Original Article

TRAUMA

Trauma
2015, Vol. 17(2) 114–122

DOI: 10.1177/1460408614551978
tra.sagepub.com
SAGE

Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care

Brittany S Sansbury[1], Kelly Graves[2,3] and Wendy Scott[2]

There is a growing interest in conceptual frameworks related to preventing stress responses among mental health clinicians working with survivors of trauma. The following paper comprehensively compares and contrasts vicarious traumatization with compassion fatigue (i.e. secondary trauma), and it considers how these two traumatic stress responses can lead to professional burnout. It reviews the historical development and empirical support related to the effects of trauma work on clinicians, and it provides practical guidelines for both individuals and organizations to protect clinicians from traumatic stress responses.

Keywords
Vicarious trauma, burnout, compassion fatigue, clinician self-care

Introduction

There is growing attention to the prevalence of trauma and its negative consequences. A myriad of research studies have shown that trauma can chronically and pervasively impact multiple developmental areas, including social, cognitive, psychological, and biological development across the lifespan.[1–3] Recent research has documented that trauma exposure can impact at the DNA level, as children who were exposed to trauma showed signs of biological aging (''wear and tear'') on DNA sequences called telomeres, which are responsible for aging and progression of disease states.[4,5] In addition, the financial costs of childhood trauma are astronomical-approximately $4379 per incident[2] and $103.8 billion per year in the United States.[6] If one expands statistics to both human-made and natural disasters, authors elaborate that over nine million deaths and 7000 traumas occurred around the world between 1951 and 2000.[7]

Although the field has been looking intensively at the impact of trauma on clients, we know less as a field about the impact of trauma-specific treatment on the ''helpers''. As many as 24 million or 8% of US residents will experience a traumatic stress response during their lives; but the rate is an estimated 15%[8] to 50%,[9] potentially nearly six times higher, among mental health workers. Traumatic exposure responses, in general, have been referred to as the ways in which the ''*world looks and feels like a different place to you as a result of your doing your work*''.[10] Trauma work demands that clinicians are astutely aware of the core principles of trauma-informed care, namely safety, empowerment, trust, collaboration, and choice.[11] Every action that a clinician takes must be consistent with these core principles as trauma-informed treatment has been shown to be more beneficial than the usual standard of care. Given the intensity of trauma-specific treatment, clinicians also must maintain self-care practices to manage their own traumatic stress responses. The next section compares and contrasts vicarious traumatization with compassion fatigue (i.e. secondary trauma).

[1]University of Memphis Institute on Disability, University of Memphis, TN, USA
[2]Center for Behavioral Health and Wellness, North Carolina A&T State University, NC, USA
[3]Department of Human Development and Services, North Carolina A & T State University, NC, USA

Corresponding author:
Brittany S Sansbury, The University of Memphis Institute on Disability, Ball Hall 100, Memphis, TN 38152 USA.
Email: bssnsbry@memphis.edu

Vicarious traumatization

In the 1990s, Pearlman and colleagues defined vicarious traumatization as "*the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae*".[12] The transformation occurs when managing trauma among clients results in altered memory systems and cognitive schemas associated with five need areas: safety, dependency or trust, power, esteem, and intimacy.[13] When these disruptions occur, clinicians demonstrate increased vulnerability or awareness of how fragile life can be and can become suspicious or distrusting of others. These experiences can prompt unexplainable changes in affect, like anger or sadness, which can complicate how an individual interacts with both colleagues in the work environment as well as in interactions within their personal lives.[14] The incidence and severity of clinician symptomology depends on how salient the need area is in his or her life.[11] For example, a person who struggles with trust, is more likely to relive reports from a client about being betrayed or violated in family incest. These need areas also can be particularly salient for clinicians who have their own traumatic histories.[12]

More recent theory and research broadens the concept of vicarious traumatization to include countertransference, empathy, and emotional contagion.[14] Related to countertransference, clinicians who fail to contain reactions to client emotion are susceptible to changes in their own belief systems,[14,15] reduced awareness, and increased defensiveness. Related to empathy, the ability to connect with client suffering helps the clients, but also increases vicarious trauma if clinicians cannot "manage" the empathic process.[14]

Finally, emotional contagion involves unconsciously reliving the trauma of a client, beyond simply attempting to understand it with empathy. Older studies support the "catching" of depression[16] and anxiety symptoms by clinicians who seek to mimic or parallel clients' affect.[17] The capacity to put oneself in the emotional world of others can assist a trauma worker in learning about them. Nonetheless, emotional contagion is most dangerous when a lack of self-awareness gives way to an unconscious and prolonged shift from personal views to clients' traumatic affect. Interviews with trauma clinicians confirm several life areas impacted by vicarious traumatization such as seeing the world in a negative way, feeling unsafe, reduced sense-of-self, reduced connection to work, less interest in others, and increased negative affect.[18,19] This collection of stress responses is a hallmark of vicarious traumatization.

