

# Vicarious Trauma and Clinical Supervision: Assessment Toolkit for members of the VAW Forum – Central West Region of Ontario

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## What Happens When Workers are Exposed to Traumatic Material?

### Vicarious Trauma, Secondary Traumatic Stress and Burnout

Vicarious traumatization (VT) and secondary traumatic stress (STS, also called “compassion fatigue”) are reactions to the emotional demands on helpers from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories. These terms are often used interchangeably, however, despite some overlap, there are some differences (see Jenkins & Baird, 2002).

Figley (1983, as cited in Jenkins & Baird, 2002, p. 424) first defined STS as the emotional duress experienced by persons having close contact with a trauma survivor. The symptoms of secondary trauma are nearly identical to those of posttraumatic stress disorder (PTSD). A burnout aspect was later added to the construct to capture the energy depletion characteristic of secondary trauma that represents the exhaustion of providing ongoing support to the chronically affected primary victim (Figley & Kleber, 1995, as cited in Jenkins & Baird, p. 424).

Pearlman and Saakvitne (1995, as cited in Jenkins & Baird, 2002, p. 424) defined VT as the permanent “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ traumatic material.” The main symptoms of VT are disturbances in the therapists’ cognitive frame of reference. Verbal exposure to traumatic material theoretically changes cognitive schemas regarding both self and others in the areas of trust, safety, control, esteem, and intimacy. Intrusive imagery and other PTSD symptoms also appear as disruptions to the therapist’s imagery system and emotions associated with the client’s traumatic memories. These effects may

be profound and long-lasting (McCann & Pearlman, 1990a, as cited in Jenkins & Baird, 2002, p. 424).

Burnout, a term which is often confused with VT and STS, is usually defined as a prolonged response to chronic emotional and interpersonal stressors on the job (which are not necessarily trauma-related) and consists of exhaustion, depersonalization (disengagement or detachment from the world around you), and diminished feelings of self-efficacy in the workplace (Meichenbaum, 2007).

### The Violence against Women Sector

Specific to the Violence against Women (VAW) sector, anti-violence agencies are unique in their exclusive focus on and exposure to women's and children's experience of violence (Richardson, 2001). Anti-violence workers' exposure to traumatic material and bearing witness to atrocities is constant, routine and day-to-day. Part of the healing process for women and children victimized by violence involves the telling of their stories, sometimes in gruesome detail (Richardson, 2001). It is impossible to block out these experiences and the repetitive, cumulative effect can become highly invasive. Jenkins and Baird (2002) suggest that some individuals may be drawn to sexual assault or domestic violence work because they wish to help others through assaults that they themselves have experienced. It has been suggested by some researchers (Baird & Jenkins, 2003) that having a personal trauma history is a major risk factor for developing VT or STS, although not all findings have substantiated this.

Slattery and Goodman (2009) suggest that STS/VT can be considered a type of occupational hazard in settings where there are high levels of traumatized clients. **As a result, organizations providing services to trauma victims have a practical and ethical responsibility to address this risk.**

It should be noted that although some studies have indicated that approximately 38% of social workers experience moderate to high levels of STS (Cornille & Meyers, 1999, as cited in Bell, Kulkarni, & Dalton, 2003, p. 464; Dalton, 2001, as cited in Bell, Kulkarni, & Dalton, p. 464), Sabin-Farrell and Turpin (2003) contend that the evidence for VT in trauma workers is inconsistent and ambiguous (as cited in Meichenbaum, 2007, p. 4). Following their review of the literature, Kadambi and Ennis (2004) concluded that efforts to substantiate the notion that mental health professionals working with traumatized clients are significantly and adversely affected by their clinical work have been largely unsuccessful, as research in this area has been plagued by lack of baseline data, disparate results, and methodological limitations.

### **Vicarious Posttraumatic Growth**

In contrast to the deleterious effects of trauma work captured in the constructs of STS and VT, Arnold, Calhoun, Tedeschi, and Cann (2005) found that 86% of therapists in their study sample said that their work with trauma survivors had led to gains in areas such as sensitivity, compassion, insight, tolerance, and empathy. Several therapists also reported that working with trauma survivors deepened their appreciation for the human spirit. Arnold et al. label this phenomenon as vicarious posttraumatic growth. Similarly, Herman (1995, as cited Ben-Porat & Itzhaky, 2009, p. 508) argued that trauma work enriches workers' lives, increases their appreciation of life and their understanding of themselves and others, and enables them to form new relationships and deepen existing relationships. Pearlman (1999, as cited in Ben-Port & Itzhaky, p. 508) contended that working with trauma survivors can lead to personal growth, deepening of relationships with others, increased personal experiences, and

enhanced awareness of many dimensions of life. In a 2003 study, Bell (as cited in Ben-Port & Itzhaky, p. 508) found that 40% of a sample of therapists working in the domestic violence field had become more grateful for their lives, more appreciative of their relationships with significant others, and less judgmental.

