

VICARIOUS TRAUMA AND STAFF SUPPORT

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Photograph by Ezme Kozuszek

“Hope and fear cannot occupy the same space
at the same time. Invite one to stay.”

—Maya Angelou

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In a typical mental health agency, staff work with clients who face multiple problems including poverty, trauma, mental disorders, and social isolation. People recovering from serious interpersonal violence may experience all of these, and in addition, frequently experience a kind of absolute powerlessness and vulnerability that results from being intentionally victimized by another person or people. While the stresses of working with clients who face significant obstacles to recovery and have limited access to resources have been well documented (Lloyd, King, & Chenowith, 2002), the TRC model incorporates special attention to the risk of *vicarious trauma*—a combination of emotions and attitudes that can render staff incapable of effectively helping survivors of trauma. This chapter describes vicarious trauma and discusses how team culture, staffing, training, and institutionalizing support for staff can prevent the effects of vicarious trauma from undermining a program’s effectiveness.

What is vicarious trauma?

From a theoretical point of view, vicarious traumatization, based in constructivist self-development theory (Pearlman & McCann, 1990), is a negative transformation in the self of a trauma helper who engages empathically with traumatized clients. Its symptoms in part parallel those of PTSD, and include anxiety, despair, intrusive imagery, sleep disruption, cynicism, hostility, and difficulty in maintaining helping relationships. Beliefs that go along with vicarious trauma may include, “this situation is hopeless,” “the clients bring it on themselves,” and “there’s nothing anyone can really do to help.” Vicarious traumatization was first identified in mental health professionals working with trauma survivors, but it can also affect medical providers, law enforcement, and others who work with severely traumatized people.

Stress and burnout vs. vicarious trauma

Providing services at any social service agency can be stressful for staff who may struggle to help people coping with multiple problems in an underfunded system. Helpers experience tremendous pressure as they try to deliver services while at the same time complete needed documentation and billing, attend meetings, and cope with the feeling that they are constantly asked to do more with less. But, unlike vicarious traumatization, this stress does not bring about a specific transformation of agency workers. More serious long-term stress can result in “burnout,” a feeling of being exhausted and unmotivated. While vicarious traumatization can overlap with stress and burnout, it has specific symptoms that parallel PTSD (such as intrusive images of another person’s trauma). It can result in pervasive changes in how workers view themselves and the world, and how they relate to the trauma survivors they are ostensibly trying to help. Both stress and burnout can usually be mitigated or resolved by providing time off, support and

encouragement, professional training, or motivational workshops. While vicarious trauma is also mitigated by these strategies, it requires other intensive efforts that target it specifically.

Working with severely traumatized individuals presents different and unique challenges that go beyond stress and burnout. The effects of vicarious trauma on staff can seriously undermine the effectiveness of an agency.

The process of vicarious traumatization

Consider a TRC Clinician who, in the morning, visits someone in the hospital who has been raped and then thrown out of a moving car. In the early afternoon, the Clinician meets with a client who is recovering at home after being beaten by multiple assailants, his jaw fractured and wired shut. The final hour of the day is spent talking with a woman whose child was killed by a drive-by shooting's stray bullet. These stories are not intended to traumatize the reader; they are provided only to convey the severity of what a Trauma Recovery Center worker encounters on a daily basis. TRC Clinicians and other Trauma Recovery Center staff work closely with real people who have had such horrific experiences, day after day, week after week.

OTHER EXPOSURE. In addition to working with their own clients, TRC Clinicians may be exposed to the details of other clients' trauma when cases are discussed at team meetings, in supervision, or informally as staff debrief with each other. Without mindfulness about what is communicated and guidelines about the sharing of trauma content, this secondary exposure can cause and/or intensify the experience of vicarious trauma.