Compassion fatigue

Figley[20] coined the term secondary traumatic stress to denote suffering acute emotional crisis due to interaction with trauma survivors, whether in personal relationships or the therapeutic alliance. Early on, the author renamed this adverse psychological functioning to compassion fatigue to reduce stigma against traumatic stress responses among professionals.[21] Figley identified three domains to explain the concept: (1) re-experiencing content from a client's story; (2) avoidance and numbing toward potential triggers; and (3) burnout.[20] The first component refers to physical symptoms like sleep disturbance and gastrointestinal issues. A clinician also can endure emotional changes (the second component) such as unreasonable irritation, anxiety, or guilt. The third component is the behavioral component, which includes symptoms such over-eating or substance abuse. The last two components, pertaining to affiliations at work and with peers, involve clinicians psychologically or physically separating themselves from others. This withdrawal may result in difficulty performing tasks and consequently loss of relationships. Compassion fatigue differs from vicarious trauma in that compassion fatigue can occur with little to no contact with clients, whereas vicarious trauma only occurs when interacting directly with traumatized clients.

Burnout

Maslach and Jackson[22] popularized the concept of burnout as an occupational syndrome in systems of care characterized by high demands and little support. Burnout is a gradual and progressive process that occurs when work-related stress results in emotional exhaustion, an inability to depersonalize client experiences, and a decreased sense of accomplishment.[23] This traumatic stress response is globally affiliated with prolonged strain at work, not simply contact with clients who have experienced trauma. It is the principal assertion of this paper that burnout can emerge after extreme cases of either vicarious traumatization or compassion fatigue.[24] Recent reports on helping professionals' mental health provide empirical evidence of this triangular relationship.[25–30]

A report of 782 police officers, firefighters, and medical responders indicates a correlation between vicarious traumatization and burnout.[25] There is an inverse relationship between their role clarity and intrusive thoughts ($r = -.23$, $p < .01$), avoidance ($r = -.31$, $p < .01$), and emotional arousal ($r = -.26$, $p < .01$). Predictability at work has a moderate association with these three symptoms of vicarious traumatization ($r = -.09$, $-.16$, $-.18$, $p < .01$). A second study with 10 child welfare workers further corroborates the

relationship between the traumatic stress response and job-related psychological withdrawal.[27] It recognizes countertransference and poor coping strategies, which are historically linked to vicarious traumatization, as precursors for burnout.

Another set of studies attributes significant variance in mental health outcomes to the positive relationship between compassion fatigue and burnout. For example, Meadors et al.[29] write that burnout is responsible for nearly 32% of variance in the incidence of traumatic stress response for a group of 167 healthcare providers ($r = .56$, $p < .01$). Vilardaga and collegues[30] investigated how work-related variables impact burnout for addiction counselors. A set of factors, namely job control, coworker support, supervisor support, salary, workload, and tenure, account for considerable variance in traumatic stress responses. Specifically, the results demonstrate that these mediators for compassion fatigue explain 27% of the variance in counselors' emotional exhaustion, 16% of the variance in their depersonalization, and 22% of the variance in their sense of accomplishment at work. Psychological demand is positively associated with distress, depression, and burnout ($R^2 = .22$, $F = 8.68$, $p < .01$), with burnout showing the strongest association amongst the other mental health outcomes.

Assessing traumatic stress responses

Because burnout can emerge after extreme cases of vicarious traumatization or compassion fatigue, it is essential that clinicians, supervisors, and the organizations they work for monitor such symptoms. There are several measures to quantify the incidence and severity of traumatic stress responses by clinicians, and these scales allow clinicians to track and monitor symptoms of vicarious traumatization, compassion fatigue, and burnout. Accordingly, they serve as a first line of defense in managing traumatic stress responses as it allows for the first essential step (as described in more detail below), namely awareness of traumatic stress responses. Commonly used assessments include:

The **Traumatic Stress Institute Belief Scale** (TSI-BSL) is an 80-item standard assessment for vicarious traumatization. The TSI-BSL evaluates a clinician's impairment in self- and social-need areas such as safety, trust, control, esteem, and intimacy.[31] Its 80 items prompt him or her to respond on a 6-point Likert scale, where higher scores indicate more disruption in the memory system and cognitive schemas. The resulting composite scale has a reported internal consistency reliability of .98, and its 10 subscales possess Cronbach alpha ratings that range from .77 for other-control to .91 for self-esteem. On average, trauma clinicians and other mental health professionals score 166.83 on the TSI-BL,[13] indicating little to no impairment, yet it remains unclear how to differentiate simpler adjustment challenges from clinical symptomology in need areas.

