Acknowledgements

The author is grateful to many people who helped him in the research, editing, and original inspiration for this paper.

William A. Sollecito was my academic advisor at the University of North Carolina and primary reader for this paper. My second reader was Margaret Robbins, who is medical director of the Mountain Youth Academy in Mountain City, Tennessee, where I currently work. They have been the best critics and editors that any student could ever wish to have.

At the beginning of my work on this paper I corresponded by email with several people who sent me a number of articles and encouraged me to pursue the topic. They are far more expert in various aspects of caring for the caring than I am. Many thanks to DiAnne Borders, Keith Mobley, Ed Watkins, Sandra Bloom, Richard Gartner, Bonnie Rogers, and Judith Holder.

But the beginning of my work in public health I owe to Ron Manderschied. A providential meeting with him at the 3rd National Conference on Addiction Disorders in Orlando, Florida, in 2012 made up my mind about getting a degree in public health. I am grateful to Manderschied for his continuous support and encouragement ever since.
Abstract

Caregivers working with trauma survivors frequently struggle with compassion fatigue. Employers, supervisors, and others often encourage compassion-fatigued caregivers to cultivate resilience through the practice of self-care, but organizations may structure or influence the work of caregivers in ways that reduce or intensify compassion fatigue. In this paper "compassion fatigue" refers to the range of negative responses that caregivers may have when working with trauma survivors, comprising both the emotional exhaustion of burnout and the personality changes of vicarious traumatization. In contrast "resilience" refers here to the range of positive responses that caregivers may have when working with trauma survivors, comprising a return to previous levels of positive functioning, adapting to stressful work, post-traumatic growth, and perhaps personality transformation. This paper reviews the literature describing factors contributing to compassion fatigue and recommends particular policies based on current research to reduce compassion fatigue. Ideal policies should attend closely to caregivers’ emotional responses to their clients and work environment. Examples of such policies include the expectation of ongoing clinical supervision, customary practice of evidence-based self-care techniques during the course of the working day, and generous provision of mental health services for caregivers. Organizations committed to providing mental health services should enact all of these recommended policies as far as possible; other caregiving organizations that provide services to trauma survivors, such as public health and general healthcare, should enact as many of these policies as are relevant and possible for their settings.
Introduction

The statues and paintings of the Buddhist religion usually picture the Shakyamuni Buddha with a slight smile on his face. Thich Nhat Hanh, one of the most widely known and respected of contemporary Buddhist teachers, comments on that smile:

When I was a novice, I could not understand why, if the world is filled with suffering, the Buddha has such a beautiful smile. Why isn't he disturbed by all the suffering? Later I discovered that the Buddha has enough understanding, calmness, and strength; that is why the suffering does not overwhelm him. He is able to smile to suffering because he knows how to take care of it and to help transform it. We need to be aware of the suffering, but retain our clarity, calmness, and strength so we can help transform the situation.

(Hanh, 1998, p. 173)

This paper seeks to find ways to help caregivers working with deeply wounded people to have “enough understanding, calmness, and strength” to do the work they have chosen to do. The ancient traditions suggest various ways to do this, but the focus here is on credible contemporary research in health-related sciences. This paper discusses some ways that individual caregivers may take care of themselves, but only as part of a larger purpose. The ultimate purpose of this paper is to identify policies that employers and institutions may enact in order to encourage and support their caregivers. To this end this paper has five sections. The first section defines trauma and reviews its most obvious effects on providers who work with survivors of trauma. The second section introduces the fundamental concepts of burnout, compassion fatigue, vicarious traumatization, resilience, adaptability, post-traumatic growth, and transformation. The third section explores several possible ways to decrease negative and increase positive responses in caregivers who work with trauma survivors. The fourth section discusses policies that promote positive responses. The last section illustrates ways that public health and general healthcare may adapt these policies to their settings when they serve trauma survivors. This paper focuses on the needs of psychotherapists of all professions (psychiatrists, psychologists, social workers, and others) who work directly with trauma survivors and consequently bear intense emotional consequences from their work. The policies recommended here, however, often apply also to other caregivers, who may be less intensely involved in this care, but also less prepared to provide it.
Definition of the problem

In ancient Greek, a trauma was “a hurt or wound” to people or animals, “damage” to things, a “blow or defeat” in war, or “an indictment for wounding” in court (Liddell & Scott, 1889/1975, p. 815). This definition has persisted in the health sciences, in which trauma may be used for any “wound or injury, whether physical or psychic” (Anderson, 1994, p. 1735). Using the term in its etymological sense, a child could say that she experienced a trauma when she fell off her bicycle, scratched her knee, and treated it herself with water and a dinosaur bandage. Contemporary medicine and social sciences, however, have added further nuance to the term. In current usage, a trauma is not simply a hurt or wound or injury, but an injury that threatens the “life or bodily integrity” of the person who experienced or witnessed it and was too great for the resources of that individual to resolve (Pearlman & Saakvitne, 1995, p. 60). Using the term “trauma” with these connotations implies that relatively minor events, possibly even a bicycle accident, could be traumatic to someone exceptionally fragile in body or mind, while people endowed with good health and sturdier personality traits might be unperturbed in the face of combat or cataclysmic natural disaster.

By the end of the Nineteenth Century, before the time of Freud, psychiatrist Pierre Janet had written a masterly text on the effects of trauma on the human mind (van der Kolk, Brown, & van der Hart, 1989). At the end of the Twentieth Century, Vincent Felliti and his colleagues published their study of the consequences of trauma during childhood (Felitti et al., 1998). Felliti and colleagues created a questionnaire about the prevalence of child abuse and household dysfunction, separate events of which they called “adverse childhood experiences” (ACEs). The questionnaire originally listed only seven ACEs: psychological abuse, physical abuse, sexual abuse, living with someone with an addiction, living with someone who was mentally ill, violence against one’s mother, and living with someone engaged in sufficient criminal activity to go to prison. Later research added three more ACEs. Dube and colleagues (2001) added parental separation and divorce. Dong and colleagues (2004) were the first to present all ten ACEs, adding psychological and physical neglect. Felitti’s team mailed the original questionnaire to 13,494 adults who had received medical evaluations at a clinic in California in 1995 and 1996. Of those
sent a questionnaire, 9,508 people responded. Felliti and colleagues found that ACEs correlated with numerous physical and psychiatric illnesses and to early death. More than half of the respondents had experienced one ACE; a fourth had experienced two. But people who had experienced four or more of these conditions were four to twelve times as likely to suffer from substance abuse and depression. That is to say, the more ACEs people have to deal with, the more likely they will have a traumatic response to them. People may have sufficient resources to cope with one or more of these conditions, but their ability to cope with these conditions becomes less likely the more conditions they have to face. Felliti and colleagues proposed that ACEs contribute to psychiatric and medical diseases through the causal relations illustrated in Figure 1. In the theory they propose, the ACEs directly and negatively impact the neurological and psychological development of children. Those developmental problems appear in distressing emotions, dysfunctional social relationships, and problems with learning. Eventually many of these children turn to dysfunctional ways of coping with their problems, especially in the use of alcohol, tobacco, and other drugs and self-endangering sexual behavior. These attempts at coping ultimately have their own consequences on health, which very often lead to early death.

Research on the prevalence of violence, abuse, trauma, and their consequences continues. To say that trauma is the principal source of mental, emotional, and behavioral problems, and no small number of physical and medical issues, is perhaps an overstatement. But as Bloom (2013) has documented, innumerable studies, working from many different perspectives, have shown that trauma is a very significant factor in all these problems.

Services for people who have survived trauma and now carry its consequences have grown with awareness of the prevalence of trauma. Medical and especially psychiatric care; clinical psychology, clinical social work, counseling, and other psychotherapeutic disciplines; criminal justice; education; social services; disaster response; and pastoral and crisis ministries have become increasingly responsive to the needs of trauma survivors. All of these services can stress the people who provide them, even when the caregivers are not working with trauma survivors. But work with trauma survivors, especially when a caregiver specializes in trauma or provides depth psychotherapy for this population, may lead to unique emotional struggles. A recent collection of essays (Gartner, 2017a) illustrated the range of consequences
involved in trauma work. These consequences are both positive and negative. Gartner himself described the positive consequences of working with trauma survivors as counterresilience. He explained:

I notice my reactions to the heroic and resilient ways my patients deal with trauma and their extraordinary ability to move through it and beyond it. Seeing their reactions inspires similar ones in me. . . . I call it counterresilience. By engaging deeply with the traumatic material, the analyst grows psychologically and spiritually, reciprocally giving to the traumatized patient and gaining, in return, a new understanding of how human beings can survive and triumph over extraordinarily harrowing events.

(Gartner, 2017c, p. 24)
Most of the research on working with trauma survivors, however, has focused on the negative consequences of that work. In Gartner's volume, Bellinson (2017) described working with people immediately after they have survived natural disasters or disasters of human making—which may be considered trauma in its simplest form. Even this earliest response to trauma can be stressful and exhausting, with long hours and chaotic surroundings. Other contributors to the volume explored the effects on university students as they begin to see the depth of the brokenness of the world (Alpert, 2017) and the struggles of clinical supervisors overseeing the work of clinicians working directly with survivors (Saakvitne, 2017). Gartner (2017b) described his complicated work with male sexual abuse survivors. He described the dark and profoundly disturbing feelings he experienced as he worked with a man who had been deliberately, repeatedly, and cruelly abused as a boy. Gartner read versions of that essay to professional audiences many times before the essay was published. “When I finished reading the paper,” he said, “there was usually a long stunned silence” (Gartner, 2017a, p. 9).

The current state of care for trauma survivors within healthcare in the United States is self-contradictory and confusing. On the one hand, more people appear to be talking about trauma than ever before and research has shown the effectiveness of a number of interventions to help trauma survivors. Furthermore, the Patient Protection and Affordable Care Act of 2010 has increased the availability of services for great numbers of people. On the other hand, the widespread adoption of the “triple aim” for healthcare—improving outcomes, improving customer satisfaction, and reducing costs—appears to be correlated with increasing stress among physicians, nurses, and other healthcare professionals. This level of stress has led some writers to call for a “quadruple aim” for healthcare, now including care for providers as indispensable to achieving the original triple aim (Bodenheimer & Sinsky, 2014; Miller D., 2016; Sikka, Morath, & Leape, 2015). When the needs of clients are so pressing and caring for them is so demanding, institutions and agencies typically begin to limit the care they give to their providers. This seldom happens by formal policy; it typically happens in the actual practice and attitudes of the agency, often in glaring contradiction to the written vision, mission, policy, and procedures of the agency. For example, agencies surely tell their counselors that they should take some time to take care of themselves after a particularly stressful session with a difficult client; an agency straightforwardly telling counselors not to take care of
themselves at such times is hard to imagine. But many agencies have daily schedules that give clinicians almost no time between clients—and therefore the clinicians cannot take time away from their offices when they may desperately want to.

