see an 'us against them' attitude driven by the Department."… "Often those in business/administrative positions <u>do not</u> have an awareness of the clinical issues involved in working with this caseload, so they minimize its requirements."… "I'm concerned about the dysfunction in the system that makes my job difficult."… "Experience with the Department has been oppressive and overbearing."

From the Literature

A flexible organizational structure that encourages an atmosphere of mutual purpose can help reduce turnover rates, increase staff morale, and contribute to a program's total effectiveness. (U.S. Dept. of Health & Human Services, 2000)

From Maine Caregivers

"I want an environment where a better trained multidisciplinary team could develop a service model to care for clients with trauma histories, allowing for a shared caseload with supportive colleagues."… " There is not enough communication between levels of service and between workers and managers. Not enough team effort."… "I would like to be closer to my co-workers. There are some people who are just here to work and not bond or build relationships. I don't know what can be done about this. I think, though, that acknowledgement of the problem of burnout and/or VT by the administration would be helpful."… "A very positive development in our agency has been the creation of multi-disciplinary teams that meet regularly, even daily, for communication and support for each other around treatment."

"Mine is a great agency to work for with very supportive team and great supervision."… "I work with very supportive people and make consistent efforts to support my staff."… "I feel <u>very</u> lucky to work for an organization that recognizes that people need a lot of support to do this kind of work."

Treatment Perspective

From the Literature

<u>*The recognition of the centrality of childhood trauma to psychological identity and distress opens us to a dramatically different way of understanding psychopathology and symptoms.*</u> *These shifts have inexorably changed the nature of our profession and our work. They include a move from an emphasis on psychopathology to etiology and meaning, from a model that emphasizes illness and symptoms to one that emphasizes adaptation and survival, and from a view of psychotherapy as a unidirectional, authoritarian process between expert doctor and his patient to a view of therapy as mutual venture within an intersubjective field. (Pearlman & Saakvitne, 1995a)*

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the [trauma survivor] patient's present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. (Herman, 1992)

…the mental health profession overuse[s]…the medical model approach to human psychological functioning. This model assumes that if an individual is distressed, then the source of the problem lies with her/him. This leads to individualistic interpretations and prescriptions of human behavior and de-emphasizes or ignores any important social variables. (Esper, 1986)

From Maine Caregivers

"I have feelings of frustration at times when staff think seclusion and restraint are the answer to controlling behavior."… "Staff are in <u>great</u> need of training in both the basics of trauma and ways to prevent VT and burnout."… "Having empathy in my experiences of dealing with the cruelty that adults inflict on children has been used against me by administration."… "More training, including trainings with survivors sharing their experiences concerning hospital treatment would be useful."

"We need to be able to ask the client to tell us what they need to get better. We need less blaming of consumers and more real offering of help."… "We need a richer statement about what it is to be a whole and healthy person and how we can help people to get there."… "We need support and respect from psychiatrists. It is very frustrating to be dismissed, even when working with the client regularly, due to hierarchical perspectives and prerogatives." … "A lot of the positive effects for clients go unnoticed or are invalidated simply because parties may not agree with the approach."

From the Literature

Victims often avoid mental health practitioners in order to avoid what they correctly perceive as a high risk of revictimization in a field that inadvertently patronizes and stigmatizes its clientele. A victim, by definition, has been violated and belittled; he or she can ill afford a second affront. (Ochberg, 1988)

This term [Borderline Personality Disorder] is frequently used within the mental health professions as little more than a sophisticated insult… Some clinicians have argued that the term 'borderline' has become so prejudicial that it should be abandoned altogether, just as its predecessor term hysteria had to be abandoned. (Herman, 1992)

From Maine Caregivers

"What concerns me is the lack of support and/or labeling done by higher ups, especially supervisors. 'She's just a Borderline; you can't believe what she says,' for example."... "If we de-institutionalize clients then we shouldn't re-institutionalize them by putting them in restrictive and over-controlled houses. Consumers are not being helped to work in ways that help them to really reach out into the community."… "I think one entity that is most

often the perpetrator of trauma is the existing social service system itself, i.e. the human service system, the legal system, hospitals, etc."

"I believe that VT is a problem of a dysfunctional 'helping system'."… " I experience major frustration/anger/hopelessness about the diminishing level of care for mental health, substance abuse/trauma consumers – lack of resources, poor communication, conflicting treatment philosophies, throwing meds at all symptoms, lack of respect for 'spiritual' principles, denial of the effects of trauma, etc."… "I feel the trauma related to patients' past and current trauma, the revolving door of readmissions of people."… " I am frustrated at the frequent, almost ubiquitous, presence of past trauma in people with major mental illness, often from or related to past contacts with the system."

Working Conditions

Attitudes and Values

From the Literature

Prevention of potentially harmful effects from VT involves attention to both concrete issues, such as provision of supervision and adequate time off, as well as to less tangible sources of support, such as the organization's attitude toward the impact of trauma on helpers. (Rosenbloom et al, 1995, Revised 1999a)

The organizational context within which the [worker] is developing his experience, skills, and identity will also influence the countertransference and vicarious traumatization he experiences at work. If the organization acknowledges the difficulty of the work and the inevitable vicarious traumatization it creates, he may have more support for the work and be able to work …with less shame, anger, anxiety, and strain. (Pearlman & Saakvitne, 1995a)

Our relationship with coworkers and our workplace can also fuel our responses to certain clients. It is very common for clients to get caught in the middle of conflicts among staff. (Saakvitne et al, 1999)

From Maine Caregivers

"I experience institutions and the system itself as traumatizing."…"Systems conflicts re-enact trauma for victims. Workers feeling injured or 'pissed' by the system have a harder time keeping empathy with patients."… "I find it frustrating that I, as a hospital staff person, am not supported or encouraged to help patients deal with trauma."… "Staff here are traumatized daily."

"**There is nothing in place for preventing vicarious traumatization or burnout. I have found administration of the hospital to be antagonistic toward me and my coworkers when this issue was brought up, e.g. denial of vacation time, reprimands for use of sick time, undue demands for overtime work – mandating it – and placing restrictions on work sites."**… "Workers need support and understanding, due to the widespread denial of abuse/trauma and its treatment, which affects them, too."… "I have been able to do very little to prevent VT or burnout because my boss does not value clinical supervision (only administrative)

and I fear retribution if I point out mismanagement practices."… "Nothing has been done in my environment to prevent VT or burnout."… "What comes up for me is that I must work in an environment that dehumanizes staff."… "No one listens to our complaints who can or will affect change."

From the Literature

A high level of employee functioning and a low burnout rate will be pursued by maintaining policies that are respectful of individual differences and responsive to the traumatizing effects of this work [with trauma survivors] on staff. (Catherall, 1995)

From Maine Caregivers

"Burnout occurs when the worker does not feel supported, understood and management applies too many rules and not enough listening."… "Preventing burnout is a constant struggle; everything is about money and paperwork and the clients and providers come last!"… "Under 'burnout' there should be a question about communication between front-line staff and management/supervisors. We don't feel supported."… "I feel more traumatized by my boss' style of managing staff than I feel affected by my clients' trauma histories."… "My employer (a hospital) is the largest contributor to stress and burnout. Administration gives lip service to support, but no real support to workers."

"Recognition of the <u>potential,</u> as well as actual, trauma staff experiences regularly is needed. Currently there is no mechanism for dealing with these issues with staff."… "I believe funding for the true cost of delivery would reduce the need for [workers] to do so much direct service, reduce vicarious traumatization and allow us to find a balance in our lives, so that we have the energy to help clients empower themselves."

From the Literature

Some organizational supports require the allocation of funds. Many, however, simply require an attitude of respect for the difficulty of the work and a commitment to address the potential harm to workers and clients. (Saakvitne & Pearlman, 1996)

A less tangible contribution organizations make to their [caregiver] employees and their clients is an atmosphere of respect for both clients and employees. (Pearlman & Saakvitne, 1995b)

From Maine Caregivers

"I would like recognition of how much we put into our jobs."… "I would like the administration to say thank you and provide more support for taking care of ourselves and cease creating in us a sense of our doing something wrong."… "<u>Recognition</u> of hard work and hard effort is important in every aspect of our lives, from childhood to old age."… "I do not feel that my agency supports or values me."… "Give recognition when a job is well done."… "Listening to the workers and not assuming anything about them beforehand would make me feel like a human being again."

When an organizational environment is unresponsive to people -- to their aspirations, their limitations and the way they work -- chronic burnout is the inevitable result. Human values are not a luxury but a necessity…it is far too costly to tolerate the erosion of burnout. (Maslach and Leiter, 1997)

An institution that cannot be flexible and make allowances for the personal needs and proclivities of individual workers is a poor environment for people working with trauma. (Catherall, 1995)

From Maine Caregivers

      "We're at the bottom of the ladder."… "Workers want to feel at least as empowered as the client. We often feel discounted."… "Many of my fellow employees are not filling this form out because they feel, what's the use. Nothing changes on our level."... "Just listen, for starters. Treat us as human beings."… "We, down in the trenches, continue to be overburdened, overwhelmed, and burning out. I'm pulling back more and more from direct care and from clinical functions. I am in a space where I need to take care of myself."… "More understanding/flexibility with family issues is needed, i.e. daycare problems or children's sickness. I feel little sensitivity about my need to stay home with them."… "We can feel as traumatized as the client by the system (e.g. Medicaid or the medical profession)."… "The work with consumers is not difficult. It is the system and environment in which we work that makes it hard. Sometimes that is more traumatizing than the actual work."… "Don't tie staff's hands with inflexible rules."

The Importance of Support

From the Literature

*Several roads lead to greater harmony between people and their jobs –
in fact there are six of them.*

- *Sustainable workload*
- *Feelings of choice and control*
- *Recognition and reward*
- *A sense of community*
- *Fairness, respect and justice*
- *Meaningful and valued work*

      (Maslach & Leiter, 1997)

Some work environments offer less support than others for helping professionals doing the difficult work of creating therapeutic relationships with trauma survivor clients. The less the workplace acknowledges the challenge of the work, the more difficult it is for individuals to talk about what is hard, to get support from each other, and to acknowledge their inevitable mistakes. (Saakvitne, et al, 1999)

From Maine Caregivers

"There is no formal support mechanism to deal with emotional issues that come up in everyday work. Or when a crisis comes up. Clinical supervision is just nuts and bolts of what goes on with my caseload."… "Very specific complaints that my coworkers and I have about the hospital are that we fear retribution for any attempt to push for change. And anything less than a push is completely ineffective. And then there is the threat of discipline hanging over our heads."… "Issues of not being heard traumatize me."… "I know how to relieve the depression of the after effects of this work – medication. This method is used by a number of my coworkers."… "There should be a continuing recognition that the work should not be done without adequate support."

"We need training and supervision for support to do the work, to not 'go under' hearing the stories with no place to go with them."… "I take charge for myself outside of work. The office offers nothing."… "Having to cope with my own situation <u>without</u> adequate support (clinical or otherwise) as well as coping with the issues of clients – AHHHH!"… "I have to rely on personal resources. I don't get help from my employer."

From the Literature

Too often training programs and work settings directly or inadvertently support a position which leaves helpers feeling weak, incompetent, or emotionally unstable if impacted by work with clients. It is a more realistic and, therefore, more helpful position to recognize the inevitability of being affected by the work. (Rosenbloom et al, 1995, Revised 1999)

The caregiver should expect to lose her balance from time to time with such patients. She is not infallible. The guarantee of her integrity is not her omnipotence but her capacity to trust others. The work of recovery requires a secure and reliable support system… (Herman, 1992)

If a work setting holds the view that [caregivers] shouldn't have feelings about their clients or about the work, or subscribes to the belief that it is unprofessional to be emotionally affected by the work, [caregivers] and clients will be at risk. (Saakvitne, 1995)

From Maine Caregivers

"Recognize the cycle of emotions we deal with daily."… "I need management to stand behind me and support me when I am sharing my experience."… "We could use more training in relevant skills, adequate time to process intense feelings and to prepare for client interactions, and adequate vacation time."… "We need supervision outside the administrative chain, with confidentiality, so weaknesses can be admitted without fear of consequences."… "Having time to listen to peers' concerns and allowing staff to vent without interruption or correction is important."… "Management's understanding the energy cost of working with very traumatized clients would hopefully result in more manageable caseload requirements."… "We have no ways to de-stress at our workplace."

From the Literature

[Caregivers] who work without adequate employee benefits, such as health insurance with provision for mental health care and time off for vacations, are facing strains that make their

work even more stressful, and thus endanger the well-being of clients, the [workers] and the organization and profession. (Pearlman & Saakvitne, 1995b)

From Maine Caregivers

"It is unfortunate that the most demanding work seems to pay the least … sends quite a message to the worker, doesn't it!"… "When I have to work for long periods without a vacation, I become numb and blasé."… "I would feel more valued if my salary was commensurate with the experience I have and the quality of work I do."… "Most of the time when we put in for vacation, it's denied or we are told we have to check in halfway through our vacation to see if we can have the rest of our time off."… "Burnout is actually promoted in this system by the systematic destruction of a career ladder, and the lack of adequate financial compensation for the job."… "I think the people who make rules for us direct care workers should walk in our shoes and work 40 hour weeks, directly on the unit with patients, and not just walk through the unit, in order to really know what would work on a practical level."

"Seven and eight day stretches of work are a problem. Many would like to go to four ten-hour days, allowing more time off duty."… "I consciously need to limit how many clients I see in a day, but I worry about having enough direct hours, and over the years, direct hours requirements have increased by 20 hours."… "There is insufficient time in my schedule for adequate history taking and psychotherapy."… "I feel frustration with the requirements on my time, the need to 'produce' and the limitation set by insurers."…"We have to meet direct service hours and do reports in our sleep."

"I would appreciate a system whereby people with high trauma histories could be evenly distributed among clinicians."… "Adjust schedules to avoid assigning too many/too high a percentage of trauma cases to one person."… "The assignment of cases is one of the most important issues, especially the number of cases."… "Caseload sizes are much too large making it difficult for staff to take time off without feeling they are sacrificing quality or will be overwhelmed upon return."

"It is always beneficial to be able to connect with peers and unload; however, there is no time to do this anymore."… "Provide a support group to help us process burnout issues and offer more sincere support from the direct administrator."… "Give a place to vent any and all concerns."… "What occurs far too infrequently are staff retreats, staff training/meetings, and staff supervision."

"I'm affected when I'm questioned on every decision I make and when my skills and experience are also questioned."… "Layoffs, downsizing, department shifts, questionable promotional practices all serve to undermine workers' confidence and generally adds to staff feeling unappreciated and undervalued."… "Frequently our work in undermined by investigations, insufficient insurance coverage, etc."

"I am fortunate to work where there has been self care education for all employees. There is an appropriate but informal work atmosphere, clinical supervision on a regular basis and available on short notice for emergencies, and the supervisor has an open door policy."… "We all have time off each week and have our vacations."

What Would Help

<u>**From the Literature**</u>

It is important to solicit input from staff members on what issues are compelling to them – asking, for example, what they perceive to be the sources of their burnout [or VT], then get their recommendations regarding how to address it most effectively; they are often the best resources in this situation. (U.S. Dept. of Health & Human Services, 2000)

<u>**From Maine Caregiver**</u>

"Keep this issue (VT and burnout) at the forefront."… "Stop number crunching and learn to deal with people as people, not numbers."… "Currently the environment at the hospital, and throughout the state system, frowns on taking days off unless physically ill. Allow team members to have mental health days."… "There is such pressure to get units that I'm not even able to eat lunch. The attitude is that there's something wrong with you, you can't cut it, if you can't get units in."

