Fact Sheet: Vicarious Trauma

Vicarious trauma was first identified in 1980s as the "cost of caring" (Figley, 1982). It is sometimes referred to as "compassion fatigue" (Perlman & Saakvitne, 1995). Symptoms can parallel those of PTSD – re-experiencing, numbness, avoidance, and persistent arousal (Figley, 1996).

Professionals working with survivors of trauma (e.g. sexual assault) report changes to how they see the world – for example, that the world is not just or safe (Salston & Figley, 2003). Professionals with previous trauma histories show significantly higher secondary trauma symptoms than those with no trauma histories (Folette, Polusny, & Milbeck, 1994).

Definition of Vicarious Trauma

- The emotional residue of exposure to traumatic stories and experiences of others through work; witnessing fear, pain, and terror that others have experienced; a pre-occupation with horrific stories told to the professional (American Counseling Association, 2016)
- Sometimes referred to as "secondary traumatization, secondary stress disorder, or insidious trauma" (ACA, 2016)
- Included in the DSM-5 as part of the cluster of "trauma and stressor-related disorders"
- Vicarious Trauma is not the same as "burnout"

Definition of Compassion Fatigue

- Beyond empathy, it is also known as secondary traumatic stress (STS), a condition characterized by a gradual lessening of compassion over time.
- Can happen quite quickly (as opposed to vicarious trauma or burnout) and is responsive to evidence-based treatment interventions

Definition of Controlled Empathy

- Constant monitoring of emotions so as to not react to stories and testimony, absorbing the information without showing emotion
- Requires vigorous neurological activity
  - Autonomic empathy – involves both sides of the brain, reacting to stories with appropriate emotion, allows brain to react, release tension
  - Controlled empathy – taking control of the empathic response and taxing the right hemisphere of the brain

Definition of Burnout

- Long term stress reaction and process that occurs among professionals who work with people in some capacity (Freudenberger, 1974; Maslach, 1982; Maslach and Schaufeli, 1993)
- Can be brought about by workplace conflict, overload of responsibilities, perception of inequality and inadequate rewards, and consistent exposure to traumatic materials (Chamberlain and Miller, 2008)
- Emotional exhaustion, depersonalization, and reduced personal accomplishment
- Feelings of being emotionally overextended, depleted or self-doubt
- Increasing disillusionment (Edelwich and Brodsky, 1980)
- End result – depersonalization and apathy

Workplace Symptoms of Vicarious/Secondary Trauma (BOLO)

Behavioral:
- Frequent job changes
- Tardiness
- Free floating anger/irritability
- Absenteeism
- Irresponsibility
- Overwork
- Irritability
- Exhaustion
- Talking to oneself (critical symptom)
- Going out to avoid being alone
- Dropping out of community engagements
- Rejecting closeness

Interpersonal:
- Staff conflict
- Blaming others
- Conflictual engagement
- Poor relationships
- Poor communication
- Impatience
- Avoidance of working with clients with trauma histories
- Lack of collaboration
- Withdrawal and isolation from colleagues
- Change in relationships with colleagues
- Difficulty having rewarding relationships

Personal values/beliefs:
- Dissatisfaction
- Negative perception
- Loss of interest
- Apathy
- Blaming others
- Lack of appreciation
- Lack of interest and caring
- Detachment
- Hopelessness
- Low self-image
- Worried about not doing enough
- Questioning frame of reference – world view, spirituality, identity
- Disruption in self-capacity
- Disruption in needs, beliefs, and relationships

Job performance:
- Low motivation
- Increased errors
- Decreased quality
- Avoidance of job responsibilities
- Over-involvement in details/perfectionism
- Lack of flexibility

Personal Symptoms of Vicarious Trauma (i.e., what others won't see) (ACA)

Behavioral:
- Sleep disturbances
- Nightmares
- Appetite changes
- Hypervigilance
- Exaggerated startle response
- Losing things
- Clumsiness
- Self-harm behaviors
- Negative coping – smoking drinking, acting out

Physical:
- Panic symptoms – sweating, rapid heartrate, difficulty breathing, dizziness
- Aches and pains
- Weakened immune system

