

BIBLIOGRAPHY

Managing Stress in Humanitarian, Health Care, and Human Rights Workers

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Introduction

The listings in this bibliography are divided into five groups with distinct but somewhat overlapping focuses.

Part I contains books and articles that focus primarily on staff of humanitarian aid and development organizations, health care workers, human rights workers, and journalists. The work of these groups typically involves repeated or prolonged contact with people who have been

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emotionally traumatized by their experiences. Their primary role is to provide material assistance or training or other services or to gather information, however; it is not to provide mental health services or directly respond to the emotional effects of traumatic experiences.

Part II contains books and articles that focus on first responders such as policemen and fireman, rescue and relief workers, and emergency medical workers. These are groups that respond to disasters – individual disasters such as motor vehicle accidents or fires as well as mass disasters such as plane crashes, earthquakes, and hurricanes. Their involvement with the victims may occur closer to the time of the traumatic events than the first group's, but like the first group, their work usually does not involve a direct focus on treating the emotional effects of the disaster.

Part III contains materials that focus on mental health workers – therapists, counselors, and paraprofessionals -- whose major role is to respond directly to the emotional needs of survivors of traumatic events of all sorts (including both individually traumatic experiences and mass disasters). There is a large literature on this topic. I have selected primarily books and articles that deal with mental health workers in disaster and complex humanitarian emergency situations.

Part IV is a “miscellaneous” section, containing references to material that deals with several of the groups described above as well as with conceptual and organizational issues.

Part V contains items that focus not on the caregivers but on the survivors of traumatic events themselves. They provide additional insights into the individual, family, and community effects of traumatic events and the ways these effects may interact with the work of those who seek to aid them. In many cases, they also contain material on secondary traumatization and other issues of direct concern to aid workers. There is a large literature on this topic and only a few more general references have been included.

I. Resources on Burnout and Vicarious Traumatic Stress Among Humanitarian Aid Workers, Health Workers, and Human Rights Workers

Manuals and Books

Ajdukovic, D., & Ajdukovic, M. (eds.) (2000). **Mental Health Care of Helpers**. Zagreb, Croatia: Society for Psychological Assistance (Order at <http://www.dpp.hr>). ISBN No. 9536353121.

This book grew out of materials prepared for a training program on "Help and Self-Help for the Protection of the Mental Health of Helpers," developed to meet the needs of care-providers in Croatia and Bosnia during the Balkan war. It includes chapters on stress, burnout, and vicarious traumatization, coping with occupational stress, strategies of self help, debriefing, and stress-reduction techniques, critical incident and refer them for additional psychological help.

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Barron, R.A. (1999). **Psychological trauma and relief workers**. In J. Leaning et al. (eds.), *Humanitarian Crises: The Medical and Public Health Responses*. Cambridge, MA: Harvard University Press, pp. 143-175.

A relatively academic article, but potentially useful for managers. Discusses traumatic stress, burnout, factors that place workers at increased risk of stress, interventions with individuals to decrease worker traumatization, institutional responses to decrease worker traumatization.

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Cutts, M., & Dingle, A. (1995). **Safety first: Protecting NGO employees who work in areas of conflict**. London: Save the Children (17 Grove Lane, London, SE5 8RD).

Aimed at project managers, but usable by field staff, covers preparing for emergencies, staying healthy, use of vehicles, responding to attacks, evacuation procedures, and related topic's. Includes brief sections on coping to stress.

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Danielli, Yael (Ed.) (2002) **Sharing the front line and the back hills: International protectors and providers: Peacekeepers, humanitarian aid workers and the media in the midst of crisis**. Amityville, NY: Baywood Publishing Co. ISBN No.0895032635.

Contains sections on humanitarian aid workers, peacekeepers, human rights workers, and journalists The book discusses, develops, and advocates specific policies and practices that enable these workers to serve effectively and safely. It reviews existing knowledge, identifies approaches that have proven useful, explores and suggests future directions, and makes policy recommendations to relevant implementing organizations. A further goal of this book is to describe the major initial steps taken by the various international organizations. The chapters include a detailed consideration of the requirements of pre-mission selection, assignment and

training, support during mission, and post-mission assistance and counseling. They consider distinct problems posed by intensive, short-term involvement as compared with extended assignments.

* * *

Davis, J., & Lambert, R. (2002). **Engineering in Emergencies: A Practical Guide for Relief Workers.** (2nd Ed.). London: ITDG Publishing.