A logic model graphically illustrates the problem this paper seeks to address and is displayed as Figure 2. A logic model is a way of thinking backwards from the goal desired to the most fundamental things needed. A logic model for a program for trauma survivors thus begins with the ultimate goal of a program having to do with trauma, called its impact in the language of logic models: to reduce the consequences of trauma to the point that traumatized people can live as healthily as possible. This means that trauma survivors develop functional ways of coping with the ordinary stresses of life, ways that are life-enhancing and not causes of further suffering and impairment. The outcomes of a program for trauma survivors, as logic models designate the proximal goals of a program, are the elimination or significant reduction of symptoms of the various physical and psychiatric disorders consequent to trauma, such as addiction and depression. For people who suffered traumas as children, another desired outcome is the correction of deficits that trauma produced in cognitive, emotional, and behavioral development. The things needed for these outcomes to occur are labelled outputs in logic models. Manifestly, not all trauma survivors need the same things. Some people have sufficient resilience that they learn how to deal with their traumas without any kind of help from other people, just as some people cease addictive behavior by their own efforts. Furthermore, not all possible outputs are within the purview or competence of healthcare. For example, some people deal with their traumas much more effectively through a spiritual practice than through any psychotherapeutic intervention. As Jung said to one of the founders of Alcoholics Anonymous, “vital spiritual experiences” sometimes bring about sobriety when all psychotherapeutic attempts fail (Alcoholics Anonymous World Services, 1986, p. 27). Within ordinary healthcare, however, the outputs required for the outcomes include such things as sustained periods of abstinence from alcohol and other drugs, sustained periods of lack of suicide attempts, the acquiring of habits and skills to manage hitherto unmanageable emotions, and the production of a coherent narrative of past trauma. The activities required for these outputs to be achieved within typical psychotherapeutic care include individual and
group psychotherapy, psychoeducation, medications for psychiatric issues and other medical issues, and sometimes lengthy stays in residential treatment.

What is needed to accomplish the ordinary activities of healthcare for trauma survivors? These activities require competent, compassionate, and committed caregivers; this study focuses on psychotherapists, but caregivers of many kinds may also be involved. What are the resources that these caregivers need? This is the central question of this paper. Both providers and employers usually think of salaries, offices, equipment, and supplies. But these are not truly essential. Caregivers are not always paid well and sometimes not paid at all. Very good psychotherapeutic work does not strictly require an office or any equipment, manuals, or supplies. What then are the resources that caring for trauma
survivors truly require? When they are paid and have the typical accouterments of psychotherapy, what else do they need? What do they need to do their work well?

The consequences of caring

Research has probed both the negative and the positive consequences of working with trauma survivors.

Beginning with case studies and anecdotal evidence such as those in Gartner’s anthology, researchers have conducted many studies to define and explore the consequences of caring for trauma survivors. Several terms for and conceptualizations of these consequences arose in the late Twentieth Century; these theories largely overlap one another, but retain some differences in nuance.

The term “burnout” came into clinical usage with Freudenberger (1974). Maslach and Goldberg (1998) noted that burnout has emotional, interpersonal, and self-evaluatory dimensions: Burnout is marked by emotional exhaustion; “depersonalization,” by which they meant “a negative, callous, or excessively detached response to other people,” which can lead to “dehumanization”; and “reduced personal accomplishment . . . a decline in feelings of competence and productivity at work” (Maslach & Goldberg, 1998, p. 64). The term “burnout” is not unique to therapists or to people who work with survivors of trauma. “Burnout” refers to general feelings of exhaustion from long and demanding work in any occupation. It is common, however, in current healthcare. In 2011 Shanafelt and colleagues surveyed 7288 American physicians and found that 45.8% of them had at least one symptom of burnout (Shanafelt et al., 2012). In a follow-up study of 6880 American physicians in 2014, Shanafelt and colleagues found that 54.4% of the physicians had at least one symptom of burnout (Shanafelt et al., 2015).

Other writers explored the nuances of burnout among psychotherapists and other helpers who focus on the emotional dimensions of surviving trauma. Figley’s work brought the terms “compassion fatigue” and “secondary stress disorder” into common usage among caregivers (Figley, 1995). He described caregivers who had symptoms of Post-Traumatic Stress Disorder after working with trauma survivors. Figley observed:
The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others.

(Figley, 2002, p. 1434)

Pearlman and Saakvitne (1995) used the even more nuanced expression “vicarious traumatization.” In her essay in Gartner’s anthology, Saakvitne summarized her earlier work:

Vicarious traumatization . . . is cumulative and reflects a change in the self of the therapist as a result of empathic engagement with and responsibility to and for traumatized clients . . . . It extends outside not only the clinical relationship with a particular client, but outside the professional role of the therapist into all aspects of his or her personal and internal life.

(Saakvitne, 2017, p. 241)

The opposite of compassion fatigue is often called resilience. From a study of 279 articles having to do with resilience, Gill derived this definition:

Resilience is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and “bouncing back” in the face of adversity. Across the life course, the experience of resilience will vary.

(Gill, 2011, p. 163)

Another article more succinctly defined resilience as “the ability to adapt successfully in the face of trauma, adversity, tragedy or significant threat” (Rakesh, Pier, & Costales, 2017, p. 3). But the reference to “adapting” in these definitions raises questions: Is resilience simply becoming accustomed to stress and knowing how to manage it? That is surely a worthy goal and in some situations the only goal that people can achieve. But does resilience mean that caregivers should feel no better about their work than they would feel about staying in a loveless marriage solely for financial reasons? Mere adaptation seems to fall far short of finding “joy and meaning in work” (Sikka, Morath, & Leape, 2015, p. 608).

Herrmann and colleagues note several terms other than resilience that are opposites of compassion fatigue:

Hardiness is a dispositional characteristic that includes a sense of control over one’s life, a commitment to ascribing meaning to one’s existence, and viewing change as a challenge. Benefit finding is the ability to make sense of adversity by focusing on the positive changes or personal growth. Thriving occurs when the person not only returns to a prestress level of functioning but also attains an even higher level of functioning with the acquisition of new skills, knowledge, confidence, or improved social relationships. Posttraumatic growth is a stage beyond thriving and resilience. It is a construct with multiple dimensions, including an increased appreciation of life, closer intimate
relationships, a greater sense of personal strength, finding new opportunities, and increased spiritual development.

(Herrman et al., 2011, p. 262)

The term resilience, moreover, is not confined to psychology. The term is also used in ecology. Some research in that field suggests that the terms Herrmann and colleagues proposed do not catch the extent of the positive changes that may arise from working with trauma. Walker and colleagues noted that “resilience is the capacity of a system to absorb disturbance and reorganize while undergoing change so as to still retain essentially the same function, structure, identity, and feedbacks” (Walker, Holling, Carpenter, & Kinzig, 2004, p. 2). They defined adaptability as “the capacity of actors in a system to influence resilience. In a SES [social-ecological system], this amounts to the capacity of humans to manage resilience” (p. 3) But beyond both resilience and adaptability is transformability: “the capacity to create a fundamentally new system when ecological, economic, or social (including political) conditions make the existing system untenable” (p. 3). These distinctions between resilience, adaptability, and transformability raise questions for further research and reflection. Overcoming trauma clearly changes people, both those who have survived trauma and those who seek to help them. Are those changes so profound that they should be called a transformation? If so, from what kind of person to what other kind of person are the survivors and caregivers transformed? And if a nation or a society overcomes trauma, what kind of transformation might that be?

Resolving these semantic and philosophical issues is beyond the scope of this paper. This paper generally uses single terms, with regrettable loss of richness of meaning. This paper generally refers hereafter to burnout, compassion fatigue, secondary traumatization, and vicarious traumatization under the single designation of compassion fatigue. This paper generally refers hereafter to resilience, adaptability, hardiness, benefit-finding, thriving, post-traumatic growth, and transformability under the single designation of resilience.

When caregivers find themselves dealing with compassion fatigue, they themselves and the agencies that employ them may respond to the situation in a great number of particular ways. But these responses fall into three categories. First, an affected caregiver or the agency in which an affected caregiver works may resolve the compassion fatigue resiliently. For example, while working with a
traumatized client, a caregiver may realize that he is remembering traumas in his own life that are like the traumas in the client's life. That caregiver may then find a therapist with whom he can explore these memories and grieve whatever losses they may contain. Or, for another example, a supervisor in an agency may perceive that a clinician is working too long and too hard and showing signs of compassion fatigue. The supervisor may then insist that the clinician take a nine-day vacation; that intervention might be sufficient to de-stress and return the clinician to adequate levels of functioning. Several remedies for compassion fatigue are effective and the following section of this paper explores them in more detail.

A second possible outcome of compassion fatigue is that the caregiver resolves the compassion fatigue, but not resiliently. An obvious example is falling into addiction, either to substances, sex, food, gambling, or many other compulsive behaviors, as a way of coping with the stress of work. But many caregivers simply change jobs or change professions, either by their own choice or by the actions of others. Of course, some turnover in an agency is to be expected and for many reasons. But employee turnover is always relationally, emotionally, and financially expensive, not only to the caregivers who change jobs, but to the institutions that train and employ them. This is a particularly large problem for substance abuse counselors, many of whose clients have had multiple ACEs. In their 2010 longitudinal study of 739 counselors and 188 supervisors, Eby and colleagues found that the annual turnover rate for substance abuse counselors was 33.2%, of which 24.9% was employee-initiated. The annual turnover rate for supervisors in substance abuse treatment settings was 23.4%, of which 14.4% was employee-initiated. The same article noted that the Bureau of Labor Statistics reported at that time that the voluntary turnover in healthcare and social services in general was 19.6% (Eby, Burk, & Maher, 2010).

A third possible outcome of compassion fatigue is that no remedies are employed. The affected caregiver may or may not even know that he or she is struggling with compassion fatigue; in any case he or she simply stays in a stressed-out condition. Likewise, others in the caregiver’s agency may not notice that the caregiver is experiencing anything beyond the ordinary stress of work—or else they notice some unusual behavior, but say and do nothing about it. This outcome is worse than leaving the job or the profession. In the best of these situations the caregiver continues working, but with contagious feelings of boredom, sadness, anger, or bitterness. In the worst of these situations the trauma-conditioned traits of the
survivors link with trauma-conditioned traits of the providers. While this kind of emotional connection happens as a matter of course, some providers are unable to contain its intensity and consequently violate the ethical boundaries of caregiving (see Pearlman and Saakvitne, 1995).

