Resilience for Supervisors:

Emerging Practices in Addressing Vicarious Trauma

The information in this manual was compiled by Cathy Alexander, LISW-S.

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www.odvn.org

Table of Contents

Resetting Your Inner Compass

RESETTING YOUR INNER COMPASS

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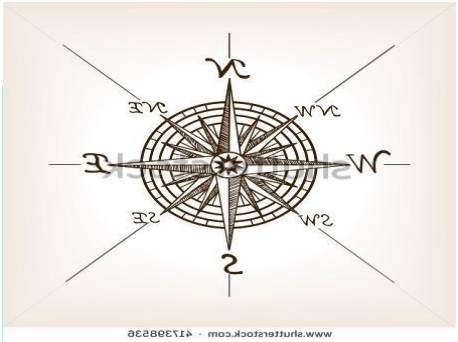
RESOURCES FOR THE BREATH



FOCUS

REMEMBER
YOU ARE
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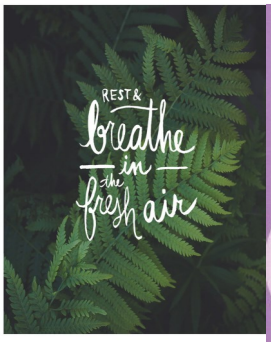

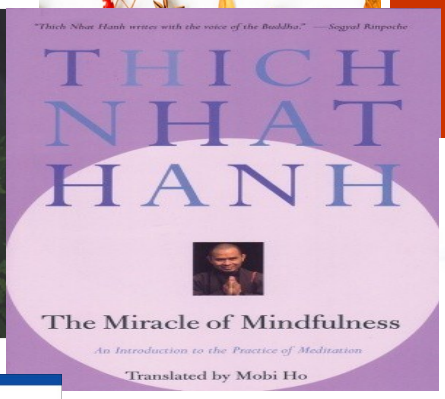

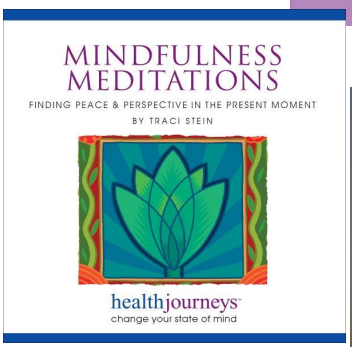

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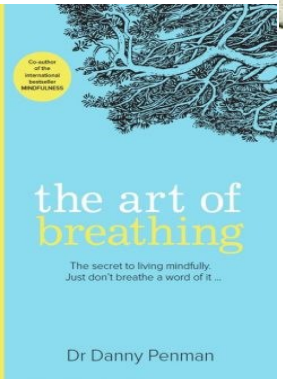

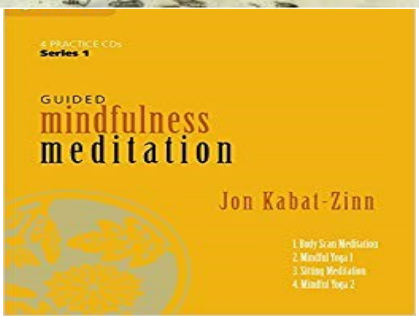

CREATE

IMAGINE

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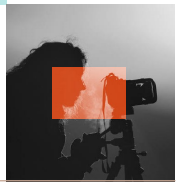
ODVN

soniaf@odvn.org
cathya@odvn.org

School of Fine Art

www.fineartschool.net

Your business tagline



Fall Curriculum:

Photography

Course, Product, or Service Description:
The purpose of a data sheet is to sell products or services to a targeted audience, or to advertise upcoming classes or events. Data sheets can be a great way to market your products or services, and also build your organization's identity.

Date: 00/00/0000
Time: 00:00
Location: address

Price/Fee: $ 000.00

Painting

Course, Product, or Service Description:
The purpose of a data sheet is to sell products or services to a targeted audience, or to advertise upcoming classes or events. Data sheets can be a great way to market your products or services, and also build your organization's identity.

Date: 00/00/0000
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Location: address

Price/Fee: $ 000.00

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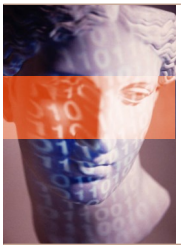

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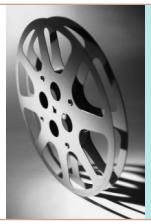

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Date: 00/00/0000
Time: 00:00
Location: address

Price/Fee: $ 000.00

Primary Business Address
Your Address Line 2
Your Address Line 3
Your Address Line 4

Phone: 555-555-5555
Mobile: 555-555-5555
Fax: 555-555-5555
Email: someone@example.com

Vicarious trauma is the <u>process of change</u> that happens because <u>you care about other people</u> who have been hurt, and <u>feel committed or responsible to help</u> them. Over time this process can lead to changes <u>in your psychological, physical, and spiritual well-being</u>

<u>(changed during your work):</u>

- What are some of the ways you have changed during your work?

<u>(because you care about other people)</u>

- What sort of problems or people do you find it especially easy to empathize with?

- What are some ways that caring about people who have been hurt affects you?

(feel committed or responsible)

- How does your sense of commitment and responsibility to your work help you?

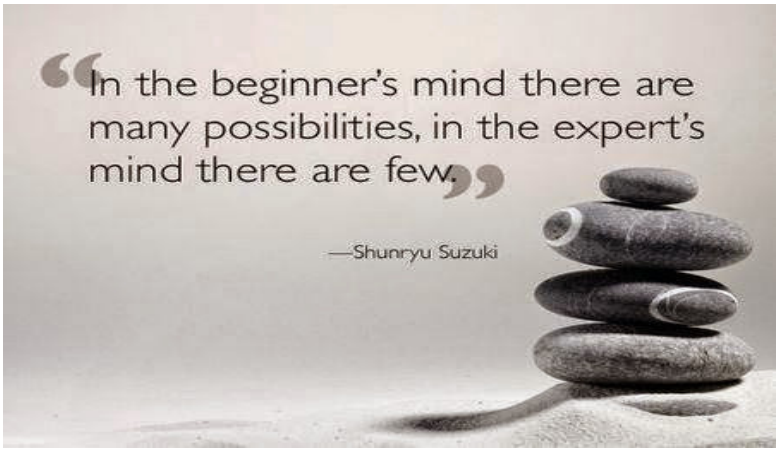
- Are there ways in which your sense of commitment and responsibility to your work might hurt you? How?

(changes in psychological, physical and spiritual well being)

- What are two ways you feel your work has had a positive influence on the way you see the world, yourself, or what matters to you (your sense of meaning and purpose, hope and faith)?

- What are two ways you feel your work has had a negative influence on the way you see the world, yourself, or what matters to you (your sense of meaning and purpose, hope and faith)?

WHAT IS VICARIOUS TRAUMA?



Stories have the power to create social change and inspire community.
--Terry Tempest Williams

Those women and men who have chosen to dedicate their lives to anti-violence work understand the power of stories to both heal the hurting soul and build a powerful movement.

For it is from individual survivor stories told in whispers over the phone, through tears in hospital emergency rooms, through the drawings of second-graders, and late at night over a cup of coffee that victim services and societal change have flourished over the last four decades.

The movement to address intimate partner violence started with the stories told by survivors who found the courage to break the silence and talk about what often occurred in secret, behind closed doors. The grass roots shelter movement was built on these stories, as safe places were created from conversations at kitchen tables.

As the movement to end violence has grown and evolved into a multi-system, comprehensive set of prevention and intervention efforts, one thing has remained constant.

The stories.

Connecting with survivors by sitting with them and hearing their stories is still the most powerful intervention available to the Victim Advocates who work across our state of Ohio and around the country. Yet, even as the stories continue to serve as the foundation for survivor healing, they also can accumulate and live on in the hearts and bodies of their advocates in the form of secondary trauma.

In recognition of the power of listening and the courage of victim advocates, this section is

designed to provide guidance, resources, and promising practices to victim service programs as they enhance their programmatic infrastructure to address the critical need for secondary trauma services for program staff.

> ***Vicarious trauma*** *is defined as a transformation in the helper's inner sense of identity and existence that results from utilizing controlled empathy when listening to clients' trauma-content narratives.*
>
> *In other words,* ***vicarious trauma*** *is what happens to your neurological (or cognitive), physical, psychological, emotional, and spiritual health when you listen to traumatic stories day after day or respond to traumatic situations while having to control your reaction.--------Vicarious Trauma Institute*

Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyches react to the expressions of profound despair, rage and pain. Personal balance can be lost for a moment or for a long time. The waves of agony and pain can bombard the spirit and seep in, draining strength, confidence, desire, friendship, calmness, laughter and good health. Confusion, apathy, isolation, anxiety, sadness and illness are all too often the result.

Many theorists working in the area of trauma theory have speculated that the emotional impact of this type of traumatic material can be contagious and transmitted through the process of empathy; because you care about people who have been hurt and you feel committed to help them.

To be an effective helper, the advocate controls their reaction to the horrific and terrifying situations the survivor shares with them. It is the process of controlling their emotions that can result in numbing, disconnecting and experiencing other trauma reactions, which are similar to the reactions that trauma survivor's experience.

Terms like compassion fatigue, secondary traumatization, and secondary stress disorder are all used to describe what is happening to the helper. There are several different terms that have been used to describe the phenomenon of being impacted by the exposure to trauma (secondary or primary) in the workplace. These terms and their definitions are listed below:

IN THE WORKPLACE VICARIOUS TRAUMA HAS BEEN ASSOCIATED WITH:

- ✓ ***Higher rates of physical illness***
- ✓ ***Greater use of sick leave***
- ✓ ***Higher turnover***
- ✓ ***Lower morale***
- ✓ ***Lower productivity that may lead to errors with survivors***

- **Burnout:** The physical and emotional exhaustion helpers may experience due to low job satisfaction, feelings of powerless, and being overwhelmed in the workplace (Mathieu, 2011, p. 10). This definition does not include exposure to trauma but this term has been used when talking about the anti-violence workforce.

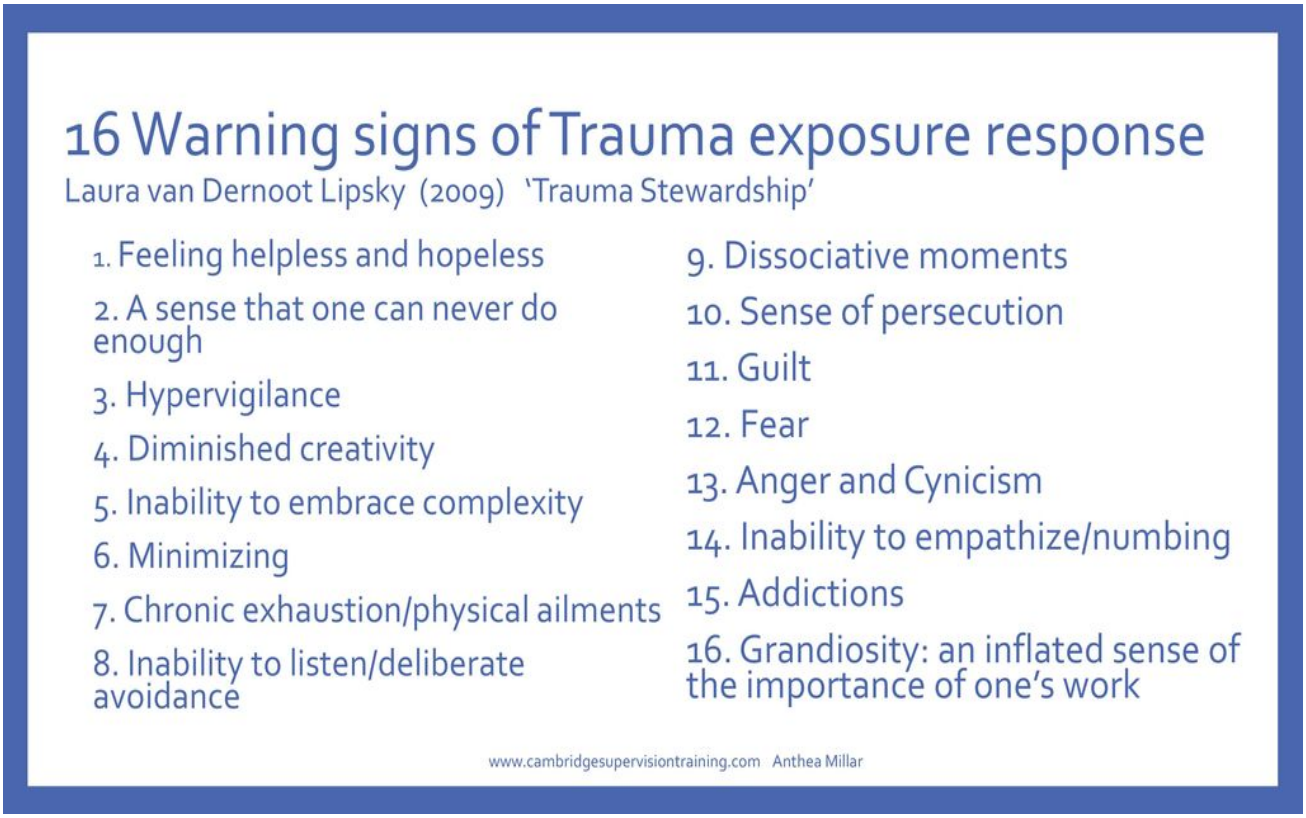
- **Compassion fatigue:** The profound emotional and physical exhaustion that helping professionals and caregivers can develop over the course of their career as helpers. This is a gradual erosion of the things that keep them connected to others in their caregiver role (Mathieu, 2011, p. 14).

- **Secondary traumatic stress (STS):** Work-related, secondary exposure to extremely or traumatically stressful events (Mathieu, 2011, p. 27).

- **Vicarious trauma:** The profound shift that helpers experience in their world view when working with clients who experience trauma. Fundamental beliefs about the world are altered and possibly damaged due to repeated exposure to traumatic material. (Mathieu, 2011, p. 14)

There are also certain individuals working at domestic violence agencies that might be more at risk of developing vicarious trauma. Characteristics for these individuals include:

- A personal history of trauma
- Being overworked
- Having poor boundaries with survivors
- Working with too many trauma survivors
- Having limited professional experience
- Working with a high percentage of traumatized children
- Working with survivors who aren't able to get the support (such as housing, medical care, etc.) they need to be safe.



HOPE AND RESILIENCE FOR SUPERVISORS

Ohio Domestic Violence Network
Cathy Alexander
Sonia Ferencik
Denise Kontras

BACKGROUND FOR TODAY AND TOMORROW

- define vicarious trauma and traumatization, secondary traumatic stress, compassion fatigue, burnout, resilience, and vicarious resilience;
- discuss how working with a traumatized population affects victim services staff;
- discuss the impact of vicarious trauma on organizations; and
- identify particular strategies that enhance both personal and professional resilience.

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."

(Remen, 2006)

- Stress
  - Acute
  - Chronic
- Traumatic stress

- Vicarious trauma
- Vicarious traumatization
- Secondary traumatic stress
- Compassion fatigue
- Burnout

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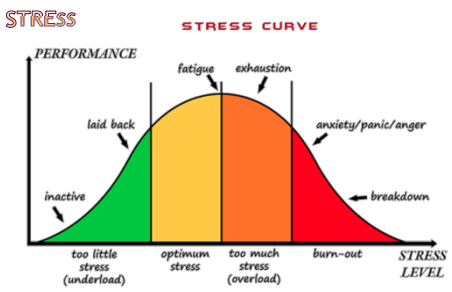


THE STRESS RESPONSE

The brain and body's alarmed and alert response to a threatening situation

Integral to the life of every living organism.

Our natural defense against danger.

