SELF-CARE FOR TRAUMA PSYCHOTHERAPISTS AND CAREGIVERS: INDIVIDUAL, SOCIAL AND ORGANIZATIONAL INTERVENTIONS

Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo
Waterloo, Ontario, Canada
and
Research Director of
The Melissa Institute for Violence Prevention and Treatment of Victims of Violence
Miami, Florida

(www.melissainstitute.org)

Email: **dhmeich@aol.com**

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PROLOGUE

Trauma-focused treatments can be emotionally difficult and taxing for therapists and care-givers leading to vicarious traumatization, burnout, secondary stress disorder and compassion fatigue. Research indicates that

-50 % of professionals who work with trauma patients report feeling distressed

-30% of trauma psychotherapists report experiencing "extreme distress"

Such distress is exacerbated by the fact that some30% of psychotherapists have experienced trauma during their own childhood (see Brady et al., 1999; Figley, 1995; Kohlenberg et al., 2006; Pearlman & Mac Ian, 1995; Pope & Feldman-Summers, 1992).

At a personal level, I have treated and supervised trauma psychotherapists, as well as having to deal with my own emotional reactions of working with a wide variety of victimized individuals, families and communities. I have often been asked how I cope with such stressful situations? This **Handout** addresses how to:

1) ***increase self-awareness of possible vicarious traumatization;***

2) ***engage in self-care skills and self-soothing activities;***

3) ***engage social supports***

4) ***mobilize organizational supports to prevent and address vicarious traumatization;***

5) ***and where indicated, access personal therapy.***

In addition, I will address the special case of having to deal with violent clients and the suicide of one's clients.

This Handout is dedicated to the memory of an esteemed colleague and friend who wrote insightfully about vicarious traumatization. We miss you Michael Mahoney

CONCEPTUALIZATION OF VICARIOUS TRAUMATIZATION

Milton Erickson used to say to his patients, "My voice will go with you." His voice did. What he did <u>not</u> say was that our clients' voices can also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us. (Mahoney, 2003, p. 195).

Vicarious Traumatization (VT) –is defined by Pearlman and Saakvitne (1995, p. 31), as the "negative effects of caring about and caring for others". VT is the "cumulative transformation in the inner experience of the therapist that comes about as a result of <u>empathic engagement</u> with the client's traumatic material". Empathy is the helper's greatest asset and also possibly his/her greatest liability.

VT is <u>not</u> the same as burnout, although burnout may be exacerbated by VT. VT places emphasis on changes in meanings, beliefs, schemas and adaptation. VT is more likely to lead to imagery intrusions and sensory reactions. Hatfield Cacioppo and Rapson (1994) describe the type of emotional contagion that may lead psychotherapists to the "catching of emotions" of their clients.

VT permanently transforms helpers' sense of self and their world. VT can influence Countertransference responses

Burnout is often defined as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components: Exhaustion, depersonalization (defined as : disengagement or detachment from the world around you) and diminished feelings of self-efficacy in the workplace. It reflects a form of "energy depletion".

Secondary Traumatic Stress or what Figley (1995) calls **Compassion Fatigue,** refers to the adverse reactions of helpers who seek to aid trauma survivors. STS is often used interchangeably with VT, although VT implies more permanent, than temporary stress responses (See Stamm, 1999).

Countertransference implies that the helper's response is influenced by the helper's own unresolved issues (e.g., lingering impact of the helper's victimization experiences). This may lead to avoidance and overidentification with the client. The helper may take on a protective role for the client, becoming the "champion" of the client and adopt a role of "rescuer". The helper may inadvertently become a "surrogate frontal lobe" for the client.

CAVEAT: STATUS OF THE CONCEPT OF VT

While the concept of VT has received widespread attention (Avery, 2001; Blair & Ramones, 1996; Danieli, 1988; Norcross, 2000; Pearlman & MacIan, 1995; Neumann & Gamble, 1995; Schauben & Frazier, 1995; Sexton, 1999; Stamm, 1997) leading to various self-help books for mental health workers (Baker, 2003; Gamble, 2002; Herbert & Wetmore, 1999; Rothschild, 2006; Saakvitne et al., 2000; Saakvitne & Pearlman, 1996; Williams & Sommer, 1995), Sabin-Farrell and Turpin (2003) provide a number of cautionary observations that are critical to keep in mind.

