Vicarious Trauma and Resilience

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a behavioral health professional or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
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Faculty

S. Megan Berthold, PhD, LCSW, CTS, is a licensed clinical social worker, holds a PhD in social welfare, and is a Certified Trauma Specialist. She is a clinician, trainer, and researcher who specializes in the cross-cultural assessment and treatment of survivors of torture and other traumas. She is an Assistant Professor at the University of Connecticut's School of Social Work and worked with the Program for Torture Victims (PTV) in Los Angeles for 13 years, where she was a psychotherapist and the Director of Research and Evaluation. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, S. Megan Berthold, PhD, LCSW, CTS, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planners Disclosure

The division planners have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, marriage and family therapists, nurses, mental health counselors, and allied health professionals who work with trauma survivors.

Accreditations & Approvals

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Designations of Credit

NetCE designates this continuing education activity for 15 ANCC contact hours.

NetCE designates this continuing education activity for 18 hours for Alabama nurses.

A complete Works Cited list begins on page 61.

AACN Synergy CERP Category C.

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Disclosure Statement

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Course Objective

The purpose of this course is to expand health and mental health professionals' abilities to identify and understand countertransference reactions common in work with trauma survivors, the causes and signs of burnout and compassion fatigue, and factors contributing to vicarious trauma and resilience.

Learning Objectives

Upon completion of this course, you should be able to:

1. Identify factors contributing to distress in health and mental health professionals who work with trauma survivors.
2. Discuss the importance of developing a self-care plan for trauma professionals.
3. Define countertransference.
4. Identify common countertransference reactions (CTRs) in working with trauma survivors.
5. Define compassion satisfaction and compassion fatigue and its relationship to burnout and vicarious traumatic stress.
6. Identify common signs and symptoms of burnout.
7. Discuss strategies to prevent the development of burnout.
8. Define vicarious trauma.
9. Explain common causes of vicarious or secondary traumatic stress in health and mental health professionals who work with survivors of trauma.
10. Analyze the relationship between vicarious trauma and constructivist self-development theory.
11. Identify various strategies to address or prevent vicarious or secondary trauma.
12. Define vicarious resilience.
13. Identify factors that empower and promote the well-being of trauma professionals.
14. Define trauma stewardship.
15. Describe components of a self-care plan.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Working with trauma survivors as a health or mental health professional is often challenging and frequently places the professional at risk for difficult countertransference reactions, vicarious trauma, and over time, symptoms of burnout [1; 2; 3; 4; 5; 6; 7]. Until recently, much of the work in this field has emphasized the negative consequences on professionals of working with trauma survivors. In contrast, vicarious resilience is a concept that has emerged relatively recently to reflect the reality that professionals may experience positive outcomes as well and find that they gain improved skills to reframe and cope with negative events in the process [8; 9]. Working with trauma survivors can be very rewarding and inspiring.

This course is designed to expand health and mental health professionals' abilities to identify and understand countertransference reactions common in work with trauma survivors and the causes and signs of compassion fatigue (including burnout and vicarious or secondary trauma) and the factors contributing to vicarious resilience. While there are similarities between some of these terms and they are often used interchangeably (with the exception of vicarious resilience), there are also important differences, which will be clarified and described in detail later in this course. Some of these concepts have evolved over the years as a result of additional research. The basic concepts of trauma stewardship will be presented as well [10].

Participants will be provided with tools to assist them in addressing their own signs of distress and burnout, enhance their sense of well-being and ability to care for themselves, and build vicarious resilience. Finally, participants will be offered another approach to meet the challenges of trauma work and take care of themselves through trauma stewardship, which encourages professionals to reflect deeply on what led them to engage in trauma work, the impact it has, and the meaning of and lessons gained from the work. Trauma stewardship guides us to build a long-term approach to enable us to remain healthy so that we can continue to do this work.

WHY STUDY VICARIOUS TRAUMA, RESILIENCE, AND SELF CARE?

Health and mental health practitioners frequently work with individuals and families who have been exposed to trauma in their lives, in some cases multiple traumas (e.g., cancer patients, survivors of child abuse, survivors of domestic violence, torture survivors who may also have experienced community violence and war trauma). However, significant trauma exposure is not limited to health and mental health professionals. It is also experienced by other professionals who interact with trauma survivors on a regular basis, such as immigration lawyers and judges who work with asylum seekers and routinely hear stories of torture and severe persecution and professional interpreters who work with trauma survivors [11; 12; 13; 14; 15; 16]. Vicarious trauma reactions are found in legal and emergency service professionals and others who are exposed to significant trauma; these reactions are similar to those experienced by health and mental health professionals. In this course, the emphasis is on the experience of health and mental health professionals, although much of what follows may be relevant to other professionals as well.

Health and mental health professionals, and those they serve, benefit when they are aware of their own reactions to listening and working with those clients who have been traumatized and understand how these reactions and experiences may either facilitate or impede the therapeutic process and recovery of their clients. These reactions include countertransference and vicarious trauma reactions [1; 2; 17; 18]. Vicarious or secondary trauma involves a transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material. The health or mental health professional may develop some symptoms that mirror the post-traumatic stress disorder (PTSD) or depression symptoms experienced by clients who were directly traumatized [19]. Over time, professionals may be at risk of developing compassion fatigue (burnout or vicarious traumatic stress), such as when the sense of ineffectiveness is dominant and the clinician's sense of efficacy is

challenged [3; 4]. Burnout is a condition of feeling exhausted or worn out. Compassion fatigue is often seen as one of the costs of caring for those in emotional distress; this concept has been well developed by Figley and further developed in recent years by Stamm and Figley [3; 19]. Rather than being a one-time event, burnout is a form of compassion fatigue that develops as a result of gradual processes that build over time.

It might be asked why busy health and mental health professionals who work with trauma survivors should spend their hard-to-find time studying vicarious trauma, resilience, and self care, especially if they are not able to use or supported in using work time to do so. At a basic level, it is because we matter and the quality of our lives matter, too. Health and mental health professionals are often oriented toward prioritizing the well-being of their clients or patients over themselves. They may feel guilty if they give priority to themselves and their own needs. It is sobering, however, to examine what the alternative might be. If healthcare professionals burn out, it may have an impact on clients, colleagues/agency, family, friends, and on their own health and well-being. Professionals who do not examine or attend to these issues and take care of themselves effectively not only harm themselves (including possibly developing health and mental health problems), but are at risk of engaging in incompetent or unethical professional behavior—perhaps not consciously, but they are at risk of this nonetheless.

In order to enhance their sense of well-being and sustain a high quality of work over time, health and mental health professionals benefit from being aware of risk factors that may contribute to developing compassion fatigue in the form of becoming burnt out or experiencing vicarious trauma reactions. They often lack the insight, knowledge, or energy to develop and sustain effective self-care strategies. They may also work in institutions or settings that do not emphasize, support, or promote healthy work environments or the well-being of staff. This course will place emphasis on developing strategies and tools for assessing one's own symptoms of distress, and building a preliminary self-care plan to prevent burnout and enhance clinician well-being.

In addition, participants will be introduced to the relatively new concepts of vicarious resilience and trauma stewardship [8; 9; 10]. Many health and mental health practitioners are not aware of these concepts and thus are not able to benefit (or not benefit fully) from how they can help to promote the well-being of trauma practitioners and enable them to continue to work in the field of trauma for many years.

COMMON COUNTER-TRANSFERENCE REACTIONS WHEN WORKING WITH TRAUMA SURVIVORS

DEFINITION AND CAUSES

Mental health clinicians and other counseling professionals from various disciplines are routinely introduced to the concepts and phenomenon of transference and countertransference during their training. These concepts may be less familiar to some allied health professionals, but they can be important in understanding experiences as they work with their clients and patients and ensuring that these reactions do not interfere with their ability to deliver appropriate services.

Traditionally, the client or patient is seen to develop transference reactions toward their therapist that can include symbolic role relationships, emotional states, and behavior [1]. The transference reactions may be related to experiences and relationships clients have had at any point or points in their life that they have not resolved or integrated, including traumatic experiences they may have had (i.e., trauma-specific transference).

A traumatized client may unconsciously assign a trauma-related role to their therapist. For example, the client may relate to their therapist as though the therapist was their perpetrator, a collaborator, a fellow survivor, or their rescuer. Countertransference develops in the therapist or other helping professional in the process of interacting with their client or patient. The therapist may feel or act as if they had taken on the role assigned to them by their client. The impact of client and therapist on one another, and the accompanying transference and countertransference processes, is reciprocal in nature.

Wilson and Lindy have provided a useful summary of the conceptual and theoretical foundations related to the development of countertransference reactions in therapists who treat trauma survivors who suffer from PTSD [1]. Countertransference arises in the therapist as a result of interacting with their client and identifying with their client's feelings and experiences, as well as when the therapist's own repressed emotions are aroused [1; 20; 21]. When professionals work with survivors of severe human-perpetrated trauma, the countertransference reactions may be particularly intense.

The therapist's countertransference is characterized by emotional reactions that develop due to the interaction between multiple factors, including the therapist's own unresolved inner conflicts, the stories the client shares with them (including of trauma), and the client's behavior and personal characteristics [6; 7]. Unless a therapist's countertransference causes overt problems, they may not be aware of it. Those who develop vicarious trauma, a topic covered at length later in this course, may experience stronger countertransference reactions [21]. In addition, they may have less awareness of their countertransference and be prone to making more clinical mistakes as a result. As is routine in good clinical practice, the clinician is encouraged to actively explore and become aware of their countertransference reactions. These reactions inevitably arise in clinical practice and can be a very valuable source of information relevant for assessment and treatment purposes.

EMPATHIC STRAIN

The trauma stories told by survivors are personal and are influenced or colored by many factors including, in part, the survivors' unique life experiences, cultures, family and psychosocial histories, religious or spiritual orientations, and personalities. These same factors influence the therapist or other professional working with the trauma survivor, along with their particular professional role and orientation. These factors in the survivor and professional interact with one another during the therapeutic process. The recovery from trauma is promoted when the survivor experiences the therapy environment as a safe and secure place to integrate and work through the trauma and its effects. One of the key tasks (and challenges) of the therapist in this endeavor is to sustain empathy for the client throughout the process. Empathy involves the capacity to understand, be aware of, and vicariously experience the world and perspective of another and feel their distress [1; 21; 23]. The clinician's capacity to maintain their empathic stance and stay in tune with the client can become strained as the survivor shares more and more pain and details of their traumatic experiences [1]. Factors that stimulate empathic strain vary from clinician to clinician. While empathic strain can result from a variety of sources, one of the prominent sources is countertransference reactions.

Wilson and Lindy describe that the empathic strain developed by a clinician working with trauma survivors may be either objective or subjective in nature [1]:

- Objective empathic strain/countertransference reaction: This type of empathic strain includes cognitive and/or affective reactions that are expectable and develop in response to the client's trauma story, behavior, and personality.
- Subjective empathic strain/countertransference reaction: In contrast to the objective type of empathic strain, these reactions develop from the clinician's own conflicts and unresolved or idiosyncratic issues from their development over their lifespan.

Whether objective or subjective in nature, empathic strain is a type of countertransference reaction that can compromise clinicians' ability to be empathic with the trauma survivors they work with. The therapeutic relationship and clinician's response to the survivor is injured, weakened, or stretched beyond its appropriate boundaries [1; 20].

CLASSIFICATION OF COMMON COUNTERTRANSFERENCE REACTIONS

The following classification of common reactions clinicians may have when working with survivors of trauma is drawn from Wilson and Lindy [1]. Interested readers are encouraged to consult the source for a fuller description and explanation of this complex material. Wilson and Lindy consider that the primary cause of failed PTSD treatment is likely countertransference reactions [1]. They divide the types of countertransference reactions into two main categories: Type I countertransference reactions, which are associated with avoidance/counterphobia and detachment, and Type II countertransference reactions in which clinicians display an active over-identification stance. Clinicians may be predisposed to developing one type of countertransference reaction over another, but some may experience both during the course of their work. As discussed, some countertransference reactions may result in the clinician developing an objective or subjective empathic strain.

Wilson and Lindy's model includes four distinct modes of empathic strain: empathic withdrawal, empathic repression, empathic enmeshment, and empathic disequilibrium [1]. During the treatment of a given trauma survivor, a clinician may experience one or more (or all) of these styles of empathic strain. These four modes result from the interaction of two axes: Type I vs. Type II countertransference reactions, and objective vs. subjective empathic strain. Both Type I and Type II countertransference reactions can be either objective or subjective in nature and yield particular characteristic outcomes in the therapist that represent types of empathic strain as follows [1]:

Type I Countertransference Reactions: Avoidance/Counterphobic and Detachment Reactions

Type I reactions involve the professional's seeking to do one or more of the following: minimize the trauma, shift the focus away from the trauma, denial of the existence of some of the symptoms of the client, and/or distancing themselves from the trauma and/or client. At times it may even involve some measure of hostility or blame on the part of the clinician toward their client.

Type I countertransference reactions can include any of the following types of empathic withdrawal or empathic repression, sometimes with a combination of several (or alternating between different reactions):

- Empathic withdrawal (objective-type reaction)
  - Blank-screen façade
  - Intellectualization
  - Misconception of dynamics
- Empathic repression (subjective-type reaction)
  - Withdrawal
  - Denial
  - Distancing

Therapists who have not experienced significant trauma in their own lives tend to be more vulnerable to developing empathic withdrawal in working with trauma survivors [1]. These therapists tend to view the world as a just and fair place. They may not have had intensive training about trauma and/or the treatment of trauma survivors. These clinicians, therefore, may not be adequately prepared to be exposed to the powerful experiences of death threats, significant loss, horror, physical and psychological pain, and other severe traumas of their clients. The therapist may develop a host of painful emotions as a result of listening to the trauma stories and witnessing the distress of clients in session (e.g., horror, terror, hostility, desire for revenge). These emotions may be extremely hard

for the therapist to tolerate. In order to avoid the pain associated with these feelings as well as to avoid threats to their view of a decent and fair world, these therapists may unconsciously seek to distance themselves and withdraw from clients through various means, such as intellectualization, denial, isolation, disbelieving or disavowing the reality of the client's experience, and/or using a blank-screen façade with their client. As a result of empathic withdrawal on the part of the therapist, the survivor's integration of their trauma may be blocked and the therapist's inaccurate assumptions may lead to misinterpretations. Receiving appropriate and extensive training about trauma and post-traumatic stress reactions is generally very helpful as part of a plan to prevent or combat empathic withdrawal.

In the situation of empathic repression, significant unresolved personal conflicts or issues in the therapist are reactivated in the course of the work with the trauma survivor. The survivor's way of relating to the therapist may resemble their past relationships with other significant people in their lives; this transference often stimulates a reactivation in the therapist. The therapist becomes withdrawn and focused on personal issues or conflicts at the expense of being fully engaged with the survivor. Therapists with a history of significant trauma, especially those who continue to suffer from personal trauma related to that of their client, tend to be at most risk for developing empathic repression.

Case Study: Type I
Countertransference Reaction

Mr. A is a psychotherapist who has worked at a community mental health clinic for the past 10 years serving adults with a wide range of presenting problems. He has been treating Patient M for the past 6 months. Patient M is a highly educated, married woman, 35 years of age, from a country in Latin America and has been in the United States for the past 2 years. She was referred to the mental health clinic by her primary care doctor because of her severe and frequent panic attacks, nightmares, seeing and hearing dead people talking to her, and severe depression. Over the course of the first several months of treatment, Patient M has shared bits and pieces of her story with Mr. A. He has learned that the patient was working as a teacher in her community and was active in one of the opposition political groups in her country. She fled her country after soldiers killed opposition party supporters and their families in her town one night, including her husband and child. She was at a distant neighbor's house when the massacre took place, tending to a sick friend, and she believes that is why the soldiers did not find her. She tells Mr. A that she is too afraid to return to her country and is seeking asylum in the United States.

Mr. A finds himself flooded with many painful emotions in and after sessions with Patient M. He often feels horrified and has desires for revenge as she discusses her memories of finding her dead husband and child when she returned home that night. He feels terrified by the thought that Patient M may be deported to her native country where her life may be in danger. Mr. A has not experienced much trauma in his own life and definitely does not identify with Patient M's experiences.

Mr. A finds it extremely difficult to tolerate the intensity of his feelings when working with this patient. In order to avoid the pain associated with these feelings, he unconsciously develops empathic withdrawal toward Patient M. Mr. A's countertransference reactions alternate between intellectualizing, blank-screen façade, and misconception of the dynamics with his client. For example, Mr. A has unconsciously distanced himself from Patient M and often blankly stares at her when she brings up anything related to her traumas. Mr. A's reactions have led him to neglect to thoroughly assess the patient's traumatic experiences and the origins of her current symptoms. This, in turn, has led him to inaccurately assume and interpret Patient M's experiences of seeing and hearing of dead people talking to her as psychotic symptoms rather than as possibly part of her post-traumatic stress reaction. Patient M has not experienced any significant relief of symptoms.

Reflection Questions

- What might be the impact on Patient M if the course of therapy and Mr. A's reactions continue in the same manner as it has up until now?
- What can Mr. A do to address his countertransference reactions and positively affect the course of his treatment with Patient M?
- Have you ever found yourself intellectualizing or otherwise empathically withdrawing from a trauma client?
- What did you do when you realized that this was happening?
- Did you notice any negative impact of this in your work with your client?
- Did your countertransference reaction(s) shift or change during the course of your work with a given client? If so, what was/were the shift(s)? What factors seemed to be associated with the(se) shift(s)?
- What one strategy could you employ on an experimental basis to either enhance your awareness of your countertransference reactions or address the impact?

Type II Countertransference Reactions: Over-Identification Reactions

Clinicians who experience over-identification reactions may try to do things too quickly in their work with their client; engage in excessive advocacy on behalf of the client; have tendencies to rescue the client; become enmeshed with the client; develop a blurring of role boundaries; develop an unhealthy or "pathological" bond with the client; or focus excessively on the client's traumatic experiences [1]. Type II countertransference reactions can include any of the following types of empathic disequilibrium or empathic enmeshment, or a combination of several. As with Type I countertransference reactions, the professional may also alternate between different Type II reactions:

- Empathic disequilibrium (objective-type reaction)
  - Uncertainty
  - Vulnerability
  - Unmodulated affect
- Empathic enmeshment (subjective-type reaction)
  - Loss of boundaries
  - Over-involvement
  - Reciprocal dependency

Clinicians who experience empathic disequilibrium often develop increased physiological and psychological arousal as a result of their countertransference reactions. For example, clinicians may develop distressing somatic symptoms (e.g., stomach pains, headaches, pressure in their chest, motor tension) and/or become overwhelmed by characteristic types of emotional distress (e.g., uncertainty about how to proceed with the treatment, feelings of vulnerability or insecurity about their own capacities or abilities, self-doubt, strong anxiety). They may also be flooded with graphic and grotesque images associated with the traumatic material of the survivor(s) they are working with.

Wilson and Lindy describe that therapists who are most vulnerable for empathic disequilibrium are those who are relatively naïve about the intense physiological and psychological arousal reactions that they may experience associated with exposure to such aspects of the trauma as the inhumanity of man, the existential shame and horror evoked by the trauma, complex and multiple traumas, and the impossible choices faced by those going through the trauma [1]. In a state of disequilibrium, therapists find that usually effective defense or coping mechanisms no longer work for them. They tend to be beset by exhaustion and may start to despair. If not addressed, or if ineffectively addressed, therapists may become burnt out and even depressed. Therapists who find that they are experiencing empathic disequilibrium will usually benefit considerably from adequate rest, time to recuperate and rejuvenate themselves, proper supervision and

support, and reducing their exposure to trauma and minimizing work with highly traumatized clients. If addressed effectively, therapists may be able to successfully move out of a state of empathic disequilibrium, although they may find themselves moving into a state of empathic enmeshment or withdrawal instead [1].

When a therapist experiences empathic enmeshment he or she is no longer acting in the therapeutic role or maintaining appropriate professional boundaries. The therapist typically becomes overidentified and overinvolved with the survivor or survivors to the extent of becoming pathologically enmeshed with the client(s). Wilson and Lindy suggest that therapists who are most at risk of developing this type of empathic strain are those who have their own significant history of trauma, particularly if they have not yet worked through or healed from their traumatic experience(s) [1]. Such traumatized therapists may try to rescue the trauma survivor(s) they work with as an indirect means of attempting to address or work through their own unresolved traumas. These efforts are unconscious and can greatly interfere with or derail treatment if not quickly and effectively addressed, and the client may become victimized again. There is also a danger that the client's original transference issues and challenges (e.g., fear of abandonment, fear of betrayal, difficulty trusting others, sense of control or safety, self-esteem, ability to control one's affect) may become worse in the process.

Case Study: Type II Countertransference Reaction

Ms. B is a relatively new therapist who works at a center that serves women who predominantly have experienced domestic violence and abuse as children. She is only one year out of graduate school and has not had extensive specialized training about trauma or the impact of trauma work on herself. She has begun to feel extremely overwhelmed in her work with Patient P, a young Cambodian woman, 19 years of age.

Patient P was referred to Ms. B's center by the Federal Bureau of Investigation (FBI) a month ago after they rescued her from a sexual human trafficking ring in a sting operation. The FBI has arranged for the patient to stay at a secure shelter, and they have certified her as a trafficking victim in exchange for her cooperation in prosecuting her traffickers. She should be eligible to be granted a T-visa, which would entitle her to legal status in the United States as well as work authorization because of her cooperation with the federal authorities. Patient P will be required to testify in court against her traffickers, something that frightens her considerably, particularly because they threatened to harm her and her family back in Cambodia if she ever reported them to the authorities. She worries that her traffickers may see her when she leaves the shelter to go to the store or to the center.

In the past month, Patient P has shared with Ms. B about the extensive emotional and physical abuse she experienced as a child—abuse that left her with a broken arm and two broken ribs. She was eventually sent by her parents to live with a distant aunt in the capital Phnom Penh. When Patient P was 16 years of age, her aunt lost her job and became financially destitute. The aunt told Patient P that she had found a well paying job for her with a family, but when she showed up for her first day of work she quickly learned that her aunt had sold her into a life as a sex worker. Patient P initially refused to cooperate, and her traffickers beat her daily and drugged her in order to force her to submit to engaging in prostitution. They kept her locked up and, after several months, trafficked her to the United States, where she continued to be forced to engage in sex work, servicing up to 8 or 10 men a day, 7 days a week. She developed gonorrhea and herpes and became pregnant. She had an abortion, and her traffickers forced her to return to sex work after only 2 days of rest.

