Trauma and Caregiving

- *Secondary Trauma*

    - *Service Providers*
    - *Countertransference*

- *Inflicting Trauma on Caregivers*

"There is a cost to caring"- **Charles Figley**

The National Child Traumatic Stress Network: Secondary Traumatic Stress.
A Fact Sheet for Child Serving Professionals (2011).

"Most likely you will get stung from time to time, however careful you are."

Philip Chandler; ***The Barefoot Beekeeper.*** http://www.biobees.com/how_to_start_beekeeping.php

'The smartest ideas come from those who've learnt to surf the unpredictable and the unexpected.
Sure they get dumped occasionally, but that's no excuse to get out of the water.'

John Hunt and Sam Nhlengethwa; **the art of an idea – and how it can change your life**; Zebra Press; 2009

This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

The toll on our South African field social work and psych resources is exceptionally high. Understaffed and under resourced they battle on gamely at considerable cost to themselves.

A key component of TRISI's work will be to improve the resilience of these brave South Africans and make the career a more attractive choice for young people to consider.

Secondary Trauma

Patricia Shannon, PhD, LP; **The Trauma of Working with Victims of Torture***; CW360o Secondary Trauma and the Child Welfare Workforce •*
Spring 2012

Secondary trauma refers to the adverse impact of working with trauma survivors on the social worker who cares for them. It is the deliberate listening and caring, the empathic connection between you and the individuals, children and families whom you hope to help that ultimately becomes too much to bear at times. This empathic connection is how you come to know what trauma feels like to others, how it can be overwhelming and what it feels like to be helpless, hopeless, and consumed by sadness and rage. This is also how you can succumb to feeling overwhelmed by the pain of others, so overwhelmed that you may become unavailable to your clients, remote to your family and friends, and disconnected from yourself.

Charles R. Figley, PhD; **Helping that Hurts: Child Welfare Secondary Traumatic Stress Reactions**; CW360 Secondary Trauma and the Child
Welfare Workforce • Spring 2012

The foundations for the concept of secondary traumatic stress can be found in early examinations of the phenomenon of worker burnout. Freudenberger (1974) was the first to discuss work-related distress resulting in a bad outcome for the worker in his essay "Staff burn-out" in the Journal of Social Issues. What followed was a period of study regarding the concept resulting in several books (e.g., Cherniss, 1980 and Edelwich & Brodsky, 1980). Next, researcher attention shifted to the examination of worker stress associated with burnout; this condition of increased worker stress was associated with job dissatisfaction, often leading to higher workforce turnover. Maslach (1982) and others applied considerable scholarship to determine early on that when a worker, including but not limited to social workers, experienced long-term exhaustion, it resulted in diminished interest in working.

National Child Traumatic Stress Network; **Secondary Traumatic Stress;** http://www.nctsn.org/resources/topics/secondary-traumatic-stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence.

A partial list of symptoms and conditions associated with secondary traumatic stress includes:

■ Hypervigilance	■ Minimizing	■ Fear	■ Inability to embrace complexity
■ Hopelessness	■ Anger and Cynicism	■ Chronic Exhaustion	■ Inability to listen or avoidance of clients
■ Guilt	■ Sleeplessness	■ Physical Ailments	■ Diminished Self-Care
■ Avoidance	■ Insensitivity to Violence	■ Disconnection	
■ Survival Coping	■ Anger or Cynicism	■ Poor Boundaries	
■ Social Withdrawal	■ Illness	■ Loss of Creativity	

Client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Compassion satisfaction refers to the positive feelings dervied from competent performance as a trauma professionals. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the terms is not used to describe the effects of indirect trauma exposure specifically.

National Child Traumatic Stress Network; **Secondary Traumatic Stress;**
http://www.nctsn.org/resources/topics/secondary-traumatic-stress

Jason M. Newell and Gordon A. MacNeil; **Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue**: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers;
http://www.iupui.edu/~mswd/S501/multimedia/word_doc/burnoutarticle.pdf

'The emotional and psychological risks associated with providing direct social work services to vulnerable populations have been largely overlooked in social work educational curriculum and agency training (Cunningham, 2004; Courtois, 2002; Shackelford, 2006). These risks should be conceptualized as occurring in two separate forms: trauma-related stress and professional burnout. Vicarious trauma, secondary traumatic stress, and compassion fatigue are conditions related specifically to work with trauma populations, while professional burnout is considered a more general phenomenon which may occur within any social service setting. The forms of trauma-related stress conditions and professional burnout are often erroneously discussed either interchangeably or grouped together as one condition in the literature. It is best to conceptualize each of these conditions separately in order to have a comprehensive understanding of these complex phenomena.'

