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Metro North Mental Health – Alcohol and Drug Service

Managing and Preventing Vicarious Trauma: Guidelines for MNMH-ADS Staff

Queensland Government

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Executive Summary

There is a high prevalence of clients in AOD services in Australia who have been exposed to various types of trauma and many who would meet criteria for a diagnosis of Posttraumatic Stress Disorder or Complex Posttraumatic Stress Disorder. A recent study of AOD workers in Australia found 19.9% met the criteria for secondary traumatic stress[1] (Ewer, Teesson, Sannibale, Roche & Mills, 2015).

MNMH-ADS has developed a *Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment* to guide staff in responding more effectively and appropriately to the needs of clients who may be affected by trauma related difficulties. Workforce development and support is a critical component of providing trauma informed care and practice (TICP). In order to equip staff with the necessary skills, knowledge and resources, MNMH-ADS has developed these guidelines to assist in the prevention and management of vicarious trauma (VT) by reducing risk factors and enhancing protective factors that have been demonstrated to influence vicarious trauma.

> "I gradually came to realise that the only thing that makes it possible to do the work of healing trauma is awe at the dedication to survival that enabled my patients to endure their abuse and then to endure the dark nights of the soul that inevitably occur on the road to recovery" (Van Der Kolk, 2014, p. 213).

What is Vicarious Trauma?

***"*Vicarious Trauma refers to the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them"** (Pearlman & Caringi, 2009, p. 202).

Although there are varying definitions of VT, it can be best understood as an occupational hazard associated with helping those who have experienced trauma. Vicarious trauma overlaps with the constructs of secondary traumatic stress, burnout[2] and compassion fatigue[3] but more specifically describes the negative changes in clinicians working with clients affected by trauma over time[4]. It involves a more enduring stress response mirroring the effects of trauma and can evoke PTSD symptoms such as hyperarousal, hypervigilance, re-experiencing of traumatic content, withdrawal or avoidance behaviours and emotional numbing. Some people may also experience difficulties with affect dysregulation, negative self-concept and disturbances in relationships.

While there are individual differences regarding how clinicians are affected and how they respond to trauma exposed clients, there also are environmental variables that increase the

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[1] Secondary traumatic stress is a syndrome of symptoms that parallels posttraumatic stress.
[2] Burnout can be experienced across a wide range of occupations and is strongly associated with stress. It is characterised by feelings of exhaustion and depletion and is associated with cynicism, detachment and a sense of being ineffective (Devilly, Wright & Varker, 2009). Predictors of burnout are perceived lack of social and organisational support, working long hours, unreasonable expectations, low case load satisfaction, role conflict and role ambiguity.
[3] Compassion fatigue refers to the lessening of compassion over time that may be experienced by health professionals working with those affected by disaster, trauma or illness.
[4] These guidelines will use the term "vicarious trauma" to also include broader negative alterations and difficulties experienced by helpers when working with trauma affected clients.

likelihood of VT. Clinicians working with populations who have experienced trauma can benefit from recognising early signs of VT and engaging in preventative strategies to reduce their risk of harm. **Importantly, being affected by VT is not a result of personal weakness but is a risk faced by anyone who is exposed to severe or cumulative trauma associated with their work.**

> "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (Remen, 2006, p.52).

How does vicarious trauma occur?

Secondary traumatic stress responses can include a continuum of negative consequences ranging from compassion fatigue to PTSD and they arise from the interaction that occurs between the clinician and the situation (M'Cann & Pearlman 1990). From 2013, the APA has included indirect trauma as a qualifying event for making a PTSD diagnosis in the DSM-V (APA, 2013). Health care workers are frequently exposed to trauma indirectly in their places of work. This often involves exposure to the stories of the trauma experienced by clients and may also include witnessing the effects of trauma. While we might think about an incident of violence or other critical incident in the workplace as the most damaging, cumulative stress associated with working with trauma affected clients is likely to be as potentially problematic over the course of a career.

A hypothetical empathic mechanism is commonly described as a key ingredient involved in VT. When clinicians empathically engage with clients' who are experiencing trauma related difficulties and their emotional responses are not adequately processed, VT can result (Pearlman and Caringi, 2009).

The relationship between trauma exposure and VT is complex and multi-factorial. Findings from studies on VT have been inconsistent, with some studies showing there is no evidence that clinicians are affected by exposure to trauma in clients (Baird & Kracen, 2006). The following points have been derived from several studies and foreground factors that may play a contributing role. However, many of these variables are correlational and the direction of the relationship can be unclear (e.g. clinicians with pre-existing anxiety and stress may be more likely to be affected by VT and VT can cause high levels of anxiety and stress).