Ms. B develops intense stomach pains and headaches during and following sessions with Patient P. She finds herself full of uncertainty about how to proceed with treatment and overwhelmed by intense anxiety and horror, as well as graphic images of the patient's repeated abuse. She is plagued by self-doubt and insecurities about her ability as a therapist to help Patient P heal from the traumas she has experienced and prepare psychologically to testify against her traffickers. Ms. B feels exhausted every day and at times feels despair; her countertransference reactions are illustrative of empathic disequilibrium.

Reflection Questions

- What are the factors that appear to have made Ms. B at risk for developing empathic withdrawal?
- What might be the impact of Ms. B's countertransference reactions on Patient P?
- Have you ever found yourself experiencing signs of empathic withdrawal or another Type II countertransference reaction? If so, what were they? If not, what factor(s) do you think helped to protect you from developing these reactions?
- How did you handle or address any Type II countertransference reactions you may have developed?
- Were your efforts at addressing these reactions successful? Why or why not?
- Would you do anything differently the next time you found yourself in such a situation? If so, what would you do differently and why?

While not all countertransference reactions are problematic, each of the discussed reactions would likely have a less than optimal impact on the therapeutic relationship and course of treatment of the survivor. It is an ethical duty, above all, for health and mental health professionals not to do harm to their clients and patients. Therefore, it is essential that clinicians strive to become aware of, understand, and develop the skills to address or make therapeutic use of the information provided by their countertransference reactions. Attending effectively and appropriately to one's countertransference reactions will also enhance one's professionalism and the quality of one's work.

IMPACT OF REACTIONS ON THE PROFESSIONAL AND THE THERAPEUTIC RELATIONSHIP

There are common signs that are indicative of distressing and problematic countertransference reactions in clinicians serving survivors with significant post-traumatic stress reactions [1; 20; 24]. Countertransference reactions can affect multiple realms of a clinician's life and also negatively affect the professional's relationship with the survivor they are trying to serve.

As mentioned previously, clinicians may develop somatic reactions, sleep disturbance, agitation, or other physiological reactions. They may find that they develop intense emotional reactions including sadness, depression, confusion, fear, anxiety, irritability, anger, rage, or horror. Clinicians may become over-identified with or detached from their client. They may develop a sense that they have shared a unique and profound experience with the survivor—one laden with intense and private experiences of suffering that cannot be adequately described [24]. Given the ethical and legal requirements of maintaining confidentiality, clinicians may feel very alone with a sense of a heavy burden, which can have an impact on relationships with other clients or patients and more broadly on other relationships outside of work [24]. Over time, professionals who work with trauma survivors may become intolerant of working with non-traumatized clients, viewing their problems as insignificant in comparison to those of their trauma survivor clients. They may also become intolerant of and increasingly sensitive to violence and conflict and feel more personally vulnerable to danger [24].

Behavioral signs or symptoms of clinician countertransference reactions may include loss of boundaries with clients, the denial of their own feelings or the feelings of clients, the expression of excessive concern, challenges with remaining empathic, and even the expression of anger toward clients. Clinicians may also display defensiveness, and this may be expressed in various ways, such as difficulty in meeting or scheduling an appointment (e.g., double-scheduling, canceling, rescheduling, or forgetting appointments) or being condescending, derisive, judgmental, or critical [25].

An empathic break in the clinician's stance toward his or her client(s) is often associated with various harmful or injurious outcomes in the trauma survivor, such as intensification of troubling or unhealthy aspects of the client's transference reaction toward the therapist; "acting-out" behavior; regression in therapy; lack of progress or fixation in a particular phase of the therapy; or an end to the process of recovery in treatment [1]. When clinicians are not able to maintain an empathic stance, there are numerous possible negative effects on traumatized clients, not the least of which is significant challenges in healing from the traumatic experiences. It may also reinforce their negative self-image and feelings about themselves, have a harmful effect on their ability to have healthy relationships with others, and cause a host of other problems. Ethical practitioners should keep these consequences in the forefront of their minds.

When problematic or harmful countertransference reactions occur, particularly when they become a pattern, it is a red flag that intervention is needed. Supervision, further training, and one's own personal therapy can often be quite valuable in identifying and addressing these situations. Even better than waiting for such a situation to arise or become extreme, however, is to implement preventive strategies, for the sake of the clinician and clients alike. Discussion of such prevention strategies is included later in this course.

Kinzie has suggested that certain personal qualities and defense mechanisms appear to be most helpful in clinicians who work with survivors of trauma [24]. These personal qualities are those of warmth, equanimity, and maturity. The defense mechanisms considered to be mature are most useful and commonly found in effective trauma clinicians, such as those of altruism, suppression, and humor [26].

FACTORS ASSOCIATED WITH VARIOUS COUNTERTRANSFERENCE REACTIONS

Deepening one's understanding of the various factors associated with countertransference reactions is helpful in developing a successful prevention or intervention plan. Some of the main components associated with the development of countertransference reactions are [1]:

- The nature of the traumatic stressor and the trauma story:
  - Was it a natural disaster or human-perpetrated trauma?
  - Was it a single trauma event or multiple/complex traumas?
  - Did the trauma involve any ethical or moral dilemma(s)?
  - Did the trauma involve death, mutilation, injury, and/or abuse? Were there particularly grotesque or gory aspects of the trauma?
  - What was the client's role(s) in the traumatic event(s)?
  - What developmental stage(s) was the client at when the trauma(s) occurred?
  - What were the duration, frequency, and severity of the trauma exposure?
  - Was the community involved in the trauma? If yes, in what way and to what degree?
  - What was/were the nature of the relationship(s) between the various people involved in the trauma, including the nature of the relationship between the perpetrator(s) and the client?

- The particular characteristics of the trauma survivor client:
  - What are the demographic characteristics of the client, such as their age, gender, race, ethnicity, sexual orientation, religious/spiritual beliefs, culture, marital status, and parental status?
  - What are the personality characteristics of the client?
  - What defense mechanisms and coping strategies does the client typically employ?
  - What is/was the client's role(s) in the traumatic event(s) (e.g., witness, victim, perpetrator, or a combination of these roles)?
  - What are the dynamics and background of the client's family?
  - What, if any, post-traumatic stress symptoms and injuries were sustained by the client and how severe were they?
  - What was the pre-trauma level of functioning and ego strength of the client? If multiple traumas were experienced, this would be assessed related to the period before each trauma.
- The personal characteristics of the therapist or helper:
  - What are the demographic characteristics of the therapist or helper and how closely do they match or differ from those of the client?
  - What are the personal beliefs, ideological systems, and preconceptions of the therapist relevant to the situation and issues presented by the client?
  - What is the therapist's theoretical orientation and assumptions about life-cycle development and personality?
  - What defensive styles and mechanisms are used by the therapist?
  - What motivated the therapist to work with trauma survivors?
  - How much training and professional experience has the therapist had regarding trauma?
  - What have the therapist's own life experiences been?
  - Has the therapist personally experienced any trauma? If so, was the trauma similar to that experienced by the client? Has the therapist successfully worked through or healed from the trauma? If not, is it likely that any lingering issues or problems exist that may interfere with his or her work with a given trauma survivor or community?
- Factors in the therapist's organization or institution:
  - What is the political context of the therapist's organization and how supportive is it of work with trauma survivors in general (and specifically of the given survivor)?
  - What is the organization's attitude and stance toward the survivor population served?
  - Are the organization's resources sufficient for the task at hand? Are they sufficient in some realms but not in others? What impact might this have on the treatment or other services?
  - If outside resources or specialty services are needed for the treatment to be successful, are these resources available? Is the organization part of a network or collaborative treatment team that might help provide some of the needed resources or services?

  - Does the organization provide support to its staff, including adequate supervision and other resources or opportunities to assist them in addressing countertransference reactions and self care? Are these resources internal or external to the organization?
  - How flexible or rigid is the organization in responding to change relevant to the service delivery system? Do the organization's policies and culture allow staff to adapt their services to match the client's need (within appropriate professional and ethical guidelines and laws)?

This is not a complete list of all possible factors associated with countertransference reactions, but they are fairly common and may be beneficial to explore. By systematically exploring these factors, health or mental health professionals may become aware of relevant dynamics or issues that they may have otherwise overlooked that will aid them in their work with survivors of trauma. Without such awareness and knowledge it is highly unlikely that the professional will be able to successfully intervene or address these negative factors.

ADDRESSING COUNTER-TRANSFERENCE REACTIONS

Yael Danieli, a psychologist and trauma expert with several decades of experience serving and advocating for survivors of the Holocaust and other traumas around the world and those who serve them, has developed principles to guide professionals to be better able to recognize, contain, and heal from countertransference reactions acquired working in the trauma field [27]. Danieli recommends promoting recognition of one's countertransference reactions by [27]:

- Enhancing one's awareness of the somatic signs of distressing countertransference reactions by developing skills at recognizing these early warning signs (e.g., headaches, tightness in throat or stomach, sensation of heaviness on chest)
- Finding the words to precisely label and express one's inner feelings and experiences related to working with trauma survivors

Danieli also advocates taking the following steps to facilitate the containment of one's countertransference reactions [27]:

- Ascertain one's current level of readiness, ability, and tolerance to hear the details of survivors' trauma and witness their associated distress
- Build on this foundation through further training, consultation, and/or supervision to gradually enhance one's openness and ability to hear anything the survivor may need or want to share
- Recognize that there is a beginning, middle, and end to all emotions, and develop one's ability to tolerate the expression of such intense emotions. One is encouraged to enhance one's skills at addressing fear of becoming overwhelmed by the powerful emotions expressed by trauma survivors without falling back on the use of countertransference reactions to defend against them in a way that might be damaging to the client.

Finally, to promote healing and growth from one's countertransference reactions when working with trauma survivors, Danieli recommends [27; 28]:

- Recognizing and accepting that trauma changes things profoundly and that things will not be the same
- When you are feeling distressed or badly affected by the impact of your work (feeling "wounded"), take the time needed to assess the situation, do things to soothe yourself, and let yourself heal. Taking this time and being kind and gentle with yourself makes it more likely that you may be able to become rejuvenated and emotionally healthy again to the extent that you will be able to continue to work, including in the trauma field.

- Arrange for consultation or therapy to address areas triggered by the stories of the survivors you work with or reactions that have not been adequately explored in the past or that require additional attention.
- Recognize that your emotional reactions to your work with trauma survivors (e.g., rage, grief, and fear) may be interacting with old experiences that you have not yet fully worked through or resolved. By integrating your insights about these interactions, you may be able to grow professionally and personally and turn your vulnerabilities into a source of strength and wisdom.
- Set up a supportive network of others to create a "safe holding environment" in which you can talk about and process trauma work. This network may consist of professional colleagues who do similar trauma work, a consultation group, ongoing supervision, and/or one's own therapy. Establishing such a network can make an enormous difference in reducing the clinician's sense of isolation in doing this work.
- Engage in relaxation and creative activities or hobbies to provide avenues for self-expression and regenerate energy on a regular basis. It is not a luxury or self-indulgent to have fun and unwind; it is essential in order to stay healthy if you wish to continue to professionally engage in trauma work.

EMPATHIC GROWTH

Throughout the course of trauma treatment, breaks or ruptures in empathy and the therapeutic process are possible as a result of countertransference reactions. It is important to note, however, that clinicians and their clients may also achieve empathic growth, wherein their ability to empathize is stretched beyond their initial capability [29]. Empathic growth or stretch is a process that takes place as the therapist and traumatized client work together to understand and make sense out of the trauma and its meaning for the client. In order to achieve empathic growth it is essential in part to maintain a vigilant lookout for sources that contribute to empathic strain. These sources need to be identified, acknowledged, and effectively and appropriately dealt with so as not to interfere with the client's process of recovery.

The development of empathic growth in a therapist is supported when he or she is able to sustain a stance of empathic inquiry and attunement in work with trauma survivors. Therapists are encouraged to develop what Wilson, Lindy, and Raphael refer to as a "critical therapeutic structure" [29]. The containment of the client's traumatic experiences and associated images, memories, and emotions (as well as their trauma-specific and related transferences) is facilitated by such a critical therapeutic structure [29].

Empathic growth results in transformation for the therapist; the form of that transformation can vary from distressing (e.g., vicarious traumatization) to highly positive. Wilson, Lindy, and Raphael describe positive outcomes of this process as a, "generative orientation toward the meaning of life and the existential nature of personal relationships" [29; 30]. In the absence of this positive empathic growth, professionals who work in the trauma field may be at increased risk for the development of compassion fatigue, including burnout and vicarious traumatic stress. Understanding the overall impact of such work on one's professional quality of life is a vital step in being able to promote healthy outcomes in trauma survivors and in oneself.

PROFESSIONAL QUALITY OF LIFE

Professional quality of life has been defined as the quality that a helper or caregiver feels in relation to their work [31]. It is influenced by both the positive and negative effects of one's work. Professionals' ability to provide effective help to trauma survivors while maintaining their own balance and well-being is enhanced by gaining a deeper understanding of the positive and negative effects of their work with trauma survivors.

Worldwide, helping professionals who respond to traumatic situations are a diverse group. Helpers work in a wide range of settings and come from a variety of professional backgrounds. They may be health or mental health professionals, teachers, social service workers, police officers, firefighters, emergency medical technicians (EMTs), attorneys, religious leaders, staff of airlines or other transportation companies, disaster site clean-up personnel, community leaders, members of emergency response teams, or others who help at the time of the trauma and/or for the days, months, and years following. The trauma or crisis generally affects individuals, but it may also be community-wide, national, and/or international in its nature and impact. The impact of the work can vary considerably from one helper to the next, given the diversity of backgrounds and roles of helpers and the multiple factors associated with the situations in which they intervene.

Professional quality of life is comprised of two aspects of the helping process: compassion satisfaction (the positive aspect) and compassion fatigue (the negative aspect). Professionals whose work involves helping individuals, communities, or nations that have experienced significant trauma and suffering would benefit from understanding these concepts in more depth, given that they are integral to their own ability to effectively care for themselves and others.

COMPASSION SATISFACTION

The enjoyment and gratification that professional trauma helpers feel when they are able to perform their work well is referred to as compassion satisfaction [31]. Helpers who experience compassion satisfaction typically feel that they are able to handle new protocols and technology as they emerge, feel successful and happy with their work, and want to continue to engage in their work. They feel satisfied and invigorated by their job and from the act of helping itself. Some helpers may experience enormous pleasure or contentment when the traumatized survivor or community they have worked with heals or is able to function better. Helpers may develop positive feelings toward their co-workers or feel optimistic about their ability to make a constructive difference in their work environment or the larger community.

The concept of compassion satisfaction is supported by evidence indicating that while some professional helpers exposed to their clients' traumatic material become negatively affected, many others do not [32]. In recent years, recognition of protective factors and positive effects of helping has increased.

COMPASSION FATIGUE: BURNOUT AND VICARIOUS TRAUMATIC STRESS

Compassion fatigue is comprised of two components: burnout and vicarious traumatic stress [19]. The first component consists of characteristic negative feelings such as frustration, anger, exhaustion, and depression. The second component, vicarious traumatic stress, may result when the professional is negatively affected through vicarious or indirect exposure to trauma material through their work.

Burnout Defined

A number of negative feelings can accompany feeling burnt out, including unhappiness, hopelessness, exhaustion, disconnectedness (including from the person you want to be), a lack of sustaining beliefs, feeling overwhelmed or bogged down, and feeling that your hard work never can make a difference [31]. These feelings are associated with difficulties one experiences over time in doing work effectively and may be amplified by a high workload or an unsupportive work environment [19].

Freudenberger has defined burnout as, "a depletion or exhaustion of a person's mental and physical resources attributed to his or her prolonged yet unsuccessful striving toward unrealistic expectations, internally or externally derived" [33]. It is important to emphasize that unmet expectations can have a variety of origins, not all residing within the person. Frequently, the sources of burnout from external sources are the most difficult to address and resolve, as they are outside of the individuals' scope of influence. These sources are systemic in

nature. In the environment of economic downturn and crisis, when resources are scarcer than ever, this is particularly pronounced. Burnout typically emerges gradually as the person becomes increasingly emotionally exhausted over time.

Most health and mental health professionals enter their profession because they want to help others in need. They tend to have strong empathic skills and be compassionate people. Those who choose to work with survivors of trauma are no exception. The very capacity for empathy and compassion among these professionals, however, in combination with the intensity of their work, their own personal vulnerabilities, and the rather extreme situations in which they may be asked to intervene (often with inadequate training, support, and/or resources) can leave these professionals at risk for compassion fatigue.

Impact of Burnout on the Professional and the Therapeutic Relationship

Those who study psychotherapists who are impaired or no longer functioning effectively often consider burnout to be an end phase of severe distress [33]. Some professionals opt to quit or retire (perhaps taking an early retirement) when they reach this phase. Others soldier on doing the best they can, often hurting themselves and others in the process (by providing less than optimal care to themselves and others). Psychotherapists who are burnt out may not have the energy to provide the care that client(s) need, or they may feel so overwhelmed that it compromises their ability to accurately assess the client's situation or needs or to implement the most appropriate treatment plan. All of these scenarios can negatively affect psychotherapists' relationship with the survivor(s) they serve and may in turn affect the survivor(s) ability to trust and form an effective therapeutic working relationship with other professionals.

Case Study: Anticipating and Preventing Burnout

Before Ms. C decided to apply for admission to a Master's in Social Work (MSW) graduate program, she reflected on whether this was a good choice for her or not. She had heard stories about social workers who burned out. Professionals, once passionate about their work with runaway teens or domestic violence victims, had become disillusioned and exhausted and had lost their passion and energy for their work. This gave Ms. C pause and made her worried. She was nervous about entering a profession that seemed to pose a high risk for burning out, but she was raised in a family where she was encouraged to pursue a career that she was passionate about and was surrounded by examples of family who remained energized and fulfilled in their work after many years. Ms. C was told that she had many options open. She had not had any significant contact with social workers up until then, and she was not sure if this would be a career she loved. She did know, however, that many jobs were definitely a poor match for her abilities and interests.

Ultimately, Ms. C decided to give social work a try and applied to graduate school. Before she applied to a MSW program, however, she developed a plan and commitment to herself that served her well over more than two decades in the field. Her plan was to check in with herself often about how she was feeling and functioning in relation to work and life in general. Ms. C vowed that if she ever found that she was starting to burn out, she would make a change by switching the population she worked with or changing her role and duties; she could leave clinical work altogether and do policy- or community-based advocacy, or she could combine clinical work with research and policy work. Ms. C was relieved to know that the options within the profession of social work were many. Just knowing that she had options and the power and ability to be in control of her choices and work life made a huge difference. Over the years, she made several

changes in her work setting, role(s), and the populations served. Ms. C is pleased to report that she has successfully avoided burning out.

Reflection Questions

- Do you check in with yourself regularly to assess how you are feeling and functioning at work and in other realms of your life?
- Are there particular aspects of your work to which you feel you are well suited? What are those and why?
- Are there particular populations, issues, settings, or roles that you think may be difficult for you to work with or in? Why or why not?
- Is there anything that you have found to be helpful in preventing you from burning out in your work?
- Do you have a burnout prevention plan in place? If so, what is it? If not, what would the first step be to develop one?

It is possible to recover from burnout, and compassion fatigue in general. Not all of the symptoms are extreme or long-term in nature. Burnout and compassion fatigue exist on a continuum of severity. It can be helpful when one becomes aware that they have developed a sign or symptom of burnout or compassion fatigue, as this could serve as a signal of the need to do something about it. Without such awareness, it is less likely for professionals to make positive changes in their lives to promote well-being. Ideally, however, professionals will develop plans to prevent becoming burnt out or developing compassion fatigue in the first place.

Prevention and Treatment of Burnout

Being aware of the factors that increase a professional's risk of burnout is very valuable in contributing to a prevention strategy. Contributing factors may be individual/personal, systemic, or frequently a combination of both. It is important to know what does not work (or what makes a toxic environment) first in order to prevent exposure and the associated fallout from such exposure.

A review of many of the possible contributing individual or personal factors has been discussed in previous sections of this course. Systemic risk factors include [3; 18]:

- Excessive workload
- High-stress settings, including being on the front line ("in the trenches")
- Sense of powerlessness or minimal or no control
- Frustration about bureaucracy
- Insufficient resources
- Inadequate opportunities for reward, promotion, or professional growth (feelings of stagnation)
- Inadequate supervision and/or training
- Interpersonal tensions or strains
- Lack of fairness or perception of fairness
- Value or ethical conflicts
- Feelings of isolation or disconnection from family or friends regarding the traumatic and/or otherwise challenging nature of one's work

It is possible to prevent or recover from burnout and compassion fatigue and even to be resilient in the face of conditions or environments that may make these conditions more likely to develop [34]. The more one is able to anticipate risk factors and identify early warning signs of burnout or compassion fatigue, the more likely it may be to effectively deal with the situation and even become resilient.

One tool that can be used to assess burnout is the Copenhagen Burnout Inventory (CBI). The CBI is a self-administered tool with 19 items that measure the frequency of symptoms of burnout using a five-point scale. It includes three subscales covering different domains of burnout: personal burnout, work-related burnout, and client-related burnout. A prospective study of more than 1900 human service employees found that the CBI was effective in differentiating between human services occupational groups and responses were correlated with other measures of low energy and psychological well-being [35]. In addition, the

three subscales accurately predicted persons who had sleep problems, used pain killers, intended to quit their jobs, and would be absent in the future due to sickness. Over the course of the prospective study, high percentages of the employees reported changes in their level of burnout. The CBI has high internal reliability and good predictive validity, has been used in many countries, and has been translated into eight languages [35]. A copy of the CBI can be viewed online at http://www.arbejdsmiljoforskning.dk.

Essential to preventing and treating burnout and compassion fatigue is creating and maintaining a healthy balance in one's life [34]. The need for self care has been stressed, for example, in professionals who specialize in oncology, hospice, and palliative care [36; 37; 38]. This balance may be different from individual to individual and within a given individual over time. Common components to achieving balance and optimal functioning involve the following basic self-care strategies: taking time off work periodically to rejuvenate oneself; building in time in one's schedule to attend to one's own needs; regular exercise, keeping one's body healthy, and attention to one's overall health; getting enough sleep on a regular basis; and eating healthy foods regularly and maintaining a healthy weight. Caregivers who do not attend to these basic strategies are more likely to be physically and emotionally vulnerable and less resilient over time.

