Self-Care and a Healthy Workplace

Supporting people who are survivors of multi-abuse trauma can be immensely rewarding. Providers who do trauma work report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of survivors’ courage, determination and hope (Herman, 1997).

However, working with survivors also carries risks for advocates and other providers. Trauma is contagious (Herman, 1997): Because providers bear witness on a daily basis to human cruelty, injustice and the resulting emotional pain, they can become emotionally overwhelmed and may experience to a certain degree the same terror, rage and despair as the people they serve.

Agencies serving survivors of multi-abuse trauma are often under-funded, resulting in chronic understaffing, overly large caseloads and other less than ideal working conditions. Complex issues that challenge the competence of even well-trained and experienced staff can add to feelings of emotional stress. This volatile combination of challenges, if not balanced with an appropriate level of self-care and agency support for staff, can lead to professional burnout and vicarious trauma (Warshaw & Pease, 2010).

Perlman & Caringi (2009) define vicarious trauma as “the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them.” They differentiate vicarious trauma, which refers to “the negative changes that can take place in trauma workers across time,” from burnout, which “focuses on the situation, the gap between what the helper is expected to do and what he or she is able to do.”

Despite the contrasts, both vicarious trauma and burnout may result in physical, emotional and behavioral symptoms, work-related issues and interpersonal problems (Trippany, Kress & Wilcoxon, 2004). In addition, both vicarious trauma and burnout are responsible for a decrease in concern and esteem for the people we serve, which often leads to a decline in the quality of care.

Recent research with providers who do trauma work has found responses that parallel victims’ and survivors’ adaptations, including common post-traumatic symptoms and relational patterns (Perlman & Caringi, 2009). Symptoms of post-traumatic stress such as avoidance, hyperarousal and numbing; relational adaptations such as aggression, reenactments and difficulty with boundary management; as well as general psychological stress have been identified (Warshaw & Pease, 2010).

This section explores the risk factors for vicarious trauma and burnout, and offers suggestions that can be used on the personal, professional and organizational level to diminish their negative effects.
Impact of vicarious trauma and burnout

Vicarious trauma and burnout can have a damaging impact on both providers and the people they serve. For advocates and other providers, the negative impact can be both personal and professional:

- A provider’s work may begin to suffer in a variety of ways: reduced productivity, reduced motivation for the work, lowered self-esteem and sense of competence, increased absenteeism and “sick days” (Warshaw & Pease, 2010).

- Providers may feel inadequate and question their own abilities to help people (Trippany, Dress & Wilcoxon, 2004). It is not uncommon for even experienced providers to feel suddenly incompetent and hopeless in the face of a traumatized person’s complex issues (Herman, 1997).

- When failing in their intention and commitment to assist the way they think they should, providers may experience guilt and challenges to their worldview, identity, and their own experience of meaning and hope (Perlman & Caringi, 2009). Without a sense of meaning, providers may become cynical, nihilistic, withdrawn, emotionally numb, hopeless and outraged (Trippany, Kress & Wilcoxon, 2004).

- Advocates and other providers may begin to experience work-related intrusive thoughts or nightmares. They may be left feeling they can’t discuss work with family or friends, or conversely, they may find they talk about work all the time and can’t seem to escape work-related issues (Warshaw & Pease, 2010).

- Repeated exposure to stories of human cruelty can heighten providers’ sense of personal vulnerability, causing them to become more afraid of other people in general and more distrustful even in close relationships. Providers may find themselves becoming increasingly cynical about the motives of others and pessimistic about the human condition (Herman, 1997).

- Those who experience “witness guilt” or “survivor’s guilt” may feel guilty for the fact that they were spared the suffering people they serve have had to endure. This may cause providers to have difficulty enjoying the ordinary comforts and pleasures of their own lives (Herman, 1997).

- If left unaddressed, vicarious trauma can escalate in severity until it meets criteria for a psychiatric diagnosis such as post-traumatic stress disorder, other anxiety disorders, mood disorders, and substance use disorders (Perlman & Caringi, 2009). Providers may also begin to experience health problems – increased illness or fatigue, aches and pains (Warshaw & Pease, 2010).

