

**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 Violence
Miami, Florida**

*(www.melissaistitute.org)
(www.roadmaptoresilience.com)*

Email: dhmeich@aol.com

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By way of introduction, I have spent the last 40 years of my clinical and research career working with a wide variety of clients who have experienced multiple victimizing and traumatic experiences. I have listened to clients share their stories of being victims of natural disasters, victims of intimate partner violence, sexual and physical abuse, combat exposure, victims of torture, school shootings and personal loss such as suicide by family members.

I have been involved in the training and supervision of trauma psychotherapists who have lost their clients to suicide, or whose clients experienced revictimization. This CE course is my effort to help psychotherapists bolster their resilience.

As a supplement to this course, I would encourage you the interested participant, to supplement this course by looking at my recent book [Roadmap to resilience](#) that enumerates practical ways to bolster resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual). (Please see www.roadmaptoresilience.com).

The need for such a CE course on Self-care for psychotherapists is underscored by the research findings that 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 some 30% 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).

As a result of taking this course you will be able to:

1. Increase your self-awareness and conduct a self-assessment of growth level of self-care and self-satisfaction;
2. Improve your self-care skills at the individual, collegial and organizational levels;
3. Bolster your vicarious resilience when working with victimized and traumatized clients;
4. Address the special cases of dealing with violent clients and the suicide of one's clients;
5. And where indicated, access personal therapy.

This CE course 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 TRAUMA

Milton Erickson used to say to his patients, “*My voice will go with you.*” His voice did. What he did not 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). For those stories involving trauma or human suffering, sometimes they are more difficult than other stories to relinquish from memory and can contribute to burnout and in some cases vicarious trauma.

A number of diverse constructs have been offered to describe the health care providers' reactions to working with traumatized and victimized clients (Baird & Kracen, 2006; Newell & MacNeal, 2010; Newell et al. 2015). Let's consider the differences in these varied concepts.

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 empathic engagement with the client's traumatic material”. Empathy is the helper's greatest asset and also possibly his/her greatest liability as the emotional engagement can sometimes entangle us to such a degree that it impact us, emotionally.

VT is not 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 and can influence Countertransference responses such as avoidance and/or over identification with the client.

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 over identification 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.

Vicarious Resilience. In contrast to the concepts of vicarious Traumatization, Burnout, Secondary Traumatic Stress, and Countertransference, it is important to keep in mind that trauma-focused psychotherapists can also become strengthened and more resilient as a result of working with traumatized clients who evidence PTSD and co-occurring psychiatric disorders. Consider the following findings:

- PTSD is essentially a disorder of non-recovery
- No matter what form of victimization or trauma exposure, some 70% of individuals will be impacted, but they go onto evidence resilience, or the ability to “bounce back”, and in some instances evidence post-traumatic growth. (Bonnano, 2004; Calhoun & Tedeschi, 2006; Meichenbaum, 2014).

The trauma psychotherapists willingness and ability to listen to and bear witness to their clients’ stories of healing, recovery and resilience can prove inspirational and contribute to “vicarious resilience” in psychotherapists. Like our clients, most trauma psychotherapists evidence resilience (Farrell & Turpin, 2003; Hernandez et al. 2007). Keep in mind that resilience and post-trauma stress can coexist. It is not an either-or situation. In the same ways that clients may experience the aftermath of traumatic events and victimizing experiences, they can also evidence grit, perseverance as they call upon a variety of intra and interpersonal supports and their faith. In a similar fashion, trauma psychotherapists also evidence resilience.

This CE course will highlight ways to bolster resilience in psychotherapists.

Caveat: Status Of The Concept of Vicarious Trauma (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

Vicarious Trauma can manifest in emotional, behavioral, and cognitive symptoms that impact both the individual and the organization. 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). More specifically, here are some examples of symptoms of how VT can impact the individual:

1. Individual:

A. Feelings:

- Feel overwhelmed, drained, exhausted, overloaded, burnt out
- Feel angry, enraged, and sad about client's victimization; such feelings may 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

B. 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

C. 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

2. Organizational Indicators of VT

The organization is not immune to the impacts of VT. When individuals are struggling with VT, it impacts the organization in the following ways:

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

With VT impacting both individuals and organizations, it is important to be able to identify those who may be struggling and who may be at risk for developing VT. There are a variety of measures and instruments that can help individuals and organizations identify those that may be prone to develop VT. I will discuss these instruments in a moment. First, let's discuss some of the risk factors for developing VT.

