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## Do we practice what we preach? : an exploratory study of individual, academic, and agency approaches for ameliorating vicarious trauma

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Loren Biggs  
Do We Practice What We Preach?:  
An Exploratory Study of Individual,  
Academic, and Agency Approaches  
for Ameliorating Vicarious Trauma

## **ABSTRACT**

This study was undertaken to determine what training trauma-focused clinicians are receiving at the graduate or professional level to prevent burnout, secondary traumatic stress, compassion fatigue, and vicarious trauma, as well as what individual, agency, and institutional-level interventions clinicians find effective in preventing or ameliorating these phenomena and promoting compassion satisfaction.

Thirteen trauma-focused clinicians with a broad diversity of clinical, professional, and educational backgrounds participated in a semi-structured interview which sought more information about individual self-care practices and clinicians' assessment of information and training received at the graduate and professional level related to vicarious trauma. These interviews were followed by the completion of the Professional Quality of Life survey with subscales for burnout, compassion fatigue, and compassion satisfaction.

This study found that, although trauma clinicians are uniquely at risk for secondary traumatic stress or vicarious trauma, little information on preventative factors, awareness, or support is being presented to students at the graduate or professional level. Nearly every participant identified the need to create a "culture of support" at the agency level through information, training, and trauma-informed supervision, and at the graduate level through meaningful integration of information about vicarious trauma in graduate-level curricula.

**DO WE PRACTICE WHAT WE PREACH?:**  
**AN EXPLORATORY STUDY OF INDIVIDUAL, ACADEMIC, AND AGENCY**  
**APPROACHES FOR AMELIORATING VICARIOUS TRAUMA**

A project based upon independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2013

## **ACKNOWLEDGEMENTS**

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## **CHAPTER I**

### **Introduction**

Trauma therapists face significant risk of developing burnout, compassion fatigue (CF), secondary traumatic stress (STS), and/or vicarious trauma (VT) (Bride & Figley, 2009; Tyson 2007; Pearlman & Saakvitne, 1995b). Despite the fact that this risk is widely known, and that protective and preventative factors have been identified in earlier research (Killian, 2008; Pearlman & Saakvitne, 1995b; Harrison & Westwood 2009), there is still a demonstrable need for comprehensive program development and training for agencies and educational curriculums (Bride & Figley, 2009; Cook, Dinnen, Rehman, Bufka & Courtois, 2011; Harrison & Westwood, 2009; Killian, 2008; Newell & MacNeil, 2010; Voss Horrell, Holohan, Didion & Vance, 2011).

Though Bride and Figley (2009) note that there are several good examples of employer-supported programs to prevent and mitigate STS reactions for professional caregivers, they only present two examples, the first of which was developed by the Shands Medical Center to help the nursing staff develop provider resilience, with a specific focus on professional and personal prosperity. The second was a relatively recent effort by the Brooke Army Medical Center (BAMC), called the “Caring for the Caregiver” Provider Resiliency Program, which involves prevention training and treatment through seminars and stress-management techniques. These are promising initiatives, but there is little evidence in the literature that a replicable institutional-level program specifically designed for mental health clinicians is in development. Newell and



MacNeil (2010) also note that there is a lack of education in social work curriculums on the utilization of self-care in the prevention of CF, STS, and VT.

The demand for trauma-focused clinicians is on the rise as a result of the surge in returning veterans from the wars in Iraq and Afghanistan. Voss Horell, Holohan, Didion and Vance (2011) note that future empirical research is needed on risk and resiliency factors for clinicians working with traumatized OEF/OIF veterans, given that this population is likely to grow. The need for a comprehensive understanding of what coping mechanisms are effective in preventing VT is pressing. New or inexperienced clinicians are more vulnerable to the development of these trauma-therapy related risks (Harrison & Westwood, 2009). Though new clinicians are more vulnerable to VT, more experienced clinicians would also benefit from a more fully developed, comprehensive training. Cook, Dinnen, Rehman, Bufka, and Courtois (2011) found that the majority of clinicians who work with trauma would like additional training.

The topic of this exploratory study is burnout, CF, STS, and VT in trauma therapists, with special attention to what protective factors or self-care practices are effective and which of those practices should be incorporated into trauma therapist training and social work curriculums. The results of this study provide information about what prevention/protective practices and training experienced trauma clinicians have utilized and found most effective in reducing their vulnerability to burnout, CF, STS, and VT, and clinicians' perceptions of agency and institutional commitment to training and support for the prevention of VT. Clinicians encourage their clients to engage in self-care, and clinicians are encouraged to practice self-care in order to avoid burnout, CF, STS, and VT, but questions remain about what "self-care" means and what institutional support for self-care might look like.

This study explores the questions: “What preventative, protective, and self-care strategies do experienced trauma therapists utilize and find most effective in preventing burnout, CF, STS, and VT? Do trauma therapists receive training for the prevention of these phenomena at their agencies or academic institutions? Do they find that their agencies or institutions are supportive of clinician self-care and is it integrated into the operation of their agencies? How might the most effective of these strategies be utilized to develop comprehensive training and curriculum for trauma therapists?” Essentially, this study investigates if trauma-focused clinicians, as individuals and institutions are practicing what they preach in terms of self-care. The results of this study provide information about what prevention/protective practices experienced trauma clinicians have utilized and found most effective in reducing the vulnerability to burnout, CF, STS, and VT, as well as information about what institutions are doing to create a “culture of support” around issues related to burnout, CF, STS, and VT. The findings of this study can be used to create program development and training techniques for agencies and academic institutions dedicated to educating those entering the helping professions. The results can also help agencies realize the importance of structured integration and support for their workers.

### **Statement of Formal and Operational Definitions and Concepts**

Burnout, CF, STS, and VT are somewhat distinct terms, but they are often used interchangeably. It is useful for the purposes of this study to identify the operational definitions of these terms. Maslach (1982) first identified the construct of burnout and noted that symptoms include emotional exhaustion, depersonalization and reduced personal accomplishment, and presents in the clinical setting due to factors such as caseload size or institutional stress (Stamm, 1997). Secondary Traumatic Stress occurs when professional caregivers of victims who

experienced trauma became indirect victims of that trauma and those caregivers experience stress as a result of helping or wanting to help a traumatized or suffering person (Figley, 1995; McCann & Perlman, 1990). Compassion Fatigue was first coined by Figley as an alternative term to the phenomenon of STS, but was further defined by Newell and MacNeil (2010) as a combination of the symptoms of STS and professional burnout. McCann and Pearlman (1990) introduced the term Vicarious Trauma to describe the unique impact on clinicians of working with traumatized populations. Perlman and Saakvitne (1995b) define VT as a transformation in the cognitive schemas and belief systems of clinicians as a result of empathic engagement with a client's traumatic experiences. They further note that VT causes "significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory" (p. 151) and posit that VT is unique to trauma-focused clinicians. Compassion Satisfaction is also relevant to this study. Compassion Satisfaction was first introduced by Stamm (2002) and refers to the sense of satisfaction many professionals derive from helping others.

For the purposes of this study, VT will be most frequently referenced because it is the most severe on this spectrum, though the findings would be relevant in the development of training or curriculum to prevent or protect against any of these phenomena.

This study is a mixed-methods study that is exploratory in nature. The author interviewed individuals who provide trauma-focused mental health services at a variety of agency settings in the greater Raleigh/Durham/Chapel Hill Triangle of North Carolina. The interviews took place through in-person meetings and the telephone. The thirteen respondents responded to nine demographic questions and thirteen interview questions based upon their work

as providers and the education or training they received related to burnout, STS, CF, or VT at the agency or educational level. After the interview, each respondent filled out the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL-5), which is a 30-item questionnaire designed to measure compassion satisfaction, burnout, and STS.

## **Chapter II**

### **Literature Review**

Mental health clinicians, and trauma clinicians in particular, are dedicated to serving vulnerable and traumatized populations. Sustained empathetic engagement with multiple clients with trauma histories poses an occupational hazard that can lead to conditions like burnout, STS, VT, or CF (Newell & MacNeil, 2010; Pearlman & Saakvitne, 1995b; Figley, 1995). Over the past twenty years, a variety of studies have shown that there is a cost to caregiving (Bride & Figley, 2009; Cohen & Collins, 2012; Craig & Sprang, 2010; Figley, 1995; Herman, 1992; Killian, 2008; McCann & Pearlman, 1990; Newell & MacNeil, 2010; Pearlman & MacLan, 1995; Pearlman & Saakvitne, 1995a; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1997). Though much research has been done on this issue, few studies directly ask clinicians where they initially learned these preventative strategies, and even fewer studies ask if or how agencies or institutions are creating a “culture of support” around these issues, and what systemic programming or resources agencies and institutions might incorporate or what training or support clinicians themselves would find most useful. The goal of this study is to address these questions.

## **Constructivist Self Development Theory, Vicarious Trauma, and Compassion Satisfaction**

Key concepts and theories that inform the research questions are: constructivist self development theory (CSDT; McCann & Pearlman, 1990), VT (McCann & Pearlman, 1990), and compassion satisfaction (Stamm, 2002).

CSDT was first developed by McCann and Pearlman (1990) and is the foundation for the VT construct. CSDT was developed and revised through work with a variety of survivor groups, including rape victims, childhood sexual abuse survivors, crime victims, war veterans, and survivors of natural and other disasters (Pearlman & Saakvitne, 1995a). CSDT offers a basis for understanding the psychological and interpersonal impact of trauma on the survivor, and a framework for understanding the impact of trauma work on the therapist (Pearlman & Saakvitne, 1995a). CSDT integrates psychoanalytic theory with cognitive theories, drawing upon object relations theory, interpersonal psychiatry, and self psychology and synthesizes these theories with constructivist thinking, social learning theory, and cognitive developmental theory (Pearlman & Saakvitne, 1995a). The individual's adaptation to trauma is influenced by a number of factors, including the individual's personality, personal history, and the social and cultural contexts for the traumatic event and its aftermath (Pearlman & Saakvitne, 1995a). Within the CSDT framework, aspects of the self that can be affected by psychological trauma include: Frame of Reference (which includes world view, identity, and spirituality); Self Capacities (the ability to tolerate strong affect, maintain a positive sense of self, and maintain a sense of connection with others); Ego Resources (the ability for the individual to meet psychological needs and relate to others—establishing healthy boundaries, the ability to have perspective, strive for personal growth, etc.); Psychological Needs (in relation to self and

others—safety, trust, esteem, intimacy, and control); and Memory System (verbal, affect, imagery, somatic, interpersonal) (Pearlman & Saakvitne, 1995a).

Clinicians who work with trauma survivors restructure and recreate their perceptions and realities based on repeated exposure to stories of their clients (Pearlman & Saakvitne 1995a). When clinicians empathetically engage with clients who have experienced trauma, they may have difficulty making sense of these experiences, which can lead to a sense of vulnerability, a compromised sense of personal safety, and a shift in cognitive schemas. Therapists develop VT when they are unable to consistently maintain their own sense of self and are unable to make meaning of their clients' experiences within their existing belief systems and worldviews (McCann & Pearlman, 1990; Trippany et al., 2004).

VT is exacerbated by, and perhaps rooted in, the engagement of empathy or the connection with the client that is inherent in counseling relationships (Pearlman & Saakvitne, 1995b). VT reflects exposure of counselors to clients' traumatic material and encompasses the subsequent cognitive disruptions experienced by counselors (Figley, 1995; McCann & Pearlman, 1990). VT is distinguished from the concept of countertransference as it is cumulative and takes place over time, as a result of numerous therapeutic relationships (Rasmussen, 2005). Repeated exposures to clients' traumatic experiences can cause cognitive schema shifts in the way that trauma counselors perceive themselves, others, and the world. Pearlman and Saakvitne (1995b) write:

These alterations include shifts in the therapist's identity and world view; in the ability to manage strong feelings, to maintain a positive sense of self and to connect to others; and in spirituality or sense of meaning, expectation, awareness, and connection; as well as in

basic needs for and schemata about safety, esteem, trust, and dependency, control, and intimacy (p. 152).

These shifts can have devastating effects on their personal and professional lives. Personally, therapists may experience an identity shift—those who once perceived themselves as optimistic and positive may begin to experience themselves as negative, cynical, or sarcastic; therapists experiencing these shifts may begin to isolate themselves from friends and family—those who once balanced their professional lives with an active personal life may begin to socialize less often and create either physical or emotional distance from loved ones, or they may restrict their activities due to a compromised sense of personal safety (Rasmussen, 2005).

Professionally, therapists who are usually able to empathetically engage with their clients may begin to have more blunted responses to traumatic material, may find themselves “drifting off” during client sessions, or may become angry with clients for being “stupid or naïve”; they may also begin to question their career choice and fantasize about other careers (Rasmussen, 2005). Pearlman and Saakvitne (1995b) also caution that therapists who are unaware of their VT run the risk of traumatizing their clients in both overt and subtle ways—when their emotional and psychological needs are not addressed in appropriate ways outside of the therapeutic relationship, the clinician’s needs may become a greater part of the focus than the client’s needs, which can lead to violations of the therapeutic frame and boundaries.

Compassion satisfaction refers to the sense of satisfaction many professionals derive from helping others (Stamm 2002). Pearlman and Saakvitne (1995b) write, “Sometimes when people ask us, ‘How can you do this work?’ we think ‘How could we not?’ ... The act of listening is part of the process of healing. It is personally transformative, inspiring, and rewarding to witness and be part of people’s healing” (p. 400). Reward for doing trauma therapy can include



the transformation of our clients—when our clients grow and heal, it is rewarding; the transformation of the therapist as a therapist—finding that we have something helpful to offer our clients, learning from clients about how to face our own strengths and limitations; and the transformation of the therapist as a person—“Participating in the transformation of a client’s despair is a life-altering experience for those therapists who are open to it. Our clients’ resilience and capacity to heal and to grow are powerful antidotes to the creeping cynicism that characterizes vicarious traumatization” (Pearlman & Saakvitne, 1995b, p. 403). For the purposes of this study, it is important to consider the compassion satisfaction framework to identify how compassion satisfaction might be a protective factor for burnout, STS, CF, or VT, as it supports the therapist’s ability to continue engaging in work with clients in meaningful and fulfilling ways.

### **Risk Factors**

New or inexperienced clinicians are more vulnerable to the development of these trauma-therapy related risks due to a lack of trauma-focused training, lack of information and education about the risks of trauma work, and lack of professional experience (Harrison & Westwood, 2009; Bober & Regehr, 2006; Pearlman & MacIan, 1995b; Pearlman & Caringi, 2009). Cohen and Collens (2012) did a metasynthesis of literature on VT and found that other factors that can contribute to or are associated with VT include negative coping strategies and personal trauma history. Killian (2008) interviewed twenty therapists and found several key risk factors for work stress and CF (listed in order of frequency mentioned in interviews): high caseload demands and/or workaholism; personal history of trauma; regular access to supervision; lack of a supportive work environment; lack of supportive social network/social isolation; worldview

(overabundance of optimism, or cynicism, etc.); and ability to recognize and meet one's own needs (i.e. self-awareness). The quantitative portion of his study surveyed 104 therapists and found that three variables accounted for 74% of the dependent variable for burnout: symptoms of work drain (work stress overshadows time with family), lack of work morale (frustration with agency policy, feeling like one's accomplishments are unrecognized), and neuroticism.

Professionally, if VT goes unacknowledged or untreated, the potential for clinical error or therapeutic impasse increases as the clinician's feeling of vulnerability increases (Pearlman & Saakvitne, 1995b). This can result in a compromise of therapeutic boundaries—from missed appointments to sexual or emotional abuse of clients (Pearlman & Saakvitne, 1995b).

Furthermore, clinicians may begin to doubt their skills and can potentially lose focus on client strengths and resources, as well as feel anger toward clients when they have not achieved the clinician's idealized response to therapeutic interventions (Herman, 1992). Personally, clinicians can become less emotionally accessible to their loved ones and friends (Pearlman & Saakvitne, 1995a) and trauma narratives shared by clients in session can become intrusive during intimate moments with partners, compromising the relationship (Killian, 2008).

Clinicians working with combat survivors and military social workers can be particularly vulnerable to vicarious traumatization. Tyson (2007) found that the previous deterrents to CF—including self-care, peer supervision, and individual therapy—may not be enough to meet the needs of clinicians working with combat veterans, due, in part, to the complexity of the trauma experienced by warriors in combat, but also due to the stress the clinician experiences when a client faces yet another deployment. The constant threat of redeployment leads to concerns about the client's survival, which can add to the clinician's sense of helplessness, CF, and distortions in world-view.

The recent OEF/OIF operations in Iraq and Afghanistan give rise to historically unique circumstances. Soldiers are being deployed more frequently and for longer periods of time, which leads to chronic exposure to traumatic events (Tyson, 2007). Soldiers are also more likely to survive if seriously wounded—an estimated 90% will survive a serious injury once medical aid is administered in the field (Friedman, 2004, as cited in Tyson, 2007). This unprecedented survival rate leads to a significant increase in the demand for mental health services for soldiers and their families. These circumstances increase the risk for CF (1) because clinicians may have unmanageably high trauma-focused caseloads and (2) because the types of trauma are more complex: repeated deployment exposes military members to higher levels of trauma—both physical and mental—over a longer period of time (Tyson, 2007) and soldiers have been asked to suspend their previously held psychological and moral positions in order to engage in combat activities such as government-sanctioned killing (Shay, 2002, as cited in Tyson, 2007). Additionally, clinicians who are unaware of their compassion fatigue are at risk for cutting off empathetic connection with their clients, which compromises the soldier’s access to “absolution” in the therapeutic relationship and could have deleterious effects on the combat survivor’s ability to mourn (Tyson, 2007, p. 184). In 1978, Charles Figely noted that when engaged empathically with a combat survivor, clinicians are necessarily confronted with “their own vulnerability to catastrophe, and it also challenges their moral attitudes about aggression and killing” (p. 264, as cited in Tyson, 2007). Consideration should also be given to the military social worker, who is often working on the front lines to ensure that soldiers with acute mental distress after a traumatic event can be assessed, given an intervention, and determined “fit for duty” within a time frame as narrow as 72 hours. Hall (2009) notes that during combat, “there are obvious limitations for therapy and supervision; consequently, there is even less time devoted toward

exploring the signs and symptoms of STS, especially for military social workers. Self-care should be the first line of defense for STS” (p. 339).

Ultimately, every trauma-focused clinician is vulnerable to VT, and the risks—to both clinicians and clients—are only likely to increase as the demand for trauma-focused therapy increases, which often leads to unmanageably large caseloads and overwork. Systemic solutions at agency and educational levels to promote protective factors to prevent VT are urgently needed, as will be discussed later in this chapter.

## **Protective Factors**

### ***Individual***

Pearlman and Saakvitne (1995b), posit that the following therapist-level interventions can be effective in the treatment or prevention of VT: identifying disrupted schemas (self-knowledge and reflection can help the therapist put intrusive thoughts in context); maintaining a personal life (balancing work, play, and rest); using personal psychotherapy; identifying healing activities (creating art, spending time with family and friends, pursuing hobbies, activities that reconnect the therapist with her body, like massage or exercise); and tending to spiritual needs. Bride and Figley (2009) also encouraged clinicians to maintain a personal and professional life balance by engaging in self-care, including leisure activities, exercise, meditation, spending time with loved ones, and seeking personal psychotherapy as needed. Harrison and Westwood (2009) interviewed six experienced trauma clinicians and found nine major themes across the spectrum of protective practices: countering isolation (in professional, personal, and spiritual realms); developing mindful self-awareness; consciously expanding perspectives to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional

satisfaction; and creating meaning. Voss Horrell et al. (2011) and Killian (2008) found that sense of control and autonomy are protective factors against burnout. The clinicians in this study were asked to identify what skills or techniques they utilize on the individual level to guard against burnout, STS, CF, and VT.