'As a best-practice initiative, it is appropriate that information on these conditions be infused into social work curricula as a first-line preventive measure for the training of inexperienced social workers who may be more vulnerable to the effects of these conditions (Lerias & Byrne, 2003). Information on these topics should also be included as part of agency training for practitioners already working in the field.'

'Despite evidence indicating the existence of these conditions in a variety of social work settings, there is little indication that information about them is being included in social work curricula (Courtois, 2002; Cunningham, 2003; Shackelford, 2006).'

Workshops for Helping Professions; **Compassion Fatigue Solutions & Professional Development**; www.workshopsforhelpingproffessions.ca

'Compassion fatigue has been described as "cost of caring" for others in emotional pain. (Figley, 1982) The helping field has gradually begun to recognize that workers are profoundly affected by the work they do, whether it is by direct exposure to traumatic events (for example, working as an ambulance driver, police officer, emergency hospital worker); secondary exposure (hearing clients talk about trauma they have experienced, helping people who have just been victimized, working as child protection workers) and the full gamut in between such as working with clients who are chronically in despair, witnessing people's inability to improve their very difficult life circumstances, or feeling helpless in the face of poverty, and emotional anguish. The work of helping requires helpers to open their

hearts and minds to their clients – yet, this very process of empathy is what makes helpers vulnerable to being profoundly affected and even possibly damaged by their work.'

'Vicarious trauma (VT) has been used to describe the profound shift that workers experience in their world view when they work with clients who have experienced trauma. Helpers notice that their fundamental beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material.

Burnout is a term that has been used a great deal to describe the physical and emotional exhaustion that workers can experience when they have low job satisfaction and feel powerless and overwhelmed at work. Burnout does not necessarily mean that our view of the w orld has been damaged, or that we have lost the ability to feel compassion for others.'

'Helpers can simultaneously experience Compassion Fatigue and Vicarious Trauma. They are cumulative over time and evident in our personal and professional lives. They are also an occupational hazard of working in the helping field.'

Best Start Resource Centre. (2012). W**hen Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers.** Toronto, Ontario, Canada: author.

Signs and symptoms can be used to identify someone who may be suffering from vicarious trauma or secondary trauma (see Chapter 3). They are not diagnostic, but can be helpful in flagging a concern. They can lead to deeper reflection, exploration, and/or referral to an expert.

The symptoms of vicarious or secondary trauma are the same as those of post-traumatic stress disorder. This is the foundation of understanding vicarious or secondary trauma – the helper is suffering from trauma. The source of the trauma is the impact of having a caring relationship with another person.

Comparing Burnout, Vicarious Trauma; and Secondary Trauma

Burnout	Vicarious Trauma, Compassion Fatigue	Secondary Trauma, Indirect Trauma
Cumulative, usually over long period of time	Cumulative with symptoms that are unique to each service provider	Immediate and mirrors client/patient trauma
Predictable	Less predictable	Less predictable
Work dissatisfaction	Life dissatisfaction	Life dissatisfaction
Evident in work environment	Permeates work and home	Permeates work and home
Related to work environment conditions	Related to empathic relationship with multiple client's/patient's trauma experiences	Related to empathic relationship with one client's/patient's trauma experience
Can lead to health problems	Can lead to health problems	Can lead to health problems
Feel under pressure	Feel out of control	Feel out of control
Lack of motivation and/or energy	Symptoms of post-traumatic stress disorder	Symptoms of post-traumatic stress disorder similar to client/patient
No evidence of triggers	May have triggers that are unique to practitioner	Often have triggers that are similar to the client's/patient's triggers
Remedy is time away from work (vacation, stress leave) to recharge or positive change in work environment (this might mean a new job)	Remedy is treatment of self, similar to trauma treatment	Remedy is treatment of self, similar to trauma treatment

Having a few of these symptoms does not necessarily lead to a diagnosis of vicarious or secondary trauma. Many mental health or physical conditions can have similar symptoms, such as depression, borderline personality, bi-polar disorder, or anxiety, just to name a few. As well, just having a bad day at home or in the office might raise some of

these symptoms. The difference is that the symptoms are not pervasive in time or intensity and there is no connection to compassionate work/ relationships.

