Effective Strategies for Improving Substance Use Workforce Retention by Preventing and Reducing Issues Caused by Secondary Exposure to Client Trauma

DECEMBER 2021

Prepared by:

growth partners
NHTAC New Hampshire Technical Assistance Center

Prepared for:

NH DEPT. OF HEALTH AND HUMAN SERVICES
NHBDAS
BUREAU OF DRUG AND ALCOHOL SERVICES
Promoting Prevention and Recovery

Table of Contents

About This Research Brief

Topic. Effective strategies for improving substance use workforce retention by preventing and reducing issues caused by secondary exposure to client trauma

Background. Three decades of the opioid epidemic, combined with the COVID-19 pandemic, have had a dramatic effect on the work experiences of substance use disorder (SUD) treatment professionals, taking a tremendous physical, mental, and emotional toll. The New Hampshire Bureau of Drug and Alcohol Services (BDAS)—through funding and support from the Governor's Commission on Alcohol and Other Drugs—commissioned this research brief to explore effective strategies for addressing and preventing compassion fatigue and other occupational stressors that are causing SUD treatment professionals to leave the field in growing numbers. Findings from this research will be used to design and support workplace interventions that prevent and decrease workplace stress and improve clinical staff job satisfaction and retention.

Methodology. Growth Partners reviewed and compiled research on compassion fatigue, secondary traumatic stress, vicarious trauma, compassion satisfaction, and occupational burnout among professionals that provide mental health, public health, and specifically alcohol and other drug services. Research articles dating from 2003 to 2021 were explored to define terminology, assess impacts on behavioral health professionals, and identify pilot studies that address compassion fatigue, secondary traumatic stress, and vicarious trauma.

Search Strategy. Resources were located through electronic searches of databases such as PubMed, Google Scholar, ProQuest, Science Direct and Synergy. The following were used as search terms: compassion fatigue, secondary traumatic stress, vicarious trauma, pilot studies, interventions, mental health professionals, substance use counselors, alcohol and other drug professionals, public health professionals, and COVID-19. Research was compiled using the most recent research studies, guidance, and articles on the impact of compassion fatigue, secondary traumatic stress, and vicarious trauma on caregiving professions. Research articles were included if the literature mentioned: 1) at least one of the trauma terms and 2) a behavioral health services profession. Where possible, articles that included alcohol and other drug professionals were identified and included.

About This Technical Assistance Product. The New Hampshire Technical Assistance Center, operated by Growth Partners, is funded by BDAS to provide a wide range of TA services to support the state's alcohol and other drug continuum of care. If you would like more information about this document or would like to request technical assistance (TA), please visit us at www.nhtac.org.

Issues Related to Secondary Exposure to Trauma

Overview

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet" (Remen, 2006).

Research has established strong ties between trauma and chronic physical and behavioral health conditions such as substance use, mental health disorders, and associated risky behaviors. SUD treatment clinicians and others in the behavioral health field frequently work with clients who have experienced significant trauma. Three decades of research into the quality of life experienced by those who care for trauma-affected clients underscores that these care providers are themselves vulnerable to serious issues stemming from secondary exposure to their clients' trauma.

Secondary exposure to trauma (SET) is mediated by the severity of trauma experienced by clients, the level of workplace social support care providers receive, quality of supervision they receive, and past personal trauma.[1,2] Research shows that the personal trauma histories of clinical and nonclinical staff can be exacerbated by working with others who have experienced trauma.[3]

Left unaddressed, SET can lead to a number of issues researchers have classified as Secondary Traumatic Stress (STS), Vicarious Stress (VT), and Compassion Fatigue (CF). All three of these conditions are strongly associated with Occupational Burnout (OB).