The **Compassion Fatigue Self-Test for Psychotherapists** (CFST) is a 40-item scale including items on both compassion fatigue (CFST-CF) and burnout (CFST-BO) for a total composite score.[32] Its items allow trauma clinicians and staff members to respond on a 5-point Likert scale, where higher scores indicate more stress response from trauma work. The internal consistency reliability ratings have Cronbach alphas ranging from .86 to .94.

The **Professional Quality of Life Scale** (ProQoL)[33] has 30 items and represents attempts to combine earlier subscales on compassion satisfaction with compassion fatigue.[33] Its 2002 version has three discrete subscales: the compassion satisfaction items evaluate the pleasure a trauma clinician derives from his or her work; the compassion fatigue items evaluate potential distress due to exposure to client cases; and the burnout items evaluate feelings of hopelessness and less sense of accomplishment. The subscales allegedly possess relatively high internal consistency reliability, ranging from .72 to .87. The ProQol asks trauma clinicians to answer all 30 items using a 6-point Likert scale, with higher scores indicating more psychological impairment. According to Stamm,[33] clinician scores above a 17 on the compassion fatigue subscale or a 27 on burnout subscale reflect the highest risk for severe traumatic responses.

The **Maslach Burnout Inventory** is a 22-item self-report survey with three subscales: the emotional exhaustion (EE) items refer to a clinician being strained mentally and emotionally; the depersonalization (DP) subscale evaluates his or her ability to differentiate self from client experiences; and the personal accomplishment (PA) items assess gratification and sense of efficacy from work.[22,34] The PA subscale is reverse-scored, whereas higher scores on the EE and DP items indicate burnout. The entire assessment includes 22 items with 7-point Likert responses. Its composite internal consistency reliability is .91, with Cronbach's alphas for the subscales from .81 to .92.

It is worth noting that burnout and compassion fatigue scales have presented difficulties in past empirical studies that attempted to validate them conceptually.[21,29] Specifically, there is some evidence that the domains are not reliably related to work with individuals who experience trauma. There are two assumptions to draw from this problem. Clinicians may report immediate and heightened affect after sessions with their clients, even if they appear only minimally

impacted by changes in their belief systems over time. Lastly, one can also assume that other scales could identify risks and symptoms better than the CFST or ProQol. If compassion fatigue is a construct largely focused on theory and unseen changes in cognition, applied research to monitor measurable traumatic stress for clinicians can benefit from utilizing more psychometrically established assessments.

Practical guidelines for individuals and organizations

There is a need for more practical guidelines that can unify the conceptual frameworks related to preventing traumatic stress response. As Lipsky and Burk describe:

> "*There is a difference between feeling tired because you put in a hard day's work and feeling fatigued in every cell of your being. Most of us have experienced a long day's work and the reward of hard-earned exhaustion…That is one kind of tired. The kind of tired that results from having a trauma exposure response is a bone-tired, soul-tired, heart-tired, kind of exhaustion…*" (p.110).[10]

There are positive consequences to trauma-specific work such-as when providers gain a sense of accomplishment from helping someone achieve a goal, heal from a difficult situation, or develop a pathway for recovery. In a 2012 New Delphi study, focus groups with 102 paramedics and first-responders in the UK National Health Service confirmed that knowing what happens to survivors or learning how better to assist impacted families provided more satisfaction. They reported being unsatisfied with the status quo, implying that their service inspired them to improve the quality of care for those affected by trauma.[35]

Inversely, there are also negative consequences of therapeutic work, some of which are at the conscious level, and some are unconscious. As Hilfiker[36] states, "*All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all, inherent in the relationship*". The primary question is: how can people in the helping field work toward facilitating the healing of others while limiting the negative impact on themselves? We propose that the answer to that question has multiple levels of responsibility. Both individuals and organizations have a responsibility to create an environment of wellness and support.