Summary of key contributing factors:

Possible interacting contributors to VT can be grouped as follows:

(1) Aspects of the work (situation variables)

- 'indirect trauma' via exposure to overwhelming experiences that many trauma survivors disclose and struggle with
- relational dynamics (e.g. empathy and attunement as described above)
- lack of opportunities for clinicians to access support
- amount of trauma work or exposure over time
- perceived lack of support from peers and supervisors
- lower levels of clinical supervision

(2) Aspects of the clinician (person variables)

- higher levels of anxiety and stress
- coping style
- current life stressors

- attachment style
- previous experience of trauma
- low job satisfaction
- low occupational commitment
- being new to the profession
- beliefs regarding safety and intimacy with others
- persistent avoidance of client pain
- feelings of powerlessness and guilt

(3) Sociocultural context

- Clients' marginalisation
- Lack of access to required resources and support
- Social and cultural contexts which continue to traumatise clients

How is it identified?

Five common recurring factors have been identified as markers of VT:

1. **Unmodulated affect in response to client's trauma narratives**

   e.g. intense emotional responses to a client's trauma disclosures

2. **Somatic complaints**

   e.g. recurring headaches, aches and pain without apparent illness or injury

3. **PTSD symptoms**

   e.g. hyper-vigilance or re-experiencing aspects of disclosed traumatic events in intrusive images or symptoms such as dissociation

4. **Impact on personal frame of reference**

   e.g. clinicians may report pessimistic world and life views

5. **Symptoms of acute stress disorder, depression and anxiety**

   e.g. including insomnia, social withdrawal and patterns of work and social avoidance. (Wilson & Thomas, 2004).

Broader ways vicarious trauma may impact the person

In addition to PTSD symptoms and dissociation, other related areas pertain to problems with identity, intimacy, sexual difficulties, social isolation, loss of meaning and hope. In some cases, clinicians have been found to experience re-enactments and difficulties with managing boundaries, general psychological stress and problems with judgement and decision making (Courtois & Ford 2009).

Strategies that contribute to the prevention of vicarious trauma

While exposure to clients' trauma histories may be un-avoidable, the impact it has on clinicians can be mediated to prevent VT

Organisational practices

- Training plays an integral role in equipping staff with the necessary skills and knowledge in the psychosocial treatment of comorbid substance use disorders and trauma related problems. This can help to build confidence and support clinicians to understand challenging aspects of their clients' experience and feel more effective. Specific training in awareness and management of VT is also essential.
- Organisations should address risk factors for VT such as lack of resources (for both clients and staff), inadequate clinical supervision, low morale, and failure to acknowledge the risk of VT.
- VT can also be reduced by organisational support to enhance positive personal coping styles, seeking meaning in adversity, and reducing stress through offering flexible work hours, rostered days off, and opportunities for personal self-care activities like mindfulness meditation and other stress reduction practices at work (SAMHSA, 2014).
- To promote and maintain a healthy work environment, trauma-informed organisations foster teamwork; encourage collaboration both within and outside the organisation; create formal and informal opportunities for staff to connect with one another; and offer opportunities to diversify job tasks.
- To strive for professional competency, capacity, and staff retention, trauma-informed organisations promote continuing education, professional development, and networking opportunities; provide thorough orientation and ongoing training; enable access to resources; and support staff participation in on- and offsite learning.
- To maintain the health and wellness of their staff, trauma-informed organisations recognise links between health/wellness and staff satisfaction and productivity; devote time and resources to promoting staff well-being; encourage and provide health and wellness activities; and incorporate wellness into policies and practices (Office for Victims of Crime, n.d.)

Clinicians can benefit from the same approaches used for clients who have experienced trauma. VT resistant skills amongst clinicians should begin with building an awareness of and therefore normalising the symptoms of traumatic stress and developing self-care skills, coping strategies, supportive networks, and a sense of competence (SAMHSA, 2014).

Social Support

- Social support is consistently associated with well-being and recovery from VT providing both emotional and instrumental aid.
- Formal and informal opportunities for social support are described as equally beneficial in the workplace.
- Strong personal and professional networks and communities help clinicians to feel their lives and jobs more fulfilling and connect them with a sense of identity beyond their therapeutic role.