"I need clinical supervision from an LCSW on a regular basis to talk about my cases and to get direction with the more challenging ones. We have not had this type of supervision in two years."… "How about a group session with staff and supervisors to discuss how we as the workers are feeling and dealing with our work environments."… "Provide us with psychiatrists who are accessible on weekends and after hours and who do not tell staff to not call them at home."… "Coordinate treatment plans for those who use a variety of services and caregivers."

"Reduce the paperwork! Reduce the paperwork!"… "There has been increased bureaucratic paperwork with no funding and collateral support that makes the job harder."… "Counseling takes a lot of energy that I don't mind spending, but I do get resentful at expending energy on administrative and state detail work that has little or nothing to do with treatment."… "Provide one day during the workweek as a paperwork/meeting/training day solely."

<u>**From the Literature**</u>

For both satisfaction and retention, employees [in a 1999 survey of Maine state employees, including 4.2% of DMHMRSAS employees] communicated that they felt a need for better selection and performance management processes, coaching, recognition and opportunities for growth. (Linkage Incorporated, 1999)

People with burnout need to do some basic things. First, they need to set limits on the amounts of people demands they are confronted with. This can be done by setting limits on the amount of work to be done, by changing the person's job description so that it includes a diversity of tasks, and by going on vacations to be completely free of the people demands for a period of time. An equally important second antidote to burnout is … to be with people who can be emotionally supportive…not people who will make demands, but people who will provide nurturance. (Flannery, 1994)

"Better management. Offer support, feedback and respect while together giving/finding answers to questions/problems/issues."… "Be more receptive when complaints are made by staff."… "Increase salary and include employees more in policy decision-making."

"What would help? Supervision, supervision, supervision! Team/peer support and supervision."… "Increase the frequency of <u>good</u> clinical supervision of providers in the Department <u>at all levels</u>."… "Hire qualified (trauma sensitive) supervisors."… "Compensate for outside supervision and professional support."… "What about compensation for counseling?"

"What has been good is varied routines/job expectations duties, support from my supervisor and colleagues, and attending conferences."… "The agency could easily reduce 'sick' time employees take by increasing education and by offering full time jobs with variety, such as two days on the crisis unit, two days home support, and a day as office support."… "Have stress reduction, visualization, self-care group support or other focused and systemic meetings/groups, conferences, symposiums, or talks offered that caregivers realistically can take part in without being penalized."… "We could prepare workers better about VT at the beginning of their employment, senior staff as mentors and make more self care opportunities available at work."… "Peer supervision, but not at the cost of regular supervision. Support this process without penalty. Perhaps an on-going peer group in each of the Regions that might take a half or full day monthly."

"Provide educational experience to increase our knowledge on the subject (trauma, VT, and burnout)."… "More training in working with trauma survivors."… "Provide education for all clinical staff administrators and clinical supervisors."… "Fund training/support for clinicians in agencies to debrief and also fund healing group/trainings away from the employer and worksite."

"What helps is time off: vacations and personal days."… "Preventive measures are granting vacations as requested and holding meetings to allow staff to vent and problem solve."… "Give us help with vacations. It is nearly impossible to take vacations because of the need level of clients and the difficulty of having someone else (already overloaded coworker) cover."… "More support for paid mental health time."… "Give one day a month, with pay, that is not cumulative, to all employees."… "I save earned time for mental health days."… "Give us four or five personal days per year."… "Prevent people from working too much overtime."… "The Department should have the flexibility/resources available to enable <u>long term employees</u> to take subsidized sabbaticals."… "A sabbatical program seems like it would be a valuable VT and burnout prevention and educational opportunity."

"Recommend retreats for employees."… "Have retreats written into the budget that have some time for relaxation and some training time so that people can learn how to take care of themselves."… "Allow respite breaks."

From the Literature

Making time to address vicarious traumatization is important both symbolically and pragmatically. Symbolically, the allocation underscores the importance of the issue of vicarious traumatization. Pragmatically, talking about and addressing vicarious

traumatization decreases its effects. Using all or some part of staff meetings to address vicarious traumatization will make a significant difference. (Saakvitne & Pearlman, 1996)

From Maine Caregivers

"More frequent staff meetings."… "Let staff vent in weekly meetings."… "A staff day or monthly meeting to discuss these issues (trauma, VT, and burnout) would be helpful for learning ways to cope with the trauma we see."… "More discussion among staff about staff problems and client problems."… "Make debriefing and the need for it more available."… "Acknowledge that 'dumping,' 'unloading,' and venting are an okay and renewing process."

4

Working with Trauma:
Professional and Personal Opportunities for Growth

The Big Picture

<u>**From the Literature**</u>

…[S]ome people develop Compassion Fatigue, while others do not. At the heart of the theory [about why] are the concepts of empathy and exposure. If we are not empathic with, or if we are not exposed to, the traumatized, there should be little concern for Compassion Fatigue. (Figley, 1995, Revised 1999a)

Just as trauma alters its victims, [caregivers] who work with victims may find themselves permanently altered by the experience. (McCann & Pearlman, 1990)

Talbot et al (1992) cautions that one does not adjust to the demands of trauma work over time; rather one must develop ways of coping with it. (Charney, 1998)

<u>**From Maine Caregivers**</u>

"How we treat our trauma survivors is crucial, but we have to take care of ourselves or it doesn't work."… "Over a period of time, people either find ways to deal with the stresses of human service work (subconsciously or consciously) or they become miserable and seek other types of employment."… "Even talented, capable, wise workers are touched by Compassion Fatigue issues."… "Empathic connection can diffuse boundaries or stir up countertransference issues such that empathic connection becomes more difficult."… "There is long-term wear out. I see burnout all day. What will help me in the future to stay fresh?"… "Who treats the mental health worker?"

Impact on Professional Life

<u>**From the Literature**</u>

[People] who work with trauma victims are subject to significant stress and are vulnerable to what is now called 'secondary trauma' [vicarious traumatization]. The particular traumatization comes from being exposed to a reality that is beyond ordinary comprehension and seems unbelievable…. As [providers] begin to accept the credibility of what they are hearing, their own moorings in reality may be shaken, if not shattered. (Cerney, 1995b)

Facing with our clients their wish to die, to harm and mutilate their bodies, and their inability to stop abusing substances that threaten their lives and safety reminds us that we are working in the trenches. (Saakvitne et al, 1999)

From Maine Caregivers

"The difficulty is in the complexity of our clients' stories and needs. Often we feel incapable of knowing what to do or how to help."… "It is very stressful to observe people becoming out of control (aggressive, highly anxious, etc.) when I'm doing a home visit or even in the ER – just the observation of it!"… "Trauma in the client's past is often horrific, sometimes hard to take in. There's always the fear of triggering something out of control for the client."… "I feel uncomfortable with making decisions, i.e. with client safety when the client is experiencing suicidal ideation."… "Clients' deaths cause distress in me and other providers."

"I have never been the victim of severe trauma and at times I feel distanced from what a patient may be feeling or experiencing."… *"*I am affected by the violent sexual, physical, emotional, spiritual abuses; especially of cult survivors – their experiences -- by crimes, murders and gross sexual assaults; by abuses of power – wasting of resources and ignorance; by parents who have kids they don't love or care about and have no means to take care of."… "Sometimes when a client ruminates or is stuck in past situations such as cult experiences, it becomes quite overwhelming for me and I have to step back."

From the Literature

The [caregiver] also empathically shares the patient's experience of helplessness. This may lead the [caregiver] to underestimate the value of her own knowledge and skill, or to lose sight of the patient's strengths and resources. (Herman, 1992)

From Maine Caregivers

"What I'm aware of is my own feelings of helplessness."… "What affects me is not always feeling effective in helping the client/victim identify steps to improve their coping or to identify appropriate help."… "I often have feelings of inadequacy, feeling that people deserve a better response from the system."… "I'm affected by the persistent here-and-now maladaptive behavior in my clients, either toward/with me or in their day-to-day lives."… "The client's trauma affects me in the sense that I doubt my competence to help at times."… "I often feel that I might not measure up to peers because this work is affecting me so much."… "I feel overwhelmed by the unfairness of some clients' lives and the hopelessness that they seem to feel."… "What's stressful for me is trying to respond to situations with a positive helpful solution – when sometimes there are few or no immediate positive supports available."… "The dialectic of this work is: sometimes I feel insignificant vs. sometimes I feel overly important."

"I am faced with the reality of the limitations on individual outpatient therapy – quite often the work we do is totally inadequate to the task of dealing with trauma."… "Sometimes I feel I have too much hope or give too much credit to my clients' abilities and feel very frustrated when they don't accomplish their goals."… "Professionals become de-sensitized. It's a problem."… "If a client has problems that I can't seem to help resolve or at least begin addressing, how do I let myself off the hook? This is where the line between becoming cynical or being objective gets blurred."… "I experience the feelings of hopelessness and helplessness that the clients often feel about their situations/problems in life."… "Intellectually, I am aware of many things to do: meditation, connecting to nature, therapy, exercise, relaxation, etc. In reality – due to time limitations – I often just 'stuff it' and move on to the next patient and collapse at the end of the day."

Workplace Factors

<u>**From the Literature**</u>

…[I]ndividual coping strategies alone do not alleviate the strain caused by job stress …community values and resources have a direct correlation with positive recovery [from VT] outcome. (Yassen, 1995)

[Some] values go unstated, but clearly have an effect on work settings. For instance, in some settings, it may be assumed that if employees do not work overtime, they are not committed to their work, or that clinicians who do not take vacations are more committed to their work than are others. (Yassen, 1995)

…[P]sychological manifestations of stress are directly responsible for job dissatisfaction, increased absenteeism, high job turnover, and drug and alcohol abuse. (Daleo, 1986)

<u>**From Maine Caregivers**</u>

"The consequence of failing to acknowledge workers' need for time to de-stress is the number of people who leave this environment with disabilities or diseases that are secondary effects of long-term stress (i.e. cancer, heart disease, and physical disabilites due to workplace violence)."… "My biggest issue is there is no one to talk with within the nursing profession. Sad but true."… "My extensive physical symptoms disappeared when I came to a better employment environment where more support was available."… "There's lots of talk but no real action at the agency."… "Some feel that no one hears them. Do you realize there are people working the off shifts that have never seen the dawn?"… "I'm left feeling alone <u>often</u> in a <u>sea</u> of other lonely caregivers."

Impact on Personal Life

<u>**From the Literature**</u>

Repeated exposure to stories of the human capacity for cruelty inevitably challenges the [worker's] basic faith. It also heightens her sense of personal vulnerability. She may become more fearful of other people in general and more distrustful even in close relationships. She may find herself becoming increasingly cynical about the motives of others and pessimistic about the human condition. (Herman, 1992)

…[R]esearchers find many behavioral correlates of stress among [workers] who engage in this type of work, including somatic complaints, sleep disturbance, increases in alcohol consumption, exhaustion, poor concentration, increased sensitivity to violence, experiencing family and friends as too demanding or not understanding, and expressing increased safety concerns. (Charney, 1998)

      "What bothers me is the carry over effect after hours."… "I'm deeply affected by a client's disclosing past trauma which has occurred as a result of cult abuse. This abuse occurred in the same town I live in. It makes me feel very unsafe in my community and at home at night. It has also affected my spiritual life."… "The client's past trauma comes up for me in terms of intensive imagery during sexual activity and at other times."… "I find it hard to let go of some issues that happen to some families I work with."… "I concern myself with how vulnerable we all are in some circumstances, no matter how competent and strong we may normally be."… "Addressing issues that are overwhelming and sensitive and then being vulnerable to liability issues causes feelings of unsafety and distrust."… "We take really good care of our clients. We just get majorly stuck at taking care of ourselves."

      "Everyone I know is looking for a new job."… "The amount of demands placed on staff is well beyond the available resources to support the same. The resulting burnout creates high levels of worker turnover and thus lack of continuity for clients."… "Honestly, if I had been working full time rather than 28 to 34 hours per week, I really think that in spite of my best efforts to protect myself, I would have failed."… "I am in the process of making a job change because of how working with trauma survivors affects me.

What Already Helps

Overview

From the Literature

There are two fundamental modes of approaching vicarious traumatization. The first focuses on the general need for better self-care and addresses the stress inherent in vicarious traumatization. The second focuses on the specific need for transformation of negative beliefs, despair, and loss of meaning and directly addresses the demoralization and loss of hope created by vicarious traumatization. <u>Antidotes for vicarious traumatization must address both the stress and demoralization</u>. (Saakvitne, 1996)

From Maine Caregivers

      "I take care of myself, especially with daily spiritual activities. I weekly hike in the mountains. I consult with respected peers when I'm having problems with a case. I have good friends who are emotionally supportive I can vent with"… "I take good care of myself and work only 30 hours/week, which enables me to balance work with a nurturing personal life."… "What works for me is frequent vacations (one of which is 6 weeks long), limiting caseloads, sharing difficult clients in a collaborative practice, supportive supervision and peer supervision."… "How do I take care of myself? With lots of capable, intelligent, experienced peer supervision (2 hours plus per week in various forms/groups), physical exercise and involvement with nature daily, regular meditation/yoga and/or visualization practice, attending at least one in-depth (2-3 day) conference for education and networking per year, support from family, and community involvement in areas where I can see positive results."… "What I do: vent with coworkers, supervision at times, professional reading and seminars, writing poetry,

inspirational reading, e-mail people close to me, general reading and music. At the workplace: coworker bonding, humor, agency or unit retreats, gatherings, in-services, storm days, and team format."… "I use music, reading, exercise, hobbies, and the support of my peers in the agency, along with supervision, meditation, and exercise to sustain me."

Organizational Strategies

From the Literature

An effective organizational strategy to prevent burnout and build engagement begins with a staff survey on key aspects of organizational life. Identifying the hot issues is a critical contribution of the survey. (Maslach & Leiter, 1997a)

In seeking to minimize the impact of secondary exposure on [caregivers], this study [surveying members of three professional organizations] supports the following suggestions:
Increased supervision and support for the beginning trauma [worker] seems particularly important.
Certain periodic participation in training activities may perform an important mediating function for trauma [workers].
Participating in a variety of activities rather than engaging in full-time clinical work with trauma survivors appears advisable.

(Chrestman, 1995, Revised 1999a)

From Maine Caregivers

"Thanks for asking. Just the asking and the effort are promising to me."… "Thanks for the survey."… "Thanks for caring."… "Good job."… "It seems the questions are right on."… "Thanks for all your good works."… "Thank you for taking the time and consideration of the staff."… "Just the Department asking/recognizing the reality of this phenomenon is encouraging!"… "I feel good that the Trauma Office is keeping an eye on the larger picture."

"When you first began your career and became exposed to folks with trauma diagnosis, did anyone ever talk to you about VT? Many of us have come from other disciplines where we experienced VT prior to our current positions. We brought this with us and had no name for it. Thanks."… "I feel protected from VT and burnout by having an awesome supervisor I can talk to about my feelings, recognizing that I need to do things to take care of myself, and doing them, such as writing, exercising, and doing things that nurture me."… "I have a gifted supervisor, so I deal with a lot of burnout issues in supervision once a week."… "I work with a good, caring supportive team of professionals with whom I can consult at almost anytime."… "Important to my stability is a supportive clinical supervisor, peer supervision, team meetings, team trust outings, working together with our clients for everyone's benefit, and changing the system."