These three categories of responses to compassion fatigue lead to a re-phrasing of the questions concluding the foregoing section. To ask what caregivers need in order to work with trauma survivors is actually to ask: What can increase the frequency of remedying compassion fatigue? What can decrease the frequency of caregivers’ leaving their jobs or staying in them while providing poor and even destructive treatment? The goal is not mere symptom reduction. Finding ways to help providers be less stressed, but still leaving them stressed, is not sufficient. The goal is to find ways for providers to attain and maintain genuine resilience. Moreover, the goal is not simply to list ways that providers may take care of themselves. Resilience and the cultivation and enhancement of resilience are properties not only of individual human beings, but also of systems (Nemeth, Wears, Woods, Hollnagel, & Cook, 2008). Both healthcare agencies that directly employ caregivers and healthcare institutions that fund and regulate caregivers create work conditions that either enhance or inhibit a caregiver’s attempts at self-care. How may agencies and institutions enable their caregivers to provide optimal service to trauma survivors?

Potential solutions for compassion fatigue

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services has produced a consensus document that lists recommendations to address the consequences of compassion fatigue. This treatment improvement protocol puts the most important of its recommendations in a table (SAMHSA, 2014, p. 198), but also recommends a few other strategies in its text. The protocol makes no recommendations regarding the physical space in which caregivers work (see Bell, Kulkarni, & Dalton, 2003, and Peltzer, Matseke, & Louw, 2014) or vacations that caregivers may take (see de Bloom et al., 2009, and de Bloom, Geurts, & Kompier, 2013). Following the lead of this treatment improvement protocol and these other sources, this section of this paper defines and expands the following areas of recommendations for reducing caregiver stress:
• Adequacy and safety of the work environment
• Training related to trauma
• Diversity of caseload
• Adequacy of clinical supervision
• Emotional support from colleagues
• Autonomy in decision-making
• Self-care, which includes:
  o Vacation
  o Stress reduction during the workday
  o Personal counseling and psychotherapy
  o Existential and spiritual issues

**Adequacy and safety of the work environment**

People suffer trauma and people try to help their neighbors who have suffered trauma all over the world. The adequacy and safety of the environment for public health workers and healthcare providers vary immensely in different parts of the world, but always have some impact on the work and its consequences on the caregivers. In the developing nations and in many responses to disasters in the developed world, problems often arise with the most fundamental aspects of work space for providers. Peltzer, Matseke, and Louw briefly discussed the challenges of the work environment for lay counselors confronting the human immunodeficiency virus in South Africa. They wrote:

*Most lay counselors were affected by inadequate working space, consisting of either one or no counselling rooms. In cases where there are no designated counselling rooms, they claimed that they had to use immunisation rooms, store rooms, dressing rooms, consulting rooms, medicine rooms, doctor’s rooms, emergency rooms, or rooms for telephoning, photocopying and faxing. Inadequate working space poses a serious problem since it compromises the privacy of the counselling sessions. According to some lay counsellors, some clients are even turned away from attending counselling sessions due to lack of privacy.*

[One counselor said:] “We have no counselling rooms at present; we just use any other room that was available at the time. There is also a lack of privacy in our counselling sessions because anybody can come in the room to fetch something that might be needed.”  

*(Peltzer, Matseke, & Louw, 2014, p. 417)*
Even greater challenges relating to work space may arise when counselors are working in dangerous areas. When caregivers are responding to disasters, the cause of the disaster (war, flood, earthquake) may still imperil the site of the response and all of the people in it. In prisons, residential psychiatric facilities, and high-crime neighborhoods, highly volatile people can and sometimes do attack the providers working with them. Bell, Kulkarni, and Dalton quoted a dissertation that reported that clients or their relatives had threatened 57.6% and assaulted 16.6% of a sample of social workers (Bell, Kulkarni, & Dalton, 2003).

The work environment for providers of services for trauma survivors may also support the providers in emotional ways. Bell, Kulkarni, and Dalton suggested that these workplaces include “personally meaningful items” such as “pictures of their children or of places they have visited, scenes of nature or quotes that help them remember who they are and why they do this work.” These writers also suggested “pictures of scenic environments (rather than agency rules and regulations) in the waiting rooms, staff meeting rooms, and break rooms” in order to stress “the importance of the personal in the professional.” These writers further recommended amenities such as “a break room that is separate from clients . . . a coffee maker, soft music, and comfortable furniture” (all quotations in this paragraph from Bell, Kulkarni, & Dalton, 2003, p. 467).

Beyond safety and emotional encouragement, some research has indicated that the presence of beauty in the environment also contributes to coping with the stress of trauma. Madan and colleagues found that aesthetic improvements in the physical environment of a psychiatric hospital, “for example, repainting walls with warm colors, using decorative rugs and plants, and replacing and restructuring furniture in common areas” (Madan et al., 2014, p. 1273) had a greater impact on reducing the use of restraints and seclusion than training the staff about trauma, changes to unit rules and policies, and involving patients in treatment planning. Wikström, Westerlund, and Erkkilä found that healthcare professionals are aware not only of the use of art in social interactions and as a source of comfort, but of the aesthetic value of art in a hospital setting (2012). They noted, “The field of aesthetics is a neglected area in many hospital environments” (p. 188)—and that is manifestly true of facilities of many kinds that provide healthcare. Clarifying the principles of aesthetics—the definition of beauty and its relation to
personal taste and current fashion—and how they relate to human health and well-being, both for people receiving healthcare and people providing it, will be a challenge for ongoing research and philosophical reflection.

**Training relating to trauma**

Research on the training that psychotherapists receive about trauma appears to be inconsistent. On the one hand, Cook and colleagues boldly claimed as recently as 2011 that:

> trauma-related material is not routinely included in the professional training of most psychologists, nor is it included in the training of allied professionals. [...] there are still relatively few clinical or counseling programs and internship sites that routinely offer such topics as part of their training. The result is a major gap in service needs and the ability to deliver specialized trauma-relevant and responsive services.

(Cook, Rehman, Bufka, Dinnen, & Courtois, 2011, p. 254)

In a slightly earlier study of substance abuse counselors, Bride, Hatcher, and Humble agreed with Cook and colleagues that “most substance abuse counselors are not being prepared for practice with traumatized populations in their formal academic or internship or practicum training” (Bride, Hatcher, & Humble, 2009, p. 102). Bride, Hatcher, and Humble also found, however, that 39% of substance abuse counselors had some academic coursework, 19% had an internship, and 82% had continuing education in relation to trauma during their lifetimes. Furthermore, in the past year 21% of substance abuse counselors had an in-service training, 39% had attended a professional meeting or conference, and 35% had attended a workshop or seminar, all these trainings being related to trauma.

Training about trauma is valuable for providers for many reasons, but how may training lessen compassion fatigue? Lee, Lim, Yang, and Lee note that psychologists have known for more than 40 years that “psychotherapists expect their work to be difficult and even stressful, but they also expect their therapeutic efforts to ‘pay off.’ Providing constant caring without the compensation of success (e.g., positive changes in their clients) apparently produces burnout in psychotherapists” (Lee, Lim, Yang, & Lee, 2011, p. 252). If training about trauma is to reduce compassion fatigue, it needs to improve the likelihood of success in the treatment of people who have experienced trauma. The goal of statistically-supported practices (SSPs), which are more commonly known as evidence-based practices or empirically-supported
practices, is precisely to increase the likelihood of success in treating particular populations with particular problems (see Magnabosco & Maderscheid, 2011, and Straus, Glasziou, Richardson, & Haynes, 2011).

At the time of the writing of this paper, SAMHSA’s National Registry of Evidence-Based Programs and Practices listed 454 interventions; Table 1 (below and on the following page) lists 56 of these interventions related to trauma (SAMHSA, 2017). These interventions have been drawn from many, if not all, of the theoretical approaches to therapy.

Table 1
Statistically-Supported Programs and Practices Relating to Trauma

Newly reviewed interventions with effective or promising outcomes:

- Accelerated Resolution Therapy
- All Babies Cry
- Attachment-Based Family Therapy (ABFT)
- Beyond Violence: A Prevention Program for Criminal Justice-Involved Women
- Child First
- Child-Centered Play Therapy
- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) / Bounce Back
- Complicated Grief Treatment
- Critical Incident Stress Debriefing (CISD)
- Forever Free
- I Feel Better Now Program
- Journey of Hope Coping with and Normalizing Emotions
- Kognito At-Risk in Primary Care
- Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION)
- Mind-Body Bridging Sleep Program
- Mind-Body Bridging Substance Abuse Program (MBBSAP)
- Mindfulness-Based Substance Abuse Treatment (MBSAT) for Adolescents
- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)
- Parenting with Love and Limits (PLL)
- Peaceful Alternatives to Tough Situations (PATTS)
- San Francisco (Calif.) Behavioral Health Court
- Sensory Motor Arousal Regulation Treatment
- Skills Training in Affective and Interpersonal Regulation for Adolescents (STAIR-A)
- Sobriety Treatment and Recovery Teams (START)

The terms “evidence-based practices” and “empirically-supported practices” are common but implicitly pejorative. They imply that other psychotherapeutic or medical practices lack evidence or consist of merely theoretical constructs. These terms disrespect the traditions of psychotherapy and medicine and discount the experience and observations of living clinicians. This paper suggests “statistically-supported practices” as a more precise and less offensive term.
Support for Students Exposed to Trauma (SSET)
Surviving Cancer Competently Intervention Program (SCCIP)
Teaching Family Model
Telemedicine-based Collaborative Care
Theraplay
Thought Field Therapy for the Treatment of Post-Traumatic Stress Symptoms
Trauma Affect Regulation: Guide for Education and Treatment (TARGET)
Trauma Recovery and Empowerment Model (TREM)
Trauma Sensitive Yoga
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
VR Job Interview Training (VR-JIT)
Wellness Recovery Action Plan (WRAP)

Legacy programs and practices:

A Woman’s Path to Recovery (Based on A Woman’s Addiction Workbook)
Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women
Child and Family Traumatic Stress Intervention
Child-Parent Psychotherapy (CPP)
Cognitive Processing Therapy for Posttraumatic Stress Disorder
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are at Risk for Physical Abuse
Coordinated Anxiety Learning and Management (CALM) Tools for Living Program
Eye Movement Desensitization and Reprocessing
Family Centered Treatment (FCT)
Healing Our Women (HOW)
Helping Women Recover and Beyond Trauma
IMPACT (Improving Mood—Promoting Access to Collaborative Treatment)
Kognito Family of Heroes
Living in the Face of Trauma (LIFT): An Intervention for Coping with HIV and Trauma
Model Adolescent Suicide Prevention Program (MASPP)
Preschool PTSD Treatment (PPT)
Prolonged Exposure Therapy for Posttraumatic Stress Disorders
Seeking Safety
SITCAP—ART
Traumatic Incident Reduction

Note. Foregoing are results of a search for interventions with the keyword “trauma” from Substance Abuse and Mental Health Services Administration (2017).