Health and mental health professionals who work with trauma survivors are mandated by law and ethics to keep confidential the identities of their clients and the content of their sessions or work with clients. This is frequently the very material or content that they would benefit from addressing with others as part of their plan to take care of themselves. Resilient trauma professionals are not isolated and have strong connections with and support from others, both in their personal and professional lives. Trauma professionals are encouraged to find appropriate outlets and venues for processing the impact of their work on themselves without violating the confidentiality of their clients, such as in confidential clinical team case conference meetings, in supervision, and in their own therapy.

Remaining vigilant to the signs and symptoms of burnout in oneself is essential in order to act to regain one's equilibrium and balance and prevent the situation from escalating. After symptoms of burnout have developed, steps can be taken to address these symptoms, including but not limited to [34]:

- Restore a healthy balance in one's life regarding basic self care, including good sleep, good nutrition, and regular exercise.
- Maintain a balance between work and attention to one's own personal needs.
- Build in recreational activities that provide a healthy outlet from the intensity of trauma work ("mini-breaks").
- Do not turn to unhealthy ways of self-medicating one's distress, such as alcohol, drugs, or addictive gambling.
- Make good use of positive support systems (personal and professional) to process your feelings.
- If needed, get medical or psychological treatment for symptoms of distress, such as insomnia, that are contributing to difficulty functioning.
- Consider creative outlets for the healthy expression of your feelings, such as music, art, journaling, or other writing.
- Develop a ritual for the end of one's work day to facilitate transition into non-work life (develop a capacity for leaving work stress and worries at work) (***Table 1***).

LEAVING WORK AT WORK: THE RITUALS OF TRAUMA PROFESSIONALS

Some trauma professionals find that it is enormously helpful to engage in one or more rituals at the end of each work day to facilitate their ability to transition from work to home and to be able to "leave work at work." Developing rituals can be an important strategy to take care of yourself and prevent burnout. Rituals may include such things as:

- Walking or biking home from work through a beautiful neighborhood or park
- Reading an engaging and relaxing novel while taking the bus or metro home from work rather than driving in rush hour traffic
- Changing out of work clothes and putting them away as soon as you get home
- Taking a 5- or 10-minute period to be quiet (or to meditate) before leaving the office or when you first get home to shift gears away from work and the traumatic material and other work-related stresses
- Going for a run or exercising
- Playing with your dog or child when you first get home
- Putting away any work papers or charts at the end of the work day and locking your office (symbolically putting away your attention to work matters and any traumatic images or distress encountered there for the remainder of the day and night)
- Watering plants in the office at the end of each work week before starting the weekend (a metaphor for life and growth, reminding you to save time for your own life and personal growth outside of work)

Questions for reflection and suggestions for experimentation:

- Is there anything that you do that helps you to leave your work at work?
- Do you allow yourself any transition time between work and home?
- Do you have any ritual that you follow at the end of your work day? If not, for the next week, experiment by trying some ritual, reflecting on it and its affect on you. If it was not helpful or did not have the intended affect, change it. Talk to friends and colleagues and find out about any rituals they may have that they would recommend. Continue to experiment until you find something that works for you.

Source: [34] *Table 1*

If, over time, a trauma professional is not able to regularly leave their work at work, then they are putting themselves at risk not only of becoming burnt out but also at risk for vicarious traumatization.

Vicarious Traumatic Stress

Compassion fatigue can also result when professionals or other caregivers become overwhelmed by exposures to the intense traumatic material or feelings of those they serve [3]. Vicarious traumatic stress refers to professionals' secondary exposure to very stressful and traumatic events through their work. Professionals may frequently or repeatedly hear trauma stories at work about horrible things that have happened to others (also known as vicarious trauma). This has been studied in many populations, such as lawyers, those who work in oncology and palliative care, and other clinicians [13; 17; 19; 39; 40]. Characteristic symptoms of distress can develop as a result, including fear, anxiety, depression, pain, loss of energy, nightmares and other sleep disturbance, and intrusive traumatic thoughts.

Compassion fatigue usually develops over time, as a cumulative result of helping many clients in challenging circumstances. It can, however, develop quickly when a professional responds to a case that is especially traumatic or challenging, in which case the symptoms of vicarious traumatic stress may have a rapid onset [31]. The professional may become traumatized as a result of becoming strongly focused and concerned with the suffering of the client while he or she is in a state of strong anxiety. This possible traumatizing reaction has been called vicarious traumatization [3; 31].

Trauma professionals may be directly and/or indirectly exposed to trauma on the job. For example, a police officer who is shot at while intervening in a domestic violence dispute experiences direct exposure. Other examples of primary trauma are found in combat soldiers or humanitarian aide workers working in war zones who are directly in danger. An example of vicarious exposure is when a police officer hears the traumatic details of what happened from a victim who was beaten by their partner. Child protective service workers or emergency room personnel are examples of professionals who are frequently exposed to indirect or secondary trauma.

Vicarious Trauma and Countertransference

Unlike with countertransference, a professional's pre-existing personal characteristics may not have a bearing on his or her reactions to a client's trauma story. Vicarious trauma and countertransference are different experiences or constructs, but they can affect one another. For example, countertransference reactions exist in all therapists (and, it could be argued, in other allied health and mental health professionals as well). Countertransference reactions are specific to each client and the individual therapist-client dyad. Vicarious traumatic stress's effects, on the other hand, are experienced beyond any given therapy relationship and develop due to the accumulation of experiences, generally across clinical relationships with multiple clients.

When vicarious trauma develops, it typically transforms the clinician (in some cases permanently) and affects not only professional life but personal life as well. Vicarious trauma in effect changes the very self of the clinician, and it is this self that is the context for the development of countertransference reactions. Clinicians who experience more pronounced vicarious traumatization may also have stronger countertransference reactions and may be less aware of these reactions given the effects of the vicarious trauma [1]. This situation may in turn be associated with more clinical error or impediments to the progress of treatment and can also result in even more vicarious trauma.

According to the Registered Nurses' Association of Ontario, organizations should develop policies and structures related to peer debriefing following exposure to traumatic events or stories. Policies should be developed to support staff and minimize vicarious trauma.

(http://www.guideline.gov/content.aspx?id=15615. Last accessed May 20, 2014.)

Level of Evidence: Expert Opinion/Consensus Statement

Associated Characteristics

Trauma professionals who are suffering from vicarious traumatic stress often find that they are preoccupied with thoughts about those they have tried to help. Helpers may feel overwhelmed, as though they are trapped or on edge, and contaminated by the trauma material of their client(s) [31]. Characteristics of vicarious traumatic stress can include increased forgetfulness about important matters, sleep disturbance, and challenges maintaining boundaries between one's personal and professional lives. Affected professionals may feel as though they are experiencing aspects of the trauma described by someone they have served, such as developing avoidance symptoms to triggers of the trauma (i.e., avoiding particular activities that remind them of the trauma) [31]. Vicarious traumatization occurs when a professional is changed deeply and negatively by their work with the suffering of others; this can manifest in many ways, such as a negative sense of self. Pearlman developed the Trauma and Attachment Belief Scale for use with trauma survivors, although researchers have also used this scale to evaluate the impact of vicarious trauma [41]. The scale assesses beliefs and cognitive schemas in five domains that may be affected by trauma: safety, trust, esteem, intimacy, and control.

Case Study: An Early Warning Sign

Ms. C's first job after graduating with her MSW degree was as a psychiatric social worker and trainer of paraprofessional refugee counselors in a first asylum camp for Vietnamese boatpeople on an isolated island in the Philippines. When she arrived, she found that she had the most mental health training of anyone on the island. The Filipino non-profit she worked for had psychiatrists on call for consultation by phone and would fly a psychiatrist in for several days every two months to assess and prescribe medications. There were very few telephones on the island, and Ms. C had to borrow another agency's phone to make a call. Often, the connection was poor, and it was hard to communicate with the psychiatrist. Ms. C had a caseload of more than 100 clients who had fled Vietnam by boat and had experienced multiple traumas. Many of the clients were suffering from severe mental health problems, and some faced ongoing violence. Ms. C found herself working with multiple cases of trauma with both the perpetrator(s) and victim(s) at the same time. She only had access to peer supervision, with only sporadic access to a more senior, experienced supervisor when they visited the island.

Within several months, Ms. C's sleep became routinely disrupted. She began to have frequent nightmares. When she examined her nightmares, she realized that they were not her own—they were those of her clients, especially those who had experienced atrocities on the high seas during their escapes from Vietnam. The nightmares were filled with images of Ms. C hanging on to driftwood, watching helplessly as her loved ones lost strength and drowned in front of her. She also saw images of herself being attacked by pirates at sea, shot, and left for dead in a pile of dead bodies, and pretending to be dead until the pirates left. She had a recurrent nightmare of watching her brother murdered by others on the boat and seeing them eat his corpse in order to stay alive.

Instead of becoming alarmed at this development, however, her anticipatory work prior to starting the MSW program (vowing to check in regularly with how she was feeling and functioning) proved protective and reassuring. Her approach was to view these nightmares as fortuitous, because it gave her the opportunity to develop and implement a prevention plan and recognize the importance of taking care of herself and creating balance in her life very early in her career. More than two decades later, she is still working with trauma survivors. Her role has evolved and expanded and the population she works with is different (survivors of state-sponsored torture from all over the world—no longer restricted solely to Southeast Asian refugees). She also reports that she no longer has the nightmares of her clients.

Reflection Questions

- Have you ever developed nightmares that include images from your clients' traumatic experiences or themes related to these experiences?
- Have you experienced other signs or symptoms of vicarious trauma?
- Are there particular settings or situations that tend to trigger your vicarious trauma reactions? If so, what are these?
- Have you switched populations, work settings, or professional roles as a result of developing symptoms of vicarious traumatic stress?
- How do you address your vicarious trauma reactions?
- Have your efforts been successful?
- Are there things you would like to try differently to address these reactions or, in general, to take care of yourself?

Many people (including trauma specialists) have experienced some trauma in their lives by the time they reach adulthood. There are a host of possible consequences of trauma exposure. Two of the most common psychological conditions among survivors are PTSD and depression. Stamm notes that while approximately half of all the people in the United States have been exposed to at least one traumatic event that would qualify as a trigger for PTSD, only about 8% develop the disorder [32]. The rate of PTSD and depression in the general population is relatively low (past 12-month prevalence rates of 3.5% and 6.7%, respectively) [42].

Professionals who work with trauma survivors may find that over time they develop some symptoms of PTSD or depression similar to those experienced by clients who were directly traumatized, even if they have not experienced significant trauma themselves [43]. The development of such traumatic stress reactions as a direct result of working with trauma survivors is known as vicarious trauma. It is important to note, however, that not all vicariously traumatized professionals will develop PTSD or depression [31].

Vicarious or secondary trauma refers to "a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with the client's trauma material" [44]. It is considered to be a natural and inevitable outcome of engaging in work with trauma survivors and involves the cumulative effect of this work on the feelings, memories, self-esteem, cognitive schemas, and sense of safety of the clinician.

Pearlman and Mac Ian studied the effects of trauma work on therapists and found that the development of vicarious trauma is not evidence of psychopathology in the therapist or the client [44]. It is normal and to be expected under the circumstances. Some studies have found that trauma professionals who have experienced trauma themselves or those who work longer hours with trauma survivors (e.g., child protective service workers) or have higher rates of exposure to traumatic material experience more vicarious trauma and compassion fatigue [2; 45; 46; 47]. Professionals who have developed post-traumatic reactions from their own traumas may be more at risk of developing vicarious trauma, particularly if there are strong similarities between aspects of their own traumas and those of their clients. Some stories may be harder to hear or may stimulate longer lasting reactions than others. For example, a professional therapist who has a phobic reaction to snakes and works closely with a client who was tortured with snakes may develop more distressing post-traumatic symptoms, including nightmares or intrusive traumatic thoughts similar to their client's.

Therapists and other trauma practitioners who develop vicarious trauma may have their assumptions about the world and themselves disrupted as a result of their trauma work. McCann and Pearlman have found that this shattering of assumptions can result in long-lasting changes in the trauma professional's cognitive schema [43]. Trauma survivors are susceptible to a range of effects as a result of this disruption, including no longer believing that they are protected or invulnerable (the world becomes a frightening place and they are personally at risk); the world is no longer viewed as predictable, orderly, and easily comprehended—rather the world may appear as a chaotic place where trauma can randomly happen to anyone; and/or their prior healthy self-esteem may be negatively affected, resulting in feelings of fear and powerlessness [48].

Constructivist Self-Development Theory

According to Saakvitne and Pearlman, vicarious trauma as a concept is based on constructivist self-development theory [49]. Constructivist self-development theory was developed to be an integrative clinical theory, one that is based on a holistic view of the self in context, addresses the multiple aspects of the self that are seen to be affected by trauma, and emphasizes adaptation [50]. It is a personality theory that explains how the development of self is affected by traumatic events and their context(s). Clinical and empirical data drawn from a number of different trauma survivor populations were used in the development of this theory. It incorporates a

number of existing theories, including psychoanalytic theory, cognitive development theory, social learning theory, and constructivist thinking, while also emphasizing the importance of the person's cultural, social, and developmental contexts [50; 51; 52; 53; 54].

According to constructivist self-development theory, there are five areas of the self that are seen to be affected by trauma [49; 50]:

- A person's frame of reference: The typical way of understanding oneself, one's identity, and relationships with others and the larger world; the lens through which one interprets experiences and the world. This includes spirituality, which may be altered (strengthened, changed, or diminished) as a result of trauma and may bring about an experience of existential crisis or growth.
- A person's self-capacities: The capacity to be aware of, tolerate, and integrate one's affect while sustaining a compassionate connection with caring for others and oneself. This includes one's sense of being deserving of love and life and the ability to maintain a sense of inner balance and self-soothe.
- A person's ego resources: One's ability to be self-observant and self-aware and to use social and cognitive skills to protect oneself and sustain relationships with others — all abilities necessary in order to meet psychological needs and make decisions in a mature and healthy fashion. Relevant skills are those of empathy, insight, sense of humor, taking initiative, using willpower, motivation for personal growth, setting healthy boundaries, anticipating consequences, and making self-protective decisions.
- A person's central psychological needs: Manifested in a disruption of cognitive schemas or beliefs about oneself or others in the areas of trust (or dependence), intimacy, safety, esteem, and control.
- A person's perceptual and memory system: Refers to sensory experience and biological/neurochemical adaptations. Traumatic experiences are processed and recalled through cognitive/narrative, affective/emotional, somatic and sensory, visual, and/or interpersonal or behavioral modes; traumatic memories may involve dissociation and are generally fragmented as disconnected feelings or images in the absence of a narrative account.

Trauma survivors typically strive to create meaning out of their experiences as they construct an individualized trauma narrative. Constructivist self-development theory recognizes personality development as a complex interaction of a number of factors, including in part one's core self-capacities (stemming from one's ego resources and one's early relationship experiences and attachments) and one's constructed schemas and beliefs (connected to the accumulation of one's life experiences and the meanings one associates with those experiences) that shape one's experience and perception [50].

An individual's adaptive response to trauma is seen as a function of the interaction between his or her distinctive personal and family history, development, personality, the traumatic event, and the sociocultural context and consequences of the trauma. The meaning of the trauma and the post-trauma reality and the adaptive strategies employed are individually constructed by each survivor, and thus are unique to the particular survivor. The survivor's way of relating to self and others is seen to be deeply influenced by early development. Traumas are understood to be reconstructed and reinterpreted at each developmental stage. The symptoms expressed by trauma survivors are seen as adaptive strategies by constructivist self-development theory, strategies that help the survivor manage perceived threats to their safety and integrity [50].

For example, beliefs that appear to be distorted or irrational are viewed by constructivist self-development theory to be survivors' efforts to protect their meaning system and themselves from the threat of the trauma. Unlike many other theories, the constructivist self-development theory does not view the person's strategies in response to trauma as pathological or emphasize stigmatizing diagnoses [49]. Instead, responses to trauma are considered to be protective according to this theory. The developers of the theory provide the example of adult survivors of childhood abuse to illustrate this concept. They describe that the adult survivor's persistent and intense shame developed initially as a child in response to being abused by parent(s) was functional and protective for the child, serving to protect the image of his or her parent(s) as good and right (and the child as bad and unworthy) [49]. They go on to explain that the child's belief that he or she is responsible for the abuse helps the child to feel less helpless, powerless, and fearful. The adult survivor's persistent shame and related guilt may no longer be adaptive and functional, and it may lead to self-destructive behavior. Of course, if not properly and fully understood by the trauma professional working with the adult survivor of childhood abuse, interventions may not be effective.

Constructivist self-development theory identifies areas that may be damaged by trauma but also areas of potential post-traumatic growth. It provides an explanation for and predicts how trauma can produce dysfunctional beliefs and adaptations as well as positive transformations in survivors [50].

Saakvitne and Pearlman describe how trauma professionals or other helpers will be affected in similar ways to the trauma survivor (as discussed), but note that the intensity and extent of the impact will be less than that experienced by the primary survivor [49]. They argue that if professionals do not have an appropriate theoretical framework, such as that of constructivist self-development theory, to understand the impact of the trauma on their client, including the meaning of the client's symptoms or coping strategies, efforts to treat the client will likely be unsuccessful. Furthermore, over time, with repeated lack of success, the trauma professional may become discouraged, despairing, and at risk for the development of vicarious trauma.

The interested reader is encouraged to consult Saakvitne, Tennen and Affleck, and Saakvitne and Pearlman for a much fuller examination and analysis of constructivist self-development theory [49; 50]. These sources elaborate, among other things, on the contribution of constructivist self-development theory to informing research and clinical practice related to the impact of trauma and the possibility for post-traumatic growth and healing following trauma exposure and to the phenomenon of vicarious trauma. There is a growing body of literature documenting positive outcomes and growth after exposure to trauma [22; 55; 56; 57]. Research by Bonanno, Westphal, and Mancini found that resilience is the most common outcome of potentially traumatic events [58]. The literature is mixed, however, on outcomes of trauma for those who live in contexts of ongoing war and chronic terrorism [59].

Why Vicarious Traumatic Stress Develops

Health and mental health professionals who serve survivors of trauma are trained and expected to exhibit empathy toward survivors and to engage with empathy with the traumatic material of their client(s). The helper is transformed in the process and their empathic stance puts them at risk for vicarious traumatic stress [49]. It is possible for vicarious trauma to appear to develop suddenly, even in seasoned trauma specialists who have not struggled significantly or at all with vicarious trauma after years of working with survivors. A sudden onset often leaves the professional feeling a sense of disruption or powerlessness, especially if he or she has been socialized to believe that professionals should be able to handle exposure to trauma. It is important to note that this factor varies widely depending on the profession and environment; some professions and work settings

have cultures that promote "toughness" in trauma professionals, maintaining that they should not be affected by their work, while others are more open to acknowledging and normalizing the presence of vicarious trauma.

It can be hard (at times seemingly impossible) for some trauma professionals to admit to themselves, their colleagues, or others that they are experiencing symptoms of vicarious trauma or burnout, particularly if they or their colleagues hold the view that trauma professionals should be above being negatively affected by their work. Admitting the impact of the work on oneself is actually an important strength and demonstrates a clinician's professionalism. It also provides the professional with an opportunity to improve on an established self-care plan and promotes his or her ability to provide better service to traumatized clients.

In addition to the role of empathy in the development of vicarious trauma reactions, there are a host of other possible contributing factors, such as [49]:

- Situational factors
  - The nature of the particular work
  - The nature of the professional's clients or patients
  - The context of the work setting or organization
  - The cultural and social context
  - The cumulative exposure to trauma
- Individual or personal factors
  - Personal history
  - Personality
  - Typical defensive and other coping mechanisms
  - Context of one's current life
  - Training and professional experience
  - Supervision experiences
  - Engagement in and impact of personal therapy

The overall outcome is the result of the interaction between these various factors. Of course, the result will be unique for each individual, just as life experiences, personality, and profile of contributing factors are unique. Weingarten developed a model to explain how various factors may affect therapists' reactions when they are exposed to violence in their work with survivors [60]. She hypothesizes that therapists who are aware of the meaning of the violent events experienced by clients but who find themselves helpless to take action or without any path for taking constructive action are the most at risk for developing vicarious trauma.

Impact of Vicarious Traumatic Stress on Self, Relationships, and Work

Vicarious traumatic stress can affect a trauma professional in profound ways, many of them similar to the impact of trauma on the client. In addition to the possibility of developing symptoms of PTSD (e.g., nightmares, intrusive traumatic images and thoughts) and/or depression (e.g., hopelessness, depressed mood, generalized despair), the experience of working closely with survivors of trauma, particularly survivors of human perpetrated trauma, can affect the professional in other significant ways. These clinicians have reported [19; 49; 61]:

- Alterations in views of themselves, their identity, their society, and the larger world
- Loss of a sense of personal safety and control
- Feelings of fear, anger, and being overwhelmed
- Diminished confidence in capacities and frustration with the limits of what one can do to improve a situation
- Increased sensitivity to violence
- Altered sensory experiences, such as symptoms of dissociation
- Loss of ability to trust other individuals and institutions
- Inability to empathize with others
- Social withdrawal
- Disconnection from loved ones

SECONDARY TRAUMATIC STRESS SCALE					
The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement, then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.					
Question	**Never**	**Rarely**	**Occasionally**	**Often**	**Very Often**
1. I felt emotionally numb.	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).	1	2	3	4	5
4. I had trouble sleeping.	1	2	3	4	5
5. I felt discouraged about the future.	1	2	3	4	5
6. Reminders of my work with clients upset me.	1	2	3	4	5
7. I had little interest in being around others.	1	2	3	4	5
8. I felt jumpy.	1	2	3	4	5
9. I was less active than usual.	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.	1	2	3	4	5
11. I had trouble concentrating.	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.	1	2	3	4	5
13. I had disturbing dreams about my work with clients.	1	2	3	4	5
14. I wanted to avoid working with some clients.	1	2	3	4	5
15. I was easily annoyed.	1	2	3	4	5
16. I expected something bad to happen.	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.	1	2	3	4	5

Source: [62] Bride BE, Robinson MM, Yegidis B, Figley CR. Research on Social Work Practice (Vol. 14, No. 1). pp. 27-35. Copyright © 2004 by Sage Publications. Reprinted by permission of Sage Publications. *Table 2*

- Inability to be emotionally intimate with others
- Lack of time or energy for oneself
- Changes in spirituality and belief systems
- Cynicism
- Loss of self-esteem and sense of independence

Some of these effects can also have an impact on one's ongoing work with trauma survivors. For example, the therapeutic relationship can be damaged or compromised if one is less able to effectively empathize with one's clients or patients. In addition, a psychotherapist who develops distrust in others and no longer feels safe or in control may have a harder time assisting survivor clients with these same issues.