The participants in Killian's (2008) study felt that engaging in self-care included: process time and supervision, quality time with friends and family, exercise, and spirituality, and also felt that it was important to regularly practice self care as a model for their clients. In the quantitative portion of the study, Killian (2008) found that three variables accounted for 41% of the dependent variable of compassion satisfaction: social support (friends, family, the community) was the most significant predictor of compassion satisfaction; working a greater number of hours per week with traumatized clients reduced reported levels of compassion satisfaction; having a greater sense of control over the workplace was associated with higher compassion satisfaction. Though most clinicians interviewed identified self-care as an important area of professional development, it had rarely been addressed in their clinical training or in continuing education (Killian, 2008).

### ***Agency and Organizational Level***

On the professional level, it is necessary that clinicians arrange for regular supervision with an experienced trauma-therapy supervisor, develop meaningful professional connections in order to combat the sense of disconnection common to VT, and develop and maintain a balanced work life (Pearlman & Saakvitne, 1995b; Newell & MacNeil, 2010). Another effective agency-level intervention is to provide clinicians with a manageable and varied caseload of clients with and without trauma (Pearlman & Saakvitne, 1995b; Trippany, Kress & Wilcoxon, 2004; Bride & Figley, 2009, Bober & Regehr, 2006; Pearlman & Caringi, 2009; Killian, 2008). Phelps, Lloyd,

Creamer, and Forbes (2009) highlighted that, though it is integral to trauma work to be empathetic and engaged, it is important for the clinician to maintain healthy emotional boundaries in their work with clients as a protective mechanism against CF and VT. A sense of achievement was also found to be an important protective factor for clinicians, as demonstrated, for example, by pay raises and promotions that acknowledged the clinicians' good work (Bride & Figley, 2005; Trippany, Kress & Wilcoxon, 2004). Killian (2008) found that clinicians who worked in clearly defined teams suffered less psychological strain, had great job satisfaction, and reported greater organizational commitment. Those who can rely on their colleagues for peer support have a go-to source for collaboration, processing, and reality testing when working with challenging clients.

Interestingly, Killian (2008) found no evidence that individual coping strategies were protective factors, and no significant correlation between the use of various coping strategies and the level of compassion satisfaction vs. compassion fatigue. Bober and Regehr (2006) found that, even in cases where therapists believed that coping strategies were useful and regularly recommended them to clients, this belief did not translate into time devoted to engaging in these activities, and found no association between time devoted to coping strategies and traumatic stress scores. Provocatively, Bober and Regehr (2006) argue that offering educational seminars that encourage therapists to engage in individual self-care is tantamount to "blaming the victim," as it implies that clinicians who feel traumatized by their work are not balancing life and work adequately, and may not be making effective use of self-care, leisure time, or supervision. They found that the primary predictor of trauma scores is hours per week spent with traumatized people and called for organizations to determine ways of distributing the workload to limit each clinician's trauma exposure (Bober & Regehr, 2006). Phelps et al. (2009) argue that the primary

prevention should be to identify and minimize work-related sources of stress (isolation, overwork, lacking support or supervision) at an agency level, with self-assessment and self-care at the individual level as a secondary prevention. These findings support the argument that individual strategies are not enough and protective strategies must be initiated and supported at the organizational level in order to be ultimately effective.

Part of the organizational responsibility to clinical staff is to create a climate where clinicians can openly talk about their experiences and reactions to working with traumatized individuals, to normalize STS and VT as an occupational hazard, to create opportunities for clinicians to vary their caseload, to create an atmosphere of respect for therapists and clients, and to ensure that clinicians can look to experienced trauma-focused clinicians for supervision (Pearlman & Saakvitne, 1995b; Catherall, 1995; Bride & Figley, 2009; Bell, Kulkarni & Dalton, 2003).

It is important for agency administrators, when possible, to ensure that their clinicians have manageable caseloads, to set limits to avoid overwork or role strain, and to create an atmosphere where clinicians have a sense of autonomy and control over their professional lives—which includes having input at work, having their own work space, and being able to anticipate and control how many hours they work each day (Killian, 2008). Admittedly, given the reality of large waitlists, challenges to access for clients, and the threat of continuous funding cuts for many mental health care programs, it may not always be realistic to reduce caseloads or balance between trauma-focused and non-trauma focused work (especially in agencies that specialize in trauma treatment). It is, however, important for agencies to do what they can in order to reduce burnout, STS, CF and VT, because employee turnover is also a costly and significant risk. Harrison and Westwood (2010) found that a supportive agency-level

intervention is for administrators and supervisors to promote a non-authoritative and inclusive style of working.

Though many therapists are aware of the risks of empathetic engagement with clients with trauma histories, seeking out resources for preventative or protective factors has largely been seen as the responsibility of the individual (Bober & Regehr, 2006). Most clinicians interviewed in Killian's (2008) study identified self-care as an important area of professional development, but reported that it had rarely been addressed in their clinical training or continuing education. Educational institutions and agencies have an ethical responsibility to their clients and clinicians to implement systemic support for their workers (Pearlman & Carinigi, 2009; Killian, 2008; Bober & Regehr, 2006). Harrison and Westwood (2009) feel that addressing and ameliorating VT is an ethical responsibility shared by employers, educators, professional bodies, and individuals.

### **Extant Agency Level Programs to Prevent and Mitigate Secondary Traumatic Stress**

Bride and Figley (2009) note that there are several good examples of employer-supported programs to prevent and mitigate STS reactions for trauma-focused caregivers. They present two examples, the first of which was developed by the Shands Medical Center to help the nursing staff, and the second was a relatively recent effort by the Brooke Army Medical Center (BAMC).

At Shands, Dr. Rose Rivers, the vice president for nursing, began to recognize the need for institutional change to counteract traumatic stress reactions in nurses in 2000. By 2008, the Medical Center implemented the "Shands Prosperity Program and Toolkit," which helps staff outline a plan not just for self-care, but for prosperity, with the expectation that the goal is not



simply to maintain professional empathy and engagement, but to thrive both professionally and personally. Bride and Figley cite the seven steps of the plan from the *Toolkit to Promote Nurse Self Care and Self-Advocacy* (Rivers, 2008):

1. Make a commitment toward prosperity tool
2. Select and meet with your life coach to get oriented to the individual prosperity plan
3. Complete the self-care assessment tool
4. Meet with your coach for consultation
5. Complete the individual prosperity tool
6. Meet with the coach weekly to review progress on the specified goals and objectives
7. End of six-month period ceremony where coaches and participants celebrate achievements and progress (2009, p. 325).

The Shands example is particularly noteworthy because it is not specifically designed to prevent burnout or secondary traumatization, but to ensure that the nurses are thriving in multiple areas of their lives, not just professionally. While some clinicians may find this approach a bit onerous (in addition to the already existing professional requirements for supervision, etc.), a time-limited, structured approach to identifying and pursuing personal goals could be an ideal model for how to integrate this type of thoughtful personal reflection in educational curriculum and agencies. Cohen and Collens (2012) write that clinicians engage in “existential meaning-making processes” in order to make sense of their vicarious experiences (p. 6). These meaning-making processes can lead to both positive and negative shifts in personal schemas. The Shands model provides “scaffolding” for these types of processes and the focus on prosperity intentionally guides this meaning-making in a strengths-based positive direction. Harrison and Westwood (2009) found that when clinicians purposefully remind themselves that life is about

more than trauma, they are able to “counterbalance their skewed perspective on the world...they can accept the inevitability of pain and suffering as well as life’s potential for beauty, joy, and growth” (p. 210). This prosperity-focused personal reflection model at Shands provides a structured and concrete way for clinicians to balance their perspectives, which encourages positive vicarious post-traumatic growth for the clinician.

In May 2009 at BAMC, Col. Kathryn Gaylord, director of the Provider Resiliency Program, USAISR Commander Col. Lorne Blackbourne and Col. Kimberly Smith, chief nurse of USAISR Burn Center, joined together and opened the doors of a relaxation room for multidisciplinary caregivers of injured service men and women. The relaxation room was a compliment to the Provider Resiliency program, which includes a series of prevention training and treatment through the use of seminars and stress-management techniques, all designed specifically to assist the clinical staff with stress management, CF and burnout, while increasing compassion satisfaction. "Research has demonstrated that providing a better work environment will increase retention, decrease burnout, and increase patient care and satisfaction. The long-term goal is better patient outcomes," said Gaylord (Rodriguez, 2009). Grant funding made this program available to the multidisciplinary surgical research staff, but certain aspects, like the Tranquility Room, are accessed based on priority—the clinical burn staff is given first priority and other staff has access to the room by appointment only and is limited to 8-10 minute sessions (Rodriguez, 2009). Replication of the program was an important component from its inception, as the goal was for BAMC to develop a program that could be successfully duplicated for the entire Army Medical Center Staff.

These are promising initiatives that suggest implementing systemic approaches to self-care and caregiver resiliency is possible (though research on the efficacy of these programs is not

yet available), but there is little evidence in the literature that replicable institutional-level programs for social work students or clinicians are in development.

One anticipated critique from agencies is that these types of programs might be difficult to implement, given that caseloads are high and funding for such programs is difficult to come by. Sprang, Clark and Whitt-Woolsey (2007) found that educating clinicians about risk and protective factors for CF, as well as providing resources to enhance protection might help reduce the levels of CF and burnout. They further posit that, in spite of the challenges posed by organizational barriers and the pressures posed by managed care, providing such education and training opportunities, along with flexibility in terms of capacity management and caseload mix development “would not only be humane, but probably cost-effective in the long run if they prevent staff turnover, lost time at work, and protective disengagement” (p. 276). Newell and MacNeil (2010) note that there is a lack of general education in social work curriculums on the utilization of self-care in the prevention of CF, STS, and VT, which indicates that the problem of lack of education around self-care and preventative factors is not limited to agencies or professional institutions, but also to institutions of higher education.

It is also important to reflect on the shortcomings of the approaches outlined above: both of these programs—while creating an atmosphere of support for clinicians and demonstrating an agency commitment to providing protective opportunities to their staff—still put the onus of self-care on the individual worker, instead of taking alternate systematic approaches, such as ensuring that their clinicians are not overly burdened by their caseloads. Creating a manageable and varied caseload for clinicians can be a significant challenge for community mental health agencies that rely on state or federally-funded programs to subsidize services, for agencies that exist specifically to serve traumatized populations (rape crisis organizations, emergency response

mental health practitioners, etc.), or for agencies that serve a population that is disproportionately exposed to trauma as a result of their occupation (for example, Veterans Affairs). Pearlman and Caringi (2009) address this reality, but also caution that, though community mental health, child welfare, and substance abuse treatment are all generally underfunded, the attitude that all resources must go directly to client care is shortsighted, as research and clinical experience increasingly support staff care as an essential component to the continued success of these workers and agencies.

### **Education and Training**

The need for a comprehensive understanding of what coping mechanisms are effective in preventing VT that could be implemented in systemically significant ways is pressing. The demand for trauma-focused clinicians is on the rise as a result of the surge in returning veterans from the wars in Iraq and Afghanistan. Voss Horell, Holohan, Didion and Vance (2011) note that future empirical research is needed on risk and resiliency factors for clinicians working with traumatized OEF/OIF veterans, given that this population is likely to grow. Newell and MacNeil (2010) note that individual, social, and institutional strategies may be useful in preventing or intervening in burnout, VT, STS, or CF, but that it is necessary to introduce these strategies to social work students in foundational macro and micro social work courses prior to the beginning of their field education as a way to raise awareness about and protect against the development of these organizational risk factors and decrease these students' vulnerability to burnout.

Though new clinicians are more vulnerable to VT, more experienced clinicians would also benefit from a more fully developed, comprehensive training. The American Psychological Association's Practice Organization (APAPO) conducted a survey of practicing psychologists

and included the two following items: the amount of clinical time spent working with trauma survivors and interest in additional training in trauma. In reporting on the preliminary findings of these two items, Cook, Dinnen, Rehman, Bufka, and Courtois (2011) found that 64% of the respondents (whom identified as non-trauma and trauma-focused) expressed interest in participating in educational endeavors to learn more about trauma and its treatment. They called for further research on what training prepared practitioners to provide psychological services to trauma survivors and what additional training practitioners need in order to provide high quality services and on what topics (e.g. particular types of trauma, etc.) and formats (e. g. weekend workshops, web-based instruction, video courses).

Trauma-focused training can provide clinicians with new ways of doing trauma-focused work as well as the opportunity to build a supportive network of trauma-focused clinicians (Pearlman & Saakvitne, 1995a). Sprang, Clark, and Whitt-Woolsey (2007) found that specialized trauma training of therapists significantly increased compassion satisfaction and decreased CF and burnout. Pearlman and Saakvitne (1995a) found that training without a trauma focus can also serve as a protective factor, as it allows trauma-focused clinicians to develop broader skills and interests, as well as the opportunity to meet clinicians with other specialties and to consider one's own approaches from a different perspective. Conversely, Bober and Regeher (2006), argue that strategies that focus on education and coping skills unduly individualize the problem, which suggests that a more comprehensive, systemic approach with top-down support is necessary. Harrison and Westwood (2009) feel that addressing and ameliorating VT is an ethical responsibility shared by employers, educators, professional bodies, and individuals.

## Summary

The literature reviewed provides a foundation for further exploring the question: “*What preventative, protective, and self-care strategies do trauma therapists utilize and find most effective in preventing burnout, CF, STS, and VT and how might these strategies be institutionally implemented in a structured way?*” Varying conceptions of risk and protective factors and the need for more substantial education and training is presented. VT theory, CSDT, and Compassion Satisfaction are presented, and the implications for each in this study are examined. These theoretical foundations have informed the interview questions, methodology, and the findings.

## **Chapter III**

### **Methodology**

The purpose of this exploratory study is to identify what training trauma-focused clinicians are receiving at the graduate or professional level to prevent burnout, STS, CF, and VT. This study also seeks to identify which individual, agency, and institutional-level interventions are effective in preventing burnout, STS, CF, and VT, and in promoting compassion satisfaction. Effective individual, agency, and institutional-level interventions are identified. The data collected provides a springboard for further discussion about what interventions, education, and training can be incorporated into social work curriculums as well as implemented or supported by mental health agencies.

#### **Research Type, Method, and Design**

This study explored the questions: *“Are trauma therapists receiving training for the prevention of burnout, STS, CF, and VT at their agencies or academic institutions? Do clinicians find that their agencies or institutions are supportive of clinician self-care and is it integrated into the operation of their agencies? What preventative, protective, and self-care strategies do experienced trauma therapists utilize and find most effective in preventing burnout, STS, CF, and VT? How might the most effective of these strategies be utilized to develop comprehensive training and curriculum for trauma therapists?”* Essentially, this study investigated if mental health clinicians, as individuals and institutions are practicing what we preach in terms of self-care.

The results of this study provide information about what prevention/protective practices experienced trauma clinicians have utilized and found most effective in reducing the vulnerability to burnout, STS, CF, and VT, as well as information about what agencies and clinicians are doing to support and implement clinician self-care.

This exploratory study utilized a mixed-methods research approach in which data collection was based on a one-on-one, open-ended, 30-45 minute interview followed by the participants' completion of the thirty-question Professional Quality of Life Scale (ProQOL-5), which took no longer than 5-10 minutes to complete (see Appendix A for complete interview guide, and Appendix B for the ProQOL-5 questions).

A semi-structured interviewing style, utilizing the interview guide approach (Rubin & Babbie, 2010), was used to ensure that relevant topics and issues were covered, but the sequencing and wording of questions could be adapted to each interview. A strictly quantitative approach, with fixed data categories, would not have allowed the respondents the flexibility needed for a richer narrative and advanced exploration of these issues. The questions were purposely designed to cover all relevant topics and create logical narrative that could then be easily coded into relevant themes. The interviews were documented through the use of a recording device. The interviews were then transcribed in a password-protected word processing program. The use of the ProQOL-5 in this study is an objective measure designed to provide useful descriptive statistics related to the levels of burnout, STS, and Compassion Satisfaction for the participants. Due to the small sample size required of this qualitative study, the data gathered from the ProQOL-5 was not intended to provide inferential statistics.

Participants were recruited using a combination of non-probability availability sampling and purposive sampling of licensed trauma-focused clinicians with two or more years of



experience in the field of trauma therapy, located in the Durham, North Carolina area. The author sought first to achieve her sample through a recruitment e-mail sent to the director of her internship agency and an external clinical social work supervisor with many professional connections in the area. The author asked that they forward the recruitment message to eligible clinicians in their agency or professional network that might be interested in participating in the study. Planned for secondary recruitment techniques included a message posted to social media websites and an e-mail for professional listserv recruitment. These secondary techniques ultimately proved unnecessary because the desired sample size was reached through the initial recruitment technique.

The author created a recruitment form letter sent via e-mail for eligible colleagues and acquaintances (Appendix C), a recruitment message for social media websites (Appendix D), and recruitment e-mail for the professional listserv of the American Association for Psychoanalysis in Clinical Social Work (AAPCSW), of which the author is a member (Appendix E). The author requested permission from the director of the agency of her internship and the moderator of the professional listserv prior to distribution of the recruitment message. The director and moderator granted permission to distribute the recruitment message. The agency director's approval letter has not been included in the appendices to better protect the confidentiality of the participants. The listserv moderator's approval letter has been included (Appendix F), as the requisite number of participants for the study was reached through the initial recruitment strategy, and inclusion of this letter poses less of a risk to maintaining the confidentiality of participants.

## **Characteristics of Participants**

Participants in this study included thirteen trauma-focused therapists practicing in geographic proximity to Durham, North Carolina. “Trauma-focused” included any clinician who reported that their clinical caseload was comprised of 50% or more trauma-focused work. Participants were all licensed therapists with a minimum of a Master’s degree in one of the following disciplines: Clinical Social Work, Mental Health Counseling, or Clinical Psychology. Participants had no less than two years experience prior to participation in the study. Participants practiced in a variety of outpatient settings including: social agencies, hospitals, Veterans Affairs clinics, private practice, home-based services, residential juvenile rehabilitative centers, and substance abuse clinics. Participants utilized a diverse range of modalities and theoretical orientations within their treatment. Exclusion criteria included: non-English speakers, those who do not identify more than 50% of their caseload as trauma-focused, those who have not completed their degree, and those who are not fully licensed.

Demographic data collection included questions about age, race, level of degree (MSW, Ph.D, etc.) as well as licensure (counseling psychologist or licensed clinical social worker), number of years practiced, and area of expertise (Appendix A).

An effort was made to solicit a sample that represents diversity in the cultural identification and practice of the clinicians (i.e. diversity in the trauma history of the clients served—combat, sexual assault, natural disaster, childhood abuse, etc.). With that said, as this study is exploratory in nature, the researcher’s priority was to obtain a sufficient number of potential participants who meet inclusion criteria as opposed to ensuring demographic diversity. No eligible participant was excluded due to race, ethnicity, or gender.

## **Data Collection**

The interview data was collected through one-on-one in-person and phone interviews. Prior to meeting with participants for the scheduled interview, the interviewer sent them two informed consent forms (Appendix G), one for their records and one for the interviewer's records. This form explained the nature of participation, the risks and benefits of participating in the study, their ability to end their participation at any time, as well as an explanation of how the data obtained through the interview will be stored and analyzed. The researcher then contacted the participant to determine if they agreed to the informed consent and were willing to proceed with the interview or if they declined the informed consent and chose not to participate in the interview.

The ProQOL-5 (Appendix B) is a screening and research tool that provides information but does not yield a diagnosis. Stamm (2010) notes that, of the 100 published research papers on CF, STS and VT, nearly half have utilized the ProQOL-5 or one of its earlier versions. The three scales measure separate constructs. The CF scale is distinct. The inter-scale correlations show 2% shared variance ( $r = -.23$ ;  $\text{co-o} = 5\%$ ;  $n = 1187$ ) with STS and 5% shared variance ( $r = -.14$ ;  $\text{co-o} = 2\%$ ;  $n = 1187$ ) with Burnout. While there is shared variance between Burnout and STS, the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales is 34% ( $r = .58$ ;  $\text{co-o} = 34\%$ ;  $n = 1187$ ). The author of the ProQOL-5 asserts that the material therein may be freely copied as long as the author is credited, no changes are made, and it is not sold except for in agreement specifically with the author (Stamm, 2010).