One of the keys to diagnosis is that the symptoms are NOT consistent with the individual in terms of their personality, behaviour and characteristics. Their behaviour is viewed as abnormal by friends, family and colleagues.

A red flag for full blown vicarious or secondary trauma is the impact on the individual's world view. Vicarious or secondary trauma changes the way you think about the world and yourself. Symptoms associated with this include:
Feelings of being helpless, hopeless and/or powerless
Feelings of lack of safety, trust n Alienation from others
Shattered assumptions about basic beliefs about life or people n Loss of faith (anger with God)

The Headington Institute identifies 3 worldviews that are impacted by vicarious or secondary trauma (www.headington-institute.org):
1. Changes in spirituality – changes in beliefs regarding meaning, purpose, causality, connection, hope, and faith
2. Changes in identity – changes in the way you practice or think about your identity as a service provider, friend, or family member
3. Changes in beliefs related to major psychological needs – beliefs regarding safety, control, trust, esteem, and intimacy.

Service Providers

"So often we try to be strong for our clients.
We don't share our feelings as we try to attend to them and our professional role.
But we are touched by their stories nonetheless and we are human."
Patricia Shannon, PhD, LP; **The Trauma of Working with Victims of Torture**;
CW360o Secondary Trauma and the Child Welfare Workforce • Spring 2012

Ann Jennings, Ph.D.; **Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services** A 2008 Update
'Trauma affects staff members as well as consumers in human service programs. Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is "secondary" or "vicarious" traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do "more and more with less and less" becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.'

Kezelman, C., Stavropoulos, P. **Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.** Adults Surviving Child Abuse (ASCA) 2012
'As Shapiro reiterates, `[m]yriad studies show that the strength of the therapeutic relationship is the strongest predictor of a good outcome'. But the ability to connect with complex trauma clients (who *because* of their cumulative trauma, may be experiencing healthy connection for the first time) also underlines the importance of *therapist* self-care, and the high and many stakes of this. It is now well recognised that working with, as distinct from directly experiencing, trauma is highly demanding. The literature on `vicarious trauma'232 is expanding and widely available (although greater awareness of the associated risks does not guarantee that they will be circumvented or effectively addressed). But if all therapeutic work is demanding, treatment of complex trauma is particularly so.'

'In this context, it has been noted that while the goal is to facilitate a new existence for the client, `the treatment can also profoundly change the therapist'. To the extent that this view may be less familiar than is the now frequent emphasis on the need for `self-care', it suggests particularly challenging problematics and risks in relation to the treatment of complex trauma. It also suggests potential pitfalls which may not initially be apparent. It follows that guidelines need to address the many complexities in this area, both to safeguard therapist well-being (which in turn

benefits clients) and to conform to high standards of ethical and professional practice (one component and requirement of which is professional supervision). The importance of *boundaries* in effective treatment of complex trauma is crucial (where `boundaries' also apply to aspects of relating which again may not always be readily detectable). The new prevalence of `mindfulness' as a technique and strategy, both in therapy and the wider society, is highly valuable here. Note that `mindfulness' is also much *more* than a `strategy', and as its links with Buddhism suggest, it is hardly `new'. As Rothschild explains, mindfulness is `an active process that simply involves a purposeful focus of awareness or attention'.'

Best Start Resource Centre. (2012). W**hen Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers.** Toronto, Ontario, Canada: author.

Risk Factors High levels of stress have become the accepted norm in many workplaces, and run the risk of being ignored. The emotional work undertaken by prenatal and child service providers has biological consequences. Identifying physical stress triggers in the workplace is essential to building resilience. Each of us is unique. Although we can identify risk factors, what impacts one person, may not impact another. Risk factors can be inherent in the individual, in their family and in their environments (home, work and community). The more empathic a service provider is, the greater the risk. Ineffective supervision, large caseloads, lack of recovery time between client contacts, traumatized or complex clients, lack of team approach in the workplace, and a lack of supports to meet client/patient needs are other risk factors (Florio, 2010).

Who is at risk? The simple, and perhaps most concerning answer is everyone. At the same time, we know that the same stressful or traumatic experience may impact one service provider deeply, but not another. Just like smoking increases the risk of developing cancer, not all who smoke will get cancer. Similarly, although we may all be at risk for burnout, vicarious or secondary trauma, not all will experience it.