Assessing Vicarious Traumatic Stress Reactions

Thankfully, it is rare for a trauma professional to develop full-blown vicarious traumatic stress. When it does occur, it can be quite disruptive and distressing. However, the effects of vicarious traumatic stress can be effectively addressed. A deeper understanding of and plan to prevent and address one's vicarious traumatic reactions can assist one in achieving vicarious transformation as well.

The first step in addressing vicarious traumatic stress is to assess one's situation thoroughly. A complete assessment will make it easier to develop an appropriate strategy and plan that is likely to succeed. A commonly used measure to assist in the assessment of symptoms of vicarious traumatic stress is the Secondary Traumatic Stress Scale (STSS) (***Table 2***) [62].

The STSS was designed to be self-administered in less than 10 minutes and consists of 17 questions. It has strong psychometric properties, including construct, convergent, and discriminant validity. The STSS was developed to measure the presence of symptoms of the following in social workers and other helping professionals [62]:

- Intrusion: Nightmares, reliving the trauma(s) experienced by survivors, being upset by reminders of one's work with survivors, having uncontrollable intrusive thoughts about the trauma experienced by clients
- Avoidance: Feeling emotionally numb, avoiding people and situations that serve as reminders of work with trauma survivors
- Arousal: Concentration problems and increased irritability associated with a professional's indirect exposure to the traumatic experiences of survivors

Higher scores are indicative of greater frequency of vicarious traumatic stress symptoms and risk for burnout [62].

COMPASSION SATISFACTION AND COMPASSION FATIGUE

Knowledge related to the impact of work with trauma survivors on professionals has grown considerably over the past two decades as a result of the explosion of research in this area [31]. Some of the initial concepts have evolved since the 1990s.

In 2009, Hudnall Stamm copyrighted a theoretical model to illustrate the theory behind the constructs of compassion satisfaction and compassion fatigue. A graphic representation of the Compassion Satisfaction-Compassion Fatigue theoretical model (CS-CF Model) can be found online at http://www.proqol.org/Full_CS-CF_Model.html. Additional detailed information about this model can be found in the Professional Quality of Life (ProQOL) 5 Manual, also available online at http://www.proqol.org/ProQOl_Test_Manuals.html [31]. The CS-CF Model illustrates how the positive and negative aspects of helping trauma survivors are affected by three key environments: the helper's work environment; the environment of the client or person(s) being helped; and the personal environment that the helper brings to the work. The various tools and resources provided by the ProQOL website are discussed in ***Appendix 1***.

Compassion fatigue and vicarious exposure to trauma are distinct processes separate from PTSD or the development of symptoms of vicarious traumatic stress [31; 63; 64; 65]. It is possible, and fairly common, for trauma professionals to experience some negative effects as a result of their vicarious exposure to trauma without developing PTSD. While compassion fatigue is not considered a diagnosis, some professionals who experience compassion fatigue may also have a psychological disorder. The psychological disorder may predate the secondary exposure to trauma through their work, be exacerbated by their work, or develop after exposure to trauma on the job. Some trauma professionals who become burnt out may also be clinically depressed, and others (or even the same professional) may meet the diagnostic criteria for PTSD or another psychological or physical condition linked (at least in part) to compassion fatigue.

In the last several years, researchers and clinicians have focused increased attention on the phenomenon of resiliency and the possibility of trauma professionals transforming negative effects into positive ones [19; 64; 66]. Compassion satisfaction has been found to moderate vicarious trauma and compassion fatigue [66]. Compassion satisfaction has been rarely found when burnout is present, and the most negative outcomes in trauma professionals appear to develop when both vicarious trauma and burnout are experienced.

Professionals who work with trauma survivors are protected, in part, from developing compassion fatigue if they have received good training and are able to maintain their professional role and appropriate boundaries with their clients [67]. Despite these protective factors, however, any professional with a strong capacity for compassion, empathy, caring, and concern is at risk for developing compassion fatigue. It is perhaps paradoxical that one of the biggest strengths of health and mental health professionals—their compassion that supports their ability to make a strong therapeutic connection with their clients and patients—is the very factor that leaves them exposed to the risk of developing compassion fatigue. Notwithstanding this risk, it is clearly not recommended to fail to show or feel compassion toward the survivors one serves. Instead, one can inform oneself about the phenomenon of compassion fatigue and develop skills to prevent it and address the symptoms if they emerge. Additional factors that increase the trauma professional's vulnerability to developing compassion fatigue include significant isolation from others in one's personal and/or professional life, prolonged traumatic exposure (the more prolonged the period the greater the risk), working too many hours without adequate rest periods, and more intense demands in one's personal life [67]. The greater number of these factors present, the more vulnerable a professional may be.

It is possible to recover from compassion fatigue, but adequate self-awareness, support, and an effectively implemented plan is needed. The first step is being able to recognize the signs and symptoms of compassion fatigue.

Warning Signs and Symptoms

After compassion fatigue sets in, the professional typically displays signs and symptoms resembling, in part, those of PTSD. The cause of the symptoms of compassion fatigue, however, differs from those of PTSD. PTSD symptoms develop in some people after they are directly exposed to a significant trauma. The symptoms of compassion fatigue arise in those who help others, in relation to the traumas of the clients they serve. Frequently, professionals' attitudes toward their work or career changes, and they may become less enthusiastic and increasingly dispirited, hopeless, and/or cynical. They may find that they have become preoccupied or obsessed about a distressing case or client situation. Professionals may start to leave work early or call in sick, or alternatively, they may have the tendency to stay late [67].

A complete list of signs and symptoms associated with compassion fatigue is undoubtedly long and affects all realms of a person's life, including the physical, cognitive, emotional/psychological, interpersonal, sexual, behavioral, spiritual, and outlook on life and humanity. It is beyond the scope of this course to provide an exhaustive list. However, a few of the more common physical symptoms are [19; 49; 61]:

- Headaches
- Stomach or joint pain
- Fatigue
- Impaired immune response, characterized by more frequent colds or other illnesses and exacerbation of pre-existing health problems

Emotional/psychological effects are also many and can include such symptoms as [19; 49; 61]:

- Feeling estranged from others (difficulty sharing feelings with others)
- Difficulty falling or staying asleep
- Feeling weak, tired, or rundown as a result of one's work
- Feeling trapped by one's work
- Having little compassion toward most of one's co-workers
- Feeling that one is working more for money than for personal fulfillment
- Troubling dreams similar to a client's trauma experiences
- Intrusive thoughts of sessions with especially difficult clients and their families

- Suddenly and involuntarily recalling a frightening experience while working with a client
- Flashbacks connected to one's clients and/or their families
- Feeling frightened of things traumatized people and their family have said or done
- Increased frustration
- Discouragement
- Hopelessness
- A sense of worthlessness, disillusionment, and/or resentment associated with one's work
- Disengagement
- Mood swings, including depression and increased irritability
- Increased anxiety, hyperarousal, and startle reaction
- Emotional drain, exhaustion, and depletion

Potential cognitive effects include, but are not limited to [19; 49; 61]:

- Cynicism and pessimism
- Thoughts that one is not succeeding at achieving one's life goals
- Thoughts of violence or retribution against the person or persons who victimized the client
- Preoccupation with thoughts about clients or their families

Interpersonal and sexual challenges include [19; 49; 61]:

- Interpersonal tensions or conflicts
- A change in communication patterns
- Social withdrawal
- Lack of sufficient close friends
- Alterations in sexual desire or performance

Behavioral symptoms can include [19; 49; 61]:

- Difficulty separating work from personal life
- Use or abuse of alcohol or drugs
- Irritability, anger, or violent outbursts with little provocation
- Absenteeism
- Working too hard with few breaks

Spiritual effects may include [19; 49; 61]:

- Existential questions or crises
- Strengthening or weakening of religious/spiritual faith
- Spiritual crisis

VICARIOUS RESILIENCE

Up to this point, this course has focused largely on the negative consequences experienced by professionals who work with survivors of trauma. However, trauma professionals are not solely at risk for experiencing distress and harmful effects from their work. They often have the opportunity to experience positive outcomes as well, such as the development of vicarious resilience, which may leave them better able to cope with stressful or traumatic events in their own lives.

OVERVIEW

Health and mental health clinicians who work with survivors of severe trauma typically hear stories of horrible traumas and observe the resulting associated pain and other distress. Yet their work does not need to (and ideally should not) focus only on horrors and suffering. Trauma practitioners also frequently have the opportunity to bear witness to the enormous resilience possessed by many survivors, although not all clinicians draw this out of their clients or focus on the positive. In addition to being affected by their clients' trauma stories, clinicians can be affected by and learn something from their clients' stories and examples of resilience as well, in a positive way. If clinicians working with trauma survivors inevitably became burnt out, developed compassion fatigue, and experienced vicarious trauma to the extent that it was debilitating, experiencing no positive effects, then certainly their overall well-being would be negatively compromised. Many might be driven to leave the field. This is not the case for all clinicians who serve trauma survivors.

Some clinical trauma specialists do suffer and quit their jobs or shift to work that involves less exposure to trauma. Others, however, are able to stay in the field working with trauma survivors for years or decades because they have not only learned how to effectively prevent or deal with the negative effects, but because they have also developed vicarious resilience. It is not usually all negative or all positive; frequently, trauma specialists simultaneously have symptoms of vicarious trauma and resilience [68]. Being aware of the possibility of vicarious resilience may make it easier to achieve, and bringing conscious attention to the existence of vicarious resilience in the clinician can strengthen it [8].

Vicarious resilience is a relatively new concept developed by Hernandez, Gangsei, and Engstrom based on their research with psychotherapists who treated victims of political violence and their family members [8]. It involves the process of clinicians learning about overcoming adversity from the trauma survivors they work with and the resulting positive transformation and empowerment in those clinicians through their empathy for and interaction with clients. Just as vicarious trauma involves the transformation of the clinician through the empathic engagement with clients' trauma stories, so too does the process of vicarious resilience, but in a different (more positive and healing) direction. Both processes are seen as natural and normal in the context of trauma work and can co-occur simultaneously in any given trauma clinician [68].

The formulation of the concept of vicarious resilience was informed by clinical theory and practice as well as by research findings. It recognizes that clinical trauma specialists are affected vicariously by and can learn from the experiences and stories of their traumatized clients. For many years, experts in the field have focused on the negative affects only, such as vicarious traumatization, burnout, or compassion fatigue [3; 4; 49]. Those who developed the concept of vicarious resilience have brought attention to the fact that clinicians can also be vicariously affected in positive ways. They contend that it appears to be necessary for clinicians to have empathy toward their trauma survivor clients in order for vicarious resilience to develop [9]. In particular, they outline several factors that they believe contribute to the development of vicarious resilience, including the dynamics of the therapist-client relationship; the nature and extent of clinicians' connection with their clients' growth, resilience, and pain; empathic attunement with the client; and what has been termed "core empathic capacities" (i.e., tolerance, resistance, endurance, capacity) [8; 9; 68]. Overall, the authors argue that the literature and research has focused largely on the negative effects of empathy in trauma work and further research is needed to more fully explore and document empathy's role in creating vicarious resilience, thereby positively transforming the experience of trauma professionals.

Vicarious resilience also builds on the concept of resiliency in the face of severe trauma and other adversities, such that survivors of trauma are able to survive through strategies of coping and by relying on successful adaptive processes that are developmental, ecological, and relational in nature [69; 70; 71; 72]. Among the many factors identified in the literature that appear to support positive outcomes and resilience are unconditionally supportive social networks that include those outside the survivor's family; protective personal characteristics of the person developed over time as he or she relates to the environment; and psychotherapeutic interventions that focus on building on the strengths of the client, fostering the client's sense of personal control, and the promotion and development of authentic relationships [73; 74; 75; 76]. Clinicians working with these survivors can be positively affected by witnessing how the survivors cope effectively and overcome significant trauma to lead healthy and meaningful lives.

There are numerous examples that illustrate the many factors associated with resilience in professionals working with a variety of types of trauma in different contexts [77; 78; 79]:

- Secure attachments in social workers working after the attacks of September 11, 2001, which may promote resilience and help to prevent them from developing considerable compassion fatigue
- Supportive relationships, education, cultural and spiritual beliefs, resource finding, self care, and a sense of altruistic purpose related to their work among women leaders in the fields of early childhood health, human services, and education
- Higher levels of optimism, greater internal locus of control, less emotion-oriented coping, more use of social diversion and task-oriented coping, greater perceived family support associated with resilience to depression, anxiety, and vicarious traumatic stress disorder among mental health professionals

These factors are certainly not exhaustive of those that have been found to be associated with resilience in trauma professionals, but begin to demonstrate the breadth of relevant factors.

While McCann and Pearlman are perhaps best known for their work on vicarious trauma, they also have identified various positive effects of trauma work on clinicians, including a profound sense of meaning in their life derived from work with survivors; increased empathy and compassion for other peoples' suffering and pain; increased knowledge and awareness of the sociopolitical context of violence; enhanced motivation for and commitment to engaging in social activism; enhanced self-esteem as a result of work with survivors; increased sense of hope that people can actually endure and overcome traumatic experiences and transform those experiences; and the development of a more realistic and less idealistic worldview [2]. Another study found positive effects among women clinicians working with rape survivors related to seeing their clients experience growth and positive changes and feelings of satisfaction of personally contributing to the process of healing of their clients [47].

A qualitative study of Jewish interviewers of Holocaust survivors found that they reported positive transformative affects, which could be considered signs of resilience, from their experiences as interviewers that they perceived to outweigh any negative impacts they encountered [80]. The positive effects included an increased appreciation for their own life and good fortune; deepened appreciation for the resilience and strength of Holocaust survivors; enhanced empathy, compassion, and sensitivity toward survivors and other people in general; a greater sense of justice; a stronger identification as a Jew; and a greater sensitivity to prejudice. The negative impacts were challenges in their ability to listen to the Holocaust survivors' trauma stories; signs of vicarious trauma or compassion fatigue (in one interviewer); stronger fear and a greater sense of personal vulnerability as a Jew; and a pervasive sadness about humanity's dark side [80].

Results from a qualitative study of mental health clinicians serving torture survivors in the United States found that the clients' stories of resilience and capacity to thrive in the face of adversity positively affected the clinicians [9]. Elements of resilience mentioned frequently by clinicians in the study were the survivors' courage and ability to survive their torture experiences, their successful escape from danger, and their abilities to be resourceful and start a new life in the United States. The clinicians also reported that their perspectives on the world and their own lives had been positively changed as a result of this work [9]. For example, these clinicians were more fully able to appreciate the freedom in their own lives; take things less for granted; put their own problems into perspective, seeing them as less severe and more manageable; feel stronger and more motivated for life; feel more hopeful; focus more on positive things in their own life; and reframe

situations so they were able to see the positive aspects of a given experience that they previously viewed as negative. They also reported that the work with torture survivors connected them with a network of supportive colleagues with shared values and commitments and strengthened their professional motivation, as they had found a way to contribute professionally to advocate against human rights violations and provide therapeutic services to survivors [9]. The authors determined that these factors that emerged as a result of working with torture survivors empowered the therapists they interviewed. The presence of one or more of these factors constituted vicarious resilience in the trauma practitioners. The clinicians also reported that they perceived that the therapeutic process served to enhance their clients' resilience and left the clinicians feeling more efficacious in their work. They shared that the resilience they experienced re-energized them and made them even more committed to continuing their work with survivors of torture. Engstrom, Hernandez, and Gangsei suggest that clinicians who experienced a positive re-evaluating and revaluing of their work may be less at risk for developing job related exhaustion and burnout [9].

MEASURING RESILIENCE

The construct of resilience is used rather widely these days in the field of psychology, although it has been defined and measured in a variety of ways. It is generally considered to be a complex phenomenon involving multiple factors or dimensions [73; 81; 83]. Resilience is frequently described as a defense mechanism that makes it possible for people to thrive when confronted by adversity [84]. Enhancing one's ability to be resilient and live well after facing significant stress or adversity (or increasing one's resilience and positive health and mental health) has become a valued outcome and focus for treatment [85; 86].

In the professional literature, the terms resilience and coping have been used somewhat interchangeably, in a way that can lead to confusion. The literature often refers to resilience as an important component or way of coping with adverse situations (i.e., a person avoids or recovers from negative outcomes through resilience), while other authors hold the opposite—that coping is part of resilience. There is a vast and long history of literature on coping, in sharp contrast to the relatively recent attention to resiliency in the literature. Leipold and Greve maintain that resilience serves as a stabilizing force and is a key part of the bridge (conceptually) between coping and development, in that resilience supports the process of successful healthy aging and other positive developmental outcomes [87]. Resilient people are those who use coping strategies such as assimilation and accommodation successfully over time across a variety of adverse or stressful situations.

Davydov, Stewart, Ritchie, and Chaddieu have developed a model of resilience that is multileveled and biopsychosocial in nature, one that attends to the complex array of factors and series of events that contribute to the development of resilience across one's lifespan [84]. They hope that their model will help to unify and sharpen the theoretical understanding of this concept.

Assessing Resilience and Vulnerability to Stress

An important element that contributes to a person's reactions and way of dealing with stress is their level of resilience [88]. Resilience is often defined as positive adaptation to stress or trauma and is thought to be associated with a wide range of strengths and positive mental states found in some people. Measuring resilience in individuals with post-traumatic stress responses (including but not limited to PTSD, other anxiety reactions, and depression) is used as a treatment outcome measure in some cases. A survivor's improved resilience over time may indicate a better prognosis.

Some health and mental health professionals who work in the trauma field are more vulnerable to stress than others. This vulnerability, as well as the level of resilience in the face of trauma and stress, can be measured and tracked over time.

The following sections will outline some of the most cited and commonly used measures of resilience and vulnerability to stress. However, it is important to note that it remains to be determined if the different resiliency scales are measuring similar constructs or not.

Connor-Davidson Resilience Scale

The Connor-Davidson Resilience Scale (CD-RISC) is a well-validated measure, is easy to use, and the various versions have been found to have strong psychometric properties [88; 89]. A number of studies have used the CD-RISC scale with a wide range of populations, such as Turkish earthquake survivors, Chinese earthquake survivors, and in undergraduate students in the United States [90; 91; 92]. The CD-RISC is effective in distinguishing between those with different levels of resilience and showed that resilience can improve over time. The CS-RISC had good sensitivity to treatment effects, such that an increase in the score on the CD-RISC was associated with more treatment improvement as well as greater global improvement in an individual's clinical state. The CD-RISC can be self-rated, allowing for a person to easily monitor his or her own resilience over time. A nonspecialist can be trained to use the scale in the field quickly and easily. Connor and Davidson initially developed a 25-item resilience scale and tested it in a variety of adult populations (i.e., community sample, general psychiatric outpatients, primary care outpatients, and in clinical trials of PTSD and generalized anxiety disorder) [89]. Each of the items is rated on a five-point scale (scored 0 to 4); higher scores indicate greater resilience. Over time, other versions of the CD-RISC were developed, including a 10-item and an abbreviated 2-item version [92; 93]. Analysis of the original 25-item version yielded five separate factors, labeled as personal competence and tenacity; trust in one's instincts and tolerance of negative affect; positive acceptance of change and secure relationships; control; and spiritual influences [89]. A later factor analysis conducted by Campbell-Sills and Stein with more than 1700 undergraduate students yielded only four factors: hardiness; social support/purpose; faith; and persistence [92]. Further work by Campbell-Sills and Stein led them to propose a modified version of the CD-RISC that consisted of only 10-items with stronger psychometric properties [92].

Vaishnavi, Connor, and Davidson developed a 2-item version of this scale that they called the CD-RISC2 [93]. The 2 items were "able to adapt to change" and "tend to bounce back after illness or hardship," as the original scale developers viewed these two items as representing the essence of resilience. The CD-RISC2 is a brief, self-rated resilience measure with relatively strong psychometric properties. It may be valuable and practical in clinical settings as a brief screening measure or a measure of treatment progress, or in research contexts as a brief outcome tool.

Resilience Scale for Adults

The Resilience Scale for Adults (RSA) was developed in Norway as a measure of the presence or absence of interpersonal and intrapersonal protective resources thought to facilitate tolerance to stress and adverse negative life events and facilitate adaptation and promote resilience in adults [94; 95; 96]. The RSA consists of 33 items that are organized in 6 categories:

- Personal strength, composed of two subfactors: positive perception of self (6 items) and positive perception of the future (4 items)
- Social competence (6 items)
- Structured style (4 items related to organization, routines, planning, and goals)
- Family cohesion (6 items)
- Social resources (7 items)

Responses are scored using a 7-point semantic differential scale with a total possible score ranging from 33 to 231. The RSA has good psychometric properties, and it was found to be a useful, versatile, and valid instrument to reliably predict individual differences in self-reported stress and pain [96]. It has demonstrated protective effects against life events that are stressful in a laboratory context as well as in real-life settings [96]. One example incorporating the scale is utilizing the RSA in a clinical setting with individuals suffering from chronic pain. Friborg and colleagues conducted a study of resilience as a possible moderator of pain and stress and concluded that the RSA may be useful in identifying individual differences in overall functioning, the experience of pain, and perhaps also in the use of pain medication [96]. These researchers also suggest that pretreatment scores on the RSA may predict treatment effects, including the effects of psychological treatment [96].

The Resilience Scale for Adolescents

The Resilience Scale for Adolescents (READ) is a 28-item measure of resilience, originally validated on a representative sample of 6,723 Norwegian senior high school students between 18 and 20 years of age [97]. It was found to have strong psychometric properties and to load on 5 factors considered by some to cover the central aspects of the construct of resiliency: personal competence, social competence, structured style, family cohesion, and social resources. The authors advocate it as a useful tool for research examining risk factors and resilience [97].