Published in association with RedR - Engineers for Disaster Relief. Primarily on engineering issues, but includes a chapter on "Personal effectiveness" and a chapter on "Personal security." The former includes observations on personal planning before a disaster assignment and brief sections on self-care after the assignment, on health care, and on stress.

* * *

Ehrenreich, J. H. (2002). **A Guide for Humanitarian Aid, Health Care, and Human Rights Workers: Caring for Others, Caring for Yourself.** (32 pp). Old Westbury, NY: Center for Psychology and Society. (Available on line at "<http://www.mhwwb.org/disasters.htm>," or from John Ehrenreich, Center for Psychology and Society, State University of New York, College at Old Westbury, Box 210, Old Westbury, NY 11568, U.S.A.).

Discusses the phenomenon of emotional traumatization; the effects traumatization has on interactions between humanitarian workers of all sorts and the people they seek to serve; techniques for working with traumatized people that contribute to healing and minimize the likelihood of retraumatization; and approaches to preventing burnout, compassion fatigue, and secondary traumatization among aid workers. Includes relaxation exercises and information on other specific techniques. Aimed at field workers.

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Howell, K. (2002). **Health and Safety in Aid Agencies.** London: People in Aid ("<http://www.peopleinaid.org>").

Aimed at managers, this manual discusses legal and practical issues of risk assessment and response to health and safety issues.

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International Committee of the Red Cross (2001). **Humanitarian action and armed conflict: Coping with stress.** (28 pp). Geneva: International Committee of the Red Cross. (Available from ICRC, Publications Division, 19, avenue de la Paix, 1202 Geneva, Switzerland; e-mail: icrc.gva@icrc.org).

Aimed at field workers, this brief manual identifies different types of stress reactions found in field staff, especially those working in zones of armed conflict, and suggests several courses of action to reduce stress.

* * *

Kosovar Rehabilitation Center for Torture Victims (2002). **Stress and Trauma**. Pristina, Kosovo: KCRT. Available by e-mailing kcert_org@hotmail.com.

A brief booklet on stress and stress reduction. Also includes a section on PTSD. Aimed at field workers.

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Lankester, T. (2000). **The travellers' good health guide**. London: Sheldon Press. ISBN # 0-85969-827-0.

Published by InterHealth (a British organization that acts as travel health adviser and/or provides healthcare and support to some 150 agencies and voluntary organizations as well as to individuals and families who are traveling on short or long-term assignments overseas), this book includes a section on stress management as well as sections on physical health and on safety and security.

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Lovell-Hawker, D. (2002). **Effective Debriefing Handbook**. London: People in Aid <http://www.peopleinaid.org>).

This handbook is a summary of a People In Aid workshop on effective debriefing. Aimed at field managers, it includes detailed instructions for debriefing sessions of various kinds, including critical incident debriefing and routine debriefing for individuals after their return home. The manual includes a section on cross cultural issues and several handouts (e.g., "Coming Home", "Symptoms of stress or depression," and "Ways to cope with stress/trauma"). References to books and useful web sites are included.

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O'Donnell, K. (Ed.). (2002). **Doing member care well: Perspectives and practices from around the world**. Waynesboro, GA:William Carey Library. ISBN No.0878084460.

This book explores how religiously-oriented organizations support their mission and aid personnel around the world. It includes personal accounts, guidelines, case studies, program descriptions, worksheets, and practical advice.

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Office of the United Nations Security Coordinator (1998). **Security in the Field**. New York: United Nations. (Available at <http://www.unep.org/restrict/security/security.doc>).

This 65 page manual, aimed at field workers, focuses on safety and security. It includes sections on emotional reactions to such incidents as being held hostage, being raped, and a chapter on "Coping with stress." The latter focuses primarily on chronic occupational stress. It refers to procedures such as debriefing but is more educational than prescriptive.

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Oxfam (U.K.). (2002.). **Managing to cope.** (12pp). Oxfam (U.K.). (2002.). **Post trauma stress.** (4 pp). **Preparation and support of staff working in conflict areas: Guidance for managers.** (9 pp). Oxfam (U.K.). (n.d.). Available from Oxfam. E-mail staffhealthservice@oxfam.org.uk.