RISK FACTORS FOR DEVELOPING VT

We begin with a consideration of three classes of risk factors that increase the likelihood of psychotherapists developing VT, namely, the characteristics of the clients, the features of the work setting, and the attributes of the helpers/psychotherapists.

1. Characteristics of the CLIENT that can contribute to VT include:

- 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 and patients who have a history of violence towards others
- Work with survivors who are also perpetrators.
- Work with clients who may relate trauma stories of human cruelty and intense suffering such as
 - 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 of aspects of the trauma
 - Ongoing risk of further revictimization to client and possible threats to health care providers (e.g., work in domestic shelters)

2. Characteristics of the Job/Work Setting that can contribute to VT

- Large caseloads – overextension due to work demands, excessive overtime or on call
- Large percentage of clientele who have trauma experiences and suffer PTSD and co-occurring disorders
- Back-to-back clients who are trauma survivors
- Cumulative exposure to traumatized clients over time
- Lack of clinical/personal peer support in the workplace
- Absence of clinical supervision
- Few resources to which to refer clients for ancillary services
- Professional isolation – poor collegiality and peer support

- Cultural clash between clients and the treatment agency
- Workplace structural and personal strains-lack of resources, personnel, and time to complete a job
- Role conflict or ambiguity
- Reimbursement issues, managed care, poor compensation
- Legal consequences for helper
- Barriers to achieve interventions and treatment goals
- Barriers to the helper seeking help – concerns about confidentiality, fear of stigmatization

3. Characteristics of the Helper/Psychotherapist that can contribute to VT

- Personal victimization history that is unresolved – issues of shame, guilt, anxiety, anger, grief
- Lack of experience – novice workers are at greater risk
- Additive effects of trauma and other stressors (personal, job-related)
- Lack of coping skills-impose excessive demands on oneself, others or work situation
- 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
- Helpers who are more aware of VT and countertransference are less susceptible to Secondary Traumatic Stress
- 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.
- Failed to share ones “story” of victimization with supportive others (keeping one’s story of trauma and victimization a secret).

ASSESSMENT TOOLS OF VT AND RELATED REACTIONS

There are a variety of standardized assessment protocols that are available for assessing VT as well as self-assessment measures and techniques. (*See Website Addresses at end of this Handout*)

1. Measures

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|---|------------------------|
| Professional Quality of Life Scale (ProQOL) | Stamm, 2004 |
| 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 |
| 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 |

You can conduct a self-assessment of your level of Compassion Satisfaction and Fatigue by downloading the PROQol measure developed by Hamm. Go to the following Website www.PROQol.org.

This Self-assessment Questionnaire can be supplemented by answering the following questions.

2. Self-assessment of VT

The following self-assessment questions are designed to assist psychotherapists in becoming more aware of where they are emotionally, behaviorally, and cognitively. These are general questions that you can ask yourself. However, it is suggested that you 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? Positively, and perhaps, negatively?”*
- *“What changes, if any, do I see in myself that I do not 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 not 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 not 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?” Remember, what cannot be talked about can also not be put to rest!*

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

- **“What are the most difficult and the most rewarding aspects of my job?”**
- **"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?"**

The self-assessment and standardized assessments are designed as a means for clinicians to help identify the symptoms of VT. Let’s discuss intervention strategies and ways to cope with VT.