## Prevention and Intervention Considerations

### Workplace contributors to psychological well-being

Based on their review of the literature, Slattery and Goodman (2009) suggest that three of the most important workplace contributors to psychological well-being in trauma workers may be **social support, clinical supervision, and access to power**. The issue of access to power is of particular interest due to organizational shifts toward more hierarchical structures which have occurred in many domestic violence shelters (Shepard, 1999, as cited in Slattery & Goodman, p. 1362; Thomas, 1999, as cited in Slattery & Goodman, p. 1362).

### Individual coping strategies

Individual coping strategies identified in the literature which might mitigate the impact of STS/VT include **debriefing/peer support; physical activity and other types of self-care activities; monitoring the level of trauma in ones' caseload** (this could be viewed as the responsibility of both the individual and the agency); **identifying clients' resilience and strength; sociopolitical involvement** (Iliffe & Steed, 2000); **and continuing education in the area of trauma** (Pearlman, 1999, as cited in Sommer, 2008, p. 65). Workers' perceptions that they had

adequate training to effectively assist survivors has also been identified as influencing STS/VT symptoms (Ortlepp & Friedman, 2002, as cited in Bober & Regehr, 2006, p. 2). Bober & Regehr (p. 2) cite several authors who recommend seeking psychotherapeutic treatment to assist with countertransference issues related to unresolved events in ones' personal history and STS/VT, and maintaining a balance between work and personal life. Using a strengths perspective, Bell (2003) identified strategies and resources that prevented symptoms of STS in the majority of counselors in the sample, including a sense of competence about their coping, maintaining an objective motivation for their work, resolving their own personal traumas, drawing on early positive role models of coping, and having buffering personal beliefs.



In their 2006 study, Bober & Regehr did not find that engaging in any coping strategy recommended for reducing distress had an impact on immediate trauma symptoms and caution that focusing on the use of individual coping strategies might imply that those who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, self-care, or supervision, thus in effect blaming the victim. They suggest that the **solution to STS/VT seems to be more structural than individual and emphasize that organizations must determine ways of distributing workload in order to limit the traumatic exposure of any one worker.**



## Supervision

Richardson (2001) suggests that supervision is a complicated issue for anti-violence workers, and **how supervision is provided is as critical as actually participating in supervision.** Supervision that is linked to performance or perceived to be linked to performance can lead to fear or worry. Workers may be more reluctant to disclose negative feelings associated with a client if they are concerned that it will result in an unfavourable review. Pearlman and Saakvitne (1995, as cited in Sommer, 2008, p. 64) recommend four components necessary for successful supervision of trauma workers: (1) a strong theoretical grounding in trauma therapy; (2) attention to both conscious and unconscious aspects of treatment; (3) a mutually respectful interpersonal climate; and (4) educational components that directly address VT. Etherington (2000, as cited in Sommer, p. 64) suggests that the supervisor should be alert to changes in workers' behaviour with and reactions to clients, intrusions of client stories in workers' lives, signs of burnout and feelings of being overwhelmed, signs of withdrawal in either relationships with clients or in the supervisory relationship, and signs of stress and an inability to engage in self-care. Sommer and Cox (2005, as cited in Sommer, p. 64) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatization; and use a collaborative, strength-based approach.

## Self-Assessment

Richardson (2001) suggests that completing one or more self-assessment scales at the beginning of employment in an anti-violence agency and repeating it



every six months may help employees to monitor and maintain positive control over their health. Staff can use the original assessment scale as a benchmark for scales completed in the future. Completing the scales every six months or annually may help alert individuals to changes that can be supported through self-care practices. It is important to note that these assessments are personal documents, not a personnel or human resource tool to be used for performance evaluation.

### **Assessment Tools**

Although several scales exist which measure reactions related to VT and STS, such as PTSD and burnout (see Meichenbaum, 2007), only those assessment tools which (a) measure reactions specific to workers; and (b) are related to exposure to trauma material are included in this section. It should be noted that Rubinstein (1990, as cited in Goodman & Slattery, 2009, p. 1360) recommended the use of PTSD scales to measure STS, which might be preferable to the use of some existing scales specifically designed to measure VT and STS, as Sabin-Farrell and Turpin (2003, as cited in Meichenbaum, 2007, p. 4) caution that no existing questionnaire measures VT in its entirety. Tools which measure use of coping strategies as well as positive effects of trauma are also included in this list. Contrary to those tools which measure deleterious effects included in this section, the Post-Traumatic Growth Inventory is not specific to worker reactions; it is included because a strengths-focused assessment might also prove beneficial.

**1. Compassion Fatigue Self-Test (CFST) for psychotherapists (Figley, 1995a, as cited in Jenkins & Baird, 2002, p. 424).**

The CFST measures STS, and is self-administered, self-scored, and self-interpreted; scoring instructions and interpretations are provided in Figley, 1995 (as cited in Baird & Jenkins, 2003, p. 73). The instrument contains a total scale score (CFST-SUM) and two subscales, CFST-CF (23 items), which measures STS, and CFST-BO (17 items), which measures burnout. Baird & Jenkins find questionable the conceptualization of burnout used by Figley, as it differs from the burnout measurement generally used (Maslach Burnout Inventory, Maslach & Jackson, 1981, as cited in Baird & Jenkins, 2003, p. 73), and is not highly correlated with it (Jenkins & Baird, 2002). Reported internal consistency reliability alphas range from .86 to .94 (as cited in Jenkins & Baird, 2002, p. 427). In Jenkins & Baird's 2002 study, Cronbach's alphas of .84 for the CF subscale, .83 for the BO subscale, and .90 for the CFST-SUM were obtained.