Understanding Trauma

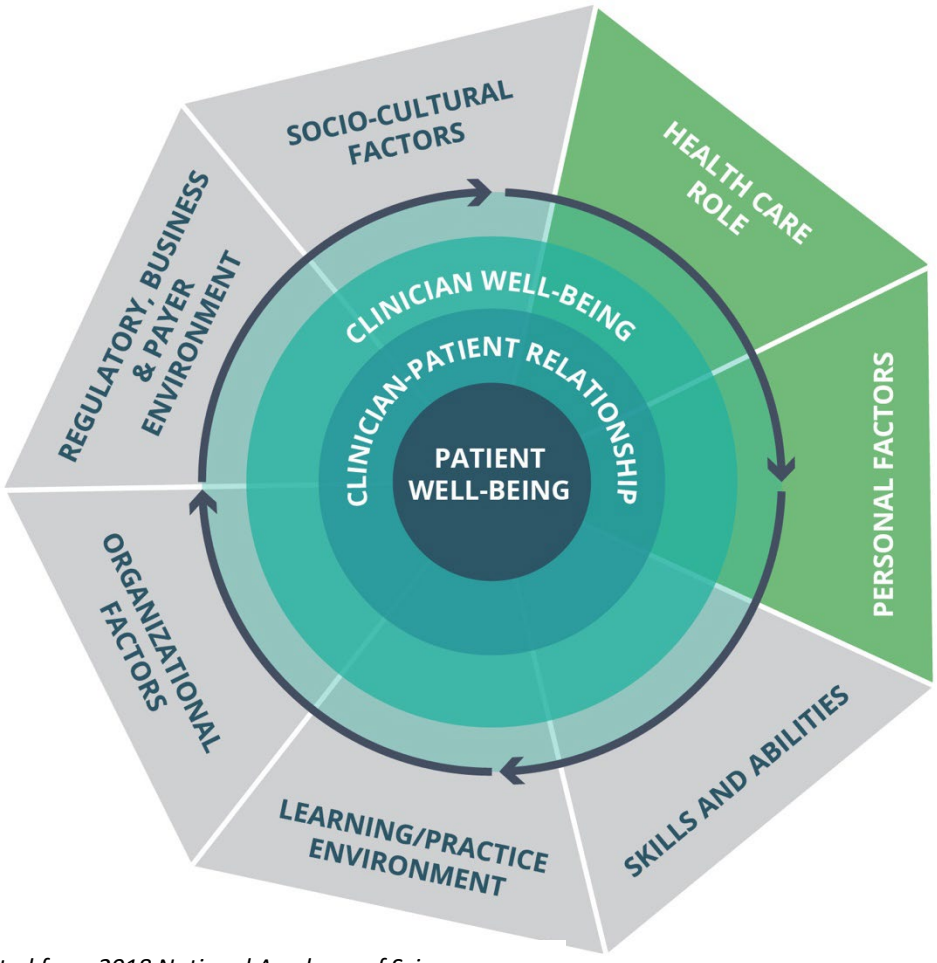
While there is no universally accepted definition of trauma, the definition used by the Substance Abuse and Mental Health Services Administration is commonly referenced: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[4]

Examples of trauma include, but are not limited to:

- Experiencing or observing physical, sexual, and/or emotional abuse
- Childhood neglect
- Having a family member with a mental health or substance use disorder
- Experiencing or witnessing violence in the community or while serving in the military
- Poverty and systemic discrimination

In January 2017, the National Academy of Medicine (NAM) responded to alarming rates of OB among clinicians by launching an Action Collaborative on Clinician Well-Being and Resilience (Action Collaborative on Clinician Well-Being and Resilience). Noting the serious consequences

of OB—including reduced job performance, increased turnover, medical errors, and clinician suicide—NAM has been working to (1) build a national community around clinician well-being and (2) create a national strategy to support clinician well-being. NAM's conceptual model (below) identifies seven domains that play a role in clinician well-being and subsequently shape clinician–patient relationships and patient well-being. Factors associated with each domain can be viewed at Conceptual Model 7.19.19 (nam.edu).



Adapted from 2018 National Academy of Sciences

The COVID-19 pandemic has significantly exacerbated issues involving SET for healthcare workers, including SUD clinicians who have held frontline positions addressing an opioid epidemic which has now spanned three decades. In New Hampshire, anecdotal, survey, and other data indicate an escalation in SET-related issues since the onset of the COVID-19 pandemic. For example, referrals of doctors, nursing assistants, and nurses to the New Hampshire Professionals Health Program for assistance with issues such as SUDs and mental health concerns has increased 30 to 35 percent since the pandemic began.[5]

Types of Issues Related to Secondary Exposure to Trauma

While issues related to SET are conceptually similar—and the terms used to describe them are often used interchangeably—there are some differences. These include differences in symptoms; the characteristics of those affected; periods of onset; and impacts on health, work, and life. The research on issues related to SET is evolving. While researchers have not come to consensus on terminology—or which issues precede or lead to others—commonly used terminology and the characteristics associated with each are described below.

Secondary Traumatic Stress (STS)

STS symptoms tend to develop suddenly and can arise after a single exposure to a trauma victim. Accordingly, STS is more likely to affect newer clinicians and workforce members. Its symptoms are very similar to Post-Traumatic Stress Disorder (PTSD) and include difficulty sleeping, fear and anxiety, disruptive thoughts, and client avoidance.

