

Effects of Trauma^{*}

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Synopsis

This packet is intended to give you some information and resources related to the effects of trauma on survivors. We will detail some potential physical, emotional, cognitive and social reaction to single and/or cumulative trauma. We will also talk about the diagnosis of Post-Traumatic Stress Disorder (although you will not be expected or encouraged to diagnose anyone).

In addition, you will learn about coping skills and how to best support survivors by meeting them where they are at and aiding in their healing process. Finally, we will discuss vicarious trauma and the very real ways that this work affects us all. In this vein, we will end with a conversation on the importance of self care when doing work with trauma survivors.

“Trauma is not a disorder but a reaction to a kind of wound. It is a reaction to profoundly injurious events and situations in the real world and, indeed, to a world in which people are routinely wounded.”

“Trauma is a concrete physical, cognitive, affective, and spiritual response by individual and communities to events and situations that are objectively traumatizing. On a simpler level, for the most part, people feel traumatized or wounded because they *have been* wounded.” – Dr. Bonnie Burstow, Feminist Therapist

* Special thanks to Lyndi Burton for compiling much of the information found in this packet.

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About Trauma

This page briefly summarizes some of what we know about traumatic symptoms and responses, and includes links describing PTSD symptoms and coping strategies. Other links lead to more research-oriented issues, such as measuring treatment efficacy, etc.

Succeeding pages at this site provide additional links to more detailed references, online articles, and web resources helpful in understanding trauma responses and treatment.

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Traumatic experiences shake the foundations of our beliefs about safety, and shatter our assumptions of trust.

Because they are so far outside what we would expect, these events provoke reactions that feel strange and "crazy". Perhaps the most helpful thing I can say here is that even though these reactions are unusual and disturbing, they are typical and expectable. By and large, these are normal responses to abnormal events.

Trauma symptoms are probably adaptive, and originally evolved to help us recognize and avoid other dangerous situations quickly -- before it was too late. Sometimes these symptoms resolve within a few days or weeks of a disturbing experience: Not everyone who experiences a traumatic event will develop PTSD. It is when many symptoms persist for weeks or months, or when they are extreme, that professional help may be indicated. On the other hand, if symptoms persist for several months without treatment, then avoidance can become the best available method to cope with the trauma -- and this strategy interferes with seeking professional help. Postponing needed intervention for a year or more, and allowing avoidance defenses to develop, could make this work much more difficult.

We create meaning out of the context in which events occur. Consequently, there is always a strong subjective component in people's responses to traumatic events. This can be seen most clearly in disasters, where a broad cross-section of the population is exposed to objectively the same traumatic experience. Some of the individual differences in susceptibility to PTSD following trauma probably stem from temperament, others from prior history and its effect on this subjectivity.

Traumatic experiences shake the foundations of our beliefs about safety, and shatter our assumptions of trust

In the "purest" sense, trauma involves exposure to a life-threatening experience. This fits with its phylogenetic roots in life-or-death issues of survival, and with the involvement of older brain structures (e.g., reptilian or **limbic system**) in responses to stress and terror. Yet, many individuals exposed to violations by people or institutions they must depend on or trust also show PTSD-like symptoms -- even if their abuse was not directly life-threatening. Although the mechanisms of this

connection to traumatic symptoms are not well understood, it appears that betrayal by someone on whom you depend for survival (as a child on a parent) may produce consequences similar to those from more obviously life-threatening traumas. Examples include some physically or sexually abused children as well as Vietnam veterans, but **monkeys also show a sense of fairness**, so our sensitivity to betrayal may not be limited to humans. Experience of **betrayal trauma** may increase the likelihood of psychogenic amnesia, as compared to fear-based trauma. Forgetting may help maintain necessary attachments (e.g., during childhood), improving chances for survival; if so, this has far-reaching theoretical implications for psychological research. Of course, some traumas include elements of betrayal and fear; perhaps all involve

feelings of helplessness.

PTSD Symptoms



Post-traumatic Stress Disorder (PTSD) is the most common diagnostic category used to describe symptoms arising from emotionally traumatic experience(s). This disorder presumes that the person experienced a traumatic event involving actual or threatened death or injury to themselves or others -- and where they felt fear, helplessness or horror. Three additional symptom clusters, if they persist for more than a month after the traumatic event and cause clinically significant distress or impairment, make up the diagnostic criteria.