## **Data Analysis**

Interviews were transcribed completely for purposes of accuracy. During the

transcription process, the grounded theory method of memoing was utilized to highlight areas of potential significance in each interview that were then coded and formed the basis of preliminary conclusions that were revised over the course of data analysis (Rubin & Babbie, 2010). Patterns and themes emerged from these memos and provided the foundation for categories. Those categories were entered into a spreadsheet, and the most relevant or recurring themes were identified.

The sample size was too small for inferential statistical analysis of the ProQOL-5, but the data collected was relevant in terms of the descriptive statistics of the clinicians interviewed. An employee of Smith College School for Social Work completed statistical analysis of this data.

### **Limitations**

This study is limited in that it relies on the interpretations and impressions of the workers. While care was taken to obtain a diverse sample of organizations, it is impossible to create a representative sample. The participants included twelve women and one man, so the sample was not ideally diverse in terms of gender. Nine of the interviewed clinicians identified as white or Caucasian; one identified as Caucasian and ethnically Jewish; one identified as Caucasian and Native American; and one identified as Caucasian and Hungarian-American, so the sample was also not as ethnically or culturally diverse as the author hoped it might be. Though restricting the study to a particular community in the southeastern United States provided the researcher with the potential to gather more information about the “community” of support around these issues in the geographic area, this restriction limits the generalizability of the results, as does the sample size. Determining causality between what clinicians believe to be resiliency or protective factors and other variables is difficult. The use of the ProQOL-5 in this study is an objective measure

designed to counterbalance the subjective nature of the interviews.

### **Ethical Considerations**

Ethical concerns specific to this study included issues of confidentiality and risk of distress related to vicarious trauma. Though those interviewed were experienced clinicians, the questions could have potentially brought up experiences and memories, burnout, CF, STS, or VT over the course of their work with clients. Although the clinicians were not asked to explicitly discuss their burnout, CF, STS or VT, the questions could have triggered distressing memories associated with their professional or personal experience. Care was taken to reduce these risks. Informed consent forms, which included information regarding the risks and benefits of participation, were discussed and signed prior to interview (Appendix G).

Participants were encouraged to disguise any identifying information regarding their clients during the interviews. If this study is used for publication or presentation, any possible identifying information about participants will be further disguised and all of the demographic data will be presented in aggregate. In regard to the confidentiality of the participants, once the interviews were transcribed, and the ProQOL-5 responses calculated, all identifying information was removed or coded and all additional documentation was securely stored. An external transcriptionist transcribed a small number of the interviews. The external transcriptionist signed a confidentiality agreement (Appendix H). The research advisor had access to the data only after identifying information had been removed. To ensure that participants are not identifiable, the data will be an amalgam of the participant responses. Quotes and illustrative vignettes from the qualitative interviews were disguised to ensure the confidentiality of the participants.

One final ethical consideration is that of interviewer bias. Bias could be reflected through the interview questions themselves and elicited through the more informal, flexible interview process. An effort to limit this bias included review and approval of interview questions by the research advisor and the Smith College Human Subjects Review Board (Appendix I).

## **CHAPTER IV**

### **Findings**

#### **Purpose of Study**

The purpose of this exploratory study is to identify what training trauma-focused clinicians are receiving at the educational or institutional level to prevent burnout, STS, CF, and VT. This study also identifies which individual, agency, and institutional-level interventions are effective in preventing burnout, STS, CF, and VT, and in promoting compassion satisfaction. Within this chapter, the reader will find a brief summary of the demographics of the study sample, as well as a compilation of the various manifestations of burnout, STS, CF, and VT, and the most and least effective techniques utilized to guard against these phenomena at the individual and agency levels. The reader will also find a compilation of information about the education or training the participants received in graduate school or through their agencies over the course of their career, as well as suggestions for improvement in education and training. Participants' insights have been coded and categorized according to the following major themes: Self-Care, Stigma, Manifestations, Preventative Techniques and Protective Factors, Graduate-Level Information and Training, Agency-Level Information and Training, Agency and Community Support, and Compassion Satisfaction. A more in-depth analysis regarding the ways in which this study builds and extends earlier research findings and additional areas of need in future research will follow in the Discussion Chapter.

#### **Sample Demographics**

## **Organizations**

The study population consists of thirteen clinicians from different agencies within the greater Durham, North Carolina area. Agencies represented include: a center for drug addicted prenatal women and mothers; acute in-patient psychiatric units in different hospitals; a residential youth rehabilitation facility run by the Department of Juvenile Justice; a research clinic for childhood traumatic stress; a Veterans Affairs clinic; a program for pregnant and postpartum women offered through the Department of Public Health; a home-visiting therapy program for adolescents; a university-run clinic for adults with mood, anxiety, and sleep disorders; and a private practice. The organizations varied by target population, but all participants identified as trauma-focused clinicians.

## **Participants**

Participants represented a total of 180 years of direct practice. The range of years practiced was from 4-35 years, with an average of 14 years, and a median of 10 years. All participants held advanced degrees and licensure in Clinical Social Work, Clinical Psychology, Psychology, or Counseling. The participants' educational background represented twelve different graduate programs. Participant ages ranged from 30-64 years with an average age of 46 years and a median age of 45 years. Participation in the study required a caseload that was at least 50% trauma-focused. When clinicians were asked what percentage of their caseload consisted of trauma work the average of the responses was 88% with a mean of 100%. The majority of participants were direct-practice clinicians or researchers, and one participant was an agency director who also carried a part-time clinical caseload within the agency. Participants' client populations included children, adolescents, and adults who presented for clinical treatment for a variety of reasons including, but not limited to: childhood trauma, anxiety disorders, and



substance abuse disorders. Many of the clinicians work with clients who have come in voluntarily for treatment, but several also work with clients who received services as a result of involuntary hospitalization, social services investigations or legal mandate. Clinical interventions occurred in a variety of settings including hospitals (civilian in-patient and veterans affairs), clinics, in-home visits, and residential juvenile rehabilitation centers. Twelve of the thirteen participants identified as female, and one identified as male. Ten of the participants identified as Caucasian or white, one identified as White/Jewish, one as Caucasian/Native American, and one as Hungarian/American.

### **What is Self-Care?**

Each clinician was asked the question: *How would you define self-care?* The majority of respondents replied with some variant of “taking care of yourself.” A few expanded this concept into helping others and fewer still provided concrete examples or techniques for self-care. Here is a representative sample of responses from those who defined self-care as “taking care of yourself”:

Um...well...let's see...I guess I hadn't defined it too well before...um...I guess the way that I prevent myself from becoming burnt out or, I guess, from feeling STS, um, yeah, that would be I guess how I define self-care...to take care of myself to prevent those things from happening.

Oh, um...hm. Well the most literal definition is taking care of yourself.

Um...taking care of your personal and uh, emotional and physical needs.

Self-care is...doing things to nourish yourself...um...and I'm trying to say something other than "take care of yourself" but...doing things for your own benefit, or um...kind of purposefully doing activities that make you feel better.

A few respondents took this definition a bit further and connected it to being able to help others:

Self care is doing the things for myself that keep me able to be who I am and why I got into this field so that I can bring as much as I can to what I do.

Taking time to care and look after yourself, because the work we do can be overwhelming; if I don't take care of myself then how do I think I'm going to be able to take care of others?

Well...um...introspection, being able to be aware of yourself and you need to be aware of your feelings and how you're dealing in your own life...if you're not doing well, then you can't help other people.

And fewer still cited concrete examples of self-care techniques that they utilized in order to be able to continue to be effective in their work:

My working self-care has a lot to do about general balance. So that's across my interest level and fun and rest and some kind of activity. My self-care is those four working things.

Um...just being sure that, um, basing it really as a therapist, taking care of myself?

Being sure that I even have certain patients scheduled on certain days. There are 2, 3, or 4 that I find pretty empty. I really don't do well seeing those people all in a row, so I try to arrange the caseload to where I do really feel more energized by some more than others and try to kind of keep that in mind. I exercise; I swim every morning. I have a lot of contact with other therapists. I also have a support group, a lunch group, a dinner

group, and a movie group. I have a lot of things to be sure I'm feeling okay. Family, networking, all is really important to me and to really try to figure out what caseload I can have without taking it home.

Though operational definitions for burnout, STS, CF, and VT were provided at the beginning of this interview, this question was included because the suggestion to practice "self-care" is often the only instruction that clinicians receive in their graduate institutions or at their professional agencies, the findings of which will be reviewed in more detail in the "Education" and "Agency-Level interventions" sections later in this chapter. As one participant noted: "I don't understand why there isn't top-down support for this...as far as self-care is concerned; there is an expectation that we already know how to do it, so we should."

The fact that the responses to this question were largely vague or used the phrase "self-care" or some variant thereof to define it, could indicate that, though self-care is encouraged and often discussed, that may have little meaning for students or clinicians who have not received practical instruction in the utilization of self-care techniques.

## **Stigma**

Operational definitions for burnout, CF, STS, and VT were provided to each participant before the interview began, and an opportunity to review/revise each definition was offered. When asked, "*Have you experienced vicarious traumatization, secondary traumatic stress, compassion fatigue or burnout in your work with clients?*" twelve of the respondents said yes and the remaining one, an administrator, did not experience these phenomena in work with clients, but found that administrative work often lead to burnout that could briefly manifest as compassion fatigue with clients. Eight of the participants answered affirmatively without

indicating which of these phenomena they had specifically experienced. Four of the participants clarified that, though they had experienced burnout, CF, and STS, they had not experienced VT. The remaining participant was the only one who noted that she had specifically experienced each of these phenomena, including VT. Of the four that said they had not experienced VT, three listed manifestations congruent with the definition of VT: crisis of professional confidence; the feeling of being desensitized/disengaged with clients and loved ones; and a distorted world-view. This last point deserves further consideration, as each participant was given a written definition and many of them reviewed the definitions periodically throughout the interview. This would suggest that, even though a definition of VT was provided, these clinicians may have either not realized that they had experienced VT—which could suggest a lack of familiarity with the concept—or were reluctant to admit that they had experienced VT, even when they exhibited awareness about what it was.

This reluctance to admit to having experienced VT might be rooted in the perception of an added stigma associated with VT, and the lack of familiarity with the manifestations of VT among trauma-focused clinicians might perpetuate the stigma associated with experiencing VT. One respondent said:

I don't think we should need too much as therapists. You'd have to be a really unhealthy therapist to be getting vicarious trauma. I mean there's times, yeah, that I've had a bad dream or something, especially after doing a TF-CBT narrative, and certain things maybe stick out, but I don't consider that being traumatized, so I think you'd have to be really weak in your skill as a clinician in order to allow yourself to really be traumatized.

For the clinicians who indicated that they had experienced these phenomena—both those who did not specify VT and the one clinician who did—there was an acknowledgement that there was perceived stigma related to having experienced burnout, CF, STS, or VT:

Some people are embarrassed to even say it because you know it's like "Oh, no, I never have burnout" instead of: "Of course, we all do."

I feel alone; and I feel at work awfully alone about it – like I'm the only one experiencing it and I judge myself and feel too emotional about it.

We still have stigma within. We're horrible, it's horrible. You know, pick any diagnosis and anyone in our department has had that, we've had it all, it's a department of 300 people, of course we have. Everyone goes out-of-network for help because it's got to be this big secret that everyone has to hide. It's not surprising because, if it is known that you have some sort of issue, there's this huge liability or risk-assessment response, rather than a supportive response. They call in legal when they should be calling in employee-supported services.

In discussing possible ways to reduce this stigma or normalize this experience, a few respondents reflected on the challenges they faced at the graduate level and in their agencies, and how they might have been handled more effectively. One respondent reflected on her experience in a competitive graduate program and what might have benefitted her:

To be able to see that I'm not alone in having this, so the same thing we do with trauma treatment, to help people reconnect and realize that they are not alone in their experience of shame or degradation or whatever the trauma presented to them, or their anger, whatever it is. I think for people in graduate school who are competitive and "the best at

everything” it might help to say, okay, here are the statistics, many people have this experience, therefore, if you have this experience, you are not a weirdo.

Two participants reflected on the way stigma related to this experience surfaces in their agencies:

What I notice constantly is an ongoing battle between getting crusty and burnout and then there’s the next step where we actually begin to criticize each other for being burnt out. We kick the dog.

In fact, the problem, in my own experience and several others, are these horrifying witch hunts...if the person is identified as faltering in some way, either because they’re irritated or they’re not sharp, or something, there’s almost stigma and punishment that happens, there’s not wrap-around care.

These experiences suggest that the reluctance to admit to one’s own experience with burnout, CF, STS, and perhaps particularly VT is not unfounded. Several suggestions for how to reduce the stigma and change the narrative around these phenomena were offered, and will be discussed later in this chapter.

### **Manifestations of Burnout, CF, STS, and VT**

When asked about manifestations of these phenomena, clinicians cited a variety of responses that were reduced to the following categories: Depression; Guilt; Irritability; Over-Identification with Clients; Crisis of Professional Confidence/Feeling Helpless; Substance Abuse; Becoming Desensitized/Disengaged; Exhaustion, Stress/Anxiety; Distorted World View; Intrusive Thoughts/Rumination; Dread of Coming to Work; Losing Sleep; Overly Emotional; and Somatic Responses, which included migraines, stomach aches, and various other physical ailments. Of these, the five most prevalent were: Crisis of Professional Confidence/Feeling

Helpless; Becoming Desensitized/Disengaged; Intrusive Thoughts/Rumination; Depression; and Distorted World View.

### **Crisis of Professional Confidence/Feeling Helpless**

When speaking about a crisis of confidence one clinician experienced mid-career the clinician said:

I was just thinking...uh...20 more years of doing this, am I really helping anybody? I started questioning my own abilities, capabilities, and interests and just thought: I don't know if I want to do this for 20 more years.

Others echoed this sense of feeling professionally overwhelmed or helpless:

There were times when you sort of started to wonder if there was any point in trying to do this; I first hit that wall within the first five years. The depth of problems seemed so great I felt I wasn't making any difference and feels so broad while you're in it and it feels so intransigent.

Another clinician reported this feeling of helplessness, coupled with manifestations of somatic disturbance:

I had migraines 2-3 times a week; I couldn't sleep at night; I had a baby die under my services. I got to where I felt like: I just can't do this anymore.

Others experienced this helplessness connected to institutional stress:

There's less and less of the resources and more and more people who need them. Where am I supposed to go, which way? I try not to let that affect my mood, but sometimes it does.

Another clinician reflected on a particularly difficult time when attending a specialized training on Exposure Therapy:

I was pretty seasoned by that time, well trained, 3-5 years experience, an older student at that time. And even with all that I thought: “I can’t handle this, even with what I know.”

### **Becoming Desensitized/Disengaged**

Many clinicians reported that becoming desensitized or disengaged with their clients or loved ones was an indicator that they might be experiencing burnout, STS, CF, or VT. One clinician, who works with patients who have been hospitalized with an acute crisis said:

I start to notice that I don’t give a crap anymore and I don’t have any sympathy or empathy for people, like: oh you tried to commit suicide...uh...okay. Not really jaded, but just desensitized to it.

Another clinician, who works with women in a substance abuse program said:

It is difficult to continually listen to people’s stories of rape, of incest, and...not get hardened to it, I think at some point, I was kind of getting hardened to it.

I notice that I start to dread going to work, or I start to feel kind of numb...those are my signals, especially when it feels like a burden to do it. It’s like an emotional grayness comes over you and you start to wonder: Can I keep doing this?

Another clinician, on a different acute in-patient psychiatric unit in a hospital said:

I’ve got to be really aware of myself, not to seem like I’m being insensitive to people.

Sometimes I feel like I’m blocking out what people are telling me because I just want to go home and forget about it.

Another clinician, who works at an outpatient facility for adults with mood and anxiety disorders, said:



My energy, when my energy gets down, when my mood is flat, if I'm feeling bored or disengaged with clients I know I need to mix some things up or step in with some ways to take care of myself.

One clinician, who works at a clinic for traumatized children and families said:

My "wake up call" was when a parent, at the conclusion of our work together, said something to the effect of: "Thank you so much, you've helped me so much," really wanting me to know how much she appreciated the work that I do. Those are the moments that I usually cherish because I really like helping people and I like feeling like the work that I do makes a difference, and I didn't...care. And I don't mean that...it sounds bad to say that I didn't care, but that numbing, that emotional numbing...I just didn't care.

Though becoming desensitized or disengaged was a warning signal for many clinicians, becoming overly consumed by a client or case, as manifested by intrusive thoughts or excessive rumination was also a trigger or cause for concern.

### **Intrusive Thoughts/Rumination**

Several clinicians found that they were beginning to experience these phenomena because they were unable to maintain the boundary between their work and personal life, or "leave work at work," which they first noticed either by ruminating on certain clients or cases and/or having intrusive thoughts or nightmares. One clinician said that during the Christmas holidays she was with her family, but found that she kept thinking about several of her clients who all happened to have experienced significant loss in quick succession earlier that year:

I'm pretty good at separating what I do at work and not taking it home, but I just got slightly depressed, focused on it more, thought about it more. I couldn't help but think

about what their holidays were like. I felt for them in an over-identifying way, of course, we always feel some empathy, but I think I was just too focused on it for a while and did need to get some distance.

Another clinician noted that she found it difficult to go home from her job on the acute inpatient psychiatric unit at the hospital without thinking about events from that day or the weeks before:

I've certainly had intrusive thoughts when I came home and brought somebody home with me.

One clinician spoke of her struggles at a former agency when she was working on a research project that dealt with cases of child abuse, and the way that manifested similarly in her work with veterans:

I don't know, I guess I had a hard time not thinking about some of the kids or the situations, there was one kid in particular that I had fleeting fantasies about adopting...and now, I'm working with a different population, but it can creep in in similar ways, for example, I'll be at home with my family and suddenly find that I'm distracted from what I'm doing in that moment because I'm ruminating on someone's trauma story.

Another clinician had a combination of intrusive thoughts while awake and experienced interrupted sleep and bad dreams:

I started having nightmares when I slept and found myself thinking, at different points in the day: "I can't get that thought out of my head."

## **Depression**

Several therapists said that depression was an indicator that they might be experiencing burnout, CF, STS, or VT:

I was reaching a point where I just knew that there was something happening inside where I was getting more depressed. I take Celexa for depression—I'm a therapist, of course I'm going to have issues.

Another clinician, who reported rarely experiencing burnout, noted that depression was an early indicator of its onset:

I think I first start to notice that I'm feeling depressed, not feeling enjoyment in my work, then feeling like I want to sleep all the time and just a general personal negativity, which is unusual for me.

Although not all clinicians specifically identified depression, many listed manifestations that could also be signs of depression: loss of interest in formerly pleasurable activities, inability to concentrate, fatigue, etc.

## **Distorted World View**

Many clinicians noted that these phenomena were made manifest over the duration of their experience via cognitive distortions about their view of the world:

I'll kind of go to this place where I'll think things that I know to be cognitive distortions, like: "the world is this dark and horrible place" or "How can people continue to exist in the face of this overwhelming evil?" that kind of thing.

There's also this...barrage of things, not so much a particular kind of trauma but the depravity of humankind when they have certain kinds of stressors. When you hear about them day after day after day and then you feel like you've heard the worst of it and then

you hear something beyond even that. You begin to question whether you can really take care of yourself in light of what you're hearing every day.

I began to suspect that I might be experiencing vicarious trauma when I realized that I would see people on the streets and be shaking my head, like maybe not having the compassion towards them I once did. When I first started in social work, I felt like I could really save the world, but it didn't take long to realize that I couldn't. I used to have the view that there was good in everybody and I can find the good. And now my view is there are a lot of evil and crappy people in the world. Even though I love my job now, I still feel like I have more of a negative feeling towards humankind in general—and towards the work that I do—than I did when I first started.

These disruptions in cognitive schemas are consistent with indicators of the development of VT, which will be further addressed in the Discussion chapter.

### **Preventative Techniques and Protective Factors**

When asked what techniques or resources they used to prevent burnout, CF, STS, or VT, three or more clinicians said they utilized the following: Supervision; Individual Therapy; Peer Support; Time Off/Breaks; Establishing Firm Boundaries; Time Spent with Family/Social Support; Leisure Activities; Spirituality; Exercise; Self-Awareness; Autonomy Over Scheduling; and Experience. Of these, clinicians were asked to identify what they felt was their most effective and least effective techniques, which will be discussed in further detail later in this section. First, it is important to examine more closely the role of Supervision and Experience in serving as supportive or protective factors, though neither of these was specifically identified as

the “most effective” technique or practice, each was cited frequently during interviews as an important protective factor.