INSTITUTIONALIZED TRAUMA. If enough individual staff members suffer from unmitigated vicarious trauma, there is also a risk that it becomes institutionalized. For example, when senior staff or program managers communicate a sense of hopelessness or despair, or an attitude of blaming the survivor, this can create a culture that reinforces vicarious trauma. Possible outcomes then include the erosion of healthy communication and boundaries among staff, and the risk of truly dysfunctional interpersonal dynamics in which staff may view each other or leadership as perpetrators of harm and themselves as victims. All staff who work with severely traumatized people are vulnerable to the experience of vicarious trauma. This is recognized in the DSM-5 under the criteria for Post-Traumatic Stress Disorder, which includes "Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)" (American Psychiatric Association, 2013). Many TRC Clinicians go through intermittent periods of

feeling more intensely impacted by the stories and experiences of their clients. Research has shown that helpers have increased vulnerability to vicarious trauma early in their careers, while they are still developing their own effective coping strategies (Pearlman & McCann, 1995). Vulnerability also increases during periods of personal stress, i.e., undergoing a divorce, or the serious illness or death of a family member. The degree to which a clinician identifies with the experience of a client, either because of similar sociocultural demographics or a similar past trauma experience, also increases vulnerability to vicarious trauma.

Manifestations of vicarious traumatization

OVERIDENTIFICATION WITH CLIENTS. Staff can become overwhelmed and come to identify themselves as helpless victims. They deeply sympathize with clients, but have trouble establishing appropriate boundaries, and their own emotional reactions to witnessing trauma in their clients prevent them from being able to provide effective help. They may experience the normal friction that happens in any agency as persecution, and experience changes in their world view that results in feelings of despair and hopelessness.

CYNICISM AND HOSTILITY. The other typical manifestation of long-term, unmitigated vicarious traumatization is the development of a stance of cynicism, or “compassion fatigue” (Figley, 2002). The cognitive dissonance caused by repeatedly seeing bad things happen to good people can cause providers to take on the view that clients are responsible for their own victimization. This survivor-blaming reduces staff performance and efficacy, both because staff’s negativity precludes them from establishing rapport with clients, and because their view of clients as “bad people” gives them little motivation to try to be helpful. They may unknowingly justify their unhelpful stance by thinking, “The client was asking for it” or “The client deserved it.”

If vicarious trauma goes unrecognized and unmitigated, staff develop an entrenched sense of personal victimization, globalized helplessness, and/or a cynical, blame-the-survivor point of view. When these cognitive and emotional symptoms of vicarious trauma persist for a significant length of time, they can be difficult to reverse.

Workforce and agency problems

In addition to observing the behaviors described above, management may observe the following problems that originate in vicarious trauma:

- Staff absenteeism

- High staff turnover
- Pervasive negativity in staff meetings and other collegial communication
- Low staff morale
- Client complaints about staff on satisfaction surveys, to other agencies, etc.
- Grievances filed by staff
- Grievances filed by clients
- Low client retention rates

Strategies to Institutionalize Staff “Self Care” and Promote Organizational Well-being

The challenge of vicarious trauma can be met by implementing a system of supports into the program from the beginning. When implemented together, the following strategies help mitigate the impacts of vicarious trauma on staff and promote an organizational culture of wellness and efficacy.

Culture of compassion

Leadership needs to develop a culture of compassion and support throughout all levels of the program in order to keep staff healthy and effective. This culture must include all staff and volunteers, including professionals, paraprofessionals, trainees, front office reception, clerical staff, evaluation and research staff, and senior management.

This culture should be developed and maintained through specific policies, procedures, and regular activities, such as those outlined below. Because staff must be supported in order for them to be able to help clients, a culture of support does not conflict with making client-centered services an agency’s top priority.

Hiring

From the very beginning, emphasize the core values of TRC: compassion, respect for each other and clients, and a shared commitment to working with underserved populations. Initial job postings and position descriptions should refer to the core values.

During the interviewing process, explicitly mention TRC core values and assess applicants’ fit. This is necessary for all levels of staffing.

The interview process should assess the capacities of the applicant to know when they are experiencing stress and to use healthy coping strategies. In addition, applicants with previous experience working with traumatized people should be queried about attitudes that can result from vicarious trauma, such as excessive cynicism. These can be red flags in the interviewing process.

Promoting “self care” through self care groups

“Self care” refers to the staff taking care of themselves in a regular, organized way. However, rather than relying solely on individual staff’s coping strategies that are implemented in their personal time, such as exercising and getting enough sleep, TRC emphasizes making an organizational commitment to staff well-being by providing one or more self care groups at dedicated times during the work schedule.

SCHEDULE. A weekly group is necessary in order to have sufficient impact. Often the self care group is scheduled for one hour per week. While this is “protected” time, attendance needs to be voluntary, as mandatory self care can feel like more of a burden than an opportunity. New employees and trainees should be oriented to the importance of setting this time aside, and not working through it.