"My past experience and the education I have sought for myself (i.e. conferences, reading) allow me a level of comfort that facilitates the work I do with trauma survivors. Limiting my hours and being attentive to my own needs has kept me sane, but I would be the first to say the work is difficult."… "Often there is little training on when or how to know one's own limits and in how to deal with others' trauma. Further training on how to keep one's

thumb on one's own pulse (inner feelings) would be helpful."… "I use support from coworkers and personal self-development."

"It is images connected to survivors' childhood abuse that can affect me, especially if I do not have a balanced caseload including many individuals who are not trauma survivors." … "I personally need space for myself to escape the environment for my breaks."… "Methods I use are prayer and meditation, along with education. These methods are not talked about in my work environment, nor is time given for these activities in the workplace, even after traumatic occurrences."… "I use sick time for mental relief."… "Flextime gives me breathing space in between crises."… "Sometimes I get out during the day for a walk or a trip to the Natural Foods Store. I see people being kind to one another and I realize that is the norm, not my clients' experiences. These breaks help me with my perspective, so I can empathize better"… "I try to have a physical activity to do after work so as to remove my mind from the day's events."… "What helps me is having autonomy over my caseload, respecting individual styles in my office, and keeping a sense of humor."… "I work with a variety of clients, have a variety of shifts, and exercise to reduce stress."… "I use prayer and meditation, and in the summer – gardening, and in the winter –ice fishing."

Personal Awareness and Therapeutic Processing

From the Literature

In order to be as self-aware and available to our clients as possible, helpers need to be aware of their own issues and seek the necessary support, for example, through their own therapy. (Rosenbloom et al, 1995, Revised 1999a)

In some cases, counselors may want to seek personal help through therapy that will allow them to work more successfully with this population. Among its other potential benefits, psychotherapy can help counselors come to terms with their own limitations. (US Dept. Health and Human Services, 2000)

I believe all therapists have an ethical responsibility to their clients as well as themselves to have had significant, intense, in-depth individual psychotherapy. We must address our own history and its on-going influence in our work. (Saakvitne, 1991)

From Maine Caregivers

"My own therapy has also been essential in helping me to stay clear and not get overwhelmed."… "I get support from private therapy, reality checks with coworkers, having strong (not always fruitful) defenses, and re-visualization."… "Through awareness I keep my personal baggage from affecting my job or allowing my 'buttons' to be pushed by others."… "I see a therapist, and with help from therapist and family, I dance, I journal – creative/expressive stuff."… "Not much is provided at work. I pay privately for supervision and therapy. I need to deal with it."… "I rely on my own psychotherapy, supervision, having fun, knowing my limits and boundaries."

From the Literature

The helper must be able to acknowledge, express, and work through these painful experiences in a supportive environment. This process is essential if [workers] are to prevent or ameliorate some of the potentially damaging effects of their work. If these feelings are not openly acknowledged and resolved, … the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathic, and responsive stance with clients. (McCann & Pearlman, 1990)

What appears to be most helpful to [caregivers] who work with trauma victims is for them to acknowledge that they cannot treat every patient. They must also be connected to peers in support groups and supervision groups. They must not isolate themselves. To maintain some opportunity to express their feeling of pain, guilt, and responsibility, they need to discuss their cases regularly with their colleagues and supervisors… It is important …to develop a sense of humor. It is silly for any one of us to think we have all the answers or the only way of resolving the trauma question! We should also admit that we will make mistakes. We need to take ourselves less seriously. (Cerny, 1995b)

From Maine Caregivers

"I have enlarged my non-work life to include spiritual, recreational, and educational activities."… "I debrief with team members."… "I benefit from weekly clinical staff meetings and monthly consultation with an outside consultant."… "I keep talking to other professionals, use the concepts of Alanon, and maintain a regular spiritual practice."… "I meet biweekly with peers for supervision and support."

"When I leave work, for the most part, I forget about it and concentrate on my personal life."… "What has helped is learning how to 'nip it in the bud' by taking a few more (limited though they may be) 'mental health' days."… "I take time off, am good to myself, and have understanding supervisors."… "I take care of myself by taking time off to rest myself physically and mentally."… "I do yoga in the evening when time allows, try to wisely space my vacations out, and am involved in therapy for myself when possible."

"What helps me is telling jokes, finding the humorous, not magnifying mistakes, enjoying the beauty of nature and the children I meet in families, prayer, and belief in God."… "Stress management workshops, self-care discussions and HUMOR all help reduce the stress as well."… "I do things that feed my soul – laughter, horseback riding."… "Ours is an enjoyable Community Support Program where a sense of humor is valued. I also strive to separate my free time from my work, doing hobbies, relaxing, etc. to take care of myself."… "I benefit from exercise, supportive team members, and joking around with peers."

"I keep my expectation for the client realistic."… "From the beginning I realized I needed time for myself. I have always put that first. I needed to pace myself, come to grips with goals that were reasonable, and be convinced that I am only a tool that can be used in the process of healing -- I can't do it for them."… "I try to leave frustrations at work and not bring them home. I occupy my time with other interests as not to dwell on things I cannot fix or control."

Creating Balance

In addition to professional support, the [caregiver] must attend to the balance in her own professional and personal life, paying respect and attention to her own needs.
(Herman, 1992)

Balancing work, play and rest helps us to remain grounded in various aspects of our complex identities. Practices that renew a cherished sense of identity or that expand one's identity beyond that of trauma [worker] are helpful in this realm. (Pearlman, 1995, 1999a)

From Maine Caregivers

"I have made a consistent effort to separate the '1/3 of Life' – 1/3 work, 1/3 personal growth away from work (exercise, art, etc.), 1/3 rest and sleep. Also important are the support of supervisory fellow workers and the availability of appropriate reading material. Videotapes, training conferences, and other education have been helpful."… "Creating time between the time I leave work and the time I get home to my family helps me to readjust my focus."… "Learning healthy mental/psychological boundary-setting skills helps protect me."… "Balance – balance – balance (my own). Education – Socializing – Recreation – Spirituality – Physical Exercise."… "I choose to spend time with non-therapist friends and read entertaining novels, use mindfulness to help lower the emotionality."… "I try really hard to take care of myself <u>outside</u> of work by eating and sleeping well, getting my own therapy, exercise, hobbies, etc."… "Prozac, 'psychiatry days' off, vacations, shopping sprees, eating, church counseling, perks at work, good friends and family support my mental health."

From the Literature

Reasonable mastery of daily events, caring attachments to others, and a meaningful purpose in life are the three basic domains that lead to good physical and mental health and a sense of well being (e.g., contentment, peace of mind, basic happiness, and satisfaction with one's self). Each of us needs these three general sets of abilities as we confront the stressful events of daily life that can befall any of us. (Flannery, 1994)

From Maine Caregivers

"I laugh a lot, socialize with others, use recreation, exercise. I live a spiritual life. I do not take the job home."… "I monitor my energy through interest and involvement in sports/hobbies separate from work."… "I try to leave work issues related to trauma at work and have a life with family, friends, etc. outside of work."… "I use a number of images that help me feel protected from the toxic energy that often is part of the picture when people have been traumatized."… "Weekends, especially long weekends, are very helpful – I realize there IS a life out there, which can be enjoyed. Also family relationships are crucial."

From the Literature

Maintaining good physical health is a necessity. Without stamina, we cannot tolerate the stress that working with trauma victims entails. A balance of work and play, supported by a balanced diet with appropriate exercise and sufficient rest, will resolve many a stressful situation. (Cerny, 1995b)

From Maine Caregivers

"When I find time to workout and eat properly, it helps. Time off is important, too."… "I appreciate being able to use the gym and computer."… "I use self-relaxation techniques like exercise."… "I <u>need</u> to exercise regularly."… "I take very good care of myself – exercise, good food, etc. – and I try not to bring home any work."… "I workout 3 times a week and stay connected to my own inner process and creative process."… "I take care of myself by doing physical activities I find enjoyable, i.e. hiking, motorcycling, canoeing, and running when I am able."… "I use exercise: power walking, stretching, weight lifting, tennis."… "I use yoga, music, hiking and meditation."

Making Meaning

From the Literature

Anytime you actively challenge, or allow your experience to challenge cynicism and negativity, you reclaim meaning and transform vicarious traumatization. (Saakvitne, 1999)

Spirituality is important. The most insidious effects of vicarious traumatization are evident in the loss of hope, wonder, and other spiritual aspects of the self … many aspects of this work evoke sadness, despair, frustration and fatigue. This fact needs to be balanced by the recognition that psychotherapy is fundamentally about hope, connection and healing. (Saakvitne, 1995)

From Maine Caregivers

"In my early years of practice, the sheer intensity of the work was sometimes overwhelming but also a very rewarding challenge with so much learning. Now trauma work is an integrated and satisfying part of my work life."… "It helps to keep things in perspective and have a life outside of work which is meaningful through giving to others."

"I hold a belief that the psyche is self-healing and that I am not the healer. The psyche has its own time and sense of timing."… "Ongoing daily spiritual practices and emotional release exercises create both an outlet and an in-pouring of coping, healing, and self-protective energies that lessen the long-term effects of VT."… "I rely on spiritual practice/church."… "First and foremost is my relationship with God. He is the source of my strength and peace of mind."… "What help's me is faith and staying relaxed in a crisis."… "I stay stable by taking walks with family, talking with positive people, enjoying home life, going to a good movie, listening to soothing music."… "I do not bring paperwork home and I have a spiritual practice."

Appreciating the Benefits

From the Literature

It is necessary to want to do this work. In fact, we think it is necessary to love some aspect of your work when you work as a helping professional. This is not just another job. In order to offset the pain of the work, there needs to be some reward inherent in the work for you. (Saakvitne et al, 1999)

Working with survivors of trauma teaches us not only about the devastation of cruelty and neglect, but also about the resilience of the human spirit and the resourcefulness of the human mind. In order to transform vicarious traumatization, we need to stay aware of both parts; devastation and resilience, hurt and healing, despair and hope. When we believe our work and our pain have some meaning, we can find hope alongside despair, purpose in routine, and connection in our actions. (Saakvitne et al, 1999)

…. positive effects include a heightened sensitivity and enhanced empathy for the suffering of victims, resulting in a deeper sense of connection with others; increased feelings of self esteem from helping trauma victims regain a sense of wholeness and meaning in their lives; a deep sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic experiences; and a more realistic view of the world, through the integration of the dark sides of humanity with healing images. Although we may be sadder but wiser, it is important to acknowledge the many ways this important work has enriched our own lives as well as countless others. (McCann & Pearlman, 1990)

From Maine Caregivers

"The most significant factor for me regarding burnout prevention is that I am convinced at this time that I should be in the exact profession that I am working in, so burnout is not an option. Therefore, any factor that could possibly contribute to burnout must be eliminated."… "When I help somebody, I feel happy inside."… "I try to focus on the marvelous survival skills of my clients."… "I create positive relationships with consumers and care providers by looking at the possibilities in the situation."… "What helps me is finding positives, looking at my own life and being thankful for what I have"… "Given the conditions in this mixed up world, I concentrate on positive things and am very thankful for what I have."

5

When the Caregiver is a Trauma Survivor:
Challenges and Benefits

The Big Picture

From the Literature

Given the high incidence rates for incest and child abuse among the general public indicated by studies done by Diane Russell (1984), David Finkelhor (1979) and others, there is a statistical probability that therapists as a group, and female therapists in particular, will include survivors of childhood trauma. (Saakvitne, 1991)

Many mental health workers and therapists have personal histories of childhood abuse and neglect. (Pope & Feldman-Summers, 1992; Elliott & Guy, 1993; Kassen-Adams, 1995; and Schauben & Frazier, 1995). (Quoted in Saakvitne, et al, 1999)

Some counselors are recovering from substance abuse disorders and were themselves abused or neglected as children, and they may find themselves in a professional situation where they have to confront their own abuse experience and its impact on their lives. (US Dept Health & Humans Services, 20001)

This topic [the therapist as trauma survivor]…is noteworthy for its neglect and absence in psychological and psychotherapeutic literature. It reflects … the need for silence and secrecy … because of the danger of stigmatization and pathologizing. The message is that to be seen as a survivor means to be seen as somehow damaged, devalued, and inadequate as a therapist. (Saakvitne, 1991)

In keeping with the cultural tendency toward denial of the reality of child abuse in general, the mental health field has encouraged an "us/them" split whereby "we," the mental health providers, are presumed to be very different from "them," the mental health consumers. We believe this is a weakness in the field. (Saakvitne, et al, 1999)

From Maine Caregivers

"I think it is important to acknowledge, for some caregivers anyway, that sometimes they also have been victims of trauma and are in the recovery process, and that doing this work can push some buttons."… "The system needs to acknowledge that the professionals providing service to those who have experienced trauma may also have suffered trauma themselves."… "Many professionals are themselves trauma survivors. We want support mechanisms for dealing with this challenge."… "It would be wonderful if an environment could be created in the field where we could talk about these issues and the impact (both positive and negative) of being a survivor on one's profession as a helper. It does not always feel safe to admit that I am a survivor even though I am also a very competent therapist."… "Workshops about trauma can retraumatize people. If the workshop triggers my trauma stuff, and there are

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other workers to witness me, the workshop is an unsafe place to deal with it. I fear it being used against me later in the workplace."

Challenges to the Professional

<u>**From the Literature**</u>

For therapist-survivors, VT is sometimes made more intense by a special identification with survivor clients, parallels in the clinical material to events in the therapist's own life, and the added isolation and prohibition against speaking about one's experience that the survivor-therapist is likely to feel. (Neuman & Gamble, 1995)

…[R]easons why trauma workers are especially vulnerable to compassion fatigue (VT):
* 1. Empathy is a major resource for trauma workers to help the traumatized.*
* 2. Most trauma workers have experienced some traumatic event in their lives.*
* 3. Unresolved trauma of the worker will be activated by reports of similar trauma in*
*   clients.*
* 4. Children's trauma is also provocative for caregivers.   (Figley, 1995b)*

If the helper's own trauma history remains unrecognized, unprocessed, or unresolved, … helpers may be sensitized to their own disrupted need areas, and at greater risk for missing the clients even more pressing themes. In addition, helpers may be more likely to experience the client's intrusive imagery or re-experience his or her own imagery which is reawakened by the client's material. (Rosenbloom, et al, 1995, Revised 1999a)

<u>**From Maine Caregivers**</u>

      "Sometimes my own trauma issues or sensitivities get triggered and I become emotionally vulnerable."… "Traumatic experiences of clients cause me pain, particularly when I have had similar experiences."… "What comes up for me is my own past issues of childhood as well as the trauma and abuse I felt when I worked at AMHI"… "Hearing the tremendous atrocities experienced by my clients brings up personal issues."… "The hardest part is my awareness of how prevalent trauma and abuse are in our lives. The next hardest part has been keeping my own trauma history and my own work around this in check and taking care of myself so as not to get triggered by clients' stories."

      "Being a victim of trauma myself, I often question if I have the effectiveness to help clients."… "I have a tendency to over-identify with clients who have had similar childhood experiences as myself. It's difficult for me to approach these clients objectively and consider possible differences from my own experiences."… "I believe it is our duty to help reduce the trauma and institutionalization when possible, but we often are struggling with our own issues."