The Adolescent Resilience Scale

The Adolescent Resiliency Scale (ARS) was developed for use with adolescents to measure their "mental recuperative power" [98]. The 21-item version of the ARS scale has three sub-scales related to novelty seeking (i.e., ability to demonstrate concern about and interest in a variety of events), emotional regulation (i.e., ability to control one's emotions and remain composed), and positive future orientation (related to one's goals for, outlook toward, and dreams about the future). It is meant as a measure of potential protective factors rather than as a measure of resilience as an outcome. It has strong psychometric properties and can be accessed online at http://psy.isc.chubu.ac.jp/~oshiolab/research/scales/ARS_in_English.pdf.

Resilience Scale

The Resilience Scale (RS) is a 25-item scale, with an optional 26th item, that has been translated into at least 15 languages, with more being translated [99]. It has been used for people from 13 to older than 100 years of age and is deemed suitable for those with a 6th grade equivalent level of education. The original 25-item version of the RS has been used for two decades and has strong psychometric properties. A shorter 14-item version is relatively new but has demonstrated very good psychometric properties as well. Studies have found the RS to be associated with self-management of illness and strong health-promoting behaviors. The RS measures the following characteristics of resilience: perseverance, self-reliance, meaningful life, existential aloneness, and equanimity [99]. Higher scores on the RS are considered to be indicative of fewer symptoms of anxiety, depression, and stress. Better potential for illness self-management is thought to be associated with moderate to moderately high scores on the RS. More information about the resilience scale, including how to obtain the scale and its user guide, can be found on the official scale website at http://www.resiliencescale.com.

Core Self-Evaluations Scale

The Core Self-Evaluations Scale (CSES) was developed in 2003 and is comprised of 12 items that measure the following traits: self-esteem, locus of control, self-efficacy, and emotional stability [100]. It has been argued that these traits represent a common quality, are similar conceptually, and play a contributing role in the processes of stress and coping [101]. Specifically, the core-self evaluations have been seen to be related to the use of less avoidance coping strategies and less perception of strain and life stressors and is thought to represent traits that may link coping, stress, and resilience. The CSES has good internal and test-retest reliability and acceptable validity scores [100]. It has been found to correlate with other measures of life satisfaction, job performance, and job satisfaction. This scale has been found to be easy to administer, is not proprietary, and does not require permission for use.

Sheehan Stress Vulnerability Scale

The Sheehan Stress Vulnerability Scale (SVS) is a 1-item, self-rated visual analog scale with 11 points that can be used to monitor one's perceived vulnerability to the impact of stress over time [102]. Greater vulnerability to stress or impaired resilience is associated with higher scores on the scale. The SVS is easy to self-administer and translate and has been found to have good validity and reliability.

Vicarious Resilience Scale

Hernandez-Wolfe and colleagues are in the process of development and validation of the Vicarious Resilience Scale [103]. It is anticipated that this scale will be a valuable resource for clinicians and others who work with trauma survivors in assessing the positive impact of their work and tracking it over time. Used in combination with scales to assess vicarious trauma and self care, practitioners will be able to assess the impact of their work more holistically, allowing them to build on their vicarious resilience while developing targeted plans to care for themselves.

MAKING SENSE OF THE IMPACT OF TRAUMA WORK

Clinicians who specialize in treating survivors of torture or other extreme forms of human-perpetrated violence often are asked how they do it or how can they tolerate such work. The task, in part, is one of making sense of the impact of trauma on one's own life. Just as survivors of trauma often struggle to make sense of their traumatic experiences, so do clinicians who treat trauma survivors. Developing and enhancing one's vicarious resilience may help trauma clinicians to strengthen and find new meaning in their work with survivors.

Case Study: Making Sense of Trauma Work

I remember being on the stand in court as an expert witness in the asylum hearing for a torture survivor and the judge stated that I must find my work to be very depressing. I recall responding that no, I did not find it to be depressing but rather inspiring because so many of the torture survivors I work with have enormous strengths and are resilient people. This same feeling is recounted by the clinicians studied by Hernandez, Gangsei, and Engstrom, who reported that they became inspired and gained strength and a sense of meaning from their work with survivors of severe trauma [8; 9]. This is perhaps what enables some professionals to work with survivors of torture and other forms of severe trauma for years and decades.

FACTORS THAT EMPOWER AND PROMOTE THEIR WELL-BEING

Hernandez, Gangsei, and Engstrom found that vicarious resilience in psychotherapists working with trauma survivors was a factor that helped to empower them, sustain them in their work, and promote their personal and professional growth [8]. Some of the most frequent themes mentioned by the therapists who work with survivors of political violence or kidnapping studied by Hernandez, Gangsei, and Engstrom were [8]:

- The power of witnessing and reflecting on survivors' enormous capacity to heal from serious trauma

- Becoming transformed and taking control over areas of their own lives that were within their control
- The therapists were led through their work with survivors to reassess the dimensions of their own problems (e.g., seeing their own problems as less serious than before, altering their definitions of problems, seeing the opportunities available in the situation, and recognizing that their problems can be overcome)
- Deepened understanding of the role of religion and spirituality in healing from trauma
- Becoming better able to tolerate frustration
- Developing hope and commitment to the work
- Experiencing their clients as models and important sources of information for the therapists' own learning about coping with trauma and hardships

Vicarious resilience often instills in trauma clinicians the hope, understanding, and belief that it is possible to recover from serious trauma and other challenges. Having such a positive stance can promote the well-being of trauma professionals while at the same time sustain them in their work. Many learn from their clients to become more resourceful, active, and resolute in conquering their struggles and problems. Often, in comparison to what their clients have faced and overcome, the therapist's own struggles seem manageable.

The development of vicarious resilience was also found by Hernandez, Gangsei, and Engstrom to increase therapists' sense of self-efficacy in their work and deepen their understanding of the process of resiliency and the therapeutic process [8]. Vicarious resilience can serve as an important resource for trauma professionals, and its presence and strength can be increased if the clinician becomes aware of and learns how to promote and nurture it. Learning how to prevent and combat the draining and other negative effects of vicarious trauma while cultivating vicarious resilience supports the health and well-being of clinicians who choose to work with survivors of severe trauma. What they learn from the resilience of their clients may even help them to deal with their own personal challenges and crises.

WHY VICARIOUS RESILIENCE IS IMPORTANT

Hernandez, Gangsei, and Engstrom argue that there are valuable pragmatic reasons for further developing and promoting the concept of vicarious resilience in the traumatic stress field among those who work with survivors of political violence. The six reasons they identify are [8]:

- The development of vicarious resilience is highly useful in combating the exhausting processes that many therapists experience that may otherwise lead them to feel victimized by their traumatized clients. The health and well-being of trauma practitioners is strengthened when they attend to both their vicarious trauma and vicarious resilience reactions.
- The motivation and determination of therapists to continue to work with survivors of political violence may be strengthened if they become aware of the processes of vicarious resilience. Promoting opportunities and contexts for clinicians to explore vicarious resilience may serve to enhance their experience of it and allow them to find new meaning related to their work.
- Including the concept of vicarious resilience in clinician training and supervision sessions can help support trauma professionals to take better care of themselves.
- Trauma clinicians may generalize what they have learned about resilience from the survivors they work with and apply it to other areas of their own lives, such as crises they may confront outside of work.

- Informing clients about the concept of vicarious resilience may be therapeutic in allaying any worries clients may have about infecting their therapist with their toxic trauma stories and thereby may support the process of therapy.
- Trauma clinicians may find that their view of their clinical work and career development is enhanced and expanded through their deepened awareness of the presence of vicarious resilience in their work.

SELF-ASSESSMENT STRATEGIES

There are a number of strategies that one can use to assess the impact of trauma work on personal and professional functioning, and there are different avenues available for discovering more about the impact of working with trauma survivors on one's well-being. Information about assessment tools for assessing one's level of compassion satisfaction, compassion fatigue, vicarious trauma, and vicarious resilience have been included throughout the text of this course (including information about how to access the assessment measures).

USING THE PROQOL TO PROMOTE PROFESSIONAL WELL-BEING

Individual trauma practitioners, their supervisors, and agency or project administrators can use findings from the ProQOL to promote their own well-being or the well-being of their professional staff as a means of supporting more effective and healthy work environments. Using terminology from the ProQOL materials, trauma practitioners (and the supervisors and administrators from their workplaces) should ideally seek to experience or promote high compassion satisfaction coupled with low or no burnout and vicarious traumatic stress [31].

Preliminary research results and practice knowledge indicate interesting emerging findings from non-ideal work environments [31]. Some trauma professionals experience high vicarious traumatic stress at the same time as high compassion satisfaction and pronounced feelings of altruism. Some of these professionals appear to be able to remain effective in their trauma work and may be helped by a short-term intervention aimed at their symptoms of vicarious traumatic stress. There are individual differences between professionals in how such an intervention is best implemented, but some are apparently able to achieve improvement in their symptoms while continuing their trauma work. Others may need a break from their work or a reassignment of activities and focus.

The literature suggests that trauma professionals most at risk may be those who experience high levels of burnout and vicarious traumatic stress [31]. Typically, these professionals experience fear related to their work and do not have hope that their situation or symptoms will change. This combination can greatly compromise their ability to be effective in their work with survivors. Individualized intervention plans along with work reassignment (at least during the intervention period) are generally needed.

The ProQOL assessment measure can be a useful tool in promoting change and improved quality of professional life. It can stimulate self-reflection and guide brainstorming about what is working well and what is not in order to identify appropriate targets for intervention in clinicians' work and personal environments. Professionals can self-administer the ProQOL measure once to get a snapshot of their professional quality of life or at multiple points over time to check in and monitor how they are doing and whether they are making progress or not in particular areas that they find challenging. The results can be used to suggest changes in one's self-care plan, or in the team's or workplace's self-care plan, if one exists. Changes in scores on the ProQOL over time are considered representative of actual changes in the person, not due to instability of the measure [31].

Organizational administrators or supervisors can also administer the ProQOL among their staff to obtain a deeper understanding of the levels of compassion satisfaction and fatigue in the workplace. They also can use the ProQOL to identify organizational factors that may be altered to promote better professional quality of life for the organization's workers and a more effective organization. Some organizational leaders take this issue seriously, while others appear to not prioritize it, ignore it completely (e.g., believe workers should tough it out or find a different job), or feel that they are powerless to effect any change.

In some cases, there may be very apparent and reasonable needs for change in an organization, but the change may not be realistically achievable (e.g., the need for additional therapists to treat clients and reduce waiting lists with a lack of sufficient resources to add additional therapists to the staff). The best that may be possible is to identify alternatives to the ideal intervention (e.g., forming more groups in order to accommodate clients who are waiting on a list for individual therapy) to lessen the negative impact while searching for additional resources or possibilities. As Stamm points out, some of the negative realities of trauma work are inevitable, objectively horrific, and cannot be normalized [31]. One cannot, or should not, pretend that serious wounds or burns are not serious. Professionals intervening with survivors may still be provided the opportunity for feeling that they made a difference, despite the awful circumstances and limits to their power to change the situation, and may experience some compassion satisfaction as a result. In addition, some of the negative effects of trauma work can be healthy and functional responses to one's environment. For example, it may not be advisable to completely eliminate a professional responder's fear or hypervigilance if he or she is working in an objectively speaking dangerous environment, such as in a war zone. In such a work setting, it may be vital and self-protective to remain ever alert and on guard.

USING MULTIPLE MODALITIES TO PROMOTE ENHANCED PROFESSIONAL QUALITY OF LIFE

In addition to using self-assessment tools, a well-developed strategy to address (and hopefully prevent) compassion fatigue and vicarious trauma and promote compassion satisfaction and vicarious resilience will include multiple modalities. These have been written about extensively elsewhere and can include (among other strategies) any combination of continuing education, personal therapy, supervision, and peer support, including peer supervision groups [49; 104; 105].

Continuing Education

Professionals who work with trauma survivors should strive to continually update their knowledge and skill set for both ethical and practical reasons, especially given that the field of traumatic stress is constantly evolving. For example, the last several years have seen new developments in brain research related to knowledge about the impact of trauma on the brain. In addition, the knowledge base about emerging, promising, and best practices with diverse traumatized populations is ever growing. Numerous scientific meetings and conferences abound around the world each year and contribute to the dissemination of research and clinical knowledge in the field of traumatic stress. One example is the annual conference held by the International Society of Traumatic Stress Studies (ISTSS). This organization's website (http://www.istss.org) provides updated information about conferences and learning opportunities related to trauma. In addition, there are a number of professional journals that publish findings in the traumatic stress field. More information is available in the Resources section at the end of this course.

Personal Therapy

Engaging in one's own personal therapy used to be promoted, and at some schools required, for graduate students studying to be psychotherapists. Trauma treatment providers who wish to become certified trauma specialists through the Association for Traumatic Stress Specialists are required, as part of their qualifications, to certify that they have received at least 50 hours of counseling. This personal counseling is encouraged in order for trauma specialists to explore, enhance their awareness of, and address any issues that may negatively or positively affect their ability to work with trauma survivors.

Supervision

Trauma professionals are strongly encouraged to continue to obtain ongoing supervision throughout their career in addition to engaging in their own psychotherapy. This supervision should ideally be provided by more seasoned and expert trauma specialists, or supervisors who have expertise relevant to the population(s) with whom the practitioner is working. Saakvitne and Pearlman recommend five key components that should be covered in the supervision of trauma therapists [49]:

- Theory: Theoretical orientation that provides a clear understanding and conceptualization of how trauma affects psychological functioning and psychotherapeutic treatment goals and techniques
- Education: Information and education about the management of symptoms as well as the most common dissociative and post-traumatic adaptations
- Relationship: Attention to the therapeutic relationship
- Safety: Safety issues addressed and a safe and respectful space provided to attend to countertransference issues
- Vicarious trauma: Education about vicarious trauma as well as guidance regarding developing a plan to attend to vicarious trauma (and education and mentoring to enhance one's vicarious resilience)

Peer Support and Self-Care Techniques

In addition to individual supervision, it can also be valuable to participate in peer group supervision. This can provide an effective avenue of support for preventing and attending to negative impacts of the trauma work as well as fostering vicarious resilience [106].

The practice of mindfulness has emerged as a key component of various approaches to working with survivors of complex trauma, including in Briere's Self-Trauma Model. Of note, Briere is currently expanding his model to include more emphasis on mindfulness and is writing on a new book on the subject [107; 108]. Meditation and other mindfulness practices have been proven effective in supporting the well-being of trauma professionals and other care providers, including helping to prevent them from experiencing compassion fatigue [109]. Trauma professionals are encouraged to consider adding mindfulness practices into their repertoire for enhancing their professional quality of life.

Compassion Meditation for Caregivers

Buddhist meditators and meditators from some other traditions strive to achieve and maintain a state of equanimity from moment to moment through mindful meditation. Equanimity is an evenness of mind, especially under stress. Mindfulness can be defined as a receptive and non-judgmental state of mind in which an individual observes his or her feelings, sensations, and thoughts with acceptance, without trying to change, suppress, or deny them. It is a way of knowing, seeing, and being. When one is in a state of mindfulness, one is acutely focused and aware of the reality of the present moment, moment by moment, acknowledging and accepting it as it is [110].

Several studies have been conducted with experienced meditators in an effort to better understand these phenomena and the impact on health and well-being [109; 111]. Empirical studies over the past two decades suggest that meditation and other contemplative practices can help to relieve the symptoms of burnout and compassion fatigue, including such symptoms as anxiety, depression, weakened immune system, and insomnia [109]. The well-being and resiliency of caregivers has been found to be strengthened through these practices as well. Meditation, in particular, is associated with the development of the following five qualities that appear to help prevent and address compassion fatigue and burnout: compassion and self-compassion; resilience; self-awareness; metacognition and attention; and meaning [109].

Neuroscience research has found that similar parts of the brain are activated in the person who feels empathy for another who is suffering and in the person who is suffering [109; 112]. Early findings of studies with Buddhist monks suggest that it may be empathy, if present without accompanying compassion and altruistic love, that puts us at risk for becoming burnt out [112]. This area of research shows promise for caregivers and trauma professionals who are at risk of becoming burnt out.

TRAUMA STEWARDSHIP

TRAUMA STEWARDSHIP: A NEW CONCEPT DEFINED

Trauma stewardship is another relatively new concept in this field, one offered to assist those who work in many different capacities with trauma. A general dictionary definition of stewardship is "the office, duties, and obligations of a steward" or "the conducting, supervising, or managing of something; especially the careful and responsible management of something entrusted to one's care" [113]. Trauma stewardship, as conceptualized by Lipsky, is [10]:

> A daily practice through which individuals, organizations, and societies tend to the hardship, pain, or trauma experienced by humans, other living beings, or our planet itself. Those who support trauma stewardship believe that both joy and pain are realities of life, and that suffering can be transformed into meaningful growth and healing when a quality of presence is cultivated and maintained even in the face of great suffering.

Lipsky encourages trauma practitioners to learn how to live fully while still being able to bear witness to trauma [10]. She urges professionals to cultivate self-awareness and mindfulness, staying fully present and grounded in the realities of the present moment without judging oneself or others. She introduces the concept of trauma stewardship as a means for trauma practitioners to enhance their understanding of the ways in which trauma impacts them and the important factors that protect themselves and others from the negative effects, such as becoming numb, drained, exhausted, cynical, and overwhelmed to the point of feeling helpless and hopeless. Rather than pathologizing these effects, however, Lipsky normalizes them as natural and universal reactions to trauma, similar to the approach that trauma therapists generally take with survivors [10]. Lipsky calls this universal reaction the "trauma exposure response" and identifies a path that will sustain trauma professions so they can work for change and a better society, one free from privilege and oppression, for decades and generations to come [10].

The 16 prominent warning signs of trauma exposure response detailed by Lipsky are reminiscent of those described earlier in this course. They are feeling helpless and hopeless; feeling like one can never do enough; hypervigilance; diminished creativity; inability to embrace complexity; minimizing; physical ailments and chronic exhaustion; deliberate avoidance and inability to listen; dissociative moments; sense of persecution; guilt; fear; anger and cynicism; numbing and inability to

empathize; addictions; and a sense of grandiosity or inflated importance related to one's work [10]. It is not her classification of the reactions to trauma work that is new, but her conceptualization of "a new framework of meaning" [10].

The concept of trauma stewardship is relevant not only for health and mental health professionals, but for all who work with the pain, suffering, and trauma of other people or the environment [10]. These workers include, but are not limited to, social workers, domestic violence and animal shelter workers, police officers, firefighters, medical and public health workers, teachers, spiritual advisors, members of the military, international relief workers, biologists, ecologists, environmentalists, and activists for social change.

Trauma stewardship offers another approach to meet the challenges of trauma work. It is based on the premise that the effects of exposure to trauma can be managed and encourages practitioners to take care of themselves through reflecting deeply on what led them to engage in trauma work, the impact it has on them, and the meaning of and lessons gained from the work. Trauma stewardship guides trauma clinicians to build a long-term approach to remain healthy so they can continue to work with trauma survivors, an approach that is intentional and grounded in mindfulness. As such, it promotes a path to self care and guides trauma clinicians to integrate this concept into their lives and practices.

A PATH TO PROMOTE SELF CARE

Trauma practitioners, even (and maybe most especially) seasoned ones, may be in denial and have a hard time recognizing the full extent of the impact of their exposure to trauma in their lives. Lipsky shares examples from her own life and those of many others throughout her book to illustrate the paths they followed to recognize the impact of their trauma work and to develop ways of taking care of themselves [10]. Interested readers are encouraged to explore these vignettes of trauma stewardship as well as the many exercises sprinkled throughout Lipsky's book to inspire and support their own development of a path to self care [10].

Lipsky describes how she thought that she was just fine despite repeated encouragement from loved ones to take time off or consider engaging in a different type of work [10]. She shares how her wake-up moment came when she was standing on a cliff with a beautiful view on vacation with family and her thoughts turned to wondering how many people had committed suicide by jumping off the cliff. It finally struck her that not everyone would have those thoughts and that her own world view had radically changed as a result of her trauma work. This is a great example relevant for many who enter into trauma work with great passion for the work and cause, but often with an attitude of being tough (i.e., able to bear whatever the consequences silently and without problem) while lacking adequate internal resources to take care of themselves. It is not possible, however, to be unaffected by trauma work. Lipsky uses humor to communicate many of her points and to enable the reader to examine what is really going on with fresh and honest eyes [10]. The use of humor can be incredibly healing and promotes stress reduction while making it easier to remain compassionate toward oneself and others. This is a helpful (and disarming) approach to the topic, one that likely will make it quite accessible to many trauma practitioners.

Trauma stewardship reminds practitioners to never forget that it is a gift to accompany survivors on their path to healing from trauma and also of their responsibility to take care of themselves and cultivate their capacity to serve [10]. Trauma stewards are called upon to uphold the highest standards of professionalism, integrity, and ethics at all times in their work with survivors who have entrusted them to safeguard their deeply painful and personal stories and their lives.

In the face of such responsibility and the importance of the work, trauma stewards might be tempted to view their own personal needs as inconsequential and not warranting of attention or care. This, however, would be disastrous in the sense that the well-being of neither the trauma survivor (or the environment, depending on who or what is the focus of the trauma work) nor the trauma steward would be promoted. Trauma stewardship offers instead a path to rejuvenation and revitalization, whereby practitioners and members of the community alike can achieve balance and experience joy and meaning in their work and lives [10].

HOW TO INTEGRATE TRAUMA STEWARDSHIP INTO ONE'S LIFE AND PRACTICE

Lipsky created a tool that she calls "The Five Directions" to help those who work with trauma survivors to make choices and assess how they are doing and what they need to take care of themselves as practitioners and as people [10]. She envisions that everyone must find their own unique path and that The Five Directions serve merely as a compass to guide professionals and offer suggestions along the way rather than being a specific set of step-by-step instructions. This compass can be referred back to in order to check in with oneself and reassess needs and direction over time.