> ***"There is yet no one questionnaire that has been designed to measure the concept of VT as a whole." (p. 469)***
>
> ***"Symptoms of PTSD, burnout and general psychological distress have been found by some studies, although most correlates are weak." (p. 472)***
>
> ***"The evidence for VT in trauma workers is inconsistent and ambiguous." (p. 472)***

With these caveats in mind, there does appear to be some mental health workers for whom the work with victimized clients is traumatizing and can cause PTSD symptoms, particularly intrusive symptoms, and more general symptomatic distress and disruptions in beliefs concerning safety, trust and world view. Helpers who have a personal trauma history, who are newer to such work, who have had little or no past or ongoing supervision, and who experience high related job stress may be most vulnerable to developing VT. What are the signs of VT and what can be done to reduce and prevent VT?

MOST COMMON SIGNS OF VT: INCREASING SELF-AWARENESS

Feelings

- Feel overwhelmed, drained, emotionally draining and exhausted, overloaded, burnt out
- Feel angry, enraged, and sad about client's victimization; these feelings linger
- Feel loss of pleasure, apathetic, depressed, despairing that anything can improve
- Overly involved emotionally with the client
- Feel isolated, alienated, distant, detached, rejected by colleagues
- Experience bystander guilt, shame, feelings of self-doubt

Cognitions

- Preoccupied with thoughts of clients outside of your work. Overidentification with the client. (Have horror and rescue fantasies.)
- Loss of hope, pessimism, cynicism, nihilism
- Question competence, self-worth, low job satisfaction
- Challenge basic beliefs of safety, trust, esteem, intimacy and control. Feel heightened sense of vulnerability and personal threats

Behavior

- Distancing, numbing, detachment, cutting clients off, staying busy. Avoid listening to client's story of traumatic experiences
- May experience symptoms similar to those seen in clients (intrusive imagery, somatic symptoms)
- Impact personal relationships and ability to experience intimacy
- High overall general distress level
- Overextend self and assimilate client's traumatic material
- Difficulty maintaining professional boundaries with the client

Organizational Indicators of VT

- High job turnover
- Low morale
- Absenteeism
- Job Dissatisfaction
- Organizational contagion

In summary, the negative impact of VT can involve personal costs of altered beliefs and frames of reference, negative impact on feelings and relationships, poor decision-making social and professional withdrawal, substance abuse and clinical problems (Pearlman & Saakvitne, 1995a, b, c; Rothschild, 2006)

RISK FACTORS FOR DEVELOPING VT

Characteristics of the CLIENT that can contribute to VT

- Work with demanding patients who evidence therapy-interfering behaviors (e.g., no shows, non-payment, noncompliance with treatment regimen, calling too frequently, repeatedly demanding extra session time)
- Working with patients who are hostile and threatening the therapist, others, or the treatment program (e.g., verbally and physically threatening, stalking the therapist, bringing weapons to sessions)
- Work with suicidal patients
- Work with clients who may relate trauma stories of human cruelty and intense suffering
    - Graphic details of trauma, especially sexual abuse, work with rape and torture victims, Holocaust survivors
    - Descriptions of acts of intentional cruelty and hatred (e.g., child physical and sexual abuse)
    - Client reenactments in therapy aspects of the trauma
    - Ongoing risk of further revictimization to client and possible threats to health care providers (e.g., work in domestic shelters)
    - High suicide risk or risk of aggression against others
- Work with survivors who are also perpetrators.

Characteristics of the JOB/Work Setting that can contribute to VT

Job-Related Stressors that Increase the Risk of Developing VT

- Large caseloads – overextension due to work demands
- Large percentage of clientele who have trauma experiences and suffer PTSD
- Back-to-back clients who are trauma survivors
- Cumulative exposure to traumatized clients over time
- Lack of clinical/personal support in the workplace
- Absence of peer support and supervision
- Few resources to which to refer clients for ancillary services
- Professional isolation
- Cultural clash between clients and agency
- Workplace structural and personal strains-lack of resources, personnel, and time to complete a job
- Reimbursement issues, managed care
- Legal consequences for helper
- Barriers to achieve interventions goals
- Barriers to the helper seeking help – concerns about confidentiality, fear of stigmatization

Characteristics of the HELPER that can contribute to VT

- Personal victimization history that is unresolved – issues of shame, guilt, anxiety, anger
- Lack of experience – novice workers are at greater risk
- Additive effects of trauma and other stressors
- Lack of coping skills-impose excessive demands from self, others or work situation

- Current personal stress experience
- Helpers who are more aware of VT and countertransference are less susceptible to Secondary Traumatic Stress
- Low level of subjective personal accomplishments – low fulfillment of goals. (There is a need for psychotherapists to establish doable goals in each session)
- Unrealistic expectations around recovery of patients
- Excessive time in the same job
- Presence of protective factors that promote resiliency including high self-esteem, resourcefulness, desire and ability to help others, faith, and opportunities for meaningful action and activities.

