When Compassion Hurts:

Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers

best start
meilleur départ

by/par health nexus santé

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Introduction:

In prenatal and early childhood services, there is a close connection between the service provider and the person being served. This relationship exposes workers to the distress and pain experienced by mothers, fathers, infants and young children, yet is strengthened through empathy and a desire to alleviate pain and suffering. Caseloads invariably include people who are living with the impact of trauma, death, violence, fear, poverty, depression, hopelessness, helplessness and a myriad of other physical and mental health issues. As a result, the question is not whether stress will appear as a result of this exposure, but *to what extent* (Wicks, 2006).

There is no doubt that there is an impact. The greatest debate involves terminology (Stamm, 1997). Burnout, vicarious trauma, secondary trauma, secondary traumatic stress and compassion fatigue are some of the words used. There is also a range of descriptions as to what each word expresses. This manual will use burnout, vicarious trauma and secondary trauma to encompass the various words and descriptions used to describe the impact of stress on workers. More in-depth definitions are contained in Chapter 1.

Anna's Story

"While providing aftercare to high risk mothers, I worked with a 17 year old who became pregnant when her infant was just 3 months old. She continued to smoke, drink and party throughout her pregnancy. Child Protection services did not have enough evidence to intervene. When her baby was born, there were physical deformities and the baby died after a few days. I was at the birth and saw the baby. I can't get the picture of that baby out of my mind. I blamed the mother, but I also blamed myself for not being able to help the mother stop using. I thought maybe if I had spent more time, or had more skill, I would have been able to prevent this. Now, I have been on stress leave for five months. I feel so alone and my partner just broke up with me because I am not there for him. I just started taking medication for depression. Funny, I know how terrible my life is, but I just don't care anymore. What is the sense of anything, anyway?"

The story above depicts secondary trauma. Although Anna is not an actual person, there are thousands of service provider testimonials depicting the personal distress resulting from client/patient traumatic experiences. Most often, the distress is not anticipated.

As much as we need to understand burnout, vicarious trauma and secondary trauma and how they can be prevented, we also need to know how to identify and respond to them when they do occur. Managers and organizations have a critical role in preventing burnout, vicarious trauma and secondary trauma by focusing on building trauma resiliency and by developing appropriate policies and procedures. Although it may not be possible to eliminate the distress associated with our work, it may be reduced and healing can take place.

There is no shame in experiencing burnout, vicarious trauma or secondary trauma. Without compassion and empathy for others, there would be no impact.

Chapter 1: Definitions

There are many terms found in the literature and practice describing the impact of stress and trauma on service providers. More confusing, they are often used interchangeably. Having a clear understanding of the differences is important. Although there is some discrepancy, the following descriptions provide an introduction to each term as it is used in this manual and clarification of the impact on the service provider.

There are four categories related to being negatively impacted by our work:

1. **Burnout**
2. **Compassion Fatigue/Vicarious Trauma/Empathy Fatigue**
3. **Secondary Trauma/Indirect Trauma/Secondary Traumatic Stress Disorder**
4. **Countertransference/Traumatic Countertransference**

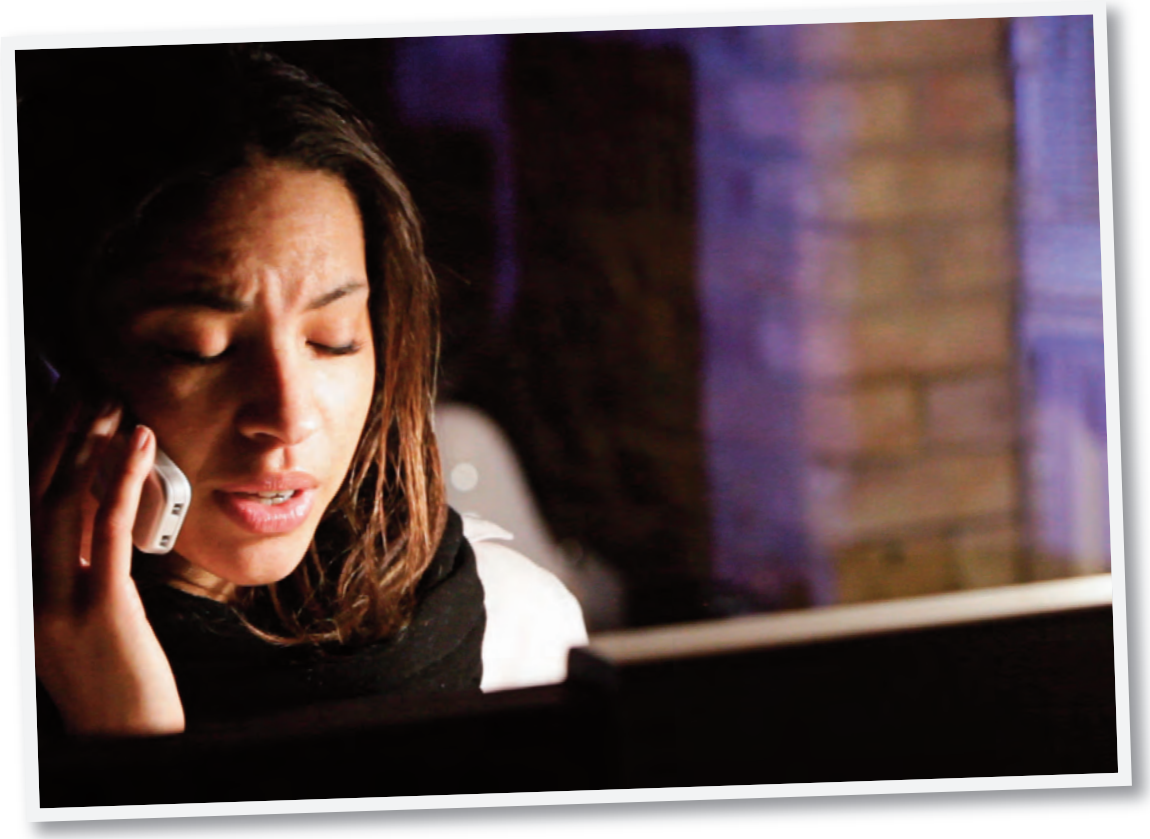
1. Burnout

Burnout is usually the result of prolonged stress or frustration, resulting in exhaustion of physical strength, emotional strength and/or motivation (Maslach, 2003). Burnout tends to be associated with the workplace, and is often a predictable outcome when the work environment demands a great deal from workers. One of the characteristics of burnout is that it occurs over a fairly long period of time and is cumulative. It does not afflict a person after one bad day.

Burnout is associated with unsupportive management, lack of challenges in the workplace, low salaries, and difficulties in providing client services (Stamm, 1997; Soderfeldt, Soderfeldt & Warg, 1995). It can lead to impaired decision making and other conflicts related to the client/helper relationship (Florio, 2010). A battery is a useful metaphor to describe burnout. Imagine that energy is produced from a small battery in your body. As you expend energy throughout the day, power is drained from the battery. Through breaks, lunch, laughter, feeling good about your work, receiving complements and so forth, your battery is recharged and you continue to function well. What would happen if there was not enough positive input from work and from life outside of work, to recharge your battery?

Peter's Story

Peter has worked as a home visitor for 10 years. He has always excelled at his work and whenever anyone needed something extra done, he would be the first to volunteer. He worked late many nights and often took work home. He has asked for a smaller caseload, but his manager was unsympathetic saying that his years of service should make his work easy. In addition, the agency has suffered cutbacks in staff and resources. As a result, he has not had any professional development opportunities for three years. Over the last year, colleagues have noticed changes in Peter. He seems quiet, never comes out for lunch with his co-workers, is always tired and is behind in his paperwork. He is often late for work, which is very unusual. Peter finds it hard to get up in the morning. When he thinks about work he feels angry and resentful. He watches the clock when he is at work, and can hardly wait to go home at five o'clock.



2. Vicarious Trauma/Compassion Fatigue/Empathy Fatigue

These terms have been used interchangeably to describe the impact of a specific type of experience and outcome. Vicarious trauma is a permanent change in the service provider resulting from empathetic engagement with a client's/patient's traumatic background (Pearlman & Saakvitne, 1995). Although there are some parallels to burnout, including symptoms such as exhaustion, feeling overwhelmed, isolated and disconnected, vicarious trauma is much more pervasive, impacting all facets of life, including the body, mind, character and belief systems. The relationship of the person suffering from vicarious trauma to the world around them becomes altered.