Lipsky's model is based on a wheel that encompasses the four cardinal directions (north, east, south, and west) and adds a fifth direction (the center or spiritual direction) envisioned by various ancient cultures. The first four directions are described as [10]:

- North: Associated with water and creating space for inquiry regarding why one is doing trauma work and exploring whether the path is working for them. For some it may involve aspects of trauma mastery.
- East: Associated with fire and choosing one's focus while also developing a Plan B. Also involves opening oneself up to other possibilities and perspectives.
- South: Associated with earth and building compassion for oneself and others, creating a community to ground and support oneself, and examining what one can do to contribute to systemic change.
- West: Associated with air and finding balance and being engaged with one's non-work life, keeping energy moving, and having gratitude.

The fifth direction stands for the centered self. This direction encourages practitioners to maintain a daily practice of centering oneself through connecting with "innate qualities of wisdom, free will, compassion, and balance" [10].

So many things involved in the practice of trauma work, and life in general, are outside of our control. Trauma stewardship, in keeping with many spiritual traditions, encourages a shift in perspective away from counting on other people or things outside of oneself to create well-being or happiness. Individuals can learn that they can influence their own reactions to experiences in the moment. In the process of doing so, they can create a positive transformation and balance in themselves such that they are able to achieve or maintain well-being. This transformation can also support or sustain one's ability to care for others and the world. This process does not require denying or eliminating all pain out of life, as this would prevent one from truly experiencing joy. Lipsky calls for professionals to embrace this paradox [10].

One of the most helpful tools that one can possess to promote trauma stewardship is a well-developed knowledge of one's own feelings, values, and experiences, as well as the knowledge of one's own most effective strategies for self care [10]. Having cour-

age, curiosity, and an open and flexible attitude and approach (along with compassion for oneself and others) is vital in order to be successful in this endeavor.

People who are more resistant to stress and able to recover from trauma have been found to share a number of traits, including strong social support, a sense of personal control in their lives, making healthy lifestyle choices, and engaging in tasks that are meaningful to themselves [114]. Lipsky argues that trauma practitioners who use The Five Directions approach to trauma stewardship are enhancing their internal resources in ways that make them more stress resistant [10]. She stresses that practitioners' sense of personal control is bolstered when they focus on creating space for inquiry (north) and choosing a focus (east). When individuals focus on building compassion and community (south) and finding balance (west), they become stronger as these efforts foster making healthy choices and generating a supportive environment.

Exercises to Explore the Five Directions

Lipsky lays out a number of suggested exercises that professionals can use to develop a practice of attending to and exploring The Five Directions related to work with trauma survivors [10]. A few of these exercises are included here in the hope that they may help inspire the incorporation of trauma stewardship into practice.

Choosing One's Focus (East)

Write down three things about a challenging work situation that you found made it particularly challenging as well as three things that you appreciated about the situation. As you review your lists, ask yourself what you are most likely to focus on (the challenging parts or the parts you appreciated) and why [10].

Identifying and Moving Toward an Alternate Plan (North)

Develop a list of five things you could do over the next five weeks that would move you nearer to making your alternate plan a reality. Ask what you would love to do if you were not doing your current work [10].

Building a Supportive Community (South)

Who is in your microculture? Reflect on how well they help to nurture integrity, hopefulness, and accountability in you. Are they strong role models for you or could you use stronger role models in one or more of these areas [10]?

Finding and Creating Balance (West)

What one thing would you love to incorporate into your daily work life or routine to help you find or create more balance but you fear you could not? Marshall all your powers to make it happen [10].

Centering Yourself (Center)

Ask yourself each night what you can be done with and do not need to hold onto or focus energy on for another day. Then, before going to sleep, put it down and do not pick it up or focus on it the next day [10]. You might also try doing something similar to this exercise each day as you leave your office or finish your work for the day.

Putting trauma stewardship into practice consistently and in a way that can be sustained over time is an art rather than a science. By definition, it is a very personal process that evolves over time and involves finding one's own unique path and direction.

PUTTING IT ALL TOGETHER: DEVELOPING A SELF-CARE PLAN

BENEFITS OF DEVELOPING A SELF-CARE PLAN

Many experts in the field emphasize the importance of developing one's own self-care plan and provide helpful models and suggestions for doing so. This is critically important, and some approaches to this will be reviewed in the following sections. As well thought out and promising as any self-care plan may be, however, it may not be effective if there are not simultaneous changes or improvements in key structural factors contributing to the professional's vicarious traumatic stress or burnout. It is essential, therefore, to incorporate structural strategies into one's plan and to seek support from other professionals or organizations in advocating for such changes. There can be strength in numbers, particularly when the group is able to frame the issue to the institution in compelling terms of the opportunity costs of not addressing the structural factors that contribute to a toxic or unhealthy work environment. This may also involve helping those running the institution engage in a full cost-benefit analysis that includes the potential benefits of improving work conditions.

There are many benefits to be gained from developing a self-care plan. However, unless one devotes time and attention to developing a plan to take care of oneself, it rarely or only sporadically happens. In addition, one is less likely to spontaneously implement an optimally effective plan without some planning. Equally important is reviewing this plan periodically to reflect on whether it is working (in part or in whole) and/or whether changes should or need to be made.

It is important to emphasize that the notion of taking care of oneself can be experienced as selfish and antithetical to the communal values of some cultures. In addition, some human rights defenders struggle with making it a priority to take care of themselves, feeling that to be committed to their cause they should devote all their energies to caring for others [115]. Without effective self care, it can be difficult or impossible to fulfill one's professional duties effectively or, for some, to sustain the ability to continue to engage in one's work at all. Rather than framing self care as an individual endeavor—a goal that does not fit culturally for many—identifying self care as a collective concern of the individual, the organization he or she works for, and his or her community may be beneficial [115].

Implementing an effective self-care plan is likely to lead to positive benefits for others in one's environment (e.g., family members and other loved ones, coworkers, friends, clients). One's demeanor and the quality of the energy that projected into the environment can affect those around trauma professionals. Classic examples occur when someone is angry, fearful, or very anxious. If one remains calm and retains a positive attitude in a situation where another is anxious or fearful, it can have a calming effect. Psychotherapists use this principle all the time, for example when they consciously use a calm tone of voice and unpressured pace of speaking with clients who are very anxious. Over time it may serve to calm the client's anxiety and slow the pace of his or her speech and breathing as well, serving to induce a more relaxed state.

COMPONENTS OF A SELF-CARE PLAN

The components of a self-care plan vary from individual to individual depending on their needs, abilities, personal styles, personality, culture, and preferences. There are several tools available to assist professionals in assessing their attitudes toward self care and their needs, including the tools included throughout this course. Baker has developed a questionnaire for psychotherapists

to use to assess and identify what they need to promote their well-being [61]. This questionnaire guides practitioners to examine their professional self, their experience with therapy, and emotional demands and stresses in their life. They are asked to reflect on the challenges they have faced as a professional and whether they have ever considered leaving their profession (and if so, why). They are guided to examine various aspects of self care, such as [61]:

- Personal definitions of what constitutes self care
- Attitudes toward self care (e.g., conflictual feeling about self care, prioritizing of self care)
- Awareness of one's own needs regarding self care
- Useful and effective self-care strategies

These are just a sampling of the questions one is encouraged to ask oneself. While Baker developed this tool for psychotherapists, most of the questions are relevant for other health and mental health professionals as well [61].

Saakvitne, Pearlman, and the staff of the Traumatic Stress Institute/Center for Adult and Adolescent Psychotherapy (TSI/CAAP) developed a useful assessment worksheet for assessing self care in the context of the work they do with clinicians around vicarious traumatization [49]. Professionals rate themselves across five main categories of self care: physical self care; psychological self care; emotional self care; spiritual self care; and workplace or professional self care. Many examples are provided in each of these categories to stimulate thinking about each, encouraging the professional to provide examples unique to one's own life experiences. Professionals are also instructed to rate themselves according to how often they strive for balance within their work life and, separately, among different dimensions of their life (i.e., family, work, relationships, recreation).

In reviewing one's self-ratings on this assessment worksheet, the professional is often able to see patterns that can be helpful in identifying areas of self care most needing improvement. For example, professionals might notice that while they frequently do one or more things to attend to their psychological and spiritual self care, they rarely attend to their physical self care (e.g., they do not eat regularly, exercise, get enough sleep, get medical care when needed, or take time off when they are sick). As they work on this exercise, professionals are encouraged to pay attention to their internal dialogue and thoughts about self care and to reflect on whether or not they are making their own well-being a priority. When used in a group workshop (with participants working alone to assess themselves and then discussing their findings in dyads and later with the group), this exercise often yields rich material for discussion and brainstorming with peers about self care.

Trauma professionals often have a wide range of self-care strategies in their repertoires: regular massages, exercise, regularly reading novels that have nothing to do with their work, and maintaining a meditation practice. The important consideration is to find something that works and to be open to the possibility that what works may change over time just as one's needs and vulnerabilities may evolve as well.

When working to understand the impact of trauma work on well-being and developing self-care plans, it may be beneficial to draw upon the self-assessment worksheet developed by the staff of The Traumatic Stress Institute/Center for Adult and Adolescent Psychotherapy (described previously) to assess one's self care over time [49]. This tool is helpful in facilitating participants' awareness of key areas in their lives that are and are not working for them. It is useful for pinpointing areas of self care that they may want to address. Some of the items on the worksheet are things that people do not often think of but are important components to maintain equilibrium and promote well-being, such as remembering to eat regularly, practice receiving

from others, or being open to not knowing. This self-care assessment tool also covers a broad range of possibilities such that most participants are able to identify at least some of the areas of self care that apply to them and that they can address in their lives. It also is a useful measure for stimulating thought-provoking discussion among peers and encouraging deep reflection and self-awareness. Trauma professionals can use self-assessment measures such as this to periodically reassess how well they are taking care of themselves and identify other approaches that they may want to try.

It may sound like it should be easy to set limits and establish a self-care plan. However, many dedicated health and mental health professionals who work in under-resourced settings with clients or patients with enormous needs overextend themselves and have a hard time setting appropriate limits. These situational factors are common professional hazards that can contribute to the development of burnout. Many professionals chose their particular area of specialization because the work feels meaningful and important. They generally feel very committed to the cause they are working for. They may feel selfish or feel bad in some other way if they have the knowledge or ability to do something for others and they do not extend themselves to do it. Ultimately, however, there is a limit to what can be considered a healthy workload and what is not, and the consequences of not setting appropriate limits can be severe.

Case Study: Mindfulness as a Self-Care Strategy

I was originally introduced to meditation as a high school student by my school principal. Years later, as a professional social worker working with traumatized refugees, two colleagues encouraged me to further explore and deepen my study of meditation. I had already experienced some benefits of meditation in my daily life and for some years had worked with Buddhist refugees in refugee camps in Asia and in the U.S. I had seen for myself the benefits that some of my clients experienced from meditation practice in coping and living with the impact of their traumas and other life challenges.

As my meditation practice deepened, in addition to setting time aside in my day to formally "sit" and meditate, I began to integrate it into my clinical sessions with survivors of state-sponsored torture. At first I was not aware that I was doing this. Soon I began to notice that I was focusing on my own breath, particularly during the portions of sessions when I would be talking with survivors about their histories of torture and other traumas and when they were expressing extreme distress in session. I would split my awareness and continue to attend carefully to my client while at the same time focus a portion of my awareness on my own breath, as I had learned to do in my meditation practice. I spoke with several meditation teachers about what I had discovered that I was doing in session, and they encouraged me to consciously expand what I was doing to include not only an awareness of my breath but also my physical sensations during sessions with my traumatized clients. As I became more adept at doing this with practice, I found that it was quite beneficial in various regards. It seemed to make it easier for me to remain calm, composed, nonreactive, and centered even while listening to horrific details of torture or while my clients were experiencing flashbacks to their torture or expressing utter hopelessness and suicidal thoughts in session. This in turn appeared to contribute to a calmer and safer atmosphere for the clients, one in which they seemed to be able to more fully express themselves (including about particularly gruesome details or events that were taboo or considered deeply shameful or stigmatizing in their culture and society) without feeling that they were harming or contaminating me or being harshly judged.

The calmer state of mind I experienced when using these meditation skills made it easier for me to think clearly and calmly about how to proceed in session. I was better able to access my professional knowledge and experience and intervene appropriately. Integrating an awareness of my breath and sensations during sessions with trauma survivor clients appears to promote my ability not to take my work home with me in that I am better able to attend to and process my distress in the moment as I am with my clients. Utilizing these skills in session with my clients also appears to enhance my ability to be aware of my countertransference reactions. This increased self-awareness in turn enables me to be less likely to be unconsciously driven by my countertransference in negative ways and facilitates my ability to respond professionally.

I also find these same tools extremely valuable in helping me to manage my performance anxiety and function better during stressful moments as I am cross-examined in court, where I often testify as an expert witness, or when I am presenting in front of a challenging audience. Several of my colleagues employ similar meditation skills in session with their trauma survivor clients with great success. If you are not already an experienced meditation practitioner, it may help to obtain some instruction in meditation first and have a meditation teacher available to consult with you in the early phases of experimenting with these techniques.

Case Study: New Year's Resolutions

For many years, starting as a youth, I practiced the time-honored tradition that is widespread in the United States of making New Year's resolutions. Not just one resolution a year, but a list of things I would do differently or goals I would achieve each year. Inevitably, I would not be successful and would eventually, one by one, abandon most, if not all, of my resolutions as the year marched on. Some years, I achieved success or partial success, but in hindsight my efforts seemed haphazard. Clearly, my old approach was not working for me. I, like many people I know, grew to laugh about and expect this as inevitable. Some friends and colleagues gave up or never developed New Year's resolutions at all.

Some years ago, I decided to adopt a very different approach to New Year's and use it as an opportunity to recommit myself to taking care of myself, something that was so important to my personal and professional lives. What I have found works the best for me is to adopt an overall theme of "self care" instead of a more traditional New Year's resolution. My plan includes routinely and frequently checking in with myself and asking myself if whatever I am doing or planning to do is in keeping with my self care. I have found that this strategy is profoundly more helpful and easy to follow and stick with. It supports my setting boundaries and limits and makes it easier for me to weed through the many emails I receive each day and requests for my time in an efficient manner.

I spend much less time agonizing over how I can juggle my schedule to accommodate conducting a training course, attending an interesting workshop, or squeezing in another meeting. I used to have a harder time saying no when I was asked to do something that I knew I had the skill set to do or something that inherently interested me but conflicted with my other responsibilities. Now I find it generally easy to say, "Sorry, I do not have time right now to do that," or "I am overextended as it is and I cannot take that on right now."

An important component of my new strategy includes being gentle and not overly harsh or critical with myself if I slip in my self care occasionally. I am going for an overall commitment to self care for the long-haul, as a lifestyle change. Beating myself up if I have a bad day or neglect myself occasionally is, after all, antithetical to self care. I use that opportunity as a wake-up call to assess what happened and rededicate myself to taking care of myself.

STRATEGIES FOR SUCCESSFUL IMPLEMENTATION

Acknowledging the importance of having a self-care plan, identifying what a plan may include, and developing a plan for self care are not sufficient. The most important step is actually implementing the plan. There are many potential challenges that may emerge when one is seeking to implement a self-care plan. It is important to anticipate and examine what may impede self care, or more specifically, impede the components of one's self-care plan and put a proactive plan in place to prevent or overcome these obstacles. This approach is similar to how effective clinicians work with clients toward achieving their goals.

Ideally, one's approach to self care should be comprehensive and multipronged, encompassing the multiple dimensions of one's professional and personal lives. If not, it is harder to achieve optimal well-being and a healthy balance between the personal and professional. Strategies should be developed to address key challenges or symptoms of distress in the physical, emotional/psychological, behavioral, interpersonal, and spiritual realms of one's personal life. At the same time, attention to major stressors in the workplace or professional life must also be addressed. Overall, enhancing one's self-awareness and ability to regulate stress both personally and professionally is an important goal. This may seem (and be) daunting. It is essential to be realistic, tackle only one or two changes at a time, and implement changes gradually in steps over time if there is to be lasting substantive improvement. This is similar to the approach advocated by some weight-loss experts who share the benefits and wisdom of making healthy lifestyle changes that can be sustained over time when trying to achieve and maintain weight loss. It may help to save the most challenging strategies and changes, those that will likely be more difficult to achieve, until later. Starting with easier changes first is likely to boost your morale and motivation to tackle the harder issues.

The intervention strategies advocated by Saakvitne and Pearlman are compelling and effective in addressing each realm of the trauma professional's life [49]. For example, in the professional realm, they suggest the importance of:

- Adequate opportunities for effective supervision and consultation
- Attention to client load and distribution of cases when scheduling (e.g., manageable case load, variety of types and severity of cases)
- Balance and variety of tasks for each professional
- Opportunities to give and receive ongoing education
- Adequate work space
- Delegation of certain tasks that can be handled by others

What is needed in each of these areas may vary from professional to professional. In terms of work space required, for example, this can include confidential meeting space, adequate lighting, temperature control, ergonomics, and minimal noise pollution.

In the organizational realm, the institution should be responsible to ensure:

- Forums are provided for issues or problems to be discussed and addressed (in a non-threatening and effective manner).
- Support from colleagues should be available and encouraged.
- Supervision should be routinely available.
- Atmosphere of respect exists for both staff and clients.
- Adequate resources are provided for staff to do their job (e.g., health and mental health benefits, appropriate work space, time, manageable work loads).

Recommended workplace or agency strategies include:

- Implementing effective safety plans (preventive and in response to incidents that may occur)
- Promoting empowerment
- Normalizing countertransference, vicarious stress, and burnout reactions
- Maintaining open communication (i.e., avoiding the collusion of silence)
- Holding multidisciplinary case conferences on a regular basis to provide opportunities for the provision of support and the exchange of ideas and information, and to decrease professional isolation
- Holding weekly supervision sessions
- Mentoring of new professionals
- Providing work-free periods and varied work duties
- Supporting continuing professional education

In the personal realm, the following is recommended:

- Personal psychotherapy
- Attention to health
- Attention to one's spiritual well-being
- Nurturing all aspects of oneself, including the emotional, physical, spiritual, interpersonal, creative, and artistic
- Finding time for leisure activities that ideally are physical, creative, spontaneous, and relaxing
- Making one's personal life a priority

Making one's personal life a priority is critical during heavy work periods with important deadlines. At these times, it can be extremely challenging to carve out enough time to attend to one's personal life and not let work consume most of one's waking hours.

Overall, Saakvitne and Pearlman encourage trauma professionals to stress the following in all realms of life [49]:

- Mindfulness and self-awareness
- Self-nurturance
- Balance among activities of work, play, and rest
- Meaning and connection

Ultimately, after all the planning is in place, it is valuable to make a firm personal commitment to oneself—not one that is taken lightly or is easily set aside. Without such a serious pledge it is less likely that the plan will be successful or sustainable. Some professionals have a hard time justifying to themselves (or others) that they deserve to make their own needs a priority; some might even call that a common professional liability.

Why is it important to make a personal commitment to oneself to focus on self care? The answer is simple and compelling, as presented by Saakvitne and Pearlman [49]:

- Because I hurt.
- Because I matter.
- Because my clients matter.
- Because the work I do matters.
- Because the profession matters.
- Because I must.

Individual strategies for successful implementation of a self-care plan vary and may evolve over time for a given individual. What works for one person may not for another. What works at one point and time may not be as effective at a later point or in another context. Components to consider when implementing one's self-care plan include, but are not limited to, [49]:

- Anticipate obstacles to your plan.
- Develop a plan to prevent those obstacles you have control over and work with others to try to address obstacles outside of your control.

- Find a self care buddy or a group. Do not try to implement a plan in isolation. At a minimum, tell someone about your plan and ask them to check in periodically.
- Take it one day at a time. Anticipate setbacks, and do not punish yourself or abandon your plan if you slip up.
- Look for positive outlets and reward yourself periodically as you make small steps toward your goals.
- Take it one step and one change at a time.
- Be realistic. Try not to set yourself up for failure by being overly ambitious or aiming for things that depend heavily on others or are outside of your own control.
- Do at least one thing in each realm of self care (i.e., physical, emotional/psychological, spiritual, interpersonal). Be sure not to neglect any realm completely.
- Increase your self-acceptance and mindfulness.
- Make time and space for what you love to do and do it.
- Remember your commitment to yourself.
- Above all, do not give up.

Of course, some of these strategies are beyond an individual's control, such as those that involve changing institutional factors, but most people find that there are at least some areas they do have control to change that can result in significant benefits.

RESOURCES

In addition to the rich materials available on the ProQOL website described in Appendix 1, there are a host of other valuable resources available online. These resources may be used to further study on the topic or develop one's own self-care plan.

Trauma Stewardship Institute

http://traumastewardship.com

Laura van Dernoot Lipsky's institute on trauma stewardship provides organizational consulting, workshops and retreats, keynote presentations, and support for professionals responding to disasters.

Risking Connection

http://www.riskingconnection.com

A training curriculum for trauma professionals and others who serve trauma survivors [116]. Risking Connection is a three-day training course that provides foundational material on the effects of trauma, the healing process, and how trauma professionals can effectively take care of themselves. The Risking Connection curriculum teaches skills for serving trauma survivors within a relational framework whereby the relationship is seen to be a prime healing factor. It addresses, among other topics, countertransference, vicarious trauma, and burnout. It provides a philosophy of treatment rather than endorsing a particular treatment technique. It is firmly grounded in relational and attachment theory. The Risking Connection curriculum is copyrighted by the Sidran Institute, which provides traumatic stress education and training resources/publications and supports advocacy.

Sidran Institute for Traumatic Stress Education and Advocacy

http://www.sidran.org

The Sidran Institute is a non-profit that develops traumatic stress materials, such as:

- Educational programs for the general public about trauma
- Books, workbooks, videotapes, DVDs, and educational brochures
- Assessment measures and teaching tools
- Training and consultation for clinical and frontline trauma workers (including the Risking Connection curriculum)
- Consultation on trauma-informed services
- Pilot and demonstration projects on collaborative trauma services
- Customized resources to meet the needs of specific trauma provider and consumer populations

Trauma Research, Education, and Training Institute (TREATI), Inc.

http://www.treati.org

TREATI was founded in 1996 by principals of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy (TSI/CAAP) to promote research, community education, and expanded professional training and education about traumatic stress studies (specifically in the areas of psychological consequences of trauma on survivors, the affect of treatment on helpers and clients, and effective intervention strategies for both clients and helpers). TREATI provides support to frontline trauma workers and therapists who work in many settings with a wide range of survivors and is the licensed provider of Risking Connection training for outpatient mental health providers, mental health organizations serving children and adults, residential treatment programs for children and adolescents, psychiatric hospitals, community-based mental health services, juvenile justice centers, and substance abuse treatment centers.