INTERVENTIONS: WAYS TO COPE WITH VT

1. GENERAL GUIDELINES

There are many strategies addressing ways to cope with the VT, both at the individual, social and the organization levels. For the individual, the psychotherapist has many innate tools at his/her disposal. Using self-care strategies, using one’s cognitive abilities, engaging in behavioral activities, and even reaching out to colleagues can be effective methods for addressing VT. For the organization, strategies can involve team meetings, ongoing supervision, and even more in-depth interventions such as Stress Inoculation Training and General Resilience training. As general guidelines in preventing and treating VT, it is important that psychotherapists keep in mind these following items:

- Remember treating trauma patients is not for everyone. As responsible psychotherapists, we each need to know our limitations and what type of clients we can and cannot work with effectively.
- In treating trauma victims, we will hear some emotionally difficult stories. The longer we treat clients, the more stories we will hear. It is important to know that being proactive in managing VT, rather than ignoring the possibility of VT is a good first step towards prevention.
- 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. It should be a policy identified and implemented at the organizational level rather than having the individual psychotherapist to “fend for him/herself.”
- 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

Now that we covered some of the general guidelines, let's spend consider specific to cope with VT at the individual level.

WAYS TO COPE WITH VT: AN OVERVIEW

1. Individual Level:

To cope with VT at the individual level, increasing your self-awareness, engaging in self-care behaviors, using your cognitive abilities, and engaging in behavioral activities can all help mitigate the impact of VT.

A. Practice Self Care

As psychotherapists, many of us will go out of our way to ensure the well-being of our clients. However, when it comes to taking care of ourselves, we can put our own needs on the backburner. Self-care is a necessary element for psychotherapists who treat trauma victims in order to address and prevent VT. It involves, ensuring physical and mental well-being, having an outlet for emotional discharge, and engaging in healing activities to renew life both in and out of therapy. 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.). As Norcross and Guy (2007) observes, learn how to leave your distress at the office.

B. Increase Your Self-observations

Recognize and chart signs of stress, vicarious traumatization, and burnout. The assessments and measures discussed above can be effective ways for the psychotherapist to monitor his/her own VT. When dealing with difficult or challenging clients and their stories, it is good for the psychotherapist to be aware of the possible impact simply by maintaining self-awareness. Conducting a quick self-analysis by asking yourself the self-assessment questions cited above or by filling out one of the Self-report Scales will increase self-awareness.

C. Engage in Emotional Self-care Behaviors

Taking care of oneself is easy to overlook, but self-care is vital to VT prevention and maintenance. Self-care behaviors don't have to be elaborate rituals or procedures. They can be simple, daily activities such as:

- Engage in relaxing and self-soothing activities like yoga, relaxation exercises, mindfulness, and/or meditation between clients or after work. Develop a ritual for leaving work in order to help you leave work stress and work identity at the office.
- Engage in physical and mental well-being through exercise or outdoor activities. Replenish by having a getaway weekend or vacation. Give yourself permission to escape when necessary. Cherish your friendships and intimacy with family.
- Maintain a healthy balance in your life; don't let work consume you. Have outside outlets and interests such as hobbies, social activities, etc. that allow you to reinforce your identity outside your professional one and that allow for you to recharge. 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.
- Engage in expressive or healing activities both in and outside of therapy. 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 that help you express feelings through writing, gardening, painting, art, dance, or other mediums that allow you to express your emotions or thoughts freely.

D. Use Your Cognitive Abilities

Most psychotherapists will be aware of or familiar with Cognitive Behavioral Techniques used to help clients. Psychotherapists can use these same coping strategies on themselves.

- Recognize that you are not alone: Normalize and monitor your “story-telling narratives.” 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” you tell yourself and others and ensure that your story is one of empowerment and healing, “redemptive”.
- Set realistic expectations to enhance feelings of accomplishment. Recognize your limitations and the fact that therapists will make mistakes. The percentage of goals and sub goals achieved is critical to foster feelings of accomplishment. Avoid wishful thinking. Set specific achievable goals for each session. Use **SMART** goals (specific, measurable, attainable, relevant and time-limited).
- Adopt a more philosophical accepting stance. Appreciate the rewards. Use your spirituality. Accept those aspects that cannot be changed, 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.
- Do not take on responsibility to “heal” your clients”: 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”***
- Challenge negativity: Don’t play the blame game! Find meaning and hope. Solicit “the rest of the client’s story”. Focus on resilience in therapy. 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.

