

CHAPTER 17



# **Vicarious Traumatization and the Need for Self-Care in Working with Traumatized Young Children**

Joy D. Osofsky

In this book, the issue of vicarious traumatization or compassion fatigue for individuals who work with traumatized young children and their families, including mental health evaluators and therapists, judges, lawyers, child welfare professionals, first responders, and all other adults, has not been discussed directly. However, working with traumatized young children can take its toll because it often is very difficult to witness hardship and human suffering, and at the same time, as professionals, be required to maintain boundaries and professional roles, to make decisions about children's lives, and to take actions to help vulnerable young children and their families. Individuals find different ways of coping with these difficult feelings—some may just avoid thinking about it. In this chapter, the issues of vicarious trauma and compassion fatigue are defined and discussed, examples from different disciplines are presented, and suggestions that are offered relate to individual and professional strategies for prevention and intervention, including the importance of self-care.

## **HOW TO UNDERSTAND VICARIOUS TRAUMATIZATION AND COMPASSION FATIGUE**

Vicarious traumatization (VT) or compassion fatigue (CF), also called secondary trauma, refers to the cumulative effect of working with survivors of traumatic life events, or perpetrators, as part of everyday work. Figley (1996) and Pearlman and Saakvitne (1995) emphasize that people who engage empathically with victims or survivors are particularly vulnerable. They also discuss risk factors for VT or CF (Figley, 1995), which include measuring one's self-worth by how much one helps others, having unrealistic expectations of oneself and others, being self-critical and a perfectionist, fear of being judged by others if one shows "weakness" (e.g., seeking help or expressing one's feelings), being unable to give or receive emotional support, overextending oneself, and letting work bleed over into one's personal time. Secondary traumatic stress (STS) reactions were studied in health care providers, journalists, attorneys, first responders, supportive services, military personnel, volunteers, and media personnel by Figley (2002), and in judges by Jaffee, Crooks, Dunford-Jackson, and Town (2003). In some settings, due to the nature and organization of the work, prevention, intervention, and coping strategies are included as part of the work environment to support and help those who may be impacted. Support may at times just be an opportunity to debrief after dealing with a traumatic situation or event. However, in many work settings, especially those with heavy caseloads and a culture of not talking about issues, VT or CF is neither admitted nor dealt with for several reasons. One problem is that many professionals are not used to talking about emotions and issues that can impact their performance. For some, talking about the daily work impacting a professional in a personal and emotional way may be perceived as a sign of weakness. Within the legal profession or among first responders, the issue of VT or CF is rarely discussed; in most settings, prevention or intervention strategies related to "psychological reactions" are not considered a part of the culture. Individuals find their own ways to cope and adjust, and if their coping strategies are maladaptive, leading to irritability, impulsiveness, insensitivity, or arbitrariness in their work, they may leave the job. At times, individuals may also be asked to leave, if their performance suffers because the situation is too stressful.

### **VICARIOUS TRAUMATIZATION FOR INDIVIDUALS WORKING WITH TRAUMATIZED YOUNG CHILDREN**

#### **Issues in Juvenile Court from Multidisciplinary Perspectives**

In April 2010, I attended a meeting of multidisciplinary professionals working with juvenile court systems, including judges, lawyers, and mental

health professionals; and child welfare, early intervention, and child care professionals. In preparation for a presentation on VT and CF, I asked the group to fill out the Professional Quality of Life Scale assessing compassion satisfaction and CF (Stamm, 2009). The results were both interesting and informative. This group of dedicated professionals working with juvenile courts reported many positive feelings about their jobs and the work that they do. The majority reported being caring people, liking and getting satisfaction from their work, very much wanting to help other people, and being pleased that they chose to do this work. They also stated that they often feel very successful as helpers, believing they can make a difference in people's lives. However, many also reported negative feelings, including being "bogged down" by the system, overwhelmed at times by the work, and sometimes feeling worn out because of their work as a helper. A small percentage reported that it is difficult at times to separate one's personal life from one's life as a helper and feeling impacted by the traumatic stress of others. Some reported even experiencing the trauma of someone they helped. Almost half of the respondents reported sometimes feeling "on edge." The majority reported that their beliefs helped sustain them in work that, for many, appeared to be a strong protective factor. Unfortunately, for those who work with traumatized young children and families, the personal impact is not often taken into account, and the importance of providing a supportive environment to sustain both individuals and systems doing this work is crucial.