Research has begun to show that the use of SSPs may contribute to the reduction of compassion fatigue. Sprang, Clark, and Whitt-Woosley (2007) compared 445 therapists with specialized training in trauma with 633 therapists who lacked such training; the study defined specialized training as either having training in any of the SSPs or having had experience in inpatient or outpatient trauma treatment centers. These researchers found “that specialized trauma training did enhance CS [compassion
satisfaction] and reduce levels of CF [compassion fatigue] and burnout, suggesting that knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang, Clark, & Whitt-Woosley, 2007, p. 272). Aarons and colleagues (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009) had suggestive but mixed findings from their study of 153 home-based providers over a period of 29 months. They conducted a 2 x 2 study, comparing providers using an SSP with those who provided the usual array of services in their work; the researchers further compared in each of those groups the providers who received monitoring for fidelity and those who did not. They found that the providers using an SSP with monitoring for fidelity to the practice had a higher rate of job retention than the providers using an SSP without monitoring and the providers following services as usual with monitoring; providers using an SSP with monitoring for fidelity did not have a higher rate of retention than providers following services as usual without monitoring. Aarons and colleagues noted that other factors besides the SSPs had an impact on these results. Referring to precisely these studies, Miller and Sprang summarized the importance of using these statistically-supported interventions:

Clinicians who use evidence-based practices report lower levels of compassion fatigue . . . and stay in their jobs longer . . . . Satisfaction with clinical work improves when therapists believe that they have effective tools. This fact also explains why distress levels are highest in young and less seasoned clinicians . . . , as these therapists are less likely to feel that they have mastered therapeutic skills.

(Miller & Sprang, 2017, p. 158)

The use of SSPs, however, faces several challenges. Many caregivers lack serious training in these practices (see Cook, Rehman, Bufka, Dinnen, & Courtois, 2011, and Couineau & Forbes, 2011). Furthermore, a sizable number of practitioners are not interested or are minimally interested in receiving any training relating to trauma (Cook, Rehman, Bufka, Dinnen, & Courtois, 2011). The nature of organizations also poses great challenges to the implementation of SSPs (Aarons, Hurlburt, & Horwitz, 2011).

**Diversity of caseload**

"Caseload" refers to “the total number of cases that a doctor, social worker, probation officer, or other professional person or agency is concerned with at any one time" (Oxford English Dictionary, 2017). In clinical practice the word “caseload” is subtler than simply number: It reflects both the number and the
complexity of the cases with which a clinician is working. The number of clients on a counselor’s caseload, the mix of clients with and without trauma issues, and complicating conditions such as developmental disabilities, addictions, and personality disorders (which themselves arise from childhood interpersonal trauma)—all affect a counselor’s likelihood of developing compassion fatigue.

The greater the number of clients that a counselor has on his or her caseload, the more hours a counselor will work in a week to provide adequate services. As Galek and colleagues summarized the literature, the more hours a person works in a week, the more stress a person will have, and the greater the scores on measures of burnout (Galek, Flannelly, Greene, & Kudler, 2011). Galek and colleagues also found an exception that proves the rule. A sample of clinicians in one study averaged fewer than 17 hours of client contact in a week and had lower scores on measures of burnout. Dalton’s dissertation (2013) added nuance to this research. In Dalton’s sample, therapists with a larger caseload had lower levels of stress, but Dalton noted three confounding variables. First, some of the therapists in his sample served patients covered by Medicaid. Medicaid is notorious for demanding much paperwork and increasing stress on providers. The less-stressed therapists in Dalton’s sample appear to have kept their caseloads small precisely so that they could manage stress precipitated by Medicaid. Secondly, some of the therapists with very large caseloads served many patients who were receiving medications and minimal other services from their mental health agencies. These patients had to be assigned to a therapist—but the therapist might see them only once every 90 days. These patients therefore added little to the stress of the therapist. Thirdly, in Dalton’s sample, therapists had considerable choice as to the size of their caseloads. Therapists who felt competent to take on more clients chose to take them. Those who felt stressed with the number of clients maintained smaller caseloads.

Most counselors do not work exclusively with survivors of trauma—and most counselors are very happy to have a mix of more and less demanding clients. Keeping such a mix would seem to be a way to reduce compassion fatigue. But the issue is not as simple as that. Ivicic and Motta (2017) have summarized several studies of this problem. On the one hand, longer hours at work seem to have significant adverse effects on disaster mental health workers and child protective workers. On the other hand, emergency room workers seem not to be affected and sexual assault counselors and domestic
violence counselors have fewer secondary trauma symptoms. Having a diversity of cases, including some survivors of trauma and some people who have not experienced trauma, may be a way to reduce stress for counselors, but other factors (such as the presence of developmental disabilities, addictions, and personality disorders) appear to be more significant.

**Adequacy of clinical supervision**

All industries and professions have people who have oversight of other people. In psychotherapy oversight has two forms. *Administrative* supervision is a kind of management, equivalent to the oversight that occurs in other occupations; administrative supervision focuses on hiring, firing, evaluations of employee performance, program planning, rules, regulations, productivity, and the like. *Clinical* supervision is a kind of individualized instruction or training in psychotherapy, much like an apprenticeship in a traditional art or craft. As clinicians prepare for licensure, state regulations define very precisely who may provide clinical supervision and who may receive it. But these requirements do not define the essence of clinical supervision. Clinical supervision as such is not defined by who gives it (or their age, education, or credential) or by who receives it (or their job title or status); clinical supervision is defined as one person helping another person in caring for a third person with a clinical condition. Clinical supervision is legally required for therapists as they come into the profession of psychotherapy—but psychotherapy presents constant challenges to practitioners throughout their careers, so conscientious therapists generally seek out and receive some supervision as long as they actively practice. Bernard and Goodyear (2014) discuss the definition of clinical supervision in detail in the introductory chapter of their classic text.

Clinical supervision differs, furthermore, from psychotherapy. In most industries and in most disciplines within healthcare this distinction needs no further discussion. Neither a master wordworker nor a senior surgeon attempts to provide any kind of therapy for an apprentice or resident. But both therapists and supervisors often confuse clinical supervision for psychotherapists with psychotherapy. The confusion arises from two sources. On the one hand, supervisors for psychotherapists are themselves psychotherapists by training; they are prone to do in supervision what they have done in therapy. On the other hand, the practice of psychotherapy inevitably arouses feelings within therapists that deserve therapy. Such feelings always arise in honest supervision. But exploring those feelings as such is not the
province of supervision; clinical supervision is focused on the needs of a client, not the therapeutic needs of a provider. Under ordinary circumstances, a supervisor will refer a therapist to another therapist to address the supervised therapist’s internal issues. This paper discusses psychotherapy for psychotherapists in a later subsection, under the heading of self-care for psychotherapists. The ethical boundaries between supervision and psychotherapy are discussed in detail in Thomas (2010).

Since trauma causes especially profound problems for survivors, requires complicated interventions, and stirs extremely painful emotions both for the survivors and for those who listen to them, most psychotherapists seek out supervision when they are working with trauma survivors. Many books and articles recommend clinical supervision as a way of reducing the likelihood of compassion fatigue; for two examples see Merriman (2013) and Saakvitne (2017).

Nonetheless, having an overseer with the title of “supervisor” or having a “supervisor” who provides merely administrative rather than authentically clinical supervision is of little or no value in reducing compassion fatigue. In a study of supervision for child protective workers in Australia, Gibbs (2001) paints a damning portrait of supervisors who focus on administrative rules and neglect the emotional support of the people working with children and abusive families. Similarly, in an opinion essay addressed to marriage and family therapists (MFTs), Franco (2015) asks, “As MFT supervisors, it is important to remember our skills in empathy that we learned as clinicians and ask ourselves, are we creating work environments that promote burnout in our therapists?”

Reducing compassion fatigue, therefore, appears to require that a counselor have a positive relationship with a person who serves as his or her supervisor. At the least this means that the counselor must have ample time and conversation with a genuinely supportive person who can provide an objective perspective on the work of the counselor and, it is greatly to be hoped, some new insight on how to work with the trauma survivors the counselor is seeking to help. Current research, however, has not precisely specified what else might be required for quality of supervision. Knudsen and colleagues explain:

It is not yet clear whether the elements of high-quality supervision reflect certain personality traits of supervisors, expertise based on their own clinical experiences and training, or simply the right “fit” between a given supervisor and his or her subordinates. Disentangling the factors that lead to high quality supervision is important since there are unique implications. For example, if
effective supervision were largely personality-based, then a key implication would be that treatment organizations would benefit from being able to identify and hire supervisors with these personality characteristics. In contrast, if effective supervision skills can be taught, then training becomes a critical workforce issue. 

(Knudsen, Roman, & Abraham, 2013, p. 532)

As noted in the discussion of SSPs, current research has identified hundreds of interventions that are effective (that is, statistically superior to other interventions) for particular problems and populations. Current research has not determined, however, whether any overarching theory of therapy or supervision is statistically more effective than another. Many such models are now available, as illustrated in the 11 volumes and accompanying videos of the Clinical Supervision Essentials Series, recently published by the American Psychological Association (for examples see Newman & Kaplan, 2016, and Sarnat, 2016). All of the common approaches to psychotherapy and supervision work well for some populations of clients and for some clinicians; furthermore, some are better for certain populations or problems than others.

Research has specified, however, some of the content that must be discussed in effective supervision. On the one hand, clinical supervision in psychotherapy, like clinical supervision in other disciplines in healthcare, must focus on assessment and intervention skills, diagnostic and theoretical concepts, and matters of technique. On the other hand, clinical supervision in psychotherapy, more than any other of the healthcare professions, must also focus on personal, relational, emotional, and subjective issues. Fifty years of research have consistently shown that the relationship between a counselor and a client is far more important to the outcome of psychotherapy than the technique or theoretical stance of the counselor (Duncan, Miller, Wampold, & Hubble, 2009; Egan, 2009). Therefore, if a counselor is to be effective, a counselor must know how to convey empathy and how to respect a client. In other words, for SSPs to be successful, they must be complemented by these softer skills, which are typically taught in clinical supervision.