- Be sure to ask your clients "What they have been able to achieve in spite of the lifetime history of victimization?" Ask them "how" and "what" questions (not "why" questions) on how they were able to achieve these personal life accomplishments and goods.

E. Engage in Behavioral Activities

Behavioral activities refer to the changes you can do in your work and personal life to modify the routine or procedures that is more conducive to well-being and preventative measure for VT.

These can include:

- Balance the composition of caseloads (victims and non -victims). 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).
- Limit overall caseloads. Monitor work balance and work/life balance. Don't take on more than you can handle. Know when to refer out if you are at your limit.
- Share reactions with clients: Nurture therapeutic alliance and monitor and impose personal limits. 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).

- When necessary, take time off. Take a break (daily, weekly, monthly). If you notice the symptoms of burnout, don't ignore them. Take time off to recharge when you need to. Give yourself permission to be cared for and counseled. Enjoy yourself. Finally, when and if necessary, take a break from PTSD practice and seeing new PTSD clients. Engage in other activities like teaching, research, clinical, administrative activities to allow yourself to recharge and come back to work gradually.

Mindfulness-based Stress Reduction (MBSR), as developed by Kabat-Zinn (1990) has been used to reduce work-related stress, anxiety, depression, by increasing empathy, positive emotions, self-compassion and serenity in psychotherapists, social workers and counselors (Brown et al, 2016; Gerber, 2009; Hick, 2009). Learning to focus attention on the present in a non-judgmental mindful manner can be combined with a number of cognitive behavioral interventions including relaxation, guided imagery, perspective taking, self-talk, and supplemented by meditation and yoga.

2. Peer and Collegial level

Engaging with other professionals at the collegial level can help to mitigate the effects of VT. The psychotherapist or “helper” should be able to reach out to professional social networks, supervisors, and even be available to other professions, if and when appropriate.

A. Helper Initiated Activities

Activities that help you take stock and reach out to colleagues when necessary can be important. They don't have to be overly formal or complicated. They can include the following:

- Assess social support network. Draw a map of supportive people. Who is there to provide emotional, informational, material supports? Note, it may not 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 "supportive, holding environment"?
- Seek social support from supervisors, colleagues, and family members. 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.

- Provide support: Don't overdo it! 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".
- Use buddy system, especially for novices. 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.
- Obtain peer supervision- use Consultation Teams. Review cases on a regular basis. 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 Dialectical 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".

- Engage in “debriefing”. Develop informal opportunities to connect. 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 experienced 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?”

- Participate in training opportunities 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.)
- Participate in agency building or community building activities. Join others around a common purpose or value.
- Continue to learn more professionally. Join a study group, consultation group, attend continuing education conferences, join divisions or organizations that specialize in trauma or take workshops and study evidence-based interventions. (See Website List).

One way to reduce staff burnout is to enhance therapists' capabilities and motivation by means of implementing effective evidence-based interventions such as Dialectical 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.

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

3. ORGANIZATIONAL AND AGENCY LEVEL

Organizations and agencies should be proactive in helping psychotherapists reduce burnout and VT. There are a variety of strategies organizations can implement to help the psychotherapist individually and collectively. These include:

- Scheduling team meetings as a means of “emotional check-ups.”
- Agency should balance the psychotherapist's (helper's) caseload. Agencies should work collaboratively and proactively towards distributing and decreasing the number of demanding victimized clients.
- Provide ongoing supervision, especially for novice psychotherapists.
- Promote education and training about vicarious traumatization, burnout, and wellness programs to foster awareness and interventions.
- Ensure staff takes care of themselves in terms of nutrition, exercise, sleep and that they take frequent breaks. Help foster spiritual renewal.
- Maintain professional connections and identity. Collaborate with other helping agencies to foster a sense of team working toward common objectives.
- Address boundary issues, "Manage boundaries". Support “altruistic” activities. Agencies should conduct meetings and run workshops on boundary issues between clients and helpers to reduce this source of stress. Help helpers limit their trauma exposure outside of work.
- 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”.
- Provide Stress Inoculation Training, General Resilience Training Acceptance/Mindfulness Skills Training that have each been found to reduce job-related stress in helpers. Reivich and Shatte (2002) 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.