Across multidisciplinary groups, several identified areas and topics are helpful for all professional and support groups dealing with traumatized young children. All groups agreed that they could benefit from learning about developmental issues and ways to understand the effects of trauma on children of different ages, and "red flags" to identify children who may have been traumatized. Several groups have expressed interest in learning about the effects of trauma on children over time. It would be helpful to have training videos and cross-disciplinary training for judges, lawyers, mental health professionals, and child welfare workers. All agreed that learning more about evidence-based evaluations, practice, and services that support young traumatized children and their families would be helpful. These groups also suggested that it is important to learn about protective factors, risk, and resilience (Masten, 2001, in press). Finally, related to the focus of this chapter, they expressed interest in learning more about VT and CF, as well as both personal and institutional prevention and intervention strategies.

### **Issues for Juvenile Judges**

An issue that leads to considerable stress and potential traumatization for those working with juvenile court is finding ways to support and help sub-

stance-abusing parents and caretakers. Due to the nature of their problems, these parents struggle with their recovery and may relapse as part of their recovery, leaving their children once again and failing to keep them safe. For judges, mental health professionals, caseworkers, and others, this process can be both frustrating and at times traumatizing. In discussions with judges, many shared their concerns about VT resulting from hearing about horrors every day, seeing grisly photographs, and witnessing the suffering of young children. Although the judges described their commitment to being fair and helpful, the result for some may be anger, depression, and anxiety that, without being addressed, may have the potential to impact on the judge's ability to create a supportive, problem-solving court environment. It is crucial to address the issue of VT with all who work in juvenile court and provide needed support through the institutional environment.

In 2003, Jaffee and his colleagues reported on a study of 105 judges who, while attending National Council of Juvenile and Family Court Judges (NCJFCJ) workshops, responded to a self-report measure that included symptoms of VT, coping strategies, and prevention suggestions. While it is recognized that this sample may not be representative of judges in different jurisdictions, the findings were still informative. It is noteworthy that the majority of the judges representing criminal, domestic/civil, and juvenile courts reported one or more symptoms of VT. Consistent with data on police officers' reports of traumatic symptoms, female judges reported more symptoms than male judges, and those with 7 or more years of experience reported more symptoms. The authors concluded that although judges reported different types of coping and prevention strategies, there is a need for greater awareness of these issues and more support for judges. Education about trauma and how it might impact those exposed every day is rarely included in education for any discipline doing work with traumatized children and families. While some work environments build in more support for professionals who repeatedly work with trauma, such supports are rare in the court environment. In informal focus groups held with judges, in addition to the many positive comments about satisfaction with the work, the judges also shared the following concerns: difficulties of managing large caseloads; stress level at work; the nonjudgmental role that a judge has to take; a lonely world and profession; inability to share cases and decisions, or to "take cases home" and get support; reluctance to seek help if needed; difficulty in sharing personal issues; and feelings of anger and frustration, helplessness, hopelessness, and, at times, depression about the cases.

A collaboration was developed between the National Child Traumatic Stress Network (NCTSN) and the NCJFCJ through the NCTSN Judicial Consortium that led to focus groups being held with approximately 26 judges. The participating judges worked in different court settings, including juvenile dependency and delinquency, domestic violence, and divorce/

custody cases. Based on a concurrent survey by the NCTSN, the results indicated that over half (52%) of the judges had not received training about child trauma, about how such children could be assessed, and about established evidence-based treatments. Judges expressed many concerns related to child trauma, including at times feeling overwhelmed by the prevalence of trauma in the courtroom, the amount of need and the limited availability of resources, concerns about how to ensure that placement related to the best interest of the child, ways to facilitate coordination with other services systems, and how to maintain support and confidentiality while supporting children who receive help.