Practical guidelines for individuals

When considering the ways in which clinicians can actively work to prevent burnout, it is important to understand that the process of preventing burnout is an active one. The clinician is not a passive recipient in which all the stress gets wiped away by breaks or organizational magic wands. Instead, the clinician must be actively involved in a process of self-care. Readers are encouraged to review the 16 signs of trauma exposure responses as outlined in *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*,[10] for specific examples of the ways in which trauma responses "show themselves" in the everyday lives of clinicians. Here, we have reviewed and synthesized a four-step process for clinicians to utilize on their journey to self-care.

Step 1 – Know thyself. Clinicians must be aware of their own arousal states. Rothschild and Rand[24] indicate that "*we are most vulnerable to compassion fatigue or vicarious traumatization when we are unaware of the state of our own body and mind*". This is the first step to creating an individual climate of self-care. Mindfulness regarding the "status" of one's body and autonomic nervous system activity, otherwise known as arousal awareness, is a core tenet of "knowing thyself."

Step 2 - Commit to address the stress. The first step should be closely followed by the second one of knowing or learning how to manage various identified arousal states (i.e., reducing stress). This requires recognizing that distress may, at times, be present at a somatic level. Clinicians should pay attention to their own body posture, facial expressions, muscle tensions, breathing patterns, and other bodily sensations.[24] Particularly during the process of joining with the client and providing empathy while the client is sharing emotional content, it is quite possible for clinicians to start unconsciously mimicking the somatic feelings of their clients. It is thereby essential for clinicians to develop the skills in which they can dually monitor the somatic experiences of not only their client but also of themselves.

Part of this monitoring process may be to understand boundaries not only in terms of work-life balance, but also within the therapeutic context. For those who are healing from trauma, this modeling opportunity can be strong therapeutic material that can set the stage for how they can set appropriate, healthy boundaries in other relationships. For clinicians, the concept of boundaries also extends to physical space. Simple adjustments can be made that can create a sense of safety, such as altering the space between the client and therapist chair or the room layout. Clinicians also can create personal space through eye contact. Hodges and Wegner documented that simply changing your gaze from a client to something else, even if momentarily, can assist clinicians in regulating their own emotional responses to the

client.[36] Wilhelm Reich[37] has since coined the term ocular defense to describe this process. Additionally, clinicians should remember why they chose to go into their field and continue to make their work personally rewarding. For some, remembering the reasons for becoming involved in the work such as spiritual purpose, or ''a calling'', can help shift overwhelming experiences. Addressing the stress can help some clinicians recognize that they have not been maintaining balance and look at their stress as an opportunity to refocus and realign. Accordingly, they should develop a list of activities that they find personally rewarding that can serve as stress reduction strategies.

Step 3 – Make a personal plan of action. Research has documented that whenever someone attempts to change a behavior, planning for that behavioral change is an essential element. The stages of change model views this phase as the ''preparation'' stage that combines intention to make changes coupled with specific ways to attempt the change. The process of clinicians making an active plan for self-care is no exception. Self-care is an active process; and thus, a plan should be in place in order to achieve sustainable success.

The planning process should be informed by what you have learned in Steps 1 and 2. Clinicians should ask themselves: How do I tend to show my stress? How is my body reacting? What steps might be important for me to address those reactions? With these questions, it becomes clear why *Step 1 – Know Thyself* is so essential. Clinicians must become aware of their arousal reactions if they are to plan how best to intervene and decrease negative responses.

Once aware of their arousal states, clinicians also need to develop a strategy for how to regulate these arousal states to an optimal level. To do so, we must know what coping skills and strategies tend to achieve this goal. Thus, part of the personal plan of action should include a variety of different coping mechanisms that clinicians actively practise. Some of these might be daily coping skills such as listening to relaxing music between clients, journaling, going for a walk at lunch, or engaging in positive self-talk. Other individuals can benefit from weekly practices like attending a yoga class or enjoying a night out with friends. Whichever coping skills clinicians chose, it is important that they are actively and consistently practicing them.

A final strategy for informing the development of a personal plan of action is to ask your colleagues, family members, friends, supervisors, or other trusted individuals for feedback. What are they telling you? These close peers can normalize feelings or identify areas for potential growth based on prior interaction and experiences.

Step 4 – Act on the plan. Create support systems internally that can gently hold each person accountable to healthy coping and self-care. This can look different across different organizational structures, but essentially, it is about finding a trusted colleague where, together, you actively ''check in'' with each other about the action plan for self-care. This may be an opportunity to also discuss how personal experiences may be contributing to work-related stress responses.

