Chapter 22

Caring for the Caregiver: Avoiding and Treating Vicarious Traumatization

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Vicarious traumatization is a term that describes the cumulative transformative effect on the helper of working with survivors of traumatic life events. The symptoms can appear much like those of posttraumatic stress disorder (PTSD), but also encompass changes in frame of reference, identity, sense of safety, ability to trust, self-esteem, intimacy, and a sense of control. The presence of vicarious traumatization has been noted in many groups of helping professionals who have close contact with people who have experienced traumatic events. Caregivers are at even higher risk if they have a history of trauma in their own backgrounds and if they extend themselves beyond the boundaries of good self-care or professional conduct.

The actual causes of vicarious traumatization have not yet been established, but this article proposes a broad view of causality that includes the biologically based notion of emotional contagion; the psychological impact of losing positive illusions; the professional prohibition against using normal social obstacles to defend against emotional contagion and the loss of positive illusions; organizational dysfunction that contributes to excessive vulnerability on the part of the caregiver; and conflicts inherent in the ideological framework of present-day caregiving. These conflicts include the desacralization of healing, the commodification of health care, shortcomings of the medical model, a bias toward individualism, and the presence of individual violence embedded within a context of cultural violence.

Individual steps can be taken to address the individual and organizational aspects of vicarious traumatization. These steps begin with a self-assessment of the presence of vicarious traumatization and an evaluation of present and possible strategies to address vicarious traumatization framed within an ecological model. Ultimately, it will be the responsibility of every caregiving and service organization to develop some "universal precautions" effective in protecting helpers against the impact of violence, even in its indirect form.

Key Point
The symptoms of vicarious traumatization resemble those of PTSD, but also encompass changes in frame of reference, identify, sense of safety, ability to trust, self-esteem, intimacy, and sense of control.

What Is It?

As a social species, human beings are sociobiologically connected to each other. Witnessing another person's suffering is so traumatic that torturers frequently force their victim to observe the torture of another in order to elicit information. It has long been recognized that emergency workers, physicians, nurses, police officers, firemen, journalists, clergy, social service workers, colleagues, family members, and other witnesses and bystanders to disasters and other trauma can experience secondary symptoms themselves.

Currently the terms that are used most frequently to describe these symptoms are secondary traumatic stress, compassion fatigue, and vicarious traumatization. Although there are some differences, these terms will be used interchangeably in this chapter. Secondary traumatic stress is defined as the natural, consequent behavior and emotions that result from knowledge about a traumatizing event experienced by another and the stress resulting from helping or wanting to help a traumatized or suffering person. The symptoms are almost identical to those of PTSD (Catherall, 1995). Compassion fatigue is described as the natural, predictable, treatable, and preventable unwanted consequence of working with suffering people (Figley, 1995). Vicarious traumatization is defined as the cumulative transformative effect on the helper of working with survivors of traumatic life events, both positive and negative (McCann & Pearlman, 1990).

There is a relationship between terms used to describe this reaction to dealing with people exposed to trauma and the more traditional terms of "burnout," and "countertransference." The more familiar term, "burnout" refers to a collection of symptoms associated with emotional exhaustion and generally attributed to increased work load and institutional stress, described by a process that includes gradual exposure to job strain, erosion of idealism, and a lack of achievement (Pines & Arenson, 1988). Burnout may then be the result of repetitive or chronic exposure to vicarious traumatization that is unrecognized and unsupported by the organizational setting. In contrast, "countertransference" is a far broader term, referring to all reactions to a client and the material he or she brings. Countertransference reactions are specific to the particular client and are tied to interactions with that client. In this case, vicarious traumatization can be seen as a specific form of countertransference experience, differentiated from other countertransference reactions in that vicarious traumatization can continue to affect our lives and our work long after interactions with the other person have ceased (Stamm, 1997).

Various authors have described the signs and symptoms of secondary traumatic stress and vicarious traumatization. Secondary traumatic stress in a helper of someone who has been traumatized closely resembles PTSD and includes symptoms of hyperarousal, emotional numbing, avoidance, and intrusive experiences. Vicarious traumatization symptoms include typical symptoms of posttraumatic stress but also encompass symptoms indicative of a disrupted frame of reference, including disruptions in identity, worldview, and spirituality, and impacts on psychological need areas.