- Provide a psychologically healthy workplace programs. Some programs can 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 centers; 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 (scenario training).

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).

Increased incidents of violence against mental health staff and dealing with suicidal clients can all add additional emotional and physical stressors on psychotherapists. 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).

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

I have discussed this topic at some length elsewhere (See Meichenbaum 1994, 2001, 2005). However, there is a need to be informed about possible warning or danger signs and for psychotherapists to conduct ongoing risk assessment. 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). Moreover, there is a need for psychotherapists to Document, Document, Document in their progress notes their ongoing assessment of risk and protective factors and interventions,

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 and 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. Also see the Oxford Handbook of Behavioral Emergencies and Crises edited by Philip Kleespies.

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

You can also visit my article on the Melissa Institute “35 years working with suicidal patients: Lessons learned” (www.melissainstitute.org).

A number of authors have discussed ways to improve self-care in psychotherapists and other health care providers. The interested reader can find useful suggestions in the writings of Baker, 2003; Corey & Corey, 2015; Cox & Sterner, 2013; Figley, 1995; Kabat-Zinn, 1990; Maslach & Lecter, 2005; Meichenbaum, 2014; Norcross & Guy, 2007; Pearlman & Saakvithe, 1995; Pope & Vasquez, 2005; Pryce et al. 2007; Rothschild, 2006; Saakvitne & Pearlman, 1996; Skovholt & Trotter-Matheson, 2016; Stamm, 1999; Wicks, 2008 and Wicks & Maynard, 2014.

SUMMARY:

Work with traumatized patients can alter psychotherapists' views of the world and of themselves and can affect many aspects of their psychotherapeutic efforts. Vicarious Traumatization (VT) comes with the territory of working with victimized individuals. The present Handout enumerates many 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? How can you bolster your level of resilience?**

MY PERSONAL SELF-CARE ACTION PLAN

Now that I have worked through the Self-care CE material, I need to identify at least three specific activities that I can undertake to improve my level of self-care and bolster my resilience. I need to develop and implement a specific Action Plan.

To begin with, I can start by taking a moment and answer the following questions.

Self-reflection Exercise

Take a moment and reflect on what are the most rewarding parts of your job as a therapist?

What are the proudest moments of your professional career?

Have you shared these proudest moments with a colleague, a family member, a novice helper entering your profession?

What challenges do you face on your job?

How can you anticipate and address these challenges? (See Self-care Checklist)

1. At the personal level, I can and will take the following actions.

2. At the collegial level, I can and will take the following actions.

3. At the organizational level, I can and will take the following actions.

After accomplishing my personal goals, I can retake the self-assessment of my level of Self-care and Compassion Satisfaction and Fatigue.