Emotional support from colleagues
In addition to receiving emotional support and clinical direction from clinical supervisors, therapists working with trauma survivors need the support of their colleagues, particularly their colleagues in the agencies in which they work. Many authors recommend that counselors working with trauma survivors increase the level of support that they receive from their peers (for examples see Figley, 2002; Perkins &
Oser, 2014; and Oser, Biebel, Pullen, & Harp, 2013). Receiving support from colleagues is important for clinicians providing care for trauma survivors for at least two reasons.

Support from colleagues may be as important or even more important than clinical supervision, even when the clinical supervision is of unquestionably high quality, for the simple reason that a therapist's clinical supervisor is often not available for consultation when a crisis with a client has arisen. Clinical supervision is a formal, highly structured process, with supervisor and supervised typically meeting no more than once a week. When caregivers must have help immediately when dealing with their clients, the caregivers often must turn to their colleagues for an in-the-hall consultation. This practice is of unquestionable value, but may become problematic when caregivers prefer these spontaneous consultations to the guidance they receive from their clinical supervisors (Farber, 2017).

Collegial support is also important because of the structure and system of an agency. Maslach and Goldberg explain:

People thrive in community and function best when they share praise, comfort, happiness, and humor with people they like and respect. Unfortunately, some jobs isolate people from each other, or make social contact impersonal. What is most destructive of community, however, is chronic and unresolved conflict with others on the job. Such conflict produces constant negative feelings of frustration and hostility, and reduces the likelihood of social support. (Maslach & Goldberg, 1998, p. 72)

Merely having colleagues, even highly competent colleagues, is not sufficient support for caregivers of trauma survivors. If caregivers do not get along well enough with their colleagues to resolve disagreements and conflicts, they will not be so vulnerable as to discuss their real feelings when dealing with traumatized clients.

**Autonomy in decision-making**

Trauma is partially defined by the experience of helplessness and hopelessness, by being overpowered by other people or things. This is especially obvious with children who have survived abuse. Bloom writes:

For children raised in abusive or neglectful homes, this failure to achieve a feeling of competence or efficacy often pervades their entire development. Regardless of what they do, how hard they try to please, how fast they run away, how strenuously they try not to cry—nothing stops the
abuse. As a result, they often give up any notion that they can affect the course of their lives in a positive way.

(Bloom, 2013, p. 33)

The most fundamental goal of therapy with trauma survivors is to regain—or perhaps gain for the first time—their own power and self-efficacy in order to overcome the consequences of trauma in their lives.

Psychotherapists working with trauma survivors will often absorb the survivors’ feelings of helplessness and hopelessness. In the psychoanalytic tradition this is called a concordant countertransference (Racker, 1968/1982). This is one of many possible countertransferential responses to traumatized people (Gartner, 2017c; Pearlman & Saakvitne, 1995). When a client perceives that his or her counselor shares the feelings of despair, the client might at first think that the counselor is exceptionally compassionate and sensitive. But if the counselor continues to feel hopeless and helpless with the client, the client’s despair will deepen to the point of abandoning all hope for help, even from therapy, and will leave therapy—or worse.

A caregiver’s response to a client may, however, take a very different turn. Instead of sharing the feelings of the client, the caregiver may begin to experience the feelings of the most important people in the client’s life. The psychoanalysts call this a complementary countertransference (Racker, 1968/1982). For example, a caregiver may ordinarily be very compassionate toward a child who has been abandoned. But with this new child the caregiver is talking with, the caregiver does not feel compassionate; he or she feels annoyed, distrustful, ready to scold. This neglected child does not seem to differ much from other neglected children. What then is leading the caregiver to feel so differently toward this child? Many causes are possible, but perhaps the child is doing things, saying things, taking a certain tone of voice, or holding a certain body posture that evokes the same feelings in the caregiver that the neglectful parent had toward the child.

Learning how to prevent countertransferences from ruining a course of therapy is a large part of supervision and collegial support; this is a clinical issue beyond the scope of this paper. But anything happening in an agency that intensifies a counselor’s feelings of hopelessness and helplessness is within the scope of this paper: Such situations will lead counselors to believe that their despairing—or angry or
bitter or rejecting—countertransferences are valid and justifiable. Such situations then hasten the
caregiver's compassion fatigue and contribute to treatment failure.

What might intensify such dark feelings? Caregivers stand between two forces: Their clients on
the one hand and their supervisors and managers on the other. Certainly without intending to do so, some
clients will push the caregivers to act like their neglectful, rejecting, and abusive parents, grandparents,
and others in their pasts. But some supervisors and managers also push the caregivers to treat the clients in
neglectful, rejecting, and abusive ways. They insist upon productivity, meeting quotas, meeting deadlines.
Perhaps without intending to do so, they have reduced the clients to numbers, objects to be manipulated
for the financial well-being of the company, “a typical borderline,” “just another defiant delinquent.”
Caregivers have serious problems avoiding the traps their clients lay before them; they find it many times
harder to avoid those traps if their employers make it easier for them to fall into them.

Hence the importance of genuine autonomy for caregivers in their work. Autonomy may be
defined as follows:

> Respect for autonomy is one aspect of a larger principle, namely, respect for persons, which is a
fundamental principle of all morality. Respect for persons affirms that each and every person has
moral value and dignity in his or her own right. In this sense, the principle of respect applies to
every encounter between persons, regardless of their situation, stage, or state of life. One
implication of respect for persons is a respect for personal autonomy, that is, acknowledging the
moral right of every competent individual to choose and follow his or her own plan of life and actions.
(Jonsen, Siegler, & Winslade, 2015, p. 49; italics in the original)

Autonomy has become one of the cardinal principles of contemporary ethics, particularly in bioethics, which
has exalted this principle for patients (Beauchamp & Childress, 2001). When caregivers exercise
autonomy, however, many agencies and institutions may label that caregiver as “arrogant,”
“insubordinate,” and “not a team player.” Caregivers may then find themselves in the midst of moral
dilemma. On the one hand, by accepting employment caregivers implicitly agree to abide by the policies
of their employers and agree to follow the directions of their supervisors and managers, even though they
may disagree or disapprove of some of the policies and directions. That is to say, if employees strongly
object to the policies of an agency as a while or the usual directions of an employer, they have a moral
obligation not to accept employment or to leave their position. On the other hand, caregivers also need
the right and the authority to object to certain policies and directions. Without an internal voice for morals
and ethics, systems of care for trauma survivors may become as abusive as the families from which their clients have escaped.

Reaching a satisfactory resolution to this ethical dilemma is both a great need and a great challenge in supporting people who provide care for trauma survivors. Some writers have proposed particular ways that systems may give appropriate autonomy to caregivers. Dalton (2013) mentioned that his sample of counselors had some control over the number of people and the depth of problems on their caseloads. Both the treatment improvement protocol about trauma-informed services (SAMHSA, 2014) and Maslach and Goldberg (1998) stress the importance of including caregivers in policy-making decisions within agencies. Bloom and Farragher (2013) have made this principle one of the seven core commitments of their Sanctuary Model of trauma-informed care.

Self-care

A considerable body of literature, not to mention a sizable industry of trainings, has evolved around clinician self-care, to the point that many people think that alleviating compassion fatigue is equivalent to caregivers' self-care. Maslach and Goldberg observed the same assumption nearly 20 years ago. They said:

A review of the relevant literature reveals that very little attention has been given to situational or organizational strategies for burnout. Even when a proposal has dealt with worksite strategies, the focus has not been on changing the job, but on changing people to adjust to the job. (Maslach & Goldberg, 1998, p. 68)

Manifestly, all caregivers seeking to help survivors of trauma do need to take care of themselves.

The Green Cross Academy of Traumatology (n.d.) holds that a caregiver’s not taking care of himself or herself is unethical, stressing that “every helper, regardless of her or his role or employer, has a right to wellness associated with self care.” Employers and regulating agencies, however, may sometimes use the language of “self-care” and even the term “resilience” itself, as ways to evade their own responsibilities. The employers of caregivers and other institutions affecting the work of caregivers may either help or hinder their efforts at self-care. Agency policies and practices may increase or diminish at least four dimensions of self-care.
**Vacation.** Perhaps the quickest and easiest way to deal with any kind of stress is simply to get away from it. Everyone who works with trauma survivors needs to have some hours off every day and a day or two off every week. Research has shown, however, that a vacation is likely to have a more powerful effect on health and wellness than weekends or evenings off, but this beneficial effect was not very powerful and lasted only two to four weeks (de Bloom et al., 2009). A later study found that “relaxation, pleasure derived from activities and savoring were most strongly associated with improvements in H&W [health and wellness] during and after vacation”; furthermore, “It may not be most crucial which specific activity vacationers pursue during vacation, as long as they perceive engaging in this activity as pleasant” (de Bloom, Geurts, & Kompier, 2013, p. 628). That study also found that the length of a vacation made no difference on the effect or its duration.

In a study of 259 providers, Bober and Regher (2006) found that most providers believe in the various coping skills recommended in this paper and throughout the literature, but do not actually practice those skills. Bober and Regher found that the only effective way to reduce providers’ traumatic stress was to reduce the number of hours in a week that they work with traumatized people. Nonetheless, how many hours a caregiver should work with trauma survivors in a week and remain healthy is a vexing question. The number of hours that anybody may work in any field varies not only from one individual to another, but from one country to another. In the United States, a standard workweek is still assumed to be 40 hours, though in practice many people work 47 hours or more; in some other countries the average worker works more hours in a week and in many countries the average worker works fewer (Isidore & Luhby, 2015; McCarthy, 2014; Snyder & Jones, 2015). Some people vehemently argue that people in the United States (and apparently a few other countries) work too much in general (de Graaf, 2003) and recommend the development of policy to encourage working fewer hours in a week. If that is so for Americans in general, then it would seem to be even more so for caregivers for trauma survivors.

Others argue that the issue is not the work week, but working beyond what is expected. Freudenberger expressed this in his original article on burnout:

Limit the number of hours a single person works for you. Build in nine-hour shifts, if it is a therapeutic community. Don’t let people exceed their nine hours, except in cases of emergency. If
there are too many emergencies, find out what’s really taking place. Is a staff member promoting emergencies in order to work and stay longer? Or is it something that’s wrong in the facility? Make sure that no one individual always works nights, for instance. And stagger people’s hours. If someone comes in oftener than required or puts in more hours than his share, find out why. 
(Freudenberger, 1974, p. 163)

When an agency is not fully staffed or at times when staff are away from their jobs, employees will necessarily work more than the standard number of hours in a week. This would not be a problem if it seldom happened. But when employees work more than a standard number of hours with some frequency, the likelihood of compassion fatigue increases.