Like burnout, vicarious trauma typically develops over a period of time, after many sessions of listening to painful experiences with an empathic listener.

Nicki's Story

Nicki is an early child care worker in a women's shelter. She has been there for six years and has heard hundreds of horrific stories and witnessed the impact of violence on young children. Nicki's colleagues find that she is very different over the past six months. She is quiet and moody. She does not join the other staff for lunch or breaks and has become quite disorganized. When Nicki gets home she usually goes right to her room and watches television. She snaps at her children and husband to the point where they have started to avoid her. Nicki has lost 15 pounds and has severe headaches that come and go throughout the day.

3. Secondary Trauma/Indirect Trauma/Secondary Traumatic Stress Disorder

Secondary or indirect trauma occurs when a service provider relates to someone who has undergone a traumatic event or a series of traumatic events to the extent that they begin to experience similar symptoms of post-traumatic stress disorder that the trauma victim is experiencing (Baird & Kracen, 2006). In secondary trauma, the traumatizing event experienced by a client/patient becomes a traumatizing event for the service provider (Perry, Conroy & Ravitz, 1991). The difference between secondary trauma and vicarious trauma is that secondary trauma can happen suddenly, in one session, while vicarious trauma is a response to an accumulation of exposure to the pain of others (Figley, 1995). The symptoms of secondary trauma are nearly identical to those of vicarious trauma.

It should be noted that the term vicarious trauma is defined by some experts as being more like secondary or indirect trauma. Although the exact use of terms may vary slightly, there is agreement that the impact on the helper is pervasive and replicates the impact of a traumatic reaction.

Jennifer's Story

Jennifer has been working in the maternity ward of the hospital for 12 years. She has always loved her work and was constantly praised by staff and patients. Mary was admitted to the hospital with pregnancy complications. Jennifer often spent time with Mary, talking about the baby, pregnancy, family and life in general. She helped Mary feel calmer about being in the hospital and positive about her pregnancy. One day, when Jennifer came in for her shift, she saw that Mary was no longer there. When she asked where Mary was, she was told that the baby went into distress and an emergency caesarean section was performed. The baby did not survive. Jennifer felt horrible and immediately went to see Mary in the surgery ward. When she entered the room Mary started to scream uncontrollably, "You told me the baby would be fine, you lied to me." One of the nurses told Jennifer she should leave. That night Jennifer had terrible nightmares about Mary and the baby. She felt terrible, empty and sick to her stomach. She took the next day off sick. She found that anything that reminded her of a baby made her want to throw up and break down into a crying fit. Television ads, babies at the mall, the sound of crying, all of these became triggers. At work she could not think clearly and began to make mistakes, putting things in the wrong place, writing the wrong instructions down, mixing up patients. Her supervisor told her to take some time off and get away from work for a while. Jennifer did take holidays, but spent most of the time in bed, in a darkened bedroom, crying and feeling like there was no sense in life.

4. Countertransference/Traumatic Countertransference

Countertransference occurs when a service provider relates to the client/patient in a manner that replicates an existing relationship (often child-parent). While vicarious trauma can be associated with countertransference, it is not the same.

In many life situations, we may find ourselves in a transference or countertransference situation. A client/patient may respond to you as if you are their sister who died, or their mother who was abusive, or you may find yourself strangely connected to a young mother who you feel great sympathy for, but, you are not sure why. Later, you reflect on how similar this client/patient is to your younger sister. We are all subject to this phenomena, because it is usually at work at the unconscious level. If left unattended, it can be harmful to the helping relationship, since the helping relationship needs to be based upon the client/patient in the context of who they are and what they need.

Organizations and agencies should provide training to staff to help them better understand and know how to respond to transference/countertransference. This is especially important since this phenomenon not only exists in helper/client relationships, but also occurs in supervisor/supervisee relationships and between co-workers.

Mariam's Story

Mariam is working with a mother, Judy, who has a high risk pregnancy. Mariam is well liked by her clients and normally has a very calm and reassuring approach. However, whenever Mariam sees Judy, she feels upset and takes a long time to calm down. She often finds she wants to say something to Judy, but holds back, choosing instead to bite her lip. In supervision, she talks about feeling angry. Her supervisor suspects countertransference and asks her if Judy reminds her of anyone. Mariam thinks for a moment and suddenly it comes to her. "Judy is just like my mother... opinionated and never listening to what I have to say. I get so mad, but I just end up saying nothing." Her supervisor nods, "Yes, it's countertransference."

Comparing Burnout, Vicarious Trauma and Secondary Trauma

Burnout	Vicarious Trauma, Compassion Fatigue	Secondary Trauma, Indirect Trauma
Cumulative, usually over long period of time	Cumulative with symptoms that are unique to each service provider	Immediate and mirrors client/patient trauma
Predictable	Less predictable	Less predictable
Work dissatisfaction	Life dissatisfaction	Life dissatisfaction
Evident in work environment	Permeates work and home	Permeates work and home
Related to work environment conditions	Related to empathic relationship with multiple client's/patient's trauma experiences	Related to empathic relationship with one client's/patient's trauma experience
Can lead to health problems	Can lead to health problems	Can lead to health problems
Feel under pressure	Feel out of control	Feel out of control
Lack of motivation and/or energy	Symptoms of post-traumatic stress disorder	Symptoms of post-traumatic stress disorder similar to client/patient
No evidence of triggers	May have triggers that are unique to practitioner	Often have triggers that are similar to the client's/patient's triggers
Remedy is time away from work (vacation, stress leave) to recharge or positive change in work environment (this might mean a new job)	Remedy is treatment of self, similar to trauma treatment	Remedy is treatment of self, similar to trauma treatment

Signs and symptoms can be used to identify someone who *may* be suffering from vicarious trauma or secondary trauma (see Chapter 3). They are not diagnostic, but can be helpful in flagging a concern. They can lead to deeper reflection, exploration, and/or referral to an expert.

Note: *For the purpose of this document we will refer to the term vicarious trauma to cover the labels of compassion fatigue and empathy fatigue; and secondary trauma to include indirect trauma, and secondary traumatic stress disorder.*

Reflective Questions

1. Quickly write down 5 words that you think of when you hear burnout.

2. Quickly write down 5 words that you think of when you hear vicarious trauma.

3. Quickly write down 5 words that you think of when you hear secondary trauma.

4. Look over the three lists and think about how they are different.

5. Have you experienced any burnout, vicarious or secondary trauma symptoms?

6. Have you noticed a colleague/friend/relative that has experienced burnout or vicarious or secondary trauma?

Other Resources:

Anechaiarico, B. (n.d.). *Vicarious Trauma* (PowerPoint). Retrieved from: www.cpcamerica.com/Presentations/Vicarious%20Trauma%20Presentation.pdf

National Child Welfare Resource Center for Adoption. (2010). *Child Welfare Worker: Compassion Fatigue: Secondary Stress Disorder, Burnout, Vicarious Trauma* [Powerpoint]. Retrieved from: www.nrcadoption.org/pdfs/acc/TG%20-%20Compassion%20Fatigue%203-10.pdf

Perry, B. D. (2003). *The cost of caring: Secondary traumatic stress and the impact of working with high risk children and families*. Child Trauma Academy. Retrieved from: www.ebookbrowse.com/the-cost-of-caring-secondary-traumatic-stress-pdf-d91520558

Chapter 2: Biology of Stress and Trauma

It is helpful to understand the biological mechanics of stress or trauma in order to understand their nature and impact. How does trauma affect our body and why? Given the same situation, why is one person traumatized but another is not? When a person has stress or experiences a traumatic event, chemical and biological processes take place. The same processes occur in those experiencing vicarious or secondary trauma.

Our stress response is controlled by our Autonomic Nervous System (ANS). The ANS is in charge of preparing our body for flight, fight or freezing when there is a perceived threat. Imagine yourself in a stressful situation. What are some of the body changes that occur? Increased heartbeat, cold hands, dry mouth and tensing of muscles are all directed by your ANS.

During a traumatic event the ANS activates the victim towards fight, flight or freeze. Service providers working with highly stressed or traumatized individuals are also vulnerable to an ANS response (Rothschild, 2006).

Our ANS has two branches, the Sympathetic Nervous System (SNS) and the Parasympathetic Nervous System (PNS). They work together to promote survival of the individual and to maintain balance in the body. The SNS activates under conditions of stress, such as traumatic stress at the most extreme. The PNS is activated during rest and relaxation, and during distress such as sadness (Rothschild, 2006).

