How to Maintain Emotional Health When Working with Trauma

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ABSTRACT

Vicarious traumatization, compassion fatigue, or secondary traumatization refers to the cumulative effect of working with survivors of traumatic life events as part of everyday work. Although this issue has been acknowledged and addressed among professionals such as police officers and medical professionals, it has been discussed less among juvenile and family court judges who also experience secondary traumatic stress. In fact, in one recent study, a majority of judges reported one or more symptoms of secondary traumatization. This article describes the common signs and symptoms of secondary trauma, job-related factors that contribute to secondary trauma among judges, and the potential negative impact on organizational performance. The authors conclude with specific recommendations tailored for juvenile and family court judges.

INTRODUCTION

Definition

Vicarious traumatization (VT) or compassion fatigue (CF), also labeled secondary trauma, refers to the cumulative effect of working with survivors of traumatic life events, or perpetrators, as part of everyday work. People who engage empathically with victims or survivors are particularly vulnerable (Figley, 1995; Pearlman & Saakvitne, 1995). Risk

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factors for VT or CF include measuring your self worth by how much you help others; having unrealistic expectations of yourself and others; being self critical and a perfectionist; fearing others will judge you if you show "weakness" (e.g., seek help or express your feelings); being unable to give or receive emotional support, overextending yourself; and letting work bleed over into your personal time (Figley, 1995).

In a 2002 study, Figley reported secondary stress reactions in health care providers, attorneys, first responders, supportive services, military personnel, volunteers, and media personnel. Judges were not included in this study, but a later paper by Jaffe, Crooks, Dunford-Jackson, and Town (2003) indicated that judges also experience secondary traumatic stress. In some professional environments, for example those involving mental health supervision, care is taken to build in prevention, intervention, and coping strategies in the work environment to support and help those who may be impacted. At times, this support may just be an opportunity to debrief after dealing with a traumatic situation or event. In many work settings, however, VT or CF is neither acknowledged nor dealt with as it may be perceived as a sign of weakness. Within the judiciary and the legal profession, or among first responders, the issue of VT or CF is rarely discussed, and prevention or intervention strategies related to "psychological reactions" are not considered a part of the culture. Observations of professionals who work in such environments indicate they often find their own ways to cope and adjust; if their strategies are maladaptive, they may leave that type of work, or in some cases be asked to leave if their performance suffers due to the situation being too stressful.

The purpose of this paper is to review the effects of vicarious traumatization and compassion fatigue on professionals who face trauma every day as part of their work responsibilities. It is assumed that professionals who work in child welfare, law enforcement, health care, and mental health are impacted. Because dealing with the effects of trauma and violence is a part of their work responsibilities, judges also may experience vicarious traumatization and compassion fatigue. Therefore, specific issues that may emerge for judges are discussed including how juvenile court judges may be impacted by their work and the strategies they may use to cope with the inevitable stresses in their environment.

THE EFFECTS OF VICARIOUS TRAUMATIZATION ON CHILD WELFARE, LAW ENFORCEMENT, AND HEALTH PROFESSIONALS WHO WORK WITH TRAUMATIZED CHILDREN AND FAMILIES

Child Welfare

Child welfare systems deal with child abuse and neglect, family violence, and trauma on a daily basis. Most child welfare/child protection systems are multilayered, and the traumatized children and troubled families served by the system are usually seen by a large number of professionals including child protection workers, police officers, social workers, doctors and nurses, Court Appointed Special Advocates (CASA) and Guardians

TABLE 1
Signs and Symptoms of Secondary Traumatization in Child Welfare Workers

- Cynicism, anger, or irritability
- Anxiety or new fears, e.g., about the safety of one's family
- Emotional detachment, depersonalization, or a sense of numbness
- Sadness, depression
- Intrusive imagery or thoughts about victims, patients, or clients
- Nightmares and difficulty sleeping
- Social withdrawal and disconnection from family and friends
- Changes in world view—sense of futility or pessimism about people
- Changes in spiritual beliefs
- Diminished self-care
- Increased physical ailments and illness
- Use of alcohol/drugs to "forget about work" or "relax"

ad Litem (GALs), prosecutors, and judges. In addition, there are often foster parents and volunteers who spend considerable amounts of time caring for or working with traumatized children. In the course of performing their jobs, these professionals and volunteers routinely encounter disturbing, disheartening, disgusting, shocking, and frightening accounts and situations.