Three informal papers dealing with stress management for humanitarian workers and guidance for supervisors of staff. The first two are aimed at staff, the third at managers

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Roberts, D.L. (1999). **Staying alive: Safety and security guidelines for humanitarian volunteers in conflict areas.** (125 pp). Geneva: International Committee of the Red Cross. (Available from ICRC, Publications Division, 19, avenue de la Paix, 1202 Geneva, Switzerland; e-mail icrc.gva@icrc.org).

Focuses on individual and team behavior promoting safety in armed conflict situations. Includes very brief comments about stress.

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UNHCR, Staff Welfare Unit (2001). **Managing the Stress of Humanitarian Emergencies.** Geneva: UNHCR Career and Staff Support Service (30 pp).

Aimed at managers. Surveys the concept of stress, signs of cumulative stress, signs of burnout, and critical events. Discusses basic stress and burnout management.

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U.S. Agency for International Development (1998). **Field Operations Guide for Disaster Assessment and Response** (Version 3.0). Washington, D.C.: U.S. Government Printing Office (ISBN # 0-16-049721-3). (Available at <http://www.info.usaid.gov/ofda/>).

Designed as a pocket manual to serve as a general reference tool for individuals sent to disaster sites to perform initial assessments or to participate as members of a Disaster Assistance Response Team. Includes brief sections on medical emergencies, personal health, safety and security, and a very brief section (one page) on managing stress.

Articles

Berk, Jay H. **Trauma and resilience during war: A look at the children and humanitarian aid workers of Bosnia.** *Psychoanalytic Review*. 1998 Aug Vol 85(4) 639-65.

In the author's experience working with Bosnian children, resilience in both the children and the humanitarian aid workers helping them had aspects which appeared similar. Both groups required support and a need to distance themselves from the impact of the suffering.

Bierens de Haan, Barthold (1998). **Le debriefing émotionnel collectif des intervenants humanitaires: l'expérience du CICR [Emotional group debriefing of humanitarian aid workers: the experience of ICRC].** *Schweizer Archiv für Neurologie und Psychiatrie*, v.

149, no. 5, pp. 218-228.

Humanitarian aid workers working in armed conflict and disaster situations are suffering from increasingly violent emotional reactions. In order to help them to complete their job successfully, to increase their resistance to stress and their efficiency in the field, they must be supported. This paper reports on different interventions from the ICRC Stress Management Unit. The principles of emotional group debriefing are underlined. This procedure might be effective because it is based on an encounter group whose healing capacity is well known. A simplified four steps procedure is proposed to make the conduct of such supportive groups easier. [A]

Britt TW, Adler AB. (1999). **Stress and health during medical humanitarian assistance missions.** *Military Medicine*, vol. 164 (4), 275-279

Team members deployed on a medical humanitarian assistance mission to Kazakstan were surveyed before and during their deployment. They underestimated how much stress they would experience in terms of isolation and inability to help the local population. They also used less adaptive coping mechanisms than anticipated and showed elevations in alcohol and cigarette consumption. Despite these negative experiences, reports of depression and physical symptoms did not increase during the deployment. Possible explanations are discussed. (M)

Danielli, Y. (1996). **Who takes care of the caretakers: The emotional consequences of working with children traumatized by war and communal violence.** In R.J. Apfel & B. Simon (eds.), *Minefields in their Hearts*. New Haven: Yale University Press, pp. 189-205.

Eisenman, David P; Bergner, Sharone; Cohen, Ilene (2000). **An ideal victim: idealizing trauma victims causes traumatic stress in human rights workers.** *Human Rights Review*, v. , no. 4, pp. 106-114.

The idealization of torture victims leads to the collapse of the space necessary for self-reflection and self-care on the part of the worker. Elevation of the survivor's needs and feelings leaves insufficient room for the interviewer to recognize and to think about the complex reactions and feelings sparked through the work. As a result, selective features of the survivor's experience are focused upon and emphasized, while other features, which contribute to the interviewer's less visible feelings and reactions, are excluded. When such a situation develops neither the survivor's nor the interviewer's experience is fully acknowledged. [T, p. 106]

Eriksson, Cynthia B. (1997). **Traumatic exposure and reentry symptomatology in international relief and development personnel.** Doctoral Dissertation: Fuller Theological Seminary, School of Psychology, 1997