When a threat is perceived, the SNS is the primary system aroused and the body reacts quickly. Pupils dilate, heartbeat increases and blood flow is redirected from the skin to the muscle, digestion stops, oxygen supply increases and the body readies for fight or flight. When the threat is over, the PNS takes over helping the body return to a calm relaxed state.

When there is extreme life-threatening danger, the SNS and PNS can both be activated to their highest level, causing the body to freeze, like a deer caught in the headlights. The person experiencing freezing has an altered perception of time and space, and feels less pain and emotion. Time slows down and they are no longer afraid. Freezing can be viewed as an extremely valuable survival defense in some conditions (Rothschild, 2006).

This threat perception and response occurs at the unconscious level and is not subject to a cognitive or rational process. Personality, emotional content, experiential background, beliefs and internal resources play a large role in determining the perception of threat or danger. This explains why two people in the same situation can have very different reactions. Understanding the biology of stress and its automatic and unconscious nature is important to alleviate the sense of guilt and/or shame experienced by those suffering from vicarious or secondary trauma.

There is increasing research on the dynamics of empathy, in particular the mirroring of emotions and body movements. This is the capacity to unconsciously and automatically mirror the emotions of others. If we see someone yawn, we may also want to yawn. You might even have to yawn right now. Laughter also is also contagious. In our work, we may note that we are matching our clients/patients in emotions and body movement and vice versa.

Beth was interviewing a young mother (Nathalie) who was registering her two-year-old in the day care program. Nathalie was very anxious, almost shaking. She had her knees crossed and was shaking her foot. Beth was trying to help Nathalie feel more comfortable, but when she looked down she noticed she had also crossed her legs and was shaking her foot. She paid attention to her body. She focused on her breathing and noticed that she was taking quick, shallow breaths and her chest felt tight. When she looked at Nathalie, Beth quickly noticed that the young mother was breathing in exactly that way. Beth put down her pen and asked Nathalie to sit back, centre herself and take three deep breaths. Beth did the same...

We are all vulnerable to vicarious and/or secondary trauma. Our vulnerability increases if we focus on the distress of others to the extent that we lose focus of our own needs.

Reflective Questions

1. When you have felt threatened, what signs do you have that your ANS had been activated?

2. Have you ever noticed a client/patient/colleague moving into a frozen state?

3. How do you make sense of this in terms of the ANS?

4. How can you pay more attention to mirroring clients/patients in a session?

5. What are the possible issues related to mirroring emotions?

6. What are the possible benefits related to mirroring emotions?

Other Resources:

Article providing detailed information on automatic nervous system and various sub functions:
www.nda.ox.ac.uk/wfsa/html/u05/u05_010.htm

Audio on mirror neuron research: www.pbs.org/wgbh/nova/body/glaser-monkey.html

Information on latest findings related to the biology of stress and trauma:
www.mentalhelp.net/poc/view_doc.php?type=doc&id=15639&cn=117

Research findings on study on PTSD and how the body is impacted by trauma:
www.youtube.com/watch?v=EiEFrs8Ez2M

Chapter 3: Signs and Symptoms

A range of behaviours and symptoms are associated with stress, burnout, vicarious or secondary trauma. Unfortunately, there is not a specific set of behaviours and symptoms that automatically signals a diagnosis of burnout, vicarious or secondary trauma. Each person is unique and their experience is unique. One person may experience sleep issues, while the next is able to sleep well, but has headaches and recurring images or flashbacks. There are almost always several symptoms. If only one symptom is present, burnout, vicarious or secondary trauma is not likely the cause.

Some of the physical signs of stress are:

- Heart problems
- Anxiety
- Headaches
- Allergies
- Arthritis
- Eating problems
- Infections
- High blood pressure
- Immune system problems
- Nervous tics
- Rapid heart beat
- Backaches
- Cancer
- Stroke
- Ulcers
- Sleep disorders
- Addiction
- Depression
- Burnout
- Poor self esteem
- Colds/flu
- Bowel problems
- Hives
- Jaw pain

In addition, some common behaviors and emotions signalling stress are:

- Difficulty managing emotions
- Not feeling okay about self
- Relationship problems
- Social withdrawal
- Irritable, moody
- Difficulty problem solving
- Boundaries not as clear (work/home)
- Loss of meaning/value of life
- Feeling of powerlessness
- Taking on too much responsibility
- Staying at work long hours, taking work home
- Trying to control lives of others
- Accident prone
- Addictive behaviours
- Hyperarousal/hypervigilence
- Avoidance of strong emotions
- Emotional volatility
- Fear
- Silencing response (see page 14)
- Not being able to focus or losing focus easily
- Triggers (connected to client/patient trauma)
- Repeated thoughts or images of the traumatic event
- Impulsivity
- Feeling numb
- Sensitivity to violence
- Decrease in pleasurable activities
- Re-directing conversations that create distress
- Feeling disconnected from work/home or relationships
- Cynicism
- Guilt
- Absence from work
- Obsessive compulsive behavior
- Mental lapses

A red flag for full blown vicarious or secondary trauma is the impact on the individual's world view. Vicarious or secondary trauma changes the way you think about the world and yourself. Symptoms associated with this include:

- Feelings of being helpless, hopeless and/or powerless
- Feelings of lack of safety, trust
- Alienation from others
- Shattered assumptions about basic beliefs about life or people
- Loss of faith (anger with God)

The Headington Institute identifies 3 worldviews that are impacted by vicarious or secondary trauma (www.headington-institute.org):

1. **Changes in spirituality –** changes in beliefs regarding meaning, purpose, causality, connection, hope, and faith
2. **Changes in identity –** changes in the way you practice or think about your identity as a service provider, friend, or family member
3. **Changes in beliefs related to major psychological needs –** beliefs regarding safety, control, trust, esteem, and intimacy

The symptoms of vicarious or secondary trauma are the same as those of post-traumatic stress disorder. This is the foundation of understanding vicarious or secondary trauma – the helper is suffering from trauma. The source of the trauma is the impact of having a caring relationship with another person.

Having a few of these symptoms does not necessarily lead to a diagnosis of vicarious or secondary trauma. Many mental health or physical conditions can have similar symptoms, such as depression, borderline personality, bi-polar disorder, or anxiety, just to name a few. As well, just having a bad day at home or in the office might raise some of these symptoms. The difference is that the symptoms are not pervasive in time or intensity and there is no connection to compassionate work/ relationships.

One of the keys to diagnosis is that the symptoms are NOT consistent with the individual in terms of their personality, behaviour and characteristics. Their behaviour is viewed as abnormal by friends, family and colleagues. People who know the person often say, "That is not how they used to be."

Reflective Questions

1. Have you experienced any of the physical signs, behaviours or emotions identified in the list in the last month? Which ones?

2. Have you noticed any colleagues exhibiting any of the symptoms?

3. Where can you or your colleague go for help?

4. What can you or your agency do to help people identify the signs and symptoms?

Other Resources:

Mayo Clinic Health Stress Signs: www.mayoclinic.com/health/stress/SR00001

The Silencing Response

The silencing response refers to the helper's inability to attend to the stories/experiences of our clients by redirecting to material that is less distressing or uncomfortable. (Baranowsky, 2002)

Signs include:

- Changing the subject
- Providing pat answers
- Being angry or sarcastic with clients
- Using humour to change or minimize the subject
- Blaming clients for their experiences
- Faking listening
- Not being able to pay attention
- Being afraid of what is going to be said
- Suggesting the person just, "get over it"

Chapter 4: Risk Factors

High levels of stress have become the accepted norm in many workplaces, and run the risk of being ignored. The emotional work undertaken by prenatal and child service providers has biological consequences. Identifying physical stress triggers in the workplace is essential to building resilience.

Each of us is unique. Although we can identify risk factors, what impacts one person, may not impact another. Risk factors can be inherent in the individual, in their family and in their environments (home, work and community). The more empathic a service provider is, the greater the risk. Ineffective supervision, large caseloads, lack of recovery time between client contacts, traumatized or complex clients, lack of team approach in the workplace, and a lack of supports to meet client/patient needs are other risk factors (Florio, 2010).

Who is at risk?