ASSESSMENT TOOLS OF VT AND RELATED REACTIONS

(See Website Addresses at end of this Handout)

Measures

Traumatic Stress Inventory (TSI-BSL)	Pearlman, 1996a
Traumatic Stress Inventory Life Event Questionnaire (LEQ)	Pearlman, 1996b
Compassion Fatigue Self-Test	Figley, 1995a
Maslach Burnout Inventory	Maslach, 1996
Secondary Trauma Questionnaire	Motta et al., 1999
Professional Quality of Life Scale (ProQOL)	Stamm, 2004
Self-report Posttraumatic Stress Disorder Scale (PSS-SR)	Foa et al., 1993
Impact of Event Scale – IES	Horowitz et al., 1979
Trauma Symptom Checklist-40	Elliott & Briere, 1992
Symptom Checklist-90 (Revised SCL-90-R)	Derogatis, 1983
Brief Symptom Inventory	Derogatis, 1993

Self-assessment of VT

Review these questions with a trusted and supportive colleague.

"How am I doing?"

"What do I need?" "What would I like to change?"

"What is hardest about this work?"

"What worries me most about my work?"

"How have I changed since I began this work? Both positively, and perhaps, negatively?"

"What changes, if any, do I see in myself that I do <u>not</u> like?"

"Am I experiencing any signs of VT?" (See the previous list of common reactions.)

"What am I doing and what have I done to address my VT?"

"As I think of my work with my clients, what are my specific goals? How successful am I in achieving these goals?"

"What is my sense of personal accomplishment in my work?"

"What work barriers get in the way of my having more satisfaction and how can these barriers be addressed?"

"What am I going to do to take care of myself?"

"How can I keep going as a person while working with traumatized clients?"

"How can I use social supports more effectively?" Draw a picture (web diagram) of your social supports on the job (colleagues) and in non job-related areas (family, friends).

"For instance, have I talked to other people about my concerns, feelings and rewards of my job?"

"Who did I talk to (both in the past and now)? What were their reactions" What did he or she say or do that I found helpful (unhelpful)?

"What were my reactions to their reactions?"

"Is there anything about my work experience or other stressful events in my life that I have <u>not</u> told anyone, that is 'unspeakable', that I have kept to myself (a secret)?" (Try putting it into words, such as, "I haven't' shared it because …" or "I am very hesitant to share it because …" What is the

possible ongoing impact, toll, emotional price of <u>not</u> sharing and working through these feelings?)

"Is there anything about my stress experience that I keep from myself? An area or an event that I have pushed away or kept at arm's length from myself? Or about which I say to myself, 'I can't handle that."? What aspect of my life have I not put into words yet, that is still lurking in that corner of my mind that I have not looked into yet?"

"How will sharing these feelings help?" <u>Remember, what cannot be talked about can also not be put to rest</u>!

In addition, Kohlenberg et al. (2006, p. 189) challenges psychotherapists to ask themselves the following questions:

"What are my own issues and how do they play out in my therapeutic work?"

"How do I find the balance between caring too much and caring too little?"

"How do I handle the situation when what is in the best interest of the client clashes with what is in my own best interest?"

"How can I keep growing as a therapist and as a person while working with my clients?"

INTERVENTIONS: WAYS TO COPE WITH VT

<u>GENERAL GUIDELINES</u>

- Remember treating trauma patients is not for everyone
- Issue is managing VT, rather than totally avoiding it
- Emphasis should be on early identification and treatment, reducing the long-term negative impact of VT
- Interventions need to be multi-leveled and should not be left up to the individual
- Psychotherapist or helper should not feel ashamed or guilty about experiencing VT. Attitude should be on validating and normalizing such reactions. Reframe VT as being a sign of being a committed and a sensitive therapist.
- Nurture Awareness, Balance and Connections

WAYS TO COPE WITH VT: AN OVERVIEW

(See the next pages for a fuller description of each coping strategy.)