Supervision

- The importance of ongoing, trauma-informed (and trauma and SUD focused) professional supervision is well supported by the literature (Pearlman & Courtois, 2005).
- Intense and complex transference–countertransference dynamics that arise in working with clients with complex trauma can cause harm and distress for both client and clinician.
- Supervision plays an essential role in facilitating clinicians' ability to make sense of their own responses and their clients' often intense emotions and behaviours.

Spiritual Renewal

- Trauma can impact a person's meaning systems and assumptions of a "just world". The role of spirituality in trauma work and the management of VT is often overlooked (Pearlman & Caringi, 2009).
- Clinicians are encouraged to find their own meaningful spiritual beliefs and practices to help protect them against the sometimes dispiriting and apparently meaningless suffering that people can experience.
- Vicarious transformation describes a similar process to post-traumatic growth and how a clinician may undergo spiritual renewal that empowers and fosters personal growth (Pearlman & Caringi, 2009).

Vicarious Resilience

Vicarious resilience describes the ways that clinicians may respond and interact with client's stories in ways that promote growth and hope (Hernandez, Gangsei, & Engstrom, 2007). Some of the positive aspects of working with trauma affected clients that are associated with resilience are:

- witnessing and reflecting on human beings' capacity to heal
- reassessing the significance of the therapists' own problems
- incorporating spirituality as a valuable dimension in treatment
- developing hope and commitment
- articulating personal and professional positions regarding political violence
- articulating frameworks for healing
- developing tolerance to frustration
- developing time, setting, and intervention boundaries that fit therapeutic intervention in context
- using community interventions
- developing the use of self in therapy

Self-Care

Self-care is regarded as an ethical imperative for those who work with complex trauma. Forms of self-care that should be practiced frequently and intentionally are:

- engaging in activities that offer distraction and/or personal growth
- physical exercise

- having fun, resting, relaxing, and connect with one's body
- using imagery or symbolic strategies to let go of distress or worry associated with clients (e.g. cleansing light that washes away work related emotional difficulties)
- developing and maintaining intimate, family, and other interpersonal relationships disengaging from activities and relationships that are depleting and replacing them with those that are sustaining (Pearlman & Caringi, 2009)

Working Protectively

Perspective

- Developing a theoretical framework that underpins treatment and explores process issues associated with working with complex trauma is important (e.g. processing countertransference in the therapeutic relationship). The theoretical approach can provide structure and guidance in the context of complex treatment situations.
- Clinicians should have acceptance of the limitations of therapy and realistic expectations about the therapeutic process and what can reasonably be achieved.
- Having a strengths and process focus rather than concentrating on outcomes is helpful. This includes recognising that healing can be a long process and change occurs incrementally. There is value in emphasising and reinforcing small gains rather than getting caught up with disappointments and frustrations with therapy.

Practice

- Awareness of professional guidelines and responsibilities of the clinician's role is also critical (e.g. ethical practice, risk, time constraints, organisational policy, collaboration, TIC guidelines).
- Awareness of professional guidelines and responsibilities is a key component of work with clients affected by complex trauma. Clients have often had previous experiences where boundaries have been violated and unclear expectations in the therapeutic relationship can cause ruptures creating difficulty for both client and clinician.
- Boundaries are also implicated in the clinician's ability to separate work from personal life (e.g. having strategies to disengage from worry and rumination associated with work).
- It is also important for the clinician to be mindful of their present experience and bodily and emotional responses so they can manage their own affect and maintain a calm, compassionate presence (Pearlman & Caringi, 2009).
- The mirroring that is associated with empathic attunement can be managed as a way to create distance when feeling overwhelmed in session. "Unmirroring" through shifting body/posture, changing breathing, tensing and relaxing muscles, and using a notebook to create a barrier are ways that clinicians may be able to disconnect a little when connection is too intense (Rothschild, 2006).
- Writing progress notes can provide an opportunity for the clinician to reflect and gain perspective on the session and the overall process of therapy (Pearlman & Caringi, 2009). This can also help with formulation which should be an ongoing process and assists in making sense of the client's changing difficulties can help the supervisee to feel less disempowered and overwhelmed.

- Clinicians may also find it useful to do something different between appointments such as drawing or sketching, mindfulness, deep breathing, stretching, taking a walk, exercising, or connecting with colleagues.

