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Pro-Actively reducing vicarious trauma: what are we missing?

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PRO-ACTIVELY REDUCING VICARIOUS TRAUMA: WHAT ARE WE

MISSING?

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PRO-ACTIVELY REDUCING VICARIOUS TRAUMA: WHAT ARE WE MISSING?

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Abstract

This project addressed the need for Vicarious Trauma education for new counsellors who are exposed to client trauma a regular basis. A literature review was conducted prior to the development of a psycho-educational training manual which teaches, via an eight-week group meeting program, a solid foundation of knowledge and protective strategies for mitigating the effects of vicarious trauma. Integrating traditional Cognitive Behavioural Therapy approaches to Vicarious Trauma mitigation with new developments in Post-Traumatic Stress Disorder treatment that involve somatic, psychophysiological and sensorimotor psychotherapy. The blending of these theories gives new insight into techniques to prevent, reduce and protect counsellors from Vicarious Trauma.

KEYWORDS. Group, counsellors, psycho-education, mental health, professionals, Cognitive Behavioural Therapy, Post-Traumatic Stress Disorder, Somatic Therapy, Psychophysiology, Sensorimotor Psychotherapy, Vicarious Trauma

Acknowledgements

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Chapter 1: Introduction

Vicarious trauma (VT) is a growing impairment amongst mental health

professionals. Considered to be a change to the inner constructs and beliefs regarding the

self of a helping professional in relation to emotional interactions with a traumatized

client or patient and related to a combination of factors, VT is believed to be mitigated by

a combination of supervision, education, and the use of healthy coping techniques. To

reduce the development of VT during clinical practice, researchers suggest that therapists

educate themselves on a variety of mitigation techniques (Sabin-Farrell & Turpin, 2003).

Research shows that cognitive behavioral therapy is the most effective means of helping

clinicians understand how VT may impinge on their self-identity, worldview, spirituality,

psychological understanding of personal safety, trust, and sense of control (Lerias &

Byrne, 2003; Sexton, 1999). When robust, such factors are the best defense to protecting

oneself from developing debilitating VT.

The symptoms of VT are unique from other emotionally draining physical and

psychological conditions (such as burnout, compassion fatigue and occupational stress).

VT affects individuals who work with traumatized individuals in a professional capacity.

As examples, therapists working with survivors of sexual assault or domestic violence,

police officers, and paramedics who experience ongoing exposure to the death, dying,

and abuse of others are often reported to experience high levels of VT (Pearlman &

Saakvitne, 1995).

Significance of Research

While VT has been described comprehensively in the literature, questions remain

as to whether there are effective protection techniques via cognitive therapies and coping

strategies alone. This final project, synthesizes research regarding the methods of

contracting, mitigating, treating and recovering from VT and research on Post Traumatic Stress Disorder (PTSD) that VT researchers have not yet focused on directly. Additionally, the financial cost and human resources impact of VT on the agencies and organizations for which at-risk individuals work will be reviewed. The overwhelming conclusion is that mitigating the effects of VT is of utmost importance.

Still largely under-studied, the transfer of trauma from client to therapist via the empathetic connection is beginning to emerge as the greatest risk factor to both the cognitive, psychosomatic and psychophysiological health of the therapist who treats highly traumatized clients. The literature review explores the impact of this unique empathetic connection, how the brain-body connection impacts the therapist's VT experience and how this experience is recognized, experienced, ameliorated and mitigated by the therapist.

Intent & Project Rationale

This research informs the development of an eight-week psycho-educational group and facilitator manual; both empirical and practical evidence published in current literature were used to develop techniques to educate therapists to protect themselves from contracting VT. Thus, a section of the literature review below examines how therapists can best engage in a group learning setting, and the unique challenges that a room full of therapists may present.

The manual, titled *Fighting Back against Vicarious Trauma*, centers on helping therapists mitigate the effects of VT and aims to increase understanding of the research into changes in trauma therapists' cognitive schemas and develop a basis in understanding the new research into psychophysiology and somatic psychology. The

manual engages relevant ethical issues regarding work with traumatic material and trains individuals to work with traumatic material with awareness of risk. Also reviewed in the manual are the basics of assessing group participants for the potential impacts of their own unresolved trauma, how to facilitate the group, how to obtain informed consent regarding the risk of exposure to triggering material, and how to navigate exclusion criteria that may evolve as the group proceeds. The literature review will culminate with suggestions for future research and questions regarding the potential cohesion of PTSD and VT research.

Statement of Interest

Over the last three years I have worked with individuals from diverse professional backgrounds; cardiac nurses, psychiatric nurses, young adults with diplomas or Bachelor's degrees in psychology or counselling, certificates in child and youth care, or a collection of various life experiences considered equivalent. These individuals formed teams that provided intensive round-the-clock care for groups of women aged 17-24 who suffered from complex and comorbid psychiatric conditions, addictions and eating disorders. Often, in addition to their primary diagnoses, these young women were also the victims of historic, systemic and/or acute traumatic events or abuses. Day in and day out I worked with this team as we walked into traumatic flashbacks with these young women, listened to the stories that nobody in their lives believed, saw the scars on their bodies that their experiences had left, protected them from their abusers who showed up on the treatment center doorstop, and little by little I began to see the effects of this work take a toll on my teammates and coworkers. I began to see them struggle with nightmares and panic attacks. They developed debilitating headaches and flu-like

symptoms that they couldn't shake. They became ill and called in sick more often, became bitter or jaded. They avoided working with difficult clients or stopped spending time socializing with coworkers. Requests for resources from our superiors were met without compassion and additional training in working with complex trauma clients was not provided. Eventually, good staff members became poor staff members, unreliable staff members and burned out staff members and our team withered. We lost energetic and creative people who did great work because the work took a toll on them. It is because of those coworkers that I took an interest in Vicarious Trauma. People who work with complex trauma come from all sorts of backgrounds and all sorts of training paths and do not always receive (either from their educational institution or from their agency of employment) training in how to protect themselves from the debilitation that comes from spending each and every day embedded in the trauma of others. This project, and the training provided in the *Fighting Back against Vicarious Trauma* manual is designed to offer specific resources to therapists as well as those who work with and support those therapists and are exposed to client trauma.

Key Definitions

Throughout this project, I will use the DSM-V definitions whenever possible. Vicarious Trauma, Burnout, Compassion Fatigue and other related conditions that affect the performance of therapeutic professionals, however, are not listed in the DSM-V and are subject to shifting definitions depending on the author quoted. For the purposes of this project, I will attempt to clarify differences between definitions whenever applicable but otherwise use standard peer reviewed definitions.

Vicarious Trauma is generally defined as the indirect distress and trauma to the therapist caused by continuous and graphic descriptions of clients' trauma experiences (McCann & Pearlman, 1990) as well as the changes in beliefs and attitudes that can affect self/professional identity, world view and psychological beliefs related to esteem, intimacy and spirituality (Sabin-Farrell & Turpin, 2003).

Post-Traumatic Stress Disorder is defined in the DSM-V as "history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity" (American Psychological Association, p. 265).

Compassion Fatigue is defined by Figley (2002) as a type of secondary traumatic stress which is the natural consequence of behaviors and emotions which result from knowing about trauma experienced by a significant other. The stress comes specifically from wanting to help this suffering or traumatized person.

Emotional contagion is defined as the "convergence of one person's emotions with another's (Rothschild & Rand, 2006).

Burnout has no generally accepted definition nor an accepted form of measure. Weber and Jaekel-Reinhard (2000, p. 512) suggest that the most common description is "exhaustion, depersonalization and reduced satisfaction in performance" and is considered a type of chronic stress.

Project Overview

This project includes a comprehensive review of Vicarious Trauma (VT) literature which focuses heavily on Cognitive Behavioral and Cognitive Restructuring approaches to symptom alleviation and mitigation. Chapter 1 will define the key terms

identified in VT literature, give a thorough overview of the project, the rationale behind it and the significance of the research. Chapter 2 will outline the methodology used in the creation of the project and outline the Masters of Education Final Project guidelines adhered to. The Chapter 3 Literature review will examine VT awareness and treatment not only through the traditional cognitive approaches but will also introduce somatic, psychophysiological and sensorimotor psychotherapy approaches. A portion of the literature review is dedicated to examining the impact of VT on the agencies and organizations who employ trauma therapists and their responsibility to assist in the mitigation and amelioration of VT symptoms via creating safe work spaces.

In chapter 4, the *Fighting Back against Vicarious Trauma* 8-week psychoeducational group is presented. This group is accompanied by a facilitator's manual and is designed to be used to teach trauma therapists Cognitive Behavioral (CBT) as well as Psychophysiological and Sensorimotor Psychotherapy based approaches to VT mitigation and VT recovery. Additionally, portions of the *Fighting Back against Vicarious Trauma* group allow participants to self-check and familiarize with their own baseline VT levels so that they can monitor themselves for changes. Aspects of the *Fighting Back against Vicarious Trauma* group allow participants to practice new skills.

The training is designed to increase understanding and awareness of the concept of VT, its effects, its developmental patterns, and a variety of coping/mitigation techniques. From a professional perspective, this training program will bring awareness of the impact of trauma work on mental health staff and therapists. Further, it can be used by management and supervisory teams to create safe working environments, monitor

staff for signs of VT, and foster an environment that includes mitigation factors such as regular staff meetings, professional supervision, peer supervision, and ongoing training.

The project is based on the Vicarious Trauma literature review and will include an examination of both qualitative and quantitative research regarding the experience of trauma therapists. Chapter 5 includes a discussion of the strengths and limitations of this project as well as future considerations based on my research project.

Chapter Two: Methods

This chapter provides information regarding the use of online databases, peer-reviewed journals, University of Lethbridge dissertations and other sources of scholarly materials for research for this project. As no unique research was undertaken for this project, no primary data and no interpretation of data was necessary. No animals were hurt in the creation of this project.

Databases and Search Methods

As a University of Lethbridge distance student, The University of Lethbridge online library databases were the primary research resource. The databases used were: PsycINFO, Wiley Online Library, JSTOR, SAGE Journals Online, and Google Scholar were utilized.

In addition to online journal articles, textbooks by leading scholars in trauma treatment, sensorimotor psychotherapy, somatic therapies, and psychophysiology were used to develop an understanding of how trauma affects the brain and the autonomic nervous system.

In the online search, specific search terms included but were not limited to: VT, vicarious trauma, trauma, cognitive behavioral therapy, compassion fatigue, burnout, CBT, trauma, contagion, Levine, somatic, lizard brain, occupational stress, VT + work, cost of VT, VT + psychometrics + compassion fatigue, self-report + trauma,. Boolean search methods were utilized whenever possible to reduce the number of responses found within search engines and databases. No specific date range for research was used and peer-reviewed research regarding VT was found dating as far back as 1982 and as recently as 2016.

In the fourth chapter, the Fighting Back against Vicarious Trauma group therapy manual and accompanying eight group sessions are based directly on the information in the literature review. The groups begin with the cognitive restructuring aspects touted by CBT as being the most important means of mitigating VT in a trauma therapist and move into the new PTSD somatic therapies where participants will learn to control their autonomic nervous system and gauge their own levels of activation throughout sessions (or days) working with trauma clients so that they can learn to control and manage their VT exposure in the moment. During these groups, participants also learn about emotional contagion and how emotion and feeling can be transmitted from one person to another without either person being consciously aware.

Research Guidelines

The *Publication Manual of the American Psychological Association*, sixth edition (APA manual) and the University of Lethbridge Thesis, Project, and Capstone Guidelines were followed in the creation of this Master of Education: Counselling Psychology project. These documents were used in areas such as, but not limited to, formatting, editing, and citations. In the workshop manual portion of this project, creative expression was used in terms of formatting, layout, graphics, and font style.

Ethics

The Faculty of Education ethical guidelines were followed and a human subjects ethical review was not required for this final project as the project contains empirical research only.

Chapter 3 – Literature Review

Beyond the basic definitions of the symptoms of Vicarious Trauma, this literature review focuses on the relationship between exposure to trauma and the effects of attempted mitigation of VT. Additionally, it focusses on the differences between the cognitive schematic approach to treating VT and sensorimotor or psychophysiological approaches to trauma treatment. Also examined was the importance of fostering a culture of acceptance and understanding in the therapeutic community that contributes to working environments that develop and enhance the mental health of therapists working with traumatized clients. A portion of the review will explore steps that agencies and organizations – as well as managers and supervisors within these organizations – can take to enhance the safety of their employees who work closely with trauma caseloads.

Recognizing the impact of VT on therapists at the organizational level will contribute not only the well-being of the individual but to the organization as a whole by reducing absenteeism due to stress and illness and by reducing financial and other resource losses due to employee turnover. Finally, this literature review is the basis for *Fighting Back against Vicarious Trauma*; an eight-week psychoeducational and experiential therapy group and corresponding facilitator's manual that will teach trauma therapists how to recognize, mitigate and ameliorate the impact and symptoms of VT on themselves and on their organizations before they become personally or professionally impaired.

Part 1: What is Vicarious Trauma?

Vicarious Trauma is the experience of distress or trauma had by a therapist as a result of continuous and graphic descriptions of clients' trauma experiences (McCann &

Pearlman, 1990). After being coined as a distinct term in 1990 by researchers McCann and Perlman, the construct of VT became the subject of intense scrutiny. The research to date has almost exclusively targeted professions considered at-risk, including police, paramedics, domestic violence therapists, sexual trauma therapists, and those working with veterans (Bell, Kulkarni, & Dalton, 2003; Collins & Long, 2003; Hesse, 2002; Lerias & Byrne, 2003). These professions are considered high risk due to high levels of exposure to the trauma experiences of others. Much of the recent research on VT consists of literature reviews with added qualitative or anecdotal information that presents nothing new, or that conflicts with previous research (Sabin-Farrell& Turpin, 2003).

This review will expand the understanding of VT to include psychophysiology and somatic psychology. Given the success of Post-Traumatic Stress Disorder recovery reported in the fields of neuropsychology and somatic psychology, it seemed warranted to incorporate the new understandings of the brain and the impact of trauma on the nervous systems into the discussion of VT and how therapists experience, understand, and treat it. PTSD, the primary trauma experience, is often treated from a cognitive restructuring perspective but research has also shown promise in the somatic realm (Levine, 2007; Ogden, 2015, Rothschild & Rand, 2006). Integrating the cognitive perspective with the somatic perspective in VT mitigation has the potential to demonstrate change in a new way. At this time, the fields of sensorimotor psychotherapy, somatic psychotherapy and psychophysiology are new to the PTSD literature and are relatively unknown in the VT field of research. Due to this deficit of research, primary and groundbreaking researchers will be used repeatedly in this final project.