The simple, and perhaps most concerning answer is everyone. At the same time, we know that the same stressful or traumatic experience may impact one service provider deeply, but not another. Just like smoking increases the risk of developing cancer, not all who smoke will get cancer. Similarly, although we may all be at risk for burnout, vicarious or secondary trauma, not all will experience it.

Risk Factors fall into several categories:

Individual Risk Factors	Work Risk Factors	Community Risk Factors
Personality and coping style	Role at work	Culture
Current life circumstance	Work setting and exposure	Resources at large
Social supports	Work conditions	Community factors
Spiritual connection and resources	Agency support	
Work style	Affected populations responses and reactions	
Personal history		

1. Individual Risk Factors

Personality and Coping Style

Each of us is born with a temperament, framing how we relate to the outside world. We have personality traits that define our individuality, likes and dislikes. Early in life we develop our coping styles in relation to stress. For example in the same stressful situation one person may become anxious, another becomes energized to take action, and yet another may sit back and think about what is happening.

Personal History

Did our parents stay together, or did they separate or divorce? Were we middle class or grow up in poverty? Was our family close and nurturing, or was there addiction or violence in the home? Certain experiences or life events will leave lasting imprints on who we are and how we see or define others. These will also define how vulnerable we are to certain stresses or issues. Experiences that remind us of what we have been unable to resolve during our life, particularly in our early relationships, increase our vulnerability.

Current Life Circumstance

Am I unhappy at work, or having conflict with the boss or co-workers? Do I have children? Do I feel like a successful parent? Did I just buy a new house, move, become engaged or break up with a long-term partner? Each of us has our own unique life story. The reality is that current life circumstances are always changing. Today you may be feeling confident and full of energy. Tomorrow, circumstances may bring about unexpected stress, significantly altering your mood. Change is very much related to stress. Change can take time and energy, making us more susceptible.

Social Supports

Social supports are a key component of resilience. Having people who we can turn to when we feel overwhelmed or distressed, and who love and value us, is very important. Support people can help us to find balance, perspective or just help us feel that we are not alone. When social supports are weak or non-existent, stress, pain and suffering are often accentuated. Isolation decreases access to resources and available options.

Spiritual Connection and Resources

Many people experience higher resilience through a faith filled life. Belief in a higher being, in the values and principles of their faith, and being part of a larger faith community, provide a perspective for their lives and a source of support in times of distress.

Work Style

Do we have a type A or type B personality? Are we socially connected in our workplace? Or do we just sit at the desk and churn out the work, with no time to chat with colleagues? Are we concerned about promotions and moving up the hierarchy? Or would we prefer to focus on what we do well? These examples demonstrate our work style and work ethics. A work style that is accommodated or appreciated in the workplace will lower the risks. A work style that clashes with policy and procedures, colleagues, managerial preferences, etc., will heighten the risk.

2. Work Risk Factors

Role at Work

What is your position and role within the organization? What is your role in relation to other staff? Are you a newbie or one of the veterans? What expectations do others have of you and do you have for yourself? Are you a manager or consultant? Are you mentoring other staff? Do you like the role that you have, or do you feel stuck, unable to advance or take on new interests? Are there layoffs in the near future? Are you at risk of being laid-off? These are examples of the role factors that can either increase or decrease your risk.

Work Setting and Exposure to Trauma

Is the organization large or small? Is it situated in an urban or rural setting? Is there a large management structure? Is the agency financially stable? Are there professional development resources? These are all conditions within the workplace that can have a dramatic impact on stress and how staff members are able to manage.

Unfortunately, not all agencies are equal. Some are resourced better than others. Some are led better than others. Each agency develops its own personality and coping style, complete with belief systems, experiential history, problem-solving mechanisms, etc.

Each staff member has a different exposure in the work setting. Some staff may work in sub-offices or in home offices. They may report to different managers who have different management styles.

Perhaps the most important factor is the amount of traumatic content staff members are exposed to, as well as the proportion of challenging cases. The greater the exposure and concentration of challenging cases, the higher the risk for burnout, vicarious or secondary trauma.

Work Setting Factors

Higher Risk	Lower Risk (Resilience)
Absent or inconsistent policy & procedures	Clear and consistent policies and procedures
Different application of rules for different employees	Fair and consistent application of rules for all employees
Lack of resources to meet expectations	Adequate resources to meet expectations
Leadership has difficulty making decisions	Leadership is able to make quick decisions
Leadership is unable/unwilling to correct errors made by leadership	Leadership is able to and willing to take corrective action when errors are made by leadership
There is no tolerance of errors	Errors are seen as an opportunity to learn
There is no recognition for good work	Recognition is given and employees feel valued
Workers feel unsafe	Workers feel safe, or if conditions are unsafe steps will be taken
Communication is limited	Communication is open and issues are dealt with
There is an atmosphere of secrecy	Issues are raised when they occur
You never know when you might be in trouble	There are no surprises
Environment conditions absent	Environment conditions present
No opportunities (and few opportunities) to debrief with and access support from peers	Peer support is built into the organizational structure and accessible
Reflective practice is not entrenched into or encouraged by the organization	Reflective practice is standard practice for the organization

Environmental Conditions

Here are the six environmental conditions required for health and growth, in an individual, a family, an organization or a community:

1. **Safety**
2. **Belonging**
3. **Consistency/Predictability**
4. **Opportunity**
5. **Acceptance/Love**
6. **Hope**

When one or more of these conditions is absent or has been compromised, it will be more difficult for a person or group to reach their full potential. These conditions should be present throughout an organization including interactions with clients/patients.

Agency and Supervisory Support

How supportive is the agency to its staff? Is there recognition of good work, adequate compensation, manageable caseloads, etc.? What resources are in place to support staff? Do regular supervision, evaluation and feedback to and from employees take place? Do employees feel valued and connected to the mission of the organization?

Research on vicarious trauma is clear on the importance of staff treatment and in particular how supported they feel when difficulties arise. This is critical when staff are exposed to clients who have been traumatized, or if the interaction with clients/patients is traumatic in itself. Reflective practice is a key best practice in the management of vicarious trauma in an organization. See Chapter 7 to learn more about reflective practice.

3. Community Risk Factors

Culture

Are there common cultural issues, including language, ethnic origin, and belief systems? Many agencies are working with new immigrants where values and cultural practices may conflict with western practices and thinking. Are clients/patients able to effectively communicate in English? Are translation services available? What are the circumstances for leaving their home country? What are their cultural norms regarding the sharing of traumatic experiences? What are the worker's comfort levels in working with a range of cultural groups?

Community Resources

What resources are available in the community to respond to the needs of clients/patients? Basic needs include housing, employment, and access to good nutrition. Agencies may not provide for the basic needs of the client/patient. Helping people who are suffering and who cannot get help to meet their basic needs, also adds to the empathic stress of workers.

Martina's Story

Another worker had been with the pregnant client (Molly) most of the day. When I came onboard after 4pm, I was told to have Molly admitted to a psychiatric hospital for suicidal ideation. It took a while to make the arrangements, and then we headed out for a several hour drive. I asked her if she had eaten and she said, "Not since I left home this morning." I bought Molly dinner, knowing that my organization would not pay for it. I paid for all of her snacks throughout the trip. Buying food for clients became a constant in this job, since I felt that it was wrong to let clients and their children go hungry. How can we tell people we value them and then contribute to their pain and suffering while they are in our care?

Community Factors

Are there community realities impacting the population as a whole? Do they put pressure on the community and on helping services? High poverty rates, working with a high need community, victims of a tornado or earthquake, and so forth, are examples of community stresses. Some of these may promote the onset of trauma, but at minimum they make growth and development more precarious.

Reflective Questions

1. What are your risk factors under each of these categories?

   - Personal

   - Work

   - Community

2. Which area(s) produce your highest risk factors?

3. What are some common issues triggering vicarious trauma in prenatal and early childhood service providers?

Other Resources:

Headington Institute: Risk Factors for Vicarious Trauma
www.headington-institute.org/Default.aspx?tabid=2649

Work personality types:
en.wikipedia.org/wiki/Type_A_and_Type_B_personality_theory

Chapter 5: Protective Factors

A focus on prevention avoids more serious problems later on. Like risk factors, there are protective factors inherent in the person and protective factors inherent in the organization. An individual approach is needed to protect service providers against vicarious trauma. Protective factors, like risk factors, are unique to the individual along with their specific personality, characteristics, experiential background, etc. One key protective strategy is reflective practice. See Chapter 7 to learn more about reflective practice.