The three main symptom clusters in PTSD are: Intrusions, such as flashbacks or nightmares, where the traumatic event is re-experienced. Avoidance, when the person tries to reduce exposure to people or things that might bring on their intrusive symptoms. And Hyperarousal, meaning physiologic signs of increased arousal, such as hyper vigilance or increased startle response. The actual symptoms used in the United States are described in the Diagnostic and Statistical Manual of Mental Disorders, or DSM. The most current version of the DSM is the Fourth Edition, Text Revision (DSM-IV-TR), published in June 2000 by the American Psychiatric Association (**DSM-IV-TR; 2000**). The **DSM-V** is not expected to appear until 2011, or later. Similar symptoms (from the 1994 edition, DSM-IV) are **summarized here** and **here**. Coding issues and changes in the DSM-IV-TR version are described **here**. If a traumatic event occurred recently, then an individual might suffer from **Acute Stress Disorder**, which involves symptoms similar to PTSD but without the one month duration requirement. An alternative classification system, the World Health Organization's International Classification of Diseases, or ICD-10, uses a comparable but somewhat different **symptom summary**.

Trauma symptoms are probably adaptive, and originally evolved to help us recognize and avoid dangerous situations

PTSD is officially classed as an anxiety disorder, but some have argued that it fits more closely with the dissociative disorders, and others feel it belongs by itself. There has also been discussion over differential diagnoses for simple vs. chronic traumatic histories (such as Complex PTSD, or the proposed DESNOS diagnosis: for Disorders of Extreme Stress, Not Otherwise Specified). Recent work suggests that DESNOS may be more frequent among individuals whose subsequent adult traumas complicate chronic or unresolved childhood traumatic experiences, and that DESNOS has important implications for treatment. The proposed DESNOS disorder (not yet contained in the DSM) is discussed in articles by Bessel van der Kolk, Julian Ford, and others on the **Articles Page** at this site. Classification issues such as these will probably continue through field trials for the DSM-V (scheduled to be released in 2007).

While PTSD is the "prototypical" traumatic disorder, some people -- or some stressors -- present variations on this theme. Depression, Anxiety, and Dissociation are three other disorders that may sometimes arise after traumatic experiences, but Somatoform disorders -- and even hypertension -- can be seen in some populations. The differences may result from how the particular individual deals with or expresses their stress, probably influenced by the individual's subjective interpretation of the stress as well. Individual differences affect both the severity and the type of symptoms experienced.

Dissociation

Almost everyone dissociates to some degree, as **this illusion** illustrates. Dissociation is a fairly normal coping strategy in the face of overwhelming stress, but extreme dissociative tendencies may be pathological. At this extreme, Dissociative Identity Disorder, or **DID** (formerly called MPD), is a condition requiring specialized **treatment**. Using Taxometric Analysis, **Niels Waller** and colleagues identified a separate 'taxon' of pathological dissociation useful in screening suspected dissociative disorders. This clinically-important probability score is calculated from a subset of items in the DES, or Dissociative Experiences Scale. Thankfully, Darryl Perry has translated the algorithm into a downloadable **MS-Excel 97 spreadsheet**, described more fully at the **ISSD** website.



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Risk Factors

The Field Glass (1963)
by Rene Magritte

As you might expect, risk for PTSD increases with exposure to trauma. In other words, chronic or multiple traumatic experiences are likely to be more difficult to overcome than most single instances. PTSD is also more likely if passive defenses, such as freezing or dissociation, are used -- rather than active defenses such as fight or flight. **Epidemiological estimates** suggest that the incidence and lifetime prevalence rates of PTSD in the general population are around 1% and 9%, respectively. But these levels increase markedly for young adults living in inner cities (23%), and for wounded combat veterans (20%). There is also evidence that **early traumatic experiences** (e.g., during childhood), especially if these are prolonged or repeated, may increase the risk of developing PTSD after traumatic exposure as an adult. This may result from state-dependent learning, where previous responses to a terrifying event are repeated even though more appropriate responses (i.e., active defenses) may now be possible.

Several animal studies have suggested the possibility of permanent physical damage (including shrinkage) in the **hippocampus** and changes in the **amygdala** when severe or chronic trauma -- and its symptoms -- persists (see especially work by Robert Sapolsky and by **Joseph LeDoux**, respectively). Unfortunately, there is no easy way to compare the relative types or degree of trauma across species. The most recent human data, including **Gilbertson et al's (2002) twin study**, suggest that response to trauma may be influenced by pre-existing individual differences in hippocampal volume. Perhaps both processes are involved.