Advantages for the Client

<u>**From the Literature**</u>

First, the helper's own trauma history will influence the nature of response to clients' trauma material. … [I]t may deepen their understanding and sensitivity to client reactions, thereby enhancing the client's feeling of being understood and not judged. (Rosenbloom, et al, 1995, Revised 1999a)

This personal history [as childhood abuse survivors] can make survivors well suited to the role of [caregiver] in certain ways, including their acute sensitivity to the affects, needs, and unspoken defenses of another, as well as their highly developed capacity for empathy. (Saakvitne, 1991)

<u>**From Maine Caregivers**</u>

"Trauma sometimes brings to light past unpleasant memories of my own experiences. I feel nearly as helpless and trapped by these feelings as they do. It gives me a real sense of what their fears are as well as my own."… "Often my clients' situations are similar to my own history. Since I have done, and continue to do, a lot of my own work, it seldom creates problems – just the sadness that wonderful people hurt each other so much."… "What affects me is the intensity of feeling from the clients and their families; sometimes I have the awareness that the trauma parallels some of my own history, which triggers me to be more vigilante about not using the client to get my own needs met."

What Helps

Personal Therapy

<u>**From the Literature**</u>

…[W]orkers with personal histories of traumatization (e.g. abuse history, being a survivor of a natural disaster) are likely to require deliberate personal attention to their own healing process in order to manage … secondary traumatic stress reactions. (Dutton & Rubinstein, 1995)

Personal therapy or counseling is the best single resource for all mental health workers to know and understand themselves well and understand their clients' experiences. (Saakvitne, et al, 1999)

It is impressive that 100% of this sample of therapists [218 seasoned therapists] with a personal history of trauma engaged in their own therapy. It would seem likely that these therapists believe in the power of therapy. It may also be safe to assume that some of these therapists are living proof of therapeutic healing and success. (Paulus, 1997)

"A 'detoxification' of my own lifetime trauma has greatly decreased the overwhelm of vicarious traumatization/burnout which is constantly being triggered by my clients' issues and sharings."… "I have found that giving voice to these issues and taking them seriously has been incredibly supportive."… "I was in therapy for personal issues for awhile and would at times be able to discuss these issues (VT and burnout)"… "Sometimes my clients' trauma mirrors my own trauma and is a reminder. Even though I am engaged in therapy, it can be painful at times. It can be exhausting at times, as I do in-home community intensive case management services."

Peer Support and Supervision

From the Literature

It is imperative that a survivor therapist herself receive the kind of respectful attention she is giving her clients… (Pearlman & Saakvitne 1995a)

There are many survivors of child sexual abuse across the many disciplines of psychotherapists and mental health workers. These therapists need treatment, training, and supervision in order to be sensitive to the complicated issues of technique and counter transference in their clinical work. We as a field need to make this possible, to be able to learn from and support one another in our work. (Saakvitne, 1991)

From TREM [Trauma Recovery Empowerment Model] training manual: Because some leaders may remember traumatic experiences of their own, ongoing supervision and peer support should be available to all group leaders. (Copeland & Harris, 2000)

A psychotherapy group specifically for therapists who are survivors of … abuse [can] decrease isolation and shame, and … address the complicated issues of being a therapist and an incest survivor. Such a group can provide a safe place for connection and validation that can be invaluable. (Saakvitne, 1991)

It is important that the trauma [worker] who is a childhood sexual abuse survivor, … [has] at least one person with whom he or she can acknowledge the abuse and explore its interaction with trauma work. (Pearlman & Saakvitne, 1995b)

From Maine Caregivers

"When I share my own experiences, I often have flashbacks."… "I have recognized patterns of abuse in my past life, which were never validated. I continue to feel paralyzed by verbal abuse. This has impacted my relationships with supervisors, who have varying leadership styles."… "I feel, at times, I over react to criticism and that that reaction may be related to diminished self-esteem subsequent to my own trauma."… "It seems that no one wants to take responsibility for training or supervising anyone. The attitude is that people need to work out their own issues before being hired to support others. This is not helpful."

"What has helped is peer supervision, training, and when being a witness to trauma issues raises personal questions and issues, to deal with them (soul searching)"… "A time and safe space for those workers who are trauma survivors to process their experience from time to time might offer healing and growth both for clinicians and clients. It may aid a clinician to move beyond a stuck spot, too. Not therapy, per se, but an opportunity where one would find some helpful feedback from colleagues for the professional/transference thing."

6

Moving From Alienation and Isolation to Teamwork and Peer Support

The Big Picture

From the Literature

One set of contributing factors to vicarious traumatization is situational *… the kind of work…the population with whom she works, how much she works, the support or lack thereof in the workplace, the context. When we feel our work is recognized and supported at a national, state, or local level, it makes a difference. We do not feel so alone or unrecognized in the work. (Saakvitne, 1995)*

Unfortunately, because of the history of denial within the mental health profession, many [workers] find themselves trying to work with traumatized patients in the absence of a supportive context. [Those] who work with traumatized patients have to struggle to overcome their own denial. When they encounter the same denial in colleagues, they often feel discredited and silenced, just as victims do. (Herman, 1992)

From Maine Caregivers

"Because of society's lack of commitment to trauma healing, feelings of helplessness and demoralization are triggered often, even if my mind says I'm helpful."… "I find it frustrating that I, as a staff person, am not supported or encouraged to help hospital patients deal with trauma."… "Others, family, providers, etc. often do not feel that past trauma is relevant to what is happening now."… "I wish my position, case manager, would be considered by other professionals as a valid one. Schools, doctors, therapists, etc. don't feel that they have to accept my input or comply with my request for information."… "I feel discounted when my supervisor minimizes my work as a social worker because I also do activities' programs and supervise."… "My trauma is related to how some of the staff have treated me in the past/present since I have joined the agency."

From the Literature

People have always looked for a sense of community at work. They have been pleased when it is present and disappointed when it is absent. A job without at least one supportive collegial relationship is unbearably lonely. The support, recognition, and collaboration of others in the job environment permit people to focus their energy effectively, justify their involvement, and extend their achievements – in other words, a strong organizational community prevents burnout. (Maslach & Leiter, 1997a)

It is important to tap into potential sources of support in one's professional network. The helper should first avoid professional isolation by having contact with other professionals who work with victims. (McCann & Pearlman, 1990)

<u>**From Maine Caregivers**</u>

"It is difficult when dealing with my feelings around a traumatic situation with a child and having nobody available to discuss the situation with."… "My past experience with my agency when it was smaller gave me a sense of belonging to a dedicated supportive team. That carried me into the present where I feel we are too big and more impersonal. We in the rural branch offices rarely connect with the larger staff."… "I experience geographical isolation."   … "I feel isolated from my peers as we work on the road by ourselves, so I tend to not talk with peers about problems/issues as much as I used to. I have no immediate access to feedback from friends and coworkers. The nature of the job breeds isolation. The only way for me to prevent burnout is to attend a self-help group."

<u>*From the Literature*</u>

The research on burnout among therapists suggests the following as contributing factors: professional isolation, [and] the emotional drain of always being empathic, … (Bermak, as cited in McCann & Pearlman, 1990)

The helper must be able to acknowledge, express, and work through these painful experiences in a supportive environment. This process is essential if [workers] are to prevent or ameliorate some of the potentially damaging effects of their work. (McCann & Pearlman, 1990)

<u>**From Maine Caregivers**</u>

"I have to use extra care to maintain composure, to re-ground the individual and process with the group when trauma comes up. I make sure to de-brief with fellow staff members afterward."… "I'm affected by the images of horrible tragedies and the isolation of secrecy from having to keep matters confidential."… "Gratefully, supervision and peer support are generally available to me to vent if necessary and/or to center on a treatment approach."

What Helps

Teamwork

<u>**From the Literature**</u>

Counselors can minimize the likelihood of burnout. Discussing feelings and issues with others who are working with similar clients can decrease isolation through a process of shared responsibility. (Briere, 1989, cited in US Dept, Health and Human Services, 2000)

The greater the exposure to trauma clients, the greater will be the need for a treatment team. … [A] team approach can provide, on a regular basis, active intervention in prevention of

secondary traumatization… The team not only provides a healing environment for the [caregiver], but relieves the client of the burden of protecting the [him/her]. (Monroe, et al 1995a)

From Maine Caregivers

      "Working with a team reduces potential burnout."… "We laugh together, support each other in stressful times. We talk and process problems that occur and offset our balance. We have an open door with a supervisor who always welcomes us and supports us in times of need."… "I work with a very supportive team. Unfortunately, we are often overloaded with work and do not have enough time to support one another."… "My support comes form clinical supervision, peer supervision, team meetings, team trust outings, working together with our clients for everyone's benefit, and changing the system."

      "Recognizing that I was part of a team and not taking the whole responsibility was important."… "I have extremely supportive team and management services. They all trust that I am genuine in my caring and desire for the best for my clients. This is the sole item that allows me to feel safe and sure in my work, even when I need to set firm limits and/or take time for myself."… "Being a member of a supportive team of co-workers has been extremely helpful." "Team meetings have been a source of revitalization and peer support."… "Team get-togethers, such as birthday celebrations and other achievement celebrations, have brought me closer to my co-workers. I get answers from them."… "Sharing the burden and responsibility with other team members helps me to feel supported and energized."… "Debriefing with team members helps me do my job better."

Peer Support and Peer Supervision

From the Literature

Peer groups of trauma [workers] set norms, provide support, help correct distortions, and generally offer opportunities to reframe traumas. These peer-rich environments can be ripe for facilitating the ongoing work of self-care of healing secondary trauma. (Catherall, 1995, Revised 1999a)

[Those] who work with traumatized people require an ongoing support system to deal with their intense reactions. Just as no survivor can recover alone, no [caregiver] can work with trauma alone. (Herman, 1992)

[I]t is important that the group members avoid pathologizing the responses of helpers. Just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims. (McCann & Pearlman, 1990)

From Maine Caregivers

      "Search out peers who can handle trauma after effects and believe that these things do happen."… "I listen to peers' concerns and appreciate being allowed to vent without interruption or correction."… "Peer support, feedback, and validation help me."… "I have

developed a supportive group of peers."… "I benefit from lots of capable, intelligent, experienced peer supervision (2 hours plus per weeks in various forms/groups)."

"What helps me is talking with other staff, training, and post trauma review sessions."… "I get peer support and have a supportive spouse."… "What I find useful is venting to peers, reading theoretical books, excellent office staff that expedites paperwork and is sympathetic to both our efforts and the clients."… "Reality checks with coworkers helps."… "I benefit from all the following: access to supervision, trainings, reading, debriefing and coworkers."… "I use consultation with respected peers when I'm having a problem with a case." … "Respect and camaraderie in the office. Potluck lunches help unite us."

"Good clinical supervision, through colleagues and peers or privately purchased, helps."… "I rely on my supervisor and coworkers for empathy and understanding."

Other Renewal Strategies

From the Literature

Some treatment settings have established in-house support groups for counselors who work with abuse and trauma survivors. (US Dept. Health & Human Services, 2000)

Hearing others talk about their reactions normalizes one's responses and helps define strategies for coping. (Charney & Pearlman, 1998)

Finding forums in which to recall and name the rewards of doing trauma work is essential. It renews our sense of the meaning of this work, revitalizes our connection with others and with humanity itself… (Pearlman, 1995, Revised 1999a)

From Maine Caregivers

"Support groups and workshops help when people desire this support. Ask!"… "Provide support groups at place of employment (the hospital) for those who work with trauma survivors."… "Perhaps creating a time set aside, on a regular basis, to debrief as is done after catastrophic accidents, etc. That way clinicians can spend a few minutes describing some difficult cases, close calls, etc. and get support in response."… "Be more supportive. Boost employee moral. Work as a team. Be more sympathetic. The list goes on and on."… "Give us support that doesn't feel threatening would be nice. Listening to hospital workers and not assuming anything about them would make me feel like a human being again."… "Structure training/support for clinicians in agencies to debrief, etc. by providing funding for such activities (including covering clinical time lost) in contract agencies. Also, fund healing group/trainings away from the employer."… "We could use a support group to help us process burnout issues."

"Many employees in this field are aware that burnout may occur, but do not have an opportunity to talk with other coworkers about how they take care of themselves. A staff day or monthly meeting to discuss these issues with other workers would be helpful to learn other ways to cope with the trauma we see."… "Local support groups close enough to minimize travel time would be helpful. They would not have to be frequent, but their being on an

ongoing regular basis would help."… "Make it possible for us to attend a support group that would be confidential and the information would not return to work."

"Disseminate information about multidisciplinary teamwork (a positive) and how it can be achieved at the area community agencies in spite of the Department's current system of allocating funds by discipline, which impedes multidisciplinary care."… "Continue team retreats."… "I would like team involvement – someone to share with, not just for the emotional letting go, but a calm, solution-driven, strength-based person to orient and reflect with."

"I would appreciate more sincere support from my direct administrator."… "I need more positive support from team leaders and supervisor. If something is a mistake, you know immediately and have lots of paperwork to correct it, but positive remarks are rare."

"Offer more reading and information regarding vicarious traumatization. Give us down time at work for more group/colleague quiet time, and supportive supervision on an informal but regular basis."… "Provide workshops to address VT and burnout."… "Support the formation of support groups/study/discussion groups with a mix of consumer and caregiver/professional and paraprofessionals who can be involved in functional discussions and recreational pursuits."… "I would like the availability of peer support groups and a list of supervisors with trauma, VT and burnout specialties."

7

Professional Competence and Self Confidence:
Supervision, Education and Training

The Big Picture

From the Literature

[A Canadian survey of 281 providers and managers of mental health services in a variety of settings found that] … trauma work 'usually' or 'always' had a greater impact than non-trauma work to more than half of the subjects…Over 50% of the therapists reported that their college training 'did not at all' or 'rarely' helped them deal with the impact of trauma work. (Bober, 1995)

All crisis workers are at risk of experiencing secondary traumatic stress (STS). (Beaton & & Murphy, 1995)

The research on burnout among [caregivers] suggests the following as contributing factors: ... failure to live up to one's (perhaps unrealistic) expectations, leading to feelings of inadequacy or incompetence. (Deutch, 1984, as cited in McCann & Pearlman, 1990)

From Maine Caregivers

"As the team supervisor, I am acutely aware of how hard it is for my ICM's! They tell me with words and actions/non-actions how tough it is to be with their clients. The issues of personality disorders and subsequent dynamics are BIG."… "There appears to be a suppression or denial of the very real effects of VT upon human caregivers."… "Trauma in the patient's past has to be explained to staff. That trauma can cause the client to behave aggressively. It sometimes concerns me that it is misunderstood or minimized that the person was traumatized."

"I wonder if I have the skills to handle the situation."… "Lacking knowledge or understanding that the client is experiencing flashbacks makes involvement and support difficult, as we are so used to dealing with 'behavioral management' problems only."… "I am wondering if I am doing the right thing for clients with their problems."… "What concerns me is having to deal with illnesses my training doesn't deal with."… "I feel I am not trained in trauma."… "What comes up for me is my lack of skills for psychotherapy."… "Often I fear that I might not measure up to peers if this work is affecting me so much."… "There's not enough supervisory expertise/support."