When a person's frame of reference is disturbed, beliefs about other people and the world are affected as well as beliefs about causality and higher purpose (Rosenbloom, Pratt, & Pearlman, 1995). Caregivers may begin to see the world as a far more dangerous

place than they did before their exposure to trauma, and if the trauma has been interpersonal, they may come to see other people as malevolent and evil, untrustworthy, exploitative, or alienating. It may become increasingly difficult to retain a sense of hope and belief in the goodness of humanity.

Key Point

With disturbance of the frame of reference, beliefs about other people and the world are affected, including beliefs about causality and higher purpose. Caregivers then see the world as a far more dangerous place and may come to see other people as malevolent and evil, untrustworthy, exploitative, or alienating. Maintaining a sense of hope and belief in the goodness of humanity is progressively more difficult.

The psychological need areas that can be impacted by vicarious traumatization include safety, trust, esteem, intimacy, and control (Rosenbloom et al., 1995). A loss of a secure sense of safety can manifest as increased fearfulness, a heightened sense of personal vulnerability, excessive security concerns, behavior directed at increasing security, and increasing fear for the lives and safety of loved ones. The capacity to trust, particularly after interpersonal violence, may become so impaired that a belief develops that no one can be trusted. Likewise, trust in one's own judgment and perceptions can also be negatively altered. It may become very difficult, in the face of secondary exposure to traumatic events, to maintain a sense of self-esteem, particularly around areas of competence. It also may be increasingly difficult to maintain a sense of esteem about others, leading to a pervasive suspiciousness of other people's motivations and behavior. Problems with intimacy may develop, leading to difficulties in spending time alone; self-medication with food, alcohol, or drugs; or engaging in compulsive behaviors like shopping, exercise, or sex. Problems with intimacy may lead to isolating from others and withdrawing from relationships, including family, friends, and professional colleagues. Control issues may become so central that the more control the caregiver feels has been lost, the more control he or she tries to exert over self and others. Equally possible may be efforts to narrow or restrict the scope of one's world in the hope of avoiding anything that may be experienced as being outside of one's control.

The concept of vicarious traumatization emphasizes the positive as well as the negative impact of bearing witness to traumatic events. Disruptions in world view, identity, and key psychological needs provide an opportunity for radical transformations that may lead to growth and higher consciousness rather than degradation and constriction. As caregivers, it is our responsibility to make choices in our own personal, professional, and organizational lives that support positive, rather than negative, transformative changes.

Who Gets It?

Although the concept of secondary traumatic stress is less than two decades old, there is a growing body of studies detailing the existence of many different survivor groups. For example, counselors with high domestic violence caseloads have been shown to have classical symptoms of vicarious traumatization. Specific challenges of this kind

of work included difficulties with confidentiality, fear for the safety of their clients, and feelings of isolation and powerlessness (Iliffe & Steed, 2000).

People who treat victims of sexual abuse are known to experience vicarious traumatization. A study compared the rates of vicarious traumatization of clinicians working with sexual abuse victims with those working with cancer victims and found that those clinicians working with sexual abuse victims were more negatively affected (Cunningham, 1996). It has been recognized that therapists working with sexual abuse survivors may experience a grief process themselves as they come to terms with their own exposure to the sexual abuse of children (Cunningham, 1999). In addition, there are reports of negative transformations of worldview and increased fears about the safety of children (Simonds, 1996). In a study of counselors working with sexual violence survivors, the counselors who had a higher percentage of survivors in their caseload reported more disrupted beliefs, more symptoms of PTSD, and more self-reported vicarious trauma, irrespective of their own trauma histories (Schauben & Frazier, 1995).

Vicarious traumatization affects investigators of sexual abuse as well as therapists. In a study looking at the impact of secondary traumatic stress on child protective service workers, the results indicated that secondary traumatic stress symptoms were common among those surveyed and were more likely to occur in those who had worked at the job the longest, had worked longer hours, were female, and who had a history of experiencing or witnessing trauma (Meyers, 1996). In another study, among the "veterans" in child protective services (2 years or more), 62% scored in the high range on an emotional exhaustion scale, considered by some to be the heart of burnout (Anderson, 2000).