Individual Protective Factors

Self-awareness

If one is self-aware, stresses and pressures are identified early. Do you know your strengths and weaknesses? Are you aware of your belief system and how you are impacted by different people at different times?

Able to ask for help and/or get support

The days of "grin and bear it" and "suck it up" need to be banished. Those who try to keep everything inside, or hide from others, tend to turn into hidden volcanoes, eventually erupting, but with much greater fierceness. Client/patient safety is needed in order to foster open communication and a helping relationship. These same beliefs also apply to service providers.

Balance between home and work

The basis of prevention is balance. When our home and work life are in balance, our body and our mind are more likely to be in balance. Exposure to trauma can push at us so we move out of balance with ourselves, with others and/or with our environments. Do you only talk about work, even at home? Can you enjoy time watching TV with a family member without thinking about what you have to do tomorrow at work? Is it difficult to watch shows depicting suffering or dysfunction? When these things happen it may be a sign that you are out of balance and at higher risk for vicarious trauma.

Personal strategies in place for self-care

Personal strategies for self-care can include an exercise program, a hobby, or being a volunteer. If you can name three things that you do for self-care every week, you are probably in pretty good shape. If you can't, then this may be a key area for you to consider. Many people have a list of personal strategies, but it is concerning how many don't actually use them on a regular basis. To care for others, you need to be able to care for yourself.

Open to learning and growing

Given adequate salaries, research has shown that learning and gaining new knowledge are great motivators for most people. This can happen through reading, supervision, team consultation, professional development, gaining more experience or taking on new roles and/or responsibilities.

Optimistic

Is the glass half full or half empty? Research has helped to identify the risks associated with being pessimistic and the benefits of optimism.

Able to set boundaries at work and home

Can you turn down work or plan a vacation and take it? Knowing what you can do without stressing or distressing yourself is a healthy protective factor. However, this does not mean you never extend yourself, never take on an extra task, or always put your needs in front of others. Setting boundaries is related to balance and being able to know when you are able to push yourself and when you need to pull back.

Expression of feelings

In mental health, one of the most common goals for clients/patients, whether children or adults, is being able to identify and express feelings. We know the value of this and the cost of keeping feelings in, or ignoring feelings. Service providers may also need to work on expressing feelings.

Compassion satisfaction

It is important to note that although there are risks to those working in the helping field, there is also a great deal of satisfaction that one can derive from this work. This is referred to as compassion satisfaction, which can be defined as the positive feelings derived from one's ability to help others to contribute to society and achieve well-being. It is believed that compassion satisfaction is a protective factor that prevents burn out, compassion fatigue and vicarious trauma (Stamm, 1999).

People who work with trauma survivors have identified personal growth, spiritual connection, hope and respect for human resiliency as positive outcomes of their work (Ortlepp & Friedman, 2002). Ensuring individual and organizational protective factors are in place will enhance compassion satisfaction.

Organizational Protective Factors

Positive relationships within agency

How accepted do I feel in the organization? Is there a sense of belonging and being part of a team? Does my organization allow workers to say "No"? Are issues with management open and constructive? Am I unhappy, but just can't afford to leave? Enjoying what you do and who you work with is an important element for most people. Key environmental conditions, including safety, consistency/predictability, acceptance, belonging, opportunity, and hope, are key protective factors for any agency.

Early Identification of workers dealing with stress

Training for staff and management on identifying stress and vicarious trauma, and on taking positive action, is important. Organizations should not expect staff to come forward. Many who are suffering from stress or vicarious trauma will not be able to self-identify. For some, there may be a reluctance to come forward due fear of being seen as weak or unable to perform their work.

Resources available for staff

What kinds of support systems are available to staff? Are the supports ongoing or readily accessible if needed? Supports include consultation, supervision, team meetings, EAP programs and professional development.

Client centred practice

At times, organizations struggling with financial or self-preservation issues can inadvertently put workers at risk by not focusing on their primary purpose, helping those in need. Those who have greatest empathy and concern for others, are at greatest risk for vicarious trauma. Feeling alone in caring increases the risk.

Not working in a caring environment also increases the risk. Being mindful of the impact of organizational issues and sticking to the purpose help maintain client centred practice and employee satisfaction.

Issues are dealt with constructively and effectively

When agencies manage issues constructively and fairly, issues are more likely to be brought forward. In the process, staff anxiety and distress can be addressed.

Communication is open and clear

When an agency fosters and models open and clear communication, issues tend to be dealt with more pro-actively. Can supervisors or managers be accessed easily to help provide direction or provide consultation? Can staff safely speak with each other without worry about gossip or complaints being made behind their backs?

Opportunities for staff to learn and grow

When opportunities for learning and growing do not exist, high performing staff will tend to have deteriorating performance over time. Professional development, access to educational resources such as videos and books, discussion amongst team members, opportunities to lead a project or initiate a project, opportunities to move into a different position... all of these are examples of opportunities for staff to learn and grow.

Reflective Questions

1. List your risk factors under each of these categories:

    a. Personal characteristics/lifestyle _____

    b. Work environment _____

2. Which area(s) produce your highest risk factors?

_____

3. What are some common issues that trigger vicarious trauma in your work?

_____

4. Which individual protective factors are present in your life?

_____

5. Which organizational protective factors are present in your work life?

_____

6. Which factors would be helpful to add to your life at home or work?

_____

Other Resources:

Infant Mental Health Promotion Project (IMP) (2004). *Supporting practitioner effectiveness with young children in high risk families* (Position Paper of the IMP Task Force on Vicarious Trauma in the Workplace). Retrieved from: www.sickkids.ca/pdfs/IMP/11745-PositionPaper.pdf

Chapter 6: Resilience and Self-care

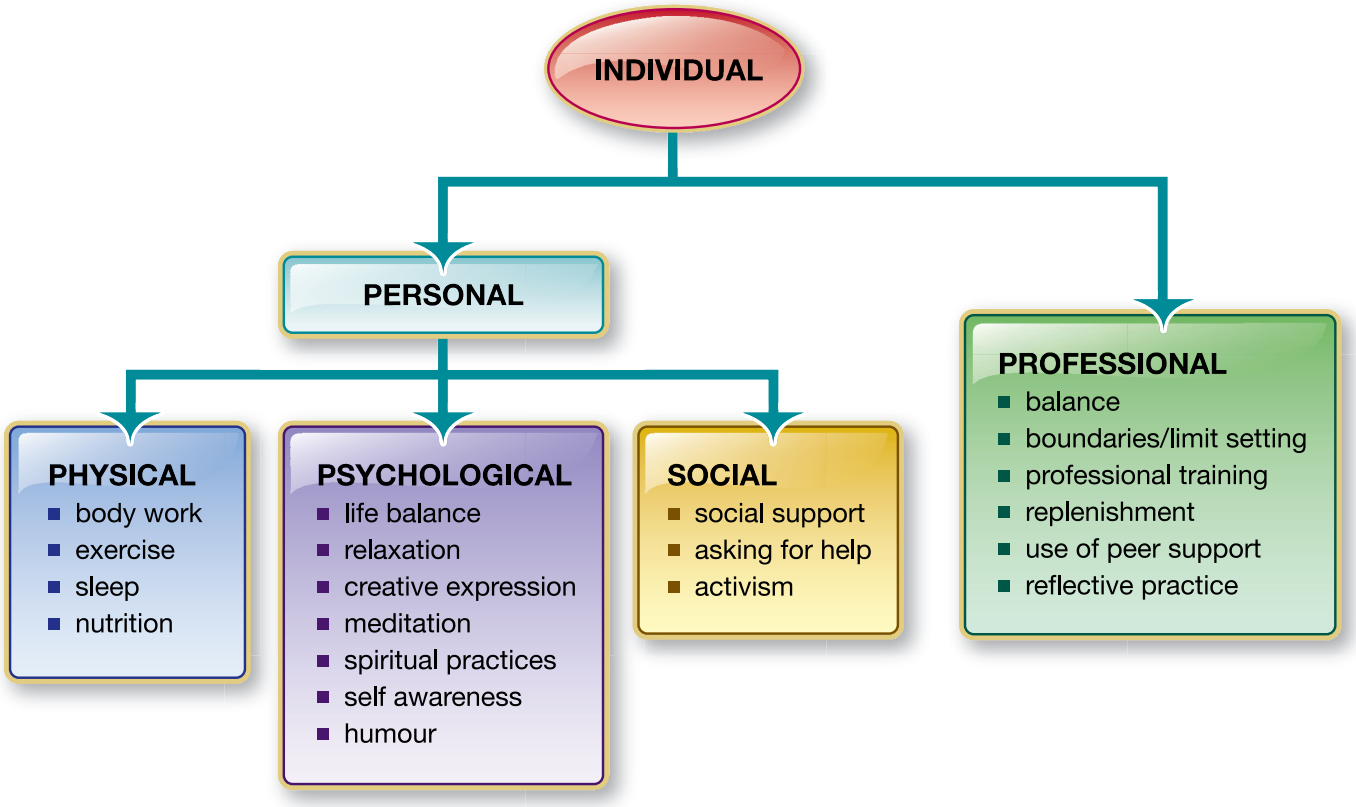
Resilience is the ability to bounce back from major stresses in life. There are two major areas that foster resilience in the workplace. One relates to what individuals are responsible for and the other is what leadership or agencies/organizations are responsible for.