I) INDIVIDUAL LEVEL: PRACTICE SELF-CARE

A. Increase Your Self-observations

1. Recognize and chart signs of stress: Vicarious traumatization and burnout. Maintain self-awareness.
2. Conduct self-analysis: Fill out Self-report Scales

B. Engage in Emotional Self-care Behaviors

3. Engage in relaxing and self-soothing activities. (Use mindfulness, meditation). Nurture Self-care.
4. Ensure physical and mental well-being
5. Maintain a healthy balance in your life.Have outside outlets
6. Engage in healing activities in and outside of therapy. Express feelings through writing or art.

C. Use Your Cognitive Abilities

7. Recognize you are not alone: Normalize and monitor your "story-telling narratives"

8. Set realistic expectations to enhance feelings of accomplishment. Avoid wishful thinking. Set specific achievable goals for each session.

9. Adopt a more philosophical accepting stance. Appreciate the rewards.

10. Do not take on responsibility to "heal" your clients": Use "midwife" metaphor

11. Challenge negativity: Don't play the blame game!
    Find meaning and hope. Solicit "the rest of the client's story". Focus on resilience in therapies.

D. Engage in Behavioral Activities

12. Balance the composition of case loads (victims and non -victims)

13. Limit overall case loads. Monitor work balance and work/life balance.

14. Share reactions with clients: Nurture therapeutic alliance and monitor and impose personal limits

15. When necessary, take time off. Take a break (daily, weekly, monthly).

II) PEER AND COLLEGIAL LEVEL

A. Helper Initiated Activities

16. Assess social support network

17. Seek social support from supervisor, colleagues, and family members

18. Provide support: Don't over do it!

19. Use buddy system, especially for novices

20. Obtain peer supervision- use Consultation Teams

21. Engage in "debriefing". Develop informal opportunities to connect

22. Participate in training opportunities

23. Participate in agency building or community building activities

24. Continue to learn more professionally

25. If indicated, participate in time-limited group therapy or individual psychotherapy

III) ORGANIZATIONAL AND AGENCY LEVEL

26. Agency should be proactive in reducing VT

27. Schedule team meetings – “emotional check-ups”

28. Agency should balance the psychotherapist's (helper's) case load

29. Provide ongoing supervision, especially for novice helpers

30. Promote education and training

31. Ensure staff takes care of themselves in terms of nutrition, exercise, sleep and that they take frequent breaks. Help foster spiritual renewel.

32. Maintain professional connections and establish professional networks.

33. Address boundary issues, "Manage boundaries".

34. Support “altruistic” activities

35. Provide Stress Inoculation Training and General Resilience Training and Acceptance/Mindfulness Skills Training, and where indicated, provide individual and group psychotherapy

36. Provide a psychologically healthy workplace

WAYS TO COPE WITH VT

I) INDIVIDUAL LEVEL: PRACTICE SELF-CARE

"Self-care is a skillful attitude that needs practice throughout the day." (Mahoney, 2003, p. 25)

A. Increase Your Self-observations

1. Recognize the signs of incipient vicarious traumatization (VT) and the impact of job stress (Burnout): Chart warning signs. Take your "emotional temperature". (See list of common VT reactions).

2. Conduct a self-analysis. (Fill out self-report measures of stress levels)

B. Engage in Self-care Behaviors

3. Engage in self-care behaviors such as relaxation exercises between clients, engage in soothing activities like going for a massage. Leave work at work. Develop a ritual for the transition for leaving work at the office. As Mahoney (2003, p. 26) suggests, ***"Even though you are likely to carry your clients' struggles with you after work, learn to formalize a transition from your profession to your personal life (a walk, a prayer, a brief period of meditation, etc.).***

4. Ensure physical and mental well-being (nutrition, sleep, relaxation, creative expression, use humor). Replenish by having a get away weekend or vacation. Give yourself permission to escape when necessary. Cherish your friendships and intimacy with family.

5. Have some outlet for emotional discharge outside of your clinical role (exercise, writing, building, gardening, family, social action). Engage in activities that are positive and that have concrete outcomes or products that foster a sense of accomplishment. Have a vocational avenue of creative and relaxing self-expression in order to regenerate energies.

6. Engage in healing activities that renew meaning of life both in therapy and out of therapy settings. For example, some therapists report bringing into their offices "signs of life and beauty" such as plants that remind them of beauty and rebirth. Engage in life-generating activities such as gardening, painting, enjoying nature.