Several studies have looked at the impact that working with sex offenders has on counselors. Similar to other findings, the rate of vicarious traumatization appears to be related to years of experience in clinical practice, the counselor's own trauma history, and particular work settings (Kostouros, 1998).

Hospital personnel are known to be vulnerable to the effects of secondary traumatic stress. Several papers have reported on the impact of exposure to trauma on nursing professionals (Alexander & Atcheson, 1998; Crouthers, 1995; Lyon, 1993; Schwann, 1998). A recent review article documents the emotional needs of both parents whose children are hospitalized and staff members who work on pediatric intensive care and neonatal intensive care units (Peebles-Klieger, 2000). In a study looking at the effects of exposure to multiple acquired immunodeficiency syndrome (AIDS)–related deaths on group therapy, group members exerted a traumatizing effect on group therapists, who experienced death images, survivor guilt, psychic numbing, suspicion of counterfeit nurturance, and a struggle for meaning (Gabriel, 1994). In another study of healthcare workers, physicians, nurses, social workers, and support staff recruited from 20 publicly funded human immunodeficiency virus (HIV) programs who were given measures of stress, coping, empathy, burnout, and secondary traumatic stress, the four groups experienced moderate levels of burnout and low levels of secondary traumatic stress (Garrett, 1999).

In a study of vicarious traumatization among law enforcement professionals, patrol officers and detectives from homicide and child sexual abuse were studied. The study found that dissociation and maladaptive coping predicted pathology and distress. It was also noted that a personal history of child abuse made it more likely that the

individual would work in units with high exposure to trauma and would be more vulnerable to dissociative and anxiety disorders (Hallett, 1996).

A summary of risk factors indicates that having a past history of traumatic experience is a substantial risk factor for developing vicarious traumatization. Caregivers who extend themselves beyond the limits of customary service delivery by overworking, ignoring healthy boundaries, or taking on too many trauma survivors in their caseload are also at risk. Less experience as a therapist can put someone at risk, but so can too much experience, presumably because of the excess of exposure to traumatic material. Having a high percentage of traumatized children, particularly sexually abused children, in one's caseload is a risk, as is working with a high number of patients suffering from dissociative disorders. Experiencing too many negative clinical outcomes is also a risk factor.

Key Points

Risk factors for vicarious traumatization include:
- Having a past history of traumatic experience
- Overwork
- Ignoring health boundaries
- Taking on too much
- Lack of experience as a therapist
- Too much experience as a therapist
- Dealing with large numbers of traumatized children, especially sexually abused children
- Working with large numbers of patients who suffer from dissociative disorders
- Having too many negative clinical outcomes

There also appear to be protective factors that help alleviate or protect against the development of vicarious traumatization. These protective factors are similar to those that have been uncovered in the studies of people who are resilient under stress (Williams & Sommer, 1995). Good social support is key. Strong ethical principles of practice, knowledge of theory, on-going training, the development of competence in practice strategies and techniques, and awareness of the potential of vicarious traumatization and the need to take deliberate steps to minimize the impact, all serve as protective factors.

What Causes It?

Trying to describe what causes vicarious traumatization is like trying to describe what causes PTSD. The reasons for why some patients develop PTSD following a traumatic event and others do not may turn out to be very similar to the reasons why some people develop vicarious traumatization and others do not. Like PTSD, vicarious traumatization can be viewed as a "normal reaction to abnormal stress," or as a picture of adaptive coping skills gone wrong. Similar to any discussion of the causality of PTSD, there are biological, psychological, social, and moral, spiritual, and philosophical components of the individual that interact with the professional and sociopolitical context of the individual's life space to produce the final outcome.