One judge stated that no one who works with children who suffer abuse and neglect, or who works rehabilitatively with their parents, is immune from feeling their pain. Juvenile and family court judges strive to improve the lives of the children and parents who appear before them. However, despite passion and dedication, these families come to court with trauma that can impact the judge emotionally. The testimony relates abuse and horror. The judge can be worn down by observing broken and abused, vulnerable children. At this point the judge may be experiencing VT. This judge suggested that all courts consider offering qualitative seminars on VT, preferably co-led by a judge and a mental health professional. To deal with VT, it is necessary for judges and others working in the juvenile court to be aware and address it directly.

## **Issues for Mental Health Professionals**

### *Working with Substance-Abusing Parents*

For mental health professionals working with substance-abusing parents, other issues may emerge. A psychologist who works in a residential program for substance-abusing mothers and their young children shared a very difficult time in treatment with a young mother in recovery, who, during a therapy session with her young baby present, started talking intensely about her own trauma. With that, she disengaged from paying any attention to the baby, who lay quietly on the floor staring at the ceiling. The therapist experienced herself as “abandoning and neglecting” the baby in her effort to be emotionally available to the mother, and being as neglectful as the mother she was trying to help. After the session, she felt worried, sad, and guilty, but most of all she kept “second-guessing” herself, wondering what she “missed” because she could not prevent the mother from relapsing and taking the baby with her. She continued struggling with her own feelings about not being able to protect the baby. With substance-abusing parents, probably one of the most common questions of therapists is “What did I miss?”

*Working in Juvenile Court*

As mental health professionals, some difficult and wrenching experiences occur when we work with young traumatized children and families within the juvenile court system. Dr. Amy Dickson, a coauthor of Chapter 7 in this book, coordinates the Orleans Parish Infant Team (Orleans Parish Zero to Three Court Team), working collaboratively with the court, lawyers, child welfare, early intervention child care specialists, and others to provide evaluation and treatment services for young children and families. Yet not a week goes by without a situation arising that results in a mixture of emotions—not only wanting to help but also anger that a young child has been treated so harshly. There is also sadness for the parent, frustration that it may be difficult to work with the many systems involved, and a sense of helplessness and hopelessness about not being able to help sufficiently to “make things better” for the child. Two poignant examples of VT and CF for mental health service providers on the Louisiana State University Health Sciences Center team may illustrate problems that can come up even in settings with much support. A very skilled mental health professional had a baby during the course of her work with the Infant Team, which provides evaluations and services for traumatized young children and families adjudicated dependent due to abuse and neglect. This young woman was referred a case of a baby in foster care who was the same age as her baby, to plan permanent placement with relatives. For this new mother, although a fine professional, it was very difficult to do the necessary work with the foster family and relatives to facilitate moving this child from the foster family when she was 10 months old. Delay of placement of the child with the relatives had been related to the failure to do investigative work with the relatives right after the baby’s birth. The mental health professional had difficulty with boundaries, overidentified with the foster parents, and could not imagine separating them when the baby had been living with them her whole life. All mental health professionals, child welfare professionals, and many judges know how difficult it may be for a child to form a secure attachment for almost a year, then have to interrupt that attachment relationship for the sake of a permanent placement. At the same time, the goal of the work is to achieve permanency and stability for the children, and to stay within the guidelines of the Adoption and Safe Families Act (ASFA; 1997). Another very difficult case that caused much distress to the whole Orleans Parish Infant Team (Orleans Parish Zero to Three Court Team) was learning that a 1-year-old child had been tortured to death, and that her sister, for whom we were providing services and support, weighed only 12 pounds, had permanent brain damage, and scars on her body. To carry out the important work effectively for this child and foster family, much processing and support from team members was needed, but even with that

extra effort, the result was much distress, sleep lost, and other concerns for team members.