STS is commonly defined as the stress resulting from indirect exposure to trauma and associated behaviors and feelings.[6] While STS is sometimes used as a blanket term for all health issues stemming from SET, there are characteristics that distinguish it. For example, STS symptoms tend to develop suddenly and can arise after a single interaction or exposure to a trauma victim and their trauma experiences. For this reason, STS may be more likely to manifest in newer clinicians and workforce members. STS symptoms closely mirror those of PTSD. As a result, common measures for assessing STS and PTSD are very similar, with differences in wording to account for the secondary vs. firsthand trauma exposure.[7,8]

Risk factors for STS include:

- The level and severity of client trauma.
- The work setting, including long workdays and the percentage of trauma-affected clients in the overall caseload.
- Inadequate trauma-specific training and supervision, including:
    - Adherence to mandated reporting guidelines.
    - Understanding of how much information to share with parents/guardians and family members.
- Personal circumstances, such as current or chronic life stressors, mental health issues, and/or unresolved trauma issues.

The most common symptom of STS is sleep problems. Workforce members may have difficulty falling asleep because they are reexperiencing a patient's story or picturing their patient's face. They may also wake up with nightmares about a patient. Other symptoms include fear and anxiety, dissociation, disruptive and invasive thoughts of clients and their traumas, and avoidance of these clients and things associated with their trauma.[9,10] Symptoms can also

include feelings of isolation, physical ailments, confusion, and helplessness, hypervigilance, mood changes, guilt, anger, challenges with concentration, exhaustion, and an impaired immune system.[11]

Vicarious Traumatization (VT)

VT tends to occur over time due to chronic exposure to trauma victims. For this reason, it tends to affect more seasoned and experienced clinicians and workforce members. Those affected may become numb or desensitized to clients, and may experience an increasingly negative outlook on the world that impacts their quality of life.

In contrast to STS, VT tends to occur over time due to chronic SET. Those affected often become numb or desensitized when listening to clients' stories, and may experience changes in cognition that negatively impact their outlook on the world and quality of life. The excerpt below, from an unpublished work by a young social worker working in a battered women's shelter, exemplifies changes in cognition associated with VT:

> *I think you see the worst of people, working here…the worst of what people do to each other. And I think when you don't have proper resources to process that, to work through it, to understand it or put it in some kind of context, it just leaves you feeling a little baffled about what's going on out there, and the way things work in the world and your role in all of that.*[12]

Risk factors for VT include:[13] (What is Vicarious Trauma? | The Vicarious Trauma Toolkit | OVC (ojp.gov)

- Prior traumatic experiences.
- Social isolation, both on and off the job.
- A tendency to avoid feelings, withdraw, or assign blame to others in stressful situations.
- Difficulty expressing feelings.
- Lack of job preparation, orientation, training, and supervision.
- Being a newer employee with less on-the-job experience.
- Constant and intense exposure to trauma with little or no variation in work tasks.
- Inadequate and/or ineffective supportive processes for discussing SET encountered through work.

Those affected by VT often develop reduced trust and confidence in others, experience a greater sense of vulnerability due to feelings of powerlessness and lack of control over their lives, and feel isolated from the rest of society.[14,15] An eroding sense of safety from secondary trauma exposure can also result in overwhelming fears of physical harm, causing those affected by VT to develop new safety practices.[16] Other common signs and symptoms of VT include lingering feelings of anger, rage, and sadness about a patient's victimization; becoming overly involved emotionally and/or over-identifying with the patient; and experiencing bystander guilt, shame,

feelings of self-doubt. These workforce members may become preoccupied with thoughts of patients outside of the work situation and experience difficulty maintaining professional boundaries, overextending themselves by trying to do more than their role permits to help the patient. Conversely, loss of hope and feelings of pessimism and cynicism can lead some workforce members to experience numbing and/or detachment, causing them to distance themselves from trauma-affected patients and avoid listening to their stories of traumatic experiences.

Compassion Fatigue (CF)

CF results in reduced capacity for empathy and compassion. While it can impact anyone, it is a particular occupational hazard for those who work with trauma victims. CF produces physical, mental, emotional, and/or spiritual exhaustion resulting in an inability to cope with one's everyday environment.