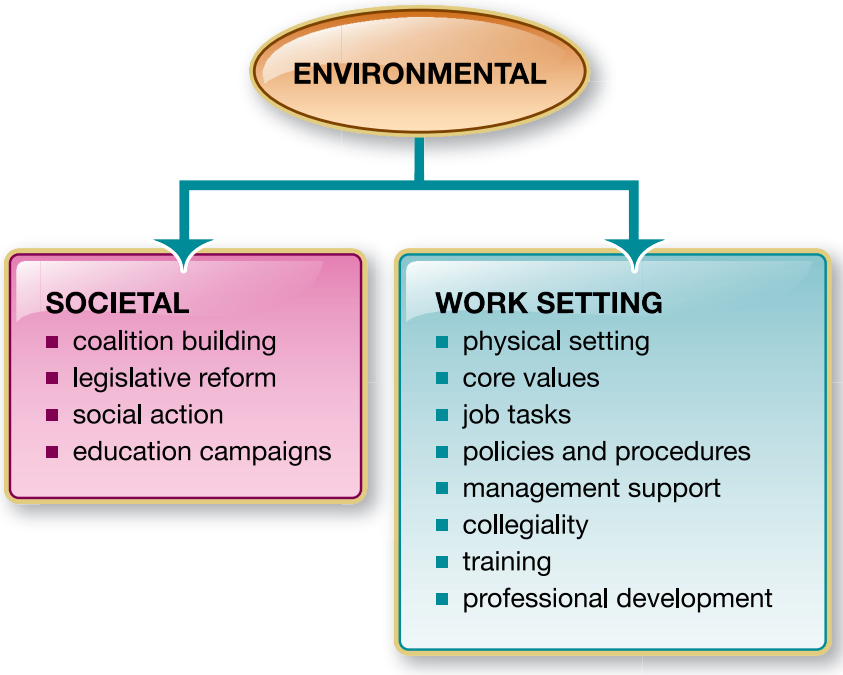
Individual Strategies

- Nutrition/balanced diet
- Exercise
- Rest
- Social connections outside of work
- Spiritual/faith life
- Personal goals
- Hobbies interests
- Set limits/avoid taking work home
- Aroma therapy
- Massage
- Connect with positive peers/friends
- Volunteer work that is totally different
- Use of reflective practice
- Have fun
- Time management skills
- Delegate
- Ask for help
- Ensure there is fit between your beliefs and work values/beliefs

Agency/Managerial Strategies

- Policies that recognize, prevent and address vicarious trauma
- Support for staff is positive
- Effective and regular supervision
- Professional development on vicarious trauma
- Limit setting for staff who are unable to do so themselves
- Build in humor and fun
- Promote diverse and balanced caseloads
- Debrief major incidents automatically
- Use reflective practice
- Demonstrate appreciation for staff
- Provide access to staff for support/help
- Train managers in vicarious trauma and how to respond





Yassen (1995) sees prevention as a multi-pronged approach encompassing strategies at the individual level (personal & professional) and strategies at the environmental level (societal & organizational). This model is a framework for planning that addresses the impact of vicarious trauma.

My Self-care Assessment

Mark on the template below the self-care tools that you use and whether you need to do more of any of them.

Activity/Strategy	Doing Fine	Like to do Better	Urgent to Change
Nutrition/balanced eating			
Exercise			
Rest			
Taking breaks and lunch			
Social connections outside work			
Social connections at work			
Setting personal goals			
Hobbies and interests			
Taking a vacation			
Spending time with family			
Visiting friends			
Doing something nice for self			
Having fun			
Time management			
Doing volunteer work			
Laughing			
Delegating			
Being able to say no/set limits			
Asking for help			

Martha's Story

I have just recently learned the importance of maintaining balance in my life. In March, my mother-in-law who was battling cancer moved in with us. As she moved quickly through the phases of her illness, I found I had very little energy for anyone else. I was so thankful to have a month off to deal with this difficult situation. Having the support for balance in my home life has definitely helped re-energize me for work.

Reflective Questions

1. What are three things you do on a regular basis for self-care?

2. What are three things your agency does on a regular basis for care of employees?

3. What are things that you have not been doing lately, but would make a difference in your self-care?

4. What are potential barriers to the things on your self-care list?

Other Resources:

Critical Incident Stress Information Sheet: ub-counseling.buffalo.edu/trauma-allegheny-doc.html

Fawcett, J. (Ed.). (2003). *Stress and trauma handbook: Strategies for flourishing in demanding environments.* World Vision International.

Green Cross Academy of Traumatology has created a set of standards for self-care in relation to VC: www.greencross.org

Hanh, T.N. (1987). *The miracle of mindfulness: An introduction to the practice of meditation.* Boston, MA: Beacon Press.

The Hospital for Sick Kids: Infant Mental Health Promotion faculty developed guidelines for agencies in relation to vicarious trauma. A number of important policies, procedures and practices were identified to minimize, prevent and respond to vicarious trauma. This is a helpful guide when developing policies and procedures for vicarious trauma. This document can be found at: www.imhpromotion.ca/Portals/0/IMHP%20PDFs/Vicarious%20Trauma.pdf

Saakvitne, K.W., Pearlman, L.A., & the Staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton.

Weiss, L. (2004). *Therapist's guide to self-care.* New York. Brunner-Routledge.

Chapter 7: Reflective Practice

Reflective practice is the process of stepping back from daily, intense hands-on work to examine, review and explore different ways of understanding the experiences we have had, in order to stimulate new solutions or new approaches. Reflective practice is recommended for regular structured use in the workplace by staff, in order to learn from work experiences, for example during supervision. It can also be a helpful tool for clients/patients in order to foster growth and development.

Reflective Practice was first formally introduced by Donald Schon in his book, The Reflective Practitioner (1983). Although there are a number of models to help frame the use of reflective practice, we will be focusing on Schon's. The other models have many similarities, usually following a circular pattern of questioning using reflection, with a focus on feelings and actions.

Over the last 30 years, there has been a growing interest and focus on experiential learning, and the development and application of reflective practice. Reflective practice has benefits for the practitioner and for the client, for example:

- Lower staff burnout
- Better outcomes for clients/patients
- Staff feel more supported
- Staff have greater confidence in finding their own solutions
- Staff are more open to reviewing their own work
- Positive work relationships and improved client/patient engagement
- Greater accuracy in observations and processing of sessions
- Prevention of countertransference reactions from interfering with client relationships
- A wider pool of ideas, resources and strategies to draw upon when supporting families
- Learning is facilitated, enhancing the quality of work
- Supportive relationships are modeled and carried over into supportive interactions with families

According to Atkins and Murphy (2004), critical skills for reflective practice include:

- **Self-awareness –** Reflect on your thoughts, feelings and actions in relation to your work and consider how a situation has affected you.
- **Self-knowledge –** Recognize who you are and how you were shaped by your experiences.
- **Critical Analysis –** Consider a situation, identify existing knowledge, challenge assumptions and explore alternatives.
- **Synthesis –** Integrate new knowledge, problem solve and predict the likely consequences of actions.
- **Evaluation –** What have you learned about yourself through this process? Does this knowledge help you better understand your experience? Has this knowledge helped you explain or solve problems?

Reflective Supervision

Reflective supervision has been found to be a strong model of supervision. It promotes learning, growth, engagement, problem identification and resolution. In order to use reflective supervision effectively, supervisors need to create an environment based upon the following characteristics.