Definition of Terms

Three consistencies found throughout the Vicarious Trauma literature are: (1) the definition, (2) VT's relationship to post-traumatic stress disorder (PTSD), and (3) the conflicting statistics on VT's rates and causes. The definition of VT (McCann & Pearlman, 1990) was created shortly prior to the amendment of PTSD in the fourth version of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV) in 1994. McCann and Pearlman (1990) stated that VT is a unique feature of working with traumatized clients, due to the continuous and graphic descriptions of clients' trauma experiences, which cause indirect distress and trauma to the therapist. The DSM-IV noted that PTSD could be triggered by "learning about trauma experienced by a family member or close friend" (Sabin-Farrell & Turpin, 2003, p. 451) and, while this does not specifically reference counselling relationships, it does suggest that trauma reactions can be triggered in individuals who do not experience the trauma first-hand.

Traditional Definitions. Sabin-Farrell and Turpin (2003) noted that a counsellor's exposure to trauma material causes a cumulative effect on their "inner experience," resulting in a negative transformation through "empathetic engagement with clients' trauma material" (p. 452). The changes in counsellors' internal processes can include (1) alterations in personal or professional identity: *I am not a good counsellor – I cannot help these people*, (2) worldview: beginning to believe *the world is not a safe place to be*, (3) spirituality: questioning what sort of God would allow these atrocities to happen, or perhaps questioning one's faith, (4) self-capacity, (5) psychological needs and beliefs as they relate to personal safety: developing a fear of travelling in certain areas due to of physical or sexual violence shared by clients, (5)trust, (6) intimacy: rejecting sexual

contact or increasing sexual contact for unhealthy reasons, and (7) sense of control: believing that *I cannot control anything in the world – I am not safe* (Sabin-Farrell & Turpin, 2003; Lerias & Byrne, 2003; Sexton, 1999). In Health Canada's *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* Richardson (2001) describes VT in a particularly narrative style:

> Vicarious trauma is the experience of bearing witness to the atrocities committed against another. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by victims searching for a way to release their own pain. It is the instant physical reaction that occurs when a particularly horrific story is told or an event is uncovered. It is the insidious way that the experiences slip under the door, finding ways to permeate the counsellor's life, accumulating in different ways, creating changes that are both subtle and pronounced. Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyche react to the profound despair, rage and pain (p. 7).

Post-Modern Definitions. Trauma itself is a word used in many contexts but is often generally defined as exposure to a "situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being" (Trippany, White Kress & Wilcoxon, 2004). Van der Kolk (2014) argues that trauma is any experience that is untenable or intolerable. Rothschild and Rand (2006) refer to "emotional contagion" and "somatic empathy" as being important terms related to Vicarious Trauma (VT). Their research revealed that unconscious, dyadic emotional mirroring results in the unintentional sharing of emotions between individuals. Emotional contagion includes the neural reactions in the human

brain that take place when interacting face-to-face with other human beings, and is based on the research of Zajonc and colleagues (1987, as described in Rothschild and Rand, 2006). Emotional contagion is defined as the "convergence of one person's emotions with another's" (p. 48) which may offer a potential explanation of the transmission of VT (Rothschild & Rand, 2006) and plays a large role in the neuroscientific explanation of PTSD. Yehuda and LeDoux (2007) argue that from a neuroscience perspective PTSD is an interruption of biochemical and emotional homeostasis and the inability to regain it – for a period of at least one month. Neuroscientific approaches to treatment include moderating the autonomic and sympathetic nervous systems as well as discharging excess energy created by the traumatic interruption in an attempt to achieve biological and neurological homeostasis (Levine, 2007)

Somatic empathy is "vicariously experiencing the state of another unconsciously" (Rothschild & Rand, 2006, p. 29) from a physical perspective (headaches, general discomfort, emotional experiences) and may be unrecognized until it is too late.

Vicarious Trauma & Conflicting Research. The relationship between PTSD and VT has been found to be both correlated and uncorrelated (Bell, Kulkarni & Dalton, 2003; Lerias & Byrne, 2003; Sabin-Farrell & Turpin, 2003; Sexton, 1999). The research is unclear as to which is predictive of the other (i.e., does a personal history of trauma increase the possibility of experiencing VT, or does the cumulative experience of VT increase the potential for the experience of PTSD?).

The DSM-IV (American Psychiatric Association [APA], 1994) and the DSM-V (APA, 2013) both recognized the contagion factor of post-traumatic stress. The sharing of traumatic information – especially when it regards someone with whom one has a close

relationship – can cause PTSD symptoms in a third party who did not experience the trauma first-hand (Sabin-Farrell & Turpin, 2003).

In their 2003 research, Sabin-Farrell and Turpin posit that correlations between trauma work and PTSD development are weak. They argue that there are more predictive individual qualities, including a direct history of trauma and being triggered if this same trauma has not been addressed. Lerias and Byrne (2003) published a comprehensive outline of predictive factors of VT in therapists, but noted that only 10-24% of therapists actually experience symptoms, and, when they do, these rarely impinge on optimal general functioning. The authors note a number of additional predictors: psychological wellbeing, social support, age and gender of therapist, education, socio-economic status, and coping styles. Women appear to suffer higher general anxieties than men, and those with lower levels of education display more severe VT symptoms. Individuals with higher levels of education seem to have a better understanding of self-care, are more likely to access social support and are more likely to access personal therapeutic interventions if necessary.

Summary

As noted earlier, the definitions for VT and its adjacent terms (compassion fatigue, burnout and emotional contagion) are flexible, fluid and permeable. They change over time and continue to evolve as the research in this area evolves and as VT research moves from the realm of cognitive restructuring and cognitive schemas into the world of somatic therapies. Trends that were observed in the middle of the 20th century may still be observed today, but we may have a distinctly different perception on the

reasons for those trends. The definitions in this section are those that will be used throughout this literature review, unless conflicting definitions require further discussion.

A more thorough discussion on how VT and PTSD are experienced differently in a therapist will follow in Part 2 of this literature review.

Part 2: Why Trauma Therapists are Different

Trauma therapists work day in and day out with individuals who have experienced difficult, painful and distressing situations. They hear the stories every day and engage in highly empathetic work. They often have emotional connections with clients, build attachments via empathetic connection and are impacted by the experiences shared in their therapy rooms.

While cognitive changes occur in all populations of care workers identified as being at high-risk for Vicarious Trauma, the therapist population warrants particular consideration due to the intensity and depth of the emotional connection between therapist and client. The therapist population has a number of characteristics (e.g. intense emotional connections with clients, relationships with clients that continue over time, practices that include clients that have suffered similar traumatic experiences, repeated exposure to similar traumatic material from multiple sources) that can both reduce and exacerbate VT in ways that are much different from the experiences of police officers, paramedics and war veterans. Most research on VT and therapists has focused on the working alliance: the emotional, psychological and physical relationship that is developed between the therapist and the client. In an early publication, Pearlman and Saakvitne (1995) suggested that VT was an occupational hazard that should be normalized for therapists working with traumatized clients. Their research indicated that therapists must be able to recognize the symptoms of VT in themselves and actively work to accept the symptoms (Pearlman & Saakvitne, 1995; Sexton, 1999). Sexton (1999) elaborated that, because VT is tied to the occupation of mental health, therapists have an ethical responsibility to attempt to prevent and ameliorate the symptoms of VT.

As described by Rogerian Person Centered Theory (Feller & Cottone, 2003), the most critical component of the development of a successful working alliance is the creation of trust and safety between the client and the therapist. This is achieved most effectively via the therapist developing an empathetic connection with the client. Sexton (1999) warns that the empathetic connection is the highest predictor of the development of VT and PTSD. That is, the empathetic connection that is the core of a trauma therapist's work is the very place in which a therapist is most vulnerable to transference and countertransference – or the ideas that counsellor experience can influence the thoughts and feelings of the client while the client experience may influence the thoughts and experience of the therapist (Sabin-Farrell & Turpin, 2003; Sexton, 1999). This reciprocal relationship is thought to cause strong emotional reactions in the therapist and can lead to either over-identifying with the client or avoiding the emotions all together (Sexton, 1999). Sexton (1999) continues that this emotional avoidance or over-identification can cause cumulative transformation to the cognitive schemas of the therapist and cause the therapist to become impaired. For example, avoidant therapists may find themselves engaging in denial, minimization, distortion, counter-phobic reactions, detachment, and disengagement while an over-identified therapist may experience enmeshment, excessive advocacy, and guilt due to perceived failure to help the client. In early VT research, these cognitive changes were considered "cumulative and permanent, and evident in both a therapist's professional and personal life (Robinson, 2001, p. 6)".

Therapist impairment on a cognitive level is indicted by changes to cognitive schemas. Sabin-Farrell and Turpin (2003) argue that the therapist's exposure to

narratives regarding abuse of trust, lack of safety, and powerlessness may challenge the

cognitive beliefs of "I am invulnerable", "My view of Self is positive" and "I believe in a

meaningful and just world" (p. 456). These changes may further impair the therapist by

evoking symptoms of PTSD. These impairments could then lead to "boundary violations

and incomplete therapies" (Sexton, 1999, p. 397), which supports the importance of

ameliorating the symptoms proactively. Research by Trippany, Kress and Wilcoxon

(2004) supports the work of Sabin-Farrell and Turpin and suggests that the changes to the

therapist as a result of VT "involve disruptions in the cognitive schemas of counselors'

identity, memory system, and belief system" (p. 31).

Similarities between Vicarious Trauma & PTSD

Research into the origins and onset of Vicarious Trauma suggest that because the

triggers for VT stem from the interpersonal, intrapsychic and social frameworks in which

therapists work, VT has slow development and sudden onset that is difficult to detect at

an early stage (Trippany, Kress & Wilcoxon, 2004). This is why mitigation is so

important.

There is no identifiable exposure to a single episode or series of specific episodes

that may trigger VT as there often are with PTSD. VT symptoms are similar to PTSD

(re-experiencing of a traumatic event, avoidance, hyperarousal) although the severity of

the symptoms tend to be lower (Gil, 2015). VT is difficult to distinguish from PTSD, the

only difference being (1) not having been the person who experienced the trauma first

hand, but experienced it via a client and (2) the symptoms are generally of lesser severity.

This symptomatic relationship between PTSD and VT indicates that while VT

may be difficult to identify and differentiate from PTSD to someone who is

inexperienced in recognizing the differences, VT is not the permanent impairment that some cognitive researchers believe it to be. Treatments for PTSD, which include Cognitive Behavioral Therapies, Mindfulness Therapies and Somatic Therapies should also be effective in treating the symptoms of VT.

Is Personal Trauma a Factor?

Conflicting with Lerias and Byrne's research, Sexton (1999) suggests that therapists are highly vulnerable to VT because they are likely to be drawn to therapeutic work due to their own trauma histories. Sexton's (1999) research indicated that over 60% of therapists polled had experienced personal trauma. He argued that VT is avoidable if specific steps are taken: using social support, obtaining professional supervision, undertaking personal therapy, taking trauma therapy training, engaging in professional development, and regularly attending organizational meetings at work. Further, developing good boundaries and living a fulfilling life outside of work help to reduce the risk of VT.

Further complicating the picture is research investigating VT mitigation (Sabin-Farrell & Turpin, 2003) that suggests that debriefing, supervision, and peer support does not reduce the risk of VT and may actually exacerbate it due to the repetition of the traumatic narrative. The authors also highlight conflicting research into VT susceptibility. For example, some research suggests that the number of trauma cases in a caseload is a predictive factor (Bell, Kulkarni & Dalton, 2003), while other studies find no measurable difference between high and low trauma caseloads in therapists with VT. There is some suspicion that the social/cultural work climate may have an effect on VT, but the opposite

data shows that these two factors do not increase VT but may actually influence basic occupational stress (Sabin-Farrell & Turpin, 2003).

Quantitative & Qualitative Exploration

Quantitative research on VT has investigated whether the reduction strategies described by McCann and Pearlman (1990) are endorsed by trauma therapists as being effective. Additionally, the same strategies are proposed to assist in reducing the VT that occurs as a result of working with highly traumatized patients.

Bober and Regehr (2006) and Schauben and Frazier (1995) undertook a quantitative study of 220-260 respondents who were professionals in the field of trauma therapy. The results lent credence to many hypotheses of qualitative research regarding the onset of VT, including the idea that the risk for VT is increased when a caseload includes a majority of trauma-related cases, a therapist does not practice self-care, and individual social supports are not available. The research also indicated that experience of personal trauma does not increase the risk for VT, that working with trauma clients does change the cognitive schemas of therapists in the same way as a PTSD experience, and that age and/or experience of a therapist impacts the development of VT. The depth and breadth of quantitative research, however, is limited, leaving the field of VT relying on anecdotal and conflicting data that focuses heavily on the cognitive aspects, to the exclusion of all other concepts.

Part 3: Where VT Literature Falls Short: Exploration into Psychophysiology and Neuroscience

Published literature on the development of PTSD symptoms following a traumatic experience extends beyond simply the cognitive perspective of changes to worldview. Researchers Pat Ogden (2006), Babette Rothschild (2000, 2006 with Rand, M.), Bessel van der Kolk, (2014), and Peter Levine (1997) have demonstrated that traumatic experiences affect the body in tandem with the brain. Only Rothschild and Rand (2006) use these theories to directly address compassion fatigue, Vicarious Trauma and the impact of the working alliance on the therapist from the psychophysiological perspective. All other researchers have focused singularly on understanding the formation of primary trauma symptoms: the formation of primary trauma and the physiological reactions to witnessing the reactions in victims of trauma. However, connections may be made on levels beyond the cognitive. By limiting investigations to solely the cognitive system, other important factors in the passive transmission of trauma material from client to therapist may have been missed, and may also partially explain conflicting and inconclusive results in the VT literature.

Ogden's, Levine's, Rothschild's, and van der Kolk's research draw our attention away from a sole focus on the cognitive level of processing into the levels of somatic, emotional, and neural processing. Integration of these multi-tasking processes may explain some of the intricacies regarding (1) how individuals develop PTSD after a traumatic event, and (2) the method of transfer of the traumatic response to the therapist or mental health professional who is exposed to the trauma of others on a regular basis. While cognitive behavioral theory addresses the changes to an individual's world perspective and their internal schemas, it is possible that somatic, emotional, and neural

processes are the missing links that could explain why VT is so difficult to pinpoint, predict, mitigate, and treat.

Psychophysiology and Vicarious Trauma

Rothschild (2000) suggested 5 major classes of resources that individuals can access to mitigate the effects of trauma: functional, physical, psychological, interpersonal, and spiritual. Ogden (2006) noted that trauma has a disruptive effect on an individual's sense of self, but disagrees with Sexton's (1999) argument that VT comes from a cognitive schema disruption. She argued, rather, that the disruption comes in the sensory-somatic forms of "intrusive sensations, images, smells, constrictions, numbing and an inability to modulate arousal" (p. 3). Rothschild (2000) echoed Ogden in arguing against the idea of addressing trauma from a solely cognitive perspective.