CF manifests as a reduced capacity for empathy and compassion. It can affect people working in nearly any occupation, but it is particularly problematic for those in helping professions—and especially among those who work closely with trauma-affected clients. In general, CF comprises a mix of physical, mental, emotional, and/or spiritual exhaustion resulting in an inability to cope with one's everyday environment.[17,18]

One 2020 study which used a brief online survey found that 82 percent of mental health providers reported the pandemic negatively affected their ability to serve their clients. In addition to tele-therapy fatigue and increased stressors in their own lives, many clinicians noted reduced emotional capacity to bear witness to other people's pain and suffering.[19]

While all health issues stemming from SET have negative and debilitating effects, some researchers have noted that CF has uniquely stigmatizing qualities because occupational norms in these professions include selflessness and "going above and beyond" to help clients. Researchers note that, as a result, CF tends to not be openly discussed by addiction professionals and is often not included in formal education or workplace trainings. In discussing CF, one counselor noted:[20]

> *Most people won't talk about it. It has to be pointed out to them that they are in a funk. I don't think they want to acknowledge that they have it quite frankly, because they think they either shouldn't have it or they think if they do have it, then they're not meant to be in the field, so they can't acknowledge it.*

Researchers have noted that experiencing traumatic events in the workplace is frequently associated with CF among mental health professionals. This kind of workplace trauma includes perceived and/or predicted risks from clients' aggressive behavior.

Risk factors for CF include both personal and organizational conditions.[21,22] Personal risk factors include:

- Having a history of trauma.
- A pre-existing psychological disorder.
- Isolation and/or lack of social support.

Organizational risk factors include:

- Inadequate professional support or supervision.
- Inadequate training.
- A high caseload of clients with traumatic experiences.

Signs and symptoms of CF include chronic physical and emotional exhaustion; headaches; psychosomatic ailments; depersonalization; feelings of inequity and/or self-contempt; negative feelings toward work, life, and others; low job satisfaction; absenteeism; and substance use.[23] CF is also significantly associated with OB.

Occupational Burnout (OB)

OB occurs due to chronic job-related stress. While it can impact anyone, it is particularly prevalent among those in helping professions such as health care. Consequences of OB include overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.

Researchers have described OB as a psychological syndrome that emerges as a prolonged response to chronic interpersonal stressors on the job. It can arise from multiple causes, but has strong associations with VT, STS, and CF.

OB has long been recognized as an occupational hazard for people-oriented professions such as behavioral and other types of health care. The relationships that providers in these professions develop with recipients require ongoing and intensive levels of contact that—while rewarding—can also be very stressful. Researchers have noted that these occupations also tend to exist in environments that are high in demands and low in resources.[24]

One systematic review of literature found age, educational level, and parental status all had positive and negative impacts on OB.[25] For example, researchers noted that psychotherapists younger than 35 have higher emotional exhaustion and depersonalization than their older counterparts. Other studies have found that professionals with higher levels of education reported more OB due to working with more challenging clients. For example, perceived personal accomplishment was lower among SUD treatment counselors with more experience due to the "manifestation of the chronically precarious conditions of the addiction counselors' field."[26] Researchers have noted that these counselors often face higher and unique demands in terms of high turnover rates, relatively low compensation, and often difficult clientele.[27]

OB appears to have become more prevalent in health care during the COVID-19 pandemic. A September 2020 study that surveyed more than 2,700 healthcare professionals in 60 countries found that approximately 51 percent reported experiencing OB during the pandemic.[28]

Key organizational risk factors associated with OB include:

- An unsustainable workload.
- Lack of a supportive environment.
- Feeling deprived of what one believes they deserve.

Symptoms of OB include overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.[29,30,31]

Strategies to Prevent and Reduce STS, VT, CF, and OB

Left unaddressed, STS, VT, CF, and OB can result in mental and physical health problems, strained personal relationships, poor work performance/inability to provide high-quality care to clients, and high rates of staff turnover. These problems can reinforce and exacerbate similar feelings in remaining employees, fueling increasingly higher rates of problems and turnover.

Fortunately, these issues are both preventable and treatable. In recent years, increasing attention and emphasis have been placed on the use of trauma-informed care to improve patient engagement and health outcomes. In addition to focusing on clients, these practices also involve organizational and clinical changes that can improve provider and staff wellness. Efforts to prevent and address STS, VT, CF, and OB can produce significant benefits, including increasing staff morale, enabling staff to function optimally, and reducing the loss of workforce expertise while decreasing the expense of hiring and training new employees.