C. Use Your Cognitive Abilities

7. Recognize that you are <u>not</u> alone in experiencing vicarious traumatization (VT) and in experiencing job stress. Validate and

normalize your reactions. It is not that you experience VT and job stress, but rather what you tell yourself and others about your reactions. Listen for the "stories" (narratives) you tell yourself and others.

8. Set realistic expectations for yourself and your clients. Recognize your limitations and the fact that therapists will make mistakes. The percentage of goals and subgoals achieved is critical to foster feelings of accomplishment.

9. Remind yourself of the treatment rationale. As Taylor (2006, p. 132) observes, the intense emotions that the client experiences is a necessary component of effective treatment.

   "Remember cognitive-behavior therapy for PTSD is similar to dentistry for treating patients with root canal problems, but represents a treatment intervention that is empirically supported and generally effective. But like dentistry, cognitive-behavior therapy enlists some degree of pain"

10. Adopt a more philosophical or religious outlook. Use your spirituality. Accept those aspects that cannot change, and work on those aspects that are potentially changeable, and as the adage goes, "know the difference". Take pride in the work you do in helping serve human development. Honor the privilege of the helping profession.

    Remind yourself that you cannot take responsibility for the client's healing, but rather you should act as a "midwife" on the client's journey toward healing. Remind yourself that there are some things (like traumatic grief) you can't fix. ***"People in deep grief want to feel that you have heard their pain. If you try to 'fix it', you may rob them of that passage. They often want someone they can trust, cry with, confess to, someone who is nonjudgmental. Remember it is a privilege to be part of the healing process,"*** as noted in Gail Sheehy's (2003, p. 366) moving account of the aftermath of September, 11.

11. Challenge negativity. Minimize self-blame and blame in others. Address feelings of shame, guilt, incompetence, frustrations. See stressors as problems-to-solved or use acceptance strategies and not as occasions to "catastrophize". Focus on finding meaning and hope by attending to the client's "rest of the story", (i.e., "signs of resilience"). Use humor.

D. Engage in Behavioral Activities

12. Where possible, balance the composition of victim and non-victim caseloads. Diversify your caseloads. Do not spend all clinical hours with trauma clients-- "dose" yourself to a manageable limit. There is a suggestion that clinicians should not spend more than 60% of their time, or at most three days, working with trauma survivors (Taylor, 2006).

13. If possible, limit overall caseloads.

14. Where appropriate, share reactions with the client in a respectful manner. For example, the helper can comment to the client:

"Sometimes there is a part of me (that is, the helper) that does not want to hear that such horrific things happened to you (the client). But there is another part of me that says that we must continue because it is important, and moreover, doing so is part of the healing process. But, I would not be honest with you (the client) if I did not comment that no one should have suffered, nor endured, what you have experienced.

I am heartened by your willingness and by your ability, your courage to share your story, as part of the healing process.

I am also impressed to learn about the "rest of your story" of what you did to survive. As I have come to know you in spite of X (specific victimization experiences) you have been able to (highlight specific examples of resilience).

Such helper statements to the client can foster a stronger respectful collaborative therapeutic alliance as the helper conveys empathy and humanity. Such statements also convey to the client that his or her reactions are not unique and that the client is being "heard" and that the helper's reactions are also not unique.

The helper can also go on and ask the client's permission to share (make a gift of his or her experiences and suffering with others) – find meaning in -- The helper can ask the client:

I would like to ask you a question. Could I obtain your permission to share what you did to survive, to keep going in spite of X, with my other clients or with my colleagues? I would not mention your name and I would describe your situation in very general terms so no one could identify you. But, I would like them to benefit from your example. Would it be okay to "make a gift" of what you have done with others I see? Would that be okay?

At the same time it is important for the therapist to also set personal

limits with challenging clients. As Miller et al. (2007) observe:

> ***"Therapists must take responsibility for monitoring their own personal limits, and clearly communicate to their clients which behaviors are tolerable and which are not. Therapists who do not do this will eventually burn out, terminate therapy, or otherwise harm clients" (p. 65)***

For example, Miller et al. (2007) suggest that a therapist might tell a challenging client:

> ***"When you mimic me, insult me, and frequently compare me (unfavorably) to your last therapist, it makes it hard for me to want to keep working with you. A different therapist might not have a problem with this, but it just crosses my personal limits" (p. 80).***

15. Be gentle with yourself. Find a comfortable pace. Make yourself comfortable at work and at home. Give yourself permission to be cared for and counseled. Enjoy yourself. Finally, when necessary, take a break from PTSD practice. Engage in other activities like teaching, research, clinical, administrative activities. Come back to work gradually.