APPENDIX ONE:

Tips for Supervisors: Aspects of complex trauma work and management of VT

Regularly revising and discussing importance of empathy and boundaries

- Supervisors should foreground ways that clinicians can engage with clients empathically whilst also maintaining clear boundaries.
- Empathic engagement conveys the clinician's care to the client (through words and actions) and boundary negotiation involves collaboration with the client to establish the expectations of both parties in the therapeutic relationship (e.g. clinician availability, appointment arrangements, third-party involvement) (Pearlman & Caringi, 2009).

Boundary issues between clinicians and clients

The following behaviours in supervisees could indicate boundary confusion with clients:

- Clinician appears reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The clinician seems to be possessive of the client and may advocate with unusual passion and/or express an unreasonable sense of responsibility for the client.
- Clinician is defensive and not open to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician may engage in personal self-disclosure to the client without any therapeutic rationale (SAMHSA, 2014).

Identifying behavioural adaptations and attachment related trauma

- Clients who have experienced complex trauma may have attachment and relational difficulties that compromise their ability to feel trust and safety in the therapeutic relationship.
- Behaviours that seem to test, manipulate or attack the therapist may be attempts to control the clinician in order to feel a sense of safety.
- Supervisors can help supervisees to understand these behaviours and process countertransference responses.

Supporting supervisees to identify and understand challenging re-enactment dynamics

- Complex trauma survivors often engage in re-enactments of victim–perpetrator–bystander dynamics as a result of unprocessed relational trauma.
- "Re-enactments can reflect disrupted memory systems; disrupted affect regulation (self-soothing through familiar behaviour patterns), memory integration (remembering by reliving), and psychological needs (for safety and control, with attempted reassertion through re-enactments)" (Pearlman & Caringi, 2009, p. 210).
- Re-enactments can be difficult to identify and can result in clinicians feeling "de-skilled" and hopeless. Supervisors can assist in recognising re-enactments and supporting supervisees to understand and respond effectively.

Identifying early signs of change in perspectives, despair and cynicism in supervisees

- Supervisors may notice supervisees displaying a reduction in empathy, a sense of detachment from their client's suffering, and dismissiveness of client's stories and experiences.
- Other signs associated with VT include reduced collegiality, dread and avoidance of client appointments, work absenteeism, and a decline in productivity.
- Empathic exploration of supervisees' responses and emotions can assist in identification of aspects of VT and what supports are needed.

Addressing supervisee's personal health needs, mental health self-care and interpersonal skill development during supervision

Personal trauma history

- There is a high prevalence of prior exposure to trauma in clinicians working with trauma affected clients. While this may be a strength for these clinicians in their ability to empathise and understand their clients, it can potentially also increase their risk of experiencing VT (although research is inconsistent here and there are many variables that make it difficult to predict).
- Supervisors can assist in encouraging openness and safety around disclosure when supervisees' personal trauma has been triggered in their work.
- Supervisors should be aware of the framework of the supervisory relationship and ensure that supervision does not become personal therapy for supervisees.
- Supervisees should be strongly encouraged to seek additional professional help for personal trauma where indicated.

Clinician avoidance

- Another factor contributing to VT is the chronic or persistent avoidance of clients' pain. While clinicians may be attempting to protect themselves and reduce their risk of experiencing VT, it does not necessarily reduce this risk and may in fact increase it. Avoidance can leave the clinician less able to process difficult emotions and counter-transference in the therapeutic relationship such as pain, fear, sorrow, frustration, anger, and resentment as this accumulates over time. Supervisors can be attentive to signs of avoidance in supervision and explore with supervisee.

APPENDIX TWO:

Vicarious Trauma: Self-Care for Mental Health Workers

(Defence Health – Australian Government, Department of Defence)

When you see clients who have been exposed to a traumatic event or disaster, you need to be aware of the potential for 'vicarious traumatisation'. Vicarious trauma causes you to question how safe you feel in the world, and with other people. It is normal to initially react strongly to the client's story, however the feelings should subside after a few weeks.

What will cause me to be vicariously traumatised?

Listening to a client's experience and feelings after witnessing or being involved in a traumatic event or disaster will expose you to images and emotions that challenge your understanding of the world. Sharing in the feelings of these stories can be emotionally draining. Your own past experiences of trauma and how you coped with those situations, as well as current life stresses and circumstances, will effect how you cope with the impact on your normal functioning.