Self Care in Social Work

http://www.selfcareinsocialwork.com

Although this website is devoted to the topic of self care in social work, it is relevant to allied helping professionals as well. It includes assessment tools, worksheets, examples of self-care stories, and a link to Cox and Steiner's book on self care in social work [117].

The Figley Institute

http://www.figleyinstitute.com

A host of trauma training and continuing education courses are available through The Figley Institute. These offerings were co-developed by Dr. Charles R. Figley and Dr. Kathleen Regan Figley and are directed at professionals and lay helpers who work with traumatized communities and individuals.

Green Cross Academy of Traumatology

http://www.greencross.org

Green Cross Academy of Traumatology was founded by Dr. Charles R. Figley in 1997. It is a non-profit international humanitarian assistance organization created to establish and maintain high standards of professionalism for the field of traumatology. It is composed of trained compassion fatigue service providers and traumatologists, most of whom are licensed mental health professionals. Green Cross is focused on helping trauma survivors in crisis and provides education, certification, and deployment of professional responders. It also offers certifications through the Figley Institute, including Field Traumatologist, Certified Traumatologist, and Compassion Fatigue certifications (for therapists and for others who work with trauma survivors).

Association of Traumatic Stress Specialists (ATSS)

http://www.atss.info

ATSS is an international non-profit membership organization that provides education and certification for trauma specialists. The Certified Trauma Specialist (CTS) certification was designed for trauma clinicians, treatment specialists, and counselors who provide individual, group, and/or family therapy, counseling, or support to trauma survivors. The Certified Trauma Responder (CTR) designation was designed for those trauma specialists who intervene immediately after a trauma using peer counseling, trauma response, and/or critical incident stress management or debriefing. The Certified Trauma Service Specialist (CTSS) certification was designed for individuals who provide immediate trauma intervention, advocacy, victim assistance, and/or crisis support.

Craig Higson-Smith Consulting: Education for Torture and Trauma Rehabilitation

http://www.craighigsonsmith.com

Provides consultation, training, and organizational support for clinicians serving survivors of torture and other traumas. The center serves programs in Cambodia, Cameroon, Ethiopia, Kenya, Namibia, Rwanda, South Africa, Sudan, and Uganda. It is an example of a program that provides courses and human rights and trauma resource materials using web-based technology. Among the web-based courses are a moderated clinical support forum for discussion of clinical material related to prevention and rehabilitation services to survivors of torture and other traumas (including attention to vicarious trauma and self care) and a monthly trauma reading group.

The Headington Institute

http://www.headington-institute.org

The Headington Institute is a non-profit organization whose mission is "to care for caregivers worldwide by determining the best ways to promote the physical hardiness, emotional resilience, and spiritual vitality of humanitarian relief and development personnel." The institute provides counseling services, training, consultation, and research related to stress, trauma, and resilience. It provides a host of trainings worldwide and also offers free online trainings on various topics, such as understanding and coping with traumatic stress; trauma and critical incident care for humanitarian workers; coping with travel and re-entry stress; understanding and addressing vicarious trauma; stress and stress management for national staff; running stress management workshops with cross-cultural groups; self care for family members of humanitarian workers; and spirituality and humanitarian work.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com

David Baldwin's Trauma Information Pages provide a wealth of information about traumatic stress, with a particular focus on emotional trauma. These pages include information about PTSD, dissociation, and other traumatic stress responses for clinicians and researchers who work with trauma survivors who have experienced a large disaster or another type of trauma. The website includes full-text articles about traumatic stress (e.g., diagnosis, treatment, PTSD, dissociation), overview information about trauma (e.g., PTSD symptoms, risk factors for developing post-traumatic stress symptoms, dissociation, vicarious trauma, coping strategies, childhood trauma), a link to trauma resources and organizations, resources for trauma support, information for those who work in disaster mental health, recommendations about trauma books and other publications, and links to other trauma related resources and topics.

Compassion Fatigue Awareness Project/Healthy Caregiving, LLC

http://www.compassionfatigue.org

The Compassion Fatigue Awareness Project documents and disseminates information about compassion satisfaction and fatigue and their affects on caregivers. Its parent organization is Healthy Caregiving, LLC (http://www.healthycaregiving.com), which has materials to support the self care of caregivers on its website, including books, posters, and training materials.

Gift From Within

http://www.giftfromwithin.org

Gift From Within is an international non-profit organization devoted to serving trauma survivors who suffer from PTSD, individuals at risk for developing PTSD, clergy, trauma professionals, and caregivers of traumatized individuals and communities. Gift From Within develops and disseminates a host of educational material and maintains a list of survivors who have expressed interest and willingness to participate in an international peer support network. Among the many resources for trauma survivors, therapists, and caregivers that are available on the Gift From Within website are videotapes, DVDs, webcasts, podcasts, articles, and books on PTSD and compassion fatigue as well as information about relevant conferences and workshops around the United States. The web and podcasts available cover such topics as compassion fatigue; how a health professional can best support a patient who has been traumatized; the impact of PTSD on brain function; trauma memories; nightmares versus flashbacks; what can be done to destigmatize PTSD for veterans; surviving interpersonal violence and creating opportunities for personal empowerment; and information about abuse, trauma, and PTSD for spiritual leaders to help them in their pastoral roles.

New Tactics in Human Rights

http://www.newtactics.org

New Tactics in Human Rights is an innovative human rights initiative created in 1999 to empower human rights practitioners and social change advocates with community, knowledge, and innovation. New Tactics in Human Rights provides a creative model of grass roots activists and trauma practitioners connecting with others around the world to provide peer support and expert peer consultation to combat the negative effects of trauma work, enhance the resilience and well-being of practitioners, and support human rights efforts worldwide. The project was developed by and is coordinated by the Center for Victims of Torture in Minneapolis, Minnesota. It has an interactive website that hosts an online community of more than 2500 human rights workers in more than 130 countries who share their knowledge, resources, and effective human rights practices to combat historic strategic and tactical isolation in the human rights arena. The resources provided facilitate the process of identifying approaches to human rights issues that have worked in other contexts as well as ideas for adapting the approaches for local application. This project goes to the heart of some of the key risk factors for compassion fatigue, including burnout and vicarious trauma, and promotes opportunities for vicarious resilience among participants.

In September 2010, the project held an online tactical dialogue devoted to the topic of vicarious trauma and resilience. Among the many valuable outcomes of this tactical online dialogue were the provision of resources and support to promote practitioner self care and organizational strategies to provide self care for its staff. For example, practitioners were encouraged to have a long-term view of their self care, be sure not to neglect the care of their bodies, develop individualized coping strategies, and pursue a sustainable lifestyle that promotes self care. Organizations were encouraged to pursue some of the following strategies for promoting the self care of its staff: create an organizational vision for staff well-being and self care; focus on prevention; hold group meetings devoted

to promoting care of the workers; build confidence and trust within the organization; create a ripple effect of efforts to promote worker self care; and be organizationally accountable for the self care of staff members.

The New Tactics in Human Rights project has a database of more than 190 examples of human rights tactics that have been successfully implemented. It provides in-person training and holds monthly peer-to-peer tactical dialogues that support an ongoing global peer support network and resource exchange. The project develops and disseminates publications and tactical notebooks that provide detailed information on how to use various human rights tactics and how they might be adapted to other settings and situations.

PROFESSIONAL ASSOCIATIONS

There are many professional associations that provide trauma practitioners with valuable opportunities for professional networking and continuing professional growth. Many of these associations hold annual conferences and provide links to useful trauma resources on their websites.

International Association of Traumatic Stress Studies (ISTSS)

http://www.istss.org

The International Society for Traumatic Stress Studies is an international professional membership organization that was founded in 1985 for trauma professionals from multiple disciplines to network and share information related to the effects of trauma. The ISTSS focuses on the development and dissemination of knowledge about traumatic stress, including such topics as the scope and consequences of traumatic exposure, trauma programs and services oriented to preventing and reducing traumatic stresses and their negative consequences, trauma theory, research methods for studying trauma, and policy initiatives. It has also published traumatic stress treatment guidelines.

ISTSS members come from a variety of professional backgrounds and settings. The ISTSS advocates for its members and the field of traumatic stress with other international and national organizations. Interested readers can explore the many resources available on the ISTSS website and learn more about the ISTSS' annual conference and other trauma related conferences and resources worldwide. The ISTSS has affiliate organizations based in Argentina, Australia, Canada, France, Germany, Japan, and the Netherlands (i.e., the European Society for Traumatic Stress Studies). The ISTSS has helpful information about traumatic stress for the general public and the media in addition to resources for trauma professionals (including materials related to self care). The ISTSS also publishes the Journal of Traumatic Stress monthly.

International Society for the Study of Trauma and Dissociation (ISSTD)

http://www.isst-d.org

The ISSTD is an international, professional, nonprofit association focused on the development and dissemination of information and resources related to trauma and dissociation. This association works to achieve one of its primary goals, education about trauma and dissociation, by holding conferences and training programs and through the publication of the Journal of Trauma and Dissociation.

The National Center for PTSD

http://www.ptsd.va.gov

The National Center for PTSD, with seven divisions across the United States, is part of the U.S. Department of Veterans Affairs and it seeks to promote better understanding of and advance science related to traumatic stress. It uses research, education, and training about PTSD and trauma in order to assist United States veterans and others.

Published International Literature on Traumatic Stress (PILOTS) database

http://www.ptsd.va.gov/professional/pilots-database/pilots-db.asp

In addition to using more general search engines, readers are encouraged to explore the Published International Literature on Traumatic Stress (PILOTS) database, the largest electronic index to the traumatic stress literature in the world. The National Center for PTSD established and manages PILOTS.

CONCLUSION

It is important for clinicians who work with survivors of trauma to become aware of their countertransference reactions and the risks and warning signs of compassion fatigue, including burnout and vicarious trauma. In addition, building one's knowledge about strategies to promote well-being and enhance vicarious resilience early in one's career is valuable. This material should be introduced during clinicians' initial training in graduate school and supported throughout their careers.

All in all, stopping on a regular basis to reflect and ask oneself if current activities are consistent with self care supports attempts to integrate self care into daily life. It is vital to find and practice what works best for yourself because, after all, you are worth it and the alternative is unacceptable.

Compassion fatigue, whether in the form of burnout or vicarious trauma that remains undetected or is not treated, can lead to a host of unwanted consequences, such as dropping out of one's profession, becoming addicted or engaging in other self-destructive behavior, or developing symptoms of depression or other serious health or mental health problems. Being self-aware and vigilant to signs that indicate the possible development of these conditions is an essential step in maintaining one's own well-being and enabling the continued work serving trauma survivors. In addition, talking to colleagues about signs of distress and supporting them in taking steps to take care of themselves, including connecting them with some of the resources referenced in this course, is essential.

There are ample opportunities for positive outcomes for health and mental health clinicians who chose to work with survivors of trauma. The consequences of engaging in such work are not all negative. Vicarious resilience and developing the practice of trauma stewardship can counterbalance the harmful effects of vicarious trauma on trauma clinicians and promote their well-being and ability to continue their chosen careers for years to come.

APPENDIX 1

PROFESSIONAL QUALITY OF LIFE WEBSITE: A RESOURCE FOR UNDERSTANDING AND ASSESSING THE POSITIVE AND NEGATIVE EFFECTS OF CAREGIVING

The Professional Quality of Life website (http://www.proqol.org) is a wealth of information about the overall quality of life of professional helpers, including compassion satisfaction, compassion fatigue, and vicarious trauma. It has many useful resources available in the public domain, and professionals are encouraged to use them to monitor the impact of their own work.

The site provides a comprehensive bibliography developed by B. Hudnall Stamm related to compassion fatigue, compassion satisfaction, and vicarious trauma. This bibliography contains more than 1000 references.

Also included on the website is the most recent version of the Professional Quality of Life (ProQOL 5) scale. The ProQOL 5 scale is a 30-item instrument that uses a 5-point Likert scale. It was designed to measure both the negative and positive impacts of caring in helpers of a wide variety of trauma survivors. It was not developed to measure stress in family caregivers, however, as a number of more specific measures of that phenomenon exist

(including the Caregiver Burden Scale) [118]. The ProQOL 5 is meant to be a research and screening tool and does not yield a diagnosis. In addition to the English version, the ProQOL is available in 10 other languages (i.e., Brazilian Portuguese, Finish, French, German, Hebrew, Italian, Japanese, Khmer, Spanish, and Turkish), although some of these languages are only available in earlier versions of the measure. The ProQOL 5 is in the public domain and is available free of charge to the public. Extensive information about the ProQOL 5, including its strong reliability and validity properties, is available on the ProQOL website.

The ProQOL Concise Manual can be downloaded for free from http://www.proqol.org/ProQOl_Test_Manuals.html. The developers of the ProQOL 5 test, manual, and associated materials have made them available to be copied for free provided that: credit is given to the author, only authorized changes are made, and none of the materials are sold. The ProQOL manual contains background information on the concepts associated with professional quality of life as well as scale definitions and properties; instructions on how to administer, score, and interpret findings from the scale; and a copy of the ProQOL measure itself and scoring worksheet.

Information about the Compassion Satisfaction-Compassion Fatigue (CS-CF) theory, including a graphic of the theoretical model, may be accessed at the ProQOL website. In addition, presentation slides are available for download and use in PowerPoint format, as long as the authors and the ProQOL website are properly credited and the slides are not sold. The slides can be altered to fit into a customized presentation and cover the domains of compassion satisfaction and fatigue (including burnout and vicarious traumatic stress).

Handouts about vicarious trauma and prevention/intervention suggestions are available on the ProQOL website as well. The handout section of the website includes a short article describing how technology may be used to support prevention of the negative effects of caregiving. A ProQOL helper pocket card is provided and includes strategies on how to take care of oneself on a daily basis based on research and the experiences of people working with trauma and crisis around the world. It is meant to serve as a handy reminder of the importance of routine self care. Readers are strongly encouraged to thoroughly explore the ProQOL website for more detailed information and additional resources.

GLOSSARY OF TERMS

Blank-screen façade: A demeanor that is expressionless and blank. It is one possible way that empathic withdrawal may be expressed by a therapist and is a form of distancing oneself from a client.

Burnout: Burnout is a condition of feeling emotionally exhausted or worn out commonly experienced as a consequence of increased workload and institutional stress. Rather than being a one-time event, burnout is a form of compassion fatigue that develops as a result of gradual processes that build over time.

Compassion: A deep awareness of the suffering of others along with a desire to ease their suffering.

Compassion fatigue: A state experienced by those helping people in distress, characterized by an extreme state of tension, vicarious traumatization, and physiological and psychological symptoms. Compassion fatigue is conceptualized to include burnout and secondary traumatic stress. Compassion fatigue is often seen as one of the costs of caring for those in emotional distress.

Compassion satisfaction: The enjoyment and gratification that a professional trauma helper feels when they are able to perform their work well.

Countertransference: The therapist's countertransference is their emotional reactions that develop due to the interaction between multiple factors, including the therapist's own unresolved inner conflicts, the stories clients share (including of trauma), and clients' behaviors and personal characteristics.

Countertransference reactions: The reactions of the therapist toward the client's behaviors and story. Countertransference reactions may be defensive in nature and include affective, cognitive, somatic, and interpersonal reactions.

Dissociation: Dissociation is the disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness. In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. For example, someone may think about an event that was tremendously upsetting yet have no feelings about it. Clinically, this is termed emotional numbing, one of the hallmarks of post-traumatic stress disorder.

Dyad: Two people linked as a pair (as in "therapist-client dyad").

Empathic disequilibrium: A Type II countertransference reaction that can be expressed in the uncertainty, vulnerability, and/or unmodulated affect of the therapist. The clinician who experiences empathic disequilibrium often develops increased physiological and psychological arousal as a result of their countertransference reactions in their work with one or more trauma survivors.

Empathic enmeshment: A Type II countertransference reaction. When a therapist experiences empathic enmeshment they are no longer acting in the therapeutic role or maintaining appropriate professional boundaries. The therapist typically becomes overidentified and overinvolved with the survivor or survivors to the extent of becoming pathologically enmeshed with the client(s). Reciprocal dependency may develop.

Empathic repression: A Type I countertransference reaction. In the situation of empathic repression, significant unresolved personal conflicts or issues in the therapist are reactivated in the course of the work with a trauma survivor. The therapist becomes withdrawn and focused on his or her own personal issues or conflicts at the expense of being fully engaged with the survivor.

Empathic strain: Events in psychotherapy that are interpersonal in nature and that injure, weaken, or stretch the appropriate boundaries of a beneficial and healthy response to the client. Empathic strain can compromise a clinician's ability to be empathic with the trauma survivor. It can be objective or subjective in nature.

Empathic withdrawal: A Type I countertransference reaction that can involve the following types of reactions by the therapist to their trauma client: blank-screen façade, intellectualization, or the misconception of dynamics.

Empathy: The psychobiological capacity to be sensitive to, vicariously feel, and understand what another is feeling along with the ability to communicate this to the other person.

Meditation: A term that describes a wide range of contemplative practices, including contemplative prayer and mindfulness meditation. All types of meditation share the common goal of training an individual's attention and awareness to become more finely attuned to events and experiences in the present moment.

Mindfulness: A receptive mind state that is nonjudgmental in which individuals observe their thoughts and feelings as they are from moment to moment, without trying to suppress or deny them.

Normalize: To acknowledge that something is a normal and nonpathological response to the situation at hand.

Objective countertransference reactions: The therapist's affective reactions during treatment that is indigenous and expectable. Objective countertransference reactions are a type of empathic strain that includes cognitive and/or affective reactions that develop in response to the client's trauma story, behavior, and personality.

Post-traumatic stress disorder (PTSD): A diagnosis in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) [82]. The essential feature of PTSD is the development of characteristic symptoms following exposure to at least one traumatic event. The trauma involves exposure to actual or threatened death, serious injury, or sexual violence and may be experienced directly, as a witness, through learning that the traumatic event(s) occurred to a close friend or family member, and/or by repeated or extreme exposure to details of the trauma (such as in the case of first responders). There is not one clinical presentation of PTSD—the symptoms or combination of symptoms that are most prominent can vary considerably. The characteristic symptoms resulting from the exposure to the traumatic event(s) include persistent intrusion symptoms, avoidance of stimuli associated with the trauma, negative alterations in cognition and mood, and marked alterations in arousal and reactivity. The full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Resilience: The ability of an individual to maintain positive adaptation in the face of significant adversity.

Safe holding environment: Winnicott's term for a therapeutic context that the client perceives as safe and protective and that can adequately contain his or her emotional difficulties.

Secondary traumatic stress (or secondary trauma): Sometimes also referred to as vicarious trauma. Vicarious or secondary trauma involves a transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material. The health or mental health professional may develop some symptoms that mirror the post-traumatic stress disorder or depression symptoms experienced by clients who were directly traumatized.

Self-compassion: The capacity to feel compassion for oneself in situations when one perceives that they are inadequate or a failure, or when they are suffering. Self-compassion is thought to be made up of three components: self-kindness, common humanity, and mindfulness.

Self-awareness: An unbiased observation and recognition of one's inner experience and behavior.

Self-capacities: Individuals' capacity to be aware of, tolerate, and integrate their affect while sustaining a compassionate connection with caring others and themselves; this includes their sense that they deserve to be loved and be alive, the ability to maintain a sense of inner balance, and the ability to self-soothe.

Self care: The act and capacity to take care of oneself across all dimensions of one's life. The ability to engage in trauma work without sacrificing other important parts of one's life. The ability to maintain a positive attitude toward the work despite challenges. Self care can also be understood as a practitioner's right to be well, safe, and fulfilled.

Subjective countertransference reactions: The therapist's affective reactions to the client's transference during treatment that are particular, idiosyncratic, and may involve unresolved personal conflicts.

Transference: The behaviors and processes used by clients to relate to their therapist that are similar to those used in their past relationships with significant others. The transference reactions may be related to experiences and relationships clients have had at any point or points in their life that they have not resolved or integrated, including traumatic experiences they may have had (trauma-specific transference).

Trauma stewardship: Trauma stewardship encourages trauma professionals to reflect deeply on what led them to engage in trauma work, the impact it has on them, and the meaning of and lessons gained from the work. Trauma stewardship guides professionals to build a long-term approach to enable them to remain healthy in order to continue to do trauma work.

Trauma story: Trauma survivors' accounts of their traumatic experiences.

Type I countertransference reactions: Countertransference reactions that include forms of detachment, denial, withdrawal, or distancing from the client.

Type II countertransference reactions: Countertransference reactions that include forms of enmeshment, overidentification, or overidealization of the client.

Vicarious resilience: Vicarious resilience involves the process of clinicians learning about overcoming adversity from the trauma survivors they work with and the resulting positive transformation and empowerment in those clinicians through their empathy for and interaction with the stories of resilience of their clients. The experience of positive outcomes by professionals who find that they gain improved skills to reframe and cope with negative events in the process of working with trauma survivors.

Vicarious trauma: Also referred to as secondary trauma (or secondary traumatic stress).

FACULTY BIOGRAPHY

S. Megan Berthold, PhD, LCSW, CTS, is a licensed clinical social worker, holds a PhD in social welfare, and is a Certified Trauma Specialist. She is a clinician, trainer, and researcher who specializes in the cross-cultural assessment and treatment of survivors of torture and other traumas. She is an Assistant Professor at the University of Connecticut's School of Social Work and worked with the Program for Torture Victims (PTV) in Los Angeles for 13 years, where she was a psychotherapist and the Director of Research and Evaluation. PTV was founded in 1980 and is the oldest program in the United States that provides specialized medical, psychological, and case management services to survivors of state-sponsored torture from around the world. Since the mid-1980's, Dr. Berthold has worked clinically with refugee and asylum-seeking survivors of political persecution, torture, war traumas, human trafficking, female genital mutilation, community violence, domestic violence, child abuse, and other traumas from many countries. She has extensive experience as a mental health professional in outpatient, inpatient, and residential settings. She has worked as a clinician and educator in refugee camps in Nepal, the Philippines, and on the Thai-Cambodian border. Dr. Berthold has conducted research funded federally by the National Institute of Mental Health, with colleagues at the RAND Corporation examining the prevalence of torture and its mental and physical health consequences among Cambodian refugees in Southern California. She has also conducted federally funded clinical outcomes research with torture survivors. In addition, Dr. Berthold frequently testifies as an expert witness in U.S. Immigration Court in the areas of torture, rape, female genital mutilation, and other forms of trauma, post-traumatic stress disorder, mental health, and psychological evaluation. Dr. Berthold is regularly called upon to train and consult with health and mental health professionals as well as attorneys and social service providers on the topics of vicarious trauma and resilience and self care. She was selected as the 2009 National Social Worker of the Year by the National Association of Social Workers. Dr. Berthold has found that an understanding of these topics and the implementation of a self-care plan has been vital to her ability to sustain her own career serving trauma survivors over the past nearly three decades.