Individual Risk Factors	Work Risk Factors	Community Risk Factors
Personality and coping style	Role at work	Culture
Current life circumstance	Work setting and exposure	Resources at large
Social supports	Work conditions	Community factors
Spiritual connection and resources	Agency support	
Work style	Affected populations responses and reactions	
Personal history		

Julie Krings, MSW, CSW; **Social Work in a Rural Community**; CW360o Secondary Trauma and the Child Welfare Workforce • Spring 2012

Being a child welfare worker in a rural community means my risk of developing secondary traumatic stress is higher due to the challenging aspects of the work. Some unique characteristics of rural child welfare practice that contribute to this risk include the lack of resources for clients, workers' visibility within the community, and dual roles of the worker.

Many of my clients need resources that are limited in the community where I work, such as public transportation, day care providers, mental health professionals, and alcohol and drug treatment services. As a rural social worker, I often need to take a generalist approach to practice and become the "jack of all trades," compared to urban social workers who tend to specialize. This puts added pressure on me to have to "know about everything" and, in some cases, be the sole service provider to families.

It is almost a given that if you practice child welfare in a rural setting, you will engage in a dual role. For example, I needed to interview a father for a child protection referral, and he happened to be our family mechanic for years. Another example of a dual role is that my daughter attended the same day care as one of the children that I worked with. My daughter would come home and talk about playing with my client. This client was a victim of sexual abuse, and the first thing I thought of was that I didn't want my daughter to be victimized in any way. Due to the nature of my job, I am aware of many of the details of my neighbors' lives and of other members of my community. This has

caused me to be hyper vigilant about my family's safety and to be overly cautious about my interactions in the community

Crystal Collins-Camargo, MSW, PhD; **Secondary Traumatic Stress and Supervisors: The Forgotten Victims**; CW360 Secondary Trauma and the Child Welfare Workforce • Spring 2012

'When one considers the complex and multifaceted supervisory role, it is no wonder that supervisors can easily fall prey to STS. In an initiative led by two federally-funded National Resource Centers, supervisors from across the country identified those job responsibilities deemed most important; generating 31 separate items. One hundred percent of those interviewed identified preventing/addressing stress, STS, and burnout for supervisors, and 95% included the same tasks associated with workers (Hess, Kanak, & Atkins, 2009).'

'Organizations must promote an organizational culture valuing and overtly demonstrating support for supervisors, involve them in the communication chain, recognize and reward good work, and address supervisory STS and burnout (Hess et al., 2009; Bell, Kulkarni, & Dalton, 2003).'

'This issue is receiving national attention. In 2011, the Social Work Policy Institute sponsored a national symposium on child welfare supervision. One of the challenges observed was trauma, safety, and vulnerability in the agency and community. Recommendations for action included development of peer consultation programs, debriefing processes, and support for middle manager supervision of frontline supervisors.'

Bruce D. Perry; **The Cost of Caring Secondary Traumatic Stress and the Impact of Working with High-Risk Children and Families**; Child Trauma Academy; https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf

Each year, millions of children are exposed to some form of severe traumatic event. Many of these children are victims of physical, sexual or emotional abuse or neglect. Many thousands more have been traumatized by natural disasters (e.g., tornadoes, hurricanes, floods), automobile accidents, drowning, community violence or interpersonal violence they witness in their own homes. The trauma suffered by these children is not benign. It can result in serious and chronic emotional and behavioral problems that are very difficult to treat. And each year, day after day thousands of teachers, caseworkers, police officers, judges, pediatricians and child mental health professionals work with and try to help these children. And each year, parents, grandparents, foster parents care for these children.

All too often the adults are working in difficult, resource-limited situations. The children may present with a host of problems that can confuse or overwhelm their caregivers and treaters. The pain and helplessness of these children can be passed on to those around them. Listening to children talk about the trauma, trying to work in a complicated, frustrating and often "insensitive" system, feeling helpless when trying to heal these children – all can make the adults working with these children vulnerable to develop their own emotional or behavioral problems.

National Child Traumatic Stress Network; **Secondary Traumatic Stress;** http://www.nctsn.org/resources/topics/secondary-traumatic-stress
'The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training.6-8 Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.'