There's no clear evidence that susceptibility to PTSD varies for members of different ethnic or minority groups (given a traumatic experience). But individual differences clearly play some role. For example, younger children have less ability to predict, avoid, make sense of, or to actively defend against, upsetting events, and more introverted or shy individuals may experience stronger emotional reactions to such experiences.

Secondary Traumatization



One additional aspect of traumatic exposure affects primarily the workers who help trauma and disaster victims. These people include psychologists and other mental health professionals, but also the emergency workers -- EMTs, physicians, fire, police, search & rescue, etc. -- exposed to an overdose of victim suffering. These professions are at-risk for secondary traumatization. Known by various names -- compassion fatigue, secondary or vicarious traumatization, and "burn out", the symptoms here are usually less severe than PTSD-like symptoms experienced by direct victims in a disaster. But they can affect the livelihoods and careers of those with considerable training and experience working with disaster and trauma survivors. Secondary trauma might also be seen in jurors, for example, or in other individuals exposed to traumatic material (e.g., journalists; news photographers). Risk for secondary trauma is not limited to professions where such exposures are commonplace. As you might expect, the risk increases when traumatic exposures are unexpected, or among those without adequate preparation.

Expect this, if you work with or are exposed to the stories of many disaster/trauma victims, and take steps to protect yourself at the first sign of trouble. Basically, there are three risk factors for secondary traumatization: 1) exposure to the stories (or images) of multiple disaster victims, 2) your empathic sensitivity to their suffering, and 3) any unresolved emotional issues that relate (affectively or symbolically) to the suffering seen.

Aside from using whatever **stress reduction** or **stress management** measures work best for you, there's little an emergency or disaster worker can do about the first two risk factors, but it does help reduce the risk for vicarious traumatization if you know your own personal vulnerabilities and unresolved upsetting issues. Those are the cases best referred to your colleagues, when possible. Beth Stamm has created a wonderful website particularly on **Secondary Traumatization** that discusses these issues in much greater detail, and Laurie Anne Pearlman has compiled a **selected bibliography** of important references in the areas of vicarious and indirect trauma.

For many exposed individuals, especially those in the at-risk professions, participation in well-run CISD (Critical Incident Stress Debriefing) groups may also help resolve upsetting experiences more quickly, as long as participation is voluntary (not mandatory). Group debriefings may be adequate for most, but brief individual sessions might be needed for 10 - 20% of those suffering the most severe exposures. In fact, one

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value of debriefing groups is to help identify those workers needing additional attention. (There are now several links to articles and references about CISD on the **Support Page**, as well as other links specifically on PTSD among police and other emergency workers.)

Coping Strategies

Several different resources give concise information about characteristic symptoms of PTSD. For example, the American Psychological Association has a short press release summarizing some **coping tips** for people who have either experienced a disaster or been traumatized. A **fact-sheet** on traumatic responses, written by Patti Levin PsyD, also provides very good general information about symptoms and some helpful things you can do about them. Finally, Lisa Beall has written an extensive **bibliographic essay** on PTSD, summarizing much literature on this disorder and some of the controversy surrounding it.

Childhood Trauma

Children, especially young ones, are apt to see things quite differently than adults; it can be very easy for a stressed-out parent to overlook or fail to recognize a child's fears about such events. If you take time to listen receptively, they'll probably tell you. Bruce Perry has given permission to make two excellent and informative booklets available here; they list clear guidelines written for adults who must work or live with **children traumatized by death** and **summarize the child's experience** of grief from a death or other loss. You will find links to many other sites specifically concerned with **childhood trauma**, on the Links page.

Miscellaneous Issues



The traumatic-stress mailing list, run by Charles Figley PhD since April 1994, has created an international forum for discussion of diverse issues related to emotional trauma. Discussions on this list were very helpful for me in building a better understanding of trauma response and healing. Some of my early posts to this list have concentrated on these topics:

- empirical evidence supporting my assertion (above) that **early traumatic experiences** can have long-term consequences,
- my response to a post asserting "**no cure for PTSD**",
- general difficulties and issues in **outcome research** with trauma populations,
- problems specific to non-self-report data (such as **biological measures**) in assessing treatment efficacy for PTSD,
- a summary of **structural equation modeling** (SEM) research regarding PTSD,
- an account of practical considerations affecting informed consent in mental health **disaster work**, and
- a summary of list members' recommendations concerning "**self-help**" **books and workbooks** for use with trauma clients.