Still others argue that the issue is neither the number of hours as such nor working beyond expectations. The issue may be what caregivers do within the hours that they are actually at work, even if the number is a standard number of work hours. Infantry soldiers do not spend all of their time in combat, even when they are on active duty and deployed on a combat mission. Likewise, caregivers should not expect, and their employers should not expect their caregivers, to work tirelessly seeing clients and producing documentation all day long. Caregivers should expect to spend some time in a working day cultivating resiliency in the various ways surveyed in this paper. The author of this paper is grateful to M. Robbins (personal communication, November 5, 2017) for this insight.

Further research is needed to clarify this issue. When employees work more than the standard number of hours more weeks than not (that is, greater than 50% of the time), the likelihood of compassion fatigue is obvious. But the determining number for increasing the likelihood of compassion fatigue may be lower than 50% of the time and may, as with Bober and Regher’s study (2006), be related to factors such as actual practice of self-care skills. Perhaps research correlating work hours with instruments such as the Maslach Burnout Inventory (Mind Garden, n.d.) and ProQOL (Stamm, 2010) could clarify this question.

Stress reduction during the workday. Everyone who works with trauma survivors with genuine compassion will have some meetings with clients that are exceptionally demanding: Their clients will tell them gruesome and horrifying stories that are difficult for any sensitive person even to hear. Everyone who works with several trauma survivors during a single day will also have some days in which no one story is especially demanding, but an entire day of anger, bitterness, sadness, anxiety, and apathy from clients, in addition to whatever other stresses the counselor may be dealing with in his or her personal life,
becomes overwhelming. For these reasons, everyone working with trauma survivors needs to have ways to manage stress and powerful emotions as they arise during a working day.

Many writers have developed lists of things that a counselor or other caregiver might do to take a break during the day. One ample list is copied in Table 2 (below). When providers can engage in such healthy and innocuous stress-reducing activities and find them genuinely helpful, surely they should do them during a difficult day. Providers should avoid activities that appear to reduce stress but eventually cause more stress or create much more serious problems, such as using alcohol, tobacco, or other drugs or engaging in various process addictions during the work day.

<table>
<thead>
<tr>
<th>Table 2</th>
</tr>
</thead>
</table>

| **Some Simple Ways to Recharge During the Day** |

1. Talk to a friend on the telephone  
2. Text a friend  
3. Have lunch with a friend or co-worker  
4. Connect to social media  
5. Exercise for 20 minutes (walking counts too!)  
6. Go outside and watch the clouds  
7. Walk/play with your pet (or offer to walk someone else’s)  
8. Play a solitary game (video, cards etc.)  
9. Read a book, magazine, newspaper or poem  
10. Take a 20 minute nap  
11. Meditate  
12. Do some stretches  
13. Listen to some music  
14. Eat some chocolate (or some other food you enjoy)  
15. Make yourself a nice hot cup of tea, coffee or soup

*Note. Copied from Suttle, n.d.*

Effective self-care during the working day, however, requires much more than activities that distract a provider from distressing feelings. Van Dernoot Lipsky (2009) described ways for caregivers of trauma providers to think through their needs for self-care in a model derived from many of the world’s religious traditions. Quenk (2002) explored the dynamics of stress from the perspective of Jungian personality theory and the Myers-Briggs Type Indicator. Quenk’s book was not related directly to trauma work but explored how different stressors trigger different personality types, who express their stress in
different ways and resolve their stress through different remedies. Miller and Sprang (2017) approached daily stress reduction from the perspective of current SSPs having to do with trauma, particularly practices relating to mindfulness and the creation of a trauma narrative. They convincingly argue that caregivers should employ in their self-care the same techniques that are known to be effective with many survivors of trauma.

**Personal counseling and psychotherapy.** Caregivers who work with trauma survivors very commonly find themselves with feelings they have never had before or have never had so intensely. Or they find themselves thinking of or wishing for or obsessing about or doing things that they have never thought about or wanted or done in the past. Sometimes caregivers remember things that they had forgotten. Sometimes they realize how capable they are of cruelty and abuse. In such times therapists need therapy for themselves. Not just training, not just an experience of therapy as might be expected in a training program, not just supervision, not just consultation—but long and protracted conversations with trusted others about their secrets, sicknesses, weaknesses, and failings. To be present with their clients in the depths of their suffering, therapists must attend to whatever arises in their own hearts and minds as they listen to their clients. In other words, therapy for a client is always as deep as the therapist can has gone in his or her own therapy.

Many (perhaps most) counselors would profit from an experience of therapy even if they never deal with trauma survivors. Galek and colleagues noted that caregivers:

> were often interpersonally sensitive children who learned to adapt to and in many cases meet the expressed and unexpressed basic needs of their parents, thereby satisfying the parents' needs that remained unaddressed from their childhood years . . . . In the process of meeting their parents' needs, however, the children's own needs remain unidentified and unmet. The outcome of this process is a tendency for helpers to repeat their childhood pattern of behavior in which they maintain their sense of self-esteem and self-worth by satisfying the needs of others.

(Galek, Flannelly, Greene, & Kudler, 2011, p. 635)

Observations in a study of ethics and self-care among psychologists doubtless apply equally well to other providers of mental health services:

> Factors such as cultural marginalization, psychological mindedness, and the experience of childhood pain tend to emerge in the personal histories of psychologists who choose to become
psychotherapists. These factors can be a source of great strength and compassion but also of vulnerability.

This study goes on to say:

In a survey of psychologists . . . , one third of respondents reported that they had experienced anxiety or depression and more than 40% reported episodes of emotional exhaustion during the previous year. In a subsequent study . . . , practicing psychologists reported greater anxiety, depression, and emotional exhaustion than did research psychologists but also a more positive influence from their work. In a classic article, the majority of psychotherapists admitted to instances of working when too distressed to be effective and that nearly all of those surveyed acknowledged that doing so is unethical . . . .

(Wise, Hersch, & Gibson, 2012, p. 489)

The foregoing mention of “childhood pain” points to the fact that many caregivers have themselves survived trauma. Since as many as 60% of the American people have experienced trauma during their lives (Cook, Rehman, Bufka, Dinnen, & Courtois, 2011, p. 253), this is not surprising. One study of nearly 3,000 professional women found that 1,452 of them reported one or more of these childhood events: physical abuse, sexual molestation, parental alcoholism, a parent hospitalized for mental illness, or the death of a parent or sibling. In every category, the percentage of female mental health professionals who had experienced the event was greater than the percentage of other female professionals who had experienced it. The findings of this study are presented in Table 3 (on page 35). Van Dernoot Lipsky calls coming to terms with one’s own history of trauma “trauma mastery.” She says:

If we are conscious that we are seeking trauma mastery, and if we navigate with insight, mindfulness, and honesty, this mechanism may contribute to our healing. More often, though, our attempts at trauma mastery lack awareness and intention. We act reflexively, attempting to salvage some sense of control. We can end up reinforcing feelings of being overwhelmed or lacking power—at its extreme, unconscious trauma mastery may even increase our risk of physical harm or exposure to dangerous situations.

(van Dernoot Lipsky, 2009, p. 156)

Van Dernoot Lipsky later adds:

We often see trauma mastery in our choice of work and careers. This dynamic is one of the reasons why people stay in “helping professions,” for example, even when they foresee a career of low-paying, difficult, and poorly resourced work. Some people feel driven to work in a field that is connected to an earlier trauma in their life; consciously or not, they intend to master the haunting echoes from a previous time. . . . Someone reviewing incoming master of social work applications once told me that every single personal essay she had read to date cited a traumatic history as a primary factor in the applicant’s decision to attend social work school.

(van Dernoot Lipsky, 2009, p. 158)
Existential and spiritual issues. Since ancient times writers have depicted the impact of trauma upon a person’s spirituality and sense of value in life. Less obvious, but no less painful, is the impact of the traumas that clients have experienced upon their therapists’ spirituality and sense of value in life. Fischman explains:

Traumatic experiences, including those resulting from human rights abuses, frequently generate questions relating to their meaning ("Why has this occurred?") or to personal fate ("Why me?"). As a result, the meaning of life and death, the role of God and religion, and other existential questions can become central to the therapy process.

As therapy proceeds, patients address such questions over and over, and clinicians may begin to struggle with similar issues. Coming in contact with the atrocities experienced by these patients can elicit feelings of grief, horror, or rage, as well as existential concerns for which there are no simple answers.

(Fischman, 1998, p. 33)

This existential process recurs in many professions dealing with trauma. Fischman was writing about working with survivors of torture. Others have written about nurses dealing constantly with cancer (Ekedahl & Wengström, 2007) and social workers dealing with trauma of all kinds (Dombo & Gray, 2013). Sikka, Morath, and Leape (2015) claim that most people working in healthcare experience a lack of joy and meaning in their work and they relate these existential struggles to several dimensions of burnout.

Table 3

Childhood Trauma Differences Between Mental Health Professional Women and Other Women

<table>
<thead>
<tr>
<th>Childhood trauma</th>
<th>n</th>
<th>Mental health professionals</th>
<th>Other professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any trauma</td>
<td>1,452</td>
<td>66.4%</td>
<td>48.8%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>200</td>
<td>13.8%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Sexual molestation</td>
<td>918</td>
<td>43.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Parental alcoholism</td>
<td>496</td>
<td>21.9%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Hospitalization of parent for a mental illness</td>
<td>167</td>
<td>8.1%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Death of a parent or sibling</td>
<td>237</td>
<td>11.4%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Note. Adapted from Elliott & Guy, 1993, p. 85.
After they have lost it, people return to a sense that life is worth living through various means, some explicitly religious, others not connected to a religious tradition. Dombo and Gray (2013, p. 95) say that “spiritual practice can be spiritual reading, attending religious services, meditation, prayer, or anything that helps the [caregiver] to find meaning beyond self, meaning in relationships, and meaning in clinical practice,” but Dombo and Gray are especially fond of meditation, particularly in several Buddhist forms. These forms of meditation, however, will meet the needs of introverted people, especially those who like to discover patterns in their inner worlds; other forms of spiritual practice are more appealing to other personality styles (Richardson, 1996). Some research stresses that religion as such is not necessarily helpful in reducing the consequences of client trauma on caregivers (Hardiman & Simmonds, 2013).

Recommended policies

When a program or agency sincerely endeavors to help trauma survivors through psychotherapeutic means, that program or agency must take care of its caregivers in ways that enhance their ability to do the work they have been asked to do. The needs of the caregivers for the purpose of working with trauma survivors, as described in the foregoing section of this paper, imply the policies that their programs or agencies should enact. This paper’s recommendations for policies are summarized in Table 4 on pages 37 and 38. This section of the paper explains the items in that table in more detail.