Recognizing that the body and the brain are intimately connected, Rothschild (2000) suggested that that the key to trauma is in the nervous system, which does not initially respond to the "rational" thoughts of cognition (p. 4). Rothschild (2000) posited that trauma is an experience that is not integrated into past memories, like most experiences, but stays current, resulting in constant visual, auditory and somatic hyperarousal as though the trauma is continuing to occur. In turn, the hyperarousal affects the survival expression of the limbic brain, resulting in somatic responses of "accelerated heart rate, cold sweats, hypervigilance, startle response ... which alone may trigger PTSD response" (p. 7-8). Rothschild (2000) noted additionally that the traumatic material is integrated into both the brain and the body, and that the emotions experienced – not only fight, flight and freeze but also anger, guilt, shame, pleasure and fear – are a result of the interdependence of the brain and the body and are, in fact, "associated with

survival – both with regard to dealing with hostile environments, and in furthering the species" (p. 59).

Sensorimotor Psychotherapy and Vicarious Trauma

Ogden (2006, see also Levine, 2007) goes a step further by recognizing that the human brain can be broken into three distinct parts (known as the Triune Brain), comprised of the Reptilian brain (arousal, homeostasis, survival instinct), the Paleomammalian brain (emotion, memory, social behavior, learning, affective knowledge, social distress and bonding), and the Neo-Cortex (cognitive process, self-awareness and conscious thought). These three levels function both independently and in concert to process emotions, cognitions and behaviors, suggesting that if trauma interferes in the areas of the brain devoted to cognitive processes, it must also live in the areas of the brain devoted to emotion and social behavior and arousal. Can it not be said, then, that treatment of VT and PTSD can take place in areas of the brain devoted to areas besides cognition as well? If PTSD is a result of emotions stored in both the body and the Triune brain, how is it possible that (1) trauma is transmitted through verbal story telling (Lerias & Byrne, 2003; Sexton, 1999; Pearlman & Saakvitne, 1995), resulting in cognitive schematic changes in the listener, and (2) VT can be treated at only a cognitive level?

Rothschild (2000) answered these questions by suggesting that behavioral socialization and emotional conformity are "survival mechanisms designed to ensure conformity with the norms of the tribe," and that shame and grief are only dissipated in a traumatized individual by sharing the emotion through contact with another non-judgmental human being (p. 62). Beyond simply the socialization of the species, the

development of the human brain may also contribute to the transmission of emotion from one person to another. The transmission of emotion on a neural level has been shown to cause changes to the physiology of the brain resulting in the vicarious traumatization of therapists who work with traumatized individuals. Van der Kolk (2014), Rothschild and Rand (2006), and Levine (1997) have all recognized that stress levels can compromise the function of various parts of the brain known to manage emotional arousal. The amygdala and hippocampus, for instance, may not be able to make rational emotional decisions if impaired by high levels of stress (Rothschild & Rand, 2006), which may result in a therapist being unable to control his or her sympathetic nervous system and becoming overwhelmed by emotional material, resulting in vicarious traumatization.

If VT Can Change our Brains, Can it Change our Emotions as well?

Rothschild and Rand (2006) challenge the VT research that grounds itself solely in the cognitive realm, arguing that "therapist self-care requires the proper functioning of at least three neuropsychological systems...necessary for the therapist to be fully in control of her own well-being even in the most distressing of situations" (p. 3). As the primary resource for VT mitigation techniques (beyond basic self-care strategies and cognitive restructuring strategies), the authors focus on the "brain mechanisms that operate in interpersonal empathy ... balance in the autonomic nervous system (ANS) and arousal regulation and ... clear thinking that relies, in part, on the balanced functioning of all brain structures (p. 3)".

The Emotional Virus

The idea of emotional contagion becomes apparent when Rothschild and Rand (2006) explain the therapist's brain-body connection and how it impacts how the therapist

receives and processes unconscious material from a client. The human body is an ideal "vehicle for emotional contagion" (p. 48). Early studies in neurophysiology have demonstrated that the human brain fires the same neurons when observing another individual feeling an emotion or engaging in an action, just as it fires when the individual him- or herself is feeling the emotion or participating in an action. The concept of "mirror neurons" (Rothschild & Rand, 2006) suggests that the human brain processes emotional and physical information in precisely the same manner regardless of whether it is experiencing the feeling or experience first-hand or vicariously; therefore, it is possible that, when a client is dealing with traumatic material, vicarious traumatization may cause the therapist to experience the traumatic material unconsciously. As described earlier by Feller and Cottone (2003) and Sexton (1999), empathy is central to the working alliance between therapist and client, and is not only necessary for the relationship to be successful, but may also contribute to the psychological and physical toll that can result in the vicarious traumatization of the therapist.

Rothschild and Rand (2006) challenge, however, the notion that empathy leads to the outcomes predicted by Feller & Cottone (2003) and Sexton (1999) (i.e., that the therapist becomes either over-involved with the client, or overwhelmed and needing to engage in emotional avoidance, thus causing cognitive structural changes to the therapist's worldview). Rather, they posit that the therapist's empathy, from both a neurophysiological and psychological perspective, may cause the therapist to feel as though he or she is experiencing the same emotions as the client.

Stepping even further away from the traditional perspective that VT is caused and mitigated only via cognitive structural changes and self-care, Rothschild and Rand (2006)

argue that human beings are constantly affected by daily person-to-person interactions on levels that affect the cognitive, somatic, and neurological. These small interactions of mirroring and emotional contagion may be so subtle as to be unnoticed on a conscious level but affect the autonomic nervous system (ANS) in ways that are only beginning to be understood.

Connecting Mind and Body

ANS arousal can be affected by client sensations, triggered by neurological or physical/somatic mirroring (facially, empathetically, or posturally). This arousal may be an additional factor in the spread of emotional contagion that may lead to VT. Rothschild and Rand (2006) state that "brain to brain and body to body communication happens all the time (p. 71)," and it is therefore important to monitor one's own "therapeutic mirroring…of the client to reduce picking up sensations and thus reducing the potential for developing VT over time" (p. 72). Taking control of one's own level of arousal during or after a session with a traumatized client may be an important factor in mitigating the onset or impact of VT.

This connection between the ANS and physical mirroring was discovered in the late 20th century; early connections demonstrated that positive emotions (happiness) and negative emotions (anger) had a biological basis and could be communicated between human beings non-verbally (Dimberg, 1982). Dimberg's research determined that human beings were "predisposed" to respond to facial stimuli and that the stimuli evoked "emotional and physiological reactions in a receiver" (p. 643). Both electrodermal and cardiac responses (related to Rothschild, Levine & Ogden's ANS responses) were shown

to be evoked in response to facial gaze and were considered, by Dimberg (1982), to be orienting responses that allowed individuals to attune to their communication partner.

Hess and Blairy (2001) suggest that this physical (or facial) mirroring results in unintentional emotional contagion. This contagion, an "affective state that matches the other's emotional display" (p. 130) and is not, as suggested by Dimberg, an automatic reflex. Hess and Blairy (2001) argue that there is a causal relationship; the facial expression in the communicator stimulates empathy in the receiver which causes the emotional contagion (or affective state matching the expression) which in turn results in a similar affective state in the receiver. Whether automatic or not, Hess and Blairy (2001) support Dimberg's (1989) argument that this facial mimicry results in an ANS response that stimulates emotion. In fact, the more intense the stimuli, the more intense the emotional reaction.

Hess and Blairy's (2001) research was unable to pinpoint the purpose of mimicry or the direct causal relationship of the emotional contagion, but the results did suggest that "emotional contagion may be mediated by a social comparison process … by which emotional states of individuals in similar situations may converge" (p. 139). Potentially, this research outcome influences Rothschild's (2000, 2006) and Ogden's (2006, 2015) belief that mimicry and interpersonal emotional and empathetic relationships impact both the communicator and the receiver via the ANS resulting in the transmission of trauma responses from the client to the therapist in a therapeutic relationship.

Levine (2007) suggests that mind-body connection pathways are tracked via neuro-peptide messengers that can spread cognitive traumatic messages into the body or somatic traumatic messages into the brain. According to Levine, "focusing only on the

cognitive impact of trauma is one-sided" (2007, p. 2) and that "body sensation, rather than intense emotion, is the key to healing trauma (p. 11)".

Rothschild and Rand (2006) are the first researchers to directly correlate somatic and neurophysiological awareness and changes as a result of trauma (discussed by van der Kolk and Levine) to the practice of VT mitigation. They report that therapists with a "high level of body awareness have a significantly lower level of VT" (p. 104) and that "VT can be healed and prevented when factors contributing are identified and made conscious" (p. 207).

Summary

In a strong departure from the coping skills designed to address changes to a therapist's worldview and changes to cognitive schemas, Rothschild, Rand, Ogden, Levine, van der Kolk and others suggest that VT is not a permanent impairment that a trauma therapist must accept if he or she is to work with a trauma caseload. In fact, these somatic PTSD researchers quite clearly demonstrate that emotion travels from one nervous system to another via unconscious physiological cues that can be compensated for in physiological ways; even going so far as to say that therapist body awareness is the key to ameliorating the effects of VT in its entirety. Through awareness of mirroring, mimicry and unconscious relating to clients, therapists can proactively prevent the impact that VT can have on cognitive schemas before the damage is done.

Part 4: Recognizing the Impact of VT on the Therapist

Health Canada's *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* Richardson (2001) includes empirical data describing how VT impacts each individual in a manner that is "cumulative, unavoidable and applicable to everyone uniquely" (p. 13). Richardson (2001) identifies some of these unique personal characteristics above those outlined by Bober and Regehr (2006) and Schauben and Frazier (1995) McCann and Pearlman (0000) and Pearlman and Saakvitne (1995) which put individual counsellors at higher risk of developing VT. Therapists with "unrealistically high ideals, or those who excessively fantasize about rescuing their clients or plot revenge, or are overly invested in meeting client needs will likely become more affected by the work" (p. 20) additionally, therapists who are new to the field or who have previously worked in crisis work and transitioned to longer term counselling may be at higher risk of developing VT.

Yassen (1995) identifies six categories which are diminished in a therapist's personal life when VT is active (cognitive, behavioural, social, spiritual, emotional, and interpersonal) as well as four aspects of professional life that suffer (performance of job tasks, morale, interpersonal, and behavioural). Reduction of activity or fatigue or participation in these areas are early indicators that VT might be having an impact on a therapist who works with traumatized clients. The stronger the VT, the more impairment in the six personal aspects and four professional aspects the therapist may experience. Regular self-monitoring and self-assessment will help therapists and (potentially) their supervisors or agencies recognize when VT is becoming a problem and when action must

be taken re re-establish balance and increase coping mechanisms or restore professional competence (Richardson, 2001).

Unfortunately, no assessment materials exist specifically designed and empirically validated to measure VT in therapists (Sabin-Farrell & Turpin, 2003). Many tools exist that measure various aspects or branches of compassion fatigue and professional burnout or the use of effective coping strategies, but none measure the reduction in personal and professional capacity that results from VT impairment. Some recommended self-assessment materials that can be used by therapists (or in supervision or in other aspects of organizations) to track changes to therapists cognitive schemas when working with trauma clients include the Traumatic Stress Institute (TSI) Belief Scale, Revision L (Pearlman & Mac Ian, 1995), the Secondary Traumatic Stress (STS) Scale (Ben-Porat & Itzhaky, 2009) and the Professional Quality of Life Scale (ProQOL) (Stamm, 2010).

The TSI Belief Scale-L is designed to measure beliefs regarding safety, self-esteem and trust, intimacy, and control: the STS assesses traumatic symptoms in the three areas of intrusive thoughts, emotional avoidance and nervous system arousal. The ProQOL is designed to measure both Compassion Satisfaction and Compassion Fatigue and is most commonly used to measure the professional impact of working with trauma clients (van Veen, 2012).

Self-Regulation and Vicarious Trauma Awareness

From the perspective of Rothschild's (2000; 2006) psychophysiology, VT is not measured through cognitive self-reports but instead via messages sent through the body. Rothschild and Rand (2006) teach that learning to manage and recognize the rise and fall

of the automatic and sympathetic nervous systems will allow a therapist to track levels of

vicarious trauma exposure throughout the day and that "simple body awareness alone

could lower the incidence of vicarious traumatization" (p. 106). Ogden's (2015)

sensorimotor psychotherapy interventions for recalibrating the nervous system invite

therapists to become familiar with the peaks and valleys of their arousal sensations and to

learn where the top and bottom of their comfort zone is – a technique known as the

Window of Tolerance (p. 553). By focusing on bodily sensations rather than on the

traumatic feelings, sensations or arousal, therapists can track their baseline arousal and

learn to return to it when trauma sensations get stronger.

VT symptoms may be difficult to observe from an outsider perspective. It is

critical that therapists who work with trauma clients be trained to track their own somatic

and cognitive experiences and recognize when their baseline changes so that

interventions can be made before personal or professional deficits are experienced. In

addition to individual experiences of VT, organizations that an individual therapist works

for may also experience deficits when therapists are affected by working with trauma

clients.

Supervisory Support in VT Mitigation

Neswald-Potter and Trippany Simmons (2016) suggest that therapists who find

themselves struggling with VT work closely with their supervisors to find ways to work

through the schematic changes that may result in isolation, hypervigilance or other means

of emotional self-protection so that post-traumatic growth can be experienced. Processing

client material and "having access to a safe environment where the clinician can make

meaning of the material is vital for assisting counsellors in moving beyond their reactions

to the traumatic material and for facilitating counsellor growth" (Neswald-Potter &

Trippany Simmons, 2016, p. 77). Encouraging personal growth and increasing personal

competency may reduce the damage to the core cognitive schemas that are believed to be

affected by VT and exposure to client's traumatic material.

By modeling appropriate self-disclosure, a supervisor can reduce the power

dynamic between themselves and the therapist, thus making it easier for the therapist to

feel comfortable processing vulnerable material and over time, the therapist may become

able to process the material on a deeper level, allowing for deeper regenerative recovery

from VT symptoms. Neswald-Potter and Trippany Simmons (2016) argue that this deeper

regenerative processing and recovery is key to allowing therapists to fully return to their

trauma work.