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REMEMBER THAT SELF-CARE IS BOTH A DAILY AND LONG-TERM ACTIVITY

SELF-CARE CHECKLIST

Individual Level

1. Increase self-awareness and personal commitment.
2. Take Self-assessment Scales.
3. Answer Self-questions of Vicarious Traumatization (VT).
4. Secure feedback from coworkers and family members.
5. Be on the lookout for warning signs of VT, Burnout, Compassion Fatigue.
6. Make self-care a priority (sleep, nutrition, exercise, bodily rest). Self-renewal is an ongoing process. ("Being too distressed decreases the quality of care.")
7. Pay attention to the "rest of the story" for evidence of your Vicarious Resilience (VR) and ways you have become strengthened as a result of working with traumatized and victimized clients. Admire and be fascinated by your clients' resilience and their ability to "bounce back". Consider your proudest moments in helping others.
8. Cultivate self-pity. Be gentle with yourself and reduce perfectionistic standards and corrosive expectations. Recognize that all psychotherapists will make mistakes.
9. Take an environmental audit of your work situation and office. Take proactive actions to reduce stress. Ensure your safety, at all times.
10. Reduce your caseload, when feasible. Diversify your clientele (not all trauma clients). Say "No" to clients for whom you do not feel comfortable and competent to treat. Know your limitations and preferences. Have a list of referral resources and have back up professional colleagues to whom you can call upon.
11. Establish and implement boundaries with your clients. Say "No" to clients who continually impose high levels of stress (no shows, comes late, threatens and harasses, makes unreasonable requests, fails to reimburse for sessions).
12. Develop and implement transition ritual designed to leave your stress at the office. Establish a boundary between work and home.
13. Engage in self-regulation routines to reduce negative stressful emotions and accompanying behaviors. For example, during the day schedule breaks (at least 10 minutes) between clients to unwind, do stretches, and reflect on what happened. Schedule time during the day to return telephone calls, write progress notes and the like.
14. Engage in self-soothing activities (relaxation, mindfulness exercises.)
15. Replenish yourself with breaks that increase the experience of positive emotions away from the office (go for a massage, take days off, vacations, mini-sabbaticals). Add to your "Bucket List."
16. Arrange for assistance for filling out Insurance and Reimbursement forms. Where feasible, enlist the help of a good secretary or office manager. "Delegate to more competent folks."

17. Solicit feedback from your clients on a regular session-by-session basis about the quality of the therapeutic alliance. Be open to feedback and adjust treatment accordingly. Be collaborative with your clients and check-in regularly. Be patient and be a catalyst ('a midwife') for a client's behavior change.
18. Take satisfaction and pride in your willingness and ability to help others; making a difference in the life of others. Savor your career satisfaction and keep a Gratitude List.

Peer and Colleague Level

19. Assess your social support network at work and in other settings. Make a list of whom you can turn to for informational consultation, practical back-up assistance, and emotional support. You may choose to go to different people for fulfilling your varied needs.
20. Adopt a team approach. Cultivate a support network at the office. Participate in peer supervision, care reviews, study groups.
21. Take advantage of training opportunities (Website training sites, CEU courses, workshops, conferences) and supervision activities.
22. Engage in agency professional and community-based activities that foster self-care.
23. When indicated, seek professional help (enter group or individual psychotherapy). ("Practice what you preach.")

Organizational Level

24. With colleagues, encourage your agency, or employer to schedule team meetings ("emotional checkups"). If in private practice, arrange for such meetings with a colleague. (Keeping stress a secret makes things worse and compromises both your therapeutic effectiveness and self-care).
25. Engage in diverse professional activities (consultation, teaching, research, supervision.) Balance your work load.

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INTERNET RESOURCES

Melissa Institute for Violence Prevention

(For additional papers by Dr. Meichenbaum visit this Website. On the top of the Home Page click on Resources then scroll down to Author Index. Then scroll down to Meichenbaum in order to open other related papers).

www.melissainstitute.org

Professional Quality of Life Scale

www.ProQol.org

Maslach Burnout Inventory

<http://maslach.socialpsychology.org>

Vicarious Traumatic Toolkit: Northeastern University

www.VTToolKit@Northeasternprojects/current/vicarious-trauma-toolkit-vtt

Self-care Starter Kit

<https://socialwork.buffalo.edu/resources/self-care-starter-kit.html>

Compassion Fatigue Awareness Project

www.compassionfatigue.com

Self-compassion: Scale and research

www.selfcompassion.org

Reach Out to Professionals

<http://au.professionals.reachout.com>

American Institute of Stress

www.stress.org

National Child Traumatic Stress Network

<http://www.nctsnet.org>

The Cost of Caring: Child Trauma Academy

<http://www.childtrauma.org>

National Center for PTSD

www.ptsd.va.gov

International Society for Traumatic Stress Studies

www.istss.org

American Psychological Association Help Center

<http://www.apahelpcenter.org>

Examples of Evidence-based Training Websites Designed To Improve Psychotherapists' "Expertise"

www.melissainstitute.org

www.musc.edu.tfcbt

www.attc.usc.edu