II) PEER AND COLLEGIAL LEVEL

A. <u>Helper Initiated Activities</u>

16. Taking stock. Assess your network of supportive people at work and outside of work. Draw a map of supportive people. Who is there to provide emotional, informational, material supports? Note, it may <u>not</u> be the same folks for each type of support. What is your "game plan" to access and use supports? Who are the people in your life who can provide a "holding environment"?

17. Seek peer support. Talk with colleagues and friends. Maintain connections with others. For example, Kohlenberg et al. (2006, p. 189) suggest that the distressed psychotherapist might say to a supportive colleague:

> ***"I am feeling very upset, hopeless and helpless right now. I don't seem to be enough for my client. I feel inadequate, angry and upset. Will you help me understand my feelings better and develop a perspective that will be helpful to my client"***

Caregivers are often quite good in nurturing self-care in their clients.

Taylor (2006) remind psychotherapists that they need to remind themselves that emotional self-care is also important.

With regard to family members, psychotherapists often set limits about what they disclose and share about their trauma work in order not to burden family members. Loved ones can provide nurturance and sustenance for the challenging work of dealing on a daily basis with human cruelties and adversities.

18. Don't be embarrassed or ashamed to ask for support, as well as reciprocate and offer support to others. But don't overdo it or you can increase your level of "caregiver stress".

19. Use a buddy system at work, especially if you are a novice helper. Novices should be buddied up with more experienced helpers. Identify a colleague with whom you can discuss your work, its challenges and rewards. Have weekly consultation meetings with a colleague to discuss their difficulties in providing treatment.

20. Obtain mentor and/or peer supervision. Review cases on a regular bases. Audiotape or videotape cases to be reviewed. Use a therapy consultation group to review difficult cases.

    One way to enhance capabilities and motivation of therapists is to use regular (weekly) **team consultation**. For example, those who advocate the use of Dialetical Behavior Therapy (DBT) with clients who are suicidal and who evidence Borderline Personality Disorder characteristics highlight the value of requiring all DBT therapists to attend such team consultation meetings. (Linehan, 1993; Miller et al. 2007). They propose that such team consultation meetings are integral to therapy and that team notes be taken and kept in the therapy records. Miller et al. (2007) propose that the team leader can use at the team meetings what they call a small "mindfulness bell" and ring it whenever team members make judgmental comments (in content or tone) about themselves, each other, or the client, or if they fail to adequately assess a problem before jumping to conclusions. The instant feedback provides members with ongoing reminders not to be " too harsh on themselves and on others".

21. Beyond case reviews, engage in "debriefing" (either informally or formally) around difficult and challenging cases (e.g., where threat of violence is an issue). In such debriefings the following questions can be addressed:

    "What is it like to work with "traumatized" clients or with client families who have experience multiple problems, or with patients who have a diagnosis of Borderline Personality Disorder?"

"What is most difficult or challenging in such cases?"

"What is most rewarding in working with these clients?"

"What do you (the helper) need right now?"

"How can we (other helpers, friends) be of most help?"

22. Participate in educational and training group forums about vicarious traumatization and job stress, focusing on possible solutions. (Do not just attend group sessions that can lead to more "emotional" contagion.)

23. Participate in agency building or community building activities. Join others around a common purpose or value.

24. Continue to learn more professionally. Join a study group, attend continuing education conferences and workshops about PTSD, and evidence-based interventions.

    One way to reduce staff burnout is to enhance therapists' capabilities and motivation by means of implementing effective evidence-based interventions such as Dialetical Behavior Therapy with suicidal patients (see Katz et al. 2004).

    Another important area for professional development is that of **Risk Assessment** of patients who are potentially violent towards others or toward themselves. Therapists can reduce their stress levels by being informed about how to conduct ongoing risk assessments and having in place backup teams or colleagues (***See discussion below***).

25. For helpers who have a history of trauma and for those who are being most impacted as a result of working with traumatized clients and high job stress, the use of time-limited group therapy can be helpful. The group can address self-doubts and countertransference issues and nurture varied levels of coping. Engage in self-analysis and use personal coping skills. Ask for and accept comfort, help and counsel. Find others whom you trust to talk to. If you can't find a therapist, create an imaginary one (who doesn't charge too much!). Embrace your spiritual searching. (See Pearlman & Saakvitne, 1995a; Saakvitne et al. 2000).