Not surprisingly, the cumulative effects of prolonged repeated exposure to these stories and situations often affect the personal lives of those who work in the system. Also not surprising is the finding that systems staffed by stressed and traumatized employees do not function optimally. Researchers have studied the effects of vicarious traumatization in a number of professions involved in the child welfare system including child protection workers, police officers, nurses, and mental health therapists (Figley, 1995, 2002; Pearlman & Saakvitne, 1995). Each of these groups has unique stressors and types of traumatic experiences, but overall, they share a set of common responses and outcomes.

Researchers who study the effects of work-related exposure to traumatized individuals and disturbing or frightening situations have identified a number of common signs and symptoms, listed in Table 1, indicating that an individual is suffering serious adverse effects.

Each professional discipline working with these families will experience a unique set of stressors and traumatic experiences that are specific to the kinds of work that they do. But all of these disciplines also share a set of common experiences and stressors based on the fact that they are working with traumatized families and encountering similar frustrations and organizational problems trying to do their jobs within the context of an overburdened, underfunded child welfare system. Such overwhelmed systems frequently experience organizational problems that increase risk for secondary traumatization of staff. Some studies have found that organizational factors are the strongest predictors of secondary traumatization in workers (Regehr, Hemsworth, Leslie, Howe, & Chau, 2004). Organizational and job problems that frequently contribute to secondary traumatization, as well as job burnout, are listed in Table 2.

TABLE 2
Organizational and Job Issues Contributing to Secondary Traumatization

- High case load
- Little support from supervisors
- Being placed in situations with conflicting roles, expectations, or values
- Lack of peer support
- Inadequate resources to meet demands
- Being forced to assume personal liability for job-related decisions and actions
- Excessive workload or paperwork
- Too many interruptions during critical or demanding tasks
- Physical risks or concerns about personal safety
- Little job recognition
- Shift work and sleep deprivation

TABLE 3
Effects of Secondary Traumatization on Organizational Function

- Increased absenteeism
- Impaired judgment
- Unwillingness to accept extra work or assume responsibility
- Low motivation
- Lower productivity and poor quality of work
- Decreased compliance with organizational requirements (e.g., completing paperwork, following guidelines)
- Greater staff friction
- High staff turnover

The secondary traumatization of employees ultimately decreases their functioning and undermines the working environment in an organization. Table 3 summarizes negative organizational effects documented across child protection, police, and mental health agencies with high rates of vicarious traumatization.

The child welfare system involves the interaction of multiple bureaucratic organizations (child protection, law enforcement, medical and mental health, judicial) operating under somewhat different mandates and timelines with respect to processing cases. People in one organization frequently do not understand the roles, demands, requirements, and legal and institutional constraints that dictate what can be expected from others who also work with the same children and families. Differences in professional orientation and training further complicate the process and impede the development of mutual trust and respect.

Not infrequently, actions or inaction by members of one organization may increase the stress or complicate the jobs of members of another. As a case is shared and decisions are made across different disciplines and agencies, individuals may feel a loss of control

while at the same time continuing to feel responsible for outcome. Often there is little or no feedback about the ultimate outcome of a case after it passes on to others in the system—and thus no indication of the success or failure of one's efforts. In aggregate, working in the child welfare system can be highly stressful and increases one's risk for secondary traumatization and/or job burnout.

Child Protection and Social Workers Working with Abused Children

Studies of child protection workers and social workers working with abused children and families in the child protection system have reported high rates of secondary traumatization. A Canadian study of hospital-based child protection workers found that one third reported emotional exhaustion, high levels of cynicism, and low levels of professional efficacy. Two thirds had considered changing jobs with three quarters of those who worked full-time with child abuse victims considering leaving the profession. A third of former child protection workers cited stress as the reason they chose to retire early or leave for other jobs (Bennett, Plint, & Clifford, 2005).

A study of master's degree social workers in North Carolina found that 70% had experienced at least one symptom of secondary traumatization in the prior week (Bride, 2007). Over half met criteria for at least one PTSD symptom cluster, and 15% met full PTSD criteria. Staff turnover was significantly higher for public child welfare workers than for other state or city government workers. A study of 365 Colorado child protection workers found half had "high" or "very high" levels of secondary traumatization (Conrad & Kellar-Guenther, 2006).

