What Organization Leaders Can Do For Therapists Who Are Victims of Vicarious Trauma

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Abstract

Organizations across the country spend many hours and dollars of their resources treating people who have been physically or emotionally abused. Many of the clients that these organizations treat have suffered some form of abuse or neglect. Day after day, the therapists and staff are bombarded with stories of horrific rape, unfathomable neglect, and other traumas. Over time, many employees burn-out after experiencing these traumas vicariously. As employers, it is imperative to anticipate vicarious trauma, heading it off when possible, or providing assistance to employees in the event that they become traumatized themselves. This article defines vicarious trauma and suggests practical ways organization leaders can help prevent it. It also addresses the kinds of support leaders can offer their employees in the event that their employees become victims of vicarious trauma.

Introduction

Counselors in virtually all settings work with clients who are survivors of trauma. Trauma is generally defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 1999). Client traumas which therapists and other mental health workers frequently encounter in clinical practice include childhood sexual abuse, physical or sexual assault, natural disasters such as earthquakes or tornadoes, domestic violence, and school and work-related violence (James & Gilliland, 2001).

Although the media has obsessively focused on the new population of traumatized clients resulting from the recent terrorist attacks on the United States and natural disasters such as hurricanes Katrina and Rita, sexual abuse issues are far more rampant. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Typical client reactions to traumas include intense fear, helplessness, or horror. As a result of trauma, a person may experience severe anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 1999).

In the residential treatment center which I direct, our therapists working with victims of sexual abuse are repeatedly exposed to traumatic images and the after-effects and consequences of trauma. These images can remain with the counselor long after the therapy session has ended; in some severe cases exposure to trauma can lead to induced trauma in the counselor. Astin

(1997), for example, wrote a personal account describing that she would imagine a rapist coming toward her – in the same manner as the rapist had approached her victimized client.

I have heard leaders of organizations unfamiliar with the grueling work of therapy criticize therapists who are personally affected by a client's horrific experiences. They insinuate that a therapist is not resilient enough, is somehow lacking in skills, or has poor boundaries if he/she becomes emotionally influenced by a client's story. Therapists who express emotional and mental exhaustion after working for months with a client who has experienced severe sexual abuse often feel shameful that they are not strong enough to "hold the client's pain". This shame is often exacerbated by the ignorance of the therapist's leader to the realities of vicarious trauma. Such suppression of emotion and feeling misunderstood and undervalued by one's superiors can quickly lead to burnout.

Research and Discussion

As Figley (1995, p.1) noted, "There is cost to caring." There are various names for this cost: countertransference (Hesse, 2002), compassion fatigue (Figley, 1995), burnout (Rosenbloom, Pratt, & Pearlman,1995), and vicarious trauma (Pearlman & Saakvitne, 1995).

Countertransference

Experts traditionally view countertransference as the therapist's reaction to, or distortion of, client material based on unconscious or unresolved conflicts from the therapist's own life experiences (Hesse, 2002). "Reactions to secondary trauma that are manifested in sessions as countertransference pose a serious ethical dilemma for therapists, as clients can actually be harmed or possibly even re-traumatized by such reactions" (Hesse, 2002, p. 303).

Burnout

Burnout, on the other hand, may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, interpersonal problems, a decrease in concern for clients, and (sometimes) a lower quality of client care (Raquepaw & Miller, 1989). Burnout can result in a "loss of energy, commitment and optimism among staff generally, with a consequent depressing effect on organisational [original spelling] climate and culture" (Sexton, 1999, p. 398). Maslach (1976) described burnout as having three dimensions: (a) emotional exhaustion; (b) depersonalization (defined as a negative attitude towards clients, a personal detachment, or loss of ideals); and (c) reduced personal accomplishment and commitment to the profession.

Vicarious Trauma

The construct of vicarious trauma (VT), however, provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors' VT reactions (McCann & Pearlman, 1990). For example, Schauben and Frazier (1995) found that clinicians working with victims of sexual assault reported effects on the vicarious traumatization measure they employed, but not on the burnout measure.

It is important to note that vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout occurs in any profession (McCann & Pearlman, 1990) and is often a result of simple exhaustion. VT is more often the result of a therapist working with a client's chronic, complex issues related to *specific traumatic experiences*. VT can lead to the changes in trust, feelings of being out of control, avoiding intimacy, damaged self-esteem, concerns for one's safety, and intrusive negative imagery (Rosenbloom, Pratt, & Pearlman, 1995).