III) ORGANIZATIONAL AND AGENCY LEVEL

26. Agency should be proactive in recognizing and accepting vicarious traumatization and job-related stressors.

27. Regularly schedule team meetings and support groups that include "emotional checkups".

28. Work toward distributing and decreasing the number of demanding victimized clients.

29. Provide ongoing supervision and mentoring (buddy system), especially for novice workers.

30. Promote education and training about vicarious traumatization and wellness programs.

31. Help workers seek spiritual renewal. (***See Handout on Spirituality by Meichenbaum on www.melissainstitute.org***)

32. Maintain professional connections and identity. Collaborate with other helping agencies to foster a sense of a team working toward common objectives.

33. Conduct meetings and run workshops on boundary issues between clients and helpers in order to reduce this source of stress. Help helpers limit their trauma exposure outside of work.

34. Agency can support a "mission" and accompanying activities to actively change the circumstances that lead to victimization. This may be done at the local, organizational and national levels such as advocating for legislative reform and social action. Help workers transform stress into ways of finding "meaning" and "purpose".

35. Provide **Stress Inoculation Training** for workers (See Dane, 2000; Meichenbaum, 1994, 2001, 2003, 2007) and **General Resilience Training** (see Reivich and Shatte, 2002). Reivich and Shatte highlight that resilience is a "mind set" and they describe how a variety of cognitive and affective factors can block or erode resilience. They propose seven skills designed to nurture resilience including:

    (1) Self-monitoring your thinking processes;

    (2) Avoid "thinking traps" such as blaming yourself or others, jumping to conclusions, making unfounded assumptions, and ruminating;

    (3) Detect "icebergs" or deeply held beliefs that lead to emotional overreactions;

    (4) Challenge these assumptive beliefs and examine the "if

..then" rules that are implicitly accepted; rather engage in problem-solving that is "realistically optimistic";

(5) Put events into perspective;

(6) Learn ways to stay calm and focused;

(7) Practice skills in real life as you change counter-productive thoughts and behaviors into more resilient thoughts and behaviors.

To be added to this list of practical skills, is the need to learn to use acceptance and meditative – mindfulness skills which emphasize the ability to accept things as one finds them, perceptual clarity and freedom from the judgmental aspects of language. These coping procedures call upon individuals to treat thoughts as "just thoughts" and they highlight the value of diminishing self-absorption, being less defensive and more open to experience, more accepting and the cultivation of moment-to-moment attention. (See Hayes et al., 1999; Kabat-Zinn, 1990; Salmon et al., 2004). In mindfulness training thoughts are viewed as "normal" and compared to clouds passing by through the sky. Individuals are encouraged to notice them and let them go and return them to the sky.

36. Promote psychologically healthy workplace programs that may include:

-employee orientation, training, development and recognition, celebrate accomplishments;

-employee involvement in decision-making;

-flexible work schedules;

-enhance communication;

-onsite health and fitness centers and child care centres;

-build a sense of communication;

-translate these objectives into actionable steps

The **Stress Inoculation Training** procedure (Meichenbaum, 2003, 2007) that has been used to reduce job stress incorporates varied cognitive-behavioral skills into a three phase intervention:

Phase I – Initial Conceptualization that collaboratively educates individuals about the nature and impact of stress and coping;

Phase II – Skills acquisition and consolidation where individuals can acquire and practice both intrapersonal and interpersonal coping skills that follow from the initial conceptualization phase;

Phase III – Application Training where individuals in groups can practice the intra and interpersonal coping skills, both in the training sessions and in vivo. These application trials should be as similar as possible to the real life demands, activities and settings.

SPECIAL CASE OF DEALING WITH VIOLENT CLIENTS: RISK ASSESSMENT, RISK MANAGEMENT AND SUICIDAL CLIENTS

There is a high co-occurrence of PTSD resulting from trauma exposure and violent behavior toward others, as well as toward oneself (see Bongar, 2002; Meichenbaum, 1994, 2001). Consider the following illustrative data and the potential impact on the stress level of psychotherapists.

INCIDENCE OF VIOLENCE AGAINST MENTAL HEALTH STAFF

-Nearly one-half of psychotherapists will be threatened, harassed or physically attacked at some point in their careers by their clients. This may take the form of unwanted calls, verbal and physical attacks, stalking behavior on self and loved ones, or even murder.