Biological Causality: Emotional Contagion

Listening to victims of trauma can produce a noxious physiological and psychological state in the listener that is strongly defended against. Therefore members of victims' social groups are likely to take measures to prevent the victims from sharing their experience and thereby spreading the contagious affect. This presents powerful negative consequences for the victims, because the tendency to avoid disclosure of emotions is associated with increased risks for physical illness, greater physiological work, and impaired information processing (Harber & Pennebaker, 1992). One theory is that stress, in activating the complex human stress response, produces many kinds of powerful neurochemicals, including cortisol, an immune system suppressor. It is thought that the chronic inhibition of negative emotions produces increasing work for the autonomic nervous system, and this increased load functions as a chronic stressor with the result that biological survival systems that should only be "on" under emergency conditions are reset to be "on" all the time (Pennebaker, 1997).

Likewise, the benefits of emotional expression have been known since ancient times. The word *catharsis* derives from the Greek, meaning purification or cleansing. People who are traumatized are often overwhelmed by their emotions, particularly in the acutely traumatized state. Suppressing emotional states is bad for their health. Caregiving relationships help surface those emotions, often long buried, and the helper is the one who is most likely to be exposed to the overwhelming nature of the victim's emotional states. Good caregiving requires that the caregiver respond to this state of emotional contagion in certain limited and prescribed ways, and respond by containing, rather than expressing, the caregiver's own physiological states of hyperarousal, fear, anger, and grief.

Psychological Causality: Loss of Positive Illusions

Working with victims of violence and interpersonal trauma is so difficult because it changes caregivers who are willing to listen. Confrontation with the magnitude of interpersonal violence shatters our own protective assumptions as we let in the reality of "It really happened." As we wrestle with this reality, we come to recognize that "It could happen to me" and feel all the vulnerability that goes along with that recognition. For some, their own past history of interpersonal violence or child abuse is a personal reality because "It did happen to me" and all the unwanted reminders of an unresolved past are triggered by the patients' stories. The recurring sense of helplessness that victims feel may also impact the helpers, bringing with it a sense of hopelessness, expressed as "There's nothing I can do."

A central focus of the concept of vicarious traumatization is a disturbed frame of reference. Trauma shatters the basic assumptions, the frame of reference of the victim. Positive illusions about oneself, other people, and the world are destroyed. Exposure to traumatized people can destroy clinicians' positive illusions when they are confronted repeatedly with the terrible things that have happened to their patients, often at the hands of other people. The maintenance of positive illusions depends on consensual validation – on other people maintaining the same illusions. Therefore, the greatest conflict, and the one most likely to produce symptoms of vicarious traumatization would revolve around cases of family violence including child abuse, spousal abuse, rape, and particularly child

sexual abuse. The reality of family violence threatens one of our most cherished cultural notions—the family as a safe place.

Key Point

The greatest conflict and the one most likely to predict symptoms involves cases of family violence (child abuse, spousal abuse, rape, and child sexual abuse in particular). The reality of family violence threatens one of the caregiver's most cherished cultural ideas: that the family is a safe place.

Social Causality: Inability to Use Normal Social Obstacles

Traumatic experiences shatter basic personal and cultural assumptions about the primary way we order reality. Suddenly there is no safety, the world no longer makes sense, other people cannot be trusted, the future is no longer predictable, and, because of dissociation, the past is no longer known (Janoff-Bulman, 1992). After the trauma, one of the most perplexing experiences for the individual victim is that the world goes on as before. Other people outside of the trauma envelope appear relatively oblivious to the traumatic event. For the victim, personal reality is no longer congruent with cultural reality. The individual spontaneously attempts to realign the two realities, and early on he or she may attempt to talk about the experience and to share the overwhelming affect states. The need to talk, to confess, to release stored tension is powerful and important for health.

The culture, however, actively inhibits the individual's responses. People normally use certain defensive maneuvers to protect themselves from the overwhelming nature of trauma victims' stories and experience. Listeners will switch the topic away from the trauma and attempt to press their own perspective on the victim. They often exaggerate the victim's personal responsibility or even avoid contact with the victim altogether. In mounting these social obstacles to meaning-making, the listeners avoid having their own cognitive schemas disrupted, and they avoid the hyperarousal that is frequently an accompaniment of emotional contagion (Coates, Wortman, & Abben, 1979; Harber & Pennebaker, 1992). The price for the individual victim, however, is a high one. Individuals cannot make meaning out of the traumatic event without a cultural context and the consensual validation that accompanies it; yet the cognitive imperative demands a resolution of the conflict and a restablization of the sense of personal reality. The only viable solution is further dissociation.