### *Specific Issues for Child Welfare*

Those who work in the child welfare system are exposed routinely to child abuse and neglect, family violence, and multiple traumatic experiences. These children often are seen by many people, including police officers, health care professionals, social workers, and judges, all of whom provide information to the child welfare professional. In addition to all of these systems, foster parents and volunteers spend much time working with and supporting traumatized children. In the course of their day-to-day work, they are exposed to frightening accounts and situations, shocking and disturbing stories, and disheartening results. Common sources of VT for individuals in the child welfare system include the death of a child or adult on the worker's caseload; having to investigate a particularly vicious abuse or neglect report; frequent and chronic exposure to emotional and detailed accounts by children of traumatic experiences; photographic images of horrific injuries and scenes of recent injury and/or death; support of grieving family members following a child abuse death; concerns about bureaucratic issues, including continued funding and adequate resources to support the work; and concerns about being identified in a difficult case when it was not possible to intervene effectively due to lack of authority or means. These professionals could benefit from more support than is often available to support them in these situations.

Researchers have studied the effects of VT on a number of professions involved in the child welfare system, including child protection workers, police officers, nurses, and mental health therapists. For example, 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. The risk of job turnover was great with two thirds considering changing jobs and three quarters of those who worked full time with child abuse victims considering leaving the profession. For those child protection workers who chose to retire early or leave for other work, one third reported stress as the major reason (Bennett, Plint, & Clifford, 2005). Bride (2007) found that of social workers within the child welfare system, 70% reported at least one symptom of secondary traumatization in the prior week. Over 50% met criteria for at least one posttraumatic stress disorder (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 similar study showed that half of 365 child protection services workers

had “high” or “very high” levels of secondary traumatization (Conrad & Keller-Guenther, 2006).

At the same time, similar to the recent survey reported by Conrad and Keller-Guenther (2006), all of the studies found that child protection services workers reported high levels of “job satisfaction” and low levels of “job burnout.” This unexpected finding shows that secondary traumatization (CF, VT, etc.) is different from job burnout, which can occur in professions that may not involve exposure to victims of abuse and violence. Stamm (2002) discussed the concept of “compassion satisfaction,” which may mitigate job burnout and is defined as pleasure and fulfillment from helping others, affection for colleagues, and a sense of making an important contribution to the welfare of others and society. Consistent with the authors’ recent survey, compassion satisfaction does not necessarily reduce secondary traumatization because those working in child protection may endorse both measures. We can hypothesize that those workers showing more compassion satisfaction may be functioning in work environments providing more support.

While each of these groups experiences unique stressors and traumatic experiences, all share in common responses and outcomes to these situations. There are a number of common signs and symptoms of VT, and adverse effects of work-related exposure to both traumatized individuals and disturbing situations can impact both personal and professional lives. Some of these signs and symptoms are anger and irritability; anxiety and new fears, especially about the safety of one’s family; emotional numbing and detachment; sadness and depression; difficulty concentrating, with intrusive thoughts about victims or perpetrators; difficulty sleeping, including nightmares; social withdrawal from family and friends; changes in beliefs about the world and more pessimism; changes in spiritual beliefs; less self-care; increased physical complaints and illness; and use of alcohol and/or drugs to “forget about work” or “relax.”

VT and stress occur in individuals in both the child welfare system and systems within which they work. Each person and each system brings a specific set of stressors to the work. At the same time, many individuals are working within the context of overburdened and sometime underfunded systems, which may increase risk for secondary traumatization. Some of the organizational and work-related problems cited frequently as related to job burnout include high caseload, and excessive workload and paperwork; little support from supervisors; having to deal with situations with conflicting roles, expectations, and values; lack of peer support; inadequate resources to meet demands; concerns about personal safety; and little job recognition. Unfortunately, the secondary traumatization that results may lead to increased absenteeism, impaired judgment, unwillingness to accept

extra work or assume responsibility, low motivation, lower productivity and poor quality of work, decreased compliance with work requirements, greater friction among staff members, and high staff turnover. Overall, there is little question that working in the child welfare system can be very stressful, lead to secondary traumatization and/or job burnout.