The Need for Trauma
Education and Training

<u>From the Literature</u>

[C]ontact with one's professional organization and with the management staff within their organization was generally rated as one of the least helpful activities in coping with the impact of trauma related work. Trauma specific training at the individual and team level was ranked highly. (Bober, 1995)

Given that the incidence of childhood abuse and trauma is quite high among individuals who enter the mental health professions, training programs for clinicians might consider directly addressing abuse-specific concerns within a curriculum. Classes taught on treatment of abuse victims with specific attention paid to issues related to counter transference may be particularly helpful for the clinical trainee.
(Elliot & Guy, 1993)

While there is no substitute for solid clinical training, it is nevertheless <u>not</u> sufficient to <u>just</u> be a good clinician. The often extreme nature of these interventions demands that the [caregiver] have a firm theoretical grounding within a traumatology perspective… (Charney & Pearlman, 1998)

We cannot overemphasize the value of trauma-specific professional education and training. [People] who work with adult survivors should obtain as much training as they need to feel comfortable with the wide range of issues these clients bring to treatment. (Pearlman & Saakvitne, 1995b)

<u>From Maine Caregivers</u>

 "I'm conerned that not enough training is being done around the state. I see this over and over in the questions being asked of me and the response I get from people I train."… "I feel there is inadequate training in trauma and response to trauma victims."… "Often there is little training on when or how to know one's limit in dealing with others' suffering from trauma. Further training in how to keep one's thumb on one's own pulse (inner feelings) would be helpful."

 "Our patients have some of the most brutal backgrounds and have horrendous lives. Naturally, they have developed some rather extreme methods of coping. It can be very frustrating not to have current tools and knowledge to help them develop new and appropriate skills."… "Give us more trauma training with people of the quality of Bessel van der Kolk, MD and Dan Brown, PhD."… "We as hospital staff should be given behavior management and de-escalating skills training focusing on <u>safety</u>, rather than waiting for a crisis, so we can help the patient develop personal insight and accountability."… "Offer more specific training – the 'how to' in dealing with trauma, VT and burnout. It's time to get to the working 'nuts and bolts'."… "What helps is attending conferences."… "DBT skill training helps me feel like I'm helping others. It gives me something to do with clients when I'm not sure what to do." … "Teach us how to examine questions about trauma and sexuality beyond the very generic."… "Have seminars/workshops on how to deal with some of the common issues that arise with

trauma clients (i.e. hearing voices, seeing things that aren't there), and on how to deal with families/family members who are over-involved."

The Need for VT and Burnout
Education and Training

From the Literature

If staff members are given the opportunities to grow, they will stay motivated and will be less likely to burn out. The agency can provide ongoing training to increase counselors' expertise in specific areas, such as preventing relapse and dealing with stress. (US Dept. Health & Human Services, 2000)

All new [workers] need to be informed that vicarious traumatization is an occupational hazard of trauma work so that they can predict, recognize, and name the distressing effects of immersion in the psychic worlds of traumatized individuals. They also need to be reassured that VT is modifiable. (Neumann & Gamble, 1995)

As teachers and supervisors, we have a responsibility to educate our students and supervisees about vicarious traumatization. We must validate the difficulty of the work and encourage ongoing discussion of its effects. (Pearlman & Saakvitne, 1995b)

We conclude that any training in trauma work MUST include education about vicarious traumatization. (Saakvitne & Pearlman, 1996)

From Maine Caregivers

"I think I need to learn how to prevent VT or burnout."… "In my opinion, with a more educated the staff, you will prevent VT and burnout."… "Openly talking about VT would help. Some people don't even know what this is."… "Provide stress relief training to learn different ways to deal with stress."… "What has helped me has been educating myself about VT."… "Employees need education about burnout and VT to be able to recognize the signs before it is too late."… "We need broader education to recognize issues (of trauma, VT and burnout) and how to relieve or work with these issues."… "More Department sponsored trainings in compassion fatigue, trauma, abuse intervention, crisis intervention, etc."… "Making training available on taking care of the caregiver supports our taking care of ourselves"… "Training at 'mental health' workshops that stresses coping skills for us and offers mini spa-type sessions for meditation and relaxation."… "Provide one conference or workshop per year, or help subsidize one through another agency, on VT and burnout. Send materials on this subject as this helps us identify the issue and consider our own status."… "I feel that having wellness programs within agencies would be helpful for self-care."

The Vital Role of Supervision

From the Literature

All trauma workers, especially those who are early in their careers, need respectful ad supportive supervision in which they can learn skills and talk about the impact of their work on themselves. (Saakvitne, et.al., 1999)

Working with persons who have been traumatized, especially if the traumas have been severe, is not for the inexperienced or beginning [caregiver], unless that [person] is supervised or mentored carefully. (Williams, 1995, Revised 1999a)

… [T]the primary function of the supervisory relationship is to provide support and education for the [caregiver]… [so] trauma therapy supervision or consultation is always a consultation on a therapy relationship, not a client. (Pearlman & Saakvitne, 1995a)

…[W]e all need to be engaged in ongoing supervision and consultation on our work… We are the tools of our trade; we use ourselves, our perceptions, affect, intelligence, insight, and intuition to understand, connect with, and help our clients. (Saakvitne, 1991)

[Caregivers] who work with trauma survivors need supportive, confidential, professional relationships within which they can process the horrific stories, graphic imagery, and destructive re-enactments that are an inevitable part of the work. (Pearlman & MacIan, 1995)

From Maine Caregivers

"When I have consistent clinical supervision I feel that it benefits me and reduces the chance of burnout."… "I have no formal support mechanism to deal with emotional or crisis issues that come up in everyday work. Clinical supervision is just nuts and bolts of what goes on with my caseload."… "Supervision gives me the chance to express my feelings."… "Supervision, with training in relevant skills, and adequate time to process intense feelings of others and to prepare for therapeutic interactions is crucial."… "What helps me is individual supervision and sharing the burdens."… "In good clinical supervision, superiors often provide praise and encouragement."… "I have an awesome supervisor who I can talk to about my feelings."… "I need the support and recognition I get from supervisors."… "Acknowledge the intensity/difficulty of the work we do with survivors. Listen and offer supervision."

From the Literature

…[O]rganizational support for continuing education, and for ongoing supervision and consultation convey a recognition of the challenges of the work and a commitment to providing the necessary component for ethical treatment. (Saakvitne, 1995)

From Maine Caregivers

"We need supervisors to help bring us up to our highest potential and to know our role as appropriate helpers."… "Supervision is extremely important – how we help ourselves and each other not to be overwhelmed by the work."… "Supportive and available supervision is

so important. It helps prevent burnout. The help is crucial."… "Instead of fostering good will and support, our supervisors more often criticize and find fault."

Risks of Inadequate Supervision

From the Literature

Many, if not most mental health workers do not get enough supervision or trauma-informed support for their work with survivors of trauma…Inadequate supervision can contribute to ineffective, unethical, or damaging treatment of clients. (Saakvitne, et al, 1999)

If the counselor sees a large number of clients (many with trauma histories), does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counseling work of this sort may put her at personal risk. This situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. (Courtois, 1988, as cited in U S Dept. Health and Human Services, 2000)

The study [of 188 self-identified therapists] indicates the need for more training in trauma therapy and more supervision and support for both newer and survivor trauma therapists. …[T]hese newest trauma therapists were not receiving supervision, and they tended to be working in hospitals. Only 17% of those therapists working in hospitals, where the most acutely distressed patients are treated, were receiving any supervision. (Pearlman & MacIan, 1995)

From Maine Caregivers

"I am aware of caseworkers' lack of knowledge and experience in trauma. Often individuals receiving service receive the caseworkers' frustration due to his/her lack of understanding of consumers' behaviors."… "A lack of supervision is hard. Standing on one's own is possible, but I need to know that I'm on the right track. The supervisor is needed on a regular basis to help the worker do a job with the whole client – not just technical, routine parts like time sheets, food and jobs – but for a well rounded person with a quality of life. We want to connect with clients as whole persons. Guidance through supervision can help us do it in a supportive collaboration. It takes teamwork to have all the talent and knowledge necessary to really help the client."

Elements of Superior Supervision: Safety, Availability, & VT Awareness

From the Literature

While a supervision relationship is not therapy, it does need to be safe and respectful. The goal of supervision is to facilitate learning. A major block to learning is shame; it is not possible to take in new information when one is trying to protect one's self-esteem…

Any model [of supervision] in which the treater's need for help, consultation, and emotional support is viewed as a personal fault or weakness is a model that needs to be challenged (Saakvitne, et al, 1999)

Supervision which is respectful of both the self of the therapist and the therapist's need to identify and express the powerful feelings elicited by this work can help to create an environment in which we can feel safe with strong affects we are asked to hold in our clinical work. (Rosenbloom, et al, 1995, Revised 1999a)

The key element in developing a support structure is that it be emotionally safe to be able to talk honestly about the impact of one's work on one's own life. (Yassen, 1995)

…[I]t is especially important in supervision … to create a safe, boundaried space in which a [worker] can speak freely… Clinicians need to talk about the strain imposed by their work and about the personal issues it raises. In order to feel safe doing this, they need a place where their disclosures do not affect their performance evaluations. (Pearlman & Saakvitne, 1995b)

From Maine Caregivers

"Wouldn't it be wonderful to have psycho-spiritual, totally confidential support from supervisors! We want recognition and support for the deep connection which holds and supports the whole recovery process."… "We can learn and grow from constructive criticism, positive support and appreciation for our talents. We want to feel free to say what we want to say in supervision. This is a problem if the supervisor is not capable/willing to do this or is in a position to have to judge a person's job performance. It makes an empathic collaboration model impossible."… "What would help is supervision outside the administrative chain, with confidentiality, so weaknesses can be admitted without consequences."… "I need someone to talk to without fear of losing my job or being labeled."

"Supervisors need updated training on supervising clinicians who do trauma work. Clinicians' effectiveness is often minimized."… "Clinical supervision could focus on VT as a topic and on experientially managing/releasing tension in a group – not just talking about cases." … "Too many supervisors and team leaders do not have clinical skills and don't know how to really engage workers in personal/professional development. We only get case management."… "Just recently supervisors got trained in VT. This training is imperative to ISCs."… "Provide additional supervisory training for supervisors."

From the Literature

The importance of available support and consultation for all mental health helping professionals is immeasurable….<u>We are suggesting that clinical supervision is not a luxury, but a clinical, ethical necessity for all individuals engaged in mental health work with survivors of childhood trauma.</u> (Saakvitne, et al, 1999)

Ideally, the [caregiver's] support system should include a safe, structured, and regular forum for reviewing her clinical work. This might be a supervisory relationship or a peer support group, preferably both. The setting must offer permission to express emotional reactions as

well as technical or intellectual concerns related to the treatment of patients with histories of trauma. (Herman, 1992)

From Maine Caregivers

"I have a gifted supervisor, so I deal with a lot of burnout issues which are discussed in supervision once a week."… "Good available supervision is very helpful."… "We benefit from clinical supervision on a regular basis and available on short notice for emergencies: an 'open door' policy to the supervisor's office."… "What helps is the availability of co-workers and supervisor to consult with on cases at any time."… "I have weekly clinical staff meetings and monthly consultation with an outside consultant."… "Give us more individual supervision – at least one hour weekly!"… "The availability of a supervisor to consult with or to just 'blow off steam' with, when the need arises, is most helpful."… "If the Department could mandate weekly clinical supervision for all mental health professionals it would help."… "We need a supportive, effective supervisor on board five days a week at the office."

The Value of Personal Therapy

From the Literature

Personal therapy or counseling is the best single resource for all mental health workers to know and understand themselves well and understand their clients' experiences. It is invaluable because:

- *It is a way to know ourselves well in the context of the past and present.*
- *It helps us to understand how different it can be to be a client and feel vulnerable.*
- *It is difficult to give something to our clients that we have never received ourselves.*
- *It helps us realize how complicated feelings can be, and how many feelings and levels of reactions there are when we take time to 'look within' ourselves.*

(Saakvitne, et al, 1999)

From Maine Caregivers

"I use my own psychotherapy and supervision to take care of myself."… "At this time I am aware I am burning out. I have recently begun therapy to address this issue and to cope with it. I have fatigue, loss of motivation."… "It would be useful if vouchers could be provided for individual therapy and supervision."… "I have to support myself with personal counseling and private supervision, not connected to the employer."

8

Management's Thoughts:
Responses to Survey on Staff
Vicarious Traumatization and Burnout

The Big Picture

<u>From the Literature</u>

Administrators of agencies that serve trauma survivors often have extraordinarily difficult jobs balancing the needs of clients, their staff, and their fiscal limitations and responsibilities. Administrators often have to answer to other authorities who do not understand trauma work or its effects on the helper. … It takes a talented administrator to balance the need for economic survival with the need for reasonable standards for direct service staff… Organizations need to be educated and members of the organizations need to take initiative. (Saakvitne & Pearlman, 1996)

Burnout <u>does</u> affect the organization's bottom line. It is not just an individual problem but much more than that. It is the employer's responsibility to improve the organization, and it turns out that organizations <u>can</u> do a lot about burnout. (Maslach & Leiter, 1997a)

…[I]t is the joint responsibility of policy makers, administrators, educators, and professional caregivers, as well as individuals, to ensure comprehensive [STS and VT] prevention planning. (Yassen, 1995)

Responses to Four Questions:

1. What have you successfully created in your work environment to help prevent or address vicarious traumatization or burnout?

"Open communication about cases where trauma is an issue."… "When a client dies we have an open door time where staff at all levels join to discuss how the client impacted their lives. Also, during weekly team meetings there is ample time and space to discuss issues and problems or intense situations with clients. Often my staff will 'debrief' immediately after a traumatic incident, then discuss it in team meeting, as well as with other teammates throughout the week. If a particularly stressful time occurs, we will pass a card around and everyone signs it with supportive words."… "Holding debriefing sessions following a traumatic work event."

"By creating an atmosphere conducive to peer sharing, consultation and support."… "Providing a team culture in which peer support is an integral part of service delivery."… "We hold regular meetings where trauma issues are discussed."… "We have treatment teams and support fun stuff, too."… "Lots of peer discussion and group discussion"

… "Peer support during a specifically scheduled time"… "Making certain there are immediate opportunities for staff to process with colleagues and in supervision."

"Offering weekly supervision."… "Supervision availability."… "Clinical supervision." … "Discussion in supervision."… "Regular supervision and staff training."

"We encourage staff to take time off."… "Restructuring to allow staff a varied workload."

"It is very difficult to address burnout. There is relatively little support in the Region to do so. We need training to recognize signs of burnout and to provide a supportive team and for the Region to assist in managing it."

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2. What are the obstacles or impediments you have found as you have sought to plan and implement staff training and/or staff support practices and activities?

"Direct service requirements. Staff resistance. Budgetary restraints, Ignorance."… "Direct service targets, coupled with administrative demands, make expansion of training and other support activities very difficult. Rate setting does not seem to recognize the increasingly complex nature of the work and the impact on billable time."… "Lack of organizational commitment to provide regular staff development. Lack of awareness of early signs of burnout."… "The problem? Money, money, money."

"Not enough time to do all the trainings needed in any expedient manor considering there are clients who need to be served and that cannot be put off."… "Time."… "Events held away from [our Regional area], requiring travel time. Lack of trauma (Departmental) access in this Region."

"Provider community and some Departmental staff in our Region are resentful of the concentration on trauma issues."… "We have received a lot of training in regards to trauma. But not much on how to take care of oneself. Working atmosphere is not conducive to this."