### **Supervision**

Eight of the thirteen clinicians said that they relied on clinical supervision to guard against burnout, CF, STS, and VT. Three of the respondents said that they had an excellent supervisor at work, and five said effective supervision was so important to them that they paid out of pocket for external clinical supervision when supervision was either lacking or unavailable through their employer.

Several clinicians said that one of the most significant aspects of their relationship with a work supervisor was feeling supported or understood:

I have a supervisor we put into place now, where she said: “If you are talking with a crying parent, come talk to me” that’s not an everyday normal experience, so you need to come talk to me after that. I’d just thought that was part of my job, but it was nice to have acknowledged that that level of emotion is stressful.

I have the luxury of being able to identify those early triggers because I have someone who cares and who isn’t going to judge me for having them because they’ve been there, or have their own manifestation of it. My supervisor is fantastic—she has done a lot of research—nothing published, but is just really well informed and does trainings here for the staff and creates an environment where it’s okay to talk about these things—she really *gets* it.

Five clinicians placed such a high value on quality supervision that they are currently paying or have paid out-of-pocket for external supervision when supervision at work was unavailable, compromised, or ineffective:

The supervision that I got when I was working on my licensed professional counselor certification was very good. I still have her. She is not a member of the agency I work for, so I pay out of pocket to continue seeing her, but it's worth it.

I have my own therapy/consultation person that I have been using to review challenging cases; I pay for that out of pocket because I can't get [my agency] to pay for it.

One clinician advocated for partially subsidized clinical supervision after taking time off as a result of burnout and compassion fatigue:

I was going through a really intense period of burnout and compassion fatigue and spoke with my administrative supervisor at work about the possibility of taking a leave or reducing my hours. She was supportive and I used FMLA to cut back to a four-day workweek for about six weeks. During that time off, I realized how much I missed having meaningful clinical supervision—I am the only clinical social worker in my department—and when I returned I advocated for myself for clinical supervision. I only get to go once a month, and my agency only covers the cost of alternate visits, so I pay out of pocket for it, but it is worth it. Clinical supervision is my number one tool...it is so fantastic, it's wonderful, it has made such a difference.

One clinician expressed the wish that the clinical social work licensing board would make clinical supervision mandatory for licensure renewal: “maybe that way, my agency will actually pay for it.” Her theory is not without support, as one of the few people who received effective clinical supervision—which was external, but paid for by her agency—was a psychologist who was required to have clinical supervision to maintain her license.

## **Experience**

Though no clinician stated explicitly that their experience was a protective factor, several made comments in the course of the interview that indicated how much their approach to self-care and prevention had evolved over the course of their careers.

One clinician, in practice for eight years, said:

Most of these things, I've learned with experience. When you do this for a while, you start to know your own triggers and your own tolerance level and you get to the point where you know you need to step back and take a break. Sometimes we want to keep pushing ourselves through because there's always more to do, but it's always going to be more to do. I think this is especially a problem for the very new or the very young, because I know that I had more difficulty with that when I was very new and very young. You think you can just keep on going and going and going until you flat out fall out and think: "What the hell is wrong with me?" I think over time, when you start to figure out your own triggers and your own buttons and you begin to realize that you need an escape, then you're better able to start telling people that that's what you need.

Another clinician, in practice for seventeen years said:

I'm thinking, too, about how different my answers would have been 10-12 years ago.

Thankfully, they're moving in the right direction.

Yet another clinician, with a decade of experience said:

I'm really good about setting firm boundaries around work and home life...I even have a ritual where I get into my car and take my ID off and start my car and visualize leaving all of my "work stuff" here before I pull out of the parking lot. I'm pretty good about

being able to leave work “at work” consistently. It took years to get to that point. After you practice for a few years, you learn how to separate more.

### **Most Effective and Least Effective Techniques**

Clinicians were asked to identify the most effective and least effective techniques utilized to guard against burnout, CF, STS, or VT. The top three most effective techniques identified were Peer Support/Peer Supervision, Spirituality, and Exercise.

#### ***Peer Support/Peer Supervision***

Peer Support/Peer Supervision was cited again and again as significant resource for clinicians. Clinicians who were either in small agencies or on smaller teams felt supported by their coworkers or team and often sought them out for support with challenging cases or clients and/or to review interventions or treatment plans to see if they could be more effective. Their coworkers were also often cited as significant factor for the clinicians continued engagement with and interest in their work. One clinician said:

The most effective technique for me...is probably being able just to talk and listen where there is a give and take with another clinician where we really are trying to figure something out, especially when one of us comes up with something significant that one of us has missed, I find that very energizing.

#### ***Spirituality***

Four of the respondents said their faith and spiritual practices were the most effective technique they used to guard against burnout, CF, STS, and VT. One clinician said that waking up early beginning her day with prayer and meditation helped her feel grounded before going into work. Others cited their religious beliefs and spiritual faith as a source of strength in the face of challenging work.



### *Exercise*

Four of the respondents noted the benefit of a regular exercise routine. For some, this included bodywork found in mindfulness practice, like yoga, or reiki. Other clinicians found that the endorphin release from endurance activities like running outside or on the treadmill helped to improve their mood.

The “least effective” techniques were more widely dispersed. A short list (with the number of respondents that cited each in parentheses) included Workshops/Training (1), Work Supervisor (1), Substance Use (2), Peer Consultation (1), Exercise (2), Family/Social Support (1), “Zoning Out”—watching youtube, internet browsing, etc. (1), Sleep (1) and “Pushing Through” (1).

Clinicians were also asked to identify what, if any, techniques they wished they used, but did not. Five clinicians said that there were no techniques they wished they used, but were not currently using, and an equal number said that they wished they exercised more or had a mindfulness practice. Those who said they wished they exercised more acknowledged that they felt better when they routinely exercised and knew on an intellectual level the reasons that it was supportive (endorphin release, etc.), but they did not enjoy exercising, so they had some resistance to routinely engaging in these activities. Those who said they wished they practiced mindfulness cited a lack of training and the prohibitive expense of professional training in mindfulness as reasons that they do not currently have a mindfulness practice.

### **Graduate-Level Information and Training for Vicarious Trauma**

When participants were asked if they received any information about VT or how to prevent it while in school, nine clinicians said they received no information in graduate school or

could not remember; three said they had heard it mentioned, but could not remember receiving any formal education or information about it; and only one clinician said that she did receive information about vicarious trauma while in graduate school. One participant, in a comment representative of those who said they heard it mentioned, said:

I feel like we had to have had discussed it...because I've definitely been aware of the concept and all that...I don't think we had a whole class on it or anything like that, but I'm pretty sure we discussed it.

The clinician who reported that she received training was a psychologist and said:

They did talk about it...they had a lot of clinical faculty and four of them have had a private practice and they talked about how much you need to watch what you're doing, notice when you get burnt out, how you need to take a break, a lot of them used techniques...they really made sure that we were taking time for ourselves, so it was nice that they did that kind of coaching with us.

Participants were also asked if they felt that awareness of burnout, STS, CF, and VT and the skills or techniques needed to prevent them were effectively addressed in educational settings. Two of the respondents said that they felt like these issues were effectively addressed in graduate school and ten of the respondents said they were not effectively addressed.

### **Most Effective and Least Effective Practices Learned in Graduate School**

The clinicians who responded that they had garnered at least some awareness about VT in graduate school were asked what was the most and least effective training or information provided to them.

### ***Most Effective Training or Information***

Two clinicians felt that the most useful resource for learning about VT was through the supervision they received at their internships or field placements:

My supervisors were helpful in that regard. The university didn't know if we were getting that; they just hoped that we were. And my second field advisor was very good about really modeling it.

The therapist who indicated she had received training said that she and her peers in the program, though appreciative of the coaching from their professors, found the most helpful information they received was the encouragement to seek individual therapy:

Most effective for me was having a therapist. Our professors all said it would be important, both to manage our stress in graduate school, but also because it would make us better therapists. We all ended up getting a therapist. I think all of us were reluctant, but then it really did help.

### ***Least Effective Training or Information***

Two clinicians identified the workload and pressure of graduate school as counterproductive in terms of learning how to establish healthy boundaries and practice self-care. One clinician spoke about a group therapy class she took, which was a process group for students in the program:

I felt like we were being squeezed, we didn't have enough support in there and I stomped around like a two year old. I had a total meltdown. So, there was talk of self-care, talk of vicarious trauma, but there was very little information about practical skills for prevention or management of these things, and very little modeling as well.

One clinician said the least effective information she received was a warning that they would all burnout in less than five years.

It was very upsetting...I really wanted to find a way to be successful in this profession and enjoy the work, I had put in all this time and money and then this professor says we will all burn out in less than five years and I thought: “Well that’s very helpful...*not*.”

### **Suggested Improvements for Graduate School Programs**

The two most prevalent suggestions for improvement at the graduate level were increased awareness and practical “how to” training. Five clinicians encouraged raising awareness about the prevalence of burnout, CF, STS, and VT for clinicians who do trauma-focused work, with a special emphasis on normalizing or reducing the stigma associated with having this experience as a professional. Six clinicians said they felt it was a significant enough issue that there should be a class on vicarious trauma and self care, with practical suggestions for how to implement certain techniques. Of these, some felt that it should be a stand-alone course, and others felt that it could be meaningfully integrated into a practice course, but all felt this would be a useful course, both in terms of learning practical applications and in raising awareness and normalizing the experience:

Graduate school was about helping everybody, but not about helping yourself while you’re helping others. I think that is an important part. I think that should be a separate course in graduate school, devoted to self-care for the professional, and include all these different things that would be beneficial to a person that’s working in a very demanding profession, because it is very demanding.

We didn't really get a chance to process except in individual supervision, and, depending on your supervisor, that was more useful to some than others. It's definitely not talked about enough, or at least not in a particularly meaningful way. I think it should be part of a required curriculum, not necessarily a whole course on self-care and vicarious trauma, but making it a part of course work and a part of preparing students. It is especially important in preparing people to go into fields where there are high levels of burnout, turnover, and institutional stress. To help people prepare for that by having it be a more formalized part of course work would be good.

It would have been helpful to have more practical information and encouragement about how to practice self-care. I think a lot of academic settings abdicate responsibility by assuming this is the "best and brightest"...they assume we know how to take care of ourselves, but few people have had the kind of experiences in life that will prepare them for the traumatic material they are going to hear from some of their clients. I think it would be helpful to get that training in the classroom setting because some people got lousy help in their internships. I felt fortunate I got what training I had because some of my cohorts did not, and few of them are still in this field. It has to be handled in a more formalized way.

Though twelve different graduate programs were represented by this sample of participants, and all but one of them either did not receive education or training about VT (or could not remember what they had received, beyond having heard the terminology), two clinicians offered anecdotal evidence to support their hope that this might be improving. These clinicians said that, in recent years, the interns they have supervised either had an established

mindfulness practice or adhered to really healthy boundaries—they left work at 5 PM, they took mental health days when needed, etc.

### **Agency-Level Information and Training to Prevent Vicarious Trauma**

Clinicians were asked if any of the agencies they had worked in since the completion of their degree had offered education or training on VT or self-care techniques, or have policies and procedures designed to mitigate the risk of VT. Eight clinicians said they had never received any education or training at the agency level and that supportive policy or procedures were not in place. Four clinicians said that they had some training or education at their current agency, but none at their former agencies. Only one clinician said that she received targeted training, which was related to her training in trauma-focused cognitive behavioral therapy. One clinician noted that, though there were no “official” trainings or supports, there was a counseling department that would provide eight therapy sessions to support employees dealing with acute personal or professional problems. Though the services provided by the personal assisted service for employees were reportedly excellent, the clinician lamented that the program was often implemented in a reactive, as opposed to proactive, way:

I'd like to try to incorporate awareness about this in a more meaningful way in this system...people are very vulnerable to [VT], we all are. But there is no built-in support or awareness for self-care. It's only when you start fumbling and then you get referred to the personal assistance service and then they say: 'Uh...we insist that you work 20 hours.' That's the only way, there's not 'please watch yourself and take care' it's like: 'Oh, you've fallen down, shame on you, this totally different...'

When asked if they felt that awareness of burnout, STS, CF, or VT and the skills and techniques needed to prevent them are effectively addressed in their current or former agencies, eight clinicians said no; three clinicians said sometimes, depending on the agency; and two clinicians said yes.

### **Most Effective and Least Effective Agency-Level Practices or Interventions**

The clinicians who responded that they had training opportunities or supportive policies in place at their agencies were asked what was the most and least effective training, policy, or procedure.

#### *Most Effective Agency-Level Practices or Interventions*

The most effective interventions or practices reported by clinicians at the agency level were: A Culture of Support, Training Opportunities, and Supervision. Creating a “culture of support” proved effective at either an agency-wide or team level, whether it was done through “official” channels like hiring practices, or through more “unofficial” practices like creating a family environment that fostered concern and care for coworkers. One clinician said:

I think the director of the center is fantastic and it makes it the kind of place where that can exist. And the person who hires people here seems to be able to identify people that are aware, sympathetic, and supportive of their coworkers.

Another clinician, who worked at a long-term residential youth rehabilitation facility said:

I think that overall we might not use that term [VT] here, but overall, just being aware of needing to support each other, there’s a lot of team stuff, and working collaboration, treatment teams, etc. And then there are other things that might

seem small but make a difference. We have potlucks that help us to kind of have a time to support each other, or there was some little thing where the staff was writing notes about another staff did something nice for them, and then we would have a drawing and get a prize. The director, when it snowed, he went out with some kids and they put blankets on all of the cars in the parking lot—we're all mandatory report employees, so we had to be here—but they covered all the cars up and we made hot chocolate, so we do stuff to make us feel like a family so that in our down times we support each other.

Several clinicians also found training helpful, even if it was not targeted specifically towards burnout, STS, CF, or VT, as long as it was relevant to their jobs and they found it interesting. One clinician noted that one of her favorite things about her former job was the number of trainings offered on-site: “I really enjoyed the trainings they offered. I got a lot of continuing education credits there.”

Training specifically targeted towards burnout, STS, CF, or VT was only found to be helpful if it was done in a sincere and supportive way, as opposed to feeling, in the context of the agency, as though it were something done to “check off a box” or something for which there was lip service but no follow through:

I guess there probably was superficial training in it at the VA where I interned, but that place was...the people who were there were quite punitive and evaluative. Here it was done in a meaningful way in a supportive environment. If you know no one else is taking it seriously, then it's like diversity training where the person next to you is snorting.



Another clinician appreciated the trauma-focused training and follow-up provided to her agency, which worked with at-risk adolescents:

We have had some trainings here where we've had people come in, because we're really trauma-focused here, so we've had people come in to discuss our work with trauma victims and how we have to be aware of how we're effected by that.

Those who found supervision effective had empathetic or supportive supervisors with whom they felt trust and mutual respect. This was especially true of supervisors who were familiar with burnout, STS, CF, or VT, and created a supportive environment within supervision and fostered awareness in the workplace about these issues through presentations and training opportunities.

#### ***Least Effective Agency-Level Practices or Interventions***

Clinicians reported that the least effective agency-level interventions or practices were: Institutional/Structural Stress; "Lip Service" or Lack of Support for policies designed to mitigate burnout, STS, CF, or VT; and Ineffective Supervision.

Institutional stress was pervasive across different agencies, and could vary depending on the person's role within the agency as well as shifting leadership, client population, or a change in ownership or management. Though some systemic stress is outside of the scope of control of the agency itself, the impact on clinicians and administrators is pronounced, and the culture that this kind of institutional stress can create can impact client care and clinician self-care in significant ways. One clinician, who worked in an acute in-patient psychiatric unit in a hospital that had recently changed leadership said:

I used to really like this job. Then a new C.E.O. started in the fall. We now have very high acuity patients... some of them come straight out of prison. They are very difficult and very dangerous. We have to keep a "full census"—all beds full at all times. It is all profit driven, patient care is secondary at best... and it's not in line with my values. It's just keeping the puppy mill moving. Institutional stress is really why I'm not happy at my job.

One clinician, who has worked in public health for over two decades, commented on the shifting landscape brought on by corporate health care providers<sup>1</sup> said:

It's really shitty, what's going on with mental health. [Company Name] took over a year ago. When a big huge company runs something...it's inferior, it's completely inferior and the consumers are losing. They are not taking anybody that does not have a SSN, so it's really hurting the Latino community. People who have insurance, the system is extremely cumbersome...just many, many, many, many steps to go through and my understanding is that people are choosing not to sign up with [company name], they are just doing fee for service kind of stuff. It is compromising client care and patient care.

One participant, who served as both a clinician and as an administrator, echoed this frustration with the systems in place that interfere with or limit client care in seemingly arbitrary ways, and pose the greatest challenge to keeping the agency open, which the clinician cited as a source of near-constant anxiety:

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<sup>1</sup>The company in question's website writes in their "About Us" section: "As the business behind healthcare, [Business Name] helps pharmacies, hospitals and ambulatory care sites focus on patient care while reducing costs, improving efficiency and quality, and increasing profitability.

In 2001 they privatized services in North Carolina. Some of the changes that came from privatization involve greater accountability, which is a good thing, but also involve some standards that are unrealistic. If you say these standards are unrealistic you get criticized for that, but some of these criticisms were unfounded and, frankly, unfair. There was an occasion last year where that unfairness was made more manifest to me than it had been previously and that made me just feel like why in the world am I continuing doing this? These structural changes just seem to me to just be unnecessary and they draw money away from direct services. Instead of making access clearer it makes it more complicated. Consumers are more confused than ever about how to access care, especially when it comes to children's services.

One clinician voiced frustration over feeling pressure internally when she has no control of the external resources that are limiting her ability to effectively discharge patients from the hospital:

I cannot discharge someone unless they have somewhere to go when they leave. We have so many people who come to psychiatric care at the hospital who are also homeless. What happens when there aren't any resources...people end up staying in the hospital longer and then it's like: "Why can't you get them out, what's the matter with you?" and my response is "well...there's nowhere for them to go." And if the hospital loses money, then, guess what? They make more cutbacks, and we lose more staff. We're supposed to have two full-time social workers at all times, and I've been the only one on staff for months. So there you go...it just gets more manifested.

Another clinician, who worked at a family care facility with pregnant women or mothers with substance abuse issues said:

So we are famous for talking about self-care but don't do it very well. In some ways, depending on your job structure, it can seem as though social work has the right idea about self-care but the nature of the work we do here doesn't provide a lot of opportunity for self care. We carry a 24-hour pager here, so it can really feel tough to do that.

One policy that is more directly affected by agency-level practices is "Lip Service"/Lack of Support for stated policies that are supposed to support clinician self-care. One clinician said:

They say you can take mental health days, but it comes out of your vacation and, though it's technically allowed, they are not very supportive of it.

Another clinician echoed this experience:

I don't think there should be lip service. For example: the research hospital that oversees my agency has a generous vacation package, but I don't know anyone who feels really supported when they want to use their benefit time. Things like that make me angry: it starts to feel like window dressing; not backed up by reality.

One clinician lamented the lack of sustained agency-level engagement. She was thrilled when her agency, at her suggestion, took a proactive step for self-care and brought in expert practitioners to train the staff in mindfulness-based stress reduction (MBSR):

Initially, when we pulled the MBSR people over here, the idea was that they would train all of the clinicians and staff, including the psychiatrists, over these two weeks, and that we would intersperse and use them with each other, but there was no follow through or reinforcement of it, so it fell away.

The importance of effective supervision was discussed earlier in this chapter, but this relationship was further complicated at the agency-level when there was a perception of a lack of enthusiasm on the supervisor's part or, particularly, when the clinician felt there was a conflict of interest. One clinician voiced her frustration that her supervisor was also the head of risk management for the hospital:

I have no connection to my supervisor at work. She is not empathetic or engaged. I do not experience her as being clinically minded. She's always worked in a hospital setting. I think having a supervisor where you work can be... I think you have to be very careful what you say in the work setting. I mean, for crying out loud she's in charge of risk management over at administration; she wears two hats.