International relief and development workers are often exposed to traumatic events which put them at risk for developing PTSD symptomatology and emotional distress during reentry to their home cultures. Surveys were administered to returned staff from five Christian relief and development agencies. As hypothesized, the amount of traumatic exposure reported correlated positively with PTSD symptomatology, and a negative correlation existed

between perceived social support and report of PTSD symptomatology. A significant interaction existed between social support and the level of trauma exposure in relation to PTSD symptoms. Participants reporting high levels of trauma exposure and low levels of social support reported higher PTSD symptomatology than those reporting high levels of exposure and high levels of social support. Returning to one's home culture after working or studying abroad is a difficult cross-cultural adjustment. International relief and development staff work in environments that require facing war, famine, poverty, and disease. These workers are routinely exposed to chronic stressors which put them at risk for developing emotional distress during reentry to their home cultures. As hypothesized, relief and development staff with higher levels of chronic stressor exposure reported higher levels of reentry distress associated with culture shock and negative affective states. A significant negative relationship also existed between perceived social support and culture shock distress. Returned relief and development staff reported significantly higher scores on measures of negative affective states for their feelings during the "worst day of reentry," than for how they "generally feel." Both quantitative and qualitative data offer a number of important practical suggestions for the agencies that sponsor relief and development work. The narrative data collected in the questionnaire offers rich insight into the range of experiences faced by international staff in their working environment. These staff offer suggestions for providing future colleagues with a more successful reentry transition. [A]

Eriksson, Cynthia B; Vande Kemp, Hendrika; Gorsuch, Richard; Hoke, Stephen; Foy, David W. (2001). **Trauma exposure and PTSD symptoms in international relief and development personnel.** *Journal of Traumatic Stress*, v. 14, no. 1, pp. 205-212.

International relief and development personnel may be directly or indirectly exposed to traumatic events that put them at risk for developing symptoms of PTSD. In order to identify areas of risk and related reactions, surveys were administered to 113 recently returned staff from 5 humanitarian aid agencies. Respondents reported high rates of direct and indirect exposure to life-threatening events. Approximately 30 percent of those surveyed reported significant symptoms of PTSD. Multiple regression analysis revealed that personal and vicarious exposure to life-threatening events and an interaction between social support and exposure to life threat accounted for a significant amount of variance in PTSD severity. These results suggest the need for personnel programs; predeployment training, risk assessment, and contingency planning may better prepare personnel for service. [A]

Fawcett, J. (2000). **Managing staff stress and trauma.** In M. Janz & J. Stead (eds.), *Complex Humanitarian Emergencies: Lessons from Practitioners*. Monrovia, CA: World Vision, pp. 92-125. (ISBN No. 188798318).

Feinstein, A., Owen, J., & Blair, N. (2002). **A hazardous profession: War, journalists, and psychopathology.** *American Journal of Psychiatry*, 159, 1570-1575.

The authors studied 140 war journalists, comparing them to journalists who had never covered war. The war journalists showed significantly elevated levels of PTSD, depression, and substance abuse.

Holtz, T.H., Salama, P., Cardozo, B.L., & Gotway, C.A. (2002). **Mental health status of**

human rights workers, Kosovo, June 2000. *Journal of Traumatic Stress*, 15, 389-395.

This paper reports on a cross-sectional survey of 70 expatriate and Kosovar Albanian staff engaged in collecting data of human rights violations in Kosovo. Factors associated with elevated PTSD symptoms, depression, and anxiety are reported.

Kilbourn, Phyllis Ann (1995). **Providing care for the caregivers.** In Kilbourn, Phyllis Ann (ed.). *Healing the children of war: a handbook for ministry to children who have suffered deep traumas*, pp. 225-237. Monrovia, California

Dealing with children's war-related crises can be a very stressful experience. The more traumatic the event, the more potential there is for caregivers to become traumatized. This chapter explores some trauma-producing stress factors caregivers encounter and describes some normal responses to these stress factors. Understanding the stress factors and the caregivers' possible responses can provide helpful insights into their needs. Includes key elements and principles to assist in planning care for the caregiver [T, p. 226]

Kramer, Gabriele (1999). **Traumatized women working with traumatized women: reflections upon life and work in a war zone.** *Women and Therapy* v. 22, no. 1, pp. 107-120.

In this article, the author shares both her personal and professional experiences in working with women and children who have been subjected to soul-destroying violence in the Former Yugoslavia in recent years. [A]

McCall, M., & Salama, P. (1999). **Selection, training, and support of relief workers: an occupational health issue.** *British Medical Journal*, 318:113-116.