The consequences to organizations which employ therapists who work with these traumatized populations are varied. Neumann and Gamble (1995) and Pearlman and MacIan (1995) list a few of the most serious:

1) More disruption of their empathic abilities resulting in therapeutic impasses and more frequent incomplete therapies.
2) Greater trouble maintaining a therapeutic stance, which can lead to engaging in more boundary violations.
3) High staff turn-over.
4) Additional costs of employing and training new staff.
5) Inexperienced trauma therapists are more likely to suffer from vicarious traumatization than their more seasoned counterparts.
6) Higher costs for supervision of novice therapists.

Suggested Solutions

In order to help those who are at risk, organizations which employ therapists have a particular responsibility. Unfortunately, it can be the administration of a particular company that accidentally encourages burnout. Unsupportive administration, lack of professional challenge, low salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Arches, 1991, Beck, 1987;, Himle, Jayaratne, & Thyness, 1986). Unfortunately, anyone who has been in this industry for more than a decade has likely experienced these frustrations. “Individual staff members suffer, and the resulting loss of experienced staff can diminish the quality of client services” (Bell, Kulkarni, & Dalton, 2003, p. 466).

Who is Susceptible

As I begin to discuss what to do about helping those who have fallen victims to VT, it is wise to first identify who is most susceptible to contracting it. Cunningham's (2003) study of VT brings up an interesting question: When a counselor encounters a victim of trauma, what kinds of trauma put that counselor at the most risk to develop VT? The answer: Clinicians who work with victims of sexual abuse are more likely to contract VT than even those counselors who work with cancer patients! Also, vicarious traumatization seems more likely to occur in clinicians new to trauma work, those who work primarily with sexual abuse clients, and those with a personal history of sexual abuse (Cunningham, 2003). This last finding was confirmed by Pearlman and MacIan (1995) who noted significantly more vicarious trauma symptoms in 60% of the therapists they surveyed who had reported a personal history of trauma.

Organizational Support

No therapist can work effectively with trauma survivors without support, just as no trauma survivor can heal alone (Herman, 1992). Organizations can ensure that adequate resources are made available to help therapists process disturbing clinical material (Figley, 1995). Examples of this support include (a) clinical supervision or consultation (preferably in session with the therapist and the trauma survivor), (b) peer process groups immediately after sessions, (c) Milan-style therapy "behind the glass" with a clinical team lending support, (d) wisdom and impartiality, and (e) company-sponsored trauma therapy training. Regularly scheduled clinical meetings are an informal way to allow therapists to cathart with peers, plan possible solutions with the company's approval, and have access in a non-threatening way to company leaders. Attendance to personal therapy can also be a great source of release for a struggling therapist (Neumann & Gamble, 1995). "Sometimes it is useful to engage external consultants in order to provide objectivity in dealing with vicarious traumatisation [original

spelling] issues where the organisational [original spelling] dynamics may be part of the problem" (Sexton, 1999, p. 399).

Supervision

Proper supervision is vital. It is widely debated in our field whether or not supervisors should address their supervisees' personal issues during supervision, when those issues may be better suited for a therapy session. I have found that, when handled sensitively and with the permission of the supervisee, in-depth discussion of personal reactions to client's issues is very healing for the therapist involved. Sexton places high priority on such close supervision of therapists dealing particularly with clientele who are trauma survivors: "A key component of this curriculum is training in the identification and working through of intense countertransference experiences" (Sexton, 1999, p. 399).

The implication is not that the therapist is weak and needs to be spoon-fed. How ironic and ignorant it is to assume that a therapist who needs therapy is weak! On the contrary, wise organizations view VT as a system-wide problem. The whole point is to avoid attributing blame to the therapist who is attempting to help a client heal. Rather, leaders should express support and encouragement to the struggling therapist (Catherall, 1995).

Peer Support

A little peer support goes a long way. In our facility, we encourage therapists to "team up" with each other spontaneously when conducting group therapy. Obviously, this means our therapists' caseloads have to be small enough to allow flexibility in their schedules, and the requirement for numbers of hours of therapy per client have to be manageable. We have found through trial and error that if a therapist carries a caseload of no more than five to seven clients and two groups (meaning weekly ninety minute sessions of individual therapy per each client,

weekly ninety minute sessions of family therapy per each client, and two ninety minute groups per week), it helps curb burnout and allows for collaboration among peers, greatly reducing the chances that the eventual VT experience will go unnoticed and untreated.