From an organizational perspective, managers and supervisors have an important

role in assisting their employees in mitigating potential VT. By being aware of the

impact of cumulative exposure to traumatic situations may affect staff and proactively

intervening and ensuring appropriate coping mechanisms are available, managers will

build the necessary rapport to enable staff to access necessary services (Pearlman &

McKay, 2008). Further, by setting a healthy example (seeking own support, using own

vacation time and being open about engaging with outside activities) managers and

supervisors can demonstrate that a healthy work/life balance takes intentionality and

practice.

In their VT training program for organizations and managers (Headington

Institute, 2008), Pearlman and McKay insist that managers and supervisors be aware of

the increased pressures on counsellors in times of crisis and to look for ways to help staff

keep perspective and remind them of their value to the organization. Focusing on

concern for the wellbeing of staff rather than their quality of work and encouraging them

to take extra time off to re-equilibrate following a difficult phase is important and allows

for regeneration and recovery from trauma-infused events. Pearlman and McKay (2008)

also insist that the most important function of organizational management in regards to

mitigating vicarious trauma in counselling staff is to refrain from stigmatizing those

members of the team who are struggling with reduced function due to VT.

Ethical Considerations

A concern for therapists in their understanding of VT is the ethical ramifications

of potential impairment. Corey, Corey, Corey and Callahan (2014) define impairment as

"the presence of chronic illness or severe psychological depletion that is likely to prevent

a professional from being able to deliver effective services and results in consistently

functioning below acceptable practice standards (p. 70)" and suggest that therapists and

counsellors who are unable to cope with stress do more harm to their clients than good.

VT is a potential cause of impairment, and it is incumbent on the therapist to ensure that

they engage in sufficient self-care in an attempt to prevent VT or to seek support if they

find themselves in a position of being psychologically unsound.

The Canadian Counselling and Psychotherapy Association (CCPA) addresses

impairment in both their Code of Ethics and Standards of Practice. The CCPA *Code of*

Ethics Section A1 states that it is the general responsibility of therapists to ensure they

meet the standards of ethical and professional competence and either practice appropriate

self-care or remove themselves from practice until they are no longer impaired. Further,

practicing while impaired is considered unethical and a burden is also placed on co-

workers or supervisors who become aware of an impaired therapist to intervene informally or, when necessary, formally by reporting the impaired therapist to the CCPA Ethics Committee. The CCPA *Standards of Practice* also address therapist impairment by stating that "counsellors should take steps to appropriately limit their professional responsibilities when their physical, mental or personal circumstances are such that they have diminished capacity to provide competent services to all or to particular clients. Counsellors in such situations may seek consultation and supervision and may need to limit, suspend, or terminate their professional services" (CCPA, 2011, p. 4).

The Canadian Association of Psychologists (CAP) also addresses therapist impairment in their *Code of Ethics* section regarding Responsible Caring. Section II.11 states that therapists are responsible for taking care of themselves if a "psychological condition reduces ability to benefit and not harm" the client (p. 63). In the following section (II.12), the CAP *Code of Ethics* becomes more specific, stating that therapists must "engage in self-care to avoid conditions (burnout, addictions, etc,) that could result in impaired judgement and interfere with ability to benefit and not harm others (p. 63)".

Both the CCPA and CAP echo Corey, et al.'s (2014) edict that therapists are responsible for maintaining their own physical and psychological health via self-care (which may include both personal therapy and supervision) in order to practice in an ethical manner.

Part 5: The Organizational Effects of VT

Health Canada's handbook *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* (Richardson, 2001) addresses the effects of VT on therapeutic organizations. Richardson points out that "vicarious trauma is a clear and present danger … and an occupational hazard of the profession (p. 5)".

No empirical research has been published regarding the effects of VT on the organizations or agencies that employ the therapists who treat traumatized individuals; an awareness needs to develop regarding the importance of the methods in which agencies and organizations address the mental health and PTSD-like VT symptoms that develop in their employees. Action must be taken to ensure that organizations are protecting their employees in any way possible; this may include providing training and awareness, providing live on-site supervision, providing regular mental health assessments of team members, providing follow up care after particularly difficult clients, creating a culture of acceptance around VT as a risk of therapeutic work and normalizing the experience of transferred empathetic trauma.

Vicarious Trauma has an Organizational Cost

Research regarding cost of employee mental health, absenteeism and turnover focuses somewhat on the health industry, but has been built mainly on the hospitality and business industries. This leaves much of the research being based on stress and burnout which is marginally related to VT but also significantly different. The effects of VT on agencies and professional organizations will be an open area for research in the future.

The USA reports over 550 million lost working days annually to absenteeism with 54% of those days being a result of stress-related illness while the UK reports a similar

360 million lost days with 50% of days lost to stress-related illness; additionally, over

$700 million USD is spent annually replacing employees aged 45-65 who leave the

workforce (agencies) early due to stress-related illnesses (Cooper & Cartwright, 1994).

The cost to agencies of having employees who struggle with VT symptoms or exposure

drastically outweighs the costs of addressing or treating VT and other stress-related

illnesses.

Many agencies focus on wellness programs via Employee Assistance Programs

(EAPs) that promote physical and mental health. Often, these programs are designed to

address the interface between the employee and the agency and focus mainly on assisting

the employee in adapting to the agency rather than focusing on the true mental health of

the employee (Cooper & Cartwright, 1994). Designed to assist an employee in managing

stress, improving physical health (quitting smoking or losing weight) or in improving

self-esteem via short-term individual counselling. This counselling and improvement in

physical health rarely addresses the symptoms of VT as addressed earlier in this literature

review and while it may enhance coping skills already in place (relationship with others,

exercise, healthy physical habits) it will not decrease symptoms of VT that will develop

on the job.

As levels of VT increase, individual stresses and personal illness will increase as

well, resulting in increased levels of incapacitation for individuals who may require more

sick time (if they have it due to working with organizations). If the levels of stress due

VT are not addressed within an organization, individuals may leave the organization to

pursue work elsewhere, thus creating a culture of turnover that will create further stresses

for those left behind in the organization. Turnover creates further stresses for

organizations and has been shown to cause increased burnout symptoms in employees

left behind (Kuypers, Guenter, & van Emmerik, 2015) and affects levels of trust between

coworkers and between employees and employers (Richardson, 2001).

Impact of Turnover on a Counselling Team

Kuypers, Guenter and van Emmerik, (2015) argue that while turnover in an

organization is frequently assessed as a financial depletion on the organization, it must

also be assessed as a depletion of team skills that disrupts team coordination, may cause

conflict amongst functioning teams and may cause a perception of reduced service

quality. The redistribution of tasks that result from the departure of employees who

succumb to VT symptoms and become unable to function in their agency roles or who

become unable to treat clients at a competent level may cause further stresses on

remaining employees which may lead to further levels of turnover and higher levels of

stress and burnout within an organization. This turnover may take an organization up to

11 months to recover from, during which time behavioral aspects of employee

performance are negatively impacted and motivation of remaining employees may drop

(Kuypers, Guenter, & van Emmerik, 2015). In an organization that employs therapists

responsible for treating traumatized clients, this increased stress levels may impact the

already lowered abilities to protect against VT and increase the risk of professional

impairment to the therapist.

Hinkin and Tracey (2000) analyzed the factors that influence an employee's

decision to stay with an organization or to move on. Personal development, support from

management and career advancement were listed amongst the most important reasons to

stay while poor working conditions, low pay and poor management were the top listed

reasons to leave. Research previously discussed by Bober and Regehr (2006) and Schauben and Frazier (1995) shows that VT causes PTSD-like symptoms so it is reasonable that supportive management who are able to provide treatment and resources to combat VT would do a better job of retaining healthy and functional employees than those employers who were unable to be supportive or recognize VT as a risk of the job.

Indicators of Healthy Organizations

Hinkin and Tracey (2000) indicate that both job support and job autonomy contribute strongly to developing coping behaviors that contribute to moderation of stress responses in the workplace. The ability to determine how and when and which skills to use when increase the autonomy experienced by an employee when demands are high and allow them to reduce the psychological strain placed on them by the work. From the perspective of the prevention of VT, this autonomy may have an impact in allowing employees who treat traumatized individuals the freedom to protect their own psychological wellbeing by taking action to protect themselves when and how they feel it necessary. It has been shown that increased control and autonomy in the workplace both increases job satisfaction but also reduces absenteeism due to illness and that employees with lower levels of job satisfaction experience poorer levels of mental health (Aldana, Merrill, Price, Hardy, & Hager, 2005; Hinkin & Tracey, 2000).

Organizations who approach employees from the perspective of collaborative communication, decision making and a participatory style will establish a structure that allows employees space to safely communicate their needs to each other and to management; particularly when it comes to burnout and VT symptoms; workplaces that

"operate within a rigid hierarch, with strict rules and routines, do not generally achieve

autonomy, support or trust" (Richarson, 2001, p. 59).

Part 6: Teaching Therapists New Tricks

Regardless of where the research into VT takes the fields of counselling and psychology, preventing the development in counsellors of disabling psychological impairment is crucial, and is likely to involve training them in how to protect themselves from the empathetic, cognitive and neurophysiological changes that can occur when working with traumatized clients. While self-care and the need for clinical supervision and personal psychotherapy can be addressed in the academic setting, the recent research into neurophysiology, neuropsychology, somatic psychology has not yet become part of mainstream training. As Levine (1997) has already argued, approaching VT from a cognitive perspective is incomplete and ineffective.

The applied component of this current project is a psycho-educational group designed to teach counsellors about VT and how to mitigate it. Engaging therapists in a group setting brings challenges requiring specific attention. Beyond the basic ethics of dual relationships, confidentiality, and privacy (Yalom, 1995) beginning therapists require specific dynamics in order to benefit from group learning.

How Therapists Learn in Groups

Group learning for therapists has been an identified area of research interest since the late 1980s, but has also been recognized as an area in which in-depth research is lacking. Through the 1990s and early 2000s, researchers (Borders, 1991; Enyedy, Arcinue, Puri, Carter, Goodyear & Getzelman, 2003; Prieto, 1996) continued to highlight the lack of attention to the needs of therapists in group settings (from both supervisory and therapeutic perspectives).

The extant literature regarding working with trained therapists in group settings offers several important considerations. Prieto (1996) argued that the type of learning occurring in a group setting is fundamentally different from the type of learning that takes place in individual settings. Groups tend towards a more "didactic vein of … micro skills training" (p. 296) as well as stronger structure which may "increase … skills gains of beginning level" (p. 304) counsellors. Prieto also suggested that group learning also encourages a higher level of "interpersonal process tasks" that increases "self-awareness or emotional growth" (p. 296). Borders (1991) notes that keeping counsellor group participants near the same skill level is beneficial as "novices speak the same language and model achievable skill levels, increasing self-efficacy and motivation to learn" (p. 248). Furthermore, there appears to be a higher emphasis placed on theory-based approaches in group training for counsellors – a notable difference from individual training or supervision. An added benefit to group training for new counsellors is that the "group format can also serve to normalize trainee anxiety surrounding clinical work, expose trainees to different treatment perspectives and provide them with peer support during their training process" (Prieto, p. 305).

Counselman and Grumpert (1993) have advised that learning groups and therapy groups need to be distinct. When a learning group crosses the threshold into a therapy group, the learning will be lost. Learning groups and therapy groups may have many similarities (Enyedy & Arcinue, et. al, 2003), and a learning group may be thrown off track by unnecessary self-disclosure, parallel processes, member interpersonal issues, or unnecessary therapeutic interpretations by a group leader. Borders (1991) suggested that the key to maintaining a counsellor's group for non-therapeutic purposes is to maintain a

learning environment, maintain a timeline and structure, ensure that supportive and critical feedback is shared by all participants, and that the group does not devolve into a one-to-one session between participants and the group leader.

Conclusion of Literature

The published literature on VT is inconclusive, with the research producing conflicting results. Three clear limitations emerged from the literature review: (1) the lack of empirically supported VT prevention strategies; (2) the inadequacy of sole reliance on self-care and cognitive restructuring to mitigate VT; and (3) the absence of a multi-dynamic approach to VT mitigation that integrates cutting edge somatic and neuroscientific research. Unfortunately, there exists a dearth of published research on any approaches to the mitigation, prevention or development of VT beyond the cognitive realm. Research into trauma responses and PTSD is moving quickly away from cognition alone and into neuropsychology, neurophysiology, somatic psychology and other versions of the mind-body connection where valuable learning on VT mitigation learning might be discovered and applied.

The literature indicates that VT can result in cognitive changes in the empathetic therapist, which can affects the therapist's understanding of personal safety in the world or of the qualities of good in the world. It suggests that VT (in some cases) causes PTSD symptoms in therapists, which can then interfere with work at different levels of severity. Self-care, training, and adequate supervision can mitigate the symptoms once they appear. Furthermore, once VT symptoms are present, the ability of the individual to engage in symptom reduction techniques is reduced. However, there lack definitive answers for how to effectively prevent VT from occurring or how to track its emergence

in non-cognitive realms. Is it that the physiological changes in the brain and the body prevent the necessary self-care from taking place? Is it that, regardless of how much self-care a therapist engages in, the mirror neurons in the brain and the polyvagal nervous system will still pick up cues from the body and face of the client, resulting in the silent transmission of traumatic sensation to the therapist? These are the areas in which research into VT is lagging behind trauma research and practice. In addition, VT should be addressed in education and training as a very real and important aspect of professional therapeutic practice. Moving forward, collaboration between organizations and agencies that employ therapists will be a key area for research as these agencies can play a key role in enhancing the mental health and psychological well-being of their employees by assisting in providing VT education and training that will allow for the development of a culture of acceptance and recognition that can lead to earlier intervention and potentially reduce the level of both personal and professional impairment that therapists who work with traumatized individuals may experience.

Until VT is recognized as a meaningful concept that affects therapists who work with traumatized clients, recognizing the impact of mitigating effects will go unnoticed. Peer-reviewed qualitative and quantitative research in the fields of neuropsychology, psychophysiology, and somatic psychology will help to demonstrate (1) the transmission of traumatic effect from one individual to another via action, movement and language, and (2) the impact of this transmission on the cognitive, physical and psychological wellbeing on the receiver. Until then, it will be important to develop methods to heighten awareness of the research currently available, and to demonstrate the various methods that therapists may find

useful in to protecting, preparing, healing, and caring for themselves when working with traumatized individuals.

Chapter 4: Fighting Back Against Vicarious Trauma Manual & Eight-Week

Psychoeducational and Experiential Group

The body of literature on VT is heavily saturated, resulting in a smaller field of research to review. Accessing the developing trauma fields of sensorimotor psychotherapy, psychophysiology, and somatic psychotherapy will help to augment the understanding of the impact of traumatic experience on the human brain and body, as well as of how the experience of trauma is passed from one human being to another, thus expanding our definitions of the development of VT in therapists and other trauma workers. While VT research has yet to delve into these new neuropsychological realms, the links are clearly developing and work is progressing in that direction.