Since the Vietnam War, there has been an increasing recognition of many forms of violent perpetration and the effects this exposure to violence has on children and adults. Good caregivers are carefully trained to avoid using the kinds of social defenses that other people use against the impact of this increased recognition. Instead, clinicians and other caregivers are taught to screen for violence, to carefully listen, to avoid giving in to their own inclinations to distance themselves, and to empathize with the experience and emotions of others. The inability to use the social barriers available to other people makes helping professionals more likely to experience vicarious traumatization.

Organizational Causality: Sick Systems

There are also organizational contributors to the development of vicarious traumatization. Organizational settings that refuse to accept the severity and pervasiveness of traumatic experience in the population they are serving will thereby refuse to provide the social support that is required for caregivers if they are to do adequate work.

Like dysfunctional families, dysfunctional systems often look very similar to each other. In such systems, there is an on-going culture of crisis, where long-term and preventative solutions are never formulated because time and resources are spent simply "putting out fires" every day. Democratic processes within the organization are given over to authoritarian decision-making with the establishment of rigid hierarchies, a culture of shaming, blaming, and judgmentalism. Conflicts are never really addressed or resolved. Instead, order is maintained through isolation, splitting, overcontrol, manipulation, and deceitful practices. Mistrust grows and people avoid relationships with each other and individualism increases. There is little humor in the environment because positive emotion is discouraged, while negative emotional expression is tolerated or even encouraged. If this situation is not rectified, a culture of toughness and meanness develops in which the threat of some form of violence is used to control others and may become actual violence if the threat is not sufficient to keep members in line. Despite this, the system denies that any real problems exist, tolerates a high level of hypocrisy in its daily functioning, and actively discourages any confrontation with reality (Bloom 1997; Bloom & Reichert, 1998).

Key Point

Dysfunctional systems resemble dysfunctional families, having some or all of the following characteristics:

- An ongoing culture of crisis, where long-term and preventive solutions are not formulated because all time and resources are spent on "putting out fires"
- The replacement of democratic processes with authoritarian decision-making and rigid hierarchies
- A culture of shaming, blaming, and judgmentalism
- Maintenance of order through isolation, splitting, overcontrol, manipulation, and deceitful practices, leading to mistrust and avoidance
- Little humor, with positive emotions discouraged and negative emotions tolerated or encouraged
- Eventual development of a culture of toughness and meanness or actual violence
- Denial that any real problems exist
- A high degree of hypocrisy in daily functioning
- Active discouragement of confronting reality

These kinds of dysfunctional systems can be significant contributors to the development of vicarious traumatization and may even be a fundamental cause. In the caregiver context, the helper can at least feel capable of providing some meaningful assistance to the victim. But the caregiver, embedded in a situation of powerlessness and

lack of social support, may find that all efforts to bring this assistance to bear are foiled by the institutional setting within which he or she is practicing. For many helpers, the stress they experience as a result of the systems within which they work is far greater, more pervasive, and disabling than anything that happens in the consulting room or office with their clients.

Moral, Spiritual, and Philosophical Causality: Theoretical Conflicts

Finally, there are profound conflicts inherent in the ideological framework of present-day caregiving that also play a role in making caregivers more vulnerable to the effects of vicarious traumatization (Bloom, 1995). The effects of these conflicts are not direct, but instead comprise a background "noise." They include the desacralization of healing, the commodification of health care, the shortcomings of the medical model, a bias toward individualism, and the issue of individual violence embedded within a context of cultural violence.