Education

Critical to combating VT is the facility's instruction of its therapists. Goldblatt & Buchbinder (2003) suggest, "In preparing to intervene with family violence we recommend implementation of anticipatory workshops where the students can (1) clarify their attitudes toward abusers and victims; (2) reflect on personal experiences of abuse in the family of origin and in intimate or other relationships; (3) become more aware of personal background factors leading them to choose family violence as a preferred field of social work intervention; and (4) learn what to expect and how this work may influence their personal relationships" (p. 271). As mentioned above, although many supervisors of new therapists hesitate to use supervision time as "therapy" time for the supervisee, not doing so deprives the inexperienced therapist of a great resource in thwarting VT: self-awareness. It is crucial to maintain a culture that does not punish therapists for minor boundary mistakes or for minor misjudgments. There must be an open-door policy between a therapist and his/her supervisor so the therapist at risk can discuss feelings and concerns freely and the supervisor can sense the onslaught of VT and proactively take action to prevent harm to the therapist.

Building Therapist Competencies

Bell (2003) suggests that therapists need five strengths: (1) competence about coping, (2) maintaining objective motivation, (3) resolving personal traumas, (4) drawing on personal role models of coping, and (5) having buffering personal beliefs. Organizations can help therapists develop these strengths. "To foster strengths, settings need to embody the philosophical

framework of the strengths perspective: that people have strengths, that they are the experts about their own experience, and that relationships of collaboration, rather than hierarchical power, assist in identifying and building on those strengths" (Bell, 2003, p. 522). The upper hierarchy of an organization, therefore, has a responsibility in this process. An intervention on the part of an administrator or supervisor to enter the realm of the therapist and assist that therapist in a particularly difficult session or group is a powerful tool to support therapists in the workplace. When the administrator is not a licensed therapist, the gap between employer and employee can still be reduced by the administrator attending a group session periodically, or otherwise involving him/herself in the day-to-day experiences of the therapist such eating lunch together, participating in after-hours activities, hosting company parties, or other informal situations.

Resiliency

Even with support, however, therapists should build resilience on their own. Sexton (1999) states, "Therapists need to learn to: (a) identify their own reactions and those salient themes that elicit strong countertransference reactions; (b) develop awareness of their own specific somatic signals of distress; (c) understand early warning signs of vicarious traumatisation [original spelling] in themselves; and (d) accurately name and articulate their own trauma-related inner experience and feelings" (p. 400). Dane's research (2000) uncovered the coping skills that therapists use to keep from experiencing VT: (1) appropriate detachment, (2) staying busy at work and after hours, (3) accepting one's limitations with the help of a wise supervisor, (4) setting limits for self and clients, and (5) "cutting off", meaning applying responsibility for healing to the client and not taking it upon oneself.

In a more pragmatic systematized approach, Kernberg, Clarkin, & Yeomans (1999) concretely proposes what they call a “pilot’s list” of priorities for treatment. Obstacles to therapy are addressed first. These include suicide or homicide threats, threats to treatment continuity, dishonesty or withholding in session, contract breaches, in-session acting out, and between-session acting out. Next, the therapist addresses overt transferences such as verbal references to the therapist, and “acting-in” (e.g., seductive body posture). Finally, therapists address nontransferential affect-laden encounters. This “pilot’s list” of priorities helps therapists keep control of their exposure to “charged” emotional reactions from their clients’ traumas and provides a framework for supervisor and therapist discussion post-session. With a plan, a therapist dramatically increases his/her own feelings of preparedness, and preparedness engenders feelings of competence and resiliency.

Spirituality

Interestingly, spiritual beliefs play an integral part in the life experiences of most workers. In Dane’s (2000) research, spirituality was often described as reinforcing that each therapist’s work has meaning. One woman described praying before she would go on a field visit or reading a passage in the Bible to give her strength. "Before going to work, or during lunch time, I stop in a nearby church and ask God to give me strength,” she said (Dane, 2000, p. 35).

If the word “spirituality” doesn’t fit in your organization, Wasco, Campbell, & Clark (2002) highly recommend that “facilities (a) allow their therapists a personal cathartic releasing of traumatic material and (b) help therapists to improve their capacity to integrate the traumatic material into [their lives]” (p. 731). One therapist said, “There were a few of us that would meet after work and give each other support in the process. And it was a weekly thing, so it didn't

build up. So we do it on our own .... As needed" (Wasco et al., 2002, p. 740). The key is for employers to be flexible enough to allow employee catharsis "as needed", not being so focused on efficiency that leaders forget what is good and sacrifice it for what they perceive as "right".