-Between **4% to 8%** of individuals brought to psychiatric emergency rooms in the U.S., **bring weapons**.

-50% of all staff compensation cases of psychiatric facilities result from patient assaults. The mental health personnel who are at the lowest ladder of the organization are the most likely to be assaulted.

CLINICAL PRACTICE AND CLIENT SUICIDE

-Full time psychotherapists will average 5 suicidal patients per month, especially among those clients who have a history of victimization.

-1 in 2 psychiatrists and 1 in 7 psychologists report losing a patient to suicide.

-1 in 3 clinical graduate students will have a patient who attempts suicide at some point during their clinical training and 1 in 6 will experience a patient's suicide.

-1 in 6 psychiatric patients who die by suicide die while in active treatment with a health care provider.

-Work with suicidal patients is considered the most stressful of all clinical endeavors. Therapists who lose a patient to suicide experience that loss as much as they would the death of a family member. It can become a career-ending event.

-Such distress in psychotherapists can be further exacerbated by possible legal actions. 25 % of family members of suicidal patients take legal action against the suicidal patient's mental

health treatment team (See Bongar, 2002).

What Can Psychotherapists and Other Mental Health Professionals Do To Address their Patient's Violence Potential Towards Others and Toward Themselves?

I have discussed this topic at some length elsewhere. See Meichenbaum1994, 2001, 2005. First, there is a need to be informed about possible warning or danger signs and conduct ongoing risk assessment. Second, there is a need to implement best practice guidelines on ways to manage violent patients and remove weapons and reduce suicidal risk. (See Meichenbaum, 2001, pages 192-195 on the "Do's" and "Don'ts" in handling violent patients and see Meichenbaum, 2005 for a Risk Assessment Checklist for suicidal patients). To be informed and prepared for probable high-risk assessment and risk management are valuable ways to reduce stress in psychotherapists. There are effective psychotherapeutic interventions for violent and suicidal patients. Third, there are resources to help clinicians who have lost patients to suicide. The American Association of Suicidology has put together a Clinical Survivor Task Force for "**Therapists as Survivors of Suicide**". Visit
http://myspace.iusb.edu/~jmcintos/basicinfo.htm
See their extensive bibliography on the impact of patient suicide on clinicians and ways to cope.

Tom Ellis, who is in charge of the listserv for the American Association of Suicidology has offered the following advice on **What To Do If You Lose a Patient To Suicide.**

1. Procedural (Immediate)
- a. Notify supervisor
- b. Notify director of service
- c. Contact hospital attorney
- d. Strongly consider contacting family
- e. Consider attending funeral

2. Emotional (soon)
- a. Attend to your need to mourn
- b. Seek support from your supervisor, colleagues, significant others
- c. Use cognitive strategies to dispute dysfunctional self-statements and beliefs

3. Educational (later with supervisor or review group)
- a. Write a case summary, including course of treatment
- b. Review case formulation, identifying risk and protective factors
- c. Review intervention strategies

See suicidology@LISTO.APA.ORG for additional resources

EPILOGUE

Work with traumatized patients can alter psychotherapists' views of the world and of themselves and can affect many aspects of their psychotherapeutic efforts. Vicarious Tramatization (VT) comes with the territory of working with victimized individuals. The present Handout enumerates over 35 different ways to cope with VT at the individual, social and organizational levels. There is a need to translate these coping strategies into active ongoing coping activities to be conducted at the individual, group and organizational levels. **How many of these coping procedures and strategies do you, your colleagues, and your agency employ?**

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INTERNET RESOURCES

American Association of Suicidology
suicidology@LISTO.APA.ORG

American Psychological Association Help Center
http://www.apahelpcenter.org/

Clinician Survivor Task Force
http://mypage.iusb.edu/~jmcintos/basicinfo.htm

Tapping Your Resilience in the Wake of Terrorism: Pointers for Practitioners
http://www.apa.org/practice/practitionerhelp.html

The Cost of Caring: Child Trauma Academy--Bruce Perry
http://childtrauma.org

Traumatic Stress and Secondary Traumatic Stress --Hudnall Stamm
http://www.iusb.edu/~bhstamm/TS.htm

Professional Quality of Life Scales assess job satisfaction, burnout and secondary stress reactions
http://www.isu.edu/~bhstamm/tests.htm

National Institute for Occupational Safety and Health
http://www.cdc.gov/niosh/stresswk.html