There are a number of ways you may begin to experience symptoms of vicarious trauma, for example:

1. When you listen to your client you will be sharing the images and feelings of grief, horror, agony, rage, shame and terror about the event. Sharing the pain from these stories may cause you to question your own views and understanding of the world, humanity, and even yourself and the safety of your daily life. These questions are similar to those also being considered by your traumatised client.
2. As a mental health worker you are trained to help clients restore their happiness and well-being. This can be particularly demanding with trauma clients, and you may find it difficult to maintain professional boundaries. Despite your best intentions or commitment there may be no or little improvement for your client. This may cause you to question your understanding of yourself as a person who is able to help or provide for others.

How will I know if I'm vicariously traumatised?

Symptoms of vicarious trauma will be just as different for each person as effects are on survivors of the initial trauma. The list below can give you an indication of feelings you may experience, and that are completely normal when they continue for a couple of weeks. If you experience any of these signs for prolonged periods, or more intensely than you expected, or if you have any concerns, you may consider professional help to cope with these feelings.

You may experience:

- Symptoms similar to the client's, such as anxiousness, irritability, being easily startled, or not feeling safe
- Trouble getting to or staying asleep
- Thinking about the trauma or the client for much of the time
- Physiological arousal such as increased heart rate or perspiration
- Avoiding or feeling anxious about certain situations or places that relate to the traumatic event
- Difficulty relating to or being overly critical of others, particularly children. This may lead to avoiding spending time with others, and withdrawing from normal social activities or commitments

- Difficulty regulating emotions (i.e. mood swings), or emotional exhaustion
- Feeling depressed, hopeless or helpless
- Over or under eating
- Increased use of alcohol, caffeine or other drugs
- Anger at the effect of the trauma on your life
- Negative feelings, including irritation, frustration and guilt about the client
- New or worsened health issues such as bowel or stomach problems, muscle pain and headaches
- Feeling overwhelmed and wanting distance from stories of the trauma
- Poor performance at work, including avoiding clients
- Difficulty thinking clearly, concentrating, and remembering things, or having difficulty making decisions
- Loss of sense of humour, motivation or energy
- Having more accidents or making more mistakes than usual

What can I do if I feel this way?

These tips may help you to cope with or prevent the symptoms above from occurring:

- Organise to have some supervision, or debriefs with colleagues
- Acknowledge the difficulties or changes you are experiencing in your thoughts, emotions and attitudes. If you are concerned, discuss them with someone
- Maintain a regular and healthy diet, and make time to exercise
- Balance your workload with relaxation, and also pay attention to the types of clients you are seeing throughout the day and week.
- Try to arrange clients so that emotional burdens do no cluster in your schedule
- Identify thoughts or beliefs that are meaningful to you or give you hope, and maintain a connection with them
- Seek professional help for physical and/or mental health problems that you are experiencing
- Maintain social and supportive relationships
- Take time to do things you enjoy by yourself, like getting a massage
- Write in a journal or diary
- Find physical activities that are fun and/or spontaneous such as swimming, dancing, playing sports, singing or running
- Allow someone else to take care of you (i.e. go somewhere you will be waited on)
- Revisit favourite books or movies
- Find activities that allow you to express feelings such as anger, happiness, grief or sadness
- Monitor and decrease any unnecessary stressors (i.e. say ‘no’ when you need to)
- Find places or people where you feel comfortable and relaxed, go there often

defence.gov.au;https://www.defence.gov.au/Health/DMH?SelfHelp/Documents/FSVicarious Traum.pdf

APPENDIX THREE:

Vicarious Trauma Screening and Assessment tools

The Copenhagen Burnout Inventory (CBI)

- The CBI consists of three scales measuring personal burnout, work-related burnout, and client-related burnout, for use in different work domains. It is a 19-item self-report inventory using a 5 point likert scale (Kristensen, Borritz, Villadsen, & Christensen, 2005).

The Secondary Traumatic Stress Scale (STSS)

- Consists of 17 items measured with a 5 point Likert-type scale designed to measure the frequency of intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events over the past 7 days. The STSS measures the symptoms outlined in the DSM-IV criteria B (intrusion), C (avoidance) and D (arousal) for PTSD with good reliability reported (Bride, Robinson, Yegidis, & Figley, 2004).

The Professional Quality of Life Scale (ProQOL)

- ProQOL is a commonly used measure of compassion fatigue and compassion satisfaction intended for use as a screening tool for the positive and negative aspects of working within a helping profession. The ProQOL consists of three subscales measuring facets of compassion satisfaction, secondary traumatic stress, and burnout (Stamm, 2010).

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