One clinician, who is required to have supervision at work, also pays out-of-pocket for external supervision because, though she feels her supervisor is generally supportive, she does not feel that the supervision offered at her agency is particularly effective: "I have an 'official' supervisor by default I call him 'my reluctant supervisor' because somebody had to do it."

Another clinician, who also paid out-of-pocket for external supervision, expressed frustration with the high turnover for supervisors at her agency, and the diminishing level of experience with newer hires:

They had very experienced supervisors at my agency, and they've gone less and less and less and less experienced so that now, supervisors may have less experience than me, or maybe not even have their license. I've kept the supervisor I used for my LPC [licensed professional counselor certification] because she's wonderful.

### **Suggested Improvements for Agency-Level Practices or Interventions**

The clinicians interviewed had a number of suggestions for improvement in agency-level policies or interventions. The three most prevalent were: “Top-Down” Buy-In; Creating a Culture of Support; and Acknowledgement/Appreciation.

#### ***“Top Down” Buy-In***

Several clinicians expressed a desire for more “top-down” support around self-care issues, from policy changes to a wish that upper-level employees would model self-care behavior as a way to create support for it throughout the agency. One clinician expressed a wish that all supervisors would be trained in vicarious trauma so that they could be both more aware and more empathetic when it was happening for employees. Another clinician said: “There should be policies and procedures that are helpful, but I think there needs to be real buy-in all the way down and out for it to be really be effective.” One therapist, who worked in a clinic for traumatized children, praised the many things that the agency does well in terms of self-care—supportive supervisors, holding an annual didactic on the topic of vicarious trauma, etc.—and then suggested that it might all be made more meaningful if supervisors and directors really modeled the behavior they were promoting:

I think it's important that people on higher levels think about what they're modeling. It would be great for them to incorporate a practice of modeling self-care because there are a lot of dedicated people here at every level that work too hard and maybe don't practice what they preach in terms of self-care.

The one administrator who participated in this study admitted that it was a topic that was challenging to address or model because, though the clinician rarely experienced burnout because of an innate resiliency, the clinician admitted to not necessarily having "very good ways to deal with it." When asked what could be done at the agency level to improve support around these issues the clinician replied, "Honestly, I don't know. I haven't thought about it much, and this is the most I've ever talked about it." This clinician was not lacking in empathy, and agreed to participate, in part, because of the opportunity to talk about it in order to get a better handle on it personally and hoped to learn from the interviews I had conducted with other participants in order to be a better source of support for the clinicians at the agency.

### *Creating a Culture of Support*

Several clinicians expressed a desire to have increased awareness, normalizing and a general "culture of support" around burnout, STS, CF, and VT.

One clinician related a transformative experience she had at a work-related training out-of-state, and the way that it enabled her to model supportive behaviors and increase awareness when she returned to work:

I went to this workshop on PTSD in Cape Cod and the guy who spoke was an expert in the field and he said: "So what? So you cried in front of a patient," and I suddenly felt okay about having had that experience. Suddenly, I knew that

having an affective response 1. is not taboo, 2. can be useful information for me within a therapy session and 3. might be something I need to discuss in supervision. Even knowing that, having him say it still felt pretty good because he's renowned like, "he's one of the APA's greatest therapists ever" kind of guy, so it felt good. A few months later, there was a clinical team meeting and someone brought up that they had an impulse to cry in front of the patient I felt a sudden tension in the room, so I shared what the APA guy said at the training and said that I, had, on occasion, cried in front of patient. It was like the tension immediately diffused. Afterwards, a lot of people came up to thank me for saying that, and said that it made them feel less alone.

Another clinician thought that, in addition to making an existing didactic mandatory, an employee process group might be effective in creating peer support and fostering awareness:

I think most people who work here have been to many of the didactics but I think making sure everybody attends the one on VT is pretty important. We've kind of been talking a lot about what else we could do. I think it could be helpful if we had an ongoing group that meets to talk about it or some other way to kind of encourage it or to make sure we're taking care of ourselves.

A few clinicians suggested introducing a survey or some kind of monitoring tool for agencies to assess the level of burnout, STS, CF, or VT in their clinicians, but cautioned that it would have to be anonymous—so that clinicians could feel secure about answering honestly without having to fear retribution or any type of punitive response. They also stressed that the goal of monitoring or assessment would be to create improved



support for clinicians and increased awareness at the agency, as opposed to operating as a means of risk assessment. One clinician said that she would love to see an agency-specific assessment/intervention model implemented:

I would love to have anyone doing clinical work take a confidential survey and then have you give a report back, with a ranking for mental health in the department and then recommendations about how to improve.

### ***Acknowledgement/Appreciation***

One of the areas that clinicians found lacking at the agency level was the sense that the work they did was valued and appreciated. One clinician said: “my administrative supervisor makes me feel undervalued,” which often gave rise to anxiety about whether or not her job would be protected if there were future budget cuts. One clinician reflected on having felt unappreciated by her supervisor at her previous job, only to learn later that the supervisor found her work exemplary:

I was at DSS and, while I was there, I felt like my supervisor was unsupportive and disapproved of my work. After I left, whenever I met clinicians who worked there, they would hear my name and say: “Oh, *you’re* [name]! [Supervisor] talks about you all the time! She’s always talking about how much she misses you.” I was her superstar but didn’t really know it until I was gone. Why didn’t she tell me that when I was there?

Supervisors may think this kind of praise is almost such a small thing as to be ineffective, but those that felt unappreciated had either left the agencies where they felt undervalued or were actively seeking other employment. The clinician who worked at DSS felt that, though that was a very challenging job, much of the institutional turnover

at the agency was related to the dysfunction of the agency itself. In her present job, she works with a similar population, but feels much more supported by her peers and much more appreciated by her supervisors and is very happy.

Another clinician indicated that she has learned to manage without praise from her superiors, but the lack of a pay raise in seven years was more challenging to accept:

You have to be a certain kind of person to be a therapist, or to be in this environment, because you don't get a lot of support or people telling you that you did a good job, but you have to be the kind of person who can be okay with that and get the satisfaction in other ways. The thing that bothers me most is: I've been at this job 7 years and I've never gotten a raise. That is a big source of burnout for me.

Clinicians also stressed that any type of appreciation or acknowledgement had to be sincere, in keeping with the needs of the clinicians, and not just a hollow gesture. One clinician, who had been working in an understaffed department for months said:

They try to do these little things, but it doesn't help. It's almost demeaning in a way. Like: "Oh, here's a pizza." That's demeaning...that's something you do for little kids. I don't want pizza; I want to be fully staffed.

### **Agency and Community Support**

It is important to note that when asked: *Do you feel that prevention of VT is most effectively addressed at an individual level, an agency/institutional level, or both?* eleven of the thirteen surveyed clinicians said that it could not happen exclusively at the individual level, or exclusively at the agency level, and that it must happen at both levels to be effective. The

participant who was also an administrator said: “I don’t have much experience with it at an agency level, I don’t necessarily know what that would look like, but ideally it would be done in some way at the agency level, which would include individual practices.”

Clinicians were also asked if they felt like they belonged to the community of the discipline, and, if so, whether or not they relied upon that community for support related to issues of burnout, STS, CF, or VT. Eight clinicians said that they felt as though they belonged to the community of their discipline, four said that they more strongly identified with their fellow clinicians at their agency, and one said that she did not particularly identify with her discipline and felt she had not collaborated with her peers as much as she could have. Those who most strongly identified with their professional peers were more likely to rely upon that community for professional support—including meeting for peer processing groups, participating in conferences, and having active involvement on a professional community listserv. Those who more strongly identified with their agency cited the quality of peer support they received at their agency as their primary community of support. One clinician noted that she more strongly identified with her peers at her agency because she felt like it was a more supportive and less competitive environment than her broader professional community:

I don’t know, in general, that I feel that I belong among psychologists or the APA (I’m not even a member) but here, I feel like I belong in this research community. I feel like psychologists in general, we, like, eat our own, we’re very competitive and, you know, “oh, psychodynamic is just bunk, it’s stupid” and the psychodynamic people are all: “oh, those CBT people are too rigid” I’m not sure...that within the larger community meaningful support is there. But I really feel that support at this agency.

## Compassion Satisfaction

This study also aimed to learn more about how compassion satisfaction—the sense of satisfaction many professionals derive from helping others (Stamm, 2002)—serves as a protective or supportive factor for trauma-focused clinicians. Each clinician was asked: *What keeps you engaged in your work with clients?* Clinicians cited a range of motivating factors, including: the relationship with the client; human interest; being able to watch a client’s progress and growth; a desire to help; the support of their peers; and a genuine love for their job. One clinician said:

I think for me the work I do is...so not a “job”...it’s hard to talk about it without using words that seem so drama laden, but it really does feel more like a calling to me. And I get paid to do it, which is great!

Of those listed, the most frequently recurring responses were related to watching client progress/growth and a deep and abiding desire to help people. Nine respondents listed one or both of these as motivating factors. One clinician said:

I just don’t enjoy seeing people in pain and I know there are actually things that help people heal and that’s what keeps me in the job. I have seen healing and it’s just wonderful to see people becoming more of who they were made to be. It’s kind of like those cool time-lapse photos of flowers blooming... who doesn’t want to watch that?

One clinician, who works in a residential youth facility, spoke about being inspired by her clients’ abilities to heal after trauma:

I’ve seen girls and guys talk about things and overcome things that I don’t see how it could be possibly human that someone would do that to them and it’s incredible. To see how much they grow and heal is amazing.

Another clinician spoke about the privilege of working with her clients and how she was able to incorporate what she learned from them when she faced challenging moments in her personal or professional life:

I feel very blessed to be with people and learning with them and going through what they're going through. To be part of that process is so valuable to me because then I can help other people and then, certainly, when I hit one of these damn roadblocks, it's like I've already had all this exposure and wisdom that I can tap into.

One clinician spoke about how rewarding it is to help people move through the process of healing, and how awed she was by the opportunity to question, through her work with clients, what it is to be human, what it means to be forever altered by trauma, and how to come to a new understanding of your essential self:

It's wonderful when I think I can help someone move closer to rejoining with the community because there's so much isolation in PTSD, but I think what's really engaging to me about it is a little more selfish. It is that almost existential question of what it is to be human, because people in the face of trauma...change...and what is it that can bring them sort of back to feeling more human? What is it that changes in them, biologically, emotionally, and cognitively? And what is the essence of the person that is left, and is there even an essence of a human being in there that is not affected by it? I don't know, but I think it's at the heart of being human and maintaining the goodness, you know? It's so awesome when I see people moving through it, it's such an honor to be a part of that process.

Almost every clinician said that, though their jobs were challenging, they found the work so rewarding that they could not imagine doing anything else.

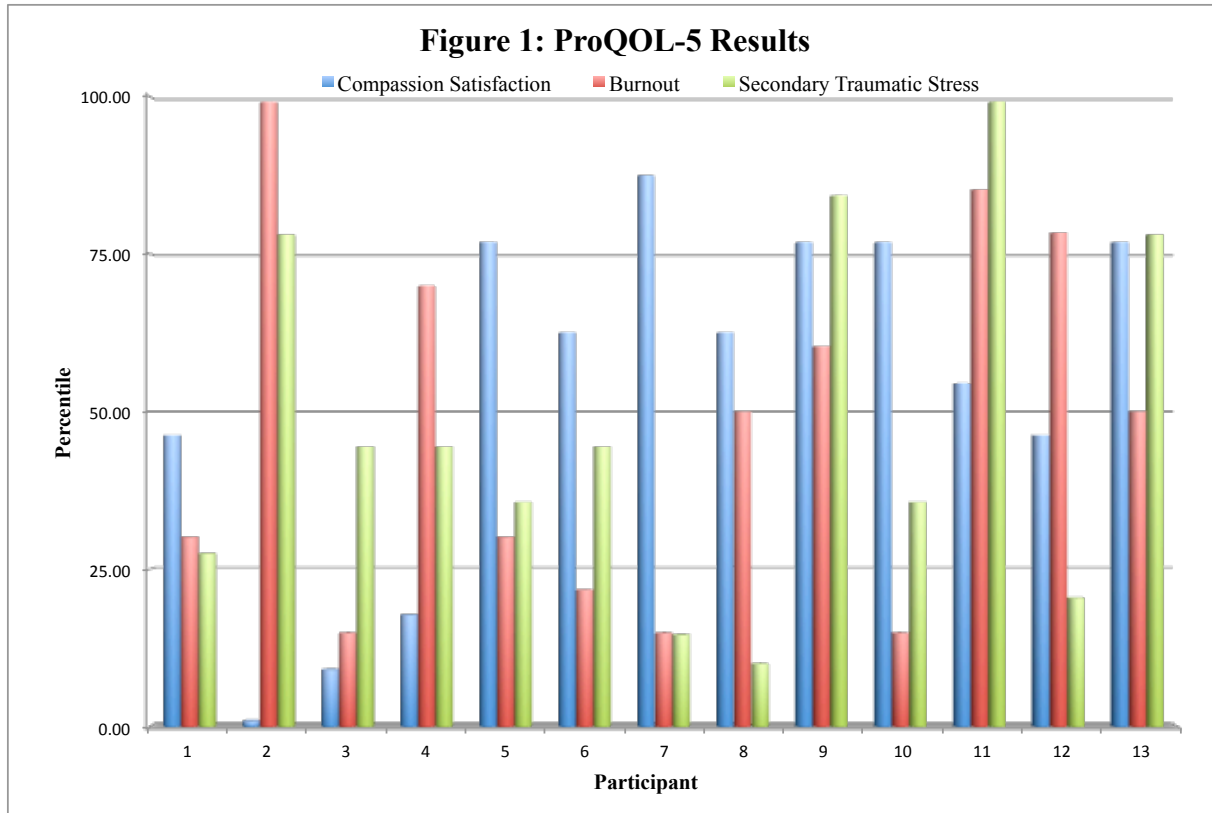
## ProQOL-5

Harrison and Westwood (2009) used the ProQOL-III (an earlier version of the ProQOL-5) to screen potential study participants for burnout and compassion fatigue. The present study did not use the ProQOL as a screening tool, as doing so may have introduced an unnecessary barrier to participation, and may have added considerable time to the data collection process. Though the sample size for this project was too small for the ProQOL-5 results to be broadly generalizable, the data was normalized (in accordance with ProQOL-5 scoring measures) to ensure a standard distribution of scores, allowing for comparison of participants' levels of compassion satisfaction, burnout, and STS. In this way, the ProQOL-5 results provide useful comparative statistics and descriptive measures for the participants.

## Results

The results of the ProQOL-5 are summarized in the following tables:

| Table 1: ProQOL-5 Results |       |       |       |       |       |       |       |       |       |       |       |       |       |
|---------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Participant               | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | 13    |
| CS Raw Score              | 40    | 29    | 34    | 36    | 44    | 42    | 46    | 42    | 44    | 44    | 41    | 40    | 44    |
| CS T Score                | 49.04 | 26.24 | 36.60 | 40.75 | 57.34 | 53.19 | 61.48 | 53.19 | 57.34 | 57.34 | 51.12 | 49.04 | 57.34 |
| CS Percentile             | 46.19 | 0.88  | 9.02  | 17.75 | 76.84 | 62.51 | 87.45 | 62.51 | 76.84 | 76.84 | 54.44 | 46.19 | 76.84 |
| CS Range                  | Avg   | Low   | Low   | Low   | High  | Avg   | High  | Avg   | High  | High  | Avg   | Avg   | High  |
|                           |       |       |       |       |       |       |       |       |       |       |       |       |       |
| BO Raw Score              | 20    | 31    | 18    | 24    | 20    | 19    | 18    | 22    | 23    | 18    | 26    | 25    | 22    |
| BO T Score                | 44.78 | 73.50 | 39.56 | 55.22 | 44.78 | 42.17 | 39.56 | 50.00 | 52.61 | 39.56 | 60.44 | 57.83 | 50.00 |
| BO Percentile             | 30.08 | 99.06 | 14.81 | 69.92 | 30.08 | 21.67 | 14.81 | 50.00 | 60.30 | 14.81 | 85.19 | 78.33 | 50.00 |
| BO Range                  | Avg   | High  | Low   | Avg   | Avg   | Low   | Low   | Avg   | Avg   | Low   | High  | High  | Avg   |
|                           |       |       |       |       |       |       |       |       |       |       |       |       |       |
| STS Raw Score             | 19    | 25    | 21    | 21    | 20    | 21    | 17    | 16    | 26    | 20    | 32    | 18    | 25    |
| STS T Score               | 44.01 | 57.75 | 48.59 | 48.59 | 46.30 | 48.59 | 39.44 | 37.15 | 60.04 | 46.30 | 73.77 | 41.73 | 57.75 |
| STS Percentile            | 27.47 | 78.07 | 44.40 | 44.40 | 35.58 | 44.40 | 14.54 | 9.94  | 84.22 | 35.58 | 99.13 | 20.40 | 78.07 |
| STS Range                 | Avg   | High  | Avg   | Avg   | Avg   | Avg   | Low   | Low   | High  | Avg   | High  | Low   | High  |



### ***Burnout***

Stamm (2010) notes that, though most people have an intuitive idea of what burnout is, it is defined in the ProQOL-5 as “the part of compassion fatigue that is characteristic of feelings of unhappiness, disconnectedness and insensitivity in the work environment” (p. 21). Onset of burnout is usually gradual and may be indicated by the feeling that “your efforts make no difference” or that your work environment is non-supportive.

A t-score in the low range indicates positive feelings about one’s ability to be effective in their work. A t-score in the average range indicates that the person carries no significant feelings of being “bogged down” or ineffective either as an individual or within the organization; their peers and patients likely perceive them as a reliable source for assistance (Stamm, 2010). A t-score in the high range indicates a feeling of inefficacy due to personal or organizational factors,

which could be the result of high workloads or poor system function. The person may feel as though there is “nothing they can do” to make things better, this may be manifest clinically as disengagement with their clients. People with high burnout scores may benefit from time off, and organizations whose staff has high levels of burnout should examine opportunities for organizational change that better support their employees (Stamm, 2010).

Generally, 25% of people have a t-score score above 57 (75<sup>th</sup> percentile) and about 25% of people have a t-score below 43 (25<sup>th</sup> percentile). Four of the participants in this study scored in the low range for burnout (25<sup>th</sup> percentile and below), six participants scored in the average range (between the 25<sup>th</sup> and 75<sup>th</sup> percentile), and three scored in the high range (75<sup>th</sup> percentile and above). Those who scored in the low range for burnout reported that the most effective individual self-care or preventative techniques they utilized were peer support, time with family, spirituality, and exercise, and the most effective agency-level interventions were supervision, a “culture of support” and training opportunities. Every clinician who scored in the high range for burnout experienced institutional stress, and several lamented ineffective supervision and a lack of support or “lip service” for existing agency policies to mitigate symptoms of burnout, STS, CF or VT.

### ***Secondary Traumatic Stress***

Stamm (2010) conceptualizes STS as “an element of compassion fatigue characterized by being preoccupied with thoughts about the people one has helped” (p. 21). The symptoms of STS are usually sudden onset and related to a specific event. Symptoms may include being afraid, having difficulty sleeping, intrusive images, or avoiding places or activities that remind one of the event.



A t-score in the low to average range indicates that the person does not suffer from any noteworthy fears related to their work. Those in the average range may not experience fear related to their work, but may benefit from opportunities for engagement or continuing education. People who score in the high range are typically overwhelmed by fear related to taking care of others who have experienced trauma. They are likely to benefit from immediate treatment for trauma (and depression, when present). Interventions might include diversifying the clinician's caseload, making changes in the work environment, and introducing or reinforcing safety measures (Stamm, 2010).

Generally, 25% of people have a t-score above 57 (75<sup>th</sup> percentile) and about 25% of people score below 43 (25<sup>th</sup> percentile). Three participants in the study scored in the low range for secondary traumatic stress (25<sup>th</sup> percentile and below), six participants scored in the average range (between the 25<sup>th</sup> and 75<sup>th</sup> percentile), and four scored in the high range (75<sup>th</sup> percentile and above). Those who scored in the high range for STS reported in interviews that they experienced institutional stress, had ineffective supervision, and their agencies showed “lip service”/lack of support for existing policies to mitigate symptoms of burnout, STS, CF, or VT. Those who scored in the low range for STS reported the protective factors of: training or continuing education opportunities, a “culture of support” and awareness among the staff of issues related to these phenomena.