As a result, the culture has set up a pressure-cooker environment that serves no one well except, perhaps, for profiteers. Demands to carry increasing caseloads with an attendant increase in paperwork combined with significant decreases in staffing and resources have made many healthcare settings unbearable. Under such conditions, it is increasingly difficult for caregivers to find the time or psychic energy to provide the level of compassion that victims of violence require if they are to take the first steps in recovery. Instead, caregivers must decide daily who they are going to hurt—themselves and their own family by not living up to the financial expectations of the companies that employ them, their patients who continue to expect a healing response, or the institutions whose survival is ever more critically dependent on their fast-paced performance. Placed in such untenable moral dilemmas that they feel powerless to affect, healthcare professionals succumb to both physical fatigue and compassion fatigue.

There are also shortcomings inherent in the traditional "medical model" of caregiving. In this model, the patient is largely passive, waiting for cure, or at least alleviation of symptoms, to be delivered by a medical practitioner. The model of sickness that is a part of the medical model places the locus of the problem within the individual who is defective in some way. In contrast, the trauma therapist rapidly learns that one of the keys to recovery for the victim is empowerment, not passivity, and that further experiences of helplessness are often damaging.

The trauma model is more clearly informed by an injury model than a sickness model, implying that previously healthy individuals were injured by a force or person outside of themselves, thus making the site of the injury not a defect within the person, but a problem of relationship and context. An injury model sets the injured party squarely within a social context within which the injury occurred or was not prevented from occurring. It also implies that there is a dual responsibility for recovery, shared by the injured party and by society. The role of the caregiver is very different in the sickness versus the injury model, leaving the caregiver vulnerable to various role strains and stresses:

• How do I keep my patient safe when only my patient has the power to keep herself safe?

- What is the best way to "empower" people?
- What is my responsibility and what is not my responsibility?
- When do my interventions promote recovery and when do they inhibit or discourage recovery?
- If this person is suffering from an injury that is a result of a social, fixable problem, what is my role in preventing further injury to this person and to others?

If they attempt to stay politically disengaged, or "scientifically neutral," caregivers may find themselves medicalizing or pathologizing disorders that are actually a result not of a medical problem, but of a social, political, or economic problem. In doing so, they may find themselves part of an oppressive system rather than countering that system.

If instead, caregivers stand up and powerfully bear witness to the violence they have observed, they are likely to be labeled as outcasts, troublemakers, lacking in scientific rigor, and subverters of the system. It is an impossible dilemma. Caregivers, schooled in individualism, tend not to turn to others in any organized fashion in order to protect themselves and therefore must contain the overwhelming emotions to which they have been exposed.

What Can Be Done About It?

Caregivers must develop their own personal and professional strategies for bringing about change in key areas that will help reduce or prevent the further evolution of a process that could lead to burnout.

Prevention strategies are focused on both individual and environmental approaches. Individual approaches encompass the personal physical, psychological, and social health of the helper, as well as the professional life of the helper, while environmental responses are divided between the organizational or work setting and societal strategies. Such strategies may be viewed in an ecological framework, including such elements as follows:

Personal—Physical

- Engage in self-care behaviors, including proper diet and sleep
- Undertake physical activity, such as exercise and yoga

Personal—Psychological

- Identify triggers that may cause you to experience vicarious traumatization
- Obtain therapy if personal issues and past traumas get in the way
- Know your own limitations
- Keep the boundaries set for yourself and others
- Know your own level of tolerance
- Engage in recreational activities, including listening to music, reading, spending time in nature
- Modify your work schedule to fit your personal life

Personal—Social

- Engage in social activities outside of work
- Garner emotional support from colleagues
- Garner emotional support from family and friends

Personal—Moral

- Adopt a philosophical or religious outlook and be reminded that you cannot take responsibility for the client's healing but rather must act as a midwife, guide, coach, or mentor
- Clarify your own sense of meaning and purpose in life
- Connect with the larger sociopolitical framework and develop social activism skills

Professional

- Become knowledgeable about the effects of trauma on self and others
- Attempt to monitor or diversify case load
- Seek consultation on difficult cases
- Get supervision from someone who understands the dynamics and treatment of PTSD
- Take breaks during workday
- Recognize that you are not alone in facing the stress of working with traumatized clients—normalize your reactions
- Use a team for support
- Maintain collegial on-the-job support, thus limiting the sense of isolation
- Understand dynamics of traumatic reenactment