CUMULATIVE STRESS

TAKING A CLOSER LOOK…

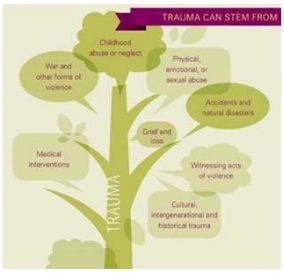
- Trauma
- Traumatic stress
- Vicarious traumatization

TRAUMATIC EVENTS

Human
Homicide
Sexual Assault
Assault/attack
War

Natural
Hurricane
Earthquake
Flood
Fire

Workplace Violence
Fight or physical attack
Threat of physical harm
Accident



WHAT MAKES AN EVENT TRAUMATIC?

- It involves a threat—real or perceived—to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves one feeling helpless.
- It changes the way a person understands the world, themselves, and others.

(American Psychiatric Association, 2000)

DEFINING TRAUMATIC STRESS

Traumatic Stress is the stress response to a traumatic event(s) in which one is a victim or witness.

- Repeated stressful and/or traumatic events can chronically elevate the body's stress response.
- 4 percent of victims suffer about 44 percent of the offenses. (chronicity)

(Farrell and Pease, 1993)

WORK-RELATED TRAUMA EXPOSURE: HOW DOES IT AFFECT US?

- Vicarious Trauma
- Compassion Fatigue
- Secondary Traumatic Stress
- Indirect Trauma
- Empathic Strain
- PTSD
- Critical Incident Stress
- Burnout

UNDERSTANDING THE DIFFERENCE BETWEEN TRAUMATIC STRESS AND VICARIOUS TRAUMATIZATION

Traumatic Stress	Vicarious Traumatization
• Extreme emotionality or absence of emotion	• Overly involved with or avoidance of victim/survivor
• Fearful, jumpy, exaggerated startle response	• Hypervigilance and fear for one's own safety (the world no longer feels safe and people can't be trusted)
• Flashbacks	• Intrusive thoughts and images, or nightmares from victims' stories

WORK-RELATED TRAUMA EXPOSURE

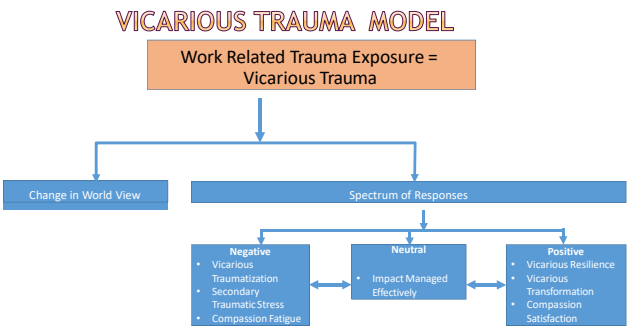
DIRECT exposure to trauma

- Post Traumatic Stress Disorder (PTSD)
- Post Traumatic Stress Symptoms
- Critical Incident Stress

INDIRECT exposure to trauma

- Post Traumatic Stress Disorder (DSM-V, 2013)
- Post Traumatic Stress Symptoms
- Empathic Strain
- Secondary Traumatic Stress Symptoms
- Vicarious Traumatization
- Compassion Fatigue

VICARIOUS TRAUMA MODEL



CHANGE IN WORLD VIEW

- "…the transformation or change in a helper's inner experience as a result of responsibility for and empathic engagement with traumatized clients."
  - (Saakvitne et al. 2000)

It's the shift in how we view the world, view others, and sense danger around us…

PREVALENCE OF VICARIOUS TRAUMATIZATION AMONG VICTIM SERVICES WORKERS

- 50 percent experience traumatic stress symptoms in the severe range; 50 percent experience high to very high levels of compassion fatigue.

(Conrad and Kellar-Guenther, 2006)

- 34 percent met PTSD diagnostic criteria from secondary exposure to trauma.

(Bride, 2007)

- 37 percent experience clinical levels of emotional distress associated with compassion fatigue.

(Cornille and Meyers, 1999)

SECONDARY TRAUMATIC STRESS (STS)

"…the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by another…the stress resulting from helping or wanting to help a traumatized or suffering person."

(Figley, 1995)

COMPASSION FATIGUE

"A combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress."

(Anewalt, 2009; Figley, 1995)

WHAT ABOUT BURNOUT?

EXAMPLES OF VICARIOUS TRAUMATIZATION: PERSONAL

• Physical	• Rapid pulse/breathing, headaches, impaired immune system, fatigue, aches
• Emotional	• Feelings of powerlessness, numbness, anxiety, guilt, fear, anger, depletion, hypersensitivity, sadness, helplessness, severe emotional distress or physical reactions to reminders
• Behavioral	• Irritability, sleep and appetite changes, isolate from friends and family, self destructive behavior, impatience, nightmares, hypervigilance, moody, easily startled or frightened
• Spiritual	• Loss of purpose, loss of meaning, questioning goodness versus evil, disillusionment, questioning prior religious beliefs, pervasive hopelessness
• Cognitive	• Diminished concentration, cynicism, pessimism, preoccupation with clients, traumatic imagery, inattention, self doubt, racing thoughts, recurrent and unwanted distressing thoughts
• Relational	• Withdrawn, decreased interest in intimacy or sex, isolation from friends or family, minimization of others' concerns, projection of anger or blame, intolerance, mistrust

(Adapted from J. Yassen in Figley, 1995)

EXAMPLES OF VICARIOUS TRAUMATIZATION: PROFESSIONAL

• Performance	• Decrease in quality/quantity of work, low motivation, task avoidance or obsession with detail, working too hard, setting perfectionist standards, difficulty with inattention, forgetfulness
• Morale	• Decrease in confidence, decrease in interest, negative attitude, apathy, dissatisfaction, demoralization, feeling undervalued and unappreciated, disconnected, reduced compassion
• Relational	• Detached/withdrawn from co-workers, poor communication, conflict, impatience, intolerance of others, sense of being the "only one who can do the job"
• Behavioral	• Calling out, arriving late, overwork, exhaustion, irresponsibility, poor follow-through

(Adapted from J. Yassen in Figley, 1995)

CONTEMPLATING THE EFFECTS

Personal Effects
- Physical
- Behavioral
- Emotional
- Spiritual
- Cognitive
- Relational

Professional Effects
- Performance
- Morale
- Relational
- Behavioral

RISK FACTORS

Personal
- Trauma history
- Pre-existing psychological disorder
- Young age
- Isolation, inadequate support system
- Loss in last 12 months

Professional
- Lack of quality supervision
- High percentage of trauma survivors in caseload
- Little experience
- Worker/organization mismatch
- Lack of professional support system
- Inadequate orientation and training for role

(Bonach and Heckert, 2012; Slattery and Goodman, 2009; Bell, Kulkarni, et al, 2003; Cornille and Meyers, 1999)

WHAT IS SELF-CARE?

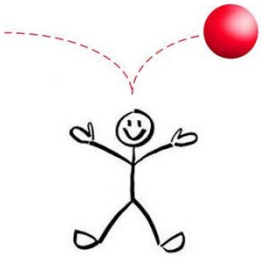
Self-care is what people do for themselves to establish and maintain health, and to prevent and deal with illness.

It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure, etc.), environmental factors (living conditions, social habits, etc.) socio-economic factors (income level, cultural beliefs, etc.), and self-medication.'

(World Health Organization, 1998)

PERSONAL SELF CARE STRATEGIES

Resilience



Resilience is the process of **adapting** well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress, such as family and relationship problems, serious health problems, or workplace and financial stressors.

It means "bouncing back" from difficult experiences.

(American Psychological Association)

Vicarious resilience

Involves the process of learning about overcoming adversity from the trauma survivor and the resulting positive transformation and empowerment through their empathy and interaction.

(Hernandez, Gangsei, and Engstrom, 2007)

IMPACT OF VICARIOUS RESILIENCE

- Greater perspective and appreciation of own problems
- More optimistic, motivated, efficacious, and reenergized
- Increased sense of hope, understanding, and belief in the possibility of recovery from trauma and other serious challenges
- Profound sense of commitment to, and finding meaning from the work

(Hernandez, et al, 2007; Engstrom, et al, 2008)

Acknowledging the Positive:

Compassion Satisfaction

Vicarious Transformation

SELF-CARE ISN'T EVERYTHING…

Vicarious trauma is an occupational challenge for those working with trauma survivors

Organizations have an ethical mandate of a **"duty to train,"** wherein workers are taught about the potential negative effects of the work and how to cope.

(Munroe, J. F., in Figley, Compassion Fatigue, 1995)

VICARIOUS TRAUMA-INFORMED ORGANIZATION

Vicarious trauma (VT), the exposure to the trauma experiences of others, is an occupational challenge for the fields of victim services, emergency medical services, fire services, law enforcement, and others. Working with victims of violence and trauma has been shown to change the worldview of responders and can also put individuals and organizations at risk for a range of negative consequences.

A *vicarious trauma-informed organization* recognizes these challenges and assumes the responsibility for proactively addressing the impact of vicarious trauma through policies, procedures, practices, and programs.

KEY ASPECTS OF A HEALTHY, VICARIOUS TRAUMA-INFORMED ORGANIZATION

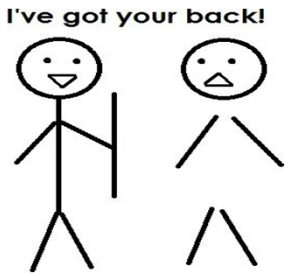
- **Leadership and Mission**
  - Effective leadership, clarity, and alignment with mission
- **Management and Supervision**
  - Clear, respectful, quality, inclusive of VT
- **Employee Empowerment and Work Environment**
  - Promotes peer support, team effectiveness
- **Training and Professional Development**
  - Adequate, ongoing, inclusive of VT
- **Staff Health and Wellness**
  - Devotes priority and resources to sustaining practices

ORGANIZATIONAL Strategies in ACTION

- Creating a healthy work environment/organizational culture
- Providing supportive leadership
- Providing quality supervision
- Debriefing staff
- Hosting staff/team meetings, retreats, formal and informal opportunities
- Encouraging formal and informal peer support Acknowledging stress, STS, and VT as real issues
- Providing training and education, including orientation to the organization and role
- Encouraging staff health and wellness (e.g.,

PEER AND SUPERVISOR SUPPORT

- Use effective communication skills
- Encourage trusting, mutual relationships
- Practice conflict resolution
- Emphasize collaboration and teamwork



What Happens When Organizations Don't Address Vicarious Trauma?

"Clients and patients will not stop needing help and support. Disasters will continue to arise. Children will get sick; trauma will occur. Helping professionals need to continue to explore ways to remain healthy while doing this deeply challenging and rewarding work."

(Mathieu, 2012)

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What Type of Work Do I Want Most?

What type of work do I want most?

Completing self-assessments can help identify what type of work you are most interested in and may help in selecting the appropriate work environment. Your personal needs will likely change over time. As part of your self-assessment, complete this exercise annually. Crisis intervention work may be well suited to your lifestyle and capacities during one time in your life and provide less satisfaction at another time.

Amongst the choices below, which type of work do I enjoy:

Intervention & Service:

_____ Crisis
_____ Short-term
_____ Long-term

Counselling:

_____ Individual counselling
_____ Group counselling

Working with:

_____ Adults
_____ Children
_____ Teens
_____ Families
_____ Volunteers

General:

_____ Advocacy
_____ Social justice efforts
_____ Outreach
_____ Administration/management
_____ Community development
_____ Flexibility of work day
_____ Constant interruptions-limited control of the workday

Shift work:

_____ Days only
_____ Days/weekends
_____ Overnights
_____ A combination

Recruitment and Hiring

Victim advocates, are not often recognized for their contributions to caring for individual survivors, navigating complex systems, or creating new and effective social and community services. Twenty four hour hotlines, mobile crisis services, emergency shelter programs, sexual assault and advocacy centers have formed an effective and unique safety net based on a strong commitment to feminist values and social justice.

Yet staff of our programs and centers, are often underpaid, overworked, and little-recognized. Attracting and retaining dedicated and qualified workers is both crucial to anti-violence efforts and challenging for program directors and supervisors.

A supervisor may be tempted to side step the issue of secondary trauma as she seeks to fill vacant positions for unappealing shifts on short notice. Over the long run, however, the earlier a staff person is introduced to the concept of vicarious trauma and oriented to available individual and organizational solutions, the more likely the employee is to adjust to and flourish within the work environment.

The recruitment and hiring phase is a critical period for the employee and for the employer. It is one of the few times when probing questions can be asked by both parties to determine if there is a good fit between the individual and the organization. A thorough recruitment, selection and interview process may take over 30 hours per new employee to complete. While this investment of time is considerable, it is also very valuable in setting the foundation for an employee's successful tenure. The fact that a prospective employee will be exposed to vicarious trauma, even if they serve in an administrative capacity, is important to highlight both in the job description and during the interview process. By placing both the organizational commitment to addressing secondary trauma at the forefront of the hiring process and openly discussing self care and resilience during employee interviews, there is a clear message of support to the prospective staff person and the opportunity for them to ask important questions related to support for self care, training and staff development opportunities, and workplace values.

Job Description

Recruitment efforts start with the creation of a job description. When creating a formal job description, one should keep in mind the realities of the job. Some of the items that should be considered include:

- Accurately describing the skills and experience needed
- Clearly describing all of the duties associated with the position.
- Providing information on both the pros of this type of work (e.g., compassion satisfaction) as well as the challenges (e.g., exposure to trauma, emotional cost of caring)
- Conveying a *culture of affirmation and caring* by providing details on support/training that will be provided to build the skills to be effective in the job and to keep staff psychologically and physically safe .

Workforce Champions

Considering who the champions are in the current workforce that can be utilized in the hiring process may be useful. Are there workers within the organization who may be able to share realities of the job, including benefits of the work, challenges, and ways to overcome those challenges.

Consider Trauma Experience and Stress-Related Questions

It is important to consider what questions are included in the interview and what information will be solicited from the potential applicant. The answers to these questions will vary greatly; however, the answer itself is not the important piece of this. By asking these questions, a message to all applicants about the nature of the work is being sent. In addition, the organization's commitment to ongoing dialogue and action around issues related to secondary traumatic stress is being modeled firsthand.

Interview Inquiries/Concepts to Consider

- Ask about applicant's experience with working with trauma survivors
- If the applicant has no experience, ask about their educational background or lived experience to see if they have been exposed to information about or experiences similar to working with trauma survivors:
  - Have you taken any classes on trauma?
  - What does resilience mean to you?
  - What are your hobbies?
  - What do you do to take care of yourself, physically, emotionally, spiritually?
  - Why is this important in this work?
- Provide some exposure of day-to-day work such as a case example that highlights trauma exposure in the job, and a tour of the facility, and look for reactions and responses
- Inquire about their personal stress management and basic self-care techniques.
- Ask about their expectations of the work culture

Remember to Touch Upon These Important Points

In addition to asking questions to learn about the applicant during the application and interview process, there are several points that should be emphasized to set the scene for the organization's supportiveness regarding work-related trauma exposure. Some points to emphasize include:

- The work is not done alone; emphasize the points of support (e.g., supervisors, peers, legal team, etc.)
- Reiterate the realities of the skills needed and duties associated with the job and ask them how they will handle these
- Convey a culture of affirmation and caring
- Provide in-depth information regarding supervision/critical debriefing protocols, and supports available like EAP, wellness plans, and peer support groups

In Summary

The hiring phase provides an opportunity to engage potential new workers and to define the realities of the job and the supports provided by the organization. This lays the groundwork for hiring a workforce that both understands the risks of the job as well as the opportunities for building resilience, developing professional competence, and experiencing the rewards of the job.

Summary of Trauma Informed Interview Questions - Examples

Assessing experience working with youth exposed to trauma

Tell me about your professional experience working with young adolescents and teens, particularly those effected by trauma?