### ***Compassion Satisfaction***

Compassion Satisfaction, as noted earlier in this chapter, is about the pleasure one derives from being able to do their work well. A person who scores in the average to high range likely receives positive reinforcement for their work; they feel skilled and successful and are invigorated by their work. They are happy about the work that they do and believe that their

work makes a difference (Stamm, 2010). A person who scores in the low range might benefit from time off, continuing education, or opportunities to engage in meaning-making about their work.

As with the other subscales, about 25% of people have a t-score above 57 and about 25% of people score below 43. Five participants scored in the high range for Compassion Satisfaction (75<sup>th</sup> percentile and above), five participants scored in the average range (25<sup>th</sup> to 75<sup>th</sup> percentile), and three participants scored in the low range (25<sup>th</sup> percentile and below). Those who scored in the low range for compassion satisfaction also cited institutional stress and “lip service”/lack of support for existing policies to mitigate burnout, STS, CF, or VT in interviews as part of the “ineffective” agency practices or policies. Those who scored in the high range reported in interviews that they regularly engaged in effective supervision, spiritual practices, and training to prevent or mitigate burnout, STS, CF, or VT and felt that they had a “culture of support” around these issues within their agency.

## **Summary**

These findings represent the perspectives of thirteen clinicians whose caseload is primarily comprised of clients with trauma-focused clinical needs. Participants’ insights have been coded and categorized according to the major themes of: Self-Care; Stigma; Manifestations; Preventative Techniques and Protective Factors; Graduate-Level Information and Training; Agency-Level Information and Training; Agency and Community Support; and Compassion Satisfaction. The following discussion will further analyze the content of these overarching themes in the context of earlier research related to CSDT, VT, and Compassion Satisfaction. Implications for future research and practice will be discussed.

## **Chapter V**

### **Discussion**

#### **Introduction**

This study's findings are directly related to the following questions: *What training are trauma-focused clinicians receiving at the graduate or professional level to prevent burnout, STS, CF, and VT? And which individual, agency, and institutional-level interventions do experienced clinicians find effective in preventing burnout, STS, CF, and VT, and in promoting compassion satisfaction?* The following chapter discusses what individual, agency, and institutional-level interventions are identified as “most effective” and “least effective,” as well as what could be done to improve the education and training received at the educational and agency levels. Further, the findings will be compared to current research on self-care techniques, protective and risk factors for burnout, CF, STS, and VT, and perceived training and educational needs. The author will address strengths and limitations for social work practice, policy, and future research.

#### **Self-Care**

The concept of “self-care” is often discussed in literature related to protective factors for burnout, STS, CF, and VT. Pearlman and Caringi (2009) define self-care as “intentional engagement in activities that offer distraction and/or personal growth; to exercise, have fun, rest, relax, and connect with one’s body; to develop and maintain sustaining, intimate family and interpersonal relationships...and to disengage from activities and relationships that are

depleting” (p. 216). The participants in Harrison and Westwood’s (2009) study reported that they took a holistic approach to self-care, which included attentiveness to physical (healthy diet, sleep, regular exercise, physical intimacy), mental (training and continuing education, mindful awareness), emotional (personal therapy, emotional expression, trusting relationships), spiritual (meditation, meaning-making), and aesthetic (“bringing beauty in”) self-care. Clinicians in Killian’s (2008) study defined self-care as “items I do for myself as proactive, to keep from experiencing burnout” and “taking time for yourself not only during the day, at work, but also at the end of the day when I go home” and specific self-care strategies included process time and supervision; quality time with friends and family; exercise; and spirituality (p. 36).

Despite the existing literature, only two clinicians in this study defined “self-care” by listing specific techniques they regularly utilize to prevent or help mitigate these phenomena. Most of the participants struggled to offer a meaningful definition of self-care beyond some variant of “it’s what you do to take care of yourself.” The author will grant that this succinct but not very informative conceptualization might be in part due to the wording of the question itself: *How do you define self-care?* is obviously less direct than, *What self-care techniques do you utilize?* The second question would likely have yielded a more specific response. Nonetheless, few clinicians were able to offer more concrete examples when prompted to talk about what self-care meant for them specifically. This may suggest that, though mental health clinicians often talk about self-care—both in terms of our own practices and in terms of suggestions we offer to our clients—what we mean by “self-care” deserves more careful consideration. Existing definitions from the literature should be better or more transparently incorporated into graduate and professional level trainings.

## **Manifestations of burnout, STS, CF, and VT**

Clinicians identified a number of manifestations of burnout, STS, CF, and VT. Those most commonly reported included: Crisis of Professional Confidence, Becoming Desensitized/Disengaged, Intrusive Thoughts/Rumination, Depression, and Distorted World View.

Crisis of Professional Confidence included clinicians' perceptions that the work they were doing was ineffective, or pointless, or that they could not continue to do the work in light of feeling helpless as a clinician, or as a result of institutional stress. This manifestation closely mirrors what Pearlman and Saakvitne (1995b) conceptualized as disruptions in self capacities. Self capacities have three components: "(1) the ability to maintain a positive sense of self, (2) the ability to modulate strong affect, and (3) the ability to maintain an inner sense of connection with others" (Pearlman & Saakvitne, 1995b, p.161). This kind of crisis of confidence can be problematic, or even dangerous for the both the therapist and the client. When working with trauma survivors, the development of self capacities is often the central focus of the work. For this reason, it is critical that the clinician is mindful of developing and maintaining their own self capacities in order to be able to effectively utilize this framework in the therapeutic relationship (Pearlman & Saakvitne, 1995b).

Becoming Desensitized/Disengaged occurred when clinicians felt as though they were depersonalizing the clients—minimizing their pain, becoming hardened to their stories, being insensitive, becoming bored, or finding it difficult to listen or recall what had been said during the session. Another signifier of disengagement was when a clinician felt unmoved by the praise and appreciation a client expressed for the quality of the interventions that she and the therapist had implemented during their work together. Such dissociation is well documented as a

symptom of burnout, STS, CF and VT. Pearlman and Caringi (2009) note that desensitization and detachment do not actually protect the helper from the negative impact of hearing trauma stories, though they may serve a defensive purpose (managing the helper's anxiety). They add: "When helpers respond persistently with avoidance, they are less able to process the pain, fear, sorrow, frustration, anger, and resentment that may build over time across these treatment relationships. This cumulative unprocessed countertransference can contribute to VT" (p. 212). Because empathetic engagement is such a critical part of therapy with traumatized patients, it is important for clinicians to be able to assess when they are experiencing this kind of disengagement, and to implement interventions to mitigate this reaction.

Intrusive Thoughts/Ruminations relate to the clinician's increasing difficulty in creating a mental boundary between work and home. This surfaced either as brief intrusions—nightmares, or specific images from trauma narratives that kept coming into the clinician's mind outside of the clinical session—or as the inability to stop thinking about the problems of certain clients during quality time with family members or friends. As Pearlman and Saakvitne (1995b) note, many trauma therapists experience intrusive thoughts or imagery of their clients' traumatic material that can be very disturbing. Similarly, Killian (2008) relates rumination to "work drain," wherein stress at work bleeds over into time spent with family and social supports, and notes that this is the most significant predictor of burnout.

Several clinicians also reported an increase in their own mental health issues, including depression, as a sign that they were experiencing one of these phenomena; this depression would become manifest as a loss of interest in enjoyable activities, a desire to isolate, or difficulty getting out of bed in the morning. When a clinician is experiencing this depressed state, it can be even more challenging to engage in the meaning-making process necessary to maintain their

frame of reference, self capacities, and ego resources, which are central to CSDT construct as a model for the trauma survivor and the clinical relationship between survivor and therapist (Pearlman & Saakvitne, 1995a).

Several clinicians also reported a distorted worldview, finding that they had begun to feel that the world “was a dark and horrible place,” or that their view on humanity generally and their ability to effectively intervene as clinicians had been significantly negatively affected by the work they do. They began to think that every romantic partnership involved an element of domestic violence, or began to feel that all parents were abusive to their children. Such distorted worldviews are often conceptualized in the literature as “disruptions in cognitive schemas” (Pearlman & Saakvitne, 1995), or an overabundance of either optimism or cynicism (Killian, 2008), and are routinely identified as a risk factor for burnout, STS, CF, or VT.

In summary, the manifestations of burnout, STS, CF, and VT are consistent with symptoms identified in earlier research—particularly the following symptoms: Crisis of Professional Confidence, Becoming Desensitized/Disengaged, Intrusive Thoughts/Rumination, Depression, and Distorted World View.

### **Protective Factors**

Identified preventative and protective factors included: Supervision; Individual Therapy Peer Support; Time Off/Breaks; Firm Boundaries; Social Support/Time Spent with Family and Friends; Leisure Activities; Spirituality; Exercise; Self-Awareness; Autonomy over Scheduling; and Experience. The preventative and protective factors most often utilized by the clinicians in this study were: 1) Supervision; 2) Peer Support; 3) Spirituality; 4) Exercise; and 5) Experience.

This is largely consistent with findings from earlier research (Killian, 2008; Pearlman & Saakvitne, 1995b; Harrison & Westwood, 2009).

### ***Supervision***

As with earlier studies, the majority of the clinicians in this study cited supervision as one of the most important factors in mitigating the effects of burnout, STS, CF, or VT. Harrison and Westwood's (2009) study noted that all of the clinicians interviewed spoke to the important role of supervision in mitigating risks of VT. Pearlman and Saakvitne (1995b) write:

Regular supervision or consultation with an experienced trauma-therapy supervisor is essential to our self-care, as well as to our ethical commitment to our clients. This work is simply too demanding to do without ongoing, regular professional consultation, regardless of level of experience. In our study of 188 trauma therapists, only 53% (or 100 people) reported that they were receiving trauma-related supervision; of these, 82% said they found it helpful (p.167).

These findings were relatively consistent with this study. Though the small sample size makes it difficult to generalize, 8 of 13 clinicians (62%) regularly utilize supervision. Of those receiving supervision, the majority found it helpful, and those that found it lacking often sought out effective external supervision.

### ***Peer Support***

Peer Support was consistently identified as one of the “most effective” protective factors. Those who worked with peers whom they regularly consulted on cases, or to whom they felt connected and able to talk openly about their professional challenges, found this resource invaluable.



Participants' identification of peer support as a protective factor is supported by existing literature. Killian (2008) also found that peer contact and consultation is a protective factor that provides clinicians the opportunity to share clinical stories and to help each other examine how one's personal life and work interact and affect each other and engage in reality testing and assessment of distorted world views. Harrison and Westwood (2009) echoed peer support/supervision's enhancement of self-awareness and ability to "self-monitor" and noted that peer groups can help clinicians reinforce their commitment to utilize self-care practices, and provide a forum wherein clinicians can benefit from learning each other's strategies to address VT symptoms.

### *Spirituality*

Spirituality is another factor clinicians identified as "most effective." Spirituality included meditation practices, prayer, and religious faith. Pearlman and Saakvitne (1995b) write, "the spiritual damage, or the loss of meaning, connection, and hope that can signal vicarious traumatization is profoundly destructive, and attending to one's spiritual health is critical to survival and growth" (p. 167). Several clinicians in this study cited spirituality as an important means by which they try to mitigate burnout, STS, CF, or VT, and said that they were able to utilize their spiritual practices to help them to "make meaning" when they struggled with particularly challenging aspects of their work or clients' trauma histories. Harrison and Westwood (2009) also found that spirituality or spiritual practices were protective for the participants in their study, "Participants described experiencing a sense of connection to a spiritual realm or sense of larger meaning that transcends individual boundaries and reason... These clinicians are comforted by the belief that they are part of something larger, meaningful and good, they are not alone in their efforts and these are not futile" (p. 209).

### *Exercise*

Several participants in this study cited exercise or body work as a preventative technique for burnout, STS, CF, or VT. Examples of exercise used by participants included yoga, going to the gym, running, walking the dog, and “anything that involves being outside and getting my heart rate up.” Killian’s (2008) participants also cited physical exercise as an “essential ingredient for their sense of well-being” (p. 36). Harrison and Westwood (2009) grouped exercise under “holistic self-care” which included physical, mental, emotional, spiritual, and aesthetic aspects of self-care. Exercise can contribute to restoring one’s sense of identity, as it applies to one’s “frame of reference” relative to CSDT. Pearlman and Saakvitne (1995a) write:

Our identities include the reality of our bodies. It is not unusual for traumatized therapists to move out of their bodies and into their minds....Being aware of one’s body is closely linked to being aware of one’s feelings. Reconnecting with one’s body frequently is essential to restoring oneself to full humanity. This can take a variety of forms: Yoga, conscious breathing, exercise, movement, dance, stretching, massage, and touch are all ways of reminding ourselves that we have bodies (p. 395).

### *Experience*

Though the participants in this study did not specifically cite experience as a protective factor, they often noted how their self-care or preventative techniques and their ability to be cognizant of their own triggers evolved over the course of their practice, by virtue of experience, and how differently they might have felt when they were new clinicians. Pearlman and Caringi (2009) note that undertrained or “newly degreed” helpers are often “thrown into the deep end” without adequate training, consultation, or supervision and caution that this is a recipe for burnout, VT, and more and can lead to misjudgments and boundary crossings or violations.

Bride and Figley (2009) note that those with less experience are at increased risk for STS, but argue that this finding could be explained by the development of coping mechanisms that comes with increased experience, which correlates with the impressions of the participants in this study.

It should be noted that experience is not necessarily a protective factor. It is possible, after all, that those most susceptible to these phenomena left the field early in their careers.

Nonetheless, “years of practice” was often cited as the clinicians’ own estimation of how they had become better able to manage certain symptoms of burnout, STS, CF, or VT over the course of their careers.

### **Risk Factors**

Phelps et al. (2009) note that a primary prevention technique is to identify and address both protective factors and risk factors:

Risk factors identified in the literature (e.g. being isolated, inexperienced, overworked, lacking support or supervision, unclear role definition) should be addressed where possible and steps taken to minimize the impact on the individual. Conversely, where recognized protective factors (e.g. retention of emotional boundaries, team spirit, and camaraderie, clear role definition and organizational support for that role, compassion satisfaction, spiritual-well-being, “making meaning” of traumatic experiences and retaining positive beliefs about the role) are lacking, strategies to create or maximize these protective factors should be introduced (p. 322).

The risk factors in this study were largely discussed as they related to ineffective interventions at the graduate and agency level. It is important to note that many of the risk factors identified (lack of a supportive work environment, distortions in worldview, institutional

stress, inexperience, etc.) were also identified in existing literature (Killian, 2008; Bride & Figley, 2009; Pearlman & Saakvitne, 1995b). It is not insignificant that the participants in this study who scored in the highest percentiles for STS and burnout also reported a lack of a supportive work environment, lack of effective supervision, and institutional stress as the “least effective” practices or techniques in the agency setting.

### **Graduate Level Information and Training**

The thirteen clinicians interviewed represented twelve distinct graduate programs in social work, psychology, and counseling. Nine of the respondents had received neither training nor information about Vicarious Trauma at the graduate level; three reported that VT was briefly talked about; and only one reported that they received targeted and practical training.

Those who received some information or training reported that the most effective graduate-level interventions were supervision through their field internships and the recommendation to get individual therapy. Participants noted that supervision related to countertransference in the clinical relationship and how that might manifest as burnout, STS, CF, or VT was particularly helpful, as was modeling of self-care by supervisors. Those who received training through supervision felt that they were lucky, as the quality of supervision was inconsistent across internships. One respondent said, “it wasn’t part of the defined curriculum...I’m sure that the school hoped I would be getting that kind of thing in supervision, but there was no way they could have known. I know that many of my classmates did not have that kind of supportive or informed experience.” Clinicians insisted that information and training about this issue must be more systematic, integrated into the curriculum itself rather than being addressed piecemeal or by chance by the supervisors at field internships.

The majority of participants (11) in this study said that the topics of burnout, STS, CF, and VT were not effectively addressed in their graduate education. This is consistent with Killian's (2008) findings: "Most of the therapists interviewed observed that they had not had any courses or specific training on professional self-care, and this was an important but neglected area of training" (p. 41). Most of the participants in this study said there was an urgent need for awareness of burnout, STS, CF, and VT and the practical skills needed to prevent or mitigate these phenomena to be meaningfully incorporated into graduate curricula.

The least effective graduate-level interventions were the amount of workload and pressure related to the student experience, and warnings that left them feeling helpless. Two clinicians identified the workload and pressure of graduate school as counterproductive in learning how to establish healthy boundaries and practice self-care. One clinician recalled her reaction to a professor telling the class that they would all burnout within five years: "I was so angry. I didn't want to burnout. But he didn't offer any alternative. It was just a statement, like being sentenced to burnout."

The most frequently occurring suggestions for improvement at the graduate level were Increased Awareness/Normalizing and Practical Training. Clinicians encouraged raising awareness about the prevalence of burnout, CF, STS, and VT for clinicians who do trauma-focused work, with a special emphasis on normalizing or reducing the stigma associated with having this experience as a professional. Participants said they felt it was a significant enough issue that there should be a class on VT and professional self care, with practical suggestions for how to implement certain techniques. Of these, some felt that it should be a stand-alone course, and others felt that it could be meaningfully integrated into a practice course.

The existing literature supports those participants who called for more education and training at the graduate level. Pearlman and Saakvitne (1995b) suggest professional education and training should be required in all graduate programs that prepare people to become clinicians. Newel and MacNeil (2010) make recommendations about how this information could be integrated into existing coursework:

The concepts of burnout and secondary traumatic stress can be introduced in human behavior and the social environment (HBSE) courses as a topic highlighting the existence of career life course trajectories (which run parallel to individual's personal development trajectories)...Social work educators should teach students the key features, warning signs, and symptoms associated with professional burnout and STS, as well as self-care strategies and techniques as preventative practice behaviors (p. 63).

Though several studies have called for more education and training at the educational level, the current study was unique in asking clinicians about the most and least effective practices or information they received at graduate school, as well as what they would like to see incorporated into current curricula.

### **Agency Level Information and Training**

Most of the participants in this study said that they had not received information and training about burnout, STS, CF, or VT at the agency level, and the majority of participants felt that awareness of these phenomena and the skills and techniques needed to prevent them are not effectively addressed in their current or former agencies.

### ***Most Effective Information and Training***

Of those who had received information or training at the professional level, the most effective agency level interventions were: 1) creating a “culture of support”; 2) training opportunities; and 3) supervision. First, creating a “culture of support” proved effective at either an agency-wide or team level, whether it was done through official channels like hiring practices, or through more unofficial practices like creating a family environment that fostered concern and care for coworkers. Creating a “culture of support” included fostering awareness about VT and normalizing the experience for professionals in order to reduce stigma for those who were experiencing burnout, STS, CF, or VT. Several of the clinicians in this study who were in the low range for burnout and STS and in the high range for compassion satisfaction reported that their agency had effectively created a “culture of support” related to information and awareness about these issues.

Second, Clinicians reported that training opportunities were effective—both those targeted to trauma-focused work and those that contributed to meeting continuing education requirements. Clinicians who found training effective felt that the opportunity to learn more about their profession or their work with clients helped them to remain engaged and gave them confidence in their professional abilities. Trainings related to VT were not considered helpful if the agency treated it like a “check the box” requirement, or if there was little demonstrative support or follow-through. The literature supports the efficacy of these identified practices. Pearlman and Saakvitne (1995b) write: “Organizations should provide opportunities for regular supervision, consultation, and case discussion for clinicians. They should provide resources for and active encouragement of professional development activities such as continuing education” (p. 170). Pearlman and Caringi (2009) stress that training that focuses on the impact of working

with traumatized clients and VT is essential. Harrison and Westwood (2009) also underscored the importance of training, ongoing professional development, mentorship, and organizational support. Half of the clinicians who scored in the high range for compassion satisfaction listed training opportunities as an effective agency-level intervention.