We would be remiss if we did not point out that the exploration and action planning around self-care strategies also can create opportunities for reflection about the positive impacts of trauma work. These reflection moments may be opportunities to explore how the provision of trauma services has contributed to personal growth for some individuals, particularly those providers who have their own trauma histories. Working in the trauma field, whilst creating a few ''scars'' (physical and/or psychological), can be enormously rewarding, restorative, and fulfilling. The ability to assist another human being on their journey to healing brings many trauma providers significant satisfaction and enjoyment of their profession.

Self-care monitoring also should include these positive reflections so that service providers do not focus solely on the deleterious impact of trauma work and trauma treatment or ''forget'' the positive impacts and original reasoning for entering the trauma services field.

Practical guidelines for organizations

Organizations have an enormous power to either mitigate or exacerbate trauma exposure responses, which highlights the need for a greater awareness of the concepts of trauma-informed approaches for service delivery at an organizational level. Organizations must have a solid infrastructure and system within which trauma caregivers and providers can work, and they must consider where group differences make a caregiver more vulnerable. For example, there is evidence that nurses and doctors who are female or younger can be more vulnerable to psychiatric reaction;[38] more experienced paramedics have shown increased signs of emotional distress during their trauma work;[39] and ethnic minorities that served as first responders after the Oklahoma City bombing reported more traumatic stress.[40] We are not suggesting that organizations discriminate in hiring practices, like only hiring White men or older personnel. However, trauma service organizations should ensure that the staff that are hired have experience or training in providing trauma-specific services, are open to receiving ongoing additional training, and subscribe to the philosophy of trauma recovery concepts. Additional skills

sets will be revealed within the hiring process, but these basic elements are essential for healthy, long-term trauma service providers.

At an organizational level, it has been documented that "*when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma*."[36] Helping staff navigate potential conflicts of interest can exemplify this support.[41,42] Lack of time or information can frustrate even the most experienced clinicians, but affiliations or kinship can further exacerbate occupational barriers when it is harder to separate personal dynamics from work-related stress. Bilal[42] offers a case where a senior administrator ordered staff to give priority to caring for physicians' family members following earthquakes in Pakistan. In all, this illustration or similar conflicts may not be rare circumstances, particularly for first responders or caregivers working in their own communities.

Thus, it is important that an organization's environment exemplify the support network clinicians recommend for their clients. Staff should focus on trauma recovery concepts such as safety, empowerment, collaboration, choice, and trust. Ask employees what, if any, changes are needed to ensure these concepts are weaved into the agency culture. If there are organizational-level conflicts that create an environment that is not healthy, they should be addressed and resolved quickly so as to decrease the "filtering down" of those issues to the client through the staff.

Organizations that serve individuals in trauma recovery have a responsibility to educate their staff about the signs and symptoms of vicarious trauma, compassion fatigue, and burnout. To start, it is essential that regular communication occurs, either in private clinical supervision or in larger staff meetings (or both); such efforts to incorporate preventative checks can raise awareness of the signs and symptoms, and they allow clinicians to monitor these signs and symptoms both individually and across the organization. Secondly, organizations also can assist by providing resource materials that provide information about self-care, such as *Trauma Stewardship: An Everyday Guide to Caring for Self while Caring for Others*[10] and *Help for the Helper: Self-Care Strategies for Managing Burnout and Stress*.[24]

To elaborate on resources, organizations have a responsibility to provide opportunities for the continual growth of their clinicians, particularly if the organization purports to deliver evidence-based practices. Pursuing more formal courses or continuing education credits can assist clinicians in remaining abreast with contemporary theory that bolsters their knowledge of trauma theory and treatment. Given that the state of science around assessment and treatment is always changing and updating, organizations should facilitate staff training that allows clinicians to feel empowered and well-equipped to handle complex cases that may come their way. Because the financial capabilities of organizations vary greatly, some organizations may be able to send clinicians to various trainings while others may not have that luxury. However, there are many lower-cost options that can be helpful, such as informative webinars, treatment resource guides, and other tools that can supplement training opportunities for organizations that may have limited budgets.

Organizations can help at the individual-level by developing a mechanism by which staff members periodically take assessments to monitor compassion fatigue, vicarious traumatization, or burnout. Staff can complete this assessment in private, but organizations can develop a structure in which staff meet regularly to process (on a voluntary basis) their scores and develop strategies to foster an environment of support and self-care. Because the processing structure could be intimidating for some clinicians, it becomes vitally important that the organization sets the tone of being trauma-informed through the integration of the organizational level concepts of safety, empowerment, trust, collaboration, and choice. If the organizational environment does not set this tone, it may be unlikely that staff would be willing to process openly with each other how they are feeling in terms of self-care.