Adequacy and safety of the work environment

The work environment for caregivers should meet all local, state, and federal legal requirements for health and safety. Professional associations and international organizations may recommend even stricter requirements. Policy should explicitly permit and encourage employees to have and display belongings that have personal emotional significance and the effect of encouraging employees in their work. Only in that context should restrictions be stated. For example, pictures of one’s children should not be permitted in prisons and mental health facilities, as some clients might see the pictures and then try to find and hurt the children—but this restriction should be noted within a more general statement inviting employees to have reminders of their families in their workspace. Facilities should have employee space away from places accessible to clients. Facilities should also have silent spaces for prayer and meditation.
### Table 4

**Checklist of Recommended Policies**

Agencies should meet all local, state, and federal legal requirements for health and safety.

Agencies should encourage employees to have and display items of personal emotional significance, with exceptions clearly stated.

Agencies should have spaces for providers away from spaces accessible to clients.

Agencies should have silent spaces for prayer or meditation.

Agencies should have comforting, soothing, and aesthetically-pleasing environments.

Agencies should adhere strictly to legal requirements regarding credentialing of caregivers.

Agencies should provide incentives for caregivers to be trained in statistically-supported practices and certifications in trauma work.

Agencies should ensure that providers have diversity of clientele, including clients who have and have not survived trauma or clients with and without other complicating conditions.

Agencies should adhere to all state requirements for clinical supervision for caregivers achieving credentials.

Agencies should enable ongoing supervision and consultation for all providers.

Agencies should sponsor regular team building events for caregivers.

Agencies should articulate the breadth of autonomy expected for caregivers.

Agencies should involve caregivers in decision- and policy-making as much as possible.

Agencies should require vacations and provide incentives for caregivers to take vacations frequently.

Agencies devoted primarily to care for trauma survivors should have adequate staff for direct-care providers when all staff are present and working.

Agencies should discourage providers from working more than standard expected hours and enact procedures for compensatory time.

Agencies should schedule and provide incentives for some resilience-building activities for providers as part of the work day.

Agencies should have high quality insurance coverage for employees seeking mental health care.

Agencies should provide employee assistance programs or more specialized therapeutic consultations or both for employees.

Agencies should develop authentic vision and mission statements, statements of values, and codes of ethics that manifest serious reflection about existential and spiritual issues.
Agencies should employ chaplains or pastoral counselors to assist both staff and clients with existential and spiritual issues.

These silent spaces may be sanctuaries for particular religious traditions, but may also be rooms that could be made appropriate for several religious traditions. Silent spaces should not, however, be used for other purposes; the space should be associated with memories of serious reflection and conscious spirituality, not with meetings of other kinds. The furniture and appearance of facilities should be comforting and soothing, avoiding an industrial, machine-like, and unnecessarily technological appearance. The work environment should be beautiful in accordance with generally recognized aesthetic principles. Carr provides a succinct summary of the many qualities to be desired in psychiatric facilities (Carr, 2017).

**Training related to trauma**

Agencies should strictly adhere to state requirements for training for psychotherapists and other professionals involved in caring for trauma survivors, but all such professionals will need further training in order to do their jobs well. All direct providers should be trained in SSPs. Providers should identify the theory of therapy to which they subscribe and be trained first in SSPs that derive from or are congruent with their chosen theory. Agencies may provide such trainings at their own expense, but because of inevitable turnover in the work force, they may attain higher numbers of providers certified in SSPs if they provide incentives to individual employees to obtain and maintain these certifications (Carise, 2012). Agencies may wish to use similar incentives to motivate providers to obtain a certification in trauma studies, such as the certificate offered by the Trauma Center at the Justice Resource Institute in Brookline, Massachusetts (The Trauma Center, 2007). SSPs, however, may be more immediately practical to employers than certificates in trauma studies because funding sources are demanding them increasingly often and, when caregivers apply them to themselves, they have more immediate benefit to the caregivers.

**Diversity of caseload**

Providers may obtain diversity of caseload in at least three ways. First, most psychotherapeutic agencies offer services for people with many kinds of issues and not strictly for trauma survivors. These agencies may make it policy for caregivers to work with people with a diversity of problems, including
some clients who have survived trauma and others who have not experienced trauma. Agencies may also make it policy for caregivers who work with trauma survivors to work with survivors with differing levels of severity, for example, some who experienced only physical abuse along with others who experienced physical abuse and another ACE or two. Second, some psychotherapeutic agencies offer services for people with particular issues, such as developmental disabilities or addictions. These agencies may enact the same policies as agencies providing more general services: Caregivers should work with some people with trauma, others without, and perhaps with differing degrees of severity. Third, some agencies work entirely or primarily with people who have survived trauma. Diversity of caseload for these providers implies diversity of complicating conditions; not all of their clients should have developmental disabilities, addictions, or personality disorders.

Adequacy of clinical supervision
Psychotherapeutic agencies must follow all state regulations regarding supervision. These laws typically do not require ongoing supervision for fully licensed providers, but if providers are working with trauma survivors, policy should require some amount of ongoing supervision. Policy should require that relatively inexperienced counselors (which is to say, all counselors still working on their academic degrees, all counselors still working on full licensure, and all counselors whatsoever with fewer than five years of experience with trauma survivors) receive formal clinical supervision from providers who are experienced in trauma work. Whenever possible, the roles of administrative supervision and clinical supervision should be separated: The clinical supervisor should have the objectivity to consider the needs of the clinician and the client and not be biased because of concerns for the employer. Agencies should provide in-house supervision or contract with external clinical supervisors as an expected business expense.

Emotional support from colleagues
Because informal supervision and peer support are highly spontaneous, creating policy to support them is difficult. Agencies should have the policy and practice, however, of regular team-building events for their providers. Even occasional meals and employee recognitions are of value, but more benefit will be gained from frequent discussions of the needs and problems of the clients and the emotional toll that they take on the providers. Some agencies may wish to create a system of peer coaching, in which
providers assist and encourage one another regularly. Agencies that develop peer coaching, however, should ensure that providers do not use or see coaching as a substitute for formal clinical supervision.

**Autonomy in decision-making**

Policy regarding the autonomy of caregivers may prove to be the most problematic of all areas of policy regarding trauma services. On the one hand, people fiercely disagree about philosophical issues: How much may a community limit individual liberty? How much authority should individuals have at different hierarchical levels of an organization? May people with authority make decisions in the best interest of others (and especially when the others disagree with the decisions of the people with authority)?

On the other hand, even when people say that adhere to a particular philosophical position, they may not follow it in practice. So, for example, a manager may say that she always considers the opinions and preferences of her employees. But she may, in fact, seldom consult with them about her decisions and, even if she does, she never changes her mind after a conversation with them. In other words, she is strictly authoritarian, even if she presents herself as quasi-democratic.

Resolving these philosophical questions and addressing the moral consistency with which people follow their own principles is beyond the scope of this paper. This paper does recommend, however, that all agencies and institutions do everything in their power to discuss and clarify these issues, reviewing them with great seriousness at frequent intervals. Wrestling with issues of autonomy, community, authority, and the responsibilities of those in authority should be evident in the vision and mission statements, values statements, codes of ethics, and formal policies and procedures of any agency or institution delivering services to trauma survivors. At best, doing so provides another resource for the caregivers and contributes to the likelihood of their success. At worst, failing to address these issues honestly and consistently contributes to the likelihood that an agency will bring even more trauma into the lives of its clients, thus violating the ancient moral maxim, "First, to do no harm."

At the very least, policy should grant clinicians as much self-determination as possible regarding who is admitted to treatment and who is on their caseload. Administrators should involve the entire team in decision-making as often and as deeply as possible. Authoritarian and anonymous decision-making should be avoided. But doing the very least reflects a lack of serious commitment to care for trauma survivors.
The full democratic model proposed by Bloom (2013) may not be practical for all agencies or institutions—but it is not impossible.

**Self-care**

**Vacation.** Mandatory vacation should be policy for all agencies providing services for trauma survivors. This policy is essential both to protect the health of highly conscientious providers and to prevent agencies from structuring themselves in such a way that constant overwork is standard operating procedure. Agencies should establish rewards or incentives for multiple short vacations during a year. Agencies should build flexibility into their schedules. Agencies should have frequent trainings on self-care and stress management. Agencies should strictly separate work from vacation; agencies should encourage providers not to check emails or take work-related calls when they are on vacation. Agencies should avoid distinguishing between vacation days, sick days, and other categories. Paid time off should be generous and no explanations for it should be required. Employees should be able to use paid time off for sickness, family needs, “mental health days,” and religious observances at their own discretion. Employers should not attempt to judge the validity of their employees’ requested absences; they should be concerned simply to meet the staffing needs of the agency and to treat all of their employees fairly.

Further research may clarify the number of hours that providers may healthily work in a week. Until such research is in hand, policy regarding the workweek should focus on preventing providers from frequently working more than standard hours, ensuring that workload assignments are not overloading providers, aggressive hiring to prevent staffing gaps, and balancing these concerns with financial realism. Agencies should explore the options for compensatory time off for providers who work extra hours.

**Stress reduction during the workday.** To a great extent, individual providers will do this for themselves as need arises. They will know when and how to take breaks and, if they have been trained in SSPs regarding care for traumatized people, they will know effective ways to reduce trauma-related stress in the course of the day. Nonetheless, policy should explicitly support not only these individual practices, but enable providers to engage in stress-reducing activities as part of the working day. An agency might, for example, have incentives for participating in physical exercise or yoga one or two days
a week during the workday. If such activities are not built into the busy workdays of most providers, other priorities will almost certainly push them out of mind and they will not happen at all.

**Personal counseling and psychotherapy.** Agencies that care for trauma survivors should provide insurance plans with extremely generous provision for mental health services for all their employees. Agencies should provide employee assistance programs with local providers (not merely telephone or video consults). Because of the depth and complexity of trauma, agencies may need to contract with additional mental health services in their local area. Therapy for a therapist is inherently challenging, especially when dealing the countertransferential issues that arise from work with trauma survivors; extreme care should be taken that the resources provided are actually helpful to the caregivers being served.

**Existential and spiritual issues.** The most important policy regarding spiritual and existential issues is that spiritual and existential issues will actually be considered in the running of the agency, even and perhaps especially when it has no religious affiliation. Agencies and institutions should ask the harder questions: What are we here for? What gives meaning and value to our work? What do we really believe about human existence, freedom, community, and purpose (the four great existential questions in Yalom, 1980)?