Allen R. Kates; **Police Dispatcher Trauma;** http://www.copshock.com/police-dispatcher-trauma.php
In the definition of PTSD, the main criterian is that the subject experienced or witnessed an event that involved actual or threatened death or serious injury. Police dispatchers witness many scenes of death, mayhem and destruction while talking on the phone to victims. Yet there is little resolution. They often don't know what eventually happened, whether the victims lived or died. When the critical incident involves a police officer such as an officer down call, suicide-by-cop, a shootout, or high-speed pursuit, the dispatchers suffer even more dramatically. They may experience adrenaline rushes, heart palpitations, anxiety, and fear. They may have sleepless nights, get irritable and angry, and develop eating disorders. Only in the past few years has police dispatcher trauma been fully recognized and understood.'

Department of Social Development. **INTEGRATED CRIME PREVENTION STRATEGY-ISCPS** Building a Caring Society. Together. ISBN: 978-0-621-40570-5 2011

'Educators are themselves both victims (direct and secondary) and, at times, perpetrators of violence within schools. In violent schools, in particular, many educators fear attending school, are unable to exercise any form of discipline in their classes and the quality of teaching is negatively impacted.'

Issue in Brief; **Building Trauma-Informed Systems of Care for Children In Ohio –**January 2015

'Many treatment and recovery support staff are themselves overburdened. However, taking a trauma-informed approach can go to the root of a client's vulnerabilities, thus helping staff and clients strengthen and sustain recovery.'

Countertransference

Best Start Resource Centre. (2012). W**hen Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers.** Toronto, Ontario, Canada: author.

Countertransference occurs when a service provider relates to the client/patient in a manner that replicates an existing relationship (often child-parent). While vicarious trauma can be associated with countertransference, it is not the same.

In many life situations, we may find ourselves in a transference or countertransference situation. A client/patient may respond to you as if you are their sister who died, or their mother who was abusive, or you may find yourself strangely connected to a young mother who you feel great sympathy for, but, you are not sure why. Later, you reflect on how similar this client/ patient is to your younger sister. We are all subject to this phenomena, because it is usually at work at the unconscious level. If left unattended, it can be harmful to the helping relationship, since the helping relationship needs to be based upon the client/patient in the context of who they are and what they need.

Hamber, B. & Lewis, S. (1997). ***An Overview of the Consequences of Violence and Trauma in South Africa***. Research report written for the Centre for the Study of Violence and Reconciliation

'A victim or survivor of violence is often mistakenly only presumed to be the person who was directly affected by a trauma or violent incident. In reality, the traumatic experience of a direct victim may also adversely affect many other individuals with whom the victim may have contact. This process has been labelled "secondary traumatisation" (Figley, 1983). The traumatic nature of violence means that any contact with the traumatic material - through witnessing or hearing of the event - can have a contaminatory and deleterious effect.

Indirect victims can include witnesses to the event, as well as the families and relatives whose loved ones have been victimised or murdered. Those who in some way have contact with narratives of violence or trauma (e.g. journalists, those in the helping professions) can also be traumatised, and may be considered victims if they experience any adverse reactions. Many people are traumatised vicariously by reading, hearing or even seeing footage of a violent incident. Post-traumatic stress symptoms have also been noted in emergency workers who are at the scene of violent crimes or environmental disasters or accidents involving loss of life (Mitchell, 1985).

Recently, signs of trauma have been acknowledged and identified in staff members of the Truth and Reconciliation Commission, who are constantly faced with the harrowing stories of victims of violence. In a recent interview Dr Boraine, Vice-Chairperson of the Commission, commented, "It revisits you in the early hours or late at night...you are haunted by terrible images..." (Sunday Times Metro, February 16, 1997). High levels of traumatisation have been observed in all regions where the TRC has operated with many of the staff. Some of these symptoms and signs of vicarious traumatisation which TRC staff have experienced have included nightmares, paranoia, emotional bluntness, physical problems (e.g. headaches, ulcers, exhaustion, etc.), high levels of anxiety, irritability and aggression, relationship difficulties and substance abuse related problems (Grenville-Grey, 1997 cited in Hamber, 1997b).[4] Problems of vicarious traumatisation have also been experienced by some of the journalists covering the TRC proceedings (cf. Krog, 1996). On a collective level, through a process like the TRC which publicises the traumas of the past, the likelihood of the entire society being affected in some way is also a possibility.