Cognitive:
- Minimization of vicarious trauma
- Lowered self-esteem and increased self-doubt
- Trouble concentrating
- Confusion/disorientation
- Perfectionism
- Racing thoughts
- Loss of interest in previously-enjoyed activities
- Lack of meaning in life
- Thoughts of harming yourself or others

Emotional:
- Helplessness and powerlessness
- Survivor guilt
- Numbness
- Oversensitivity
- Emotional unpredictability
- Fear
- Anxiety
- Sadness and/or depression

Social:
- Withdrawal and isolation
- Loneliness
- Irritability and intolerance
- Distrust
- Projection of blame and rage
- Decreased interest in intimacy
- Change in parenting style (overprotective)

Interventions for Vicarious Trauma – ABC's: Awareness, Balance, and Connection (ACA)

Individual Level:

- Monitor yourself – eat well, rest, and exercise
- Self-care – seek balance, engage in outside activities
- Set professional and personal boundaries
- Take advantage of professional development opportunities
- Utilize viable, evidence-based treatments for vicarious trauma/secondary traumatic stress that focus on changes in cognitive processes

Organizational/Social Level:

- Reduce system causes of vicarious trauma, secondary traumatic stress, and burnout such as workload and exposure to challenging cases
- Provide critical incidents debriefing
- Work with area Employee Assistance Programs (EAP) to identify areas of improvement such as in-service trainings on self-care or counseling
- Provide sabbaticals, professional education, community service, and public speaking opportunities
- Provide a Psychologist Peer Advocate – a specially-trained therapist to assist with cognitive changes resulting from vicarious trauma

Further Reading and References

American Counseling Association (n.d.). Fact Sheet #9: Vicarious trauma. Downloaded 4/20/16 http://www.wendtcenter.org

Chamberlain, J., and Miller, M. K. (2008). Stress in the courtroom: Call for research. *Psychiatry, Psychology, and Law, 15,* 237-250.

Edelwich, J., and Brodsky, A. (1980). *Burnout: States of disillusionment in the helping professions.* NY: Human Resources Press.

Figley, C. R. (1982). Traumatization and comfort: Close relationships may be hazardous to your health. Keynote presentation, Lubbock TX.

Figley, C. R. (1996). Compassion fatigue as a secondary traumatic stress disorder: An overview. In Figley, C. R. (Ed.), *Compassion fatigue*. NY: Brunner/Mazel.

Folette, V. M., Polusny, M. M., and Milbeck, K. (1994). Mental health and law enforcement professioals: Tauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25,* 275-282.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30,* 159-165.

Jaffe, P. G., Crooks, C. V., Dunford-Jackson, B. L., and Town, M. (2003). Vicarious trauma in judges: The personal challenge of dispensing justice. *Juvenile and Family Court Journal, Fall,* 1-9.

Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. S. Paine (Ed.), *Job stress and burnout: Research, theory and intervention perspectives.* Beverly Hills CA: Sage, Inc.

Maslach, C., and Schaufeli, W. B. (1993). Historical and conceptual development of burn-out. In W. B. Schaufeli, C. Maslach, and Marck, T. (Eds.) *Professional burnout.* Washington: Taylor and Francis.

Osofsky, J. D., Putnam, F. W., and Lederman, C. S. (2008). How to maintain emotional health when working with trauma. *Juvenile and Family Court Journal, 39,* 91-102.

Perlman, L. A., and Saakvitne, K. W. (1995). Trating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue*. NY: Brunner/Mazel.

Resnick, A., Myatt, K. A., and Marotta, P. V. (2011). Surviving bench stress. *Family Court Review, 49,* 610-617.

Salston, M., and Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16,* 167-174.