Conclusion

In closing, it is every mental health organization's responsibility to be constantly aware of its employees' mental health, particularly if its clientele includes sexual or physical trauma survivors. In my experience, the more attention paid to my employees' needs through hiring good managers, creating a supportive corporate culture, and allowing flexible schedules, the less sick leave is used, the less turnover I have, the happier my clients are, and the more positive the company culture becomes. The mere process of allowing a therapist to vent his/her feelings about a particularly heart-wrenching or otherwise emotionally difficult case is sometimes all it takes. However, when more serious interventions are required, organization leaders can utilize the suggestions listed in this paper to treat and prevent vicarious trauma among their employees. As leaders watch over their therapists more sympathetically, educate them, encourage their therapists' personal spirituality, foster effective supervision of therapy, engender peer-to-peer support, and build therapist competencies and resiliency, organizations will flourish and clients will directly benefit.

References

American Psychiatric Association (1999). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, D.C.: American Psychiatric Association.

Arches, J. (1991). Social structure, burnout, and job satisfaction. *Social Work, 36*, 202-206.

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), *More than a mirror: How clients influence therapists' lives* (pp. 101-109). Binghamton, NY: Haworth.

Beck, D. F. (1987). Counselor burnout in family service agencies. *Social Casework, 68*, 3-15.

Bell, H. (2003, October). Organizational Prevention of Vicarious Trauma. *Social Work, 48*(4), 513-523.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational Prevention of Vicarious Trauma. *Families in Society, 84*(4), 463-481.

Catherall, D. (1995). Coping with secondary traumatic stress: The importance of the professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 80-92). Lutherville, MD: Sidran.

Cunningham, M. (2003). Impact of Trauma Work on Social Work Clinicians: Empirical Findings. *Social Work, 48*(4), 451-460.

Dane, B. (2000). Child Welfare Workers: An Innovative Approach for Interacting with Secondary Trauma. *Journal of Social Work Education, 36*(1), 27-38.

Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. In C.R. Figley (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (pp. 1-19). New York: Brunner/Mazel.

Goldblatt, H., Buchbinder, E. (2003). Challenging Gender Roles: The Impact on Female Social Work Students of Working with Abused Women. *Journal of Social Work Education, 39*(2), 255-272.

Heppner, M. J., Good, G. E., Hillenbrand-Gunn, T. L., Hawkins, A. K., Hacquard, L. L., Nichols, R. K. (1995). Examining sex differences in altering attitudes about rape: A test of the elaboration likelihood model. *Journal of Counseling & Development, 73*, 640-747.

Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books

Hesse, A. R. (2002). Secondary Trauma: How Working With Trauma Survivors Affects Therapists. *Clinical Social Work Journal, 30*(3), 293-311.

Himle, D. P., Jayaratne, S. D., & Thyness, P. A. (1986). Predictors of job satisfaction, burnout and turnover among social workers in Norway and the USA: A cross cultural study. *International Social Work, 29*, 323-334.

James, R. K., & Gilliland, B. E. (2001). *Crisis intervention strategies*. Belmont, CA: Brooks/Cole.

Kernberg, O. F., Clarkin, J. F., Yeomans, F. E. (1999). *Psychotherapy for Borderline Personality*. New York: Wiley.

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

Maslach, C. (1976). Burn-out. *Human Behaviour, 5*(9), 16-22.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Counter-transference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32,* 341-347.

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558-565.

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice, 20*, 32-36.

Ratna, L., & Mukergee, S. (1998). The long-term effects of childhood sexual abuse: Rationale for and experience of pharmacotherapy with nefazodone. *International Journal of Psychiatry in Clinical Practice, 2*, 83-95.

Rosenbloom, D. J., Pratt, A. C., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65-79). Lutherville, MD: Sidran.

Schauben, L. J., & Frazier, P. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49-64.

Sexton, L. (1999). Vicarious Traumatisation of Counsellors and Effects on Their Workplaces. *British Journal of Guidance & Counselling, 27*(3), 393-404.

Wasco, S. M., Campbell, R., & Clark, M. (2002). *American Journal of Community Psychology, 30*(5), 731-761.