### *Compassion Fatigue for Those Who Work with Military Families*

Most clinicians who work with military families seem to manage the challenges well. Those who have more difficulties tend to be new to the military population and may become overwhelmed with the many new experiences. As in other work with traumatized young children, increased experience helps a clinician to put the stressful demands of the work in perspective. At a group meeting of clinicians working with military families, a colleague shared concerns about the possibility of mental health professionals becoming hardened to the experiences of the patients to defend themselves against the trauma they witness. This risk is consistent across all groups who work with trauma. This sensitive clinician shared the challenging experience of a new-to-the-military clinician dealing with the family of a severely combat-injured young father of three little boys, who visited him in the hospital. Like the example of the clinician working with the Orleans Parish Infant Team, this clinician was a new father himself, so seeing this very damaged young soldier with his young children, and working with the consequent confusion, family disarray, and marital tension, created emotional disturbance for him. He had difficulty with boundaries and was too personally upset by the situation to be able to support the service man and his family. He requested that this case be transferred to another clinician because he felt he could not distance himself enough to be able to help them. This example serves as an important reminder that this work cannot be done in isolation.

## **GENERAL RECOMMENDATIONS FOR SUPPORT, PREVENTION, AND TREATMENT FOR INDIVIDUALS WORKING WITH TRAUMATIZED YOUNG CHILDREN**

Recommendations for prevention and treatment by experts in STS can be divided into two types: personal and organizational. Personal recommendations focus on what the individual can do to recognize, reduce, or prevent STS effects. Organizational recommendations focus on what institutions and agencies can do to minimize secondary traumatization (and burnout) in their workers. At present, we know very little, however, about whether these recommendations are being implemented and, if so, the degree to which they are effective.

## Individual Strategies

Recommendations aimed at helping first ask the individual systematically to assess his or her exposure to secondary traumatic stressors. A number of self-administered checklists have been published and circulated that allow people to make their own assessment of the degree to which they experience secondary traumatization (see Stamm, 2008). Measures typically ask people to rate the degree to which they experience many of the symptoms described earlier. Scores are 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 people understand that these are expectable effects of exposure to the trauma and suffering of others. These scales also provide an opportunity for people to understand their level of compassion satisfaction, which can mitigate the stress.

Individuals with moderate to high scores or other evidence of secondary traumatization are urged to learn and 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, developing outside interests, and achieving a balance between work and home life. Strategies for psychological, emotional, and spiritual self-care are also often included as recommendations. A comprehensive list of these recommendations is available at the NCTSN website ([www.nctns.org](http://www.nctns.org)).

In a study of therapists who specialize in work with trauma and should know about traumatic stress effects, Bober and Regehr (2005) found that while the therapists strongly endorsed these self-care concepts and recommendations, they did not systematically practice them. Furthermore, the amount of time therapists spent working with trauma victims was most predictive of their secondary traumatization score. However, there was no relationship between the amount of time therapists devoted to coping strategies and their traumatic stress score.

## Organizational Strategies

For organizations, the research indicates that organizational issues, policies, and working environment make substantial contributions to increasing employees' risk for traumatic stress. This awareness has led to recommendations designed to redress these factors, and the knowledge that organizations have much to gain by reducing or preventing secondary traumatization and negative effects. As with individuals, the first step of the organization is to