The literature review and research shown to be best practice was used to design the *Fighting Back against Vicarious Trauma* workshop and manual to teach therapists how to recognize, experience, manage and mitigate the effects of VT. The group includes Cognitive Behavioural Therapy approaches as well as neuropsychological approaches that have a strong impact on the development of trauma therapy protocols.

This research, and the *Fighting Back against Vicarious Trauma* program impacts a number of stakeholders: Therapists who work with traumatized clients on a regular basis will benefit directly from this work – both from the collection of research as well as from participating in the group. Their clients will benefit from having therapists who are emotionally and physically healthy and who are prepared to work with them without contracting and suffering from portions of clients' own traumas. Agencies and group practices can benefit from the group as well as this research, as it will assist them in developing healthy working environments for their employees. Healthy and un-

traumatized employees (or at least, employees who are better able to understand and process their experience of their clients' trauma) may cost facilities and agencies less in sick time, leave time, training time, and employee retention.

Fighting Back against Vicarious Trauma **Program Design**

The group, *Fighting Back against Vicarious Trauma,* is designed to run over 8 sequential weeks as a closed group with all participants pre-screened and expected to attend all group sessions. As the group is psycho-educational in nature and not psychotherapeutic, it will not be a replacement for individual therapy, supervision or group therapy. Individuals who have untreated traumatic experiences will be screened out either before group begins or throughout the eight weeks and referred to additional therapy (if it is not already in place). Periodically, group topics may include homework assignments, journaling assignments or personal experiments to try before or after sessions with clients. At the beginning of each group session, group participants will have the opportunity to check in regarding their experience of the previous week's group material and their experience of the impact of their learning over the week.

At the end of each session, participants will have the opportunity to check out in order to recount aspects of group material that they considered impactful, helpful or which they feel that they can apply to their personal practice. At the end of the 8th group, participants will have developed a clearer understanding of cognitive, psychophysiological and psychosomatic symptoms and impacts of VT, mitigating effects, potential repair and prevention strategies as well as additional coping techniques to strengthen defenses against potential transmission of trauma symptoms as a result of the empathetic connection between a traumatized client and therapist.

The Fighting Back against Vicarious Trauma program will be available to potential participants via private practice group offerings and will be advertised on my personal website. Additionally, the group manual will be available for download via e-book (initially at no cost and eventually at low cost) until it is accepted for mainstream publication as a therapist resource. As an e-book or mainstream publication, *Fighting Back against Vicarious Trauma* will be widely available to be used by teachers, supervisors and agencies interested in educating their interns, supervisees or staff. Ideally, the *Fighting Back against Vicarious Trauma* group manual will eventually be adapted into a workbook appropriate for individual study available to those therapists who are unable to access the group through a local provider or through their agency. Further, the research contained in the literature review in this final project will be prepared for publication in scholastic journals in order to facilitate the synthesis of the psychophysiological approaches favoured by the PTSD researchers and the cognitive therapy approaches favoured by the VT researchers in an attempt to draw the two camps together to further the research field for the protection and healing of the mental health of therapists.

Fighting Back against Vicarious Trauma Manual

"I'm right there in the room, and no
one even acknowledges me."

Introduction*: Fighting Back against Vicarious Trauma* **Group Manual**

Vicarious trauma (VT) is a growing impairment amongst mental health practitioners. Believed to be related to a combination of factors, VT is easily mitigated or reduced by a system of supervision, education and the use of healthy coping techniques and somatic awareness. To reduce the potential of developing VT, it is suggested that therapists educate themselves on these mitigation techniques (Sabin-Farrell & Turpin, 2003) which include a strong understanding of how the impact of changes to self-identity, worldview, spirituality and sense of personal safety impact psychological health (Lerias & Byrne, 2003; Sexton, 1999) and body awareness (Rothschild, 2006). This group offers the tools to understand the processes that lead to impairment, and enables therapists to develop mitigation and self-protections skills to protect themselves and know when and how to seek help if necessary.

Background

VT is similar to Post Traumatic Stress Disorder (PTSD) and affects mental health professionals who work with individuals who have experienced horrific traumas (specifically physical or sexual in nature). North American professionals who work with sexually traumatized children have a vicarious trauma rate of 46%, compared to 7% of mental health workers in Kosovo who fight for human rights and 10% of therapists in South Africa who work with victims of bank robberies (Bober & Regehr, 1995).

VT presents itself in specific professions and with symptomatology that separates it from other emotionally draining physical and psychological conditions (such as burnout, compassion fatigue, or occupational stress) and affects those who deal with others in a professional capacity focussing on emotions (e.g. therapists working with sexual assault or domestic violence clients, police officers and paramedics who have

ongoing exposure to the death, dying and abuse of others). While VT has been described comprehensively in the literature, practical applications and methods to reduce its effects, as well as the impact of working with trauma on front-line mental health workers, have only been explored in small amounts.

Rationale for Group

Three aspects of VT that remain static throughout the literature are (1) its definition, (2) its relationship to PTSD, and (3) that the statistics on its rates and causes are conflicting. The definition of VT came about in 1990 (McCann & Pearlman, 1990) shortly before PTSD was amended in the fourth version of the American Psychological Association's Diagnostic and Statistical Manual (DSM-IV-TR) in 1994. McCann and Pearlman (1990) stated that VT is a unique feature of work with traumatized clients due to the clinician's experience of being exposed to the continuous and graphic descriptions of clients' trauma. This exposure causes indirect distress and trauma to the therapist. The DSM-IV-TR noted that PTSD could be triggered by "learning about trauma experienced by a family member or close friend" (Sabin-Farrell & Turpin, 2003, p. 451). While this does not directly identify work related traumas, such as those experienced by mental health clinicians, it does suggest that trauma reactions can be triggered in individuals who do not experience the trauma first hand.

Where PTSD and VT intersect is in the inner experience of the individual who experiences either process. Sabin-Farrell and Turpin (2003) stated that exposure to trauma material in mental health clinicians causes a cumulative effect on inner experience, resulting in a negative transformation due to "empathetic engagement with client's trauma material" (p. 452). The negative transformation can include changes in

personal and professional identity, worldview, spirituality, self-capacity and belief in

professional identity and psychological needs and beliefs as they relate to personal safety,

trust, esteem, intimacy and control (Lerias & Byrne, 2003; Sabin-Farrell & Turpin, 2003;

Sexton, 1999).

In recent Post Traumatic Stress Disorder (PTSD) publications, an emphasis on the

autonomic nervous system (ANS), regulation of the nervous system and close attention to

the fluctuation of the somatic system have shown that trauma responses can be lessened

through moderating nervous system responses (Levine, 1997; Ogden, 2015; Rothschild,

2006). This manual and the research behind it braids the VT and PTSD research in an

effort to find new ways to protect therapists from debilitating VT effects and to teach

them to effectively use active techniques to manage their personal arousal in the moment

to prevent VT before it takes hold.

Through a psychoeducational group, new therapists will be assisted in

understanding the risks associated with treating clients with traumatic histories and

develop awareness of their changing reactions and world views due to VT. This will help

ensure that new therapists are not vicariously traumatized in their practices.

Group Program

Overview

Fighting Back against Vicarious Trauma will use both psychoeducational,

cognitive behavioral therapy-based (CBT), somatic based and neuropsychology-based

techniques to allow therapists to explore a variety of ways they could prevent or mitigate

the risk of vicarious trauma (VT) when working with traumatized clients. Learning how

VT affects a counsellor and the coping skills available to self-treat VT will enable group

participants to feel secure in their roles, may extend the length of their careers by avoiding burnout or other impairments, and will provide skills to ensure that they keep their workplaces safe and healthy. Further, participants in this group will be provided with career-based resources for supervision, peer support, and referrals for further individual or group therapy as needed.

Specific Group Goals

Goals of *Fighting Back against Vicarious Trauma* include helping participants to:

- Understand the differences between compassion fatigue, burnout, occupational stress and vicarious trauma;

- Understand how the therapeutic alliance and empathetic relationship with a client can result in the transfer of symptoms and the development of VT;

- Learn to self-monitor emotions and cognitive structures associated with changes resulting from VT;

- Learn to monitor and self-regulate personal nervous system responses in the face of trauma experiences and track changes resulting from VT;

- Acquire effective coping skills for the mitigation of VT;

- Understand the professional ethical implications for therapists who may be experiencing VT;

- Understand of mitigating, ameliorating, and predictive criteria for VT;

- Learn to manage VT while reducing its effects;

- Understand when and where to seek additional support.

Group Details

Group description

Fighting Back against Vicarious Trauma will be described to participants as an 8-week psychoeducational group with both CBT, somatic, neuropsychological, experiential and didactic components. Individuals will be made aware of the subject matter of the

group and that they will be taught how to identify VT in themselves and how to take action to mitigate or prevent it.

Group Format

The group will meet weekly for 8 weeks for 2 hours per meeting. The first 30 minutes of the group will be used for check in purposes and to allow participants to settle into the group space. The following 45 minutes will be spent engaging in an interactive, didactic exercise designed to teach a new skill or piece of information related to the topics of PTSD, VT, individual coping skills, or self-awareness. A 15 minute break will follow is recommended to allow participants to socialize, move and to attend to personal needs. The final 60 minutes of group will be used to practice new skills or to engage in further skill-based activities designed to allow participants to explore their individual and personal vulnerabilities regarding the development of VT in their professional practice.

The group is to be led by 2 facilitators who are strongly educated in VT and its mitigating and ameliorating techniques. It is important to note that Fighting Back against Vicarious Trauma is a psychoeducational group and is not designed to be a replacement for psychotherapy groups, individual therapy or professional supervision.

Weekly Topics

Each week will build progressively on the next:

Week 1: Orientation, ground rules, participants getting to know each other in the first part. In the second part of the group, participants will be introduced to the terminology and epidemiology of PTSD, VT, and the importance of being aware of the symptoms and the predictive factors.

Week 2: In the first part of the group, participants will be introduced to VT psychometrics. Three self-assessments are provided to allow participants to develop and understand their baseline function of quality of life, self-care skills and current level of vicarious trauma in order to allow them to track changes over time. Psychometrics should be completed at least partially in group as part of a small group activity in order to assess participants for safety and for untreated levels of trauma that may require referrals to therapists, psychiatrists or other clinical interventionists.

Week 3: Part one of the group will focus on reviewing the two previous weeks' group material and checking in with participants regarding whether the group is currently meeting their needs and expectations. Time will be spent clarifying topics already addressed and preparing participants for upcoming topics and subjects. During this time, participants will be more thoroughly evaluated for current distress from untreated trauma or VT and referrals will be made as necessary. The psychoeducational part of Week 3 will involve a basis in CBT as it relates to VT through didactic interventions followed by group activities that invite participants to create projects that (1) remind them of the CBT-based coping skills that have been empirically proven effective to mitigate the effects of VT and (2) focus on addressing the particular core beliefs that are often changed by VT: personal or professional identity, worldview, spirituality, self-capacity, belief in professional identity, psychological needs and beliefs as they relate to personal safety, trust, esteem, intimacy, and sense of control.

Week 4: Psychophysiology and its impact on VT from the perspective of Babette Rothschild and colleagues will be introduced. A main focus of Week 4 group includes developing an increased awareness of body sensations and autonomic nervous system responses to trauma and to become aware of the impact of "client emotional mirroring" and how emotions can be transmitted and understood between individuals without words. This group is based on the Rothchild's 2006 book *Help for the helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma.*

Week 5: This group begins with a brief introduction to sensorimotor psychotherapy (as developed by Pat Ogden) and an understanding of the Window of Tolerance. Balanced with Peter Levine's Somatic Experiencing work, this group will teach participants to moderate their somatic arousal levels and control increases or decreases in arousal as necessary. Participants will learn to recognize their personal indicators of the flight, fight or freeze responses and to mitigate these reaction when necessary. This group is based on the books *Sensorimotor psychotherapy: Interventions for trauma and attachment*. (Pat Ogden, 2015) and *Waking the tiger: Healing trauma – the innate capacity to transform overwhelming experience*. (Peter Levine, 1997).

Week 6: Week 6 will offer a review of previous groups followed by an experiential activity designed to allow group participants to test their ability to moderate their ANS, regulate their somatic systems and to identify their immediate thoughts and worldview approaches to a traumatic situation. Using a contrived case study with low traumatic value, clients will take part in an activity

that allows them to rate increases or decreases in their VT-related reactions and to debrief their feelings in the moment in order to identify the impact and response of potential VT-related material. Some groups may benefit from a guest speaker who has experienced and recovered from VT: this is up to facilitator's perspective.

Week 7: This group will focus on developing an understanding of (1) the characteristics of a healthy workplace and (2) staying healthy within the workplace. Participants will develop the skills to understand how to moderate their VT responses within agency or facility work as well as to assist their peers in developing a worksite that allows for an understanding of VT as a common workplace hazard and accommodates the potential development of VT in staff and takes proactive steps to mitigate its effects. Week 7 group also begins the process of termination which concludes in the following week's group session.

Week 8: The first half of the group will consist of a review of sensorimotor psychotherapy, psychophysiological and CBT techniques to recognize and reduce VT. Participants will have the opportunity to share the most impactful part of their learning as well as anything that has stood out as especially helpful in their learning or practice. Reminders regarding referrals to additional practitioners, supervisors, or therapy groups should also continue to be available. The second half of the group will involve engaging in closing activities.

Evaluation and Feedback

A weekly feedback form has been provided as part of this manual to facilitate participant – facilitator communication.

Risks of Participation

An important part of the informed consent process is ensuring that participants are aware of the risks of engaging in group therapy. The Companion Manual to the Canadian Code of Ethics for Psychologists (2001) states that "responsible caring leads psychologists to take care to discern the potential harm and benefits involved, to predict the likelihood of their occurrence, to proceed only if the potential benefits outweigh the potential harms (p. 57). The Canadian Counselling and Psychotherapy Association echoes this in their own Code of Ethics and Standards of Practice indicating that while counsellors are responsible for maintaining their own physical and psychological wellness or for getting help if they are impaired.

Throughout Fighting Back against Vicarious Trauma, participants risk being exposed to the traumatic experiences of others and their own. Participants will be monitored on an ongoing basis for deteriorating psychological states that may require intervention or indicate that they should not continue in the group. Those participants in the *Fighting Back against Vicarious Trauma* group who are determined to be impaired will be offered assistance through referrals to personal therapy or supervision. It is the ethical responsibility of group facilitators to ensure that participants are aware of the ethical requirements of the CCPA, CAP or their individual licensing body and that those participants who are unable to attend to their impairment may be reported to the Ethics Committees of their regulatory body.