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3. How could the Department increase your ability to be more supportive of staff and prevent vicarious traumatization or burnout? (E.g. what change of policy, procedure or resources would support you in your efforts to keep your staff healthy, happy, and productive?)

"Support for lowering direct service requirements. Streamline paperwork. Provide funding for training and supervision that is relevant to daily tasks."… "Support case managers in having lower (20 or so clients) caseloads across the state so there is time to 1) serve the clients well, 2) do the reams of paperwork required, and 3) have a little left over time to attend trainings and recoup from trauma."… "Enable more time for staff, on a regular basis, that wouldn't interfere with other job priorities (so they can meet the increased client quota and paperwork demands)."

"Arrange for staff development speaker (panel or professionals) to discuss signs, implications and solution to vicarious traumatization and burnout. Provide a consultant who would be available in an ongoing way to staff around these issues."… "Allocate money from Department budget to pay for more supervision."… "Provide healthy trauma expertise on site in the Regions. Provide training opportunities closer to home."

"More staff. More respect for geography of Maine and the Regions. More specialization, fewer broad policies – we can't be all to everybody. More respite dollars and sites to serve people with MR needing longer term stabilization than crisis homes allow."… "Provide guidance to fiscal/contract staff. Collaborate with DHS on financing for training. (We serve many DHS clients; as providers in the Child Welfare system. Our training, pre-service and in-service is an allowable training cost.) Collaborate with the university system using their administrative matching opportunities. Expand career development opportunities for staff by using Child Welfare matching possibilities for higher education (both to attract and retain staff)."

"People want solutions. Solutions that they're given, like finding activities outside of work, don't work for work problems. Work related solutions are the only ones that work for work problems. Examples: teamwork (share the burden), de-briefing sessions, trauma-sensitive supervision."

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4. If we didn't ask the right questions, please add any other comments you think might be useful for us to know.

"In almost all human service professions, there is too much to do, in too little time – therefore, selfcare or peercare may be neglected! It almost should be a 'quota requirement' for us!"… "Work with providers around program finance to support a program structure that allows staff to do a variety of treatment work as opposed to one specific type of work -- a varied caseload which balances highly stressful work with less stressful."… "I find Central Office supportive and embracing of work being done in the Regions. Regional management staff are not as supportive of the work being done. Constant 'downing' of Central Office is very difficult. Aren't we all working toward the same goals?"

Part Two

The Staff Questionnaire:
Quantitative Date

Data Analysis

There is an axiom commonly accepted in the research field: you can't know what you don't ask; you can't manage what you don't measure. Asking and measuring were two of the reasons for the vicarious traumatization and burnout survey presented in this report. What would the people providing services to trauma survivors say about how the work impacts them and how it influences their ability to help others? And what would they tell us about what does, does not, or would help them do their very best work?

As to the survey questionnaire itself (Appendices A & B), in addition to asking caregivers to provide narrative responses to general questions, as reported in Chapters 1 though 8, the survey also included 20 specific questions about vicarious traumatization and 13 about burnout. Each question offered 4 answer options: Often, Sometimes, Rarely, and Never." (See Appendix C for grid of all responses.)

The most striking over-all outcome statistic is that **79% of respondents reported some experience of VT (with 46% reporting "Often" or "Sometimes") and 91% indicatd they had been affected by burnout**. In turn, those who "Never" experienced difficulty with VT numbered 21%, while only 9% "Never" had burnout-type experiences.

A further breakdown of answers by individual question illuminates certain areas where workers reported particular problems. Under **Vicarious Traumatization,** one third or more people answered "Often" or "Sometimes" to the following questions:

- Intrusive images or feelings about clients' issues   56%
- Frustration with your capacity to help   87%
- A decrease in your awareness of your skills, either interpersonal
  or self protective   48%
- Difficulty remembering things   55%
- Physical difficulties such as frequent headaches, muscular tension,
  decrease or increase in sleep or appetite   59%
- Self esteem problems   39%
- A diminished sense of safety in the world   44%
- Chronic suspicion and fears for women and children   34%
- Less ability to trust   42%
- A change in your view of the world, sense of self, and spirituality   49%
- Numbing (emotional or physical)   42%
- Social withdrawal   44%
- No time or energy for yourself   62%
- Disconnection from loved ones   39%
- Increased sensitivity to the incidence of violence   69%
- Cynicism   61%

With **Burnout Questions,** one third or more respondents answered "Rarely" or "Never" to these questions:

- I have enough time to do the work that must be done   41%
- My input is requested in relevant policy decisions   41%
- The financial rewards of my job are sufficient   48%
- Opportunities and rewards are based on merit alone   56%

The statistics offered here seem to buttress the narrative material included in earlier chapters. They also clearly suggest that paying attention to the issues of vicarious traumatization and burnout is both economically prudent and professionally ethical.

Part Three

Recommendations:
Policies, Programs, and Practices

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The Big Picture

<u>From the Literature</u>

Acknowledging Vicarious Traumatization and Burnout

We will not be able to completely prevent workers from being affected by their work with the traumatized, but we can build better environments to support workers when they are affected… It requires the administrative and policy structure to recognize the costs of caring, the challenges of providing care, and the support necessary to counteract those costs. (Rudolph & Stamm, 1955, Revised 1999a)

Overall, the management of STS [Secondary Traumatic Stress/VT] and preventing it from developing into a disorder means acknowledging its existence and preparing for it. (Yassen, 1995)

To protect clients, [providers], and the profession, we have an ethical imperative to acknowledge and address vicarious traumatization. (Pearlman & Saakvitne, 1995a)

Our research and consulting work provide clear and consistent evidence that the roots of burnout stretch far beyond the individual into the work environment… It is an occupational problem. (Maslach & Leiter, 1997b)

Recognizing The Costs of Caring

Vicarious traumatization takes a serious toll on both the [provider] and the client, as well as on the organization and the society that provide the context for their work together. The profound personal costs to the [worker] can include depression, despair, and cynicism; alienation from friends, colleagues, and family; impairment, often resulting in premature job changes; and a host of psychological and physical symptoms similar to those experienced by untreated trauma survivors. (Pearlman & Saakvitne, 1995b)

Experience has shown us that impaired providers have an impact on the consumers, clinicians, and administrative staff of an organization…. (Rudolph & Stamm, 1955, Revised 1999a)

All organizations that are exposed to STS will find that it exacts a toll on the functioning of the staff, unless deliberate steps are taken to prevent, or at least limit, its pernicious effects. (Catherall, 1995)

Addressing Workplace Conditions

…[O]rganizational strategies that develop harmony between workers and their work are key to preventing burnout. If done right, burnout prevention is an integral part of good management. (Maslach & Leiter, 1997a)

For both satisfaction and retention, [Maine State] employees [4.2 % of DMHMRSAS employees responded] communicated that they felt a need for better selection and performance management processes, coaching, recognition, and opportunities for growth. (Linkage Incorporated, 1999)

There are many things an organization can do to protect its workers – and therefore its clients and itself – from the negative effects of trauma work. For example, physical space is important; when the physical space conveys safety, respect…comfort, and beauty, the message is one of hope and esteem. Organizations can ensure all clinical staff members have adequate supervision and consultation. The organization benefits from the improved services and protection against poor or dangerous practices that can occur when work with trauma survivors occurs in isolation. (Saakvitne & Pearlman, 1996)

Accepting Prevention Responsibilities

The best financial security a service organization can have is excellence in service. (Saakvitne & Pearlman, 1996)

…[W]ith the growing knowledge of the costs of caring, it seems not only increasingly important, but feasible, to develop social and professional support networks, understanding administrative structures, and organizational, local, state and federal policies that support the well-being of workers in the field. Most of the information comes from those who are on the front lines, not from the policy world. Ironically, many of the probable solutions can be implemented most effectively at the administrative or political level. (Rudolph & Stamm, 1995, Revised 1999a)

The mission of any institution that must deal with STS should include an acknowledgement of its effects on workers – either in the mission statement or in the strategies that support the mission statement. This should be in the form of a written policy statement… (Cathrall, 1995)

Prevention is the responsibility of everyone… [including] policy makers, administrators, trauma workers, and ancillary personnel. Policy makers are responsible for identifying the need and initiating all programmatic efforts. Administrators are responsible for planning and implementing psychoeducational activities and all other planned activities, and for maintaining preparedness. Trauma workers are responsible for maintaining preparedness, implementing plans, and providing feedback to administrators and policy makers regarding the suitability and relevance of plans and psychoeducational efforts. Finally, all members of the institution are responsible for employing the skills and attitudes that acknowledge STS and facilitate healthy processing by exposed personnel. (Catherall, 1995, referring to Figley, 1989)

Providing Resources, Training & Support

When organizations provide resources and support for continuing education, the calibre of the work at the organization improves. Medical policies that offer reasonable coverage for mental health benefits are a necessity for workers in the field of trauma. Adequate pay and time off are also a necessity… (Saakvitne & Pearlman, 1996)

[Caregivers] in general haven't received much background or training on sexual abuse or violence issues, and [yet we live in] an incredibly violent culture. There should be a certificate in traumatology – just like in alcoholism and substance abuse. (Lynch 1998, as cited in Saakvitne, et al, 1999)

…[O]rganizations that undertake training of [providers] in the area of traumatic stress have an ethical responsibility to provide an environment in which (1) the inevitable mistakes inherent in the learning process are responded to in a non-blaming manner, (2) [providers] are encouraged to struggle with and tolerate the condition of 'not knowing', (3) professional development is supported by providing flexible leave and funding for work-related professional conferences, (4) personal psychotherapy is encouraged, (5) there is overt recognition and valuing of trainees' hard work, (6) attention is given to the organizational dynamics which may interfere with the trainees' development (e.g. the existence of secrets within the organization; issues of exclusion and inclusion; power struggles), and (7) efforts are made to provide trainees with education about the impact of managed care and potential national health care reform on the treatment of trauma survivors. (Neumann & Gamble, 1995)

Persons working in the trauma field are particularly vulnerable if they lack a strong foundation in all aspects of trauma theory. It is not enough to read one or two books on the treatment of a certain survivor population or to attend one or two training sessions. The International Association of Trauma Counselors, for example, is establishing broad and comprehensive training standards… The IATC has established three levels of credentialing: Certified Trauma Counselor; Associate in Trauma Support; and Certified Trauma Responder. (Williams & Sommer, 1995, Revised 1999a)

Four Recommendations for Organizations
From the Literature

1. *The Consensus Panel [a panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates that debated and discussed their particular area of expertise until they reached a consensus on best practice] makes the following recommendations about how the agency can support the counselor:*

- *Provide a sense of mission.*
- *Provide (or facilitate) ongoing, clinical supervision – if possible, by someone with a specialty in the area of child abuse and neglect.*
- *Provide trauma training to the counselors that standardizes the procedures for handling trauma cases.*
- *Empower staff members by encouraging them to share their ideas on improving the program and incorporating, as appropriate, those ideas that enhance the stated mission of the agency.*
- *Support staff members in their efforts to stay within the limitations of their roles so that they do not take on responsibilities likely to lead to burnout.*
- *Support staff members in their efforts to keep caseloads at manageable levels and, at the same time, work to educate managed care about the drawback of limiting the length or intensity of services.*
- *Model the supportive role that the agency wants the counselors to have with their clients.*
- *Allow counselors unstructured time to talk to each other to give and receive support.*
- *Train staff on such topics as new assessment tools, research findings, suicide intervention, crisis and nonviolent management of assaultive behavior, and liability issues related to abuse and false memory accusations.*
- *Bring in an outside professional occasionally to hold a group session with the staff (this can encourage staff members who have been holding in or minimizing the impact of their work on themselves to open up).*
- *Recognize and reward the work of the staff on a regular basis (e.g., ceremonies to recognize ongoing and special contributions).*
- *Hold regular social events (e.g. picnics, softball games).*

US Department of Health & Human Services, 2000, "Substance Abuse Treatment for Persons with Childhood Abuse and Neglect Issues."

*   *   *   *   *   *   *   *   *   *   *   *   *   *   *   *

2. *The organizations and agencies that employ helping professionals and offer clinical service to survivors of trauma and abuse also must incorporate an awareness of the cost of trauma work on staff, and the toll of VT on organizations or agencies. Such recognition is evident when organizations achieve the following:*

- *Provide adequate clinical supervision for all staff.*

- *Create a climate that accepts that the work will elicit strong feelings and provides a safe setting in which to discuss such feelings.*
- *Offer health benefits that include good coverage for mental health services.*
- *Explicitly acknowledge the difficulty of the work.*
- *Use staffing patterns that allow backup and sharing of clinical responsibility and coverage.*
- *Set reasonable expectations for clinical caseloads, i.e. expectations that take into account the effects of VT.*
- *Affirm the reality, pervasiveness, and severity of the effects of childhood trauma.*
- *Work with staff to identify and address signs of VT.*
- *Provide opportunities for continuing education in the area of trauma and of stress management (such as training).*

Some of these helpful responses reflect attitude and time management. Others require changes in the allocation of money and personnel. It is helpful for administrators to be able to justify changes in resource allotment on the basis of such factors as treatment efficacy, personnel longevity and reliability, decreased liability, and long-term cost effectiveness.

Saakvitne, et al, 1999, **Risking Connection**

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3. *The following describes the institutional environment that is most facilitative for the recovery of traumatized personnel.*

1. *The stressors are accepted as real and legitimate.*
2. *The problem is viewed as a problem for the entire group and not as a problem that is limited to the individual.*
3. *The general approach to the problem is to seek solutions, not to assign blame.*
4. *There is a high level of tolerance for individual disturbance.*
5. *Support is expressed clearly, directly, and abundantly in the form of praise commitment, and affection.*
6. *Communication is open and effective; there are few sanctions against what can be said. The quality of communication is good and messages are clear and direct.*
7. *There is a high degree of cohesion.*
8. *There is considerable flexibility of roles and individuals are not rigidly restricted from assuming different roles.*
9. *Resources – material, social, and institutional – are utilized efficiently.*
10. *There is no subculture of violence (emotional outbursts are not a form of violence).*
11. *There is no substance abuse.*

Catherall, 1995, "Preventing Institutional Secondary Traumatic Stress Disorder," referring to Figley, 1989.

* * * * * * * * * * * * * * * *

4. *[W]e present six policy changes implied by the chapters in this book [<u>Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators</u>]:*

- *Lower caseloads*
- *Telehealth support (making confidential online usage available)*
- *Increased staff time (regular time to discuss day-to-day operations)*
- *Leave time (access to adequate amount of vacation, sick, and family leave time)*
- *Mental health care (access to professional mental health services outside the employing organization)*
- *Supervision (the provision of regular professional clinical and/or administrative support from senior staff member)*

Rudolph & Stamm, 1995, Revised 1999a, "Maximizing Human Capital: Moderating Secondary Traumatic Stress Through Administrative and Policy Action."