Describe your experience working with youth with histories of multiple placement failures, high levels of aggression, trauma, or violence. What lessons did you apply from this experience? (Clinical Director)

What is your understanding of trauma informed practice? Tell us about a time you worked with a youth who was exposed to trauma. (Caseworker, therapist)

Tell us about a time you responded to the specific needs of a youth who had trauma exposure. (Clinician)

Please describe a time where you were able to establish a solid, therapeutic relationship with a highly resistant, hostile client? A trauma exposed client? (therapist, clinician)

Tell me about your professional experience working with young adolescents and teens? Trauma exposed youth? (Caseworker, Counselor)

Safety

Please describe the activities you will use to create a safe environment of trust and respect?

What type of environment do you work best in?

Supportive Adults

Healthy boundaries are important when working with our current population. Please explain what "healthy boundaries" mean to you and how you have demonstrated these in the past.

Specifically describe how you would establish and promote healthy boundaries with youth?

Define what "boundaries" mean to you and please provide an example of how you would establish "healthy boundaries".

What have you found to be effective techniques in developing trust relationships or rapport with youth served?

Give us some examples of how you engaged a distrustful youth or distant family member in the past.

In what ways have you developed healthy relationships with children and teens?

Self-regulation

Tell me about a time when you had to calm an upset individual who was being irrational and escalating. What worked and what was not effective?

Describe your approach to conflict resolution involving adolescents/children. Give examples of how you have applied this approach (or self-regulation skills)

Describe the steps you would take to diffuse an escalated situation with a youth or family member.

Strengths based

Please describe how you will provide feedback to youth regarding their behavior.

Please describe some of the methods you have used to measure a youth's progress toward goals or a particular task.

Tell us about a "success story"- a youth that you have had a significant role in making a difference in his/her treatment. What were the issues/problems, what were their strengths, and what did you do to make a positive impact? (Clinical Director)

Tell us about a "not such a success story"- a youth with whom you weren't able to be successful. What were the issues and what lessons did you apply from the experience? What strengths did you notice in this youth? (Clinical Director)

Self-Care

In times of high demand or increased stress, it is easy to become rattled. Tell me about a time when you became overwhelmed with your work. What were the earliest signs that you were becoming overwhelmed? And how did you resolve the situation?

Please provide an example of how you monitored/managed the morale and health of your employees to make sure they were working to their potential? (Supervisors)

Describe a situation when you worked under pressure to meet multiple deadlines; how do you handle the emotions and stress of meeting these deadlines? (Supervisors)

What have you done to support staff self-care in your most recent position? (Supervisors)

What have you done to display healthy self-care skills during the past year? What have you done to maintain a healthy work-life balance?

It is almost time to go home and your manager wants to meet with you, your voicemail is almost full, you have several emails waiting for a response, a child on your case load is struggling and needs to process and you have a staffing tomorrow that you are not fully prepared for. How do you prioritize these demands and the reasoning behind your choices? (Case Manager)

What do you need from (the agency) to help make sure you are successful with the organization?

Action List:

- Screen candidates on the basis of a balance among life experience, experience working in survivor-focused environments, and education.
- Include hiring questions on:
  - personal ideology and social justice philosophy
  - expectations of the work culture
  - practical experiences
  - vicarious trauma and self-care
  - understanding of equity issues and diversity in the workplace and among clients.
- Complete self-assessments of what type of work is preferred by the individual.
- Complete self-assessment surveys.
- Discuss personal experience with violence.
- Provide enough information of the job and work culture to candidates for them to make an informed acceptance.
- Include in the contract information on the effects of vicarious trauma.

The hiring of staff is a quest to find the right person with the best balance of skills, expertise and philosophy, with the potential to succeed in this unusual work environment. There are many reasons why individuals choose to join a work environment serving abused and assaulted women, their children or their abusers. For many, they are drawn to the agency or service because it is survivor-focused and they want to make a difference in a place that is meant to make a difference. Individuals choose to work or volunteer for a variety of reasons, including:

- to assist people in need
- to assist adult and child survivors
- to help end violence in the long term
- to contribute unique expertise to the program

- to find fulfilling work related to their educational background
- to be part of something that makes a difference
- to be part of a healing environment
- to be part of the anti-violence movement and to contribute to social justice action
- to reconcile personal trauma experiences
- to give back

The Critical First Three Months

Orientation and Training

The organizational response to addressing vicarious trauma in the first 3 months of employment should build upon efforts started during the hiring phase. It should continue to lay the foundation for the new advocate to understand what supports are available as well as beginning to demonstrate the organization's commitment to operationalize the culture of affirmation and caring which was introduced during the hiring phase.

Preparing for the New Staff Member's First Days

Before a new employee starts, make sure there is awareness of the current climate and culture in the organization, how this will impact new staff, and what can be done to prepare for this impact. This includes the morale of seasoned staff, their typical interactions with new staff, and how well they are handling the vicarious trauma encountered in their positions. Thinking this through can help determine who the workforce champions may be. Utilizing workforce champions or seasoned staff as mentors to welcome and orient new staff and share realities of the job, including benefits and challenges of the work, can help enforce the culture of affirmation and caring the new employee was hopefully introduced to when they were hired.

In addition to formal training on how to do the tasks the new position requires, the new employee should receive information on the personal impact the job may have and resources on how to prepare for that impact. This information may be integrated into formal training requirements or be adjunct to formal training and should focus on several areas:

> *"sometimes as a new advocate, you just kind of feel your training is based on 'sink or swim'"*
> *-----DV Shelter Advocate*

- Introducing the concepts of primary/secondary trauma, vicarious trauma, and resilience.
- Providing a welcome and wellness packet and reviewing the contents with the employee
- Orienting the employee to the facility and introducing them to coworkers
- Highlighting the importance of enhancing physical and psychological safety

Introducing Vicarious Trauma

An important part of the orientation for a new employee should include an introduction to the impact of Vicarious Trauma that may result from working in a trauma-exposed profession. While talking about the impact of trauma exposure is important, it is equally important to talk about the rewards of the job, reinforcing the idea that compassion satisfaction is a critical component of this work. These ideas, concepts, and resources can be reviewed with a new employee by the supervisor, or this may be an ideal time to rely on the workforce champions within an organization.

Vicarious Trauma: Signs and Symptoms

The beginning of the critical first 3 months of employment is a good time to review signs and symptoms of Vicarious Trauma. It is a good idea to set the expectation that this will be reviewed on an ongoing basis in supervision as well as encourage the new employee to pay attention to their own reactions to the work.

The *Compassion Fatigue Workbook* (Mathieu, 2011, pp. 49-59) describes physical, behavioral, and psychological signs and symptoms which may include the following:

TABLE 1 –The Personal Impact of Vicarious Trauma

Cognitive	Emotional	Behavioral	Spiritual	Interpersonal	Physical
• Diminished concentration • Confusion • Spaciness • Loss of meaning • Decreased self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm toward others • Self-doubt • Perfectionism • Minimization	• Powerlessness • Anxiety • Guilt • Survivor guilt • Shutdown • Numbness • Fear • Helplessness • Sadness • Depression • Hypersensitivity • Emotional roller coaster • Overwhelmed • Depleted	• Clingy • Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hypervigilance • Elevated startle response • Use of negative coping (smoking, alcohol or other substance misuse) • Accident proneness • Losing things • Self-harm	• Questioning the meaning of life • Loss of purpose • Lack of self-satisfaction • Pervasive hopelessness • Ennui • Anger at God • Questioning of prior religious beliefs	• Withdrawn • Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact on parenting (protectiveness, concern about aggression) • Projection of anger or blame • Intolerance • Loneliness	• Shock • Sweating • Rapid heartbeat • Breathing difficulties • Somatic reactions • Aches and pains • Dizziness • Impaired immune system

TABLE 2 – Impact of Vicarious Trauma on Professional Functioning

Performance of Job Tasks	Morale	Interpersonal	Behavioral
• Decrease in quality • Decrease in quantity • Low motivation • Avoidance of job tasks • Increase in mistakes • Setting perfectionist standards • Obsession about detail	• Decrease in confidence • Loss of interest • Dissatisfaction • Negative attitude • Apathy • Demoralization • Lack of appreciation • Detachment • Feelings of incompleteness	• Withdrawal from colleagues • Impatience • Decrease in quality of relationship • Poor communication • Subsume own needs • Staff conflicts	• Absenteeism • Exhaustion • Faulty judgement • Irritability • Tardiness • Irresponsibility • Overwork • Frequent job changes

Emotional Resilience

Helping a new worker understand the concept of resilience in the workplace is another key component to creating a culture of affirmation and caring. Pat Fisher's Complex Stress Model highlights both individual and workplace factors that can enhance resilience. For example, personal coping strategies are considered to be an individual resilience factor. If an individual has good coping skills, they are more likely to be resilient in the face of workplace stress (Fisher, 2015, p. 157). Communication, on the other hand, is an example of a workplace resilience factor. When communication is accurate, transparent, and timely, this enhances resilience in workplace.(Fisher2015, pp. 157-158).

Primary Trauma

It is critical to help a new worker understand the link between their own personal histories and how this may impact them on the job. Research has shown that more than 60% of helping professionals have experienced traumatic events of their own, which in and of itself is not the problem (Mathieu, 2011, p. 13). Problems may arise when an employee has not done their own work to heal from these traumatic experiences, which makes them more vulnerable to developing signs and symptoms of Vicarious Trauma.

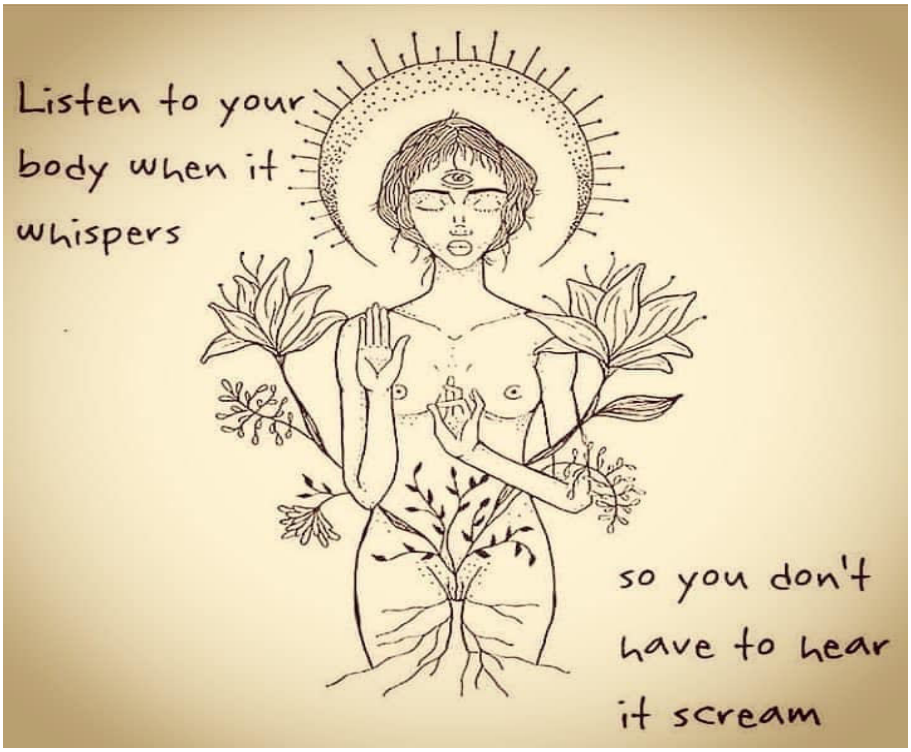
Providing and Reviewing a Welcome and Wellness Packet

The purpose of this packet is to help a new staff member get oriented in general to the agency and to provide specific information on any wellness programs or related policies and procedures. Examples of what might be contained in the packet include:

- A statement on how exposure to traumatic stories as well as the impact of working with traumatized individuals, are expectable parts of job and organizational culture
- A list of all of the signs and symptoms of Vicarious Trauma so new staff can be more aware of them in their work and for general information.
- Agency policies and protocols related to physical and psychological safety of staff
- Briefly review strategies/protocols are in place to protect physical safety (e.g., security alarms, door locks or codes, security guards)
- Briefly review training that is provided to staff on how to manage potentially dangerous situations
- Debriefing or other services to address critical incidents
- Information on what to expect from supervision sessions (e.g., when, where, how often, how to prepare; supervision models)
- How to access counseling services or other mental health services through the

agency's Employee Assistance Program (EAP), if applicable.

- A template for an Individual Wellness Plan (and a sample completed one)
- Assessment tool(s) for self-monitoring – there are multiple assessment tools available at no cost to help staff understand how they may be impacted by Vicarious Trauma
- A short and specific list of online resources, videos, or books.
- Any other resilience activities that are part of the organization



Fill in the blanks below, using the text in parentheses as your guide. You may want to complete this activity the same way you would if it were Mad-Libs, having a partner read you what is in the parenthesis and then reading your answers back to you with the blanks filled in.

I know that my stress level is beginning to affect my relationships when I _____, _____ , and _____ .

(identify three behaviors related to stress)

Other people in my life can tell that I am stressed out when I look _____ and _____.

(name two ways that you appear when you are stressed)

and I sound _____.

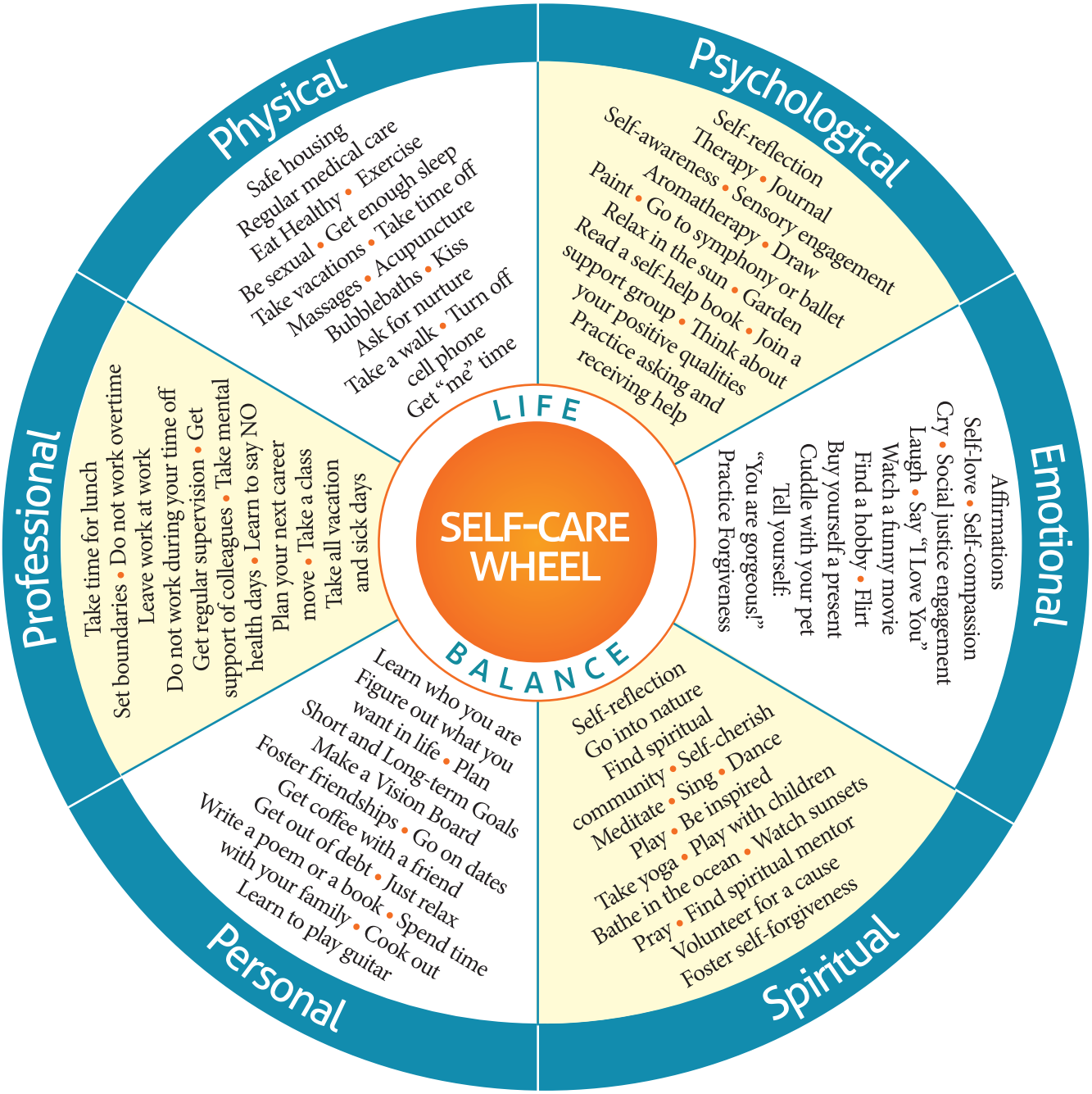
(name an unpleasant sound)

When I am feeling overwhelmed, staying connected is _____ .