Facilitators are encouraged to determine levels of participant impairment via individual conversation regarding in-group responses, via weekly feedback sheets and via encouraging participants to self-report levels of VT that may require intervention.

Further, all participants are encouraged to participate in professional supervision in order to be further assessed for suitability to practice.

Resources

The VT-based didactic and experiential aspects of the group *Fighting Back against Vicarious Trauma* will be drawn primarily from the research of Laurie-Anne Pearlman, Lisa McCann & Karen Saakvitne (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990) who, together and independently, are the leading researchers in treating therapists with VT. These three researchers represent the first-wave in understanding the importance of the empathetic relationship between the therapist and client and how it may produce a PTSD-contagion effect. Their research, both qualitatively and quantitatively, has explored many different aspects of mitigating, ameliorating, and preventing vicarious trauma in the counselling profession.

Babette Rothschild, Pat Ogden and Peter Levine are ground breaking researchers in somatic approaches to Post-Traumatic Stress Disorder (PTSD) and VT. Their works in Psychophysiology and Sensorimotor Psychotherapy are beginning to lend new insights into the development and mitigation of VT and are included in this manual as a blend of techniques between the empirically validated CBT approaches and the new wave of neuropsychology that promises to increase the depth and breadth of the VT mitigation field of research.

Experiential activities are adapted from the authors listed above. All aspects of this book will be used within copy write guidelines and with permission of the authors as necessary.

Chapter 5: Strengths, Weaknesses, Cultural Considerations & Recommendations

for Future Research

Strengths of *Fighting Back against Vicarious Trauma*

The Fighting Back against Vicarious Trauma group series was designed to combine both the cognitive and somatic aspects of trauma research in personal and embodied ways. Beginning with basic introductions to traditional definitions of trauma and trauma treatment terms, the early group sessions utilize Cognitive Behavioral Therapy techniques that allow participants to identify their on cognitive schemas, coping skills in the face of challenges, self-soothing techniques and areas for personal further development in order to prevent self-care deficits in times of higher levels of stress.

In later groups, participants are introduced to the methodologies of specific trauma specialists including Peter Levine, Pat Ogden and Babette Rothschild, all of whom has specifically targeted autonomic nervous system arousal and moderation as part of their therapies. Using exercises and theories to introduce participants to different methods of modulating their arousal levels and learning to maintain homeostasis or recognize changes in their personal baseline levels of arousal will allow participants to be aware of changes in themselves over time as they work with trauma clients in their practices or organizations.

Finally, the final groups allow participants to use these skills to test themselves in a safe environment to practice raising and lowering their arousal levels while also moderating their personal levels of self-care and cognitive schematic awareness. Grounded in both Vicarious Trauma and PTSD theory, this group will ideally allow participants to create safe and informed careers for themselves and to increase their

abilities to mitigate or ameliorate Vicarious Trauma. I also aim to bring awareness of VT

to the forefront of the minds of managers, supervisors and employers who may not

realize the extent of the additional training and support that these employees require.

This research creates a group program manual that will be accessible to both

individuals and organizations in order to provide awareness, self-protection and self-care

training and to provide a step-by-step process for employers to create a safe and secure

work environment for all employees, including training seminars and workshops that may

assist the employer in sharing the information.

To date, research on VT from as far back as the early 1980s and as recently as

March 2016 has focused on the cognitive schematic changes that trauma work causes in

the minds and experiences of trauma therapists; it focuses on the changes to the methods

in which trauma therapists relate with the world, their feelings and beliefs around

personal safety, the safety of others, spiritual and secular justice as well as beliefs and

fears around self-care. To date, the only interventions considered 'effective' in

mitigating and preventing VT in trauma therapists is strict adherence to a self-care

regimen that is designed to separate trauma images from self and keep the therapist

grounded in the world and engaged with loved ones and interests outside of the

professional; ideally to mitigate the cognitive effects of the what is seen and heard in the

therapy room each day.

While safe employment environments, healthy work sites and effective

supervision are also considered effective mitigation and amelioration factors, they are

also designed to treat and reverse the schematic changes that happen as a result of what

the literature refers to as the cognitive impact of VT and the work hazard of trauma treatment. Cognitive interventions alone, however are not enough.

Weaknesses of *Fighting Back against Vicarious Trauma*

The project guidelines of the University of Lethbridge preclude primary research, which results in the Fighting Back against Vicarious Trauma group and its accompanying facilitation manual being untested at this time. Without focus group and group trial information, the value and validity of the groups and the usefulness of the information contained within them is unknown. At this time, the groups have not been tested or efficacy or efficiency and their value to therapists and participants remains unknown.

Further, as previously noted, very little quantitative research is found in vicarious trauma literature; much of the peer-reviewed work in VT is based on anecdotal evidence. Additionally, the somatic approaches gaining ground in PTSD research have not yet achieved evidence-based status in the literature for either PTSD or VT. At this time, VT literature does not address somatic or ANS arousal directly as a means of mitigating or ameliorating VT outside of books written by trauma therapist. Very little evidence is available to weave cognitive and somatic approaches together in the treatment of therapists suffering from Vicarious Trauma.

Adaptations & Cultural Considerations

The *Fighting Back against Vicarious Trauma* group manual and facilitators guide can be adapted to meet the need of counselling agencies and organizations who work with trauma clients or who have staff with heavy trauma caseloads.   It can also be adapted for counselling or therapist students at the graduate level preparing for fieldwork. The material was developed using materials and measures for primarily English-speaking

Western adults; any other populations should have specific cultural specifics taken into

consideration. Any groups of trauma therapist preparing for specific work (natural

disasters, hostage situations, mass accidents, etc.) should adapt the material to meet their

specific needs.

Recommendations for Future Research

As research in VT moves forward, it is my hope that the interweaving of the

somatic approaches of Post-Traumatic Stress Disorder treatment and research continue to

cross paths with VT and that new approaches to somatic awareness and self-regulation

continue to be demonstrated to be effective in treating the trauma. As the PTSD research

shows, somatic awareness, psychophysiology and somatic psychology allow individuals

to identify and track their own autonomic arousal levels which is helpful in noticing

arousal when it occurs and in allowing an individual to take action to reduce it before it

impacts the nervous system in a way that causes lingering distress. Currently, very few

peer reviewed journal articles and very few research-based journal articles have been

published using the somatic approaches to treating trauma and their long-term

effectiveness on VT is unknown; leading therapists in the trauma field are having success

in practice and with books on the subject, and the material can be transferred from PTSD

practice to VT but it will be necessary to research the direct impact of these approaches

more thoroughly before drawing specific conclusions.

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Appendix A:

8 Week Group Session Guide to *Fighting Back Against Vicarious Trauma*

"*I'm right there in the room, and no one even acknowledges me.*"

Lauren Howard, MA

Table of Contents

Purpose

The *Fighting Back against Vicarious Trauma* group is designed to help participants to:

- Understand the differences between compassion fatigue, burnout, occupational stress and vicarious trauma;

- Understand how the therapeutic alliance and empathetic relationship with a client can result in the transfer of symptoms and the development of VT;

- Learn to self-monitor emotions and cognitive structures associated with changes resulting from VT;

- Learn to monitor and self-regulate personal nervous system responses in the face of trauma experiences and track changes resulting from VT;

- Acquire effective coping skills for the mitigation of VT;

- Understand the professional ethical implications for therapists who may be experiencing VT;

- Understand of mitigating, ameliorating, and predictive criteria for VT;

- Learn to manage VT while reducing its effects;

- Understand when and where to seek additional support.

Fighting Back against Vicarious Trauma will use both psychoeducational, cognitive behavioral therapy-based (CBT), somatic based and neuropsychology-based techniques to allow therapists to explore a variety of ways they could prevent or mitigate the risk of vicarious trauma (VT) when working with traumatized clients.

Facilitator Qualifications

Facilitators of *Fighting Back against Vicarious Trauma* should be qualified therapists registered with the licensing body in their area. Additional experience with trauma treatment from the perspectives of both Cognitive Behavioural Therapy and various Somatic therapies (Sensorimotor Psychotherapy, Somatic Experiencing, Psychophysiology, etc.) is suggested. It is imperative that facilitators ensure that

Fighting Back against Vicarious Trauma is a psychoeducational group only and that participants are clearly aware that it is not a substitute for psychotherapeutic groups, individual psychotherapy or professional supervision.

Target Population

  Fighting Back against Vicarious Trauma is designed to teach counsellors and therapists who work with traumatized individuals in their practices to learn the skills necessary to prolong their therapeutic careers. Learning how VT affects a counsellor and the coping skills available to self-treat VT will enable group participants to feel secure in their roles, may extend the length of their careers by avoiding burnout or other impairments, and will provide skills to ensure that they keep their workplaces safe and healthy. Further, participants in this group will be provided with career-based resources for supervision, peer support, and referrals for further individual or group therapy as needed. A weekly feedback form is included in the facilitator's guide to allow participant feedback regarding group and to allow participants to communicate with facilitators regarding requests for referrals or other concerns arising from participation in group.

Ethical Considerations

  During the course of *Fighting Back against Vicarious Trauma* it is imperative that individuals are monitored for impairment. According to CCPA and CAP Codes of Ethics it is incumbent on therapists to ensure that they are not working under the weight of psychological depletion and incumbent on the therapist community as a whole to ensure that colleagues and coworkers who may be impaired are offered support. Participants in *Fighting Back against Vicarious Trauma* may display traits of therapeutic impairment that must be addressed via informal means or via reports to the Ethics Committee of the

licensing body. Participants must be made aware in advance that these ethical

requirements exist and will be adhered to.

I. Session 1: Introduction to *Fighting Back Against Vicarious Trauma*

Materials and supplies required for session:

- Nametags
- Markers (various colours)
- Snacks, beverages
- Flipchart
- Handout 1A

Session Outline:

- Welcome to group; check-in & introductions
- Guidelines and boundary setting
- Self-awareness of personal trauma
- Definitions of VT & PTSD
- Check out

Learning Objectives:

- Participants will develop an understanding of the similarities and differences between Vicarious Trauma, Post-Traumatic Stress Disorder, Compassion Fatigue and Burnout based on common definitions provided in Handout 1A.
- Through group work, participants will identify basic skills in pro-actively recognizing the impact of VT symptoms on both themselves and their practice.

In the Beginning ….

- Co-facilitators introduce selves and meet group participants upon arrival to group space; welcome participants and encourage use of nametags and mingling with other participants. Beverages and snacks may be available.
- Work with participants to set group ground rules and guidelines regarding attendance, timeliness, confidentiality, interpersonal boundaries, etc.
- Co-facilitators to remind group participants that referrals to individual therapists, psychiatrists and group therapy are available as *Fighting Back against Vicarious Trauma* is not a replacement for personal therapy and is not intended as replacement for direct or group supervision. Each participant should maintain their own mental health and practice support in addition to the psychoeducation that the *Fighting Back against Vicarious Trauma* group offers.

Psychoeducational & Activity Segment

Part 1: Definitions of Vicarious Trauma, Compassion Fatigue and Burnout including differences and similarities (See Handout 1A for definitions).

Part 2: Facilitator #1 to lead discussion regarding participant understandings of vicarious trauma in regards to their work with clients. Did they experience VT? Did a colleague? How do they think that VT could be better managed? Where do they think their own weak spots lie? Facilitator #2 to record common themes from the discussion – including fears, concerns, successes and ideas – on flip chart

Closing Review

- Check out review of new material

Handout 1A – Definitions of Vicarious Trauma, Compassion Fatigue & Burnout

Vicarious Trauma:

The experience of bearing witness to the atrocities committed against another. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by victims searching for a way to release their own pain. It is the instant physical reaction that occurs when a particularly horrific story is told or an event is uncovered. It is the insidious way that the experiences slip under the door, finding ways to permeate the counsellor's life, accumulating in different ways, creating changes that are both subtle and pronounced. Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyche react to the profound despair, rage and pain (Richardson, 2001, *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* Richardson, p. 7).

Compassion Fatigue:

A type of secondary traumatic stress which is the natural consequence of behaviors and emotions which result from knowing about trauma experienced by a significant other. The stress comes specifically from wanting to help this suffering or traumatized person; this is very similar to PTSD except that the exposure is to the knowledge of the traumatizing event and the staste of tension and preoccupation with the traumatized person's experience and as a function of bearing witness to the suffering of others (Figley, 2002).

Burnout:

A response to chronic emotional stress comprised of emotional and/or physical exhaustion, lowered job productivity and over-depersonalization. While not proved by research, there is some evidence that burnout is correlated by low morale, negative self -concept, anger, cynicism, negative attitudes toward clientele, increased emotionality, suspiciousness, overconfidence, depression, rigidity, absenteeism, more time spent on the job, leaving the job and/or drug use (Perlman & Hartman, 1982).

II. Session 2: Vicarious Trauma Psychometrics

Materials and supplies required for session:

- Flipchart and coloured markers
- Professional Quality of Life Scale (PROQOL) (Handout 2A for use as handout)
- Self-Care Assessment Worksheet (Handout 2B for use as handout)
- Vicarious Trauma Self-Assessment (Handout 2C for use as homework or group work)

*consider copying appendices on separately coloured paper to distinguish them from each other

Session Outline:

- Introduction of tracking baseline functioning in self
- Introduction of psychometrics related to VT, compassion fatigue and traumatic stress
- Note that this is the first group that contains homework!

Learning Objectives:

- Using psychometric tools (Handouts 2A – 2C), participants will investigate their personal experiences and develop their awareness of their current levels of VT to evaluate individual baseline levels of functioning.
- Via didactic lesson and Participants will gain understanding of the risks and benefits of using psychometric analysis on themselves and to determine when and how additional support is needed.

In the Beginning ….

- Check in
- Review definitions of VT, CF & Burnout
- Have these things become noticeable over the last week?

Psychoeducational & Activity Segment

- Introduce psychometrics, discuss risks and benefits, limitations and purpose of use.
- handout Handout 2A & 2B

Co-facilitators encourage participants to fill out both self-reports to create a current baseline of functioning. *Note that the scales are available online and can be completed whenever a participant feels necessary to track potential changes to responses and changes to vicarious trauma reactions, compassion fatigue or burnout responses. A baseline score will help to track increases or deficits in functioning over time that a participant may or may not independently recognize. Allow approximately 30 minutes for this exercise + 30 minutes to discuss.

- Break participants into two smaller groups, each attended by one facilitator and provide each participant with a copy of the Meichenbaum Vicarious Trauma Self-Assessment (Handout 2C). Each group will need a flip chart and markers

Allow small groups to review the Self-Assessment questions and discuss as a group the responses in a facilitated way. Note themes and discussion topics on flipchart. Remind group participants that the purpose of the discussion is learning – not therapy. Remind participants that any disturbing insights or material should be discussed with their individual supervisors or therapists and that referrals are available upon request from the facilitators.