Readings

It was difficult to summarize what we know of trauma responses, as above, without feeling superficial and overly simplistic. To counter that, this page lists **two bibliographies** I've collected on this subject; both sets of readings concentrate on research and theory, rather than on clinical issues. The easy list is shorter and fairly accessible, with lots of Scientific American-level articles concerning emotional trauma. For those who want more detailed readings, the longer list contains additional work in this field; I found these articles very important in building my understanding of the underlying mechanisms involved in emotional trauma. Use your browser to search for specific names or words in these lists. [Please feel free to send me **email comments** about these pages.]

In association with Amazon.com, a bibliography of recommended books for professionals (clinicians, teachers, researchers, librarians), clinical students, and the public (survivors and their families or friends), is available for purchase at the **Trauma Pages Bookstore** here at this website.

TRAUMA REACTIONS AND PTSD *

Most short and long term stress reactions are natural and common responses to trauma. It is interesting that it is called Post Traumatic Stress Disorder because the symptoms of PTSD are natural and common responses to trauma. Every person is unique and will cope differently and they may or may not experience typical trauma reactions.

SHORT TERM CRISIS REACTION may include the following:

- * Shock, disorientation and numbness
- * Physical symptoms (vomiting, loss of control of bodily functions, hyperventilation, increased heart rate, etc.)
- * Increased sensory perception
- * Anger or rage
- * Frustration
- * Guilt or self-blame
- * Grief or sorrow
- * fight, flight or freeze instinct
- * heightened physical arousal followed by collapse into exhaustion
- * fear or terror
- * confusion
- * shame and humiliation

Acute Stress Disorder is primarily the same symptomology of PTSD (see below) but with the possibility of disassociation and a shorter duration (2 days to 4 weeks).

TO BE DIAGNOSED WITH PTSD¹ the individual must experience an event that is outside of the usual human experience and would be markedly distressing to almost anyone (this includes domestic and sexual violence as well as child abuse among many other things). The individual must have symptoms from the three following categories that last for at least a month. The onset of these symptoms may not begin for months or years after the event.

1. **Rexperiencing:** a) recurrent and intrusive distressing recollections of the event(s) may be associated with guilt b) recurrent distressing dreams c) sudden acting or feeling as if the event(s) were reoccurring d) intense psychological distress at exposure to event or things that symbolize or resemble an aspect of the event (triggered).
2. **Avoidance and numbing:** a) deliberate efforts to avoid thoughts or feelings associated with the event b) deliberate efforts to avoid activities or situations that arouse recollections of the event c) inability to recall and important aspect of the trauma d) diminished interest in significant activities for example, hobbies, family, etc. e) feeling of detachment or estrangement from others f) restricted range of affect and feelings g) sense of a foreshortened future, may result in substance abuse, high-risk behaviors and lack of interest in goals.
3. **Persistent Hyperarousal:** a) difficulty falling or staying asleep b) irritability or outbursts of anger c) difficulty concentrating d) hypervigilance (startle reactions) e) physical reactions at exposure to things that symbolize or resemble an aspect of the traumatic event(s).

Physical Symptoms that survivors who have PTSD may experience are:

- * stomach pains, constipation and diarrhea
- * Headaches
- * Cardiovascular problems
- * Gynecological problems
- * respiratory problems
- * muscle cramps or aches
- * chronic pain with no "medical" cause
- * chronic fatigue or fibromyalgia

PTSD is an actual medical condition in which the chemicals in the brain are affected; it can be treated. As many as 1 in 13 "Americans" will get PTSD at some point in their lives. Victims of physical and sexual assault face the greatest risk for developing PTSD. women experience PTSD at much higher rates as they are more frequently targeted for domestic and sexual violence.

PTS not PTSD

Other possible conditions that may be a response to PTSD or be present in conjunction with it, making it harder to treat and diagnose are depression, self-medication with alcohol/drugs, anxiety or panic disorders.

¹ the following information is adapted from the DSM III

Complex PTSD, also known as Acute PTSD or Disorders of extreme Stress Not Otherwise Specified (DESNOS)²: is extremely relevant in discussing domestic and sexual violence as it applies to people who have survived complex, prolonged or repeated trauma in which the person has been subjected to coercive control. Such control may be imposed through violence, threat of violence; control of bodily functions, capricious enforcement of petty rules; intermittent rewards; isolation; degradation; and enforced participation. This is currently not in the DSM largely for political reasons. Also please note that this definition includes the symptoms of PTSD as well as Traumatic Bonding (the Stockholm Syndrome).