**2. TSI Belief Scale, Revision L (TSI-BSL; Pearlman, 1996a, as cited in Jenkins & Baird, 2002, p. 424).**

The TSI-BSL measures VT. The scale has 80 items with 10 subscales measuring (1) self-safety (the belief that one is secure and safe from harm); (2) other safety; (3) self-esteem; (4) other-esteem (the belief that others are valuable); (5) self-trust (belief in one's own judgments); (6) other-trust; (7) self-intimacy (connection to self); (8) other-intimacy (connection to others); (9) self-control; and (10) other-control. The reported reliability coefficients for the subscales range from 0.62 to 0.91 (Jenkins & Baird, 2002; Pearlman & Maclan, 1995, as cited in Bober & Regehr, 2006, p. 4).

### **3. Secondary Traumatic Stress Scale (Ben-Porat & Itzhaky, 2009).**

The Secondary Traumatic Stress Scale is based on a questionnaire developed by Bride, Robinson, Yegidis, and Figley (2003, as cited in Ben-Porat & Itzhaky, 2009, p. 510). The questionnaire includes 17 items relating to traumatic symptoms, as expressed in three areas: (1) intrusion (e.g., “reminders of my work with clients upset me”); (2) avoidance (e.g., “I felt emotionally numb”); and (3) arousal (e.g., “I had trouble sleeping”). The Cronbach's alpha internal reliability of the questionnaire used by the investigators in the study was found to be .93, and the internal consistency levels for the three factors ranged from .80 for intrusion to .87 for avoidance.

### **4. Professional Quality of Life Scale (ProQOL; Stamm, 2010)**

Stamm conceptualizes professional quality of life as incorporating two aspects: the positive (Compassion Satisfaction) and the negative (Compassion Fatigue, or STS). In keeping with Figley's conceptualization, Stamm breaks compassion fatigue into two parts, STS and burnout. The ProQOL is the most commonly used measure of the positive and negative effects of trauma work. It is the most recent version of the CFST. There is good construct validity with over 200 published papers. Of the 100 published research papers on compassion fatigue, STS, and VT, nearly half have used the ProQOL or one of its earlier versions. People typically take the test and self-score. People may take the ProQOL as part of job counseling or an employee assistance program.

**5. Coping Strategies Inventory (CSI; Bober, Regehr, & Zhou, 2006; Bober & Regehr, 2006).**

The CSI is composed of two sections: (a) beliefs that workers hold regarding which coping strategies will lead to lower levels of secondary trauma and (b) time available for engaging in coping strategies. The CSI-Belief scale has three subscales: leisure, self-care, and supervision, which have reported internal reliability coefficients of 0.71 – 0.82. The CSI-Time (CSI-T) scale has four subscales: leisure, self-care, supervision, and research and development. The CSI-T subscales have reported internal reliability coefficients of 0.67 – 0.80.

**6. Self-Care Assessment Scale (Saakvitne & Pearlman, 1996, as cited in Richardson, 2001, p. 29).**

This tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, the worker is advised to choose an item from each area that they will actively work to improve. Areas include: physical self-care, psychological self-care, emotional self-care, spiritual self-care, workplace or professional self-care, and balance. The original scale can be found in Saakvitne, Pearlman, and the Staff of the Traumatic Stress Institute's seminal 1996 book *Transforming the Pain: A Workbook on Vicarious Traumatization*. A printable copy can be found on the American Counseling Association's Taskforce on Counselor Wellness and Impairment website ([http://www.counseling.org/wellness\\_taskforce/PDF/ACA\\_taskforce\\_assessment.pdf](http://www.counseling.org/wellness_taskforce/PDF/ACA_taskforce_assessment.pdf)).

### **7. Post-Traumatic Growth Inventory (PTGI; Tedeschi and Calhoun, 1996).**

The items in this scale were generated based on a review of studies conducted where persons had perceived benefits coming from an encounter with trauma. Following a principal components analysis, 21 items were selected to produce five factors labeled Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. The PTGI is reported as having good internal consistency, acceptable test-retest reliability, and that among persons reporting a variety of life difficulties, scores on the scale are approximately normally distributed. In addition, responses are generally unrelated to the motive to appear socially desirable.

### **8. Headington Institute Self-study: Understanding and Addressing Vicarious Trauma (2011).**

Although not an assessment tool, this helpful web-based self-study developed by the Headington Institute includes material on risk factors, signs and symptoms, working protectively, what organizations and managers can do, and making a VT action plan. The Headington Institute's vision is that one day all humanitarian workers will have the personal skills, social support, organization resources, and public interest needed to maintain their wellbeing and thrive in their work. This organization is approved by the American Psychological Association.

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