Note: remind participants that self-assessment psychometric tools are not a replacement for individual therapy and that referrals to professionals are available if participants are concerned about the outcome of their psychometric assessments or if their self-assessment indicated the possibility of professional impairment.

Homework

Note that next week's session will focus on self-care and ask participants to bring a small item that symbolizes a method in which they take care of themselves that they would be able to discuss with the group. This item should be inanimate and ideally unscented due to potential allergies within the group.

Closing Review

Return to large group to discuss the use, risks, benefits and purposes of psychometrics. Discuss learning obtained from reviewing Meichenbaum's Vicarious Trauma Self-Assessment (Handout 2C). Review use of baseline scores from Appendices A&B as well as information learned from group discussion of Handout C.

*Reminder to facilitators to continue to screen participants on an ongoing basis for emerging trauma responses to material/caseload or for unresolved trauma that requires clinical treatment.

Handout 2A

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL) COMPASSION SATISFACTION AND COMPASSION FATIGUE   (PROQOL) VERSION 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper].

Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

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

1. I am happy.

2. I am preoccupied with more than one person I [help].

3. I get satisfaction from being able to [help] people.

4. I feel connected to others.

5. I jump or am startled by unexpected sounds.

6. I feel invigorated after working with those I [help].

7. I find it difficult to separate my personal life from my life as a [helper].

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].

9. I think that I might have been affected by the traumatic stress of those I [help].

10. I feel trapped by my job as a [helper].

11.   Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a [helper].

13. I feel depressed because of the traumatic experiences of the people I [help].

14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a [helper].

20. I have happy thoughts and feelings about those I [help] and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].

24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a [helper].

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____ Compassion satisfaction is about the pleasure you derive from being able to do your work well.

For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. The average score is 50 (SD 10; alpha scale reliability .88).

About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____ Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset.

They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout. The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75).

About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____ The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events.

For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test and then you can compare your score to the interpretation below. To find your score on each section, total the questions listed on the left in each section and then find your score in the table on the right of the section.

Compassion Satisfaction Scale: 3. ____ 6. ____ 12. ____ 16. ____ 18. ____ 20. ____ 22. ____ 24. ____ 27. ____ 30. ____ Total: _____ **The sum of my Compassion Satisfaction questions So My Score Equals My Level of Compassion 22 or less 43 or less Low Between 23 and 41 Around 50 Average 42 or more 57 or more High**

Burnout Scale: *1. ____ = ____   *4. ____ = ____   8. ____ 10. ____ *15. ____ = ____ *17. ____ = ____   19. ____ 21. ____ 26. ____ *29. ____ = ____ **The sum of my Burnout Questions So My Score Equals My Level of Burnout 22 or**

less 43 or less Low Between 23 and 41 Around 50 Average 42 or more 57 or more High

Reverse the scores for those that are starred. 0=0, 1=5, 2=4, 3=3, 4=2, 5=1 Total: _____

Secondary Trauma Scale: 2. ____   5. ____   7. ____   9. ____ 11. ____ 13. ____ 14. ____ 23. ____ 25. ____ 28. ____ Total: _____

My Score Equals My Level of Secondary Traumatic Stress: 22 or less 43 or less Low Between 23 and 41 Around 50 Average 42 or more 57 or more High

Handout 2B

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency: 5 = Frequently 4 = Occasionally 3 = Rarely 2 = Never 1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get regular medical care for prevention

___ Get medical care when needed

___ Take time off when needed

___ Get massages

___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun

___ Take time to be sexual—with yourself, with a partner

___ Get enough sleep

___ Wear clothes you like

___ Take vacations

___ Take day trips or mini-vacations

___ Make time away from telephones

___ Other:

Psychological Self-Care

___ Make time for self-reflection

___ Have your own personal psychotherapy

___ Write in a journal

___ Read literature that is unrelated to work

___ Do something at which you are not expert or in charge

___ Decrease stress in your life

___Let others know different aspects of you

___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and   feelings

___Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance

___ Practice receiving from others

___Be curious

___ Say "no" to extra responsibilities sometimes

___ Other:

Emotional Self-Care

___ Spend time with others whose company you enjoy

___ Stay in contact with important people in your life

___ Give yourself affirmations, praise yourself

___ Love yourself

___ Re-read favorite books, re-view favorite movies

___ Identify comforting activities, objects, people, relationships, places and seek them out

___ Allow yourself to cry

___ Find things that make you laugh

___Express your outrage in social action, letters and donations, marches, protests

___Play with children

___Other:

Spiritual Self-Care

___ Make time for reflection

___ Spend time with nature

___ Find a spiritual connection or community

___Be open to inspiration

___Cherish your optimism and hope

___Be aware of nonmaterial aspects of life

___Try at times not to be in charge or the expert

___Be open to not knowing

___ Identify what in meaningful to you and notice its place in your life

___ Meditate

___ Pray

___ Sing

___ Spend time with children

___ Have experiences of awe

___ Contribute to causes in which you believe

___ Read inspirational literature (talks, music, etc.)

___ Other:

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)

___ Take time to chat with co-workers

___ Make quiet time to complete tasks

___ Identify projects or tasks that are exciting and rewarding

___ Set limits with your clients and colleagues

___ Balance your caseload so that no one day or part of a day is "too much"

___ Arrange your work space so it is comfortable and comforting

___ Get regular supervision or consultation

___ Negotiate for your needs (benefits, pay raise)

___ Have a peer support group

___ Develop a non-trauma area of professional interest

___ Other:

Balance

___ Strive for balance within your work-life and workday

___ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

Handout 2C

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 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 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?"

Meichenbaum, D. (2007). Self-care for trauma psychotherapists and caregivers: Individual, social and organizational interventions. In *11th Annual Conference of the Melissa Institute for Violence Prevention and Treatment of Victims of Violence, Miami, FL. Retrieved from http://www. melissainstitute.org/documents/Meichenbaum_SelfCare_11thconf. pdf.*

III. Session 3: Cognitive Behavioral Therapy Approach to Vicarious Trauma

Materials and supplies required for session:

- Flipchart and coloured markers
- Paper bags or small plain boxes (1 per participant)
- Glue sticks
- Scissors
- Magazines
- Stickers
- Other decorative material & paper

Session Outline:

- Introduction of VT mitigating coping skills (CBT perspective)
    - Identification of potential changes to cognitive schemas as a result of clinical work with trauma survivors
    - Empirically validated coping skills to mitigate effects of impact of clinical work with trauma survivors
- Create tangible tool to remind participants of self-care

Learning Objectives:

- Participants will increase their understanding of the importance of self-care in reducing or mitigating their experience of VT.
- Using the baseline functioning developed in the previous group, participants will increase their skill-base for self-care by creating a self-care tool kit.

In the Beginning ….

- Check-in
- Review previous weeks psychometrics
- Review homework: Ask participants if they are interested in discussing or sharing the self-care item that they brought with them.

Psychoeducational & Activity Segment

Part 1:

Facilitator reminds participants that a counsellor's exposure to trauma material causes a cumulative effect on their inner experience, which may result in changes to their cognitive schemas and worldviews. These changes to a counsellors' internal processes might include changes to personal or professional identity, worldview, spirituality, self-capacity, belief in professional identity, psychological needs and beliefs as they relate to personal safety, trust, esteem, intimacy, and sense of control. Remind participants of psychometrics and the baseline that each participant established in previous group.

Important reminder; evidence shows that self-care is a mitigating factor for these changes, but as these changes occur individuals become less likely to engage in effective self-care.

Part 2:

Invite participants to engage in creation of Self-Care Package[1]. Provide art supplies as listed above and a space to work. Encourage participants to create/decorate a bag/box with pictures, words and reminders of things or people who encourage them to take care of themselves, make them happy and keep them healthy and balanced.

Closing Review

Ask participants to discuss their understanding of the changes to cognitive schemas and perspectives as affected by clinical interactions and empathetic connections with trauma clients and the relationship between these schemas and self-care.

Participants, as part of their check out may choose to share the images and symbols on their Self-Care Package and what they intend to fill it with. *Leave extra time for extended check out.*

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[1] Activity adapted from <u>Construction of a Hope Kit</u>, described by Berk et al. (2004) in *A Cognitive Therapy Intervention for Suicide Attempters: An Overview of the Treatment and Case Examples.*

IV. Session 4: Vicarious Trauma from the Psychophysiological Perspective of Babette Rothschild

Materials and supplies required for session:

- Rothschild, B. & Rand, M. (2006) *Help for the helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma.* New York, NY: Norton & Co.

Session Outline:

- Facilitating psychophysiological experiential experience based on the work of Babette Rothschild[2].
- Allowing participants to experience the physical symptoms of emotion transfer between individuals based on somatic markers and indicators.

Learning Objectives:

- Participants will investigate somatic approaches to the mitigation of VT and develop an understanding of the difference between Psychophysiological and Cognitive Behavioral approaches.
- Using somatic exercises, participants will assess their individual abilities to recognize rises and falls of their nervous system and to begin intervening and controlling their responses to stimuli.

In the Beginning ….

- Check-in
- Review the previous weeks material
- Introduce book *Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma* by Babette Rothschild and Margaret Rand.

Psychoeducational Group Segment

- Co-facilitators share psychoeducational information regarding the psychophysiological reactions in the body that may result from the empathetic connection between client and therapist as described by Babette Rothschild in her book *Help for the Helper*. Point form notes on tracking one's autonomic nervous system and learning to become aware of body awareness can be found below:

- Learning to manage and recognize the rise and fall of the automatic and sympathetic nervous systems will allow a therapist to track levels of vicarious trauma exposure throughout the day

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[2] All examples and activities in this session are based on activities and lessons in: Rothschild, B. & Rand, M. (2006) *Help for the helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma.* New York, NY: Norton & Co.

- Body awareness alone could lower vicarious traumatization; higher levels could reduce VT
- Therapeutic mirroring of the client reduces picking up sensations and reduces the potential for developing VT over time
- Human beings are constantly affected by daily person-to-person interactions on cognitive, somatic, and neurological levels. They may be small but affect the autonomic nervous system (ANS) in ways that are only beginning to be understood.
- ANS arousal can be affected by client sensations, triggered by neurological or physical/somatic mirroring (facially, empathetically, or posturally). This arousal may be an additional factor in the spread of emotional contagion that may lead to VT.
- Rothschild and Rand (2006) disagree that empathy leads to becoming either over-involved with the client, or overwhelmed and needing to engage in emotional avoidance and causing cognitive structural changes to the therapist's worldview. Rather, they posit that the therapist's empathy, from both a neurophysiological and psychological perspective, may cause the therapist to feel as though he or she is experiencing the same emotions as the client.
- It might be the brain-body connection which how the therapist receives and processes unconscious material from a client.

- The human brain fires the same neurons when observing another individual feeling an emotion or engaging in an action, just as it fires when the individual him- or herself is feeling the emotion or participating in an action.
- The concept of "mirror neurons" suggests that the human brain processes emotional and physical information in precisely the same manner regardless of whether it is experiencing the feeling or experience first-hand or vicariously; therefore, it is possible that, when a client is dealing with traumatic material, vicarious traumatization may cause the therapist to experience the traumatic material unconsciously

Part 2:

Engage in Babette Rothchild & Margaret Rand's *Mirroring Exercise* **(2006, p.83)**

Be sure to leave enough time to discuss the pros, cons, experiences and applications of this exercise prior to closing group.

Homework:

Invite participants to create awareness this week around their interactions with clients in response to mirroring and postural imitation and how they feel before, during and after each session.

Closing Review

- Check out

V. Session 5: Finding your Window of Tolerance

Materials and supplies required for session:

- Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. WW Norton & Company.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: Norton & Co.
- Levine, P. (1997). *Waking the tiger: Healing trauma – the innate capacity to transform overwhelming experience*. Berkeley, CA: North Atlantic Books.
- Flip chart and coloured markers

Session Outline:

- Introduce concept of Window of Tolerance[3] and Pendulation[4] its relationship to the moderation of the ANS described in the previous group
- Introduce 'red' and 'blue' Vortexes and the 3Fs.

Learning Objectives:

- Participants will continue to expand their understanding of somatic responses to trauma and will demonstrate an understanding of their individual nervous system responses.
- Participants will develop additional measures of recognizing nervous system arousal levels and methods of reducing or increasing their arousal in response to external stimuli.

In the Beginning ….

- Check in
- Review previous week's introduction to postural mirroring and energetic transfer of emotions
- Review previous week's homework of developing awareness regarding ANS responses and changes before, during and after sessions in response to Psychophysiological principles as covered in previous week's group lesson

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[3] Window of Tolerance activities are adapted from Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. WW Norton & Company.

[4] Pendulation and Red/Blue Vortex activities are adapted from Levine, P. (1997). *Waking the tiger: Healing trauma – the innate capacity to transform overwhelming experience*. Berkeley, CA: North Atlantic Books.

Psychoeducational & Activity Segment

Part 1

- Odgen's perspective on trauma is that the disruption in world perspective and sense of self does not come from cognitive changes but instead comes in the sensory-somatic forms of "intrusive sensations, images, smells, constrictions, numbing [and from] an inability to modulate arousal"
- the hyperarousal of the nervous system affects the survival expression of the limbic brain, resulting in somatic responses of "accelerated heart rate, cold sweats, hypervigilance, startle response ... which alone may trigger PTSD response (Rothschild, 2000) – describe as 'red' energy

Part 2

- Introduce Fight, Flight & Freeze responses of the ANS
- Understand the symptoms, feelings and indicators of all three states and how an individual might become stuck
- Discuss ways in which individuals may recognize the 3Fs at play in their daily lives
- Introduce the concept of 'pendulation' in preparation for Part 3.
- Use flipchart to brainstorm additional words or experiences for the 3F's (dissociation, speechless, 'deer in headlights', 'hightailed it out of there', etc.)

Part 3 (Activity)

- In partners, have group members discuss low-impact personal situations that trigger anxiety or fear so that they can allow themselves to safely feel the increase in their somatic responses of the ANS and 3Fs. Remind individuals to continue to report to their partners the feelings that they experience in the moment. Once they are able to increase their ANS somatic responses, they must work to self-soothe and reduce the same responses or bring themselves out of a 3F response. Switch partners.
- Process activity with participants as large group; use flip chart to record experiential themes.