In New Hampshire, there are multiple efforts underway to prevent, mitigate, and address STS, VT, CF, and OB. One of the longest standing efforts is the Granite State Critical Incident Stress Management Team, which was formed in 1992 to meet the needs of first responders across the state who experience situations that provoke strong emotional reactions that can interfere with their ability to function. Other examples include the following:

- The Dartmouth-Hitchcock Medical System uses employee surveys to monitor OB and related issues, and has launched a multidisciplinary task force to address immediate concerns. Efforts include increasing the visibility of its employee assistance program (EAP), marketing peer support groups, and launching a Stress First Aid initiative.
- A working group of the North Country Task Force on Improving Opioid Treatment Outcomes is promoting self-care among healthcare professionals and supporting peer learning on wellness techniques, including acupuncture and massage therapy.
- The New Hampshire Department of Health and Human Services' EAP offers workshops on the signs and causes of OB and strategies for preventing and addressing it.

In general, strategies that have proven successful in preventing and addressing STS, VT, CF, and OB involve increasing awareness, developing personal professional self-protection plans, and cultivating a supportive work environment.

Increase Personal and Organizational Awareness

Recognize the Warning Signs and Symptoms

Recognizing the warning signs and symptoms of STS, VT, CF, and OB early on is a critical first step in getting help for staff who may be unable to pinpoint what they are experiencing and where the feelings came from. Some strategies include:

- Devoting portions of staff meetings to discussing signs, symptoms, and risk factors of STS, VT, CF, and OB.
- Providing trainings that help staff understand SET; raising awareness of STS, VT, CF, and OB; and offering opportunities for staff to explore their own trauma histories.
- Connecting with other organizations, TA providers, and partners that can help bring awareness and inform awareness campaigns within your organization.

Use Screening to Help Identify Those at Risk and Provide for Early Intervention

Confidential workplace screenings for STS, VT, CF, OB, and other related issues such as depression, anxiety and suicidal ideation can help identify staff members who may be at risk. Individual results can maximize opportunities for early intervention, while aggregate results can be used to inform and improve workplace policies, procedures, and practices. A number of research-based assessment tools are available:

- **The Professional Quality of Life Scale (ProQOL)** is a 30-question self-report survey using a 5-point Likert scale that measures Compassion Satisfaction (i.e., the positive aspects of helping or the pleasure and satisfaction derived from working and caregiving systems), OB, and STS. The tool can be administered to individuals, or groups: ProQOL Measure.
- **The Secondary Traumatic Stress Scale** is a 17-item survey using a 5-point Likert scale designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with STS resulting from working with traumatized populations: Secondary Traumatic Stress Scale.
- **The Silencing the Self Scale** is a 14-item survey using a 10-point Likert scale to help caregivers identify specific communication struggles in their work: Silencing the Self Scale.
- **The Vicarious Trauma Scale** (Vrklevski and Franklin, 2008) is an 8-item assessment using a 7 point-Likert scale: Vicarious Trauma Scale (on p. 115 of the linked article).
- **The TSI Belief Scale** is an 80-item self-report survey used to measure disturbances in cognition, specifically in the areas of safety, trust, esteem, intimacy, and control: Risking Connection Belief Measure.

- **The Maslach Burnout Inventory** is a 22-item instrument available to purchase that measures OB by looking at emotional exhaustion, depersonalization, and personal accomplishment: Maslach Burnout Inventory.
- **The Impact of Event Scale** is a 22-item self-report instrument used to measure one's reaction to a particular event, specifically intrusion and avoidance of a particular event: Impact of Event Scale.
- **The PTSD Checklist (PCL)** is a 20-item self-report survey that assesses the presence and severity of PTSD symptoms: Posttraumatic Stress Disorder Checklist
- **The Global Check Set (GCS)** is a 35-item rapid check of multiple key areas of psychological wellness: Global Check Set.

Develop a Personal Self-Protection Plan for the Workplace

Research shows that workplace supports, in the form of trainings and peer support, can act as protective factors against OB and CF.[32] When resources for support are lacking, compassion and resilience in the workplace can suffer. The Job Demands-Resources model posits that the combination of high job demands and low job resources poses a potential threat to mental health and well-being, while a combination of high job demands, and high job resources fosters personal and professional growth and psychological well-being. Unfortunately, many healthcare and other helping occupations fall into the high job demand/low resources category, which is a key contributor to OB—particularly when coupled with SET.