Reports on a survey of humanitarian aid organizations. Findings: Although emergency relief workers are at considerable physical and psychological risk, their mental health has been studied little. Procedures for recruitment, selection, training, field support, and follow up of relief workers vary widely. Preventive mental health measures for relief workers receive little attention. Discounting the effects of psychological trauma on workers reflects disregard for their wellbeing and that of the populations they seek to serve. Relief organizations should develop a coordinated and cooperative approach to training and managing field workers. [A]

Orsillo, Susan Marie; Roemer, Lizabeth; Litz, Brett T; Ehlich, Peter J; Friedman, Matthew J. (1998). **Psychiatric symptomatology associated with contemporary peacekeeping: an examination of post-mission functioning among peacekeepers in Somalia.** *Journal of Traumatic Stress*, v. 11, no. 4, pp. 611-625

Paton, Douglas (1996). **Responding to international needs: Critical occupations as disaster relief agencies.** In Paton, Douglas (Ed); Violanti, John M. (Ed). *Traumatic stress in critical occupations: Recognition, consequences and treatment.* (pp. 139-172). Springfield,

US, US: Charles C Thomas, Publisher; Springfield, US

This book chapter focuses on specific problems posed by international disasters for relief workers and their organizations. It discusses the preparatory and support needs of those who will provide relief services, consequences of disaster work for the families of relief workers, and organizational and management issues.

Pickett, Mary; Brennan, Ann Marie Walsh; Greenberg, Helaine S; Licht, Lois; Worrell, Judith Deignan. (1994). **Use of debriefing techniques to prevent compassion fatigue in research teams** *Nursing Research*, v. 43, no. 4, pp. 250-252.

Nurses often study subjects who have experienced traumatic events involving intense and emotionally charged consequences. This paper describes how the process of crisis debriefing can be used to mitigate the concerns of interviewers who collect data from such subjects. Some clinical practice settings, such as emergency, trauma, intensive care, and home hospice settings, provide debriefing sessions that incorporate some of the elements directed toward the prevention of secondary PTSD. However, debriefing sessions designed specifically for research team members who interview traumatized persons have not been reported in the literature. [T, p 250]

Simon, Bennett (1993). **Obstacles in the path of mental health professionals who deal with traumatic violations of human rights.** *International Journal of Law and Psychiatry*, v. 16, no. 3-4, pp. 427-440.

The first part of this paper deals with obstacles in the path of mental health professionals becoming more involved in issues of human rights violations. The second part deals with a few of the increasing number of instances in which mental health professionals have become more involved. The discussion centers around issues involving children, although most of what is said applies to both children and adults. In referring to "human rights" violations, the boundaries between the devastation of large scale wars between nations and within nations (such as the Holocaust and the Cambodian genocide) and the harm done in more narrowly defined "human rights" violations (such as the arrest, torture, and often "disappearance" of thousands in Argentina and Chile) are not exactly clear. For our purposes, the rough working definition of human rights violations includes the devastation wrought by plans to persecute and destroy individuals, classes. [T, p. 427]

Smith, Barbara; Agger, Inger; Danieli, Yael; Weisaeth, Lars.(1996). **Health activities across traumatized populations: emotional responses of international humanitarian aid workers: the contribution of non-governmental organizations.** In Danieli, Yael; Rodley, Nigel S; Weisaeth, Lars (ed.). *International responses to traumatic stress: humanitarian, human rights, justice, peace and development contributions, collaborative actions and future initiatives*, pp. 397-423. Amityville, New York: Baywood.

Topics treated include: common emotional reactions; Goma, Zaire 1994; Sarajevo, Bosnia-Herzegovina, 1992- ; the traumatic effects; development of PTSD and burn-out in an international humanitarian aid worker; stress (countertransference) reaction in helpers; enmeshment; hostility and cynicism; self-destructive behavior; dissociative responses; psychological support for aid workers; institutional factors (how do humanitarian

organizations support the professional efforts of aid workers?; how do humanitarian organizations respond to aid workers' proposals for innovation?; how do humanitarian organizations support aid workers' collaboration with other organizations?; how do humanitarian organizations meet aid workers' needs for emotional support?); employer responsibilities; conclusion

Smith, Alison (2000). **Lessons from Western Kosovo for the documentation of war crimes.** *Psychiatry, Psychology & Law. Vol 7(2)* 235-240.