Other types of vicarious traumatisation can include "second-generation" trauma survivors, these are most often the relatives or children of those who have been traumatised. This has been most clearly documented with the second generation of Holocaust survivors (Danieli, 1982; 1985; Freyberg, 1980) and Vietnam combat veterans (Kehle & Parsons, 1988), who have experienced severe social and psychological difficulties.

Those vicariously exposed to trauma can suffer from symptoms similar to those of direct victims. Symptoms that have been documented include: feelings of exhaustion and hopelessness, health problems, paranoia, and early "burn-out". Emotional and relationship problems, as well as substance abuse may also occur. At times those vicariously traumatised can act-out victim-aggressor patterns or over identify with victims. Broad existential questions with respect to the meaning of life can also trouble humanitarian and care workers (Pergamenchtchik, 1996).'

Inflicting Trauma on Caregivers

Erika Tullberg, MPA, MPH, Roni Avinadav, PhD and Claude M. Chemtob, PhD; **Going Beyond Self Care: Effectively Addressing Secondary Traumatic Stress Among Child Protective Staff**; CW360o Secondary Trauma and the Child Welfare Workforce • Spring 2012

Secondary traumatic stress (STS) is a large concern for the child welfare field. Unaddressed STS can lead child welfare staff to feel helpless, avoidant and isolated from their colleagues and supervisors; have reduced perspective and critical thinking skills; adopt a negative world view; and have difficulty recognizing and monitoring their emotions.

Being in a constant state of "survival mode" can also make it difficult for child welfare staff to recognize true emergencies and prioritize their work accordingly, which can impact the quality of their work and the safety of their clients.

If several people in a work unit are highly short-tempered, argumentative and pessimistic, it is bound to negatively affect the people around them leading the entire work area or organization to function like a traumatized person. This is particularly the case at times of heightened stress and public scrutiny where the focus – both within the agency and from outside stakeholders and the public at large – is overwhelmingly on the negative, and decisions may be made in a pressured and reactive way.

Best Start Resource Centre. (2012). W**hen Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers.** Toronto, Ontario, Canada: author.

'Environmental Conditions: Here are the six environmental conditions required for health and growth, in an individual, a family, an organization or a community:
1. Safety
2. Belonging
3. Consistency/Predictability
4. Opportunity
5. Acceptance/Love
6. Hope

When one or more of these conditions is absent or has been compromised, it will be more difficult for a person or group to reach their full potential. These conditions should be present throughout an organization including interactions with clients/patients.'

'**Work Setting and Exposure to Trauma**: Is the organization large or small? Is it situated in an urban or rural setting? Is there a large management structure? Is the agency financially stable? Are there professional development

resources? These are all conditions within the workplace that can have a dramatic impact on stress and how staff members are able to manage.

Unfortunately, not all agencies are equal. Some are resourced better than others. Some are led better than others. Each agency develops its own personality and coping style, complete with belief systems, experiential history, problem-solving mechanisms, etc. Each staff member has a different exposure in the work setting. Some staff may work in sub-offices or in home offices. They may report to different managers who have different management styles. Perhaps the most important factor is the amount of traumatic content staff members are exposed to, as well as the proportion of challenging cases. The greater the exposure and concentration of challenging cases, the higher the risk for burnout, vicarious or secondary trauma.'

Work Setting Factors

Higher Risk	Lower Risk (Resilience)
Absent or inconsistent policy & procedures	Clear and consistent policies and procedures
Different application of rules for different employees	Fair and consistent application of rules for all employees
Lack of resources to meet expectations	Adequate resources to meet expectations
Leadership has difficulty making decisions	Leadership is able to make quick decisions
Leadership is unable/unwilling to correct errors made by leadership	Leadership is able to and willing to take corrective action when errors are made by leadership
There is no tolerance of errors	Errors are seen as an opportunity to learn
There is no recognition for good work	Recognition is given and employees feel valued
Workers feel unsafe	Workers feel safe, or if conditions are unsafe steps will be taken
Communication is limited	Communication is open and issues are dealt with
There is an atmosphere of secrecy	Issues are raised when they occur
You never know when you might be in trouble	There are no surprises
Environment conditions absent	Environment conditions present
No opportunities (and few opportunities) to debrief with and access support from peers	Peer support is built into the organizational structure and accessible
Reflective practice is not entrenched into or encouraged by the organization	Reflective practice is standard practice for the organization