A Summary of Recommendations for Organizations From Maine Caregivers

Job Adjustments

- Address the paperwork issue – experienced as excessive, limiting of treatment time and energy, limiting of peer support time, and significantly lowering morale.
- Moderate/adjust direct service unit and ISP documentation requirements.
- Limit on-the-job expectations to 40 hours per week.
- Eliminate mandated overtime – use only when absolutely necessary, make that decision collaboratively with the employee, and preferably offer incentives for voluntary overtime, instead.
- Prevent further cuts to staffing.
- Enable and support variety and flexibility in work assignments, including:
  - Limiting the number of consumers with trauma-based issues in a caseload.
  - Enabling variety in job assignments.
  - Facilitating half or part-time work.
  - Enabling three and four day workweeks.
  - Making temporarily reduced work expectations possible when needed.
- Encourage and support adequate, regular, dependable opportunities for time off, both on and off the job. Examples would include: breaks, daily "down-time", retreats, social get-togethers, use of all vacation days, use of sick days when employee feels un-well, "mental health days", personal days.

Supervision

- Provide easily available, regular (preferably weekly), safe, one-on-one, quality supervision which is:
  - Sanctioned
  - Confidential.
  - Trauma, VT, and burnout informed.
  - Not just case-oriented, but a forum for workers to share vulnerabilities and work on weaknesses.
  - Separate from administrative lines of authority.
- Include frequent, quality opportunities for staff de-briefing, which sanctions and offers time for "venting/unloading."
- Provide vouchers for staff to receive supervision outside the agency or organization.

Other Support Strategies

- Make acknowledgement of the difficulty of working with trauma survivors an explicit organizational value.
- Add more clinical staff – to promote and enable worker safety and reduce caseloads.

- Develop and support, with primary input from employees, an organization-wide wellness program.
- Make regular staff meetings a priority.
- Support, organize and train for team approaches to service-provision.
- Improve health-care insurance coverage to include personal therapy, or provide vouchers for same.
- Provide opportunities for peer support, in addition to de-briefing sessions (such as regular discussion and/or study groups), space and permission for informal time.
- Sponsor staff retreats for education, collegial sharing/support, and relaxation.
- Survey staff for desired supports (such as providing vouchers or other financial assistance) for activities outside the organization:
  - Workshop attendance (for professional training and for VT and burnout prevention through self-defined self-care activities).
  - Personal counseling.
  - Formal education.
  - Health club membership.
- and for healthy activities at the workplace, such as:
  - Meditation and yoga.
  - Aerobics.
  - Stress management training and practice.
- Develop new avenues for staff support/education, such as:
  - Newsletter and/or website.
  - Warmline for staff.
  - Self care resource book.
  - Directory of state and local consumer resources.

Workplace Climate

- Discourage them/us attitudes.
- Promote an atmosphere of valuing, respect, and understanding for worker needs, strengths, and vulnerabilities.
- Create an attractive physical environment for staff and consumers.
- Consult/involve staff in program development and policy decision-making.
- Keep staff informed (open, honest communication).
- Improve worker safety – both physical and emotional.
- Create non-monetary, but meaningful, ways to acknowledge and validate staff.
- Legitimize regular informal time for staff to relax and connect.
- Provide more clerical and technological support.

Education and Training

- Provide training on trauma-sensitive care to all direct service workers.
- Deliver specific education on trauma issues to all new employees.
- Provide periodic training on self-care and VT/burnout prevention for current employees.
- Expect all supervisors to be trauma and VT/burnout trained and aware.
- Provide financial incentives and time opportunities for staff to further their education on trauma theory and practice.

Administrative and Policy Recommendations

- Articulate a clear Department mission statement so all policies, programs and procedures can be evaluated for congruence.
- Clarify Department's services vision and coordinate with DHS to avoid overlap and competition for scarce resources.
- Design and commit to a policy of Department-wide VT and burnout prevention at all levels.
- Develop confidential annual assessment instruments to:
    - Determine employee satisfaction.
    - Assess perceptions of "what's working" and "what isn't," with ideas for remedies invited.
    - Evaluate turnover rates through uniform hiring questionnaires and "exit interviews."
- Offer more widespread education on survivor needs for the public and others serving trauma survivors, e.g. doctors, dentists, P.A.s, F.N.P.s, hospital employees, police, landlords, employers, families, etc.
- Create a strong advocacy initiative (including legislative lobbying) to address issues of inadequate funding by managed care, insurance companies, and Medicaid for services specific and appropriate to the needs of trauma survivors.
- Determine and address differing geographical issues through Regional input.
- Up-date salary and payment schedules to reflect the demands and value of the work employees are doing, especially direct service employees.
- Develop a policy, procedure, and budget support for paid employee "mental health" days.
- Enable paid sabbatical leaves for long-time employees (10+ years).
- Develop a policy and protocol to address the needs of impaired employees.
- Provide access , and where necessary, funding for "alternative/adjunctive" healing resources when clinically appropriate.

Conclusion

Conclusion

*People who are intent on building a better work environment
need information that will help them make sense of the
complex relationships employees have with their work.*
(Maslach & Leiter, 1997a)

As stated in the beginning, the purpose of this survey has been to collect information about the impact on Maine's caregivers of working with survivors of abuse and other trauma, who, estimated from national prevalence data, represent a majority of the Department's clientele. The focus was on **vicarious traumatization** and **burnout** because trauma literature implicates those conditions as seriously problematic in the field – having an effect on both the worker and the clients served. The question was: how serious were those conditions for providers in Maine's system of care.

The answer is clear**. Speaking in the voice of Maine's caregivers and supported by the literature, the report is a powerful statement that vicarious traumatization and burnout are real, that workers want help, and that steps can be taken to prevent and address those situations.**

Ironically, while this document is primarily about the experience of those in the front lines, not in the policy or administrative world, many of the probable solutions must be initiated at the administrative and political level. (Rudolph & Stamm, 1995, Revised 1999a) Furthermore, it might be assumed that needed changes would be costly. A thorough reading, however, reveals that many of the recommendations are not about money but about changes of attitude or approach and about creatively tailoring existing resources to the expressed needs of care providers. Since some recommendations inevitably will require new funds, it then is recommended that careful thought be given to realigning priorities.

Overall, it is hoped that this report will be a stimulus for planning and will provide ample justification for resource adjustments.

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Appendix A

Staff Survey Packet (1999)

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

January 5, 1999

MELODIE PEET
COMMISSIONER

To Whom It May Concern,

This letter is from The Partners in Healing: Care for Caregivers Planning Group. Our purpose is to examine the effects of Vicarious Traumatization and Burnout on care providers, to consider what can be done to address those issues, and to make recommendations to DMHMRSAS, through the Office of Trauma Services. We write to encourage your input and to see if you would like to be part of our efforts.

Background:

As part of DMHMRSAS' initiative to develop a system of care sensitive to the needs of trauma/abuse survivors, the vast majority of people served by The Department, there is a clear acknowledgment that such work is tremendously demanding and can take a toll on the people working with this population. In response to that acknowledgment, the Office of Trauma Services sponsored a daylong exploratory and brainstorming meeting in February on the subject of Vicarious Traumatization and Burnout. It was a powerful and important meeting for those able to attend, for it showed us just how deep the desire of workers is to speak openly of the challenge, pain and value of doing the work we do in the world. The Partners in Healing: Care for Caregivers Planning Group came into being as a result of that meeting.

What We're About:

Our group of volunteers has been charged with assessing the nature of work-related issues that influence worker effectiveness in providing services to trauma/abuse survivors. We are specifically interested in the issues of Vicarious Traumatization and Burnout, what they are, why they happen, what has helped to prevent these situations, and how to heal from them. Our goal, at Commissioner Peet's request, is to recommend to the Department, through the Trauma Office, a program of services, policies, and procedures to address these issues. Our purpose is to help people who work with trauma/abuse survivors deal with the impact of that work on them and to foster the creation of trauma sensitive work environments.

How You Can Help:

In order to have as complete and accurate a picture as possible, we need to know from you, and many others, about your thoughts, feelings and needs. Enclosed is a feedback questionnaire, which we invite you to complete thoughtfully. Your individual responses to the questionnaire(s) will be held in strict confidence. Summary results will be compiled and used exclusively to help us consider and recommend supports for you. A separate return envelope is included to assure your privacy.

Additionally, we have included a form for you to complete if you would like to be part of our planning group. Given the demands of your job, participation may seem difficult, if not impossible, but we would like to work with you to find a way for you to join us, if you want to. Please tell us of your interest on the enclosed form. We ask that both these forms be returned by January 30, 1999.

Sincerely,

Mary-Louise Gould, LCPC
For the Partners in Healing Planning Group
Office of Trauma Services

App A (1)

Vicarious Traumatization and Burnout Questionnaire

Vicarious Traumatization: A transformation in the helper's <u>inner experience</u> resulting from <u>empathic engagement</u> with trauma/abuse clients and their material (including vivid descriptions of traumatic events, reports of intentional cruelty, and traumatic reenactments in and outside the relationship with the helper).   Saakvitne & Pearlman: *Transforming the Pain*

Specific Changes - - - Do you feel or experience?	Often	Sometimes	Rarely	Never
1. Intrusive images or feelings about clients' issues	___	___	___	___
2. Frustration with your capacity to help	___	___	___	___
3. A decrease in your awareness of your skills, either interpersonal or self protective	___	___	___	___
4. Difficulty remembering things	___	___	___	___
5. Physical difficulties such as frequent headaches, muscular tension, decrease or increase in sleep or a appetite	___	___	___	___
6. Self esteem problems	___	___	___	___
7. A diminished sense of safety in the world	___	___	___	___
8. Chronic suspicion and fears for women and children	___	___	___	___
9. Intimacy problems with loved ones	___	___	___	___
10. Less ability to trust	___	___	___	___
11. Less sense of control over your environment, including at home	___	___	___	___
12. A change in your view of the world, sense of self, and spirituality	___	___	___	___
	___	___	___	___
General Changes - - - Do you feel or experience?	___	___	___	___
13. Numbing (emotional or physical)	___	___	___	___
14. Social withdrawal	___	___	___	___
15. Frequent nightmares	___	___	___	___
16. Generalized despair and hopelessness	___	___	___	___
17. No time or energy for yourself	___	___	___	___
18. Disconnection from loved ones	___	___	___	___
19. Increased sensitivity to the incidence of violence	___	___	___	___
20. Cynicism	___	___	___	___

Burnout: The daily demands of job, family and everything in-between erodes energy, enthusiasm and self esteem. At work, a sense of community and mutual effort and respect are missing. People become isolated, cynical and try not to get involved. The joy of success and the satisfaction of achievement are difficult to attain.   Saakvitne & Pearlman: *Transforming the Pain*

	Often	Sometimes	Rarely	Never
21. I have enough time to do the work that must be done.	___	___	___	___
22. I feel that I have enough control over how I do my work.	___	___	___	___
23. I receive enough training to do my *job* well.	___	___	___	___
24. I feel valued, respected and rewarded. My contributions are recognized by peers and supervisors.	___	___	___	___
25. I receive supportive supervision.	___	___	___	___
26. My input is requested in relevant policy decisions.	___	___	___	___
27. The financial rewards of my job are sufficient.	___	___	___	___
28. I feel pride in the fact that my organization does a good job responding to the needs of the clients.	___	___	___	___
29. I experience myself as a member of a supportive team.	___	___	___	___
30. Opportunities and rewards are based on merit alone.	___	___	___	___
31. My values and the values of the organization are alike.	___	___	___	___
32. After work I am not too tired to do the things I like to do.	___	___	___	___
33. Personal issues (e.g. divorce, death in family, illness or money problems) prevent me from doing my best at work.	___	___	___	___

App A (2)

Vicarious Traumatization and Burnout Questionnaire

Please tell us, by answering the following questions, what would be helpful for us to know in developing a program of support and care for people who work with trauma survivors. Use the back of this paper if you need more room. <u>Note: Your answers to this questionnaire are anonymous.</u>

1. Which category(s) apply to you?   Hospital ___   Community Agency ___   Residential ___   Private Practice ___   Case Manager ___   Clinical Service ___   Community Support ___   Crisis Work ___ Other _____

2. What comes up for you, affects you, or concerns you in responding to trauma in your job? (e.g. trauma in the client's past, client's current trauma, and/or trauma you feel)

3. What have you been able to do and/or what conditions in your environment have worked in the service of <u>preventing</u> Vicarious Traumatization or Burnout?

4. How could the Department or your employer be more supportive of you and your efforts? What changes or resources would help you to avoid Vicarious Traumatization or Burnout?

5. If we didn't ask the right questions, please add any other comments you think might be useful for us to know.

App A (3)

Invitation for Participation
on
Partners in Healing: Care for Caregivers Planning Committee

       I am interested in being part of the volunteer group that is studying the impact of Vicarious Traumatization and Burnout on those who work with survivors of trauma and in supporting a Department (DMHMRSAS) initiative to respond to the impact. Currently the group meets once a month on a Friday from 9:30 AM to 12:00 PM.

PLEASE RETURN THIS FORM IN AN ENVELOPE <u>SEPARATE</u> FROM THE BURNOUT AND VICARIOUS TRAUMATIZATION QUESTIONNAIRE

I would most likely be able to attend meetings (please check the answer below that applies):

If they were held at night _____

If they were held on a weekend morning _____

If they were held during the work week _____

Please give particulars of your work situation or hardships that might prevent you from attending

_____

Name: _____Tel: _____

Address: _____

Job Description and Responsibilities: _____

Appendix B

Management Questionnaire

Management Questionnaire
on
Staff Vicarious Traumatization and Burnout

Please tell us, by answering the following questions, what you think would be helpful for us to know in developing a program of support and care for staff people who work with trauma survivors. In answering the questions, we encourage you to add recommendations. Use the back of this paper if you need more room.

1. What have you successfully created in your work environment to help prevent or address Vicarious Traumatization or Burnout?

2. What are the obstacles or impediments you have found as you have sought to plan and implement staff training and/or other staff support practices and activities?

3. How could the Department increase your ability to be more supportive of staff and prevent Vicarious Traumatization or Burnout? (e.g. what changes of policy, procedure, or resources would support you in your efforts to keep your staff healthy, happy and productive?)

4. If we didn't ask the right questions, please add any other comments you think might be useful for us to know.

Thank you for taking the time to give us this information.

Please return to - - Partners in Healing: Care for Caregivers Planning Group
          Office of Trauma Services, DMHMRSAS, #40 SHS, Rm 411, Augusta, Maine 04333

App B (1)

Appendix C

Quantitative Data Grid

TRAUMA-QUESTIONS REPORT

Vicarious Traumatization

Specific Change – Do you feel or experience?	Often	Sometimes	Rarely	Never	Total
1. Intrusive images or feelings about clients' issue	27	169	112	39	357
2. Frustration with your capacity to help	90	217	33	11	351
3. A decrease in your awareness of your skills, either interpersonal or self protective	30	138	143	41	352
4. Difficulty remembering things	47	147	135	24	353
5. Physical difficulties such as frequent headaches, muscular tension, decrease or increase in sleep or appetite	86	122	102	43	353
6. Self esteem problems	23	115	161	54	353
7. A diminished sense of safety in the world	42	115	139	58	354
8. Chronic suspicion and fears for women and children	37	82	138	92	349
9. Intimacy problems with loved ones	21	84	140	102	347
10. Less ability to trust	29	118	137	66	350
11. Less sense of control over your environment, including at home	27	85	153	82	347
12. A change in your view of the world, sense of self, and spirituality	45	125	104	72	346
Sub-Total Question 1 – 12	504	1,517	1,497	767	

General Changes – Do you feel or experience?