Symptomology will involve a multiplicity of symptoms (many found in PTSD):

- * Disassociation
- * Alterations of consciousness such as amnesia
- * Alterations in affect such as dysphoria, chronic suicide tendencies, self-injury, explosive or stifled anger, compulsive or stifled sexuality
- * Changes in relationships manifested by isolation, disruption of intimate relationships, distrust, failures in self-protection, searches for a rescuer
- * Alterations in self-perception manifested through helplessness, shame, defilement, and stigma
- * Alterations in belief such as loss of faith and a sense of hopelessness, despair or disgust, or adopting abuser's beliefs
- * affective change
- * transient dissociative episodes or depersonalization

Secondary Assault:³ is when long-term crisis reactions are exacerbated or mitigated by the actions of others the feelings that survivors may experience from a secondary assault are often described as "second injury." Examples may include victim blaming, feeling betrayed by the system, being judged, forcing a survivor to "forgive" exploiting of the trauma, exposure of personal events, lack of privacy, violation of boundaries, etc.

Secondary assault maybe perpetrated by the legal system, the media, family, friends, clergy, medical personnel, mental health professionals, social service workers, employers and educators, etc.

OTHER POSSIBLE LONG TERM EFFECTS OF TRAUMA:

1. **Maladaptive fear responses**: when the brain chemically adapts to a constant state of terror but then remains there even after the danger has past, resulting in a persistent state of fear that may cause hyper-vigilance, increased muscle tone, a focus on threat related cues (typically non-verbal), anxiety, impulsivity –all of which are adaptive during a threatening event but become maladaptive when the threat has ceased.⁴
2. **Difficulty expressing emotions with words and formulating flexible response strategies**: which can make some survivors of abuse prone to action, have difficulty with appropriate emotional reactions, and aggressive towards self and others. This is a reflection of actual changes in the brain that are a result of abusive or neglectful treatment.⁵
3. **Consequences of the secondary effects of the PTSD**:
 - The presence of nightmares and the sleep disturbance means that even the safety of withdrawal into unconsciousness is lost.
 - The irritability and emotional numbing mean that the relationships that are critical to the individual's sense of identity and belonging may also be threatened and undermined by the PTSD sufferer's pattern of response to his or her symptoms.
 - The disturbances of attention and concentration mean that the person is no longer able to interact with his or her current environment with the same sense of involvement. Even simple activities such as reading, conversing, and watching TV demand greater effort.⁶

² The following information is adapted from materials developed by the National Organization of Victims' Assistance.

³ *ibid.*

⁴ information given to CWS courtesy of Jean Ley, LPC, adapted from material developed by Dr. Bruce Perry

⁵ Information given to CWS by Jean Ley, LPC and Cammie Hering, LPC and adapted from *The Complexity of Adaptation to Trauma...* in *Traumatic Stress...* van der Kolk, McFarlane and Weisaeth eds. 1996

⁶ Adapted from *resilience, Vulnerability and the Course of Posttraumatic Reactions* in *Ibid.*

OTHER LONG TERM REACTIONS CONTIUNED:

4. **Traumatized Equilibrium⁷**: Individuals exist in a normal state of equilibrium. People have many ups and downs but most people can respond to stressors within their familiar range of equilibrium. Trauma throws people so far out of that range that it is difficult for them to restore a sense of a balance. Survivors of trauma will eventually develop a new equilibrium, rather than "recover" back the old one. When a survivor suffers on-going trauma they eventually modify their equilibrium to constant attack. Once this becomes their state of "normal" equilibrium, removal from that can be traumatic. For some survivors that may be one of MANY reasons why they may stay with what is known to them.

* * * * *

"It is this sense of being damaged, rather than the immediate horror of the trauma, which many victims describe as the worst aspect of their ordeal"⁸.

⁷ Information adapted from NOVA.

⁸ Excerpted from *Resilience, Vulnerability and the Course of PostTraumatic Reactions In Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society*, Edited by Bessel van der Kolk, Alexander C. McFarlane, Lars Weisaeth. 1996. Pp176-177.

Material given to CWS courtesy of L. Jean Ley, LPC.

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Common Responses to Trauma & Coping Strategies

Patti Levin, LICSW, PsyD

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After a trauma, people may go through a wide range of normal responses.

Such reactions may be experienced not only by people who experienced the trauma first-hand, but by those who have witnessed or heard about the trauma, or been involved with those immediately affected. Many reactions can be triggered by persons, places, or things associated with the trauma. Some reactions may appear totally unrelated.

Here is a list of common physical and emotional reactions to trauma, as well as a list of helpful coping strategies. These are NORMAL reactions to ABNORMAL events.