FACILITATORS. An outside facilitator can be helpful in establishing a new self care group, so that the burden does not fall on one of the staff. However, some groups may prefer to facilitate for themselves, especially after they have become established and have a good sense of what works for them. In that case, it can be helpful to have the facilitator role rotate to a new staff member every six months in order to share the work.

ACTIVITIES. Activities can vary from week to week. In a process-oriented self care group session, staff can check in with each other about the ways they are noticing that they are impacted by the work, and can offer each other normalization and coping strategies. In addition, staff may also benefit from group sessions that provide activity and camaraderie such as walking, yoga, meditation, cooking, etc. In order to accommodate different ways of coping, it can be helpful to alternate process-oriented sessions with activity-oriented sessions.

SUPERVISORS GROUP. Supervisors may not want to attend the weekly self care group comprised of the people they supervise so that staff might feel more comfortable discussing how they are impacted by the work, and can then benefit from peer support. Instead, supervisors can hold their own self care group.

REVIEW AND CHANGE. It is important to recognize that self care needs of the staff are likely to change over time and leadership needs to be sensitive to these changes. Periodic use of a survey, augmented by group discussion, can be helpful for reviewing how the self care activities are going and identifying what is working and what is not working. Changing the self care group helps meet changing needs, as well as keeping the self care activities fresh and engaging.

Staff meetings that promote optimism and support

In addition to transacting agency businesses, staff meetings are an important part of maintaining a culture of compassion, optimism and mutual support. They can incorporate institutional rituals that explicitly remind staff that—in spite of the horrific experiences of traumatized people—the world is not a bad place. To the outsider, sometimes these staff meeting practices may seem sentimental or like cheerleading. But in the context of the grim realities of helping traumatized individuals, this emphasis on the positive is healing, and necessary.

Some useful practices include:

- Staff meeting **BOOK ENDS** (informal “story telling” at the start and end of each meeting). At the beginning of the meeting, offer the opportunity for staff to share a brief summary of a client’s success. Even a “small success” is meaningful, and a cause for celebration, considering the huge obstacles TRC clients face. At the end of the meeting, offer the opportunity for staff to acknowledge each other, so that the whole group is witness to some way that a co-worker helped another out that week, or was observed doing something exceptional in their work. This reminds staff that small acts of kindness have a real impact and creates an institutional ripple effect. Practicing gratitude has been demonstrated to increase optimism, joy and other positive emotions. It increases staff resiliency, strengthens relationships and helps to increase altruism and compassion (Emmons & Mishra, 2012).
- **CELEBRATING AND RECOGNIZING THOSE WHO CONTRIBUTE TO THE “HEALING COMMUNITY.”** The concept of a “healing community” is not restricted to the four walls of the TRC. In order to support clients, staff rely on their community partners, such as other health care providers, other service agencies, law enforcement, or local businesses who donate goods to the TRC. These partners are part of the healing community, and they not only concretely support clients, but provide further evidence to clients that they are not alone, and others are “walking with them” on their healing journey. Once a month, during staff meeting, the UC San Francisco TRC chooses a community partner who has made a significant contribution to the work we do. All staff pass around and sign a thank-you card that is sent to the identified person or program. The ripple effects of gratitude

increase positive emotions among the TRC staff, reminding us that we, too, are “not alone” in working with our vulnerable clients. This practice helps to reinforce the good works of our partners while it strengthens and expands the TRC as a healing community.

- **HEALTHY VENTING.** Communication about clients explicitly excludes sharing graphic details that can engender vicarious traumatization. Staff can share how they feel, including frustration and unhappiness, but if they have a need to talk about a particularly terrible or painful occurrence they have either witnessed or been told about, this is done in individual supervision.
- Invite staff to **SHARE INSPIRATIONS**, such as quotations or events. Ask “What inspired you today?” or “What touched you today?”
- Regular **CULTURAL HUMILITY** practices create space for dialogue and help institutionalize cultural humility as a core value. The group could alternate dedicated time for discussion of issues that have arisen with clients during the week with group exercises designed to increase both self-awareness and awareness of others. An example of an exercise is asking a few people each week to volunteer to take a couple of minutes to talk about their name(s), and to share reflections on both the background of their name and their experience of having it. Note that these exercises are most beneficial when all staff feel safe to participate, and when there is general buy-in among all staff to the core value of adopting a cultural humility approach to all relationships.
- **CLIENT MEMORIALS.** At the UC San Francisco Trauma Recovery Center, staff hold client memorials twice a year to acknowledge clients and others who have died. In this way, those losses are held by the entire team, rather than solely with the TRC Clinician who worked with that client. The memorial often consists of a brief reading or acknowledgment, followed by a reading of clients’ names.
- **CELEBRATIONS**, such as receptions, staff lunches, or parties should be organized around occasions such as work anniversaries, funding awards, birthdays, and other events that have positive meaning for staff.