Works Cited

1. Wilson JP, Lindy JD (eds). *Countertransference in the Treatment of Posttraumatic Stress Disorder*. New York, NY: Guilford Press; 1994.
2. McCann IL, Pearlman LA. Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *J Trauma Stress*. 1990;3(1):131-149.
3. Figley CR (ed). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York, NY: Bruner/Mazel; 1995.
4. Figley CR. *Burnout in Families: The Systemic Costs of Caring*. Boca Raton, FL: CRC Press; 1998.
5. Figley CR, Kleber RJ. Beyond the "victim:" secondary traumatic stress. In: Kleber RJ, Figley CR, Gersons BPR (eds). *Beyond Trauma: Cultural and Societal Dynamics*. New York, NY: Plenum Press; 2013: 75-95.
6. Dalenberg CJ. *Countertransference and the Treatment of Trauma*. Washington, DC: American Psychological Association; 2000.
7. Pearlman LA, Saakvitne KW. *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York, NY: WW Norton & Company; 1995.
8. Hernández P, Gangsei D, Engstrom D. Vicarious resilience: a new concept in work with those who survive trauma. *Fam Process*. 2007;46(2):229-241.
9. Engstrom D, Hernández P, Gangsei D. Vicarious resilience: a qualitative investigation into its description. *Traumatol*. 2008;14(3): 13-21.
10. van Dernoot Lipsky L, Burk C. *Trauma Stewardship: An Everyday Guide to Caring for Self while Caring for Others*. San Francisco, CA: Berrett-Koehler Publishers; 2009.
11. Meffert SM, Musalo K, McNiel DE, Binder RL. The role of mental health professionals in political asylum processing. *J Am Acad Psychiatry Law*. 2010;38(4):479-489.
12. Lustig SL, Karnik N, Delucchi K, Teenakoon L, Kaul B, Marks DL, Slavin D. Inside the judges' chambers: narrative responses from the National Association of Immigration Judges Stress and Burnout Survey. *Georget Immgr Law J*. 2008;23(1):57-83.
13. Piwowarczyk L, Ignatius S, Crosby S, Grodin M, Heeren T, Sharma A. Secondary trauma in asylum lawyers. *Bender's Immigration Bulletin*. 2009;3:263-269.
14. Sagy T. Even heroes need to talk: psycho-legal soft spots in the field of asylum lawyering. *Bepress Legal Series*. 2006;1014.
15. Muller RT. Vicarious Trauma and the Professional Interpreter: An Interpreter Shares Her Experiences. Available at http://www.psychologytoday.com/blog/talking-about-trauma/201308/vicarious-trauma-and-the-professional-interpreter. Last accessed May 15, 2014.
16. Rana S, Shah P, Chaudhuri K. Whose trauma is it? Vicarious trauma and its impact on court interpreters. *Newsletter of the National Association of Judiciary Interpreters and Translators*. 2009–2010; 18(4):1, 6-9.
17. Devilly GJ, Wright R, Varker T. Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Aust N Z J Psychiatry*. 2009;43(4):373-385.
18. Stamm BH (ed). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators*. 2nd ed. Lutherville, MD: Sidran Press; 1999.
19. Stamm BH, Figley CR. Advances in the theory of compassion satisfaction and fatigue and its measurement with the ProQOL 5. Presented at the International Society for Traumatic Stress Studies Annual Conference. Atlanta, GA; 2009.
20. Wilson JP. Empathic strain, compassion fatigue and countertransference in the treatment of trauma and PTSD. In: Knafo D (ed). *Living with Terror, Working with Trauma: A Clinician's Handbook*. Lantham, MD: Jason Aronson; 2004: 331-368.
21. Wilson JP, Thomas RB. *Empathy in the Treatment of Trauma and PTSD*. New York, NY: Brunner-Routledge; 2004.
22. Cohen K, Collens P. The impact of trauma work on trauma workers: a metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*. 2013;5(6):570-580.
23. McCann IL, Colletti J. The dance of empathy: a hermeneutic formulation of countertransference, empathy, and understanding in the treatment of individuals who have experienced early childhood trauma. In: Wilson JP, Lindy JD (eds). *Countertransference in the Treatment of PTSD*. New York, NY: Guilford Press; 1994: 87-121.
24. Kinzie JD. Countertransference in the treatment of Southeast Asian refugees. In: Wilson JP, Lindy JD (eds). *Countertransference in the Treatment of PTSD*. New York, NY: Guilford Press; 1994: 249-262.
25. Maroda KJ. *The Power of Countertransference*. Hillsdale, NJ: The Analytic Press, Inc.; 2004.
26. Vaillant GE. *Adaptation to Life*. Boston, MA: Harvard University Press; 1998.
27. Danieli Y. Countertransference, trauma, and training. In: Wilson JP, Lindy JD (eds). *Countertransference in the Treatment of PTSD*. New York, NY: Guilford Press; 1994: 368-388.
28. Winnicott DW. *The Maturational Processes and the Facilitating Environment*. London: Karnac Books; 1996.
29. Wilson JP, Lindy JD, Raphael B. Empathic strain and therapist defense: type I and II CTRs. In: Wilson JP, Lindy JD (eds). *Countertransference in the Treatment of PTSD*. New York, NY: Guilford Press; 1994: 31-61.
30. Erikson EH. *Identity: Youth and Crisis*. New York, NY: Norton; 1968.
31. Stamm BH. *The Concise ProQOL Manual*. 2nd ed. Pocatello, ID: ProQOL.org; 2010.

32. Stamm BH. Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test. In: Figley CR (ed). *Treating Compassion Fatigue*. New York, NY: Brunner-Routledge; 2002: 107-119.
33. Freudenberger HJ. Impaired clinicians: coping with burnout. In: Keller PA, Ritt L (eds). *Innovations in Clinical Practice: A Source Book*. Vol. 3. Sarasota, FL: Professional Resource Exchange; 1984: 223-227.
34. Panos A. Promoting Resiliency in Trauma Workers. Poster presented at the 9th World Congress on Stress, Trauma, and Coping. Baltimore, MD; February 2007.
35. Kristensen TS, Borritz M, Villadsen E, Christensen KB. The Copenhagen Burnout Inventory: a new tool for the assessment of burnout. *Work Stress*. 2005;19(3);192-207.
36. Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life. *JAMA*. 2009;301(11):1155-1164.
37. Clark E. Self-care as best practice in palliative care. In: Altilio T, Otis-Green S (eds). *Oxford Textbook of Palliative Social Work*. New York, NY: Oxford University Press; 2011: 771-777.
38. Reese DJ. *Hospice Social Work*. New York, NY: Columbia University Press; 2013.
39. Quinal L, Harford S, Rutledge DN. Secondary traumatic stress in oncology staff. *Cancer Nurs*. 2009;32(4):E1-E7.
40. Vachon MLS, Muller M. Burnout and symptoms of stress in staff working in palliative care. In: Chochinov HM, Breitbart W (eds). *Handbook of Psychiatry in Palliative Medicine*. New York, NY: Oxford University Press; 2009: 236-266.
41. Pearlman LA. *Trauma and Attachment Belief Scale*. Los Angeles, CA: Western Psychological Services; 2003.
42. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):617-627.
43. McCann IL, Pearlman LA. *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*. New York, NY: Brunner/Mazel; 1990.
44. Pearlman LA, Mac Ian PS. Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. *Prof Psychol*. 1995;26(6);558-565.
45. Pearlman LA. Self-care for trauma therapists: ameliorating vicarious traumatization. In: Stamm BH (ed). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators*. 2nd ed. Lutherville, MD: Sidran Press; 1999: 51-64.
46. Meyers TW, Cornille TA. The trauma of working with traumatized children. In: Figley CR (ed). *Treating Compassion Fatigue*. New York, NY: Brunner-Routledge; 2002: 39-56.
47. Schauben LJ, Frazier PA. Vicarious trauma: the effects on female counselors of working with sexual violence survivors. *Psychol Women Q*. 1995;19(1);49-64.
48. Janoff-Bulman R. *Shattered Assumptions: Towards A New Psychology of Trauma*. New York, NY: Free Press; 1992.
49. Saakvitne KW, Pearlman LA, Staff of TSI/CAAP. *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York, NY: Norton; 1996.
50. Saakvitne KW, Tennen H, Affleck G. Exploring thriving in the context of clinical trauma theory: constructivist self development theory. *J Soc Issues*. 1998;54(2):279-299.
51. Piaget J. *Psychology and Epistemology: Towards A Theory of Knowledge*. New York, NY: Viking Press; 1971.
52. Rotter JB. *Social Learning and Clinical Psychology*. New York, NY: Prentice-Hall; 1954.
53. Mahoney MJ. Psychotherapy and human change process. In: Harvey JH, Parks MM (eds). *Psychotherapy Research and Behavior Change*. Washington, DC: American Psychological Association; 1982: 73-122.
54. Millera MK, Floresa DM, Pitcher BJ. Using constructivist self-development theory to understand judges' reactions to a courthouse shooting: an exploratory study. *Psychiatry, Psychology and Law*. 2010;17(1):121-138.
55. Stevenson AD, Phillips CB, Anderson KJ. Resilience among doctors who work in challenging areas: a qualitative study. *Br J Gen Pract*. 2011;61(588):e404-e410.
56. Joseph S, Linley P (eds). *Trauma, Recovery and Growth: Positive Psychological Perspectives on Posttraumatic Stress*. Hoboken, NJ: John Wiley and Sons; 2008.
57. Lev-Wiesel R, Goldblatt H, Eisikovits Z, Admi H. Growth in the shadow of war: the case of social workers and nurses working in a shared war reality. *Br J Soc Work*. 2009;93:1154-1174.
58. Bonanno GA, Westphal M, Mancini AD. Resilience to loss and potential trauma. *Annu Rev Clin Psychol*. 2011;7:511-535.
59. Hobfoll SE, Palmieri P, Johnson RJ, Canetti-Nisim D, Hall BJ. Trajectories of resilience, resistance, and distress during ongoing terrorism: the case of Jews and Arabs in Israel. *J Consult Clin Psychol*. 2009;77(1):138-148.
60. Weingarten K. *Common Shock: Witnessing Violence Every Day*. New York, NY: Dutton; 2003.
61. Baker EK. *Caring for Ourselves: A Therapist's Guide to Personal and Professional Well-Being*. Washington, DC: American Psychological Association; 2003.
62. Bride BE, Robinson MM, Yegidis B, Figley CR. Development and validation of the Secondary Traumatic Stress Scale. *Res Soc Work Pract*. 2004;14(1);27-35.
63. Figley CR, Roop RG. *Compassion Fatigue in the Animal-Care Community*. Washington, DC: Humane Society Press; 2006.

64. Pearlman LA, Caringi J. Living and working self-reflectively to address vicarious trauma. In: Courtois CA, Ford JD (eds). *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. New York, NY: Guilford Press; 2009: 202-224.
65. Stamm BH. Recruitment and Retention of a Quality Health Workforce in Rural Areas. Available at http://www.ruralhealthweb.org/index.cfm?objectid=407BAD48-1185-6B66-8890D59AB641651E. Last accessed May 15, 2014.
66. Stamm BH, Figley CR, Figley KR. Provider Resiliency: A Train-the-Trainer Mini Course on Compassion Satisfaction and Compassion Fatigue. Presented at the International Society for Traumatic Stress Studies Annual Conference. Montreal, Quebec, Canada; 2010.
67. Panos A. Understanding and Preventing Compassion Fatigue: A Handout for Professionals. Available at http://www.giftfromwithin.org/html/prvntcf.html. Last accessed May 15, 2014.
68. Hernandez-Wolfe P, Killian K, Engstrom D, Gangsei D. Vicarious resilience, vicarious trauma and awareness of equity in trauma work. *Journal of Humanistic Psychology*. In press.
69. Garbarino J, Dubrow N, Kostelny K, Pardo C. *Children in Danger: Coping with the Consequences of Community Violence*. San Francisco, CA: Jossey-Bass; 1992.
70. Levine SZ, Laufer A, Stein E, Hamama-Raz Y, Solomon Z. Examining the relationship between resilience and posttraumatic growth. *J Trauma Stress*. 2009;22(4):282-286.
71. Knowles R, Sasser DD, Garrison MEB. Family resilience and resiliency following Hurricane Katrina. In: Kilmer RP, Gil-Rivas V, Tedeschi RG, Calhoun LG (eds). *Helping Families and Communities Recover from Disaster: Lessons Learned from Hurricane Katrina and its Aftermath*. Washington, DC: American Psychological Association; 2010: 97-115.
72. Werner EE. Protective factors and individual resilience. In: Meisels SJ, Shonkoff JP (eds). *Handbook of Early Childhood Education*. Cambridge: Cambridge University Press; 1990: 97-116.
73. Sapienza JK, Masten AS. Understanding and promoting resilience in children and youth. *Curr Opin Psychiatry*. 2011;24(4):267-273.
74. Luthar SS, Cicchetti D. The construct of resilience: implications for interventions and social policies. *Dev Psychopathol*. 2000;12(4);857-885.
75. Bernard B. *Resiliency: What We Have Learned*. Oakland, CA: WestEd; 2004.
76. Seligman M, Peterson C. Positive clinical psychology. In: Aspinwall LG, Staudinger UM (eds). *A Psychology of Human Strengths: Fundamental Questions and Future Directions for a Positive Psychology*. Washington, DC: American Psychological Association; 2003: 305-317.
77. Tosone C, Bettmann JE, Minami T, Jasperson RA. New York City social workers after 9/11: their attachment, resiliency, and compassion fatigue. *Int J Emerg Ment Health*. 2010;12(2);103-116.
78. Turner SD. *Exploring Resilience in the Lives of Women Leaders in Early Childhood Health, Human Services, and Education*. PhD dissertation. Oregon State University; 2009. Available at http://ir.library.oregonstate.edu/xmlui/handle/1957/13122. Last accessed May 15, 2014.
79. Lucero M. *Secondary Traumatic Stress Disorder in Therapists: Factors Associated with Resilience*. PhD dissertation. Hofstra University; 2002. Available at http://proquest.umi.com/pqdlink?Ver=1&Exp=04-11-2016&FMT=7&DID=765071851&RQT=309&attempt=1. Last accessed May 15, 2014.
80. Goldenberg JE. The impact on the interviewer of holocaust survivor narratives: vicarious traumatization or transformation? *Traumatol*. 2002;8(4):237-255.
81. Windle G, Bennett KM, Noyes J. A methodological review of resilience measurement scales. *Health Qual Life Outcomes*. 2011;9:8.
82. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association.
83. Luthar SS, Doernberger CH, Zigler E. Resilience is not a unidimensional construct: insights from a prospective study of inner-city adolescents. *Dev Psychopathol*. 1993;5:703-717.
84. Davydov FM, Stewart R, Ritchie K, Chaddieu I. Resilience and mental health. *Clin Psychol Rev*. 2010;30(5):479-495.
85. Bonanno GA, Ho SMY, Chan JCK, et al. Psychological resilience and dysfunction among hospitalized survivors of the SARS epidemic in Hong Kong: a latent class approach. *Health Psychol*. 2008;27(5):659-667.
86. Bonanno GA, Galea S, Bucciarelli A, Vlahov D. What predicts psychological resilience after disaster? The role of demographics, resources, and life stress. *J Consult Clin Psychol*. 2007;75(5):671-682.
87. Leipold B, Greve W. Resilience: a conceptual bridge between coping and development. *Eur Psychol*. 2009;14(1):40-50.
88. Connor KM. Assessment of resilience in the aftermath of trauma. *J Clin Psychiatry*. 2006;67(Suppl 2):46-49.
89. Connor KM, Davidson JR. Development of a new resilience scale: the Connor Davidson Resilience Scale (CD-RISC). *Depress Anxiety*. 2003;18(2):76-82.
90. Karairmak O. Establishing the psychometric qualities of the Connor-Davidson Resilience Scale (CD-RISC) using exploratory and confirmatory factor analysis in a trauma survivor sample. *Psychiatry Res*. 2010;179(3):350-356.
91. Wang L, Shi Z, Zhang Y, Zhang Z. Psychometric properties of the 10-item Connor Davidson Resilience Scale in Chinese earthquake victims. *Psychiatry Clin Neurosci*. 2010;64(5):499-504.

92. Campbell-Sills L, Stein MB. Psychometric analysis and refinement of the Connor Davidson Resilience Scale (CD-RISC): validation of a 10-item measure of resilience. *J Trauma Stress*. 2007;20(6):1019-1028.
93. Vaishnavi S, Connor K, Davidson JRT. An abbreviated version of the Connor Davidson Resilience Scale (CD-RISC), the CD-RISC2: psychometric properties and applications in psychopharmacological trials. *Psychiatry Res*. 2007;152(2-3):293-297.
94. Friborg O, Hjemdal O, Rosenvinge JH, Martinussen M. A new rating scale for adult resilience: what are the central protective resources behind healthy adjustment? *Int J Methods Psychiatr Res*. 2003;12(2):65-76.
95. Friborg O, Hjemdal O. Resilience as a measure of adjustment. *J Norw Psychol Assoc*. 2004;41:206-208.
96. Friborg O, Hjemdal O, Rosenvinge JH, Martinussen M, Aslaksen PM, Flaten MA. Resilience as a moderator of pain and stress. *J Psychosom Res*. 2006;61(2):213-219.
97. von Soest T, Mossige S, Stefansen K, Hjemdal O. A validation study of the Resilience Scale for Adolescents (READ). *J Psychopathol Behav Assess*. 2009;32(2):215-225.
98. Oshio A, Nakaya M, Kaneko H, Nagamine S. Development and validation of an Adolescent Resilience Scale. *Jpn J Counsel Sci*. 2002;35:57-65.
99. Wagnild GM, Young HM. Development and psychometric evaluation of the resilience scale. *J Nurs Meas*. 1993;1(2):165-178.
100. Judge TA, Erez A, Bono JE, Thoresen CJ. The Core Self-Evaluations Scale (CSES): development of a measure. *Pers Psychol*. 2003;56(2):303-331.
101. Kammeyer-Mueller JD, Judge TA, Scott BA. The role of core self-evaluations in the coping process: testing an integrative model. *J Appl Psychol*. 2009;94(1):177-195.
102. Conner KM, Vaishnavi S, Davidson JR, Sheehan DV, Sheehan KH. Perceived stress in anxiety disorders and the general population: a study of the Sheehan Stress Vulnerability Scale. *Psychiatry Res*. 2007;151(3):249-254.
103. Killian K, Hernandez-Wolfe P. Development and Validation of the Vicarious Resilience Scale. Presentation at the Annual American Family Therapy Academy (AFTA) Conference. Chicago, IL; June 2013.
104. Benshoff JM, Paisley PO. The structured peer consultation model for school counselors. *J Couns Dev*. 1996;74(3):314-318.
105. Campbell JM. *Essentials of Clinical Supervision*. Hoboken, NJ: Wiley; 2006.
106. Mollica RF. The Trauma Story: An Empathic and Therapeutic Conversation with the Survivor. Webinar presentation hosted by the National Partnership for Community Training, Florida Center for Survivors of Torture. Miami Springs, FL; September 8, 2010.
107. Briere J, Lanktree C. Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth. Available at http://www.johnbriere.com/Adol%20Trauma%20Tx%20Manual%20-%20Final%208_25_08.pdf. Last accessed May 15, 2014.
108. Briere J. Treating adult survivors of severe childhood abuse and neglect: further development of an integrative model. In: Myers JEB, Berliner L, Briere J, Reid T, Jenny C (eds). *The APSAC Handbook on Child Maltreatment*. 2nd ed. Thousand Oaks, CA: Sage Publications; 2002.
109. Duerr M. *The Use of Meditation and Mindfulness Practices to Support Military Care Providers: A Prospectus*. Northampton, MA: Center for Contemplative Mind in Society; 2009.
110. Kabat-Zinn J. *Coming to Our Senses: Healing Ourselves and the World Through Mindfulness*. New York, NY: Hyperion; 2005.
111. Lutz A, Brefczynski-Lewis J, Johnstone T, Davidson RJ. Regulation of the neural circuitry of emotion by compassion meditation: effects of meditative expertise. *PLoS One*. 2008;3(3);e1897.
112. Ricard M. Is Compassion Meditation the Key to Better Caregiving? Video. Available at http://www.huffingtonpost.com/matthieu-ricard/could-compassion-meditati_b_751566.html. Last accessed May 15, 2014.
113. Merriam Webster. Online Dictionary: Stewardship. Available at http://www.merriam-webster.com/dictionary/stewardship. Last accessed May 15, 2014.
114. van der Kolk BA (ed). *Psychological Trauma*. Arlington, VA: American Psychiatric Press; 1987.
115. New Tactics in Human Rights. Self-Care for Activists: Sustaining Your Most Valuable Resource. Available at https://www.newtactics.org/conversation/self-care-activists-sustaining-your-most-valuable-resource. Last accessed May 15, 2014.
116. Saakvitne KW, Gamble SG, Pearlman LA, Lev BT. *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*. Lutherville, MD: Sidran Press; 2000.
117. Cox K, Steiner S. *Self-Care in Social Work: A Guide for Practitioners, Supervisors, and Administrators*. Washington, DC: NASW Press; 2013.
118. Montgomery RJV, Gonyea JG, Hooyman NR. Caregiving and the experience of subjective and objective burden. *Fam Relat*. 1985;34(1):19-26.

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Registered Nurses' Association of Ontario. *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*. Toronto: Registered Nurses' Association of Ontario; 2009. Summary retrieved from National Guideline Clearinghouse at http://www.guideline.gov/content.aspx?id=15615. Last accessed May 20, 2014.