Third, those who found supervision effective had empathetic or supportive supervisors with whom they felt trust and mutual respect. This was especially true of supervisors who were familiar with burnout, STS, CF, or VT, and created a supportive environment within supervision and fostered awareness in the workplace about these issues through presentations and training opportunities. The importance of effective, trauma-informed supervision will be discussed in greater depth in the following two subsections of this chapter.

Several studies (Pearlman & Saakvitne, 1995b; Trippany, Kress & Wilcoxon, 2004; Bride & Figley, 2009; Bober & Regehr, 2006; Pearlman & Caringi, 2009; Killian, 2008) claim that a manageable and varied caseload is an important agency intervention in preventing burnout, STS, CF, and VT. Clinicians in this study had an average trauma caseload of 88% and a mean trauma caseload of 100%, but none cited lack of a varied caseload as a source for their symptomology. This is due, in part, to a sense of autonomy in scheduling—they could disperse the more challenging clients across the week, instead of in succession, or were able to schedule a window of free time after a TF-CBT session involving the client’s trauma narrative. Also, most of the clinicians in this study, with the exception of those who worked in understaffed departments, felt their caseload was manageable, even if it was not varied. One participant said, “I don’t have to see that many patients...I knew a social worker who had one hundred kids on her caseload. She was insane and I didn’t understand why, but can you imagine? One hundred



abused children on your caseload?” The average caseload for the clinicians in this study was 17 clients, with a median of 15.

### ***Least Effective Information and Training***

Clinicians reported that the least effective agency-level interventions or practices were: 1) Institutional/Structural Stress; 2) “Lip Service” or Lack of Support for policies designed to mitigate burnout, STS, CF, or VT; and 3) Ineffective Supervision. Every clinician in this study who scored in the high range on the ProQOL-5 for burnout, as well as the majority of the clinicians who scored in the low range for compassion satisfaction, and half of the clinicians who scored in the high range for STS reported that institutional stress was one of the greatest sources of dissatisfaction with their jobs or agencies. Several studies support the connection between burnout, STS, CF, and VT and institutional stress (Killian, 2008; Phelps et al., 2009; Bride & Figley, 2009; Bober & Regher, 2006; Newell & MacNeil, 2010; Tyson, 2007; Pearlman & Caringi, 2009). For the clinicians surveyed in this study, institutional stress was pervasive across different agencies, and could vary depending on the person’s role within the agency as well as shifting leadership, client population, or a change in ownership or management. Examples of institutional stress included: corporate-managed or for-profit health care, lack of autonomy, lack of resources, understaffed departments, and policy changes at the federal and local levels that compromised patient care.

Clinicians found lack of support for existing policies to encourage clinician self-care or “lip service” and lack of agency-cultural support or follow-through routine, undermining and frustrating. Clinicians in this study who scored in the high range for burnout and STS and in the low range for compassion satisfaction reported “lip service”/lack of support for existing policies to prevent or mitigate burnout, STS, CF, or VT. Pearlman and Caringi (2009) offer evidence that

ineffective policies or policies that are given “lip service” but not ultimately supported can be detrimental:

Policies that inhibit helpers’ abilities to take breaks, work flexible schedules, and even access vacation time impact the balance needed to work in a service setting. Policies that allow flexible work schedules and mandate that staff take compensatory and annual leave in a timely manner provide opportunities to rest and to process and integrate the effects of the work (p. 219-220).

Participants also registered concerns about ineffective supervision. While a few clinicians reported positive relationships with their agency supervisors, the majority of the participants had no supervision or ineffective supervision within their agency. Some felt that the supervisors available through their agency were undertrained or inexperienced and others felt unable to have a meaningful supervisory relationship with their agency supervisor due to a conflict of interest on the supervisor’s part—as when the assigned supervisor was also in risk management administration—that left the employee feeling as though they could not be open and honest about their work-related challenges in supervision for fear of retribution. Pearlman and Saakvitne (1995b) highlight the importance of providing clinicians with a safe, bounded environment for supervision: “In many organizations, individuals have multiple roles. It is especially important to separate these roles and to create a safe, bounded workspace in which a therapist can speak freely about the difficulties of the work” (p. 172). The clinicians in this study who reported that they had ineffective supervision also scored in the high range on the ProQOL-5 for burnout and STS. Conversely, the majority of participants in this study who reported that they received positive, productive supervision scored in the low range for burnout and in the high range for compassion satisfaction.

### ***Suggestions for Improvement at the Agency Level***

The participants in this study suggested several ways to improve interventions at the agency level. The most frequently occurring were: 1) “Top-Down” Support; 2) Creating a Culture of Support; and 3) Acknowledgement/Appreciation.

First, suggestions to improve “Top-Down” Support included: VT-focused training for supervisors and administrators; modeling of self-care and work/life balance by supervisors and agency leadership; and support for existing policies. In order for trauma therapy supervision to be effective, the supervisor must be able to implement trauma-informed clinical supervision. Pearlman and Saakvitne (1995a) note that the four components for trauma-focused therapy supervision are:

1. A solid theoretical grounding, including a theoretical understanding of psychotherapy in general and trauma therapy in particular, a theory of the psychological responses to interpersonal violence, and an understanding of normal child development
2. A relational focus that attends to both conscious and unconscious aspects of the therapeutic relationship and the treatment process
3. A respectful interpersonal climate that allows attention to countertransference and parallel process
4. Education about and attunement to the therapist’s vicarious traumatization (p. 360).

Therapists who are not receiving regular, trauma-informed clinical supervision are at greater risk for developing VT because, without a supervisor’s attunement to issues unique to trauma work, clinicians can feel isolated or unprofessional when they develop VT symptomology, can lose sight of how their VT is influencing the work with their own clients, and lack both modeling and supportive interventions for understanding the parallel process in the

therapeutic relationship with the client. For this reason, a theoretical construct—like CSDT—that addresses the psychological impact of trauma on survivors is essential in trauma-focused supervision, because normalizing responses to traumatic experiences helps therapists to understand and make meaning of their clinical observations and experience (Pearlman & Saakvitne, 1995a). Participants also felt that it was important that agencies support existing policies to mitigate burnout, STS, CF, and VT, including encouragement and support around vacation time, breaks, and flexibility in their schedules. Pearlman and Caringi (2009) note that policies that inhibit a clinician’s ability to take breaks or utilize vacation time negatively impact the balance needed to work in service settings, and suggest that employers should allow for flexible work schedules and consider mandating annual and compensatory leave to provide the support clinicians need to take restorative and reflective breaks from the work.

Second, suggestions for creating a “culture of support” included: increased awareness/normalizing of VT; the possibility of an ongoing process group; mandatory trainings; and monitoring/agency assessments that included anonymous staff surveys and resulted in targeted interventions for agency-specific deficits. The clinicians specified that the assessments should be geared towards supportive intervention, as opposed to risk assessment or “fit for duty” assessments.

The literature offers definitive support for the need to increase awareness of and normalize VT. Many studies suggest that all trauma therapists risk developing VT, and that developing VT or STS is essentially an occupational hazard (Pearlman & Saakvitne, 1995b; Bride & Figley, 2009). Despite this fact, many clinicians acknowledged that there was a sense of shame or stigma that prevented trauma therapists from talking about it openly during supervision or with their peers. One clinician said: “I don’t think you can prevent VT, I think all therapists

run the risk of developing these things and the important thing is that they don't feel like they're alone." Increasing awareness/normalizing is an important step in reducing the stigma associated with experiencing burnout, STS, CF, or VT. Pearlman and Saakvitne (1995b) write: "As teachers and supervisors, we have a responsibility to educate our students and supervisees about vicarious trauma. We must help them understand that it is an inevitable part of the work, a natural response" (p. 171). Pearlman and Caringi (2009) note that, though it may seem paradoxical, accepting the inevitability of VT can be helpful, as can one's acceptance of personal and professional limitations.

One participant suggested that an ongoing process group might be an especially useful form of peer support in her trauma-focused agency. The Balint groups could provide a useful model for how a group such as this might be formed. Phelps et al. (2009) write:

The notion that peer support may be effective in reducing stress and burnout vulnerability led to the development of Balint groups (named after the originator, Michael Balint) for general practitioners in the United Kingdom after World War I...Balint groups, as described by Benson and Magraith (2005), are a form of peer support that provides a forum for GPs to debrief and discuss their personal reactions to patients, normalize emotional reactions, reduce stress by sharing experiences, and be reminded of the value of their work. Participation in Balint groups is intended to help group members address unrealistic expectations and maintain appropriate boundaries in their work (p. 324).

Several participants suggested that periodic agency assessments might be effective, wherein clinicians are periodically (and anonymously) assessed, and targeted interventions are implemented in response to clinician and agency need. This suggestion is well supported by existing literature. Bride and Figley (2009) suggested a similar intervention, arguing that early

intervention is very effective, and can be assessed through scales such as the Secondary Traumatic Stress Scale (STSS) and the Compassion Fatigue-Short Scale (CF-SS). Phelps et al. (2009) write that there is a need for recognizing the early symptoms of stress in oneself or one's colleagues and that this might effectively be done through self-screening questionnaires that encourage individuals to identify their own needs. Pearlman and Saakvitne (1995a) note that human service organizations can benefit from external consultation and assessment when the organization is experiencing significant interpersonal conflict, low morale, or high turnover as a result of pervasive VT symptomology in the staff. This kind of intervention and assessment reflects sensitivity and attunement on the part of agency leadership and also helps to create a "culture of support" for the staff while giving agency leadership a clearer sense of the dynamics and opportunities for change (Pearlman & Saakvitne, 1995a).

Third, participants also suggested that their work could be valued and appreciated more at the agency level. Suggested improvements included regular positive feedback, annual evaluations, and wage increases commensurate with experience or performance. When wage increases were not possible due to budget cuts, small gestures—in one case, holiday gift cards instead of bonuses—were appreciated. These gestures must be handled carefully and thoughtfully, because when they were perceived as shallow or patronizing, they were ineffective. Signs of appreciation or acknowledgement that had no monetary value—being complimented by one's supervisor on the work, being told that one was an asset to the agency/team, and so forth—were often the most appreciated. Harrison and Westwood (2009) found that clinicians derive professional satisfaction from organization cultures and managerial styles that value their expertise. A sense of achievement (as demonstrated by pay raises or promotions that

acknowledged the clinician's work) was also found to be an important protective factor in earlier research (Bride & Figley, 2009; Trippany, Kress & Wilcoxon, 2004).

If agencies wish to support their clinical employees, it is essential to reduce institutional stress where possible, and to create a "standard of care" for their own clinicians that offers more than tacit support for vacation, breaks, and creating a work/life balance. It is also imperative that agencies offer trauma-focused clinical supervision that is supportive, boundaried, and a safe space where they can share their clinical concerns without fear of retribution. Finally, it is important for agencies to consider the cost of not providing consistent, sincere acknowledgement of their employees. Though this was a small sample size, four of the participants had either left their last job or were actively seeking new employment because they felt undervalued by their supervisor or employer. Agencies should weigh the potential cost of recruiting, interviewing, hiring, and training new staff against the relatively cost-effective approach of ensuring that their existing staff feels supported by their agency and successful in their work.

### **Agency and Community Support**

Participants in this study were asked if prevention of VT was most effectively handled at the institutional level, individual level, or both. Eleven of thirteen participants said that it must be addressed at both the institutional and individual levels. Though clinicians felt it was important to be self-aware and cognizant of their own triggers and symptoms, they felt that individual self-care was insufficient to meet the challenges of VT, and that prevention and support could only be truly effective if awareness, support, and intervention happened at the agency level as well. Clinicians who most strongly identified with their professional peers were more likely to rely upon that community for professional support—including meeting for peer

processing groups, participating in conferences, and having active involvement on a professional community listserve. Those who more strongly identified with their agency cited the quality of peer support they received at their agency as their primary community of support.

The importance of intervention at both the individual and agency-level is supported by existing literature. Killian (2008) writes, “The results also indicate that we probably should stop expecting helping professionals to ‘pull themselves up by their bootstraps’ by reducing their stress with standard individual coping strategies of leisure and continuing education” (p. 42). Killian (2008) argued that, in order for prevention or protective factors to be successful, they had to be supported in a more systemic way, including ensuring that clinicians had a sense of autonomy and a varied or manageable caseload.

Bober and Regehr (2006) found that individual coping strategies for reducing distress among trauma therapists had no impact on immediate traumatic symptoms. They suggested that education about the risks and suggestions for intervention do not go far enough: “it is perhaps time that vicarious and secondary trauma intervention efforts with therapists shift from education to advocacy for improved and safer working conditions” (p. 8). Given that the participants in this study expressed a desire for more education and training at the graduate and agency level, this author feels that moving away from education at this stage is premature.

One might anticipate that already-strapped agencies with few resources for assessments, additional training, time for supervision, high wait-lists and other pre-existing barriers to client care would have reservations about dedicating funding or staff time to training, supervision, assessments and evaluations. Pearlman and Caringi (2009) write that the attitude that all resources must go to client care is shortsighted, and that staff that feels supported and effective is an essential component of continued success for workers and agencies. Sprang, Clark, and



Whitt-Woolsey (2007) found that educating clinicians about risk and protective factors for CF, as well as providing resources to enhance protection might reduce levels of CF and burnout and could “ultimately be cost-effective if they prevent staff turnover, lost time at work, and protective disengagement” (p. 276). Increased awareness and support is also important at the agency level because, as Pearlman and Saakvitne (1995) caution, therapists are often reluctant to admit that they need help, and may not be sure where to go to get it. If the agency does not promote a culture of support, the clinician’s distress could become so great that they leave the field.

Broader community support is also an important protective factor to consider. Most of the participants in this study indicated that they felt like they belonged to the community of their discipline or to the community of peers at their agency. Participants who most strongly identified with their professional peers were more likely to rely upon that community for professional support, including meeting for peer processing groups, participating in conferences, and having active involvement on a professional community listserve. Those who more strongly identified with their agency cited the quality of peer support they received at their agency as their primary community of support. In either case, the connection that they felt with their professional community or peers was considered a source of significant support around these issues.

Participation in movements for policy change can also be significant protective factor. Killian (2008) writes, “forging connections to broader community movements might help us to resist the debilitating effects of alienation, isolation, helplessness, and cynicism” (p. 42). Bell et al. (2003) note that organizations can provide a sense of hope and empowerment to their clinicians by encouraging involvement such as outreach or working to influence policy.

## **Compassion Satisfaction**

When asked what keeps them engaged in their work with clients, participants cited a range of motivating factors, including: the relationship with the client; human interest; being able to watch a client's progress and growth; a desire to help; the support of their peers; and a genuine love for their job. Of these, the most frequently occurring responses were watching client progress/growth and a genuine desire to help people, coupled with the sense that they have the knowledge and skills needed for effective intervention. Participants spoke of their work with clients as a privilege and a calling, were inspired by their clients' resilience, awed by their capacity for healing, and could not imagine doing any other kind of work. They also noted that they were able learn from their clients' positive growth after trauma and apply that knowledge to their own personal and professional growth. Pearlman and Saakvitne (1995a) echoed this experience of being devoted to their work and feeling that it was a "calling." Similarly, Harrison and Westwood (2009) found that "professional satisfaction"—derived from feeling highly skilled in their professional role, as well as feeling that they are "expanded and enriched" by their work with clients—is a protective factor for preventing VT (p. 213). The clinicians in this study who scored in the high range for compassion satisfaction on the ProQOL-5 cited spirituality, supervision, peer support, and training as supportive factors, which may indicate that the opportunity to engage in meaning-making, to reflect in a protected space about issues in the work, and to feel skilled and capable in the work that they do can lead to greater compassion satisfaction.

## **Limitations**

This study is limited in that it is susceptible to researcher and respondent bias. This author began to develop this line of inquiry due her own experience of a lack of information, training, or support related to burnout, STS, CF, or VT in the curriculum of her graduate program or in her supervision during field internships. The participants were recruited using a combination of non-probability availability sampling and purposive sampling of licensed trauma-focused clinicians with two or more years of experience in the field of trauma therapy. Those who agreed to participate may have done so because they felt strongly about the subject due to their own experiences of burnout, STS, CF, or VT, which may have lead to some amount of self-selection bias related to personal relevance. Semi-structured interviews allow for a broader range of responses than a fixed data survey might, but the flexibility in follow-up questions unique to each participant could have further introduced bias. Limiting the study participants to a particular geographic region allowed for the opportunity to assess immediate community support, but also limit the generalizability.

Another limitation to this study is the overall execution. The author is a master's student with no prior research experience, so there are likely many improvements in design, implementation, and execution of which she is not aware. Additionally, the author was the sole researcher and had limited time and resources, so intended validity measures (like a volunteer coding assistant to confirm the validity of the coding) ultimately were not completed due to the lack of time available for such assessments. Though the sample size meets the requirements for a master's thesis at Smith College—and exceeded the sample size of some of the existing literature related to this subject—13 participants is still a relatively small number from which to generalize the data collected.

## Conclusion

Trauma clinicians face risks—such as STS and VT—that are unique to their profession. Though literature supporting the existence of these phenomena has been circulating for nearly two decades, little information on preventative factors, awareness, or support is being presented to students at the graduate level or to clinicians in agencies. Recent studies suggest that implementing education and training at the graduate and professional level is urgently necessary.

Though earlier studies have suggested that education and training are necessary at the graduate level, and some (Newell & MacNeil, 2010) have even suggested where in the curriculum these issues might best be addressed, this study is unique in that it asked practicing clinicians what they wish they had learned at the graduate level. Their responses support the earlier calls for formal curriculum to increase awareness and provide practical interventions for these issues. It is also relevant for graduate programs to note that the Council on Social Work Education *requires* that self-care be a part of the social work curriculum (CSWE, 2008, as cited in Newell & MacNeil, 2010).

Peer and community support have also been consistently identified as supportive or protective factors. The quality of peer and community support is largely contingent upon the “culture of support” at individual agencies. This culture of support could be improved through systematic interventions—such as training all clinicians as a part of the core curriculum in graduate programs, and through implementing “top-down” support and training within agencies. It is imperative that the agency-level training is presented in an empathetic and sincere way, and that all staff receive training, including administrators and supervisors. It is imperative that any supervisor who provides clinical supervision to trauma-focused clinicians is well versed in the specific issues related to working with trauma survivors, as well as knowledgeable about the

manifestations of and interventions for VT. Agencies that are experiencing high levels of turnover due to burnout, STS, CF, or VT should seriously consider inviting in an external consultant to assess for these phenomena and suggest effective agency-level interventions to support their workers.

Future research should continue to focus on how best to increase awareness and foster a “culture of support” for burnout, STS, CF, and VT within educational settings and professional communities. A similar study that interviews administrators or supervisors within agencies to gauge their perception of these phenomena and their own level of awareness and training may prove interesting and shed more light on limitations and possibilities at the agency level.

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## Appendix A

### Interview Guide

#### Demographic questions:

1. Under which discipline do you practice? (Must hold at least a Master's degree in: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology)
2. How long have you been in clinical practice?
3. What degree, certification and/or licenses do you hold within your discipline?
4. How would you define your gender?
5. What is your age?
6. How do you define racially/ethnically?
7. In what setting do you practice psychotherapy (i.e. outpatient, hospital, agency etc.)?
8. What is the population that you most often serve within your practice?
9. What is the typical size of your caseload?

#### Interview questions:

1. Before this interview began, I introduced an operational definition of the terms: burnout, compassion fatigue, secondary traumatic stress, vicarious traumatization, and compassion satisfaction. Do you agree with the definitions proposed, or would you like provide your own definitions?
2. How would you define self-care?
3. In your estimation, what percentage of your caseload is trauma-focused?
4. Have you experienced vicarious traumatization, secondary traumatic stress, compassion fatigue, or burnout in your work with clients?
  - a. If so, can you say more about how that manifested for you? (The following prompts will be supplied only if needed: sleeplessness, intrusive thoughts, disengagement with your clients, etc.)
5. How do you know when you are experiencing burnout, secondary traumatic-stress, compassion fatigue, or vicarious traumatization—what are the signs or triggers that first make you aware of it?
6. What techniques, if any, do you use to guard against burnout, secondary traumatic stress, compassion fatigue or vicarious traumatization? (If participant identifies techniques, interviewer will ask the following questions as well:)
  - a. What would you identify as the most effective technique?
  - b. What would you identify as the least effective technique?
  - c. What techniques do you wish you used, but do not?
7. Where did you attend graduate school? Did you receive any information about vicarious traumatization or training to prevent it while in school?
  - a. If so, what was the most effective training or most useful information?
  - b. What was the least effective training or least useful information?
  - c. What information do you wish you had received as a graduate student, but did not?