Physical Reactions

- aches and pains like headaches, backaches, stomach aches
- sudden sweating and/or heart palpitations (fluttering)
- changes in sleep patterns, appetite, interest in sex
- constipation or diarrhea
- easily startled by noises or unexpected touch
- more susceptible to colds and illnesses
- increased use of alcohol or drugs and/or overeating

Emotional Reactions

- shock and disbelief
- fear and/or anxiety
- grief, disorientation, denial
- hyper-alertness or hypervigilance
- irritability, restlessness, outbursts of anger or rage
- emotional swings -- like crying and then laughing
- worrying or ruminating -- intrusive thoughts of the trauma
- nightmares
- flashbacks -- feeling like the trauma is happening now
- feelings of helplessness, panic, feeling out of control
- increased need to control everyday experiences
- minimizing the experience
- attempts to avoid anything associated with trauma

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- tendency to isolate oneself
- feelings of detachment
- concern over burdening others with problems
- emotional numbing or restricted range of feelings
- difficulty trusting and/or feelings of betrayal
- difficulty concentrating or remembering
- feelings of self-blame and/or survivor guilt
- shame
- diminished interest in everyday activities or depression
- unpleasant past memories resurfacing
- loss of a sense of order or fairness in the world; expectation of doom and fear of the future

Helpful Coping Strategies

- mobilize a support system n reach out and connect with others, especially those who may have shared the stressful event
- talk about the traumatic experience with empathic listeners
- cry
- hard exercise like jogging, aerobics, bicycling, walking
- relaxation exercise like yoga, stretching, massage
- humor
- prayer and/or meditation; listening to relaxing guided imagery; progressive deep muscle relaxation
- hot baths
- music and art
- maintain balanced diet and sleep cycle as much as possible
- avoid over-using stimulants like caffeine, sugar, or nicotine
- commitment to something personally meaningful and important every day
- hug those you love, pets included
- eat warm turkey, boiled onions, baked potatoes, cream-based soups n these are tryptophane activators, which help you feel tired but good (like after Thanksgiving dinner)
- proactive responses toward personal and community safety n organize or do something socially active
- write about your experience n in detail, just for yourself or to share with others

People are usually surprised that reactions to trauma can last longer than they expected. It may take weeks, months, and in some cases, many years to fully regain equilibrium. Many people will get through this period with the help and support of family and friends. But sometimes friends and family may push people to "get over it" before they're ready. Let them know that such responses are not helpful for you right now, though you appreciate that they are trying to help. Many people find that individual, group, or family counseling are helpful, and in particular, EMDR (Eye Movement Desensitization and Reprocessing) is a phenomenally rapid and wonderful therapeutic method. Either way, the key word is CONNECTION n ask for help, support, understanding, and opportunities to talk.

The Chinese character for crisis is a combination of two words -- danger and opportunity. People who fully engage in recovery from trauma discover unexpected benefits. As they gradually heal their wounds, survivors find that they are also developing inner strength, compassion for others, increasing self-awareness, and often the most surprising -- a greater ability to experience joy and serenity than ever before.

Other Resources

- Dr. Patti Levin's website: <http://www.drpattilevin.com/>
- David Baldwin's Trauma Pages: www.trauma-pages.com
- The Trauma Center of Boston: www.traumacenter.org
- Eye Movement Desensitization and Reprocessing International Assoc.: www.emdria.org
- International Association for Traumatic Stress Studies: www.istss.org

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VICARIOUS

TRAUMATIZATION

EXPOSURE TO PAINFUL
ASPECTS OF A CLIENT'S
EXPERIENCE WHICH
LEADS TO POTENTIAL
ALTERATION OF BELIEFS
ABOUT SELF AND THE
WORLD

- PERVASIVE
- CUMULATIVE

What is Vicarious Trauma?

Vicarious:

Felt or undergone as if one were taking part in the experience or feelings of another

Trauma:

- 1) A serious injury or shock to the body, as from violence or an accident.
- 2) An emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neurosis.
- 3) An event or situation that causes great distress and disruption.

Those of us working to end violence against women and children are secondary witnesses to trauma almost everyday. As we listen to survivors tell us about their trauma of domestic violence, sexual assault or memories of childhood abuse, we bear witness to their victimization. We listen, we support and we validate their feelings and their experience. We offer them the opportunity to let go of some of their burden. As witnesses and supporters, we can't help but to take in some of the emotional pain they have left with us. As the survivor releases some of her pain, we take it in. By the end of the day, we've collected bits and pieces of accounts of trauma. We may have pictures in our mind or intense feelings running through our body. We've become witness to the atrocities of domestic and sexual violence.