Substance abuse counselors face especially high turnover rates, low pay, and often difficult clientele.[33] This workplace environment makes it vital that staff have plans in place to deal with STS. One qualitative study found that substance abuse treatment professionals used some simple strategies to combat CF. They[34]:

- Rewarded themselves with mental escapes from their work—reading novels, meditating, watching TV.
- Used the transition from work to home as a time to decompress.
- Made sure to address their basic needs for good nutrition, sleep, and exercise.
- Sought support from family and friends.
- Sought advice from supervisors and colleagues about difficult clients.
- Maintained healthy boundaries with clients and with the program that employed them.

Developing a professional self-protection plan can help ensure care providers' emotional, physical, and mental well-being. This type of plan—which identifies personal protective factors and coping strategies—is essential for professionals who may be suffering from STS, VT, CF, and/or OB. These protective factors and coping strategies can be organized into three main concepts: Balance, Boundaries, and Connections.[35]

Source: Adapted from Stamm, 2012.

Seek Balance

- Self-assess—recognize and monitor signs of STS, VT, CF, and/or OB.
- Maintain a healthy work–life balance, including pursuing outside interests.
- Engage with supervisors to balance caseload to manage the number of clients with a history of trauma.
- Take regular breaks and time off when needed.
- Practice emotional self-care by engaging in relaxing and self-soothing activities. For example, research indicates that mindfulness—which involves breathing methods, guided imagery, and other practices to relax the body and mind and help reduce stress—can be a significant protective factor against OB and related issues.

Establish Boundaries

- Do not take responsibility for your patients' well-being; instead, supply them with tools to help them move to a healthier life.
- Work with supervisors and other staff to establish and maintain daily routines with regular start and stop times.
- Participate in customized trainings on how to work with trauma-affected clients.
- Use peer support and opportunities to debrief.
- Avoid avoidance; create space and time to revisit your reactions and feelings.

Create Connections

- Communicate with clinicians who are familiar with the setting and the clients to ensure caseloads match experience of staff.
- Seek professional support from colleagues, which has been shown to reduce symptoms of OB and STS. Peer support can help solve workplace problems and serve as a cathartic outlet.[36]

Cultivate a Supportive Work Environment

Adopt Workplace Policies that Normalize and Address STS, VT, CF, and OB

Creating an organizational culture that supports staff who work with trauma-affected clients requires policies that normalize the effects of SET. There are multiple policy-making opportunities, including:

- Embedding commitment to employee self-care into organizational mission or values statements.
- Establishing requirements for reviewing and balancing client caseloads for staff at all levels.
- Ensuring staff are provided—and take full advantage of—regular breaks.
- Allowing "mental health days" for staff.
- Requiring that workforce training and professional development initiatives include a focus on recognizing, preventing, and addressing SET.
- Establishing requirements and expectations for supervisors of staff who work or interact with trauma-affected clients, including debriefs, screening, intervention, and referral to resources as needed.
- Installing security systems or hiring security guards as cost of doing business for agencies that provide services to trauma-affected individuals. If such measures are cost-prohibitive, a "buddy system" can be implemented so that if one staff member is threatened by a client, another can summon help.

Develop and Implement Workplace Practices that Support Policies Designed to Prevent and Address Secondary Exposure to Trauma

Organizational practices can ensure policies are implemented by describing the specific actions that are to be taken. Practices can be informal (modeled) and/or formal (written). Examples of informal policies include:

- Building trust and safety through open and consistent communication.
- Modeling kindness and compassion in interactions at all levels.
- Instilling an attitude of respect during onboarding of new employees.
- Providing a place where employees can place meaningful items such as pictures, nature scenes, plants, and quotes to help them remember why they do this work.
- Maintaining clean and comfortable staff meeting and break rooms with coffee and other beverages, relaxing music, inviting furniture, and inspiring pictures to make employees feel safe and welcomed.

Examples of formal practices include written processes for:

- Assessing workloads on an ongoing basis to balance caseloads of trauma-affected clients with those who have not experienced trauma.

- Supporting reflective supervision, in which a service provider and supervisor meet regularly to debrief and address feelings about patient interactions and discuss the impact of their work on their professional and personal life.
- Using peer mentoring and support to support staff working with trauma-affected clients. Peer support groups can help colleagues clarify their insights, listen for and correct cognitive distortions, offer perspective/ reframing, and relate to the emotional state of the employee.[37]
- Encouraging and incentivizing practices such as physical activity, yoga, mindfulness, and meditation.
- Improving access to professional development to equip staff with the knowledge, skills, and abilities needed to proactively identify, prevent, and address issues related to SET.