Other Resources

http://www.samhsa.gov/nctic/trauma-interventions

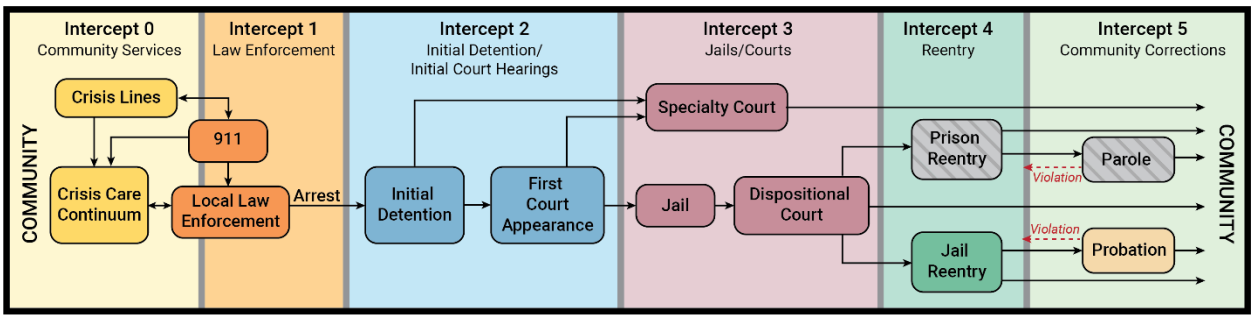
http://www.ptsd.va.gov/

http://www.nctsn.org/

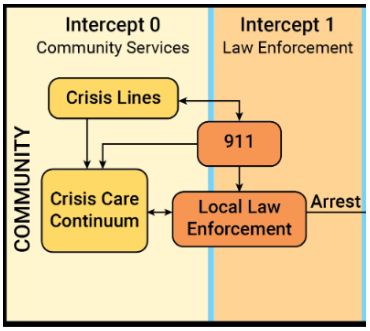
Fact Sheet: Trauma-Informed System Responses

The Sequential Intercept Model

The Sequential Intercept Model (SIM) is a linear roadmap of the common processes for which an individual may enter and exit the criminal justice system. The SIM is divided into six intercepts, starting with "Community Services" and ending with "Community Corrections". The SIM is often used as a tool for strategic planning in order to identify resources and gaps in resources for communities and their specific criminal justice system processes. The intercepts in this Fact Sheet are grouped together as intercepts 0 & 1, intercepts 2 & 3, and intercepts 4 & 5, as is common when conducting a strategic planning workshop using the SIM.



Intercepts 0 & 1: Community-Based Crisis Responders and Law Enforcement



Prior to formal interaction with the criminal justice system, persons with mental illness and co-occurring disorders may come to the attention of law enforcement personnel, other first responders, mobile crisis units, and medical and mental health personnel in hospital settings. Policies, procedures and practices related to these interactions should be examined to determine if they pose a risk for re-traumatization. These may include:

- Protocols for dispatching a responding team (e.g., availability of responding team, criteria for dispatch)
- Composition of responding team (law enforcement only, co-response, embedded response)
- Process for observation at, or admission to, appropriate emergency facility (e.g., site and design of facility, removal/substitution of personal belongings, availability of medical personnel and testing equipment)

Trauma-informed modifications might include:

- Provide instruction to crisis response personnel, including dispatchers, to allow them to better recognize and respond to persons with behavioral health concerns
- Include behavioral health personnel on crisis response teams
- Establish police-friendly crisis services at locations other than jail or a hospital Emergency Department

- In the absence of safety concerns, allow persons in crisis to retain personal clothing or belongings

With the introduction of formal criminal justice system interaction, there are many policies, procedures, and practices that must be followed to ensure safety for first responders and others at a scene. Some of these have the potential to re-traumatize the individual with whom the law enforcement professional is interacting. In an effort to diminish the potential for re-traumatization, it may be useful to examine the nature and impact of some procedures common to Intercept 1.

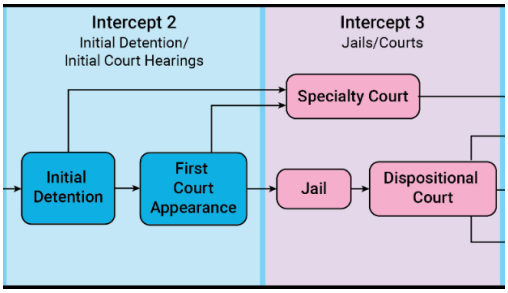
Some interactions that may be re-traumatizing include:

- Method of approach (e.g. approaching from the rear or unannounced)
- Correlates of interaction (e.g., use of force, pat-down, handcuffing)
- Mode of communication (e.g., ordering, demanding)