How can we cope with vicarious trauma?

- The most important part of coping with the intensity of the work is to acknowledge that *it will affect you*.
- Recognizing that it is NORMAL to be affected by this type of work is the most important coping skill that you can give yourself.
- You're not alone. It's okay to feel outraged, horrified, shocked, saddened, or vulnerable. You can call any hotline to debrief about your experience and get support.
- Debrief with staff and volunteers who also work at your program. We're all affected by the stories we hear, and can be wonderful supporters for each other.
- Attend to basic self-care: balance work, play and rest. Adequate diet and exercise are essential.
- Work to restore meaning and hope in your life! Each individual must find ways to reconnect with whatever in life is meaningful and gives purpose for that person. Hope and meaning are two of the primary gifts that are undercut by vicarious trauma. Restoring these to life and work is the ultimate goal of addressing these difficulties.

FACTORS CONTRIBUTING TO VICARIOUS TRAUMATIZATION:

- **When the caregiver has beliefs and training which encourages stoicism and nonresponsiveness. This often leaves the professional feeling incompetent, ashamed or silenced by their emotions.**
- **Not understanding or demonstrating good boundaries at work or away from work.**
- **Personal coping strategies that work at cross purposes with what the caregiver is trying to accomplish or model. Examples include addictions, emotional numbness, excessive intellectualization, and isolation.**
- **Current stressful personal life circumstances and losses.**
- **Participating in splitting and scape-goating behaviors with colleagues and/or clients.**
- **Reluctance and/or barriers to using supervision and consultation or seeking continuing education.**
- **Not taking opportunities to take time off to rest, get distance from work, and take vacations.**

**Adapted from Transforming the Pain
(Pearlmann and Saavtika) by
Annette U Selmer, MS LPC**

WHAT TO DO

- HAVE A SUPPORT SYSTEM
- HAVE HOPE IN PEOPLES ABILITY TO CHANGE
- UNDERSTAND AND MANAGE YOUR OWN BIASES AND REACTION AND GAIN ADEQUATE SELF KNOWLEDGE.
- IDENTIFY WHICH TRIGGERS CAUSE YOU TO EXPERIENCE VICARIOUS TRAUMATIZATION.
- PRACTICE WITHIN YOUR COMPETENCY. KNOW YOUR OWN LIMITATIONS.
- GET ONGOING SUPERVISION WITH SOMEONE WHO UNDERSTANDS PTSD AND ITS TREATMENT.
- DIVERSIFY YOUR PROFESSIONAL ACTIVITIES.
- IF OVERWHELMED, BREAK TASKS INTO MANAGEABLE COMPONENTS.
- ADDRESS YOUR OWN UNRESOLVED ISSUES
- HAVE A SUPPORT SYSTEM IN AND OUT OF WORK
- HAVE BALANCE AND SEPARATE YOUR PERSONAL AND PROFESSIONAL LIFE.
- JOURNAL WRITING.
- USE RELAXATION, PHYSICAL EXERCISE, PROPER DIET, AND SLEEP.
- AVOID UNHEALTHY ISOLATION.
- DEVELOP THE ABILITY TO SEE GRAY
- ESTABLISH AND MONITOR BOUNDARIES AND LIMITS.
- USE STRATEGIES TO BE PRESENT WITH PEOPLES STORIES.
- HAVE A SENSE OF HUMOR/PLAY/LAUGH
- BE CREATIVE/ USE INTUITIONS AND EDUCATED GUESSES.
- DEVELOP PERSONAL RITUALS TO ENSURE SAFETY AND EMPOWERMENT.
- DO SOCIAL AND POLITICAL WORK FOR CHANGE
- CLARIFY ONES SENSE OF MEANING AND PURPOSE IN LIFE.
- HAVE A BELIEF SYSTEM.
- HOLD A VISION IN MIND

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The Importance of Self-Care

"There is a cost to caring. Professionals who listen to client's stories of fear, pain and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our sense of self to the clients we serve....those who have an enormous capacity for feeling and expressing empathy tend to be more at risk of compassion fatigue." - Charles Figley

Volunteering in the domestic and sexual violence movement can be very stressful. You will have the opportunity to work with many women and children who have experienced great trauma throughout their lives. They may choose to share their stories with you as a part of their healing process. Sometimes these stories can be very overwhelming, and though not apparent at the time, may cause added stress to your personal life. As a result, we have developed some tools for you to access. These are simple ideas and suggestions that often get forgotten as we move through our busy day-to-day lives.