(give an adjective)

The relationships in my life often _____ my stress level.

SELF-CARE WHEEL



This Self-Care Wheel was inspired by and adapted from "Self-Care Assessment Worksheet" from *Transforming the Pain: A Workbook on Vicarious Traumatization* by Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996). Created by Olga Phoenix Project: Healing for Social Change (2013). Dedicated to all trauma professionals worldwide.

www.OlgaPhoenix.com

Cumulative Effect

Supervision

Lack of or inadequate or sporadic supervision appears to cause a higher percentage of personal disruption or vicarious trauma effects for individuals (Pearlman and MacIan, 1995). Supervision is a complicated issue for advocates. There is often a lack of understanding and suspicion regarding supervision. Perhaps it is the word "supervision" that conjures up such misgivings. Prior experiences of power being used over the employee in negative ways do not fit with the vision of a feminist workplace. Failed attempts at supervision, including accessing external supports, are registered in the collective memory of the group and can create a heightened resistance when supervision is reintroduced.

Supervision models can be introduced that decrease the resistance and increase the opportunity to share difficult experiences, problem solve and learn. Supervision that is linked to performance, or perceived to link to performance, can lead to fear or worry. Staff may be more reluctant to disclose a negative experience or feelings about a client if they have a concern that it will result in an unfavorable review or adversely impact their earnings. The models of supervision introduced into programs for survivors must recognize the diversity of backgrounds of the agency (i.e. cultural, educational, experiential) and complement the operating philosophy. Lack of financial resources and time constraints can be seen as taking time away from the services to women and children.

The social work profession has developed models for clinical supervision, and reliable supervision models that recognize the time to debrief with supervisors or peers are available. These models have not always been transferred successfully to anti-violence agencies and there is merit in learning the strengths and challenges of different models.

When performance management is developed incorporating the principles of learning, the experience can be rewarding to both the employee and the organization. Offering a check-in opportunity, such as once every four months, provides a direct link to an annual performance review. Regular performance management supports a work culture of no surprises and allows for discussion regarding policy comprehension.

Peer supervision or consultation provides a safe place for staff to go to unload, to vent and to debrief. It is often done in a group with a facilitator. There is respect for confidentiality and it is not linked to performance management. Peer consultation can be broken down into two components. The first component is the debriefing and problem-solving response to a group session, counselling experience or interaction with a client. If the staff feel safe, this time can be used to discuss painful emotions such as grief anger and sadness. When combined with a second component dedicated to self-care, there is a more positive and comprehensive promotion of organizational and individual self-care. The last part of peer consultation can be used for meditation, bodywork, humor or cleansing rituals. Peer consultation is not a place to discuss the power dynamics of the agency or do policy development work. In an intense or crisis-focused environment, peer consultation may be needed on a weekly basis.

Retaining an external facilitator to conduct peer consultation may be a productive option for some groups

Action List:

- Recognize the link between performance, vicarious trauma, organizational culture and stress.
- Support flexibility in policy, practices and meeting staff needs.
- Develop definitions of peer consultation and performance supervision.
- Develop with staff the peer consultation process, including group guidelines.
- Provide regular, paid opportunities for all staff, including relief and part-time.
- Develop a performance management system based on a model that promotes continuous learning.

"I was hired as a supervisor – I spent most of my time counselling the staff instead of providing clinical supervision. In the end, staff, management and I were unhappy and I left bitter and angry."

–A counsellor in a community counselling agency

4.8.1 Clinical or Counselling Practices

Action List:

- Take breaks during the work day.
- Rotate through different job assignments or tasks.

which lack the experience or trusting environment. In some communities, there are supportive therapists well trained and tuned into the experiences of anti- violence workers. These individuals can provide a valuable, supportive perspec- tive. Recognize that not all therapists have the skills to succeed at group facilitation. If an external peer support is retained by the organization, the following guidelines recommend that the facilitator:

- have the experience and expertise to guide the process
- receive an orientation to the practices and policies of the organization
- sign a confidentiality waiver that ensures there will be no breach of confidentiality between the group and the organization
- agree to terms and conditions that include what peer consultation will pro- vide and not provide (In particular, the facilitator is not there to deal with power issues or policy matters of the agency.)
- agree that it is a conflict of interest to serve as a staff member, volunteer or member of the board of directors
- agree to an evaluation process
- agree to the terms of contract renewal and contract termination.

- Share or split job roles during a shift with co-workers.
- Decrease the size of caseloads.
- Have paper days and don't see clients.
- Provide regular debriefing and diffusing times.
- Work on special projects through grants or secondments.

Some work environments are more con- ducive to supporting self-care practices than others. Agencies that have some control over scheduling appointments can support the flexibility and needs of the counsellor. Exercising choice, such as booking out time to attend community meetings, to complete administrative tasks or take longer breaks for self-care, are healthy practices. Other environ- ments, such as shelters, will have a more difficult time controlling the environment. If staff regularly assess whether the situation is a crisis or a problem, this will help them to remain focussed on time management and limit crisis-focussed emotions and solutions. Shelter co- workers may be able to share or rotate through some of the work, such as answering the crisis line. Time built into the schedule for breaks should be honoured. This may mean going to a separate part of the building or to a staff quiet room for a break.

Making Connections

Part I: Who Are You Connected To?

Make a list of all of the relationships/connections that you maintain with people throughout a "typical" week (both in and outside of work).

Part II: The Relationship Pie

Take a look at the list you just made and then fill in the pie chart below by estimating the portion of time in a week that you spend with each person or group of people on your list. For example, you might consider how much time you spend with:

- Clients
- Co-workers
- Friends
- Church or other social group/community
- Family (however you define this group – feel free to divide this into time with partner, children, parents, siblings, etc.)
- Any additional relationships that you want to make note of on your pie chart.

What Is Your Stress Index?

Stress can be difficult to understand. The emotional chaos it causes can make our daily lives miserable. It can also decrease our physical health, sometimes drastically. Strangely, we are not always aware that we are under stress. The habits, attitudes and signs that can alert us to problems may be hard to recognize because they have become so familiar.

How high is your Stress Index? Find out by scoring your answers to the questions below.

Do You Frequently:	***YES***	***NO***
Neglect your diet?	___	___
Try to do everything yourself?	___	___
Blow up easily?	___	___
Seek unrealistic goals?	___	___
Fail to see the humour in situations others find funny?	___	___
Act rude?	___	___
Make a "big deal" of everything?	___	___
Look to other people to make things happen?	___	___
Have difficulty making decisions?	___	___
Complain you are disorganized?	___	___
Avoid people whose ideas are different from your own?	___	___
Keep everything inside?	___	___
Neglect exercise?	___	___
Have few supportive relationships?	___	___
Use sleeping pills and tranquillizers without a doctor's approval?	___	___
Get too little rest?	___	___
Get angry when you are kept waiting?	___	___
Ignore stress symptoms?	___	___
Put things off until later?	___	___
Think there is only one right way to do something?	___	___
Fail to build relaxation into your day?	___	___
Gossip?	___	___
Race through the day?	___	___
Spend a lot of time complaining about the past?	___	___
Fail to get a break from noise and crowds?	___	___

Score 1 for each “YES” answer, 0 for each “NO.”

Total your score YES_____ NO _____

What Your Score Means

1–6:	There are few hassles in your life. Make sure, though, that you are not trying so hard to avoid problems that you shy away from challenges.
7–13:	You’ve got your life in fairly good control. Work on the choices and habits that could still be causing you some unnecessary stress in your life.
14–20:	You’re approaching the danger zone. You may well be suffering stress-related symptoms and your relationships could be strained. Think carefully about choices you’ve made and take relaxation breaks every day.
Above 20:	Emergency! You must stop now, re-think how you are living, change your attitudes, and pay careful attention to diet, exercise and relaxation.

Transforming Compassion Fatigue into Compassion Satisfaction: Top 12 Self-Care Tips for Helpers

By Françoise Mathieu, M.Ed., CCC., Compassion Fatigue Specialist

Dr Charles Figley, world renowned trauma expert and pioneer researcher in the field of helper burnout has called compassion fatigue a "disorder that affects those who do their work well" (1995) It is characterized by deep emotional and physical exhaustion, symptoms resembling depression and PTSD and by a shift in the helper's sense of hope and optimism about the future and the value of their work. The level of compassion fatigue a helper experiences can ebb and flow from one day to the next, and even very healthy helpers with optimal life/work balance and self care strategies can experience a higher than normal level of compassion fatigue when they are overloaded, are working with a lot of traumatic content, or find their case load suddenly heavy with clients who are all chronically in crisis.

Compassion fatigue can strike the most caring and dedicated nurses, social workers, physicians and personal support workers alike. These changes can affect both their personal and professional lives with symptoms such as difficulty concentrating, intrusive imagery, loss of hope, exhaustion and irritability. It can also lead to profound shifts in the way helpers view the world and their loved ones. Additionally, helpers may become dispirited and increasingly cynical at work, they may make clinical errors, violate client boundaries, lose a respectful stance towards their clients and contribute to a toxic work environment.

It has been shown that, when we are suffering from compassion fatigue, we work more rather than less. What suffers is our health, our relationship with others, our personal lives and eventually our clients.

Assessing your own level of Compassion Fatigue

If would you like to assess your current level of Compassion Fatigue, visit Beth Stamm's website: www.isu.edu/~bhstamm/tests.htm. Dr Stamm and Charles Figley have developed a self-test called the Proquol (professional quality of life) that can be accessed via this site. They not only look at Compassion Fatigue, they also assess

helpers' level of *compassion satisfaction* which is "about the pleasure you derive from being able to do your work well." (Stamm, 1999) I have affectionately nicknamed this test "the thingy" as I find the name ProQuol rather unwieldy. If you are interested in obtaining a free self scoring excel version of this test, email our autoresponder: thingy@aweber.com and you will instantly receive the excel version, which is far easier to use than the original version.

Developing an Early Warning System for Yourself

I believe that compassion fatigue is a normal consequence of working in the helping field. The best strategy to address compassion fatigue is to develop excellent self care strategies, as well as an early warning system that lets you know that you are moving into the caution zone of Compassion Fatigue.

For the past 7 years, I have been training and assisting helpers in developing a better understanding of this complex occupational hazard. Here is a sample of my favourite self care strategies to transform compassion fatigue into compassion satisfaction.

Top 12 Self-Care Tips for Helpers

1. Take Stock-What's on your plate?

You can't aim to make changes and improvements without truly knowing where the problem areas are. Start by taking a nonjudgmental inventory of where things are at in your life. Make a list of all the demands on your time and energy (Work, Family, Home, Health, Volunteering, other). Try to make this list as detailed as you can. Eg: Under the Work category, list the main stressors you see (number of clients, or, amount of paperwork, or difficult boss, etc).

Once you have the list, take a look at it. What stands out? What factors are contributing to making your plate too full? Life situations or things you have taken on? What would you like to change most? If you are comfortable sharing this with a trusted friend or colleague, have a brainstorming discussion with them on strategies and new ideas. A counsellor or coach can also help you with this exercise. If you would like to read more on this, we highly recommend reading Cheryl Richardson's excellent book "**Take time for your life**" (1998).

2. Start a Self-Care Idea Collection

This can be fun. You can do it with friends and at work.
With friends: Over a glass of wine or a cappucino, interview three friends on their favourite self-care strategies. Start making a list even if they are not ideas that you would do/are able to afford at the moment. Something new might emerge that you had not yet thought of.

At work: If you are doing this at work, you could even start a contest for the best self care idea of the week or have a "self care board" where people post their favourite ideas. You could have a "5 minutes of self care" at each staff meeting, where someone is in charge of bringing a new self care idea each week.

Once you have a really nice long list, pick three ideas that jump out at you. Make a commitment to implementing these in your life within the next month. Ask a friend/colleague if they would commit to supporting you (and you them) in maintaining your self care goals. This could mean that they go to the gym with you every Thursday, or that they email you at lunch to remind you to get out of your office. This is a wonderful way to stay on track and to validate your own experiences by sharing them.

3. Find time for yourself every day – Rebalance your workload

Do you work straight through lunch? Do you spend weekends running errands and catching up on your week without ever having 20 minutes to sit on the couch and do nothing? Can you think of simple ways to take mini breaks during a work day? This could simply be that you bring your favourite coffee cup to work, and have a ritual at lunch where you close your door (if you have a door) and listen to 10 minutes of your favourite music. A friend of mine has a nap on her yoga mat at work during her lunch break. What would work for you?

Not everyone has control over their caseload, but many of us do, providing we see all the clients that need to be seen. Would there be a way for you to rejig your load so that you don't see the most challenging clients all in a row?

Make sure you do one nourishing activity each day. This could be having a 30 minute bath with no one bothering you, going out to a movie, or it could simply mean taking 10 minutes during a quiet time to sit and relax. Don't wait until all the dishes are done and the counter is clean to take time off. Take it when you can, and make the most of it. Even small changes can make a difference in a busy helper's life.

4. Delegate - learn to ask for help at home and at work

Here is a home-based example: Have you ever taught a 4 year old how to make a sandwich? How long would it take you to make the same sandwich? Yes, you would likely make it in far less time and cause far less mess in the kitchen, but at the end of the day, that four year old will grow into a helpful 10 year old, and one day, you won't have to supervise the sandwich making anymore. Are there things that you are willing to let go of and let others do their own way? Don't expect others to read your mind: consider holding a regular family meeting to review the workload and discuss new options. Think of this: If you became ill and were in hospital for the next two weeks, who would look after things on the home front?

5. Have a transition from work to home

Do you have a transition time between work and home? Do you have a 20 minute walk home through a beautiful park or are you stuck in traffic for two hours? Do you walk in the door to kids fighting and hanging from the curtains or do you walk into a peaceful house? Do you have a transition process when you get home? Do you change clothes?

Helpers have told us that one of their best strategies involved a transition ritual of some kind: putting on cozy clothes when getting home and mindfully putting their work clothes "away" as in putting the day away as well, having a 10 minute quiet period to shift gears, going for a run. One workshop participant said that she had been really missing going bird watching, but that her current life with young children did not allow for this. She then told us that her new strategy would be the following: From now on, when she got home from work, instead of going into the house straight away, she would stay outside for an extra 10 minutes outside, watching her birdfeeders. Do you have a transition ritual?

6. Learn to say no (or yes) more often

Helpers are often attracted to the field because they are naturally giving to others, they may also have been raised in a family where they were expected to be the strong supportive one, the parental child etc.

Are you the person who ends up on all the committees at work? Are you on work-related boards? Do you volunteer in the helping field as well as work in it? Are you the crisis/support line to your friends and family? It can be draining to be the source of all help for all people. As helpers, we know that learning to say no is fraught with self esteem and other personal issues and triggers. Do you think you are good at setting limits? If not, this is something that needs exploring, perhaps with a counsellor. Can you think of one thing you could do to say no a bit more often?