When advocates and other providers experience vicarious trauma or burnout, the people they serve suffer in a variety of ways:
• Providers may either avoid discussing traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the individual’s abuse or pushing to identify or confront perpetrators before the person is ready (Trippany, Kress & Wilcoxon, 2004).

• Providers may begin to feel anger or disgust toward the people they serve for not responding to services in some idealized way, and may become extremely judgmental or view certain individuals as “bad victims” (Herman, 1997).

• Providers, like the people they help, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action. The most common forms of action are rescue attempts, boundary violations and attempts to control the people they serve (Herman, 1997).

• Boundary violations are particularly salient with traumatized people who have already been subjected to violations, exploitation and dual relationships (Perlman & Caringi, 2009).

Risk factors for vicarious trauma and burnout

The complex interaction between traumatized people, stressed staff, pressured organizations, and challenging social, political and economic environments combine to create the perfect conditions for vicarious trauma and burnout (Warshaw & Pease, 2010). Perlman and Caringi (2009) have identified three major factors contributing to vicarious trauma:

• **Aspects of the work.** Some aspects of working with survivors of multiple traumas increase the likelihood of vicarious trauma in any service provider. Examples include hearing multiple stories of trauma and abuse, having difficulty gaining survivors’ trust, and observing the barriers encountered by people seeking help. When the person seeking help finds it difficult to trust or respect the provider due to past traumatic experiences, or expects to be exploited by the provider in some way, this can challenge the provider’s sense of identity and function. When providers observe the multiple problems experienced by some of the people seeking their help, coupled with the difficulty many survivors have in finding appropriate services in a fragmented system, they may feel like helpless witnesses.

• **Aspects of the provider.** Many aspects of advocates or other providers as individuals (personality and temperament, ego resources, coping styles, personal history, support system) and as professionals (level of training and experience with victims of trauma, theoretical orientation and the way one works) may contribute to or protect against experiencing vicarious trauma. Hearing a traumatized person’s story will also revive any personal traumatic experiences the provider may have suffered in the past.

• **Aspects of the social-cultural environment.** People with multiple trauma issues are
often the most marginalized members of society because of both the stigma of their traumatic experiences and their complex psychological, interpersonal, physical, social, economic, and spiritual needs. Many survivors do not have the means for private treatment; thus, they receive treatment in public systems that are notoriously under-resourced. The combination of multiple needs and inadequate resources can contribute to feelings of frustration, helplessness, and hopelessness on the part of the advocate or other provider, especially if an individual’s traumatic experiences are current and ongoing (for example, homelessness, domestic violence, and various forms of re-victimization).

Organizational factors leading to vicarious trauma/burnout

An important factor contributing to vicarious trauma and burnout is the lack of support some agencies provide for services and for staff doing trauma work. The notion of staff care as essential to the well-being of both providers and the people they serve in these settings has only recently emerged (Perlman & Caringi, 2009). Golie Jansen, associate professor in the Department of Social Work at Eastern Washington University, examined the relationship between perceived organizational support and the levels of vicarious trauma in sexual assault workers. Her research found that when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma (WCSAP, 2004).

The attitude that scarce resources must be directed toward services rather than toward staff support and care may be understandable. However, researchers emphasize self-care is not a luxury but rather is essential, both for the service provider’s physical and mental health and for the welfare of the people served by the agency (Perlman & Caringi, 2009). Implications for organizations that don’t attend to self-care may include greater use of sick leave, higher turnover, lower morale, and lower productivity (Anderson, 2004).

Several organizational practices can be risk factors for vicarious trauma and burnout:

- **Unrealistic expectations.** Vicarious trauma and burnout can occur when advocates and other providers struggle to maintain high levels of empathy and caring in work situations where there is likely to be unrealized and unrealistic expectations (Anderson, 2004). Examples of unrealistic expectations include pressure to accept overly large caseloads or pushing trauma survivors to accomplish goals too quickly.

- **Management style.** “Top-down” management style, in which supervisors question and sometimes invalidate lower-level staff’s practice knowledge and self-care attempts, can be particularly disruptive (Perlman & Caringi, 2009).