Individual supervision

Individual supervision, described in detail in the Supervision chapter, is essential to preclude vicarious trauma. To address vicarious trauma, supervision should at least periodically include discussion of how the supervisee is feeling in relation to the work, and explore whether the Clinician is experiencing symptoms of vicarious trauma. The supervisor should check to see if any specifics that are not appropriate for group discussion need to be discussed individually, and encourage and facilitate the supervisee’s self care.

Training

Orienting new staff and trainees at the beginning is very important. They need to be informed about vicarious trauma, and about how a culture of compassion, optimism and support, along with regular structured activities, will help prevent it. Before they start seeing clients, they need to know why, how, and when to get support for themselves. Supervisors should inquire about staff members' mindfulness of the ways they are impacted by trauma work, as well as the specific coping strategies that are most effective for them, or that they would like to experiment with.

In addition, all staff should receive ongoing professional development training on a regular basis, such as in a weekly staff development meeting. In addition to enhancing the professional competence and efficacy of staff, these trainings also serve as a buffer to stress-related responses. Clinicians are able to engage with relevant topics and each other on a different level than during their clinical work; feelings of collegiality and increased competency are an excellent counterbalance to feelings of isolation and hopelessness. Training topics can range from new evidence-based treatment interventions to implementing a social justice lens. Sample topics include: learning new developments in the assessment and treatment of trauma, information about the history and cultures of different client populations, and how we work with the "isms" our clients experience, including racism, sexism, homophobia and transphobia.

Additional considerations for leadership

Supervisors need to maintain a balance between supporting staff in their self care activities versus meeting the demands of the organization for high productivity and adhering to high expectations for success. At the same time that practice of self care for staff is institutionalized and encouraged, the organizational culture must also stay client-centered. The provision of high-quality mental health support services for traditionally underserved clients is always the program's top priority. Self care addresses this priority by ensuring that staff remain effective in their work and promoting their longevity in the field.

When addressing vicarious trauma, supervisors also need to support staff by empowering them and believing in their resiliency, but not disempowering them by giving the message that the work is, in fact, too overwhelming. While vicarious trauma is a real work hazard, it can also be effectively managed. For example, when a supervisee discusses the impact of vicarious trauma in individual supervision, the supervisor's response should be validating and normalizing, and include the exploration of coping strategies both inside and outside of client sessions. But if a supervisee has significant

problems with attendance or time management that are negatively impacting their clients, these cannot be written off as the employee's response to vicarious trauma.

Other considerations for TRC leadership include:

- “Every voice gets heard.” Supervisors need to communicate and demonstrate that every staff member is important and has something valuable to offer.
- Leadership should promote the idea that it takes a compassionate community of people working together to heal from trauma.
- Balance out the “bad” with the “good;” balance violence and trauma with compassion and kindness; vicarious trauma with vicarious gratification/vicarious joy.
- Finding meaning in trauma/altruistic activity or client advocacy is utilized as an antidote to feeling hopeless and helpless.

Policies

A Trauma Recovery Center should adopt specific policies to help address vicarious trauma. These include:

- Explicitly encouraging staff to take regular lunch breaks, to use vacation leave, and take sick leave as needed.
- Explicit discussion of self care in staff meetings and individual supervision.
- When there is a clinical emergency, self-care is to be put on hold until the crisis is dealt with.

Closing Comments

While vicarious trauma is a formidable problem, agencies can prevent it by establishing a culture of self-care, along with concrete steps including addressing the issue in employee selection, training, supervision and staff meetings, and by establishing weekly self-care groups.

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