Yet all three studies found that child protection workers reported high levels of "job satisfaction" and low levels of "job burnout." This seemingly paradoxical finding illustrates that secondary traumatization (compassion fatigue, vicarious traumatization, etc.) is different from "job burnout," which can occur in professions that do not entail exposure to victims of abuse and violence. Stamm (2002) has advanced the concept of "compassion satisfaction" which mitigates job burnout. Compassion satisfaction is defined as getting pleasure and fulfillment from helping others, affection for colleagues, and a sense of making an important contribution to the welfare of others and society. While compassion satisfaction appears to reduce "job burnout," it does not necessarily reduce secondary traumatization as child protection workers may score high on measures of both. One might also hypothesize that those workers were functioning in settings providing more support than is available in many work environments.

Based on the studies cited above, Table 4 includes common stressors associated with secondary traumatization in child protection workers and social workers working with victims of violent crime.

Police

Police officers experience many sources of stress as part of their daily jobs. Officers are at high risk of developing PTSD as a result of direct life threat as well as secondary traumatization from repeated exposure to the aftermath of violence. They face personal

TABLE 4
Common sources of secondary trauma for child welfare workers

- The death of a child or adult on the worker's caseload
- Investigating a vicious abuse or neglect report
- Frequent/chronic exposure to emotional and detailed accounts by children of traumatic events
- Photographic images of horrific injury or scenes of a recent serious injury or death
- Helping support grieving family members following a child abuse death, including siblings of a deceased child
- Concerns about the continued funding and adequacy of resources for their agency
- Concerns about being publicly scapegoated for a tragic outcome when they did not have the means or authority to intervene effectively

danger including assaults with a weapon, seeing dead or terribly injured victims of violence or accidents, interviewing witnesses, and investigating grisly crime scenes. They may be required to use physical force or fire a weapon in the line of duty. In addition, they face verbal abuse and harassment from members of the public.

In the last decade, researchers have increasingly focused on the role that PTSD and secondary traumatization plays in the personal and professional difficulties experienced by many police officers. Researchers have found that 7%-19% of frontline police officers have duty-related PTSD (Marmar et al., 2006). Many other officers experience partial PTSD which, nonetheless, affects their personal lives and impairs professional performance.

A number of studies have ranked common police work incidents in terms of their potential to create traumatic stress. Among the incident types most frequently mentioned are: 1) shooting of another officer; 2) being involved in a shooting incident; 3) seeing abused children; 4) seeing victims of serious accidents; 5) seeing someone die; 6) seeing dead bodies; and 7) seeing homicide victims (Violanti & Gehrke, 2004). In a study of 115 police officers, seeing abused children was the most frequent incident type (68%) identified. Female officers were particularly affected by this experience, resulting in a 33-fold increased risk for PTSD; whereas this experience increased a male officer's risk by 3-fold (Violanti & Gehrke, 2004).

Medical Personnel

Job burnout in nurses has been investigated extensively and is highly implicated in nurses leaving direct patient care or the profession entirely. Secondary traumatization of nurses has been investigated in a few studies (Clark & Gioro, 1998; Maytum, Herman, & Garwick, 2004). Some nursing research suggests that initial secondary traumatization contributes to job burnout at a later point in time (Maytum et al., 2004). Working in chronic care settings or with patients likely to die are major factors. The experience of the first author in working with medical personnel and especially nurses in the post-Hurricane Katrina environment, after many had experienced extreme trauma in trying

to save patients as well as being trapped themselves, led to burnout and, in some cases, nurses choosing to leave their profession, at least for a period of time. In one recent study it was shown that psychiatrists seem to be more susceptible to secondary traumatization than other health care workers with direct patient care (Sprang, Clark, & Whitt-Woosley, 2007). The reasons for this are not entirely clear although high levels of responsibility, higher levels of day-to-day exposure to emotionally disturbing material, and low availability of support may be factors. At the same time, Calderon, Kronenberg, Many, and Osofsky (in press) proposed that preventive and posttraumatic interventions should be added to disaster planning to enhance preparedness and to mitigate secondary traumatization among health care providers.

UNDERSTANDING AND SUPPORTING PROFESSIONALS WHO WORK WITH TRAUMA: THE NCTSN JUDICIAL CONSORTIUM AND PARTNERSHIP WITH THE NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

In 2004, the National Child Traumatic Stress Network formed a Judicial Consortium, which developed a partnership with the National Council of Juvenile and Family Court Judges. The overall goal of the NCTSN Judicial Consortium was to increase collaboration between the justice system and professionals who work with child trauma and maltreatment for the best interests of children, their caregivers, and society. Soon after its formation, the issue of vicarious traumatization of juvenile and family court judges emerged as an area to explore for future joint education, training, and intervention activities.