Possible trauma-informed alternatives to avoid re-traumatizing a person being confronted or arrested include:

- Announce the actions that are necessary during the interaction/arrest
- Remain calm, keep voice relatively low and slow, if possible
- Be open and listen if the person wants to talk
- Ascertain if the person understands the directions/requests communicated by the officer

Intercepts 2 & 3: Detention/Pretrial Services and Courts/Jail/ Correctional Services



Post-arrest, many persons are initially detained in a local correctional facility pending subsequent decisions on their charges and pretrial custodial status. The staffing, conditions and services of these detention centers vary widely. Existent policies, procedures and practices may adversely impact persons with behavioral health concerns. Potential areas of concern include:

- Protocols for identifying mental health and substance use disorders
- Availability of options for diversion for persons with behavioral health concerns
- Service provision for persons identified as in need of mental health or substance abuse treatment who remain in detention
- Nature of supervision for pretrial defendants in the community

Possible trauma-informed modifications to avoid pretrial re-traumatization include:

- Adoption of validated screening and assessment instrumentation to more accurately identify risk and need for persons with co-occurring disorders in detention and in the community
- Data collection and sharing between criminal justice professionals and behavioral health treatment providers
- Enhanced pretrial supervision and diversion services to promote public safety and reduce recidivism

Court processes and interactions may negatively impact persons with trauma histories. While the maintenance of public safety must be the foundation of judicial policies and procedures, some practices may traumatize or re-traumatize participants. Of particular concern are the following procedures and practices common in court settings:

- Restraint during transport and court proceedings (e.g., handcuffing, leg irons)
- Placement in holding cells while waiting for judicial proceedings
- Elements of courtroom setting and process (e.g., elevation of judges, number and placement of security personnel, public forum that can be perceived as unsafe or humiliating, process for adjudicating person's status and sanction)

Trauma-informed modifications for adoption in courtroom settings include:

- Redesign the physical space to enhance the person's sense of personal safety (e.g., create private space for attorney-client exchanges; when possible, avoid multi-level positioning of personnel that may contribute to feelings of powerlessness; assess realistic number of court officers necessary to ensure public safety)
- Minimize inadvertent traumatizing interactions (e.g., avoid having a person's back to a large group of people)
- To the extent possible, be cognizant of the potentially traumatizing effects of temporal matters (e.g., keep to schedule; find a time that works with the demands of people's schedules)
- Minimize traumatization and enhance a sense of personal safety by minimizing triggering sounds and by incorporating interactions that promote respect (e.g., eye contact, use of personal names) and clarity of communication (e.g., inquire about person's comprehension of proceedings)
- As appropriate, employ graduated and flexible sanctions that consider the individual's personal situation, specific treatment and supervision needs, obstacles to compliance with court or treatment orders
- Particular to specialty courts, offer incentives in treatment courts to encourage compliance with court conditions (e.g., praise from judge and/or probation officer, public acknowledgement of achievement of recovery benchmarks)

The promotion of personal and institutional safety is essential for the delivery of effective jail and prison services. While furthering this goal, administrators can review institutional policies, procedures and practices to identify any interactions or processes that may traumatize or re-traumatize a detainee, or which may impede an individual's efforts to serve their time safely and productively.

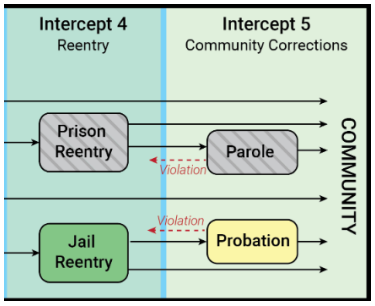
Examples of common jail and prison practices that may re-traumatize include:

- Confinement to small spaces and/or without windows or access to natural light
- Invasive or triggering aspects of searches, pat-downs and techniques for waking
- Use of scanning devices with inmates or visitors to identify contraband or weapons
- Observation during the administration of drug testing
- Shaving inmates heads is sometimes required upon entering a detention facility

Due to the primacy of security measures in correctional facilities, the modification of procedures to reflect more trauma-informed interactions can be challenging. Strategies for minimizing the potential re-traumatization include:

- Adopt strategies to demonstrate respect
- Avoid approaching individuals unannounced from behind
- Provide information on changes in schedules or placements to reduce anxiety
- Unless outweighed by security concerns, announce intentions before touching an individual
- Provide sensitivity training to staff to enhance sensitivity to a person's fear of confinement or isolation

Intercepts 4 & 5: Re-entry and Community Corrections



Effective re-entry planning is a major contributor to a person's successful return to the community, and encompasses comprehensive assessment of risks and needs, planning to address these treatment needs and risks, identification of community-based personnel to provide warranted treatment services, and coordination of planning and implementation personnel and services. Elements of transition planning may adversely impact some individuals and undermine re-entry success. Some common practices and elements that may pose challenges to an individual returning to the community include:

- Incomplete planning for accessing services in the community
- Insufficient social supports to assist the individual in adapting to the shift in the level of structure between institution and community.
- Obstacles to getting and keeping meaningful employment
- Housing issues (e.g., available housing offers little more than shelters, often in settings that don't feel safe; housing choices or opportunities may be limited because of a criminal history/record)
- Insufficient/missing familial and social supports
- Delayed access to medical care and psychotropic medications

In order to develop a more trauma-informed re-entry process, the following adaptations should be considered.

- Provide comprehensive assessment of individual risks and needs.
- Outline plans for addressing the afore-mentioned risks and needs.
- Include the individual in the reentry planning process
- Identify behavioral health personnel in the community who are able to provide necessary services
- Effectively link returning individuals with identified treatment providers in the community (e.g., warm hand-off, transport person to provider's office)
- Work with community advocates to secure safe housing for individual
- Take steps to reactivate access to social benefits prior to release
- Whenever possible, provide the returning person with sufficient medication to prevent relapse before contact with a prescribing treatment provider

Upon community re-entry, many persons are placed under the supervision of a probation or parole officer. While offering significantly greater freedom that was encountered in the detention

facility, probation and parole services can also be re-traumatizing and can impair the person's ability to successfully reintegrate into the community. Illustrations of common aspects of community corrections interactions and processes that may be re-traumatizing are outlined below.

- Frequency of meetings, check-ins, home visits and employment visits (e.g., transportation costs, effect on employment)
- Nature and frequency of substance use assessments (e.g., timing, public observation)
- Inadequate mental health assessments
- Limited availability to supervision officers with knowledge of behavioral health or trauma
- Conditions that require an individual to not associate with convicted felons or substance abusers may place limitations on ability to communicate with family members
- Probation violation hearings that are rigid and do not offer graduated sanctions

Strategies for developing trauma-informed responses in probation and parole include:

- Whenever possible, offer flexibility with consequences and graduated sanctions
- Train all staff to be sensitive to issues of relapse and recovery, particularly regarding substance use or mental health needs
- Work with clients to develop wellness plans, crisis plans
- Communicate effectively with clients to ensure requirements are understood
- Include the person in supervision planning so that personal, financial, social and family obligations are noted and respected
- Whenever possible, include treatment providers on supervision teams

Further Reading and References

Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the Paradigm for Jail Diversion for People with Mental and Substance Use Disorders: Intercept 0. *Behavioral Health Services & the Law, 35*, 380-396. DOI: 10.1002/bsl.2300

Griffin, P. A., Helibrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.) (2015). *The Sequential Intercept Model and Criminal Justice.* Promoting Community Alternatives for Individuals with Serious Mental Illness. New York. Oxford University Press. DOI: 10.1093/med/psych/9780199826759.001.0001

Munetz, M.R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services, 57*(4) 544-549. DOI: 10.1176/ps.2006.57.4.544

National GAINS Center. (2005). Developing a Comprehensive State Plan for Mental Health and Criminal Justice Collaboration. Delmar, NY. Author.

Policy Research Associates. (2017). The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders – brochure. Delmar, NY. Author.

Steadman, H. J. (2007). NIMH SBIR Adult Criss Training Curriculum (AXT) Project – Phase II Final Report. Delmar, NY. Policy Research Associates. (Technical report submitted to NIMH on 3/27/07.)