Conversely, maybe you have stopped saying yes to all requests, because you are feeling so depleted and burned down, feel resentful and taken for granted. Have you stopped saying yes to friends, to new opportunities?

Take a moment to reflect on this question and see where you fit best: Do you need to learn to say no or yes more often?

7. Assess your Trauma Inputs

Do you work with clients who have experienced trauma? Do you read about, see photos of, and are generally exposed to difficult stories and images at your work?
Take a *trauma input survey* of a typical day in your life. Starting at home, what does your day begin with? Watching morning news on tv? Listening to the radio or reading the paper? Note how many disturbing images, difficult stories, actual images of dead or maimed people you come across.

Now look at your work. Not counting direct client work, how many difficult stories do you hear, whether it be in a case conference, around the water cooler debriefing a colleague or reading files?

Now look at your return trip home. Do you listen to the news on the radio? Do you watch tv at night? What do you watch? If you have a spouse who is also in the helping field, do you talk shop and debrief each other?

It is important to recognize the amount of trauma information that we unconsciously absorb during the course of a day. Many helpers whom we meet say that they are unable to watch much of anything on television anymore, other than perhaps the cooking channel. Others say the reverse, that they are so desensitized that they will watch very violent movies and shows and feel numb when others around them are clearly disturbed by it.

In a nutshell, there is a lot of extra trauma input outside of client work that we do not necessarily need to absorb or to hear about. We can create a “trauma filter” to protect ourselves from this extraneous material.

8. Learn more about Compassion Fatigue and Vicarious Trauma

Compassion Fatigue (CF) and Vicarious Trauma (VT) are serious, profound changes that happen when helpers do their best work. Learn more about CF and VT, including ways to recognise the signs and symptoms and strategies to address the problem. Consider attending a workshop or read more on the topic. Visit our website for more information: www.compassionfatigue.ca or email us: whp@cogeco.ca

9. Consider Joining a Supervision/Peer Support Group

Not all places of work offer the opportunity for peer support. You can organise such a group on your own (whether it be face to face meetings or via email or phone). This can be as small as a group of three colleagues who meet once a month or once a week to debrief and offer support to one another.

10. Attend Workshops/Professional Training Regularly

Helpers with severe compassion fatigue often speak of feeling de-skilled and incompetent. Researchers in the field of CF and VT have identified that attending regular professional training is one of the best ways for helpers to stay renewed and healthy. There are of course several benefits to this: connecting with peers, taking time off work, and building on your clinical skills. Identify an area of expertise that you want to hone. If you are not able to travel to workshops, consider taking online courses.

11. Consider working part time (at this type of job)

Managers often cringe when we say this in our workshops, but studies have shown that one of the best protective factors against Compassion Fatigue is to work part time or at least, to see clients on a part time basis and to have other duties the rest of the time. There are some excellent books on this topic, such as ***Your money or your life*** by Joe Dominguez and Marsha Sinetar's ***Do what you love and the money will follow.***

12. Exercise

We tell our clients how important physical exercise is. Do you do it on a regular basis? Can you think of three small ways to increase your physical activity? One busy counselling service hired a yoga instructor to come once a week to their office and everyone chipped in their 10$ and did yoga together at lunch. Another agency said that they had created a walking club, and that a group of helpers walk outside for 30 minutes three times a week. The key to actually increasing physical exercise is to be realistic in the goals we set out for ourselves. If you don't exercise at all, aiming to walk around the block twice a week is a realistic goal, running a 10km run in two weeks is not.

Conclusion: "Dig where the ground is soft" *Chinese proverb*

When I was training in couples counseling with Dr Les Greenberg, he always used to say "when you are working with couples, dig where the ground is soft. Work with the client who seems most ready to change, not with the client who seems most closed and defensive." Instead of picking your trickiest area, pick the issue that you can most easily visualise improving on. (eg: "making a commitment to going for a walk every lunch time vs getting rid of my difficult supervisor").

You may not notice it right away, but making one small change to your daily routine can have tremendous results in the long term. Imagine if you started walking up two flights a stairs per day instead of using the elevator, what might happen after three months?

For more information on Compassion Fatigue Workshops and resources:
Contact Françoise Mathieu at: whp@cogeco.ca
www.compassionfatigue.ca

Françoise Mathieu is a Certified Mental Health Counsellor and Compassion Fatigue Specialist. She works individually with clients in private practice and offers workshops and consultation to agencies on topics related to compassion fatigue, wellness and self care. She and a colleague created Cameron & Mathieu Consulting in 2001 (now called WHP-Workshops for the Helping Professions) to provide workshops to helpers with a focus on personal and professional renewal.

WHP offers practical, skill-based workshops on various topics related to compassion fatigue, burnout and stress management. For more information and resources, contact Françoise Mathieu: (613) 547-3247; whp@cogeco.ca or visit our website:

www.compassionfatigue.ca

www.compassionfatigue.ca.

Recommended books on Compassion Fatigue and Vicarious Trauma:

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

McCann, I.L.; & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3: 131 - 149.

Stamm, B.H. (Ed.). (1999). Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators, 2nd Edition. Lutherville, MD: Sidran Press.

Recommended Self-Care books for Helpers:

Borysenko, J. (2003) Inner peace for busy people: 52 simple strategies for transforming your life.

Fanning, P. & Mitchener, H. (2001) The 50 best ways to simplify your life

Jeffers, S. (1987) Feel the fear and do it anyway.

O'Hanlon, B. (1999) Do one thing different: 10 simple ways to change your life.

Posen, D. (2003) Little book of stress relief.

Richardson, C. (1998) Take time for your life.

SARK, (2004) Making your creative dreams real: a plan for procrastinators, perfectionists, busy people, avoiders, and people who would rather sleep all day.

Weiss , L. (2004) Therapist's Guide to Self-care.

Principles of the Better Beginnings and Better Futures Association:

- **Promote Forums for Participation**
- **Create Egalitarian work relationships**
  - policies include responsibilities during disagreement, including mediation and arbitration
  - teams develop program goals, develop and negotiate budgets and administer the programs
- **Nourish Daily**
  - give value and relevance to small details of daily living
  - respect the social, emotional, physical and intellectual well-being of members
  - include sharing food at meetings, celebrations and circles
- **Caring for Caregivers**
  - provide training during orientation and on an ongoing basis on cultural sensitivity, team management, mediation and conflict resolution
  - accept that staff have family commitments, staff exercise their own judgment when to work at home
- **Expand the Capacity to Act Powerfully**
  - take charge of personal areas of responsibility and work in small groups
  - learn how to develop our own power
  - give hiring priority to community residents
- **Nurture Partners and Network**
  - a community advisory committee meets twice a year to support projects and fund raising

(Modlich, 1999)

Guidelines for a Vicarious Trauma-Informed Organization

Peer Support

WHAT IS A VICARIOUS TRAUMA-INFORMED ORGANIZATION?

Vicarious trauma (VT), the exposure to the trauma experiences of others, is an occupational challenge for the fields of victim services, emergency medical services, fire services, law enforcement, and others. Working with victims of violence and trauma changes the worldview of responders and puts individuals and organizations at risk for a range of negative consequences (Bell, Kulkarni, and Dalton, 2003; McCann and Pearlman, 1990; Newell and MacNeil, 2010; Vicarious Trauma Institute, 2015; Pearlman and Saakvitne, 1995; Knight, 2013). A ***vicarious trauma-informed organization*** recognizes these challenges and proactively addresses the impact of vicarious trauma through policies, procedures, practices, and programs.

For more information on vicarious trauma and its effects, visit https://vtt.ovc.ojp.gov/.

(NOTE: Although these guidelines were created by a victim services organization, they contain insights and practices that first responder organizations can modify for their own use.)

What Is Peer Support?

Peer support is a broad term that describes varied structures for worker-to-worker (rather than supervisor-to-worker) engagement so employees do not feel isolated and to help them address the impact of their exposure to trauma. Related terms include peer consultation, peer coaching, and peer debriefing, among others. Whether the peer support occurs between individuals or in groups, it provides colleagues with meaningful support and feedback, and helps leaders manage the consequences of VT among their staff and volunteers. It fosters a culture of caring, mutual support, professional self-awareness, and positive and constructive feedback (Pearlman and Saakvitne, 1995; Choi, 2011; McCann et al., 2013). Effective organizational leaders recognize, respect, and promote the value of peer support and create structured opportunities that are responsive to staff's needs. Peer support is most effective as an addition to regular, formal supervision, not a replacement for it. A few examples follow:

Peer-to-peer support: While informal support often occurs between colleagues, this is a more formal, regularly scheduled option that is typically one-to-one, has a specific purpose, and is promoted and supported by the organization's leadership.

Peer supervision: A peer or other designated facilitator can serve as a group leader or take on informal supervisory responsibilities. When agencies provide relevant training for peer leaders, they can build their facilitation and debriefing skills, which ultimately benefits their colleagues as well. Peer supervision groups meet on a regular basis, are well supported by the organization's leadership, and enable staff and volunteers to identify, discuss, and address the effects of VT.

Peer support and peer supervision address vicarious trauma by—

- engendering mutual respect among participants, a key component of employee empowerment and effective work environments (Ortlepp and Friedman, 2002);
- increasing knowledge, empathy, and effective communication and feedback skills;
- creating opportunities to discuss the positive and negative effects of the work outside of formal supervision (Trippany, Kress, and Wilcoxon, 2004);
- establishing a pathway for raising issues with supervisors in safe and productive ways (Bell, Kulkarni, and Dalton, 2003);
- identifying gaps in staff knowledge and addressing them through education and building professional confidence;
- enabling participants to learn additional coping strategies from their colleagues that address the complexities and emotional effects of their work (McCann et al., 2013);
- developing leadership skills and serving as role models for one another (Trippany, Kress, and Wilcoxon, 2004; Catherall, 1995).

Recommendations for Developing a Peer Support/Peer Supervision Program

Consider the type of peer support or peer supervision model that is best for your organization and staff: informal one-to-one peer support, formally structured peer-to-peer group debriefing, an alternative form of each, or a combination of the two. Instituting peer support and peer supervision presents both opportunities and challenges for

your organization. Whatever model you choose, thoughtful planning and implementation will help you achieve positive outcomes. The following tips can assist you in your efforts:

- Establish confidentiality protocols at the outset and ensure compliance with them.
- Identify, recruit, and train motivated and aspiring peer leaders within the organization.
- Develop agreements aimed at building trust and transparency, including—
  - a statement of purpose and intended outcomes for participants that includes specific references to the impact of vicarious trauma;
  - expectations, rights, and responsibilities of participants, including attendance and confidentiality requirements;
  - a transparent plan that is clearly communicated organization-wide and that includes procedures for how members join and end their involvement in the group, how equitable participation is ensured, how the group is facilitated, and its duration; and
  - evaluations that solicit input and feedback from participants to ensure that staff are satisfied and have achieved the stated goals.

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For more information about vicarious trauma, visit https://vtt.ovc.ojp.gov/.

Employee Satisfaction and Wellness

Case Study

For the past three years, Son-yah has worked as a Service Coordinator at a non-profit, victim assistance organization called SAFE! . She has a caseload of 20 families, and is responsible for providing case management and coordinating services for the families.

Son-yah reports to several supervisors, and she is unclear about what is expected of her. When she was hired, Son-yah asked one of her supervisors, Margot, for a job description. Margot told her that they would create one for her, but reminded her that SAFE! staff "wear many hats." She has mentioned her lack of job description several times since her initial conversation with Margot, but every time, Margot replies that "you don't need a description. You already know what to do."

One of the things that attracted Son-yah to the Service Coordinator position was the idea that she would be working on a team for an agency committed to helping families However, her multiple supervisors don't communicate with one another effectively, which leaves Son-yah feeling frustrated and confused. This is particularly apparent when the challenges and demands of work become excessive. Son-yah's work load has increased steadily over the past few years, and she sometimes works long hours to meet unrealistic deadlines.

The rest of the staff at SAFE! struggle with the same issues as Son-yah does. Staff turn-over is high, as is absenteeism, sick days and tardiness. Staff find it difficult to do their work and find themselves under constant pressure. This has created a sense of powerlessness to solve problems and a lack of teamwork. At the agency, job autonomy is low. Another issue is the lack of recognition by the organization that the case management staff are the ones who carry out the organization's mission every day, working with complicated cases and putting in long hours to meet agency deadlines.

Son-yah loves her clients and is committed to staying at SAFE!, but recognizes that the current structure isn't working. She has been on staff longer than most of the case managers, and is ready to do something about the poor work conditions, but she doesn't know where to start. She has scheduled a meeting next week with Giorgio, one of her supervisors, to talk about these issues. She thinks that out of everyone on the management team, he will be the most receptive, but she is still nervous about voicing her concerns because the management staff is notoriously unsympathetic to such conversations. She worries that if she does not clearly communicate her concerns and suggestions that the management staff will respond with more micromanagement, which only serves to diminish staff morale, self-esteem, and confidence.

Discussion Questions

1. What are the main problems facing Son-yah and other SAFE! staff?
2. What recommendations would you make to the agency to improve staff morale?
3. What recommendations would you make to Son-yah for her conversation with Georgio?
4. What steps can SAFE! take in the short-term to change the organizational culture? In the long term?
5. What are the benefits to the organization of putting better staff practices and policies into place? What are benefits to staff?
6. If you were hired as a manager at SAFE!, what would you do?

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.

Ohio Domestic Violence Network

ODVN

Ohio Domestic Violence Network

Your Scores On The ProQOL: Professional Quality of Life Screening

For more information on the ProQOL, go to http://www.isu.edu/~bhstamm

Based on your responses, your personal scores are 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.

Vicarious Trauma/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.

Advocate Be Well

I know, I am who I am and that I am not what I do.

I know I need to lead a balanced life while at home and at work.

I know that suffering and beauty co-exist in this world.

I know I need to nourish my body and soul with nutrition, love, inspiration, laughter, sleep and being present in my whole life.

I know survivors, -child, teen and adult- each deserve my best in being present while supporting their choices.

I am drinking 8 glasses of water daily.

I am practicing, breathing and centering knowing I can access my inner place of calm by pausing and then responding.

I know it is okay to begin each day while at work with awareness of being enough and leaving at the end of the day with intention ~ honoring the babies, children, teens, men and women ~ that I serve. It matters that I leave this work at work.

I know having healthy boundaries is not selfish of me in order to come back to this work everyday.

I know it is critical and necessary to have laughter, joy, tears and people in my life.

I know I can close my eyes amidst the busyness of this work, center myself with 3 deep breaths in and out and then respond to who I am interacting with.

I know I may journal, sing loudly, laugh hard, move often and experience gratitude.

I know survivors, both child and adult, deserve my best in being present while supporting them in their lives.

I know what my body is telling me and I know to pay attention to this message & respond with loving kindness towards myself making healthy choices even when I might not want too—noticing my resistance.

I know that beauty and suffering co-exist in our world.

I know I am accountable for my choices, my words my action and my care of my own life.

I know I have only to breathe in and out deeply, to come back to my inner place of calm and peace- grounding me.

~Sdcf~

Organizational Assessment

Organizational Assessment

As part of an implementation planning process, it is invaluable for an agency to examine the current status of its efforts to address Vicarious Trauma. This information can be gathered from the staff via interviews, focus groups, and/or surveys; and through the review of relevant documents such as policy and procedure manuals.