recognize that secondary traumatization is possible and may be occurring. Unless administrators and managers in an agency or organization are in day-to-day contact with traumatized staff, they are often slow to recognize the problem. A number of available survey measures allow managers to gather systematic data on levels of work-related secondary traumatization and its effects on employees (White, 2006). In order to reduce the risk of VT, it is important that organizations recognize the need to implement changes, which include reducing the workloads and caseloads; providing adequate supervision to frontline workers; providing good mental health insurance coverage; acknowledging that there may be work stress and work-related secondary traumatization for staff; providing educational workshops and informal “brown bag” lunches to increase awareness; developing peer support; and encouraging self-care, adequate backup for staff in stressful positions, and discussion of possible VT among staff and administration members. The Child Welfare Trauma Training Toolkit (2008) developed by the National Child Traumatic Stress Network provides a valuable resource to address many of these issues.

## CONCLUSION

Work with traumatized young children and families pulls a great deal from therapists, child welfare workers, judges, and others in the child’s environment. Despite being very dedicated, they can suffer from VT, burnout, CF, and strong feelings that they at times do not understand. Sometimes the extent of exposure to others’ traumatic experiences can lead to personal traumatization and resultant symptoms. A helper may find him- or herself feeling sorry for the children and wanting to rescue them; feeling as helpless and hopeless as the parents or caregivers and angry with abusive, neglectful caregivers; and feeling overwhelmed. A helper may also become frustrated when the work to help the parents become more sensitive and emotionally available to their children is slow.

It is very important for all who work with survivors of traumatic experiences to recognize that many children do well. In fact, the traumatic experiences may be short-lived, and symptoms may remit rapidly. Therapists especially must be prepared to listen, to “hold” traumatized children’s concerns, and to help them and their parents or caregivers to return to normal developmental functioning. Therapists cannot right wrongs and erase scars; however, the children can be helped and supported in their development. Each clinician, therapist, judge, and child welfare worker must find his or her own way to deal with the overwhelming affects and emotions that accompany this work. And each needs to find a way to gain support through self-care, a supportive team, or some other method, to do the work

effectively. I have heard of professionals who work with trauma welcoming a drive home through the country to unwind after a hard day at work. I have heard of others who take a walk or relax with friends. All professionals working with young traumatized children need to find individual ways to gain support and reduce the risk of ongoing VT to ensure that their work is effective and helpful.

## REFERENCES

- Adoption and Safe Families Act (ASFA) of 1997, P.L. 105-89, 111 Stat. 2115-2136.
- Bennett, S., Plint, A., & Clifford, T. J. (2005). Burnout, psychological morbidity, job satisfaction, and stress: A survey of Canadian hospital-based child protection professionals. *Archives of Diseases of Children*, *90*, 1112–1116.
- Bober, T., & Regehr, C. (2005). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, *6*, 1–9.
- Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, *52*, 63–70.
- Child Welfare Trauma Training Toolkit (2008). National Child Traumatic Stress Network. Retrieved May 1, 2010, from [www.nctsn.org](http://www.nctsn.org).
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect*, *30*, 1071–1080.
- Figley, C. R. (1996). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, *58*, 1433–1441.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York: Brunner/Mazel.
- Jaffe, P. G., Crooks, C. V., Dunford-Jackson, B. L., & Town, M. (2003, Fall). Vicarious trauma in judges: The personal challenge of dispensing justice. *Juvenile and Family Court Journal*, pp. 1–9.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*, 227–238.
- Masten, A. S. (in press). Risk and resilience in development. In P. D. Zelazo (Ed.), *Oxford handbook of developmental psychology*. New York: Oxford University Press.
- Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). New York: Brunner/Mazel.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue. In C.

- R. Figley (Ed.), *Treating compassion fatigue* (pp. 7–119). New York: Brunner/Routledge.
- Stamm, B. H. (2008). The ProQOL. Retrieved April 10, 2010, from [www.proqol.org](http://www.proqol.org).
- Stamm, B. H. (2009). The concise ProQOL manual. Available at [www.proqol.org](http://www.proqol.org).
- White, D. (2006). The hidden costs of caring: What managers need to know. *Health Care Manager*, 25, 341–347.