- **Inappropriate demands.** Chronically short-staffed agencies may pressure advocates and other providers to work in ways that mitigate against self-care— for example, working double shifts, or forgoing breaks, comp time, and vacation days. Inappropriate multi-tasking demands also contribute to feeling overwhelmed.
• An abusive workplace where bullying of staff is tolerated. In a 2007 survey of 7,740 U.S. workers conducted by Zogby International for the Workplace Bullying Institute, 37% reported either being bullied at the present time or at some point in their careers. According to the same survey, 45 percent of targeted individuals suffer stress-related health problems as a result of the abuse. As with other types of violence and abuse in our society, workplace abuse is about the perpetrator’s desire to control others (Workplace Bullying Institute, 2010).

Creating a healthy workplace

Organizations have a duty to help reduce the risk of vicarious traumatization in the workplace by offering an emotionally supportive, physically safe and respectful work environment (Brady, Poelstra & Brokaw, 1999). Here are some ways to ensure a healthy workplace:

• Provide specific training on vicarious trauma and burnout. All staff should be trained about the potential occupational hazards of trauma work and ways to protect themselves, as well as what the organization will do to help minimize the most negative effects (WCSAP, 2004). Training focused on “traumatology” is vital for trauma work and can decrease the impact of vicarious trauma (Trippany, Kress & Wilcoxon, 2004).

• Address the issue of vicarious trauma and burnout in a nonjudgmental way. Recognize that vicarious trauma is an occupational hazard of trauma work and de-stigmatize it (Warshaw & Pease, 2010). Perlman & Caringi (2009) emphasize that neither providers nor the people they serve are to blame for vicarious trauma. Rather, it is a cost of doing trauma work.

• Provide supervision, consultation and plenty of opportunities for debriefing. Staff meetings, supervision and consultation can help people begin to identify ways they are being affected and develop strategies to deal with them, like fostering self-care routines (WCSAP, 2004).

• Pay attention to special training needs. Younger, less experienced workers may need more training since research suggests that they tend to be more vicariously traumatized than more experienced workers (WCSAP, 2004).

• Limit the size of caseloads. Limiting the number of multi-abuse trauma survivors on a staff member’s caseload can help reduce feelings of being overwhelmed (Trippany, Kress & Wilcoxon, 2004). Research shows trauma workers indicate less work-related stress with a moderate number of individuals on a weekly caseload than with higher numbers.

• Create policies that encourage self-care. Policies allowing flexible work schedules and mandating that staff use compensatory and annual leave in a timely manner provide opportunities to rest and to process and integrate the efforts of the work (Perlman & Caringi, 2009). Provide adequate vacation, sick time and personal leave time. Benefits
such as paid vacation time and insurance policies covering the cost of counseling are also helpful (Trippany, Kress & Wilcoxon, 2004).

• Create a respectful working environment for both staff and the people the agency serves. How staff and supervisors interact with each other models the use of power in relationships. An abusive workplace sends an entirely wrong message.

Self-care tips for individual staff

Self-care allows providers to protect themselves in ways that enable them to provide better and more effective services to persons with multiple trauma issues. Therefore, Perlman and Caringi (2009) argue self-care is an ethical imperative. Here are some suggestions to help advocates and other providers in this vital area:

• Social support. A strong social support network can help prevent vicarious trauma (Trippany, Kress & Wilcoxon, 2004). Connection outside as well as inside the workplace is necessary. Advocates and other providers should develop and maintain sustaining intimate, family and other interpersonal relationships. Wherever possible, they should also disengage from activities and relationships that are depleting and replace them with those that are sustaining (Perlman & Caringi, 2009).

• Professional support. This might be a supervisory relationship or a peer support group, and preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to providing services to people with histories of trauma (Herman, 1997). Whereas limits of confidentiality prevent advocates and other providers from being able to debrief with support systems such as family and friends, peer supervision serves as an opportunity to debrief in an ethical manner (Trippany, Kress & Wilcoxon, 2004). In her landmark book *Trauma and Recovery*, Judith Herman, M.D., points out that just as no survivor can recover alone, no provider can work with trauma alone.

• Opportunities for continuing education and professional growth. Sending staff to conferences not only provides training, but a break from day-to-day routines.