Examples of training cited in research include the Certified Compassion Fatigue Specialist Training (CCFST) and Sharevision. CCFST seeks to decrease symptoms of CF, while Sharevision seeks to decrease the effects of SET through six integrated expressive arts workshops.[38]

Research also underscores the importance of referring employees experiencing issues related to SET to appropriate resources for assistance. Referrals can be to EAPs and similar programs that can create employee and volunteer crisis stabilization plans, assess personal supports, make referrals to counseling, and provide information on self-care strategies. For example, researchers have found that mental health counselors in recovery from SUD had less OB because of the social support they received through their own recovery and feelings of personal accomplishment.[39]

Hire a Trauma-Informed/Trauma-Capable Workforce

Hiring a trauma-informed workforce is essential to implementing a trauma-informed approach that promotes the well-being of clients as well as staff. Key considerations include previous experience with relevant patient populations, specialized training, and personality characteristics that are well suited for trauma-informed work, with an emphasis on emotional intelligence, collaboration, and empathy. Techniques like behavioral interviewing ask candidates to explain how they would address a real-world problem, such as a client who refuses to follow a treatment plan. This approach can help identify good candidates who may not have formalized training in trauma-informed care but are well suited for working with trauma-exposed clients.[40]

Appendix: Resources

Guidance

- **Action Collaborative on Clinician Well-Being and Resilience**

  Describes the National Academy of Medicine's Clinician Well-Being Collaborative and provides links to resources, including those for dealing with stress of COVID-19.

- **Building a Trauma-Informed Mindset: Lessons from CareOregon's Health Resilience Program**

  Describes CareOregon's Health Resilience Program and discusses the benefits of trauma-informed workforce.

- **Compassion Fatigue Awareness Project**

  Includes a TEDx Talk from the founder of the Compassion Fatigue Awareness Project on how to manage compassion fatigue

- **Key Ingredients for Successful Trauma-Informed Care Implementation**

  Lays out clinical and organizational changes that can improve patient engagement, health outcomes, and provider well-being.

- **Secondary Traumatic Stress**

  Discusses individual organizational prevention strategies to address secondary traumatic stress and lists resources for further learning.

- **What Is Vicarious Trauma?**

  Discusses different responses to vicarious trauma and introduces the Vicarious Trauma Toolkit, including how to use the toolkit to become more trauma informed.

Surveys, Tools, and Instruments

- **The Professional Quality of Life Scale (ProQOL)**
- **The Secondary Traumatic Stress Scale**
- **The Silencing the Self Scale**
- **The Vicarious Trauma Scale** (on p. 115 of the linked article)
- **The TSI Belief Scale**
- **The Maslach Burnout Inventory**
- **The Impact of Event Scale**
- **The PTSD Checklist (PCL)**
- **The Global Check Set (GCS)**

Journal Articles

- **Brigham, T., Barden, C., Dopp, A. L., Hengerer, A., Kaplan, J., Malone, B., … & Nora, L. M. (2018). A journey to construct an all-encompassing conceptual model of factors affecting clinician well-being and resilience. *NAM Perspectives*.**

  Reviews existing models of the effects of burnout on individuals and organizations and proposes a new model that depicts the domains and factors associated with burnout and well-being and applies them across health care professions and career stages, clearly identifying the link between clinician well-being and outcomes for clinicians, patients, and the health system.

- **Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28*(2), 83–91.**

  Examines 38 published studies to explore 17 risk factors for STS among professionals indirectly exposed to trauma through their therapeutic work with trauma victims.

- **Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32–44.**

  Surveys 124 clinicians and focuses on the stress they experience and how they cope in their work with trauma survivors, identifying factors related to resilience and burnout.

Endnotes

[1] British Medical Association. (2021). Vicarious trauma: signs and strategies for coping. https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

[2] Hooft, S. (2016). *Secondary traumatic stress, vicarious trauma, and compassion fatigue among victim advocates* [doctoral dissertation]. University of Nevada–Reno. https://scholarworks.unr.edu/bitstream/handle/11714/3285/Hooft%2C%20Sierra%202016%20Secondary%20Traumatic%20Stress%2C%20Vicarious%20Trauma%2C%20and%20Compassion%20Fatigue%20Among%20Victim%20Advocates.pdf?sequence=1&isAllowed=y

[3] Menschner, C., & Maul, A. (2016). Issue Brief: Key ingredients for successful trauma-Informed care implementation. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

[4] Menschner, C., & Maul, A. (2016). Issue Brief: Key ingredients for successful trauma-Informed care implementation. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

[5] McIntyre, M. (2020, October 25). Pandemic increases burnout among New Hampshire's healthcare workers. *NH Business Review*. https://www.nhbr.com/pandemic-increases-burnout-among-new-hampshires-healthcare-workers/

[6] Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). Sidran Press.