Empirical studies demonstrate a positive relationship between vicarious traumatization and the number of client cases with violent experiences like sexual abuse and an inverse relationship with the educational attainment of professionals.[21,39] The implications are that better management of caseloads and regular instruction from supervisors can reduce traumatic stress responses. That is, even for the most equipped, well-trained clinician, a full caseload of multiple complex, trauma cases is not recommended. To borrow an analogy from the financial management literature, caseloads should have a "diversified portfolio" of clients. That is, a caseload should have some clients that are on the lower end of severity, some in the middle, and some that have more intense needs. Simply from the structure of the caseloads, organizations can help individual clinicians achieve a sense of balance.

That being said, there are multiple organizational structures in which creating a diversified trauma caseload is not possible such as child welfare, military and emergency room providers, etc. In these situations, organizations have a particularly important responsibility to be proactive in the preparation of their workers for the inherent crises that will come. Staff training and ongoing staff development is essential in these organizations. Furthermore, a mechanism for debriefing and

other support services should be made available to staff routinely.

Organizations also can help their staff decrease the likelihood of burnout by fostering resiliency. Borrowing from the medical field, physicians are beginning to ''teach'' resiliency enhancement through programs such as the Stress Management and Resiliency Training (SMART) program, which focuses on mindfulness training, stress reduction techniques, and self-awareness.[42] Preliminary results among eight clinical trials show significant reduction in burnout at sites using this program.

Deconstructing Two Exemplars. Any efforts to confront traumatic stress responses with assessment and individual self-care strategies must be reiterated in the culture of an organization. Although many approaches can be used, there are two detailed models that provide curricula for agency-level implementation. These two models are called ''Feeling Time''[11] and a single session ''Seed Group.''[44]

McCann and Pearlman,[11] who started research on vicarious traumatization, recommend ''Feeling Time'' to normalize sharing difficult reactions to working with trauma survivors, especially because personal isolation often complicates how clinicians work through adverse psychological responses. In this model, there is a 2-hour weekly meeting, with the first hour devoted to discussing challenging cases. Participants pay careful attention to noting any discomfort they feel about revealing or hearing particularly horrific details. This caveat is important so that clinicians practise setting boundaries based on individual concerns, especially if certain traumatic material resonates with salient need areas. The precaution also provides a relative guarantee that they can assimilate contents of violent cases over an extended period of time. In the second hour, clinicians shift to dialogue about more personal feedback and strictly avoid pathologizing what they hear. Instead, the clinicians process how trauma work impacts them and their organizations. The hope is that the group format will grant participants a positive, productive setting for disclosing apprehensions.

An important premise of Feeling Time is that each clinician experiences and conveys traumatic material based on his or her needs or belief system.[11] Accordingly, developing coping strategies that target individual- and community-level issues is the final focus of the 2-hour weekly meetings. The curriculum recognizes balance, awareness and enforcing boundaries, limiting weekend and evening shifts, activism, eliminating unrealistic expectations of work, and leisure activities as strategies to reduce negative responses. Participants are encouraged to share what works or does not work for them. Incorporating coping strategies in the curriculum allows them to minimize need areas or unresolved conflicts that may be retriggered by work in trauma cases.

Feeling Time closely resembles the single-session seed group, given its mission to help participants connect with other trauma clinicians, to reduce stigma about vicarious traumatization, and to provide education on self-care. Clemans[44] demonstrated these objectives with the Vicarious Trauma Seed Group Project with New York City sexual assault programs. The author outlined a 2-hour psychoeducation session with opening exercises, an introduction to vicarious traumatization, self-care intervention, and participant feedback.

A stem sheet exercise is the integral part to starting the psychoeducation effectively. After establishing group expectations, the clinicians utilize this handout to identify their feelings about work with individuals who experience violence or grief. They answer questions related to how they are personally impacted by their job and how they cope with client material, either positively or negatively. The act of sharing these reflections sets the stage for later content and process discussions in the group. Additionally, universality or the ''all in the same boat'' phenomenon enables the clinicians to build the trust necessary to evaluate where they struggle with self-care.

The next two sections give trauma clinicians detailed information about vicarious traumatization and useful self-care practices. Participants learn the historical development of these two concepts. They also label damaging and beneficial clinician practices when reviewing case vignettes related to the three areas of vulnerability and fear, trust issues, and altered belief systems.