8. Did any of the agencies in which you have worked since the completion of your degree offer education and/or training to address vicarious traumatization, self-care techniques (the following prompts will be supplied only if needed: exercise, meditation, spending time with family members or loved ones, etc.), or have policies and procedures designed to mitigate the effects or risk of vicarious traumatization (the following prompts will be supplied, if needed: regular supervision with an experienced trauma-focused clinician, balanced caseloads, non-authoritarian management, clearly identified teams, etc.)?
  - a. If so, what was the most effective technique, policy, or procedure?
  - b. What was the least effective technique, policy, or procedure?
  - c. What technique, policy, or procedure do you wish had been included but was not?
9. Do you feel that awareness of burnout, secondary traumatic stress, compassion fatigue and vicarious trauma and the skills and techniques needed to prevent them are effectively addressed in educational and professional settings? If not, what do you think could be done to improve awareness and training?
10. Do you feel that prevention of VT is most effectively addressed at an individual level, (the following prompts will be supplied only if needed: best addressed by self-care, etc.) an agency/institutional level (the following prompts will be supplied only if needed: trainings, creating a culture of self-care, etc.), or both?
11. Do you feel like you belong to the professional community of your discipline (social work, clinical psychology, etc.)? If so, in what ways, if any have you relied upon this community for guidance and/or support with issues or instances of burnout, secondary traumatic stress, compassion fatigue, or vicarious traumatization?
12. What keeps you engaged in your work with clients?
13. Is there anything else that you find relevant to this issue that we have not yet discussed?

## Appendix B

### ProQOL-5

#### Compassion Satisfaction and Compassion Fatigue Professional Quality of Life Version 5 (Stamm, 2010)

Stamm (2010) asserts that the material therein may be freely copied as long as the author is credited, no changes are made, and it is not sold except for in agreement specifically with the author.

When you help people you have direct contact with their lives. As you may have found, your compassion for your clients or patients can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a therapist. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the **last 30 days**.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

- \_\_\_ 1. I am happy.
- \_\_\_ 2. I am preoccupied with more than one person I help.
- \_\_\_ 3. I get satisfaction from being able to help people.
- \_\_\_ 4. I feel connected to others.
- \_\_\_ 5. I jump or am startled by unexpected sounds.
- \_\_\_ 6. I feel invigorated after working with those I help.
- \_\_\_ 7. I find it difficult to separate my personal life from my life as a therapist.
- \_\_\_ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
- \_\_\_ 9. I think that I might have been affected by the traumatic stress of those I help.
- \_\_\_ 10. I feel trapped by my job as a therapist.
- \_\_\_ 11. Because of my work, I have felt "on edge" about various things.
- \_\_\_ 12. I like my work as a therapist.
- \_\_\_ 13. I feel depressed because of the traumatic experiences of the people I help.
- \_\_\_ 14. I feel as though I am experiencing the trauma of someone I have helped.
- \_\_\_ 15. I have beliefs that sustain me.
- \_\_\_ 16. I am pleased with how I am able to keep up with trauma therapy techniques and protocols.
- \_\_\_ 17. I am the person I always wanted to be.
- \_\_\_ 18. My work makes me feel satisfied.
- \_\_\_ 19. I feel worn out because of my work as a trauma-focused therapist.
- \_\_\_ 20. I have happy thoughts and feelings about those I help and how I could help them.
- \_\_\_ 21. I feel overwhelmed because my caseload seems endless.
- \_\_\_ 22. I believe I can make a difference through my work.
- \_\_\_ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
- \_\_\_ 24. I am proud of what I can do to help.

- \_\_\_ 25. As a result of my work, I have intrusive, frightening thoughts.
- \_\_\_ 26. I feel "bogged down" by the system.
- \_\_\_ 27. I have thoughts that I am a "success" as a therapist.
- \_\_\_ 28. I can't recall important parts of my work with trauma victims.
- \_\_\_ 29. I am a very caring person.
- \_\_\_ 30. I am happy that I chose to do this work.

## Appendix C

### Recruitment E-mail for Eligible Colleagues and Acquaintances

Hi, my name is Loren Biggs. I am a graduate student at Smith College School for Social Work. You may know me from \_\_\_\_\_. I am doing an exploratory study for my Master's thesis to learn more about what training or tools trauma-focused clinicians are receiving at the educational or institutional level to prevent burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization. This study also seeks to identify which individual, agency, and institutional-level interventions are effective in preventing burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization and in promoting compassion satisfaction.

For the purposes of this study, burnout, secondary traumatic stress, compassion fatigue, vicarious traumatization, and compassion satisfaction will be defined as follows:

- Burnout – emotional exhaustion, depersonalization, reduced sense of accomplishment. Can present in the clinical setting due to factors such as caseload size or institutional stress.
- Secondary Traumatic Stress (STS) –clinicians who work with victims of trauma become indirect victims of that trauma and experience stress as a result of helping or wanting to help a traumatized or suffering person.
- Compassion fatigue –a combination of the symptoms of STS and burnout
- Vicarious Traumatization- significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory.
- Compassion Satisfaction: the sense of satisfaction that clinicians derive from helping others

I would like to invite you to participate in my study, which will consist of an interview lasting no longer than 45 minutes, followed by completing the thirty-question Professional Quality of Life Scale (ProQOL-5)-5, which should take no longer than 5-10 minutes. I will first ask a limited number of demographic questions about your age, race, degree, licensure, number of years practiced, and area of expertise. Then I will use an interview guide that includes questions about what self-care strategies you, as an experienced clinician, find particularly effective, and what, if any, vicarious traumatization prevention training, education, or continuing education you have received; what you have found useful; and what you would like to see included in training and education for trauma therapists that you did not receive during your graduate or professional work.

You are eligible to participate in my study if your caseload is comprised of 50% or more trauma-focused work, are currently practicing with a Master's or Doctoral degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology, are licensed, and have been practicing for at least two years since earning your degree. Those eligible may practice in a variety of outpatient settings including: social agency, hospital or veteran's affairs clinic, private practice, and/or home-based service. Proximity to Durham, North Carolina is preferred. All identifying information collected within this study will be kept confidential and disguised when presenting the findings. All data

collected from this study will be coded and demographic data will be presented in aggregate, maintaining your privacy. The research will be used for my MSW Thesis, presentation, and dissemination, and possible publication.

If you meet criteria for participating, I encourage you to take part in my study; please reply to this email and check the appropriate boxes below so that I may send you further instructions.

If you do not meet the criteria for this study, or if you are not interested in participating, I would appreciate your **forwarding this email to any acquaintances or colleagues you know who may be eligible and willing to participate**. The forwarding of this email to other potential participants would be very helpful!

If you have any questions about my research or the nature of participation, please feel free to reply to this email ( [REDACTED] ) or contact me at a later date.

Please reply to this email and check the appropriate boxes based on your interest and eligibility:

Meet participation criteria

Interested in participating

Not interested in participating, but will forward email to others

Thank you for your time and interest in my research topic.

Sincerely,

Loren Biggs  
MSW Candidate 2013  
Smith College School for Social Work



## Appendix D

### Recruitment Message for Social Media Websites

Dear Facebook friends:

I'm working on my thesis for my Master's in Clinical Social Work from the Smith College School for Social Work and need help recruiting participants for my study!

My study is an exploratory study that aims to assess of what sort of training is being conducted at the educational and institutional/agency level to prevent the development of burnout, secondary traumatic stress (STS), compassion fatigue (CF), and vicarious traumatization (VT) in trauma-focused clinicians, as well as what individual, agency, and institutional-level interventions these therapists find most effective in preventing the development of burnout, STS, CF, or VT. For the purposes of this study, burnout, secondary traumatic stress, compassion fatigue, vicarious traumatization, and compassion satisfaction will be defined as follows:

- Burnout – emotional exhaustion, depersonalization, reduced sense of accomplishment. Can present in the clinical setting due to factors such as caseload size or institutional stress.
- Secondary Traumatic Stress (STS) –clinicians who work with victims of trauma become indirect victims of that trauma and experience stress as a result of helping or wanting to help a traumatized or suffering person.
- Compassion fatigue –a combination of the symptoms of STS and burnout
- Vicarious Traumatization- significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory.
- Compassion Satisfaction: the sense of satisfaction that clinicians derive from helping others

Psychotherapists are eligible to participate in my study if their caseload is comprised of 50% or more trauma-focused work, they are currently practicing with a Master's or Doctoral degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology, are licensed, and have been practicing for at least two years since earning their degree. Those eligible may practice in a variety of outpatient settings including: social agency, hospital or veteran's affairs clinic, private practice, and/or home-based service. Proximity to Durham, North Carolina is preferred. If you know anyone who may fit these criteria, please contact me and I will send you the formal recruitment e-mail to forward to them.

Many thanks!

## Appendix E

### Recruitment E-Mail for Professional Listserv

Hi, fellow AAPCSW members! My name is Loren Biggs. I am a graduate student at Smith College School for Social Work. I am doing an exploratory study for my Master's thesis to learn more about what training or tools trauma-focused clinicians are receiving at the educational or institutional level to prevent burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization. This study also seeks to identify which individual, agency, and institutional-level interventions are effective in preventing burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization and in promoting compassion satisfaction.

For the purposes of this study, burnout, secondary traumatic stress, compassion fatigue, vicarious traumatization, and compassion satisfaction will be defined as follows:

- Burnout – emotional exhaustion, depersonalization, reduced sense of accomplishment. Can present in the clinical setting due to factors such as caseload size or institutional stress.
- Secondary Traumatic Stress (STS) –clinicians who work with victims of trauma become indirect victims of that trauma and experience stress as a result of helping or wanting to help a traumatized or suffering person.
- Compassion fatigue –a combination of the symptoms of STS and burnout
- Vicarious Traumatization- significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory.
- Compassion Satisfaction: the sense of satisfaction that clinicians derive from helping others

I would like to invite you to participate in my study, which will consist of an interview lasting no longer than 45 minutes, followed by completing the thirty-question Professional Quality of Life Scale (ProQOL-5)-5, which should take no longer than 5-10 minutes. I will first ask a limited number of demographic questions about your age, race, degree, licensure, number of years practiced, and area of expertise. Then I will use an interview guide that includes questions about what self-care strategies you, as an experienced clinician, find particularly effective, and what, if any, vicarious traumatization prevention training, education, or continuing education you have received; what you have found useful; and what you would like to see included in training and education for trauma therapists that you did not receive during your graduate or professional work.

You are eligible to participate in my study if your caseload is comprised of 50% or more trauma-focused work, are currently practicing with a Master's or Doctoral degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology, are licensed, and have been practicing for at least two years since earning your degree. Those eligible may practice in a variety of outpatient settings including: social agency, hospital or veteran's affairs clinic, private practice, and/or home-based

service. Proximity to Durham, North Carolina is preferred. All identifying information collected within this study will be kept confidential and disguised when presenting the findings. All data collected from this study will be coded and demographic data will be presented in aggregate, maintaining your privacy. The research will be used for my MSW Thesis, presentation, and dissemination, and possible publication.

If you meet criteria for participating, I encourage you to take part in my study. Please reply to this email and check the appropriate boxes below so that I may send you further instructions.

If you do not meet the criteria for this study, or if you are not interested in participating, I would appreciate your **forwarding this email to any acquaintances or colleagues you know who may be eligible and willing to participate**. The forwarding of this email to other potential participants would be very helpful!

If you have any questions about my research or the nature of participation, please feel free to reply to this email ( [REDACTED] ) or contact me at a later date.

Please reply to this email and check the appropriate boxes based on your interest and eligibility:

Meet participation criteria

Interested in participating

Not interested in participating, but will forward email to others

Thank you for your time and interest in my research topic.

Sincerely,

Loren Biggs  
MSW Candidate 2013  
Smith College School for Social Work

## Appendix F

### Listserv Moderator Approval Letter

---

Subject: Re: Thesis Message  
From: [REDACTED]  
To: lorenbiggs [REDACTED]  
Date: Wednesday, January 23, 2013 8:10 PM

Loren: It is fine for you to send an email to the AAPCSW listserv. Good luck.

You might also want to directly contact a colleague in DC named [REDACTED] at [REDACTED] (use my name). She is an AAPCSW member, but also one of the leaders of a national trauma therapy org (I forget the name). She is well-networked in that community.

[REDACTED]  
AAPCSW Listserv

On Wed, Jan 23, 2013 at 11:29 AM, Loren Biggs <[REDACTED]> wrote:  
Hi [REDACTED],

First, I wanted to thank you for your role as moderator for the AAPCSW listserv. I am a student getting my master's in social work and the articles and discussions that happen there are invaluable in terms of profession (and sometimes personal!) growth.

I am working on a thesis as a part of my requirements for graduation. My thesis aims to assess of what sort of training is being conducted at the educational and institutional/agency level to prevent the development of burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization in trauma-focused clinicians. The working title of this study is: "Do We Practice What We Preach?: An Exploratory Study to Discover Institutional, Agency, and Individual Approaches to Clinician Self-Care and to Assess Institutional Support and Training for the Prevention of Vicarious Traumatization." I am hoping to conduct 30-45 minute interviews with licensed clinicians whose caseload is at least 50% trauma-specific.

Pending approval by my college's Human Subjects Review Board, I would like to send an e-mail to my fellow AAPCSW members via the listserv to inform them about my study, explain the inclusion/exclusion criteria, and invite them to participate if they are interested in doing so. It will only be necessary for me to do so if I do not find the 6-10 subjects I hope to interview through snowball sampling of personal and professional contacts.

Part of my HSR application submission requires that the moderator of the listserv provide a letter or e-mail indicating that it would be acceptable for me to send out such an e-mail, pending the moderator's approval of the content.

Please let me know if you have questions or concerns!

Many thanks and all best wishes,  
Loren Biggs  
MSW Candidate 2013  
Smith College School for Social Work

## Appendix G

### Informed Consent Form

Dear Participant,

My name is Loren Biggs. I am a graduate student at Smith College School for Social Work. I am conducting research to learn more about what training or tools trauma-focused clinicians are receiving at the educational or institutional level to prevent burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization. This study also seeks to identify which individual, agency, and institutional-level interventions are effective in preventing burnout, secondary traumatic stress, compassion fatigue, and vicarious traumatization and in promoting compassion satisfaction. This study will be presented as a master's degree thesis and may be used in possible future presentations, publications, or dissertations.

For the purposes of this study, burnout, secondary traumatic stress, compassion fatigue, vicarious traumatization, and compassion satisfaction will be defined as follows:

- Burnout – emotional exhaustion, depersonalization, reduced sense of accomplishment. Can present in the clinical setting due to factors such as caseload size or institutional stress.
- Secondary Traumatic Stress (STS) –clinicians who work with victims of trauma become indirect victims of that trauma and experience stress as a result of helping or wanting to help a traumatized or suffering person.
- Compassion fatigue –a combination of the symptoms of STS and burnout
- Vicarious Traumatization- significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory.
- Compassion Satisfaction: the sense of satisfaction that clinicians derive from helping others

Your participation in my study is voluntary. I am asking you to participate in a 30-45 minute interview. Within the interview, I will first ask a limited number of demographic questions about your age, race, degree, licensure, number of years practiced, and area of expertise. Then I will use an interview guide that includes questions about what self-care strategies you, as an experienced clinician, find particularly effective, and what, if any, vicarious traumatization prevention training, education, or continuing education you have received; what you have found useful; and what you would like to see included in training and education for trauma therapists that you did not receive during your graduate or professional work. The interview will be followed by completion of the thirty-question Professional Quality of Life Scale (ProQOL-5), which will take 5-10 minutes to complete. You may choose not to answer any of the questions. The questions that you do answer will be analyzed and included in aggregate data. Interviews will be recorded and transcribed by me. If a professional transcriptionist is needed for transcription, he or she will be required to sign a confidentiality agreement, as will the volunteer analyst who assists with the coding of interviews. My research advisor will only have access to the data once any identifying information is removed. You are

eligible to participate if you are able to read and write in English; have a graduate degree in counseling, psychology, clinical social work, or a related field; are a licensed practitioner with two years of practicing experience after the completion of your degree; and identify as a trauma-focused clinician (at least 50% of your caseload is trauma-focused).

Participation in this study may cause distress for you, as the questions may bring up experiences and memories of vicarious traumatization or compassion fatigue over the course of your work with clients. You will not be asked to explicitly discuss your vicarious traumatization or secondary traumatic stress, but the questions asked may trigger distressing memories associated with your professional or personal experience.

Although there is no financial benefit for your participation, this is a wonderful opportunity to share your experience and expertise. The information you share will contribute to the limited knowledge about the training and educational needs of trauma therapists. By sharing your experiences and knowledge, you are generating more interest in the field, and providing critical information that might aid in the development of comprehensive training for trauma therapists that will help to guard against vicarious traumatization, burnout, and secondary traumatic stress.

Because data will be collected through interviews, anonymity cannot be achieved, but confidentiality will be assured. You will be assigned coded identification numbers, which will appear on the transcripts and collected data. Your name will be stored separately from the collected data to ensure confidentiality. All signed informed consent forms will be kept in a secure location separate from the collected data. You will be encouraged to disguise any identifying information regarding your clients during the interviews. If this study is used for publication or presentation, any possible identifying information about you will be further disguised and all of the demographic data will be presented in aggregate.

The audio recordings of the interviews will be transcribed onto a secure, password-protected program. The original tapes will be stored in a secure location for three years after completion of the study. After three years, the tapes will be destroyed or will remain secure until no longer needed. The transcriptions will be stored in the secure program for three years as required by federal regulations, after which time they will be destroyed. It is the intent of this researcher to do all transcription of the interviews. If an assistant is required to complete the transcription, they will be required to sign a confidentiality agreement before being granted access to the files (which will be identified only by ID number).

A coding assistant will review the qualitative data to ensure the validity of the coding. Though identifying information in the data will be removed, this coding assistant will be required to sign a confidentiality agreement to minimize risk. My research advisor will have access to the data only after identifying information has been removed. To ensure that you are not identifiable, the data will be an amalgam of all responses. Quotes and illustrative vignettes from the qualitative interviews will be disguised to ensure the confidentiality of the participants.

ProQOL-5 surveys will be scanned and stored electronically, and the original hard copies will be shredded. All electronic data will be encrypted and stored in a password-secured file (i.e. digital recordings of interviews, scanned ProQOL-5 results, etc.) All data will be kept for three years, as required by Federal regulations, and then will be destroyed or kept secure for as long as they are needed. When no longer needed, data will be destroyed.

Participation in the study is voluntary and you may refuse to answer any of the questions during the interview or on the ProQOL-5. If you choose to withdraw after the interview has been completed, all materials pertaining to you will be immediately destroyed. If you wish to

withdraw from the study, you must do so by April 15, 2013. If you choose to withdraw after the interview but before April 15, 2013, none of your responses will be used within this study and the transcriptions of your interviews will be destroyed, as will your ProQOL-5 survey. Please contact the researcher at [REDACTED] should you have any questions or wish to withdraw.

If you have any concerns about your rights or about any aspect of the study, you should contact the researcher at [REDACTED]. For further questions or concerns regarding your rights, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your interest in the study.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Researcher Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Please keep the attached copy of this Informed Consent Letter for your records\*



## Appendix H

### Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also to be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Loren Biggs, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

### PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher—Loren Biggs—for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

\_\_\_\_\_  
Signature  
\_\_\_\_\_  
Date  
\_\_\_\_\_  
Loren Biggs, Researcher  
\_\_\_\_\_  
Date

## Appendix I



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 22, 2013

Loren Biggs

Dear Loren,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett' followed by a flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Acting Chair, Human Subjects Review Committee

CC: Kelly Mandarin, Research Advisor