The reflective supervisory relationship is the foundation for reflective supervision. It is a relationship for learning (Fenichel, 1992) that has the following characteristics:

- Trust
- Respect
- Collaboration
- Strengths and Resilience
- Safety
- Thinking and Feelings
- Empathic
- Nonjudgmental

The National Resource Center for Family Centered Practice (2009) identifies the following skills and barriers in utilizing reflective practice:

Reflective skills include:

- Open ended questions
- Reframing
- Metaphors
- Stories
- Hypothesis building
- Active Listening
- Summarizing
- Modeling
- Use of silence

Barriers to the use of Reflective Practice include:

- Lack of time
- Transference/countertransference
- Lack of trust in helping relationship
- Lack of trust in reflective process
- Inconsistency in use of reflective practice
- Looking for the perfect question or perfect answer
- Feelings of being judged
- Taking on responsibility for others feelings
- Need to be in control
- Over-processing

Areas for Reflection:

Schon (1983) identified two focal points to guide reflection. Brown, Fry and Marshall (1999) later built on these to identify additional focal points, known as Reflection Actions. These action points guide the type of questions you might want to ask to obtain the most helpful outcomes:

- Reflection on Action (past)
- Reflection in Action (present)
- Reflection for Action (future)

Reflections on Action

This type of reflection is used when something has already occurred and the categories of questions fit with reflection. These types of questions include:

- Hypothesizing
- Analyzing
- Reviewing
- Proposing alternatives impacts
- Focusing on something possibly missed

Reflections in Action

Reflections in action focus on what is happening in client/patient interaction. These reflections are very useful when you are feeling stuck or are unsure of what might be happening or why it is happening. Question categories to consider are:

- Affect
- Hypothesizing
- Goals/purpose
- Strategies/tools/actions/skills
- Engagement

Reflections for Action

These are essentially planning reflection and are focused on preparing for a future contact with a client. Question categories to consider are:

- Goal setting
- Strategies to use
- Hypothesizing
- Identifying potential challenges or barriers and examining ways to address them

There are three basic areas to reflect on, and each can be used in action, for action or on action. These are:

- Actions
- Thoughts/values/beliefs
- Feelings

Action Questions

- How well did the goals fit what the client/patient needs?
- What did you do that made the client/patient feel more engaged?
- What could you have done to make the client/patient feel more engaged?
- What would have been another way to help the client/patient understand what you were saying?

Thoughts, Values and Belief Questions

- Do you believe that the client/patient can achieve the goals that have been set?
- Do you trust what the client/patient is saying?
- Does your client/patient trust you or the organization? How do you know?
- What belief(s) might be preventing the client/patient from moving forward?
- What are your belief(s) about pregnancy or parenting that may impact your work with clients/patients?

Feeling Questions

- Can you identify a feeling or feelings you had when working with a particular client/patient?
- What was happening to stimulate that feeling? What was being said or done?
- Were you able to identify what the client/patient was feeling?
- What other feelings might have been involved?
- How transparent was the client/patient or you in expressing or showing your feelings?
- How might your feeling be of benefit?
- How might your feeling be a barrier or hindrance?

Practice Case Scenario

Jenny is the young mother of an 18 month old daughter named Matty. My concern is that Matty is not meeting her developmental milestones due to Jenny not stimulating her enough. I asked Jenny to do some activities with Matty, such as reading to her at bedtime, playing pat-a-cake and playing during bath time.

During my last home visit, it looked like Jenny had just got out of bed and Matty was still in her crib. Jenny started to change Matty as soon as I walked in and told me that the baby slept in this morning.

Jenny also told me she had an argument with her mother the previous day about wanting Jenny and Matty to move in. She said her mother told her that she feels that Jenny is not a good mother. Jenny feels that if she moves home, her mother will take over and she will lose all of her independence. I talked with her about her mother's suggestion and told her it was something to think about because being a single mother was very hard. It would provide her with support and perhaps even more time to do some things for herself.

Jenny told me that she had a doctor's appointment for Matty and had to leave in a few minutes. I reminded her that we had set up this session a while ago and it did not seem to be a problem. Jenny said that it was the only opening her doctor had and so she took it. I asked her how it was going with the reading at bedtime. Jenny said that Matty just tears the book apart and there is no use reading if the baby doesn't understand. Jenny then told me she had to go and started to dress Matty. I set another session with her and will see her next week. I plan on checking on the three things she was going to work on and to see if she wants to talk more about living with her mother.

In the role of caseworker, use the three areas of reflection to question your: actions; thoughts, values and beliefs; and feelings about this situation. This will help you identify actions, thoughts and feelings in order to increase the effectiveness of the intervention.

Reflection Exercises

In order to assist in using reflection, a number of exercises are available. The questions in each section can be used as a guide for you to create your own reflective journal. All information in the following section has been provided and copyrighted by Greg Lubimiv (2009). They may be used in your organization with acknowledgement to the author.

- My Reflective Journal
- Finding the Right Questions – Part 1
- Finding the Right Questions – Part 2
- Example: Finding the Right Questions – Part 1
- Example: Finding the Right Questions – Part 2
- Different Situations
- My Life Line Exercise

My Reflective Journal

Date: _____

Issue/Challenge/Question

What Happened? What is the context of this issue/challenge/question?

- Identify feelings involved.
- Identify your thoughts/beliefs.
- Identify what actions took place.
- What stands out that I learned, wonder about or concerns me? (List up to 3)

1 _____

2 _____

3 _____

Finding the Right Questions – Part 1

A. Identify an issue, problem or concern.

B. Quickly write down **10** questions you can ask related to A.
When you finish, go back and underline three that seem to be the most relevant for you.

1

2

3

4

5

6

7

8

9

10

Finding the Right Questions – Part 2

For each question you selected from Part 1, complete the following:

Place the first question at the top. Then answer the following questions. Do this for each.

- How do I feel about this?
- Which of my values or beliefs does this influence?
- What can I change or do differently?

Finally, add a section for these types of questions.

- Reflective Action Question
- Reflective Feeling Question
- Reflective Thought Question

Question (first underlined) _____

- How do I feel about this?
- Which of my values or beliefs does this influence?
- What can I change or do differently?

Question (second underline) _____

- How do I feel about this?
- Which of my values or beliefs does this influence?
- What can I change or do differently?

Question (third underline) _____

- How do I feel about this?
- Which of my values or beliefs does this influence?
- What can I change or do differently?

- Reflective Action Question
- Reflective Feeling Question
- Reflective Thought Question

Finding the Right Questions – Part 1

A. Identify an issue, problem or concern.

I am always late

B. Quickly write down **10** questions you can ask related to A.
When you finish, go back and underline three that seem to be the most relevant for you.

1. Why am I always in a rush?
2. What do others think when I am late?
3. When did I start being late for things?
4. What would it be like not to be late?
5. Why do I try to do too much?
6. Why can't I just get moving more quickly in the morning?
7. How do I impact others when I am late?
8. Does it really matter?
9. Why does something always seem to go wrong when I am in a hurry?
10. When I am on time what do I do differently?

Finding the Right Questions – Part 2

For each question you selected from Part 1, complete the following:

Place the first question at the top. Then answer the following questions. Do this for each.

- How do I feel about this?
- Which of my values or beliefs does this influence?
- What can I change or do differently?

Finally, add a section for these types of questions.

- Reflective Action Question
- Reflective Feeling Question
- Reflective Thought Question

EXAMPLE

Question (first underlined) Why am I always in a rush?

I try to do too much. I don't leave enough time to travel. I hate leaving things half done so try to finish before leaving.

- How do I feel about this?

Anxious, frustrated, worried, guilty

- Which of my values or beliefs does this influence?

I don't like letting people down. I want to be responsible. I like to finish things.

- What can I change or do differently?

Be more prepared in the morning, by getting stuff done before I go to bed. Stop trying to do extra things before I leave or have an appointment. Set an alarm 5 minutes before I have to go anywhere.

Question (second underline) How do I impact others when I am late?

They are frustrated having to wait or to have things repeated when I get there. Sometimes they might worry that I am not coming or something has happened to me.

- How do I feel about this?

Guilty, anxious, embarrassed

- Which of my values or beliefs does this influence?

I care about others. I don't want to disappoint others. I want others to be able to rely on me.

- What can I change or do differently?

Ask friends if this bothers them. Apologize. Try not to be late.