"Clinical empathy is an important element of quality health care. Empathic communication is associated with improved patient satisfaction, increased adherence to treatment, and fewer malpractice complaints. Patients' perceptions of their physicians' empathy are positively related to more favourable health outcomes. In addition to improving patient outcomes, clinical empathy is associated with increased overall well-being for the physician .High levels of practitioner empathy have been associated with decreased burnout, personal distress, depression and anxiety, along with increased life satisfaction and psychological well-being. " [136]

"Despite the clear importance of empathy in clinical settings, many physicians experience difficulty empathizing with their patients. The vast majority of individuals have the capacity for empathy, and research suggests that medical students start school with similar or higher levels of empathy compared to an age-matched control group . However, empathy significantly declines over the course of medical school. The precise underlying causes of this decline are not well understood, and multiple factors likely play a role. The decrease has been attributed to a curriculum that promotes the objectification of the patient, increasing workload, mistreatment by supervisors, and lack of emotional

support. High levels of burnout, personal distress; depression and anxiety have also been found to contribute to the erosion of empathy in medical school."

David Chenot, PhD, MDiv, LCSW; **The Vicious Cycle: Policy, the Media, and Secondary Traumatic Stress**; CW360 Secondary Trauma and the Child Welfare Workforce • Spring 2012

Not only do reactionary policy changes have an effect on the working lives of CWS social workers, they also have an impact on the services offered by these workers and, therefore, on clients. For instance, a phenomenon called "foster care panic" often follows grievous child maltreatment incidents (Crary, 2006; Kaufman, 2006; & Poitras, 2003). This is typified by the reaction to a grievous event in Connecticut: In 1995, a nine-month old was murdered by her mother's boyfriend (Lang, 1996; McClarin, 1995). This horrible event and two other child abuse deaths that followed within an eight-day period prompted direct intervention by the governor and a shift from family preservation-oriented services to a 'safety first' approach. Within a month, 100 children were removed from their families, and there was a 20% increase in children placed in foster care over the four months following these events (McClarin, 1995). Policy changes and visceral reactions to policy changes, like foster care panic, cannot help but have an impact on clients and the social workers that serve them.

Kate Richardson, Dip SW, BA; **Media Influence on Development of Secondary Traumatic Stress in Child Welfare Workers**; CW360o Secondary Trauma and the Child Welfare Workforce • Spring 2012

There is a lack of understanding around how the media may influence the development of secondary trauma in child welfare workers.

The subject of child abuse is emotive and media coverage is designed to reflect the abhorrence with which society views violence against children. The UK media view is highly critical where child welfare workers have been involved and are considered to have failed in the task of keeping children safe; the perception of these child welfare workers is that they are incompetent, uncaring, lacking in taking appropriate responsibility, and, in some cases, suggestive of complicity with abusers. A similar perception of incompetence and lack of care is applied when child welfare workers are considered to have removed children from parents inappropriately.

What motivates people to commit acts of child abuse is not well understood, and that means it is unlikely that there will be a punishment deemed adequate by society to fit the crime. This contributes to a level of frustration that in turn results in the need to find someone to 'blame.' Where there has been child welfare intervention, and it fails, the child welfare worker can become the focus for some of the anger and seeking of retribution. The call for child welfare workers to lose their jobs and the media 'name and shame' is not unusual in high profile cases, particularly when a child dies. Media responses to high profile child abuse cases have been overwhelmingly negative and hostile in their condemnation even where other members of multidisciplinary teams are considered to have missed opportunities to intervene.

Negative reporting leading to a public perception of incompetence of child welfare workers means there is less motivation to look for other ways to ensure children's safety despite their vulnerability. Without resolution of these dilemmas the profession remains potentially ignorant of issues that could assist in identifying and protecting the most vulnerable children.

David Chenot, PhD, MDiv, LCSW; **The Vicious Cycle: Policy, the Media, and Secondary Traumatic Stress**; CW360 Secondary Trauma and the Child Welfare Workforce • Spring 2012

An emphasis on positive public relations through building relationships with those in the media is valuable when grievous child maltreatment events occur.

• Agency administrators should identify those in the media that are most likely to portray the agency in a positive light (or least negative light) and cultivate professional relationships with them. These relationships may offer administrators the opportunity to present an unbiased view of the agency and its employees in the face of public scrutiny.

• Selected administrators and social workers should be trained in public speaking and how to talk with members of the media prior to crises.