Through collaboration involving education, training, and resource development, one of the Consortium's objectives was to share relevant information across both groups on the effects of trauma on children and youth and develop better ways of disseminating such knowledge for those who work in court settings. A second objective was to determine ways to support both fields, through training and resource development, in making recommendations and decisions about the "best interest of the child." To facilitate this work, the NCTSN Judicial Consortium in collaboration with NCJFCJ implemented a survey and organized focus groups to gather information from judges related to their understanding of the impact of trauma on children and adolescents and need for additional information. Further, since many professionals working with trauma are at risk for experiencing vicarious traumatization, we believed that it would also be important to learn more about the risks that judges face for VT and CF and the acceptability of prevention and intervention strategies to support judges.

Vicarious Traumatization and the Impact on Judges

In the Fall 2003 issue of the *Juvenile and Family Court Journal,* Jaffe, Crooks, Dunford-Jackson, and Town reported on a study of 105 judges who, while attending

TABLE 5
Primary Concerns mentioned by Judges Contributing to Vicarious Traumatization

- Caseload (can't manage large caseload consistently)
- Stress level with work
- Non-judgmental role that a judge has to take
- Lonely world and profession (cannot share cases and decisions)
- Can't take cases home and get support
- Does not feel safe for judges to say they are having problems and need help
- Difficult to open up about personal issues
- Anger and frustration
- Helplessness, hopelessness, and depression about the cases

NCJFCJ workshops, responded to a self-report measure that included symptoms of vicarious traumatization, coping strategies, and prevention suggestions. Recognizing that their sample might not be representative of judges in all juvenile and family courts, the findings were still informative. The majority of the judges representing criminal, domestic/civil, and juvenile courts reported one or more symptoms of vicarious traumatization. Female judges reported more symptoms than male judges (consistent with reactions of police officers) and those with seven or more years of experience reported more symptoms. While overall the judges reported different types of coping and prevention strategies, they concluded that there was a need for both greater awareness of these issues and more support for judges experiencing these reactions. As mentioned, some work environments build in support for professionals who repeatedly work with trauma; however, such supports are rarely included as part of a judicial environment.

In an informal focus group held with judges by the first author in connection with the 2007 annual conference of NCJFCJ, judges shared the primary concerns listed in Table 5.

During the NCJFCJ meetings in 2005 and again in 2007, NCTSN held focus groups with approximately 45 judges representing jurisdictions throughout the U.S. Judges who participated heard cases covering many areas including dependency, delinquency, domestic violence, and divorce/custody. In 2007, a survey of the judges participating in the focus groups found that 53% had not received training about child trauma, its assessment and treatment. Judges reported feeling overwhelmed by the prevalence of trauma in the courtroom, the magnitude of the needs of the children and families, lack of resources, placement concerns related to best interest of the child, coordination with other service systems, and confidentiality issues (National Child Traumatic Stress Network, 2008).

One of the important objectives of the NCTSN/NCJFCJ partnership through the Judicial Consortium was to learn more about the types of information and resources about trauma that would be most helpful to judges in making decisions about the "best interests of the child." Judges shared with the NCTSN mental health professionals concerns they had about the following areas:

- How to evaluate experts that appear in court and the validity of the information they provide
- Learning the most effective ways to communicate with children in court
- Being provided with relevant research including an evaluation of its quality
- Availability of educational sessions and training videos for lawyers, social workers, and child welfare professionals
- Information about developmental issues related to the effects of trauma on children of different ages and the potential impact over time
- Information on evidence-based interventions and treatments to help traumatized children of different ages
- Information on risk factors for negative outcomes and ways to support resilience in response to trauma
- Increased information about vicarious traumatization and compassion fatigue including personal and institutional prevention and intervention strategies.

General Recommendations for Prevention and Treatment

Recommendations for prevention and treatment by experts of secondary traumatic stress can be divided into two types: personal and organizational. Personal recommendations focus on what the individual can do to recognize, reduce, or prevent secondary traumatic stress effects. Organizational recommendations focus on what institutions and agencies can do to minimize secondary traumatization (and burnout) in their workers. Recommendations aimed at helping individuals usually first ask the person to stop and systematically assess his or her exposure to secondary traumatic stressors. A number of self-administered checklists have been published and circulated which allow people to make their own assessment of the degree to which they experience secondary traumatization (Figley & Stamm, 1996; Stamm, 2002; 2005). Measures typically ask the person to rate the degree to which he or she experience many of the symptoms listed in Table 1. Scores are usually grouped into general categories such as mild, moderate, and severe levels of secondary traumatic stress. Higher scores on these measures are moderately correlated with standard measures of anxiety, depression, and posttraumatic stress. The intent of self-assessment measures is not to pathologize secondary traumatic stress, but to help the person understand that these are expectable effects of exposure to the trauma and suffering of others.