Go for a 15-minute walk during a lunch or coffee break. Take other opportunities to be physically active.

Eat sensibly. Avoid excessive use of caffeine and alcohol. Drink plenty of water and juices.

Know and respect your limits. If you feel exhausted and need time off, take it. Respect commitment for regularly scheduled time off.

Spend time with family and friends. Talk to them. Listen to their stories. Listen to them if they become concerned with your health and well-being.

As much as possible, continue to participate in previous social and recreational activities.

Get some rest. If you have trouble sleeping, get up and do something relaxing or enjoyable.

Be on the lookout for any changes in your habits, attitudes and moods.

Share your own and clients' reactions and issues with colleagues. Don't hesitate to ask others for advice.

Include yourself on the list of people you are taking care of. Take some time to do something just for yourself every day. Taking care of yourself will put you in better shape to give care to others.

Be self-nurturing and don't forget to laugh.

Adapted from *Self-Care for Caregivers* at http://www.hc-sc.gc.ca/pphb-dgs90psp/publicat/oes-bsu-02/caregvr_e.html

Signs of Stress to be on the Alert For

Volunteers are usually alert to the stresses of people they help. They are not, however, always as alert to the stress and fatigue that can slowly and insidiously surface in their own lives. Volunteers, like everyone else, have also been affected by these events and need to be reminded of normal stresses that may affect them.

Common Physical/Behavioral Reactions: fatigue, loss of appetite, difficulty falling asleep, restlessness, headaches, changes in sleeping, increased blood pressure, changes in eating habits, increased susceptibility to colds, flu, infection, change in libido, changes in smoking habits, changes in alcohol and drug consumption

Common Emotional Reactions: feeling helpless, overwhelmed, inadequate, fragile, vulnerable, unable to cope or go on, increased mood swings, increased emotional liability, decreased motivation, feeling burned out, crying more frequently and easily, isolation, changes in communication patterns and other relationship dynamics, withdrawal

Common Cognitive Reactions: confusion, difficulty making decisions, difficulty problem solving, memory blanks, having ambiguous feelings, questioning why this happened in a world that is supposed to be safe, difficulty concentrating or paying attention

Volunteers are not immune to the above reactions and need to remind themselves that these are normal human responses to stressful circumstances. Although many of the underlying stresses cannot be prevented, you can increase your resistance by taking care of yourself and staying healthy. It is important to pace yourself and know your limits so you can continue to be available to the people you are assisting and your community.

SIGNS OF OVERSTRESS

(from Warren & Tall, 1997)

- Lack of concentration
- Memory loss
- Poor decision-making
- Worry, anxiety, or fear
- Depression
- Inconsistency
- Not meeting deadlines
- Irregular attendance & timekeeping
- Lowered self-esteem
- Ineffective problem-solving
- Lower standards accepted
- Overly critical or self-critical
- Participant complaints
- Poor long-term planning
- Lost objectives
- No sense of humor
- Confusion
- Errors or mistakes
- Regularly working late
- Taking work home
- Easily disgruntled
- Uncooperative relationships
- Poor work quality
- Emotional outbursts
- Unreasonable complaints
- Frequent criticism, gossip, backbiting
- Unpredictability
- Tiredness
- Canceling vacations
- Extreme mood swings
- Only concern shown is for self
- Accidents
- Eating difficulties
- Greater use of substances
- Difficulties with sleep
- Low interest in work
- Avoided by others
- Physical illness

SIGNS OF A HEALTHY STRESS LEVEL

(from Warren & Toll, 1997)

- *Good concentration*
- *High standard of work*
- *Cooperative behavior*
- *Effective problem-solving*
- *Deadlines met*
- *Good information flow*
- *Clear, confident decision-making*
- *Good attendance & time keeping*
- *Cheerful manner*
- *Concern and care for others*
- *High level of motivation*
- *Realistic about self, others*
- *Enhanced achievements*
- *Good long term planning*
- *Clear thinking*
- *Plenty of energy*
- *Appropriate sense of humor*
- *Strong interest in work*
- *Positive comments*
- *Constructive criticism given and received*

Advocate Self Care Plan

What are some signs that I may be getting burned out or experiencing compassion fatigue? What are some ways I can take care of myself physically? Emotionally? Spiritually?

Signs of Burnout or Compassion Fatigue	Ideas for Physical Self Care	Ideas for Emotional Self Care	Ideas for Social/Spiritual Self Care