• Mentoring. Both new and seasoned staff can benefit from mentoring relationships with people who have experience in the field.

• Consultation or counseling. Professional consultation or counseling allows advocates and other providers to acknowledge and reflect on their reactions to the intense feelings and extreme behaviors sometimes exhibited by survivors of multi-abuse trauma. Examining personal responses in a supportive, confidential, trauma-informed, professional counseling relationship can be a powerful source of support in identifying and managing vicarious trauma (Perlman & Caringi, 2009).
• **Realistic expectations.** Focus on process rather than outcomes. For many survivors, especially those with multiple trauma issues, healing is a long, slow process. A focus on doing what needs to be done rather than on an individual’s ability to live differently, will likely result in less frustration for both providers and the people they serve. Realize that even the most competent providers cannot accomplish miracles. They can neither undo the past nor protect people from all future harm (Perlman & Caringi, 2009). Also have realistic expectations for yourself, in terms of the workload you are capable of handling.

• **Boundary management.** Set clear boundaries between home and work. Managing boundaries appropriately includes remembering the provider’s role and mandate, treating the people one serves with respect and leaving work at the office (Perlman & Caringi, 2009).

People who last longer as advocates and helping professionals generally develop a system of closure. The method of closure is less important than the purpose it serves. Advocates with good boundaries are able to let go at the end of a day, acknowledge they have done what they can and let go long enough to actively engage in their own lives. This balanced approach fosters good health and makes it possible for advocates and other providers to continue doing their work just for today, one day at a time.

• **Respite and replenishment.** Create frequent opportunities to engage in activities offering distraction and/or personal growth, to exercise, have fun, rest, relax and connect with others. Physical activities during breaks at work such as stretching, taking a walk and exercising may provide an antidote to ongoing bodily tension and may further counter the sedentary nature of many work settings (Perlman & Caringi, 2009).

• **Spiritual renewal.** Given the central role of spirituality or meaning systems to trauma, it is essential to attend to the development of whatever is self-nourishing, whether that be traditional practices such as prayer and organized religion, or being useful to others, or enjoying nature (Perlman & Caringi, 2009). Participate in activities designed to increase your personal tolerance level. Including journaling, personal counseling, meditation, and obtaining emotional support from significant others allows reconnection to emotions (Trippany, Kress & Wilcoxon, 2004).

• **Social activism.** Advocates and other providers angry about injustices – ranging from perpetrator behavior to lack of appropriate funding levels for social service agencies, statements made by judges or defense attorneys, and societal attitudes toward victims – may find social activism is a way to channel their feelings in a productive and constructive manner (Wasco & Campbell, 2002).

• **Balance.** Confronted with the daily reality of people in need of care, advocates and other providers are in constant danger of professional over-commitment. Providers must understand their own realistic limits and strive to take as good care of themselves as they do of others. Providers have many strengths and resources they use to help traumatized people. Helping themselves, as well, serves both their own interests and the best interests of the people they serve (Herman, 1997). Balance also includes the development of
healthy habits. Getting sleep and good nutrition can reduce the toll stress places on the body. While nicotine can act as an anti-hostility agent and alcohol and other drugs can initially provide relaxation, energy or escape, reliance on these substances can pose health dangers and other risks for advocates and other providers.

The Alaska Network on Domestic Violence Training Project encourages advocates to consider alternatives to alcohol and other drug use following exposure to trauma and stressful events. We recommend debriefing following a stressful incident within 24 hours, preferably before sleep. Sharing feelings, rather than confidential details, with another trusted human being as soon as possible is critical. It is also helpful to refrain from substance use (including alcohol) for at least 72 hours (or longer) following a traumatic incident whenever possible. These choices can facilitate the internal processing of a traumatic event and serve as psychological first-aid reducing the likelihood of long-term mental health consequences.

Finally, remind yourself that you really are making a difference in people’s lives. “You don’t always know you’re helping when you’re helping, because they don’t always tell you,” says Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN. “So just hold onto that, that you can make a huge difference in people’s lives and you do make a difference” (Trujillo, 2009).

References


Herman, J.L. (1997). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. New York: Basic Books.