Individuals with moderate to high scores or other evidence of secondary traumatization are urged to utilize various self-care and stress reduction strategies. Some of these strategies involve personal lifestyle changes such as eating regularly, getting sufficient exercise and sleep, taking more time for themselves, and developing outside interests. Strategies for psychological, emotional, and spiritual self-care are also often included as recommendations. A comprehensive list of these recommendations, including the Child Welfare Trauma Training Toolkit is available at the National Child Traumatic Stress Network Web site (http://www.nctsn.org). The Self-Care Inventory can be found at http://www.nctsn.org/nctsn_assets/pdfs/cwt3_sho_inventory.pdf.

TABLE 6
Organizational Changes to Reduce Secondary Traumatization

- Reduce caseloads/workloads
- Provide adequate supervision for frontline workers
- Provide good mental health insurance coverage
- Explicitly acknowledge the job stress and the possibility of work-related secondary traumatization of staff
- Provide staff educational workshops to increase individual awareness, develop peer support, decrease traumatized individuals' sense of isolation, and encourage self-care
- Provide adequate coverage and backup for staff in stressful positions
- Encourage ongoing discussion of secondary trauma among staff and administration

Despite the availability of stress reduction approaches, many informed professionals do not practice them. A study of trauma therapists, i.e., experts on traumatic stress effects, showed that while the therapists strongly endorsed these self-care concepts and recommendations, they often did not, in fact, use them for their own self-care. The amount of time a therapist spent working with trauma victims was most predictive of their secondary traumatization score (Bober & Regehr, 2005).

The research finding that organizational issues, policies, and working environment make substantial contributions to increasing employees' risk for traumatic stress has led to recommendations designed to redress these factors (Sprang et al., 2007). Organizations have a lot to gain by reducing or preventing secondary traumatization and reducing the negative effects listed in Table 3. As with individuals, the first step is that the organization must recognize that secondary traumatization is possible and may be occurring. Acceptance of this possibility by administrators and managers is often slow because they do not experience the daily contact with traumatized individuals that frontline workers do. Table 6 lists recommendations commonly made for reducing organizational contributions to secondary traumatization.

Lessons for Judges about Vicarious Traumatization

An important lesson learned in the NCTSN focus groups with judges is that trauma experts and treatment providers must listen to judges' perceptions of traumatization and their needs and create support accordingly. For example, the judges said they are unlikely to share their personal issues or trauma in a setting with their jurisdictional colleagues, as they perceive such sharing as a sign of weakness and vulnerability. Judges are more open in forums including judges from different jurisdictions as there is less competition among those present who may be seeking election or appointment to positions in their respective communities.

Second, it is important to educate judges about potential sources of vicarious trauma so they can recognize secondary trauma in themselves more readily and manage their distress. For example, irritability on the job, increased alcohol use, depression, or posttraumatic stress reactions can all be signs of secondary traumatization.

Third, it is important for judges to know that VT is a natural result of sitting in dependency court and family court day after day, hearing multiple cases of trauma. These acts of public service carry such risks, just as first responders and EMTs face ongoing risks for VT. In recognizing these facts, judges may also allow themselves to seek support including professional help if indicated and available. They may also become more aware of the need for practicing self-care.

Fourth, judges state that they need help in learning how to listen to children tell about the horrors they have experienced at the hands of their parents and then respond to the child in a helpful, appropriate way. Maintaining the ability to be sympathetic, caring, and strong, and still dispassionate, can often be difficult and at times impossible. The effects of VT may interfere with an individual's ability to be both empathic and dispassionate.

Finally, judges need to know when it might be necessary to take a break from dependency and family court and heal. Sometimes judges hate to admit that they are human and, like everyone else, can suffer from daily exposure to their respective worlds of omnipresent deprivation and impoverishment where they are responsible for the lives of others.

Perhaps the most important message we can provide related to vicarious traumatization is that sometimes, in order to do no harm, judges must help themselves.

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