	Often	Sometimes	Rarely	Never	Total
13. Numbing (emotional or physical)	39	107	119	83	348
14. Social withdrawal	37	113	112	82	344
15. Frequent nightmares	12	41	104	192	349
16. Generalized despair and hopelessness	14	68	138	127	347
17. No time or energy for yourself	79	136	94	40	349
18. Disconnection from loved ones	21	114	117	97	349
19. Increased sensitivity to the incidence of violence	90	149	72	37	348
20. Cynicism	66	146	98	51	347
Sub-Total Question 13 - 20	358	874	854	695	

App C (1)

TRAUMA-QUESTIONS REPORT

Vicarious Traumatization

Burnout:	Often	Sometimes	Rarely	Never	Total
21. I have enough time to do the work that must be done.	95	112	92	51	350
22. I feel that I have enough control over how I do my work.	144	136	63	9	352
23. I receive enough training to do my job well.	139	150	52	11	352
24. I feel valued, respected and rewarded. My contributions are recognized by peers and supervisors.	129	142	68	14	353
25. I receive supportive supervision.	157	114	59	24	354
26. My input is requested in relevant policy decisions.	73	134	112	34	353
27. The financial rewards of my job are sufficient.	54	127	96	74	351
28. I feel pride in the fact that my organization does a good job responding to the needs of the clients.	157	148	41	8	354
29. I experience myself as a member of a supportive team.	177	129	34	13	353
30. Opportunities and rewards are based on merit alone.	38	111	127	66	342
31. My values and the values of the organization are alike.	106	176	54	12	348
32. After work I am not too tired to do the things I like to do.	82	157	88	23	350
33. Personal issues (e.g. divorce, death in family, illness or money problems) prevent me from doing my best at work	18	79	195	63	355
Sub-Total Question 21 – 33	1,369	1,715	1,081	402	
Grand Total	2,231	4,106	3,432	1,864	

App C (2)

Appendix D

Draft Report Feedback

Feedback Questionnaire

1. Does the organization of the material presented make sense to you?

   Generally, Yes_____   **Not Sure_____**   **No_____**

          Please comment:

_____
_____
_____

2. Do you agree with the "Recommendations" in Part Three?

   Totally_____   **Mostly_____**   **Not Sure_____**   **No_____**

   Please Comment:_____
_____
_____

   What recommendations would you add? _____
_____
_____
_____

   What recommendations would you omit?   **Why? _____**
_____
_____
_____

3. Who, in your opinion, should receive this report in its final form?

   _____   _____
   _____   _____
   _____   _____
   _____   _____
   _____   _____
   _____   _____

4. We would appreciate any other feedback you are willing to offer: _____
_____
_____
_____
_____

Draft Report
Vicarious Traumatization and Burnout Survey

All Feedback Data

Number of surveys mailed: **114**
Number returned: **22 (19%)**

<u>Responses by Question:</u>

1. Does the organization of the material presented make sense to you?

       Generally,   Yes__19_____   Not Sure___2_____   No____1_____

       Please comment:

"A very helpful application of research." … "It took a long time to read and digest." … "Amazingly comprehensive and organized." …"I think it is well thought out. A lot was included that clarifies conditions leading to burnout and vicarious traumatization." … "It's been so long since we met on this that it takes forever to read and remember what was going on." … "It's very elegantly written, though certainly voluminous. I'm not sure that it all needs inclusion as it is somewhat repetitive." … "There is redundancy throughout the chapters, Simplication could increase the likelihood the report will be read." … "Some parts are vague and not realistic – more time off when there is a hiring freeze." …" l) Pagination e.g. 1-200, would make for easier reading and commentary, 2) Part 1 pg. 2 ref. To 'see tables 1& 2 at end of this chapter' was confusing, 3) Part 1 pg. 3 definition of trauma ought to be consistent re: include de.f in manual, 4) respective sometimes." … "I've always believed in professionals' personal growth at work as well as at home." … "It's beautifully organized. The preface is wonderful." … "I felt the materials presented were logical and concise. I feel the information is most useful." … "I felt the information in the packet was well done and represented exactly how we as caregivers are affected by our work." … "There has to be some order to start with and I don't know how or why you would do it differently." … "There seems to be a fair amount of repetition." … "Too much information and repetitive – too comprehensive." … "Organization: This document is difficult to read. As I believe it should be provided to administrators and policy advisors, I think it should provide substantial information on a quick skimming. Therefore, I would suggest that chapters begin with a brief narrative summary of what is included in the more detailed text. Point out that the literature supports many of the points uncovered in the research findings. I would reverse the order of 'from the literature' and 'Maine caregivers' throughout, to place the emphasis on your study and the voices of Maine workers, with support from the literature. Personally, I also find the extensive use of Italics hard to read." … "What I had time to read was boring and repetitive. It may be a nice 'study' but it is too long to ever be read and used."

2. Do you agree with the "Recommendations" in Part Three?

       Totally ___6_____   Mostly____14____   Not Sure____2_____   No_____

Please Comment:

"I'm pleased to know that the state of Maine's Department of Behavioral and Developmental Services has at least researched the effects of vicarious trauma and burnout on and to the case workers/social workers." … "Not enough time to read carefully – it would take many hours to do so – but it looks like excellent reading." …"Clean up current supervisory structure by mandating academically measurable training, get rid of dead wood, follow the 1999 Supervisory Study recommendations, inaugurate a supervision of supervision policy, not to be done by some administrative person but a warm, caring, empathic informed credentialed person." … "Supervisors could plan work better." … "I agree that more training on trauma is useful, but I think it needs to be carefully considered, as some treatment methods are more effective than others. Absolutely agree with the value of the team-oriented approach! Also agree with most of the job expectations recommendations and workplace climate recommendations." … "I am in support of your recommendations and found them to be refreshing and hopeful and I am on the verge of burnout and have requested such things as a safe place to process feelings. Thank you." … "Too many supervisors have no formal training in supervision, so supervision is a broadly-applied term meaning different things to different people." … "Human potential is the caregiver's ability to succeed with balance." … "Inclusion of all parties to the mission statement will facilitate services to clients." … "I do agree with the recommendations but would also add a way to have accountability for the agency, Dept. etc. to show they are responding to the needs of the employees." … "Some issues have been addressed; some recommendations have been tried without success; many remain to be implemented in an environment with fewer resources." … "I think the recommendations are global and overwhelming. Organize from macro to micro and look for strands." … "Some recommendations seem to be clearly self-serving bids for increased benefits."

What recommendations would you add?

"Learn and teach about alternative techniques like energy work." … "Recommendations for support for a DBT and CBT–informed staff with agency and Medicaid support for all aspects of the program, including consultation team time (to treat the staff)." … "I would like to see a federal /state level of commitment to agencies who do provide such types of support because without some financial support, we are allowing the governmental system to blame or find fault with the middleman once again." … "Institute a policy that all existing departmental employees must go thru an exit interview and make that very important tool as safe and non-retributive as possible so the Department gets honest good feedback and grows in wisdom and the employee feels one has contributed and grown and learned." … "Training for supervisors – basic clinical supervision skills taught by specialists in clinical supervision, e.g. USM profs in counseling department. You can't beat good supervision as an antidote for VT and burnout." … "Increase incentives for group services. Any way to support outcome research of existing groups?" … "In the area of crisis work, I feel crisis workers should be able to rotate into other work areas for a physical and mental break." … "Remain supportive no matter what." … "Increasing the number of regulations in managing medications and healthcare creates more time wasted in paperwork and less time with clients. Consolidating and streamlining functions would be helpful." … "None until the bureaucracy gives is a few of the ones listed." … "More money. Fair reimbursement from insurance companies. Feeling valued; not being referred to as a 'shrink'." … "That the state of Maine put some 'teeth' (so to speak) or substance into taking care of the counselors and/or caregivers of traumatized persons. Mental health workers <u>need</u> mental health care days off." … "Establish a policy-based separation between clinical and administrative supervision which

includes a mechanism for supervisors to receive supervision, too." … "More specific and limited recommendations with dollar amounts estimated for implementation." … "I suggest that recommendations be included that will benefit private practitioners, since they were so involved in the early parts of this project. Perhaps state network listings?" … "Remove term trauma and focus on good service provision and burnout."… "I feel workers need change." … "More titled jobs with special needs training."

What recommendations would you omit?   Why?

"1. Non hospital treatment unit because I believe that, for the most part, trauma survivors should be treated in the community except then they are in imminent danger to self or others, at which point they require hospitalization, as do non-trauma survivors. Hospital stays should be as brief as possible in order to avoid sending the message that the individual is incapable of creating a safe life for themselves. 2. Availability of outside supervision for staff creates difficulties within the system. Instead, agencies need to ensure that supervisors are adequately trained. 3. Increase attention given rural areas – it depends on what is meant by attention. In fact, we find that trauma survivors served by our rural offices tend to do better than those in our urban office. We have found that 'less is more' in regards to services to this population. The more services that are offered seem to communicate agreement with the clients felt sense of helplessness and reinforces dependency on service providers." … "I would omit saying changing the mission statement would be helpful. Unless you were to make it contingent upon real changes. (Missions are often not followed.)" … "Change 'personal therapy' into more of an EAP perspective but train supervisors to sense when a worker's experience might make personal therapy a supervisory tool through EAP for debriefing, etc. Staff the Department with a broad range of disciplines – not just LCSWs, and enhance multi-disciplinary approaches." … " None. The Department should take better care of the staff who have the most contact with consumers. Safety is an issue." … "Try to cut by a third the number of recommendations. If this document is to go to policy-makers and administrative personnel (it should), I think that the recommendations are too numerous. Condense." … "All benefit recommendations. I feel it is opportunistic to link benefits with 'hot button' topics like trauma."

3. Who, in your opinion, should receive this report in its final form?

In BDS System		Contracted Agencies	
Commissioner	5	All contracted agencies (MH, MR, SA)	3
Entire BDS Department	2	All contracted hospitals	1
All Central Office Personnel	1	All clinical supervisors (MH, MR, SA)	1
Director of Personnel	1	Crisis agencies	2
All Admins/Management	3	CAP agencies	1
All "frontline" staffing	5		
All Regional office staff	1	Other Service Providers	
Regional Directors	1		
DBS Team Leaders	4	Child protective workers	1
Regional Medical Directors		All social services agencies	1
(psychiatrists)	1	Doctors	1
Case Mangers	1	General hospitals	1
All Program Dtrs/supers/ coordrs	5	Judges, police, courts	1
All AMHI, BHMI staff	1	Shelters	1

Nurse consultants	1	Political System	
All clinical supervisors	7		
Trauma Services	1	Governor	6
Psych techs, etc., working in		All political decision-makers	1
in-patient settings	1	Legislature (Senate & House)	4
Both union stewards	4		
Partners-in-healing group	1		
"me" (respondent)	1	Other	
Outreach support staff	1		
		No One	1
Public and Professional		Every MH facility which employs	
Insurance Companies	1	those who work with trauma	
Funding sources, e.g. United Way	1	survivors	1
Various boards of NASW, LADC,			
APA & professional licensure			
in Maine	2		
Universities/professors in			
relevant fields	1		
News media (newspapers, TV			
news, talk shows)	1		

4. We would appreciate any other feedback you are willing to offer:

"Is there any way to report on the current impact of unaddressed VT on services (the quality, availability, cost, i.e. identifying that the overall cost of not addressing VT on everyone – consumers, providers, agencies, 3rd party payors – is greater than the cost of actually addressing VT)?" … "Reduce paperwork for everyone. Encourage/enable staff to be more professional with patients." … "The roots of VT are multiple – but a lack of a spiritual base for the professional is probably the most significant." … "Part of my unit's burnout is the lack of mental health hospital beds and respite beds to handle the most difficult consumers. Crisis teams need to be expanded, especially in rural areas. Because of the areas the teams cover, it often takes from one to two hours to get to the consumers. On-call crisis workers in these areas would benefit those consumers who live 50 to 120 miles away from our regional offices. Also ASL and gestural communication would benefit those consumers who are deaf or unable to speak. These are the consumers who are at risk of having some kind of physical or sexual trauma. These consumers are most likely to need crisis interventions with people who are not able to communicate with them." … "How will this help non-hearing administrations to 'get it'?"… "I believe that the emphasis on separate specialized services for trauma survivors is short-sighted as 75% of our clients have been traumatized. I am dismayed by the sense that direct service appears to have, as reflected by their responses to this survey, that they are responsible for providing solutions for clients and the implication that it is helpful for trauma survivors to tell their stories to workers. Our work with DBT has shown that when trauma survivors are expected to be as brief as possible in order to learn and utilize skills to help them be effective in their current lives, their need to tell their stories diminishes or disappears. The telling of stories mostly has the impact of re-traumatizing them and creates STS in the worker. This can and should be avoided. Stories should only be told after skills to handle emotions are learned. And the workers who responded apparently also responded to the behaviors that resulted from trauma, which also creates STS.

When clients are validated for their emotions but challenged to be more effective in their behavior, they usually can do so, with coaching, which greatly reduces the STS in the worker."

"A lot of time can be saved by having one person enter ISP's into the CMA. A uniquely harmonizing principle for all caregivers is how one views the 'personhood' of another. Fine-tune that. Similarly, workers need to understand that in their role as caregiver, one is called upon to 'metabolize' the pain, difficulties, experiences etc. of those served according to the role/capacity of job performed. Consequently, if what is called upon to be metabolized exceeds the level of care that the role provides, then another level of care is needed. Knowing one's role, the degree of exploration required, and tailoring work output according to a skilled task that comes with experience in the context of good supervision. This assists in managing VT for front-line stresses. On the administrative side: someone humble with honest caring and knowledge of the work who is empathically motivated would be a great move in the right direction. I'd like to also say that a good supervisor does not have to be n expert in childhood abuse and neglect as cited in the recommendations, but one needs a good group on 'developmental' understanding, in my view." … "Supervision, training, education with the team or solo is half the battle to recovery. Making the client able to live again!" … "When working with human beings, incentive is the motivator. If good work is noted in a person's files, as reprimands are, there would be a better incentive for folks to aspire and maintain interest levels that have an overall positive effect." … "We need more positive things from our peers and supervisors – this project has been a couple of years in the making and the folks at my agency, anyway, are becoming more demanding and demeaning than the state was." … "There needs to be a way to evaluate the agency's response to the work; support supervision, etc for the front-line staff. The evaluations should be done by the workers, not an outside entity." … "The recommendations section is very problematic for me. All of the different typefaces and sizes are confusing. I suggest using footnotes for the citations and get the huge print out of there. Again I would provide a narrative summary of the major sections, and give Maine caregivers the lead. Look to make numbering or bullets more consistent." … "I find it close to hilarious that I was involved in this 2 years ago, retired, returned to state service and am just getting results. I think the emphasis on vicarious traumatization is inaccurate and a bit excessive."

"Good work. Thanks for your dedication." … "I appreciate the time you took to listen." … "Great job!" … "Great compilation of facts and subjective experiences?" … "Thank you for your persistence in attempting to increase awareness in our political, educational and social systems, especially in the area of vicarious traumatization. It's a slow process." "You've done a superb job but it's hard to wade thru all the supporting literature citations. It's unlikely that anyone in the current administration will appreciate the depth and value of this report. It will end up on a shelf." … "Is there any way to keep this from becoming just another report, particularly given the economic climate? The lengthy delays haven't helped." …

*Do not believe that he who seeks
        to comfort you
Lives untroubled among the simple
        and quiet words
That sometimes do you good.
His life has much difficulty and sorrow.
Were it otherwise, he never would
        have been
Able to find those words.*

Ranier Marie Rilke