Two activities, called ''*evaluative feedback*'' and ''*letter to myself*'', are especially vital in the curriculum's ending phase. The former asks participants how closely the single-session group meets or exceeds initial expectations, so that facilitators can review topics if necessary. The feedback relies on universality and disclosure to combat vicarious traumatization at individual and organizational levels. The latter involves the writing of a letter detailing what was learned from the psychoeducation and specifies the ways that he or she is committed to minimize vicarious traumatization. This format, which includes a self-addressed envelope, allows the clinician to revisit his or her coping strategies after the group session.

Conclusions

Self-care creates the environment that not only benefits the client but also the individual clinician and the organization. Both the client and clinician can achieve clearer thinking and emotional stability.

When organizations and clinicians commit to serving those recovering from trauma, an essential element of that process should be an active plan to prevent and mitigate the potential of compassion fatigue, vicarious traumatization, and burnout. Herman[45] writes, "*There is no such thing as 'getting used to combat'. Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus, psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare*". Therefore, traumatic stress responses are normal reactions for clinicians in the helping field (even though the majority of exposures to trauma do not develop into post-traumatic stress disorders). However, trauma responses must be monitored closely and given ample time and attention to be actively addressed and mitigated. Clinicians are encouraged to regularly monitor and address any signs of burnout using the four-step process outlined above and soliciting organizational and non-organizational support systems that promote clinician well-being.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of interest

The authors declare that there is no conflict of interest.

Provenance and peer review

Not commissioned, externally peer reviewed.

References

1. Cook A, Spinazzola J, Ford J, et al. Complex trauma in children and adolescents. *Psychiatr Ann* 2005; 35: 390–398.
2. D'Andrea W, Ford J, Stolbach B, et al. Understanding interpersonal trauma in children: why we need a developmentally appropriate trauma diagnosis. *Am J Orthopsychiatry* 2012; 82: 187–200.
3. Spinazzola J, Ford JD, Zucker M, et al. Survey evaluates complex trauma exposure, outcome, and intervention among children and adolescents. *Psychiatr Ann* 2005; 35: 433–439.
4. Kiecolt-Glaser JK, Gouin JP, Weng NP, et al. Childhood adversity heightens the impact of later-life caregiving stress on telomere length and inflammation. *Psychosom Med* 2011; 73: 16–22.
5. O'Donovan A, Neylan TC, Metzler T, et al. Lifetime exposure to traumatic psychological stress is associated with elevated inflammation in the Heart and Soul study. *Brain Behav Immun* 2012; 26: 642–649.
6. Wang CT and Holton J. *Total estimated cost of child abuse and neglect in the United States. Economic impact study*. Chicago, IL: Prevent Child Abuse America, 2007, pp. 1–5.
7. Sundnes KO, Birnbaum ML (eds) Health and disaster management guidelines for evaluation and research in the Utstein style. *Prehospital Disast Med* 2003; 17: 1–177.
8. Bride B. Prevalence of secondary traumatic stress among social workers. *Soc Work* 2007; 52: 63–70.
9. Conrad D and Kellar-Guenther Y. Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse Neglect* 2007; 30: 1071–1080.
10. Lipsky LV and Burk C. *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler Publishers, 2009, p. 50.
11. McCann IL and Pearlman LA. Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *J Traumatic Stress* 1990; 3: 131–149.
12. Pearlman LA and Mac Ian PS. Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. *Prof Psychol Res Pract* 1995; 26: 558–565.
13. McCann IL, Sakheim DK and Abrahamson DJ. Trauma and victimization: A model of psychological adaptation. *Counseling Psychologist* 1988; 16: 531–594.
14. Sabin-Farrell R and Turpin G. Vicarious traumatization: Implications for the mental health of health workers. *Clin Psychol Rev* 2003; 23: 449–480.
15. Gabbard GO. A contemporary psychoanalytic model of countertransference. *J Clin Psychol* 2001; 57: 983–991.
16. Joiner TE and Katz J. Contagion of depressive symptoms and mood: Meta-analytic review and explanations from cognitive, behavioral, and interpersonal viewpoints. *Clin Psychol Sci Pract* 1999; 6: 149–164.
17. Hatfield E, Cacioppo JT and Rapson RL. *Emotional contagion*. Cambridge, England: Cambridge University Press, 1994.
18. Benatar M. A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *J Trauma Dissociation* 2000; 1: 9–28.
19. Iliffe G and Steed LG. Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *J Interper Violence* 2000; 15: 393–412.
20. Figley CR. Coping with stressors on the home front. *J Soc Issues* 1993; 49: 51–71.
21. Baird S and Jenkins SR. Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence Victims* 2003; 18: 71–86.
22. Maslach C and Jackson SE. The measurement of experienced burnout. *J Occupa Behav* 1981; 2: 99–113.
23. Figley CR (ed.) *Burnout in families: the systemic costs of caring* (Vol. 1). Boca Raton, FL: CRC Press, 1998.
24. Rothschild B and Rand M. *Help for the helper: self-care strategies for managing burnout and stress*. New York, NY: W.W. Norton & Company, 2006, p. 103.
25. Argentero P and Setti I. Engagement and vicarious traumatization in rescue workers. *Int Arch Occup Environ Health* 2011; 84: 67–75.
26. Bressler S, Cicchillo VJ, Derr DM, et al. Compassion satisfaction, burnout, and secondary traumatic stress in