The recently developed *Secondary Traumatic Stress-Informed Organization Assessment* (*STSI-OA31*; Sprang et al., 2014) can be used to inform an agency's self-assessment. The *STSI-OA* examines policies and practices for addressing STS and is designed to be completed by staff at all levels of an organization. The tool examines the extent to which:

- Resilience-building activities and physical and psychological safety are promoted
- Policies, leadership practices, and routine organizational practices are VT-informed
- VT policies are evaluated and monitored

31 *Secondary Traumatic Stress-Informed Organization Assessment (STSI-OA)* available at http://www.uky.edu/CTAC/STSI-OA

As part of ongoing efforts to make changes in an agency's response to Vicarious Trauma, it recommended that a process be created to regularly obtain feedback on implementation efforts from all levels of staff in an organization. This feedback can be collected formally through surveys, interviews, and focus groups or more informally, for example, through discussions in staff meetings. In addition to helping determine whether policies and procedures are implemented as planned, this collected information can identify challenges to implementation. Gathering feedback and making modifications based on this feedback is an important foundation for successful implementation.

In order to evaluate the results of implementation efforts, it is also important to collect data over time on indicators that are linked to the targeted policies, practices, or training activities. See the following box for areas that might be assessed.

Areas that Might Be Assessed

- Staff perception of organizational policies and practices to address VT (such as with the STSI-OA described above)
- Staff satisfaction with agency efforts to address VT\
- Level of VT in the workforce
- Knowledge acquisition associated with training activities
- Other organizational indicators that could potentially be monitored include use of staff retention/turnover, use of sick leave, and general employee satisfaction

TAKING OUR PROGRAMMATIC TEMPERATURE

Please fill out the chart from the BOTTOM TO THE TOP, and circle where your program is today

Describe how your program looks when it is overwhelmed by stress

_____
_____
_____
_____

Describe how the program looks when things are very busy and beginning to feel overwhelming

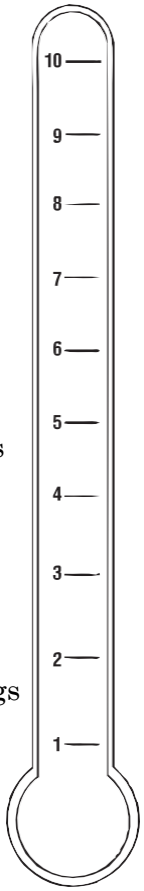
_____
_____
_____

Describe what your program looks like when things start getting busier and more stressful.

_____
_____
.
_____
_____

Describe what the program looks like when things are calm
and running smoothly

_____
_____
_____
_____



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The Secondary Traumatic Stress-Informed Organization Assessment (STSI-OA)

Secondary Traumatic Stress (STS) affects our personnel, organizational structure, policies and procedures in both subtle and overt ways. Although many organizations working with individuals exposed to trauma acknowledge that STS is present in their workforce, they may need guidance on how to reduce risk and promote staff wellness and resilience. This assessment tool will give organizations an opportunity to engage in self-assessment to determine the impact of STS in their organization and, combined with an overall trauma-informed organizational change framework, support strategic planning in specific areas of need.

Secondary Traumatic Stress refers to the trauma symptoms caused by indirect exposure to traumatic material, transmitted during the process of helping or wanting to help a traumatized person.

Resilience is an individual's ability to adapt to stress and adversity in a healthy manner.

Organization, as used in this context, refers to the workplace setting that will be the target of this assessment.

Next to each assessment item in these domains are choices based on the degree to which the organization is addressing the specified practice or protocol, including “Not at All,”Rarely", “Somewhat,” “Mostly” and “Completely”.

After reading each item, place a check mark under the appropriate choice as to how the organization performs on that indicator. These indicators can provide you with a map or framework to guide organizational change.

Center on Trauma and Children

Evidence in Action

The Secondary Traumatic Stress Informed Organization Assessment (STSI-OA)

1. The organization promotes resilience-building activities that enhance the following:

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. Basic knowledge about STS	◯	◯	◯	◯	◯	◯
b. Monitoring the impact of STS on professional well-being.	◯	◯	◯	◯	◯	◯
c. Maintaining positive focus on the core mission for which the organization exists	◯	◯	◯	◯	◯	◯
d. A sense of hope (e.g., a belief in a clients' potential for trauma recovery, healing and growth)	◯	◯	◯	◯	◯	◯
e. Specific skills that enhance a worker's sense of professional competency	◯	◯	◯	◯	◯	◯
f. Strong peer support among staff, supervisors and staff and/or outside consultants	◯	◯	◯	◯	◯	◯
g. Healthy coping strategies to deal with the psychological demands of the job	◯	◯	◯	◯	◯	◯

2. To what degree does the organization promote a sense of safety?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization protects the physical safety of staff using strategies or techniques to reduce risk (e.g. panic buttons, security alarms, multiple staff, etc.)	◯	◯	◯	◯	◯	◯
b. Staff in the organization are encouraged to not share graphic details of trauma stories unnecessarily with co-workers	◯	◯	◯	◯	◯	◯
c. Periodically, the organization conducts a safety survey or forum that assesses worker perceptions of psychological safety	◯	◯	◯	◯	◯	◯
d. Periodically, the organization conducts a safety survey or forum that assesses worker perceptions of physical safety	◯	◯	◯	◯	◯	◯
e. Organizational leaders manage risk appropriately and protect workers as much as possible from dangerous clients and/or situations	◯	◯	◯	◯	◯	◯
f. The organization provides training on how to manage potentially dangerous situations (e.g., angry clients)	◯	◯	◯	◯	◯	◯
g. The organization has a defined protocol for how to respond to staff when critical incidents occur	◯	◯	◯	◯	◯	◯

3. How STS-informed are organizational policies?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a.The organization has defined practices addressing the psychological safety of staff	◯	◯	◯	◯	◯	◯
b. The organization has defined practices addressing the physical safety of staff	◯	◯	◯	◯	◯	◯
c. The organization has defined procedures to promote resilience-building in staff (e.g. self-care workshops)	◯	◯	◯	◯	◯	◯
d. The organization's strategic plan addresses ways to enhance staff resiliency	◯	◯	◯	◯	◯	◯
e. The organization's strategic plan addresses ways to enhance staff safety	◯	◯	◯	◯	◯	◯
f. The organization has a risk management policy in place to provide interventions to those who report high levels of STS	◯	◯	◯	◯	◯	◯

4. How STS-informed are the practices of leaders (executive directors, CEOs, COOs, administration, etc..)?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. Leadership actively encourages self-care	◯	◯	◯	◯	◯	◯
b. Leadership models good self-care	◯	◯	◯	◯	◯	◯
c. Staff provides input to leaders on ways the organization can improve its policies and practices regarding STS.	◯	◯	◯	◯	◯	◯
d. Supervisors promote safety and resilience to STS by routinely-attending to the risks and signs of STS	◯	◯	◯	◯	◯	◯
e. Supervisors address STS by referring those with high levels of disturbance to trained mental health professionals	◯	◯	◯	◯	◯	◯
f. Supervisors promote safety and resilience to STS by offering consistent supervision that includes discussion of the effect of the work on the worker	◯	◯	◯	◯	◯	◯
g. Supervisors promote safety and resilience to STS by offering additional supervision during times of high risk for STS	◯	◯	◯	◯	◯	◯
h. Supervisors promote safety and resilience to STS by intentionally managing caseloads and case assignments with the dose of indirect trauma exposure in mind	◯	◯	◯	◯	◯	◯
i. Leadership responds to STS as an occupational hazard and not a weakness	◯	◯	◯	◯	◯	◯

5. How STS-informed are other routine organizational practices?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization provides formal trainings on ways to enhance psychological safety	◯	◯	◯	◯	◯	◯
b. The organization provides formal trainings on ways to enhance physical safety	◯	◯	◯	◯	◯	◯
c. The organization provides formal trainings on enhancing resilience to STS	◯	◯	◯	◯	◯	◯
d. The organization offers activities (besides trainings) that promote resilience to STS	◯	◯	◯	◯	◯	◯
e. The organization discusses STS during new employee orientation	◯	◯	◯	◯	◯	◯
f. The organization has regular opportunities to provide team and peer-support to individuals with high levels of exposure	◯	◯	◯	◯	◯	◯
g. The organization provides release time to allow employees to attend trainings focused on reslience building or STS management	◯	◯	◯	◯	◯	◯

6. How well does the organization evaluate and monitor STS policies and practices?

	Not at all	Rarely	Somewhat	Mostly	Completely	N/A
a. The organization assesses the level of STS in the workplace	◯	◯	◯	◯	◯	◯
b. The organization routinely monitors workforce trends (e.g. attrition, absenteeism) that may signify a lack of safety or an increase in STS	◯	◯	◯	◯	◯	◯
c. The organization responds to what it learns through evaluation, monitoring and/or feedback in ways that promote safety and resilience	◯	◯	◯	◯	◯	◯
d. The organization routinely seeks feedback from the workforce regarding psychosocial trends that may signify an increase in STS (e.g. increased conflict, social isolation)	◯	◯	◯	◯	◯	◯

7. What is your gender?

◯ Female

◯ Male

8. What is your age?

◯ 18 to 24

◯ 25 to 34

◯ 35 to 44

◯ 45 to 54

◯ 55 to 64

◯ 65 to 74

◯ 75 or older

9. Within which of the following service systems do you do the majority of your work with traumatized clients?

- ◯ Child welfare
- ◯ Community Mental Health
- ◯ Juvenile Justice
- ◯ Educational or School Setting
- ◯ Healthcare
- ◯ First Responder Groups (e.g. police, fire, paramedics)
- ◯ Tribal settings

Other (please specify)

10. What is your job role?

- ◯ Volunteer
- ◯ Intern
- ◯ Front Line Worker
- ◯ Clinician
- ◯ Supervisor
- ◯ Manager
- ◯ Senior Manager
- ◯ C-Level- CEO, Executive Director, COO, etc..
- ◯ Other

11. Roughly how many full-time employees currently work for your organization?

- ◯ 1-10
- ◯ 11-50
- ◯ 51-200
- ◯ 201-500
- ◯ 501-1,000
- ◯ 1,001-5,000
- ◯ 5,001-10,000
- ◯ 10,000+
- ◯ I am currenlty not employed

12. How many years have you worked as a professional helper

- ◯ 0-2 years
- ◯ 3-5 years
- ◯ 6-10 years
- ◯ 11-20 years
- ◯ 21+ years

Looking back at your responses on the stress thermometer in Activity #3.1, identify what types of supports are helpful and motivating for workers at each step on the thermometer (e.g., what people need as the stress level rises). It is also helpful to identify what is not helpful as the stress temperature rises.

When…	**What is helpful**	**What is NOT helpful**
the organization *is overwhelmed*		
things are *very busy and stressful*		
things are *beginning to get busier and more stressful*		
things are *calm and running smoothly*		

Critical Incident Debriefing

Critical Incident Debriefing

Addressing the impact of Vicarious Trauma is critical throughout all levels of the organization, and throughout the phases of the workforce highlighted in this manual, including the hiring phase, critical first three months, and as an approach to the cumulative effect of the work. However, there are circumstances that occur in anti-violence work that lead to a need for an incident-based focus as well. Critical incidents in this line of work are events that happen outside the range of what is considered normal or usual.

California State University Fullerton researcher, Dr. Joseph Davis, PhD, (2013) describes critical incidents as "any situation or event faced by emergency, public safety personnel, or employees that cause a distressing, dramatic or profound change or disruption in their physical or psychological functioning".

Examples of a Critical Incident in Anti-Violence Work

- Adult/Child/Teen fatality
- Severe physical abuse
- Severe sexual abuse
- Homicide due to domestic violence
- Violence against staff
- Bereavement due to death of a staff member
- Unsafe visits between child and parent
- Death or serious injury of staff member's family member
- Community violence or world events

Key Elements of a Critical Incident Debriefing

There are some key elements that should be included in any program offering assistance to help overcome these challenges:

- Allow for debriefing by a neutral party, whenever possible: Debriefing should focus on current stress reactions experienced by staff, not on the details of the case. As a general guideline, Pulido and Lacina (2010) recommend holding a debriefing session 24-72 hours after the critical incident, however there may be times when this is not possible or in the best interest of those involved.
- Allow the option for time off: This could include only those most involved or impacted by the critical incident, or an entire team/department, if warranted.
- Develop a peer support team: The use of peer support interventions have been shown to promote recovery from traumatic stress. Specifically with critical incident debriefing, peer support can improve coping and decrease the occurrence of PTSD and enhance a group's reaction to traumatic events by lowering tension among the group (National CI Peer Support, n.d.).
- Consider providing case consultation on high-risk cases: While this strategy may not reduce all types of critical incidents, it may prevent or reduce certain case-specific incidents like unsafe visits or violence/threats to staff. This is an attempt to intervene before a critical incident occurs, provides support to staff, and sends the message that protecting the safety of staff and clients is a team effort.
- Consider other prevention efforts: Having a supervisor go out with a worker on a difficult home visits or allowing workers to go out in pairs can be very effective.

Models of Critical Incident Debriefing

There are a few models described in the literature, however it is important to note that research on the effectiveness of these models in anti-violence settings is sparse:

Critical Incident Stress Debriefing (CISD)

CISD was developed by Jeffery Mitchell and George Everly for use with paramedics, firefighters, and law enforcement, but has been utilized with other groups outside of emergency service professionals (Mitchell, n.d.). While it was not developed specifically for child welfare workers, the concepts of the model are appropriate for debriefing of a host of critical incidents. CISD is a small-group, crisis-focused discussion of a traumatic event. CISD sessions may take 1-3 hours to complete, depending on a number of variables, including number of participants and severity of the event. Sessions move through 7 phases, with an overall goal to reduce stress and restore group cohesion. This occurs through a structured small group process, with a focus on psychoeducation and normalizing group members;' reactions. CISD attempts to enhance resistance to stress reactions, build resiliency after a traumatic experience, and facilitate a recovery from traumatic stress and a return to normal, healthy functions. For more info on CISD, please visit the CISD website.[28]

Psychological First Aid (PFA)

PFA is an evidence-informed approach designed to reduce the occurrence of PTSD that can be utilized in the aftermath of a disaster or significant critical incident. The approach was developed by the National Child Traumatic Stress Network

(NCTSN) and the National Center for PTSD. The goal of PFA is to ―reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses‖ (Brymer et al., 2006, p. 8). PFA is offered online, as a 6-hour course through the NCTSN. PFA is a disaster response model intended for professionals providing support to those impacted by the event. The online course also consists of a Learning Community, allowing participants the opportunity share their experience using PFA in the field, receive guidance during times of disaster, obtain additional resources and training, and learn from others who have implemented PFA (National Child Traumatic Stress Network, n.d.). To learn more about PFA, or to enroll in the online course, visit the NCTSN website.[29]

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[28] *Critical Incident Stress Debriefing (CISD)* available at http://www.info-trauma.org/flash/media-f/mitchellCriticalIncidentStressDebriefing.pdf

[29] *Psychological First Aid Online* – National Child Traumatic Stress Network available at

http://learn.nctsn.org/course/index.php?categoryid=11

Restoring Resiliency Response (RRR) Model

The RRR Model is a teaching approach developed by the NYSPCC specifically for implementation with child welfare workers in New York City (Pulido & Lucina, 2010). The model was developed to address the needs of child welfare workers and to provide support and strategies to manage the unique stressors associated with the job. The protocol aims to provide education about symptoms and is not designed to review what went right or wrong with the case. The RRR protocol focuses on the current stress reactions experienced by workers. The goal of the RRR protocol is to accelerate the recovery process by integrating education, emotional expression, and cognitive restructuring. RRR sessions are 75 minutes in duration, and consist of activities focused on evaluating the current level of stress and symptoms, validating reactions to the critical incident, identifying supports, and introducing coping and relaxation techniques NYSPCC provides debriefing sessions using the RRR model to agencies across New York City and Westchester County. Child welfare agencies who are interested in learning more about implementing the RRR model, or an adapted version that works for their jurisdiction, can contact the Executive Director of NYSPCC, Mary
L. Pulido, PhD, at mpulido@nyspcc.org to learn more. NYSPCC provides training on this model throughout the United States. For more information and a step-by-step guide to implementing the RRR Model, please visit the NYSPCC website.[30]

Critical Incident Plan

Emergency Kit

The sealed kit is opened by staff following a critical incident. The kit contains a procedural checklist, a pamphlet on coping with a critical incident and contact lists for police, health care, executive director and management, and trained debriefers.