[7] Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, *14*(1), 27–35.

[8] Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov, 10.

[9] Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). Sidran Press.

[10] Stamm, B. H. (2010). *The Concise Manual for the Professional Quality of Life Scale,* 2nd ed. ProQOL.org.

[11] Administration for Children and Families. (n.d.). What is secondary traumatic stress? https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress

[12] Bell, H. (1999). *The impact of counseling battered women on the mental health of counselors* [doctoral dissertation]. University of Texas at Austin, p. 175.

[13] Office of Victims of Crime. (n.d.) What is vicarious trauma? Department of Justice. https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma

[14] Hooft, S. (2016). *Secondary traumatic stress, vicarious trauma, and compassion fatigue among victim advocates* [doctoral dissertation]. University of Nevada–Reno.

[15] McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149.

[16] Landis, E. (2010). *Sharevision: A collaborative-reflective, expressive arts intervention to address secondary trauma* [doctoral dissertation]. Lesley University.

[17] Compassion Fatigue Awareness Project. (2021). What is compassion fatigue? https://compassionfatigue.org/index.html

[18] Cocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. *International Journal of Environmental Research and Public Health*, *13*(6), 618.

[19] Fish, J., & Mittal, M. (2021). Mental health providers during COVID-19: Essential to the U.S. public health workforce and in need of support. *Public Health Report, 136*(1m), 14–17.

[20] Depippo, A. (2015). *Compassion fatigue and self-care strategies among addiction professionals: A qualitative study* [doctoral dissertation]. University of South Florida, p. 125.

[21] Bonach, K., & Heckert, A. (2012). Predictors of secondary traumatic stress among children's advocacy center forensic interviewers. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 21*(3), 295–314.
[22] Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society*, *84*(4), 463–470.
[23] Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, *17*(6987), 1–28.
[24] Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111.
[25] Yang, Y., & Hayes, J. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, *57*, 426–436.
[26] Vilardaga, R., Luoma, J. B., Hayes, S. C., Pistorello, J., Levin, M. E., Hildebrandt, M. J., Bond, F. (2011). Burnout among the addiction counseling workforce: The differential roles of mindfulness and values-based processes and work-site factors. *Journal of Substance Abuse Treatment, 40,* 323–335, p. 331.
[27] Yang, Y., & Hayes, J. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, *57*, 426–436.
[28] Morgantini, L. A., Naha, U., Wang, H., Francavilla, S., Acar, Ö., Flores, J. M., ... & Weine, S. M. (2020). Factors contributing to healthcare professional burnout during the COVID-19 pandemic: A rapid turnaround global survey. *PloS one*, *15*(9), e0238217.
[29] Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111.
[30] Meadors, P., Lamson, A., Swanson, M., White, M., & Sira, N. (2009). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *Omega*, (60), 2.
[31] Stamm, B. H. (2010). *The Concise Manual for the Professional Quality of Life Scale,* 2nd ed. ProQOL.org.
[32] Hooft, S. (2016). *Secondary traumatic stress, vicarious trauma, and compassion fatigue among victim advocates* [doctoral dissertation]. University of Nevada–Reno.
[33] Yang, Y., & Hayes, J. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, *57*, 426–436.
[34] Depippo, A. (2015). *Compassion Fatigue and Self-Care Strategies among Addiction Professionals: A Qualitative Study* [doctoral dissertation]. University of South Florida.
[35] Stamm, B. H. (2012). Helping the helpers: Compassion satisfaction and compassion fatigue in self-care, management, and policy of suicide prevention hotlines. *Resources for Community Suicide Prevention*, 1–4.
[36] Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, *17*(6987), 1–28.
[37] Catherall, D. (1995). Coping with secondary traumatic stress: The importance of the professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 80—92). Sidran Press.
[38] Bercier, M. (2013). *interventions that help the helpers: A systematic review and meta-analysis of interventions targeting compassion fatigue, secondary traumatic stress and vicarious traumatization in mental health workers.* [Doctoral dissertation]. Loyola University Chicago.
[39] Yang, Y., & Hayes, J. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, *57*, 426–436.
[40] Lockert, L. (2015). Building a Trauma-Informed Mindset: Lessons from CareOregon's Health Resilience Program. Center for Health Strategies.