heart and vascular nurses. *Crit Care Nurs Q* 2011; 34: 227–234.
27. Dane B. Child welfare workers: an innovative approach to interacting with secondary trauma. *J Soc Work Educ* 2000; 36: 27–38.
28. Durand P and Marchand A. Psychological distress, depression, and burnout similar contribution of the job demand-control and job demand-control-support models? *J Occup Environ Med* 2011; 53: 185–189.
29. Meadors P, Lamson A, Swansom M, et al. Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *Omega* 2009; 60: 103–128.
30. Vilardaga R, Luoma JB, Hayes SC, et al. Burnout among the addiction counseling workforce: the differential roles of mindfulness and values-based processes and work-site factors. *J Subst Abuse Treat* 2011; 40: 323–335.
31. Pearlman LA. Psychometric review of TSI Belief Scale, Revision. In: Stamm BH (ed.) *Measurement of stress, trauma, and adaptation*. Lutherville, MD: Sidran Press, 1996, pp. 415–417.
32. Figley CR. Compassion fatigue as secondary traumatic stress disorder: an overview. In: Figley CF (ed.) *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner-Routledge, 1995, pp. 1–20.
33. Stamm B. Measuring compassion satisfaction as well as fatigue: developmental history of the compassion fatigue and satisfaction test. In: Figley CR (ed.) *Treating compassion fatigue*. New York, NY: Brunner/Mazel, 2002, pp. 107–119.
34. Maslach C. *The Maslach burnout inventory*, 3rd ed. Palo Alto, CA: Consulting Psychologists Press, 1996.
35. Drury J, et al. Psychosocial care for persons affected by emergencies and major incidents: a Delphi study to determine the needs of professional first responders for education, training and support. *Emerg Med J* 2012.
36. Hodges SD and Wegner DM. Automatic and controlled empathy. In: Ickes WJ (ed.) *Empathic accuracy*. New York, NY: Guilford Press, 1997, pp. 311–340.
37. Reich W. *Character analysis*. New York, NY: Touchstone, 1972.
38. Alexander DA and Atcheson SF. Psychiatric aspects of trauma care: survey of nurses and doctors. *Psych Bull* 1998; 22: 132–136.
39. Alexander DA and Klein S. Ambulance personnel and critical incidents: impact of accident and emergency work on mental health and emotional well-being. *Br J Psychiatry* 2001; 178: 76–81.
40. Perilla JL, Norris FJ and Lavisso E. Ethnicity, culture and disaster response: Identifying and explaining ethnic differences in rescue workers after the Oklahoma City bombing. *Am J Psychiatry* 2002; 159: 857–859.
41. Armagan E, Engindeniz Z, Devay AO, et al. Frequency of post-traumatic stress disorder among relief force workers after the tsunami in Asia: do rescuers become victims? *Prehospital Disast Med* 2006; 21: 168–172.
42. Bilal MS, Rana MH, Rahim S, et al. Psychological trauma in a relief worker—a case report from earthquake-struck areas of Northern Pakistan. *Prehospital Disast Med* 2007; 22: 458–461.
43. Sood ASV. Radiologists need SMART strategies to battle stress. *Radiol Soc North Am* 2013.
44. Clemans SE. Recognizing vicarious traumatization: a single session group model for trauma workers. *Soc Work Groups* 2005; 27(2–3): 55–74.
45. Herman J. *Trauma and recovery: the aftermath of violence- from domestic abuse to political terror*. New York, NY: Basic Books, 1997, p. 25.34.