Organizational/Work Setting

- Accept stressors as real and legitimate, impacting individuals and the group as a whole
- Work in a team
- Create a culture to counteract the effects of trauma
- Establish a clear value system within your organization
- Develop clarity about job tasks and personnel guidelines
- Obtain supervisory/management support
- Maximize collegiality
- Encourage democratic processes in decision-making and conflict resolution (S. L. Bloom, unpublished data,
- Emphasize a leveled hierarchy
- View problem as affecting the entire group, not just an individual
- Remember the general approach to the problem is to seek solutions, not assign blame

- Expect a high level of tolerance for individual disturbance
- Communicate openly and effectively
- Expect a high degree of cohesion
- Expect considerable flexibility of roles
- Join with others to deal with organizational bullies
- Eliminate any subculture of violence and abuse

Societal

- General public and professional education
- Community involvement
- Coalition building
- Legislative reform
- Social action

A summary of what a caregiver can do about vicarious traumatization includes *anticipating* vicarious traumatization and protecting oneself through awareness of the problem, *addressing* the signs of vicarious traumatization through self-care, and *transforming the pain* by creating meaning, infusing meaning into current activities, challenging negative beliefs, and participating in community building (Saakvitne, Gamble, Pearlman, & Lev, 2000).

Conclusion: Developing Organizational Universal Precautions

Anyone trained in a medical setting can recall learning about how to maintain "universal precautions" against the spread of infection. For most infections such precautions necessitate the use of gloves, gowns, masks, and frequent scrubbing of exposed body parts and other surfaces. Unfortunately, developing universal precautions against the spread of the effects of violence requires the employment of practices that are not necessarily as obvious or as easy to implement, but that are nonetheless necessary if we are to promote health and not spread disease.

It is clear that secondary traumatic stress is a predictable outcome of significant exposure to traumatized people. Therefore any caregiving environment should anticipate the occurrence of vicarious traumatization and establish built-in "hygienic" practices that can serve as antidotes to the spread of the "infection" within the organization. From what we know about individuals and groups under stress, certain characteristics stand out.

Clear, considerate, empathic communication and the promotion of social support are primary objectives for any organization that hopes to reduce the occurrence of compassion fatigue. The ability to express oneself emotionally is vital to continued well-being. This can only occur in an environment that (1) recognizes that the occurrence of secondary stress is a normal reaction to an abnormal situation and (2) condones the need for continuous positive social support as the normative standard of behavior for each individual and for the group as a whole. Likewise, each individual must establish a plan for self-care that includes adequate breaks, exercise, relaxation, and socialization. The studies of resiliency indicate that people do best if they can use their own initiative and creativity to solve problems with a maximum degree of autonomy, rather than being

required to adhere to stringent and inflexible rules that are not always relevant to the situation. They must have appropriate and clear boundaries between themselves and suffering others while still maintaining a deep sense of commitment to a set of higher beliefs and standards. One of the most under-appreciated and yet most important factors that contributes to creating a stress-reducing environment is a sense of humor and the shared laughter that often emerges as "gallows humor" in highly stressful environments. A health-promoting organization is one in which the democratic processes of decision-making and conflict resolution are routine, issues of meaning and purpose are central, and there exists a culture of active nonviolence.

       Medical care has come under close and often brutal scrutiny in the last few decades, and caregivers have repeatedly been found wanting in the qualities that most people value highly—compassion, emotional warmth, kindness, concern. It is possible that as the amount of violence has increased in our environment, the people "in the trenches"—nurses, physicians, and other healthcare workers—have caught the infection of violence through vicarious traumatization, because of the close contact with an infectious agent not recognized soon enough for its virulence. Public health workers have a professional, social, and moral responsibility to urge colleagues and patients to restructure the social environment so that the pathogen of violence finds less fertile ground to reproduce. At the same time, healthcare workers must also develop institutional universal precautions against an infection that makes them the carriers of the virulent disease called *violence*. Every episode of violence—physical, emotional, sexual, or social—must be viewed as a potentially lethal pathogen whose impact must be minimized if the environment is to become healthy. This requires providing support, concern, and care not only for patients, but among caregivers as well.

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