Management Visit

A management staff member immediately attends on site and usually becomes the designated team leader. Management is trained in defusing and provides immediate support to staff and volunteers. The manager will generally contact and arrange for the trained debriefer and peer support.

Peer Support or Debriefer

Debriefers are trained in debriefing techniques and have agreed to be contacted at any time. The debriefing follows a standard format as provided in the CISD training. Debriefers are sensitive to the anti-violence environment.

Debriefing Session

Staff directly involved in the acute incident attend a session within 72 hours of the event. The written policy confirms this, including confirmation that it is paid time. This is generally mandatory attendance for those primarily affected.

Time Off

Trauma leave is included in the personnel policies and is linked to compassionate leave. Flexibility will be required, depending on individual circumstances. The policy supports time off and a graduated return to work.

Health Screening

Screening and assessment are monitored for two years following the acute incident – using assessment checklists and informal check-ins. Note: Use standard measures for individual stress management scales. These scales are useful to alert an individual to how they are responding to stress over time.

Peer Support and Debriefing

Peer support and debriefing will continue as required. Debriefing will likely be required over a period of time, decreasing in frequency as time passes.

Positive Management Gesture

Visits, gestures of support and letters of recognition that support the difficult experience that staff went through are provided.

Personal Therapy

Provision for confidential supportive therapy is available. If there is no extended health care plan in place, the organization will cover the costs of these sessions.

LOW IMPACT DEBRIEFING

Debriefing is an important aspect of dealing with trauma and vicarious trauma—but we must remember that what we share also has an impact on the listener. One way to help ensure that we are not unwittingly traumatizing our colleagues and friends is to practice Francoise Mathieu's Low Impact Debriefing strategy.

Low Impact Debriefing is a four-step process:	
1.	**Increased Self-Awareness** How do you debrief when you have heard or seen hard things? Take a survey of a typical work week and note all of the ways in which you formally and informally debrief yourself with your colleagues. How much detail do you (or your colleagues) provide?
2.	**Fair Warning** Before you tell anyone around you a difficult story, you must give them fair warning. When you call someone with bad news, you often give them warning—for instance, "are you sitting down?"
3.	**Consent** Once you have given warning, you need to ask for consent. This can be as simple as saying: "I need to debrief something with you, is this a good time?" or "I heard something really hard today, and I could really use a debrief. Could I talk to you about it?" The listener then has a chance to decline, or to qualify what they are able/ready to hear.
4.	**Low Impact Disclosure** When you have received consent from your colleague, you can decide how much to share. Imagine that you are telling a story starting with the outer circle of the story (i.e. the least traumatic information) and you are slowly moving in toward the core (the very traumatic information) at a gradual pace. Think about what it is you need to share in order to process your feelings and reactions to the story.

Keep in mind that when someone comes to share information with you, you also can practice setting boundaries when you don't feel you are in a place to be supportive.

Adapted from *Low Impact Debriefing: Preventing Retraumatization*, Françoise Mathieu, 2008.

Critical Incident Stress Debriefing (CISD)

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Introduction and Definition of CISD:

The term "debriefing" is widely used and means many different things. In fact, there are many different types of "debriefings" in use in the world today. Most forms of debriefing do not equate to the "Critical Incident Stress Debriefing." One needs to be very careful and know exactly what type of debriefing they are discussing. Precision in the use of terminology is extremely important. Inaccurate definitions lead to faulty practice and flawed research.

Critical Incident Stress Debriefing *(CISD) is a specific, 7-phase,* ***small group****, supportive crisis intervention process.* It is just one of the many crisis intervention techniques which are included under the umbrella of a Critical Incident Stress Management (CISM) program. The CISD process does not constitute any form of psychotherapy and it should never be utilized as a substitute for psychotherapy. It is simply a supportive, crisis-focused discussion of a traumatic event (which is frequently called a "critical incident"). The Critical Incident Stress Debriefing was developed exclusively for small, *homogeneous groups* who have encountered a powerful traumatic event. It aims at reduction of distress and a restoration of group cohesion and unit performance.

A Critical Incident Stress Debriefing can best be described as a psycho-educational small group process. In other words, it is a structured group story-telling process combined with practical information to normalize group member reactions to a critical incident and facilitate their recovery. A CISD is only used in the aftermath of a significant traumatic event that has generated strong reactions in the personnel from a particular homogeneous group. The selection of a CISD as a crisis intervention tool means that a traumatic event has occurred and the group members' usual coping methods have been overwhelmed and the personnel are exhibiting signs of considerable distress, impairment or dysfunction.

The Facilitators

The CISD is led by a specially trained team of 2 to 4 people depending on the size of the group. The typical formula is one team member for every 5 to 7 group participants. A minimal team is two people, even with the smallest of groups. One of the team members is a mental health professional and the others are "peer support personnel." A unique feature of CISD is that Critical Incident Stress Management trained peer support personnel (firefighters, paramedics, police officers, military personnel, etc.) work with a mental health professional when providing a CISD to personnel from law enforcement, fire service, emergency medical, military, medical, aviation and other specialized professions. A peer is someone from the same profession or who shares a similar background as the group members. Police officers, for instance, who have been trained in Critical Incident Stress Management techniques, are selected to work with police officers who have been through the traumatic event. Fire service personnel with CISM background are chosen to work with firefighters and CISM trained emergency medical or military personnel will be placed on teams running a Critical Incident Stress Debriefing with their respective groups and so on.

Essential Concepts in CISD

A Critical Incident Stress Debriefing is small group "psychological first aid." The primary emphasis in a Critical Incident Stress Debriefing is to inform and empower a homogeneous group after a threatening or overwhelming traumatic situation. A CISD attempts to enhance resistance to stress reactions, build resiliency or the ability to "bounce back" from a traumatic experience, and facilitate both a recovery from traumatic stress and a return to normal, healthy functions.

The Critical Incident Stress Debriefing is ***not*** a stand-alone process and it is only employed within a package of crisis intervention procedures under the Critical Incident Stress Management umbrella. A CISD should be linked and blended with numerous crisis support services including, but not limited to, pre-incident education, individual crisis intervention, family support services, follow-up services, referrals for professional care, if necessary, and post incident education programs. The best effects of a CISD, which are enhanced group cohesion and unit performance, are always achieved when the CISD is part of a broader crisis support system.

Historical Perspective and Theoretical Foundations

Critical Incident Stress Debriefing was developed by Jeffrey T. Mitchell, Ph.D. in 1974 for use with small homogeneous groups of paramedics, firefighters and law enforcement officers who were distressed by an exposure to some particularly gruesome event. It is firmly rooted in the crisis intervention and group theory and practices of such notables as Thomas Salmon, Eric Lindemann, Gerald Caplan, Howard

Parad, Lillian Rapoport, Norman Faberow, Calvin Frederick and Irvin Yalom. The first article on CISD appeared in the *Journal of Emergency Medical Services* in 1983.

Over time, the use of Critical Incident Stress Debriefing spread to other groups outside of the emergency services professions. The military services, airlines, and railroads find the process helpful. This is particularly so when it is combined and linked to other crisis intervention processes. Businesses, industries, hospitals, schools, churches and community groups eventually adopted the Critical Incident Stress Debriefing model as an integral part of their overall staff crisis support programs.

Objectives

A Critical Incident Stress Debriefing has three main objectives. They are: 1) the mitigation of the impact of a traumatic incident, 2) the facilitation of the normal recovery processes and a restoration of adaptive functions in psychologically healthy people who are distressed by an unusually disturbing event. 3) A CISD functions as a screening opportunity to identify group members who might benefit from additional support services or a referral for professional care.

Required Conditions for the Application of the CISD Process

The Critical Incident Stress Debriefing requires the following conditions:
1) The small group (about 20 people) must be homogeneous, *not* heterogeneous. 2) The group members must not be currently involved in the situation. Their involvement is either complete or the situation has moved past the most acute stages. 3) Group members should have had about the same level of exposure to the experience. 4) The group should be psychologically ready and not so fatigued or distraught that they cannot participate in the discussion.

An assumption is made here that a properly trained crisis response team is prepared to provide the CISD.

The Critical Incident Stress Debriefing Process

Timing

The Critical Incident Stress Debriefing is often *not* the first intervention to follow a critical incident. A brief group informational process may have taken place and distressed individuals may have been supported with one-on-one interventions. Typically, 24 to 72 hours after the incident the small, homogeneous group gathers for the CISD. Intervention delays may occur in disasters. Personnel may be too involved in the event to hold the CISD earlier. They may not be psychologically ready to accept help until things settle down a bit after they finish work at the disaster scene. In fact, it is not uncommon in disasters that the CISD is not provided for several weeks and sometimes longer after the disaster ends. Depending on the

circumstances, a CISD may take between 1 and 3 hours to complete. The exact time will depend on the number of people attending and the intensity of the traumatic event.

Phases in the Critical Incident Stress Debriefing

A CISD is a structured process that includes the cognitive and affective domains of human experience. The phases are arranged in a specific order to facilitate the transition of the group from the cognitive domain to the affective domain and back to the cognitive again. Although mostly a psycho-educational process, emotional content can arise at any time in the CISD. Team members must be well trained and ready to help the group manage some of the emotional content if it should arise in the group.

Phase 1 – Introduction

In this phase, the team members introduce themselves and describe the process. They present guidelines for the conduct of the CISD and they motivate the participants to engage actively in the process. Participation in the discussion is voluntary and the team keeps the information discussed in the session confidential. A carefully presented introduction sets the tone of the session, anticipates problem areas and encourages active participation from the group members.

Phase 2 – Facts

Only extremely brief overviews of the facts are requested. Excessive detail is discouraged. This phase helps the participants to begin talking. It is easier to speak of what happened before they describe how the event impacted them. The fact phase, however, is not the essence of the CISD. More important parts are yet to come. But giving the group members an opportunity to contribute a small amount to the discussion is enormously important in lowering anxiety and letting the group know that they have control of the discussion. The usual question used to start the fact phase is “Can you give our team a brief overview or ‘thumbnail sketch’ of what happened in the situation from you view point? We are going to go around the room and give everybody an opportunity to speak if they wish. If you do not wish to say anything just remain silent or wave us off and we will go onto the next person.”

Phase 3 – Thoughts

The thought phase is a transition from the cognitive domain toward the affective domain. It is easier to speak of what one’s thoughts than to focus immediately on the most painful aspects of the event. The typical question addressed in this phase is “What was your first thought or your most prominent thought once you realized you were thinking? Again we will go around the room to give everybody a chance to speak if they wish. If you do not wish to contribute something, you may remain silent. This will be the last time we go around the group.”

Phase 4 – Reactions

The reaction phase is the heart of a Critical Incident Stress Debriefing. It focuses on the impact on the participants. Anger, frustration, sadness, loss, confusion, and other emotions may emerge. The trigger question is "What is the very worst thing about this event for you personally?" The support team listens carefully and gently encourages group members to add something if they wish. When the group runs out of issues or concerns that they wish to express the team moves the discussion into the next transition phase, the symptoms phase, which will lead the group from the affective domain toward the cognitive domain.

Phase 5 – Symptoms

Team members ask, "How has this tragic experience shown up in your life?" or "What cognitive, physical, emotional, or behavioral symptoms have you been dealing with since this event?" The team members listen carefully for common symptoms associated with exposure to traumatic events. The CISM team will use the signs and symptoms of distress presented by the participants as a kicking off point for the teaching phase.

Phase 6 – Teaching

The team conducting the Critical Incident Stress Debriefing normalizes the symptoms brought up by participants. They provide explanations of the participants' reactions and provide stress management information. Other pertinent topics may be addressed during the teaching phase as required. For instance, if the CISD was conducted because of a suicide of a colleague, the topic of suicide should be covered in the teaching phase.

Phase 7 – Re-entry

The participants may ask questions or make final statements. The CISD team summarizes what has been discussed in the CISD. Final explanations, information, action directives, guidance, and thoughts are presented to the group. Handouts maybe distributed.

Follow-up

The Critical Incident Stress Debriefing is usually followed by refreshments to facilitate the beginning of follow-up services. The refreshments help to "anchor" the group while team members make contact with each of the participants. One-on-one sessions are frequent after the CISD ends.

Other follow-up services include telephone calls, visits to work sites and contacts with family members of the participants if that is requested. At times, advice to supervisors may be indicated. Between one and three follow-up contacts is usually sufficient to finalize the intervention. In a few cases, referrals for professional care may be necessary.

Research:

The research on CISD is quite positive if two conditions are present. The conditions are:

1. Personnel have been properly trained in CISM.
2. Providers are adhering to well published and internationally accepted standards of CISM practice.

> Note: Without exception, every negative outcome study on CISD to date has not used trained personnel to provide the service and they have violated the core standards of practice in the CISM field. For example, they have used the CISD for individuals instead of homogeneous groups. The Cochrane Review (Wessely, Rose and Bisson, 1998) summarizes the negative outcome studies on CISD. In that review, 100% of the studies were performed on individuals. When a group process designed for homogeneous groups is used on individuals, it changes the inherent nature of the process itself and also what is being measured. In addition, the negative outcome studies applied a group process model to individuals for whom the CISD process was never intended. The Cochrane Review studies covered dog bite victims (*9% of the studies*), auto accident victims (*45% of the studies*), burn victims (*9% of the studies*), relatives of actual victims in an emergency department (*9% of the studies*), sexual assault victims and women who had a miscarriage, a cesarean section, post partum depression and other difficult pregnancy situations (*28% of the Cochrane Review studies*). The CISD small group process was not designed to manage any of these types of cases. It was developed for use with small, homogeneous groups such as fire fighters, police officers, military and emergency services personnel. CISD should be used for staff, not primary victims.

The paragraphs below present an overview of some of the positive outcome studies. There are many more beyond what can be addressed here.

Bohl (1991) assessed the use of CISD with police officers. Police officers who received a CISD within 24 hours of a critical incident (N=40) were compared to officers without CISD (31). Those with CISD were found to be less depressed, less angry and had less stress symptoms at three months than their non-debriefed colleagues.

Bohl (1995) studied the effectiveness of CISD with 30 firefighters who received CISD compared with 35 who did not. At three months, anxiety symptoms were lower in the CISD group than in the non-CISD group.

In a sample of 288 emergency, welfare, and hospital workers, 96% of emergency personnel and 77% of welfare and hospital employees who worked on traumatic events stated that they had experienced symptom reduction which was attributed partly to attendance at a CISD (Robinson & Mitchell, 1993).

After a mass shooting in which 23 people were killed and 32 were wounded, emergency medical personnel were offered CISD within 24 hours. A total of 36 respondents were involved in this longitudinal assessment of the effectiveness of CISD interventions. Recovery from the trauma appeared to be most strongly associated with participation in the CISD process. In repeated measures anxiety, depression, and traumatic stress symptoms were significantly lower for those who participated in CISD than for those who did not (Jenkins, 1996).

After a hurricane, Chemtob, Tomas, Law, and Cremniter (1997) did pre- and post-test comparisons of 41 crisis workers in a controlled time-lagged design. The intervention was a CISD and a stress management education session. The intervention reduced Posttraumatic stress symptoms in both groups.

In naturalistic quasi-experimental study emergency personnel working the civil disturbance in Los Angeles in 1992 were either given CISD or not depending on the choice of command staff. They had worked at the same events. Those who received CISD scored significantly lower on the Frederick Reaction Index at three months after intervention compared to those who did not receive it (Wee, Mills, & Koehler, 1999).

In 1994 over 900 people drowned in the sinking of the ferry, *Estonia.* Nurmi (1999) contrasted three groups of emergency personnel who received CISD with one group of emergency nurses who did not receive CISD. Symptoms of posttraumatic stress disorder were lower in each of the CISD groups than the non-CISD category.