Closing Review & Homework

- Review insights or learning moments from activities
- Encourage group participants to develop awareness throughout the coming week and record their noting of ANS and 3F fluctuations in their journals.
- Check out

VI. Session 6: Emotional, Behavioral and Cognitive Reactions to Vicarious Trauma

Materials and supplies required for session:

- Case study or story;
- Balloons (1 per participant);
- Flip chart (1);
- Markers (various colours);
- Effects of Vicarious Trauma handout: Handout 6A (1 per participant);
- Somatic Feeling Journal handout: Handout 6B (1 per participant);

Session Outline:

- Develop an understanding of how exposure to material affects individuals in unique ways;
- To explore individual experience of the somatic sensations of typical VT emotional and physical reactions;
- To facilitate increased awareness of somatic sensations via body scan meditation;
- To develop an understanding of a baseline of sensory reaction to measure for change over time.

Learning Objectives:

- Participants will apply their learning of nervous system awareness during attempts to influence arousal levels via external stimuli.

In the Beginning ….

- Check in
- Review previous weeks material
- Review any observations or awareness's from previous week based on learning

** Note: Some facilitators may choose to introduce a guest speaker as part of Part 2 of the Psychoeducational Activity. A guest speaker having experienced and recovered from VT may be a benefit to participants.

Psychoeducational Activity

Part 1

Facilitator to pass to each participant and explain activity;

> *We would like you all to close your eyes for this activity. Co-facilitator is going to read you an excerpt from a case study and we would like you to listen carefully. Each time you hear something – a word, a line, an idea – that causes a reaction in you, regardless of whether you consider the reaction positive, negative or neutral, blow into the balloon. If you have what you consider a small reaction, blow a little bit of air. If you have a stronger reaction, blow a bigger breath of*

air. As we go through the story, your balloon will get bigger. Don't forget to breathe, and try not to let any air escape. When Co-facilitator finishes reading, open your eyes and tie off your balloon.

Co-facilitator reads the chosen excerpt.

Facilitator asks participants to look around the room at the different sizes of balloons that each person is holding and reminds the group that each person reacts differently to things that they hear and experience and what may cause distress for one therapist may not cause distress for another. Learning to understand and become aware of what causes distress for *you* in your practice is the most important thing.

Introduce discussion of how each participant recognized their reaction; emotion, physical feeling or cognitive thought.

Part 2

- Review responses to the story (headaches, emotions, feelings in the body, cognitive reactions, thoughts, needs to take action)
- Focus on <u>somatic</u> responses; write brainstorm ideas on flipchart – try to identify 3F, ANS and other responses
- Process with group; relate to previous weeks activities
- Facilitate discussion of importance of somatic awareness in relation to VT mitigation (solidify learning from previous weeks)

Assign Homework – Feelings Journal

Facilitator to introduce Feelings Journal to participants along with handout regarding physical, emotional and cognitive warning signs for VT.

Co-Facilitator to hand out adjacent list of emotional, physical and cognitive warning signs of VT.

Participants reminded to work on their Feelings Journal throughout the week and to bring it back to group next week to discuss.

Closing Review

- Review responses to story and somatic sensations
- Relate experiences to previous weeks work with ANS, 3Fs, cognitive schema changes, self-reports, etc.
- Continue to encourage journal responses to awareness of reactions in sessions throughout the week
- Check out

Handout 6A

Signs & Symptoms of Vicarious Trauma: Handout

Physical Signs

Exhaustion – feeling exhausted when you start your day, dragging your feet, coming back to work after a weekend off and still feeling physically drained.

Insomnia

Headaches

Increased susceptibility to illness – getting sick more often.

Somatization and hypochondria
Somatization refers to the process whereby we translate emotional stress into physical symptoms. Examples are tension headaches, frequent stress-induced migraines, gastro-intestinal symptoms, stress-induced nausea, unexplained fainting spells, etc. The ailments are very real, but the root cause is largely emotional and stress related. You may be able to identify which organ/body part is your vulnerable area: many people say it's their gut, stomach, or head.
Hypochondriasis refers to a form of anxiety and hypervigilance about potential physical ailments that we may have (or about the health of our loved ones). When it is severe, hypochondria can become a debilitating anxiety disorder.

Behavioural Signs and Symptoms

Increased use of alcohol and drugs

Absenteeism (missing work)

Anger and Irritability
This can come out as expressed or felt anger towards colleagues, family members, clients, chronic crisis clients. You may find yourself irritated with minor events at work: hearing laughter in the lunch room, announcements at staff meetings, the phone ringing. You may feel annoyed and even angry when hearing a client talk about how they did not complete the homework you had assigned to them. You may yell at your own children for not taking out the garbage. The list goes on and on and it does not add up to a series of behaviours that make you feel good about yourself as a helper, as a parent or as a spouse.

Avoidance of clients
Examples of this can be: not returning a client's phone call in a timely fashion, hiding in a broom closet when you see a challenging family walking down the hall, delaying booking a client who is in crisis even though you should see them right away. Again, these are not behaviours that most of us feel proud of, or that we are comfortable sharing with our colleagues and supervisors, but they do sometimes occur and then we feel guilty or ashamed which feeds into the cycle of compassion fatigue.

Impaired ability to make decisions
Helpers start feeling professionally incompetent and start doubting their clinical skills. A more severe form of this can be finding yourself in the middle of an intervention of some kind, and feeling totally lost, unable to decide what should happen next. Difficulty making simple decisions can also be a symptom of depression.

Attrition

This refers to leaving the field, either by quitting or by going on extended sick leave.

Compromised care for clients
This can take many forms: using the label "borderline" for some clients as a code word for "manipulative" is one common example. Whenever a diagnosis is being used in a way that pigeonholes a client, we are showing our inability to offer them the same level of care as to other clients. There is evidence that clients with a BPD (borderline personality disorder) label often do not receive adequate care in hospitals, are not assessed for suicidal ideation properly and are often ignored and patronized.

Psychological signs and symptoms
Emotional exhaustion

Distancing
You find yourself avoiding friends and family, not spending time with colleagues at lunch or during breaks, becoming increasingly isolated. You find that you don't have the patience or the energy/interest to spend time with others.

Negative self-image
Feeling unskilled as a helper. Wondering whether you are any good at this job.

Depression
Difficulty sleeping, impaired appetite, feelings of hopelessness and guilt, suicidal thoughts, difficulty imagining that there is a future, etc.

Reduced ability to feel sympathy and empathy
This is a very common symptom among experienced helpers. Some describe feeling numb or highly desensitized to what they perceive to be minor issues in their clients or their loved ones' lives.

Cynicism
Cynicism has been called the "hallmark" of compassion fatigue and vicarious traumatization. You may express cynicism towards your colleagues, towards your clients and towards your family and friends. Eye rolling at the brand new nurse who is enthusiastically talking about an upcoming change or idea she has to improve staff morale, groaning when seeing a certain client's name on your roster and cynicism towards your children's ideas or enthusiasm.

Resentment

Dread of working with certain clients

Diminished sense of enjoyment/career (i.e., low compassion satisfaction)

Depersonalization
Dissociating frequently during sessions with clients. Again, this is a matter of frequency – many of us space out once in a while, and this is normal, but if you find that you are dissociating on a more frequent basis, it could be a symptom of VT.

Disruption of world view/heightened anxiety or irrational fears
This is one of the key symptoms caused by vicarious traumatization. When you hear a traumatic story, or five hundred traumatic stories, each one of these stories has an impact on you and your view of the world. Over time, your ability to see the world as a safe place is severely impacted. You may begin seeing the world as an unsafe place.

Problems with intimacy

Intrusive imagery
This is another symptom of vicarious trauma: Finding that your clients' stories are intruding on your own thoughts and daily activities.

Hypersensitivity to emotionally charged stimuli
Crying when you see the fluffy kittens from the toilet paper commercial; crying beyond measure in a session that is emotionally distressing (welling up is normal, sobbing is not).

Insensitivity to emotional material
Sitting in a session with a client who is telling you a very disturbing or distressing story of abuse, and you find yourself faking empathy, while inside you are either thinking either "I've heard much worse" or "Yup, I know where she is going with this story, I wonder what's for lunch at the canteen."

Loss of hope
Over time, there is a real risk of losing hope. Losing hope for clients (that they will ever get better) and maybe even hope for humanity as a whole.

Difficulty separating personal and professional lives
Many helping professionals, have no life outside of work. They work through lunch, rarely take their vacations, carry a beeper/blackberry at all times and are on several committees and boards related to their work.

Failure to nurture and develop non-work related aspects of life
Many helpers have lost track of the hobbies, sports and activities that they used to enjoy. Some collapse in bed at the end of their work day, too tired to consider joining an

amateur theatre group, go curling or join a book club. Yet, "having a life" has been identified as one of the key protective elements to remaining healthy in this field.

Material adapted from www.compassionfatiguesolutions.ca

Handout 6B

Somatic Awareness Journal (manual copy; see additional materials for landscape format)

Date & Time & Place		Encounter	Emotion	Thoughts	Somatic Awareness	Actions

VII. Week 7: Healthy Workplaces & Preparation for Group Termination

Materials and supplies required for session:

- Vicarious Trauma Plan (Handout 71)

Session Outline:

- Introducing & understanding the impact of workplace and agencies on VT and other forms of professional stress
- Understanding the employee's (counsellor's) role in mitigating workplace VT for self and others
- Begin preparing for termination in Week 8

Learning Objectives:

- Participants will demonstrate their ability to recognize personal areas of risk for VT via completion of the somatic journal assigned as homework the previous week.
- Participants will develop an understanding of the relationship between workplace structure and the development of VT in individuals.
- Building on skills developed throughout previous group sessions, participants will identify their personal areas of VT risk and develop a comprehensive plan to mitigate those risks via cognitive or somatic approaches.

In the Beginning ….

- Check in
- Review Signs and Symptoms of Vicarious Trauma handout
- Review previous 6 weeks learning (cognitive and somatic cues of VT as well as each individuals success with developing mitigating skills)
- Review feelings journal

Psychoeducational Activity

Part 1

- In research published in 1994, it was noted that stress related illness cost organizations over 700 million USD annually; short term counselling seems to increase cognitive coping mechanisms but does not seem to reduce stress (Cooper & Cartwright, 1994)
- Job related stress, PTSD or VT causes lack of trust between coworkers, conflict amongst teams and a reduction in personal development within the agency. (Kuypers, Guenter, & van Emmerik, 2015)
- Using the skills learned in previous weeks to mitigate stressful/traumatic work and reduce impact of the individual on the agency and the agency on the individual

- Managers and organizations need to do their part by providing adequate supervision, crisis management and intervention, ensuring that caseloads are balanced and recognizing that VT is a workplace hazard that is going to happen regardless of setting.

Part 2

- Develop a Vicarious Trauma Plan[5] for use at home and work. This plan is designed to be repeated every few months. See handout 71

Assign Homework

- Review VT Plan throughout the week keeping in mind attempts to use it to assess its validity in your daily life.

Closing Review

- Assess participants for levels of VT or PTSD or active trauma that require intervention by clinical specialists and offer referrals if necessary
- Check out
- Reminders of final group session the following week

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[5] Adapted from Pearlman, L. A., & McKay, L. (2008). Understanding and addressing vicarious trauma. *Headington Institute*.

Vicarious Trauma Plan (Handout 7A)

1. List the VT risk factors that may get in the way of you helping others:

From personal factors (e.g., past and current stress in your life);

From your situation (e.g., work-related factors);

From the cultural context (e.g., discrimination and attitudes of intolerance);

2. List any signs or symptoms of vicarious trauma that you are experiencing.

Physical

Psychological

Behavior and relationships

Worldview or frame of reference (spirituality, identity, and beliefs)

3. What are things that you can do to cope better with these symptoms? (Hint: Think about how you can counteract your risk factors, and remember that good coping strategies for vicarious trauma are things that help you take care of yourself – especially things that help you escape, rest, and play.)

How can you take care of yourself in the following areas?

Physical

Mental and emotional

Behavior and relationships

At work

4. What steps can you take that can help you transform your vicarious trauma on a deeper level? (Hint: transforming vicarious trauma means identifying ways to nurture a sense of meaning and hope).

Outside work

During work

5. Pick two things you have listed in response to questions 3 or 4, and think about how you will put those into practice this week. Set two specific, realistic, goals by completing the sentence below (Hint: think about how, when, and where you achieve these goals and put that in your answer too):

This week I will _____ to help prevent or manage vicarious trauma.

6. What obstacles might get in the way of you doing the two things you identified in item 5, above?

7. What might you to do overcome the obstacles listed above? What will support you in accomplishing your goals (Hint: think about people who can support you and how they might encourage you.

VIII. Week 8: Final Session

Materials and supplies required for session:

- Picture frames (Dollar store, medium)
- Craft materials from previous groups
- Flipchart & coloured markers

Session Outline:

- Review cognitive and somatic indicators of VT, recognition of impact of VT on self, mitigation techniques and awareness of VT in the workplace.
- Closing activity

Learning Objectives:

- Participants will demonstrate an increase in their knowledge of somatic and cognitive VT prevention techniques both personally and in the workplace via creating safety plans and visual reminders of interventions that can be used to reduce VT experiences.

In the Beginning ….

- Check in
- Review cognitive and somatic indicators of VT
- Review VT mitigating techniques and methods of recognizing the impact of VT
- Review methods of recognizing and mitigating VT in the workplace
- Closing ritual

Psychoeducational Activity

Part 1

- Group co-facilitators to review all previous groups and assist group participants in brainstorming important parts of previous weeks.
- List highlights on flipcharts; biggest learning moments, most useful mitigation techniques, etc., as described by participants

Part 2

- Have group participants selects paper and craft supplies from pile and create a 'safety plan' that can then be framed
- Use key words that will remind participants (but perhaps be secret from clients if kept in therapy room) of mitigation techniques, self-care techniques, things to remember about VT, etc.
- Have group members remind each other of important things they remember each other saying throughout the group weeks
- Share final framed pieces of work before leaving

Closing Review

- Check out

Weekly Feedback Form – Handout Weekly

Please fill out this feedback form prior to leaving and return to facilitators. Your feedback is confidential and you do not have to use your name!

Fighting Back Against Vicarious Trauma   Today's
Date_____

Please help us evaluate the effectiveness of *'Fighting Back against Vicarious Trauma* by taking a few moments to complete and return this form.

.

	Strongly Disagree	Disagree	Unsure	Agree
Strongly Agree				
1. The material for this week's group was well explained.	1	2	3	4
5				
2. I have a strong understanding of the topics provided this week.	1	2	3	4
5				
3. Overall, I am satisfied with the quality of this week's group.	1	2	3	4
5				
4. The goals for this week's group were achieved.	1	2	3	4
5				
5. I was given an opportunity to participate meaningfully in	1	2	3	4
5 this week's exercise.				

Additional Information

1. One thing I would like the co-facilitators to know this week is:

2. One thing I really liked this week is:

3. One thing that didn't work well for me this week is:

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