Ask friends/colleagues if they feel they can rely on me.

Question (third underline) When I am on time what do I do differently?

I don't have a bunch of things I am trying to do. I got some things ready earlier. I left more time between meetings.

- How do I feel about this?

Happy, satisfied.

- Which of my values or beliefs does this influence?

You can depend on me. I am reliable.

EXAMPLE

- Reflective Action Question What can I change or do differently?

Do something special for myself when I arrive early.

- Reflective Feeling Question How can I motivate myself to be on time?

Look forward to being there, enjoy the commute.

- Reflective Thought Question What can I do to reduce everything I try to do before I need to go somewhere?

Be prepared by keeping track of all tasks. Leave more time between meetings or get up a few minutes earlier.

Different Situations

Identify a situation involving each of the following:

1. A time when I felt my action(s) made a real difference to a client/patient or group of clients/patients
2. A time when something did not go as planned
3. A time when I could not stop thinking about something that happened in a meeting (with client/patient, co-worker or supervisor)

For each of these times, complete the template below:

Feeling I had	Action I took	Beliefs and values	How my body reacted

My Life Line Exercise

Lifeline activities can be used by staff on an individual basis or as part of team building or professional development activities. They may also be helpful for clients/patients. An example can be found online at: alumni.gsb.stanford.edu/sites/default/files/CLV_Handout.pdf

On a large piece of paper draw a long line from one side of the paper to the other. Imagine that you were born where the left side of the line. Write down your birth date.

Now imagine that the right side of the line represents where you are now. Mark down the date, or you can put your age.

Between your birth and now many things have happened that have impacted you in a major way. Think about those major events or milestones and mark them on the life line. You may find it helpful to use different colours as you complete your life line.

Think about the following categories to put on the line:

- Important people in your life (put their name on the time line when you first met)
- Important happy events
- Important sad or tragic events
- Times when you felt especially joyful in your life
- Times you felt especially sad or upset in your life
- Time when you struggled
- Special achievements

Reflect on your lifeline and consider:

- What underlying themes or insights emerge?

- What important lessons do you recall?

- When have you experienced being "in the flow" (times where you felt life and/or career was highly energized, meaningful, inspired, and/or effortless)?

- At the high points, describe what made it so positive.

- At the low points, what actions did you take to make things better?

- At times when things were turning down, what might you have done differently to address the situation?

Other Resources:

Michael Lang giving an example of using reflective questions
www.youtube.com/watch?v = EBt7SBw7PmQ

Chapter 8: Taking Action

Understanding the four categories of impact: burnout, vicarious trauma, secondary trauma and counter-transference; the processes and consequences, risk and protective factors, as well as strategies that make a difference in each category are important to employees and managers in caring professions. Review the content of this manual with co-workers and consider individual and team actions that will help to prevent and reduce the negative impacts of your work.

Below you will find examples of actions that individuals or agencies have done to prevent and provide support for workers. What can you do as an individual, a team or an agency?

Middlesex-London Health Unit

- Provides mugs to staff with caption "That which gives light must endure loving" (Viktor Frankel)
- Provides rulers with caption "Measure your stress before you're a mess"
- Provides bookmark with local resources on one side and 10 symptoms of vicarious trauma on the other

Toronto Public Health

- Provides a goose pin to remind staff of the need to work in teams and support one another
- Created a bookmark with positive and supportive messages
- Provides staff with a booklet called "Vicarious Trauma Self-care for Healthy Families" (created by Cindy Rose and Jan Lancaster)
- Makes peer to peer support program available for all staff
- Conducted a literature review on vicarious trauma and compassion fatigue in the helping professions
- Provided an education session on vicarious trauma for staff working with families
- Provides information about vicarious trauma to all new staff as part of orientation
- Developed a position statement on vicarious trauma

Alice

- Completes the self-assessment scales on a monthly basis

York Region Health Department

- Use of *Supporting Staff, Supporting Community Binder* – a resource developed for staff to pursue their self-wellness while working with high risk prenatal clients and families with children up to age 6 years
- Implementation of a Peer Support Team – a team of staff members who contact colleagues who have experienced a client serious occurrence

Rosalie Hall

- Adopted the Infant Mental Health Promotion Policy Statement on Vicarious Trauma

Phoenix Centre

- Has a FUN team made up of several staff members, who are responsible for creating fun events and activities throughout the year (funding is provided by the agency)

John

- Created comfort kits that include feel good items and items that put work in perspective. The items engage the senses with things that lift the spirit or bring a smile.
  - For work: he places pictures in his office that inspire and are positive reminders of the work
  - For car/travel: he listens to music and audio that relaxes and inspires him
  - For home: he has a box of mementos, such as cards or pictures, that he can look at when feeling stressed or overwhelmed

References

Atkins, S. & Murphy, K. (1994). *Reflective Practice*. Nursing Standard, 8/39, 49-56.

Baird, C. & Kracen, A.C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, 19(2): 181-188

Baranowsky, A.B. (2002). The silencing response in clinical practice. In C.R. Figley (Ed.), *Treating compassion fatigue.* New York: Brunner-Routledge.

Brown, M., Fry, H. & Marshall, S. (1999). Reflective Practice. In H Fry, S Ketteridge & S Marshall (Eds.), *A handbook for teaching and learning in higher education: enhancing academic practice*. London: Kogan Page

Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook.* Washington, DC: ZERO TO THREE.

Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

Florio, C. (2010). *Burnout & compassion fatigue: A guide for mental health professionals and care givers*. City: CreateSpace.

Maslach, C. (2003). *Burnout: The cost of caring*. Los Altos, CA: ISHK

Pearlman, L.A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. Figley, C.R.(Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 150-177. New York: Brunner/Mazel.

Perry, B.D, Conroy, L and Ravitz, A. (1991). Persisting psychophysiological effects of traumatic stress: The memory of "states". *Violence Update 1*:(8), 1-11, 1991. From the Child Trauma Academy. Retrieved from: www.childtrauma.org/ctamaterials/memory_states.asp

Ortlepp, K. & Friedman, M. (2002). Prevalence and correlates of secondary trauma stress in workplace lay trauma counsellors. *Journal of Traumatic Stress*, 15:3, pp213-222.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton.

Schon, D. (1983). *The reflective practitioner*. New York: Basic Books.

Soderfeldt, M., Soderfeldt, B., & Warg, L.E. (1995). Burnout in social work. *Social Work*, *40* (5), 638-646.

Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly*, 8(2),1-3

Stamm, B.H. (Ed.) (1999). *Secondary traumatic stress: selfcare issues for clinicians, researchers, and educators*. pp. 3-28. Lutherville, MD: Sidran Press.

National Resource Center for Family Centered Practice (2009). *Committed to Excellence Through Supervision*, Module III, p. 14 (USDHHS Grant #90CT0111). The University of Iowa School of Social Work.

Wicks, R. (2006). *Overcoming Secondary Stress in Medical and Nursing Practice.* Oxford: Oxford University Press.

Appendix 1 – Self-assessment Tools

There are a wide range of surveys, evaluations and self-assessment tools that can help us to gain a better understanding of ourselves, our strengths, weaknesses and needs. The following are a few of the instruments that may be useful. It is important to note that these are not meant to be diagnostic instruments. They may be helpful to indicate whether a potential assessment or intervention may be needed.

ProQOL (Professional Quality of Life Scale)

The ProQOL is the most commonly used measure of the negative and positive results of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout and compassion fatigue.
proqol.org/uploads/ProQOL_5_English_Self-Score_7_2011.pdf

Stress Test

Check list for recent stressful events automatically calculates your overall stress level.
www.healthcentral.com/sleep-disorders/stress-test-3454-143.html

Self-care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment you choose one item from each area that you will actively work to improve. Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996).
www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf

Mayo Clinic Stress Assessment. Rate Your Stress (automatic scoring)

www.mayoclinic.com/health/stress-assessment/SR00029

Presentations

"Care for the Caregiver: Development of a comprehensive plan to address vicarious trauma amongst Healthy Families staff at Toronto Public Health", presented by Cindy Rose to Sick Kids Infant Mental Health Rounds Oct. 2008
www.sickkids.ca/pdfs/IMP/20127-C%20Rose_IMP%20presentation_Oct708.pdf

Videos

Headington has developed many resources and information related to vicarious trauma and secondary trauma. Available online at: www.headington-institute.org/Default.aspx?tabid=2648

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