When CISD is combined with other interventions within a CISM program the results are even stronger. In a study on traumatized bank employees (Leeman-Conley, 1990), a year with no assistance for employees was compared with a year in which a CISM program was used. Employees fared better with the CISM program. Sick leave in the year in which the CISM program was utilized was 60% lower. Additionally, workers compensation was reduced by 68%.

Western Management Consultants (1996) did a cost benefit analysis on a CISM program for nurses. The study involved 236 nurses (41% of the work force). Sick time utilization, turnover and disability claims dropped dramatically after the program was put in place. The cost benefit analysis showed $7.09 (700% benefit) was saved for every dollar spent on building the CISM program.

A recent evaluation of group crisis interventions was undertaken by Boscarino, Adams and Figley (2005). People working in New York City at the time of the World Trade Center attacks on September 11, 2001 who were offered crisis intervention services by their employers were compared to other workers whose

employers did not offer any form of organized crisis intervention services. Assessments conducted at one and again at two years after the traumatic events of September 11, indicate that those who received group Critical Incident Stress Management services demonstrated benefits across a spectrum of outcomes in comparison to workers without crisis intervention services. Lower levels of alcohol dependency, anxiety, PTSD symptoms, and depression were among the outcomes that indicated a marked difference between those receiving CISM services and who were not offered such services.

The reader is also directed to the reviews already performed on CISM (Hiley-Young & Gerrity, 1994; Dyregrov, 1997, 1998; Flannery, 2001; Everly et al., 2001, Mitchell, 2003a, 2004b). The following paragraphs summarize the research issues in the CISM field.

With the exception of randomized controlled studies by Deahl et al. (2000) and Campfield and Hills (2001) studies supportive of CISM and the small group CISD are all quasi experimental designs. Randomized controlled trials are certainly encouraged, however, the opportunity to conduct them under disaster field conditions may be extremely difficult or impossible (Jones & Wessely, 2003).

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My Vicarious Trauma Plan

Headington Institute

MY DEFINITION OF RESILIENCE

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November 30, 2011

If I had a dime for every time someone asked me to define resilience, I would have quite a few by now. But confusion about resilience is quite understandable. Every book and magazine article has a different spin on the definition of resilience, and whether and how you can increase it.

I have been fortunate to spend the past couple of years researching and thinking deeply about resilience –my own personal resilience and resilience as a psychological characteristic. This article reflects both of these processes. I take my science seriously, so everything I present will be consistent with research I have read and conducted. But, admittedly, this isn't purely a work of science.

There is one defining characteristic of resilience that everyone seems to agree on – resilience is evident when we are confronted with significant trauma and stress. It's hard to assess resilience when things are going well, although good times may increase it. It's easier to measure it when we experience things we wish hadn't happened. Resilience determines how quickly we get back to our "steady state" after the air has been knocked out of us, when we must push through life circumstances that challenge our very being.

Let's quickly review what happens to the brain and the body when we face situations that require resilience. When you experience an extreme trauma or stressor, your physiology undergoes radical changes. Beginning in the depths of your brain, neurotransmitters and hormones tell your body that you are undergoing some type of threat. The adrenal glands, on top of you kidneys, get the message and flood your entire body with stress hormones. These hormones affect all bodily systems (cardiovascular, digestive, immune, metabolic, inflammatory, renal, etc.). And needless to say, stress has a huge impact on your brain. To put it in general terms, stress hormones move from the downstairs brain to the upstairs brain, where you access your memories and think in ways that are unique to you. If these hormones and chemicals go uncontrolled, they shut down your ability to make good decisions or think about anything other than the immediate threat. If your system stays on high alert, you end up with a brain that isn't thinking clearly and every physiological system on overload.

Fortunately, there are natural biological processes that facilitate our recovery from stress. A process called allostasis attempts to get all of the physiological systems back to their steady state after the stress response. However, numerous biological and psychological factors can interfere with allostasis. This is where resilience becomes important, because this amazing psychological characteristic facilitates the biological process of allostasis, getting our brain and body back to normal. So, what then is resilience?

There are three core psychological attributes at the heart of resilience: strength, meaning/purpose, and pleasure. If your personal life is characterized by these traits, you have the core components needed to build resilience. You feel equipped to handle both daily life and those challenging moments when you have to dig deeper. You also believe that you're contributing to the world in a way that helps others, consistent with what seems most important to you. Whether you believe that you exist in a universe controlled by a clearly defined higher power, or participate in the human collective that transcends your personal identity, your source of meaning helps you manage high stress and trauma effectively. And finally, pleasure. This isn't about drinking champagne at the French Embassy on New Year's Eve. It's about deeply enjoying that which enriches and

satisfies you. Whether it be poetry or pottery, movies or theater, having experiences that bring you a deep sense of pleasure are essential.

Strength, meaning and pleasure. These core attributes must be experienced on both an emotional and cognitive level. Resilience grows from both feelings and engagement in a thought life, bringing you strength, meaning and pleasure. Reading, thinking, working, praying, writing, conversing – these are just as important as emotional experiences that give you the feelings of strength, meaning and pleasure. The "Big Three" of resilience must be experienced both emotionally and cognitively for resilience to be fully developed.

Although it may be possible to build personal resilience on our own, we must have meaningful interpersonal relationships to build resilience most effectively. Relationships provide both emotional and cognitive opportunities for us to develop strength, meaning, and pleasure. This increases our personal resilience more than living life alone, in solitude.

So, why are these particular psychological attributes – experienced emotionally and cognitively, alone and in relationship – the key to building a resilient life? Let's go back to the concept of allostasis for some possible answers. One reason why our body doesn't return to a steady state after a stress response is because psychological reactions can hinder allostasis. If we catastrophize the event and think of nothing else, we keep the stress response from resolving. When we live a resilient life, we are more likely to put trauma, even severe life altering trauma, in a context that allows for the completion of allostasis. Our body can then heal itself.

With strength, we know we can survive. With meaning/purpose, we know there is a reason for us to live another day. With pleasure, we know that we have been given the ability to enjoy life deeply. Just as trauma is a reality in life, so is pleasure. When trauma comes, and the stress of life seems overwhelming, we can still experience strength and purpose. Eventually, pleasure will return. That's resilience.

Here's one final thought. We talked earlier about how stress hormones from the downstairs brain turn off the upstairs brain, where our ability to think and feel resides. Can you guess where such attributes as strength, meaning and pleasure reside? Of course, in the upstairs brain.

Is it possible that living a resilient life strengthens our upstairs brain to withstand the onslaught of the "fight or flight" hormones that would otherwise lead to battle or panic? Without much in the way of evidence, I will go out on a limb and say, "Yes." I suggest that living with strength, meaning, and pleasure could build up the areas of our brain that help us recover the next time life goes awry. With more certainty, I believe that a life characterized by personal strength, meaning and purpose, and feelings of unencumbered pleasure embodies the definition of resilience. One day at a time.

SAMPLE POLICY & PROCEDURES

SAFE !
Programs Policy and Procedure Manual

Section 1: GENERAL AGENCY INFORMATION
Title: Workplace Wellness Plan

Purpose: To create a trauma informed culture that supports employee and volunteers' health, safety and wellness in every aspect of their lives and that aligns with _____.

Policy: All staff and volunteers will remain knowledgeable about SAFE!' s workplace wellness plan, *PATH to Wellness,* and their knowledge will be reflected in their individual commitment to health, safety and wellness. SAFE! HR Director, in partnership with _____, will provide oversight of *PATH to Wellness,* including updates to the plan.

Definition: A workplace wellness plan is a coordinated and comprehensive set of health promotion and protection strategies implemented at the worksite that includes programs, policies, benefits, environmental supports, and links to the surrounding community designed to encourage the health and safety of all employees. (CDC.gov)

Core Areas for SAFE!'s *PATH (Personal Achievements Towards Health) to Wellness* Plan:

1. Dissemination of information.
   - *PATH to Wellness* plan will be reviewed with new staff and volunteers during their personnel orientation.
   - WorkLifeMatters Newsletter from SAFE! Employee Assistance Program is sent to staff on a monthly basis via email.
   - *PATH to Wellness* Newsletter from SAFE! TIC Work Group is sent to staff quarterly.
   - Supervisors are encouraged to review WorkLifeMatters and *PATH to Wellness* Newsletters during regularly scheduled staff meetings.
   - Supervisors are encouraged to post Newsletters in staff common areas.
   - Agency-wide meetings and work groups are encouraged to include *PATH to Wellness* as a standing agenda item.
   - All programs and departments shall report on their progress toward workplace wellness annually via SAFE!' Annual Outcomes Report.

2. SAFE! offered resources, activities and supports
   - Resources
     - SAFE! offers an Employee Assistance Program to all staff who qualifies for benefits.
     - SAFE! HR staff will promote health plan member benefits so that staff increases knowledge of the full scope of benefits and services available to staff, including wellness coaching, healthy living programs and discounted services.

- Activities
    - All SAFE! staff and volunteers are encouraged to promote and take a leadership role in activities that promote connectedness and wellness. Examples include: The Fitness Challenge, Lunchtime Walking Group, Monthly Restaurant Meet Up.
    - Supervisors are encouraged to provide reasonable flexibility with regard to staff's schedules as a way to address staff's barriers to connecting to wellness activities including: time, proximity to home or work, and financial resources.
    - SAFE! staff and volunteers are encouraged to bring ideas to their supervisor in partnership with Human Resources and Marketing & Development in order to nurture relationships with businesses that offer discounted membership and/or services that promote wellness including fitness clubs, massage schools and other holistic practitioners.
- Supports
    - SAFE! offers supervision to staff and volunteers.
    - SAFE! offers relevant training for staff and volunteers including Self-Care, TIC 101, TIC 201, TIC for Supervisors and Home Visitor Safety as well as other relevant training through partner organizations.
    - Staff and volunteers are encouraged to access the TIC Resource Library .
    - SAFE! staff and volunteers are encouraged to promote and take a leadership role in support group that promote connectedness and wellness
    - Supervisors are encouraged to provide reasonable flexibility with regard to staff's schedules as a way to address staff's barriers to connecting to support groups including: time, proximity to home or work, motivation and financial resources.

3. <u>Staff & Volunteer Appreciation</u>
    - SAFE hosts an annual staff and volunteer appreciation event.
    - Supervisors are encouraged to adopt a form of staff and volunteer appreciation into their programs or departments such as "Caught in the Act", "Mad Props", "Shout Outs", "Give Thanks Campaign" as examples.
    - Supervisors will utilize the Fun Fund at their discretion to appreciate and recognize staff and volunteers.
    - Staff and volunteers are encouraged to take the time to acknowledge and appreciate their co-workers.

Procedure:

1. All staff and volunteers will review SAFE!' workplace wellness plan - *PATH to Wellness*.
2. All staff and volunteers will be supportive of SAFE!' workplace wellness plan.3. As SAFE!' *PATH to Wellness* plan is a living document, all staff and volunteers are encouraged to provide feedback to their supervisors as a way to enhance the plan so that it best meets the needs of staff and volunteers.
4. All programs and departments shall report on their progress toward workplace wellness Yearly.

Mindfulness Lifestyle Resource List

Mindfulness Lifestyle/Practice Oriented Websites

- www.calm.com
- www.coffitivity.com (ambient noise of coffee shop)
- www.focusatwill.com (scientifically optimized music)
- www.headspace.com
- www.mindful.org
- www.themindfulword.org
- www.naturesoundsfor.me (ambient nature sounds)
- www.rainymood.com (ambient noise of thunder storm

Mindfulness and Self-Care Apps

- **Breathe2Relax** iTunes | Google Play
  A portable stress management tool. Breathe2Relax is a hands-on diaphragmatic breathing exercise. Breathing exercises have been documented to decrease the body's 'fight-or-flight' (stress) response, and help with mood stabilization, anger control, and anxiety management. Breathe2Relax can be used as a stand-alone stress reduction tool, or can be used in tandem with clinical care directed by a healthcare worker.
- **Buddhify** iTunes | Google Play
  This is a mindfulness and meditation app that is built around you. Buddhify is perfect for those who are ready to incorporate meditation and mindfulness into their entire day, with meditations that target every aspect of your life, from sleeping, to traveling, to being online. Even if you have never tried meditation before, Buddhify is a life-changer.
- **Calm** iTunes | Google Play
  Includes multiple guided as well as unguided sessions. When you decide you are ready for more than the seven-day program, you can pay for a subscription, which opens up a 21-day program.
- **Headspace** iTunes | Google Play
  This app is great for people getting started with meditation. The first level in the program teaches you meditation in easily digestible ten-minute sessions. Once this starter program is complete, you can subscribe to access thousands of hours of content available at your fingertips. What's unique about Headspace is that with over five million users, you can buddy up with friends to motivate each other and keep on the path to a healthier mind.
- **Insight Timer** iTunes | Google Play
  A meditation timer that connects you with other meditators across the globe.
- **The Mindfulness App** iTunes | Google Play
  This app allows you to select guided or silent meditations at the length of your choice so no matter what level of meditation experience you have you are covered. Users can also purchase in-app meditation lessons from renowned teachers such as Tara Brach and Eckart Tolle.
- **Omvana** iTunes | Google Play
  Omvana gives you access to many meditation sounds, music, and guided sessions with meditation experts. Focus options include: mindfulness, stress, relaxation, sleep, and more. You can choose the length of each meditation session, from three minutes to an hour.

- **Relax Melodies** iTunes | Google Play
  Relax Melodies is designed with a good night's sleep in mind. If you have difficulty getting to sleep or feeling rested in the morning, then this is the app to try.
- **Smiling Mind** iTunes | Google Play
  Smiling Mind is a nonprofit that was created to increase happiness and compassion in the world, and this app is one step toward that goal. With programs designed by age group, this app is great for kids, teens, and adults.
- **Stop, Breathe, and Think** iTunes | Google Play
  Stop, Breath & Think will recommend meditations for you to practice each day based on how you feel so that all you have to do is select one and hit play.
- **Take a break!** iTunes | Google Play
  By Meditation Oasis

Psychological Hazmat Suits for Trauma-Exposed Professionals

Psychological Hazmat Suits for Trauma-Exposed Professionals

Alison Hendricks, LCSW
Cambria Rose Walsh, LCSW

Individual Assessment Tools

- *ProQol*: Retrieved from http://proqol.org/ProQol_Test.html
- *Compassion Fatigue Self Test* (PTSD Support Services): Retrieved from http://www.ptsdsupport.net/compassion_fatugue-selftest.html
- *Child Trauma Survey - Curious about How the Work is Impacting You?*: Retrieved from http://www.childtraumaacademy.com/cost_of_caring/lesson02/page06.html
- *Self-Care Assessment*: Retrieved from http://socialwork.buffalo.edu/resources/self-care-starter-kit/self-care-assessments-exercises.html
- *Secondary Traumatic Stress Scale*: Retrieved from http://academy.extensiondlc.net/file.php/1/resources/TMCrisis20CohenSTSScale.pdf

Organizational Assessment Tools

- *Secondary Traumatic Stress Informed Organizational Assessment(STSI-OA)*: Retrieved from http://www.uky.edu/CTAC/STSI-OA

Videos/Online Training

- Online Module on STS available at http://cascw.umn.edu/portfolio-items/secondary-traumatic-stress-module/

Websites/Blogs

- Blog from Francoise Mathieu available at http://www.tendacademy.ca/blog/
- National Child Traumatic Stress Network website - http://www.nctsn.org/resources/topics/secondary-traumatic-stress
- PTSD Resources (scroll to section on Compassion Fatigue) available at http://www.giftfromwithin.org/html/articles.html
- Tend Academy website - http://www.tendacademy.ca/. Check out the Training on Compassion Fatigue & Trauma-Exposed Workforces.
- University of Buffalo Self-Care Starter Kit available at http://socialwork.buffalo.edu/resources/self-care-starter-kit.html

Workbooks

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