The first fruits of this kind of reflection should be an organizational code of ethics and a statement of values. Organizations often have statements of values and generally have vision and mission statements. Whether employees actually know the contents of those statements and actively employ them in decision-making is another question. The individual practitioners within organizations already have codes of ethics undergirding their professional practices, such as the codes of the American Psychiatric Association (2013) and the American Counseling Association (2014). But few organizational codes of ethics appear to exist. The National Association of Addiction Treatment Providers has adopted both a brief code of ethics (2016a) and a brief statement of values (2016b) that may serve as beginning points for the framing of such codes and statements in future. Authentic organizational codes of ethics should be prefatory to and enshrined in the written policies of agencies. These codes should exceed the minimal
ethical requirements articulated in state and federal law and regulations. Employees in caregiving organizations should use these codes in reasoning out the policies and procedures of the organization and consistently follow them. Such codes will necessarily, not coincidentally, also be congruent with the quality of vision statements called for in the management literature (Melum & Sinioris, 1992).

Agencies may also address existential and spiritual issues in more direct ways. Policy should encourage groups to meet for prayer or meditation, perhaps specifying preferred times for them. Many psychotherapeutic agencies should include fee-based pastoral counselors or professional chaplains on their staff. Among other functions, as the whitepaper edited by VandeCreek and Burton explains (2001), they could provide supervision and consultation (formal or informal) regarding existential and spiritual issues for both staff and clients. Spiritual care is not a subspecialty within psychotherapy; like medicine, it is a separate discipline and practice, outside the competence of most psychotherapists. But those who provide care for trauma survivors, and the trauma survivors themselves, need spiritual care as well as psychotherapy and medical care.

**Implementation of the recommended policies**

This paper has focused on the needs of psychotherapists working with trauma survivors and the policies that agencies that employ or regulate the work of psychotherapists should adopt to support them in their work. Because of the broad prevalence of trauma, all agencies that employ psychotherapists should strive to enact all of the policies listed in the foregoing section. Psychotherapists are obviously not, however, the only people who work with trauma survivors. Caregivers in other professions, such as medicine, nursing, public health, and the pastoral ministry, may also experience compassion fatigue from working with traumatized people and may also need policies to support resilience in their work.

Not all of the policies recommended here for psychotherapists will be relevant for all caregiving agencies. Just as a family physician’s office does not need to be equipped to perform any and all kinds of surgery, so do many caregiving agencies not need to be prepared to provide the most intense and time-consuming therapies for the most deeply traumatized people. But a family physician’s office does need to recognize a need for surgery when a patient presents it; a family physician needs to be able to
apply bandages and keep patients alive till they can get to a better-equipped hospital or emergency center; the physicians and physicians assistants and nurses need to be able to look at blood and broken bones and continue working. In the same way, caregivers other than psychotherapists need to recognize trauma when a patient presents it; they need to know how to refer patients to the help they need and how to motivate them to get it; they need to be able to hear stories of abuse, neglect, and war and still be able to work.

Furthermore, not all of the policies recommended here for psychotherapists will be relevant for all caregiving agencies—or even for all psychotherapeutic agencies. When an agency inhabits an old and dilapidated building, making it comfortable and beautiful may not be possible. When a community has therapists who constantly refer clients to an agency, that agency will probably not be able to make a contract with local providers to help their helpers. Only hospitals and other residential facilities are likely to need a space specifically devoted to prayer or meditation.

Three brief examples, presented here in a case study format, illustrate how caregiving in settings not primarily committed to mental health may implement relevant and possible policies from the checklist of recommended policies.

First, a local health department in a county that has lost its major industries: The clinics of this local health department saw a high proportion of patients who have experienced ACEs. Some of these patients came to trust their doctors and nurses in the health department and told at least some of their stories to them. Upon review of the checklist of recommended policies, the leaders of this local health department

---

2 The ethical issue here turns on the principle, “Ought implies can.” The maxim means that what a person or agency ought to do is something that the person can in fact do. Many writers attribute this maxim to Immanuel Kant. Kant did refer to the principle in many passages in his works. Stern (2004) quotes the most important of these passages in a philosophical analysis of them. But in his essay “Toward Perpetual Peace,” Kant uses the Latin sentence, Ultra posse nemo obligatur (quoted in Stern, 2004, p. 56), meaning, “Beyond what is possible no one is obligated.” By using this sentence Kant showed that he was indebted to an older tradition of law and ethics. This Latin maxim and several equivalents are listed in Bretzke (2013, p. 152). J. T. Bretzke noted that these maxims appear in medieval theological and ethical writings and may have much more ancient origins, but finding original written sources is extremely difficult (personal communication, November 6, 2017).
found that it already followed most of them. They decided that being trained in statistically-supported practices for psychotherapy with trauma survivors was not relevant for most of their clinicians and they were not able at the time to employ a psychotherapist in the clinic. But this team of leaders also decided that two policies needed further attention. First, they wanted to provide consultation for their clinicians from a therapist who specializes in trauma when patients presented issues related to trauma. Second, they wanted to establish an employee-assistance program that could assist all staff members in dealing with countertransferences related to trauma (in addition to the concerns that employee-assistance programs typically address, such as substance use, marital issues, and other personal matters that may affect the productivity of workers).

Second, a disaster response team in a part of the country prone to tornadoes: This community had already spent much time, energy, and money to prepare for and respond to its frequent inclement weather. The leaders of the local disaster response team, which comprised representatives from public health, ambulance services, law enforcement, local fire departments, and social services, reviewed the list of recommended policies. Several they found minimally relevant to immediate disaster response: having items of emotional significance at work, having spaces away from clients (though they liked to have a staff room in an emergency shelter), spaces for prayer or meditation (local churches and other places of worship provided that), having comforting environments (emergency shelters were gyms or churches or other makeshift accommodations). Some policies, such as those having to do with vacation, insurance, and employee-assistance programs, were within the purview of separate employers, but not the disaster response team itself. But this disaster response team remembered very well the year that a tornado hit a school with children in it, killing 24 children and three teachers. The event rocked the community. Local prevalence of suicide, divorce, and substance use increased after it. The team decided that two of the policies needed strengthening. They wanted to make sure that trained therapists were available to consult with the lay disaster response workers and they wanted to make sure that local clergy were well prepared to deal with the existential and spiritual issues that arise after a seemingly meaningless loss of life. The team arranged for local hospital chaplains to train local clergy and interested church members about these issues.
Third, a family practice office in a very sparsely populated rural community: This family physician was committed to best practices and hired a well-qualified therapist to work in the office with him. The therapist was already well trained, had a few certifications in SSPs, including a couple recommended for trauma survivors. This family practice already followed most of recommended policies, but the physician and therapist were very concerned about three of them. First, this therapist wished to receive ongoing supervision to ensure quality of care (not for licensure purposes), but no qualified clinical supervisor lived nearby. Furthermore, the therapist would have plenty of emotional support from other people in the family practice office, but she would not be able to “talk shop” about therapy with them. Second, making matters even worse, the little town had only one other counselor living in it and the recently hired therapist in the physician’s office knew instantly that she would never get along with him. The physician and the therapist addressed these matters by ensuring that the therapist would take a day away from the office every month to meet with an out-of-town supervisor or attend regional counselor peer support meetings or both. Third, even though trainings in SSPs specifically related to trauma would not be practical for most of the staff in this family practice, the newly hired counselor would provide quarterly trainings related to trauma and other mental health issues that the clinic staff typically faced.

In most agencies that provide care for trauma survivors, some policies will not be relevant, some will not be possible, and some will need serious attention. In all settings the prevention of compassion fatigue and the promotion of resilience require that whatever can be done, should be done. Whenever agencies cannot follow some of the policies, those agencies should compensate for those deficits as much as possible by more assertively observing the policies they can follow. To any objection having to do with relevance and possibility, moreover, a further question should be raised: Is this a genuine objection? Is a particular policy really not relevant to a particular service? Is this agency really unable to enact a particular policy? As a widely quoted saying has it, “Every system is perfectly designed to get the results it gets.”\(^3\) That logic forces the question: What results does a healthcare agency or institution actually

\(^3\) Many writers and speakers attribute this saying to W. Edwards Deming, but Arthur Jones was more likely the person who first said it (W. Edwards Deming Institute, 2017).
achieve? Every agency or institution providing healthcare should be able to show that its clients are better off for having received its services. But that is never the only result of an agency’s existence. Every agency also provides jobs for its employees, an assurance to the local community that it is doing something to address the health problems of the community, and, in for-profit enterprises, profits for its owners. When an agency or institution says that a particular way of caring for its caregivers is not relevant or practical to its mission, the question is always worth asking: Is this really a problem of relevance or possibility—or do the leaders of this organization value some other result more highly than the health of its clients and its caregivers?

Conclusion

Work, reflection, and scientific study have disclosed the things that make for resilience, the things that help those who work with survivors of trauma to stay in their vocation and do it well: A place of work that is safe for all, soothing to the heart, uplifting to the eye; the knowledge and wisdom of others who have worked with wounded people and the skillful means to help the greatest number of them; a respite in their work, not laboring all the time with the most demanding of people; guidance, support, and insight from those who direct their work and colleagues with whom they work; the ability to make decisions for themselves, not always being bound to the dictates of others; time away from work for rest and play, enough to restore body and mind; practicing for themselves the same skillful means that help their wounded neighbors find health; confronting the wounds that they suffered themselves, most especially those forgotten wounds that come to mind when listening to others; returning to the sources of their strength, facing again and again the great questions of life, death, and destiny, and rediscovering beauty, meaning, and faith.

Those who help others can often obtain for themselves the things that they need to remain in their work. But the places where these helpers work, and the larger institutions of finance, regulation, and law that shape their vocation, sometimes enable and sometimes encumber that vocation. When they are sincerely committed to helping people heal their wounds, these employers and institutions enact policies
that help, and do not hinder, the helpers. The experience and science of the past few decades lead to this study’s beginning list of 21 policies to this end.

As explained in the introduction of this paper, the goal for providers is that they have “enough understanding, calmness, and strength” to face the suffering of the world and do their work. The goal the providers wish for those who have survived trauma is that the survivors, too, will have “enough understanding, calmness, and strength” to live as healthily as possible. And now another goal appears: that the leaders of agencies and institutions that employ and regulate caregivers will also have “enough understanding, calmness, and strength” to lead with integrity. As the Shakyamuni Buddha said centuries ago:

This is not an impossible ideal, but something which can be actually realized. When a politician possesses enough understanding and love, he sees the truth about poverty, misery, and oppression. Such a person can find the means to reform the government in order to reduce the gap between rich and poor and cease the use of force against others.

(As paraphrased in Hanh, 1991, p. 247)
References


Farber, B. A. (2017). The typically hidden but surprisingly widespread phenomenon of "informal supervision." PowerPoint presentation at the 13th Annual Interdisciplinary Conference on Clinical Supervision, Garden City, NY.