Based upon experiences of the International Crisis Group's Humanitarian Law Documentation Project in Western Kosovo, the author advances a series of recommendations for effective intervention by aid workers in areas where considerable trauma has been inflicted on civilians. In particular, she argues that in documenting war crimes, the primary responsibility of the interviewer is to the well-being of the witness. This includes not only emergency survival needs such as adequate shelter, food and clothing; it also means taking care of their mental health needs. This should be done by training interviewers in recognizing symptoms of mental disorders and providing immediate assistance for those who need it as well as ensuring that there are facilities available in the longer term to address the inevitable consequences of mass violence. In order to provide this type of assistance, the mental health needs of humanitarian workers themselves must also be addressed. There must be adequate facilities staffed by experienced people to help both local and international workers deal with the type of work they are doing. In both of these situations, the persons providing training and treatment must themselves be trained in post-conflict situations and issues arising as a result of mass trauma. (Author's Abstract)

Spiers, Carole (1997). **Counselling and crisis intervention training for humanitarian aid workers.** *International Journal of Stress Management. Vol 4(4)* 309-313. The author describes personal experiences training humanitarian aid workers in Serbia. Specifically, the training involved a practical application of counseling skills via role play, emphasizing crisis, trauma, and posttraumatic stress. The author notes that in particular, the trainees needed additional skills to help them deal with the multifarious problems presented by clients, most of whom experienced the effects of war. Problems that exasperated posttraumatic stress disorder (PTSD) included nightmares, panic attacks, problems of separation, bereavement, identity crisis, re-settlement, rape, and murder. [P]

Stearns, S.D. (1992). **Psychological distress and relief work: Who helps the helpers?** Oxford Refugees Studies Programme, University of Oxford.

Stearns, Sarah D (1993). **Psychological distress and relief work: who helps the helpers?** *Refugee Participation Network, v. 15, pp. 3-8*

Much attention has been devoted to the negative psychological effects of violence, war, famine and torture on refugees. Less literature exists however, on the psychological difficulties encountered by relief workers, reflecting a lack of awareness on the part of institutions that trauma encountered by relief workers does not rank high on the list of priorities in emergencies. When situations are extreme and personnel is in short supply, there is little time to concentrate on workers and their troubles. It is of course possible, as

some have asserted, that relief agencies are fully aware of the effects of psychological trauma on their personnel, but refuse to recognize openly the fact lest they become targets for disability claims. It is, however, important to recognize that in many instances the problems relief workers encounter can limit the effectiveness of humanitarian assistance. The psychological difficulties helpers face may shape interactions between them and the people they endeavor to assist. Models from disaster relief literature may be used to explore methods for countering stressful or traumatic events. [T, p 13]

Zimmerman, George; Weber, Wesley (September 2000). **Care for the caregivers: a program for Canadian military chaplains after serving in NATO and United Nations peacekeeping missions in the 1990s.** *Military Medicine*, v. 165, no. 9, pp. 687-690.

The Mental Health Department of the Canadian Forces Support Unit (Ottawa) developed the Care for the Caregivers program to help participants deal with stressful events experienced directly or vicariously from the NATO and United Nations military missions of the 1990s. The program was developed after complaints of postdeployment stress were received from various military care providers. The objectives were to improve the skills of support personnel and to reduce the distress that some caregivers experienced. 31 chaplains who had been exposed to stressful military operations participated in five workshops. These educational 4-day small-group workshops covered topics such as PTSD, vicarious traumatization, coping techniques, spirituality, self-care, and family issues. An adult education model was chosen to encourage dialogue. Outcomes included reports of professional and personal benefits, requests for additional programs, local education initiatives, and referrals to mental health professionals. Having met its objectives, the program has become a normal concluding part of stressful deployments. [A]

III. Resources on Burnout and Vicarious Traumatic Stress Among First Responders, Rescue and Relief Workers, and Emergency Medical Workers

Books

Paton, D., & Violanti, J. (1996). **Traumatic stress in critical occupations: Recognition, consequences, and treatment.** Springfield, IL: Charles C. Thomas. ISBN No.0398065780.

Focuses primarily on first responders (police officers, firefighters, emergency medical service professionals). Discusses strategies designed to promote the recognition and identification of the diverse personal, organizational, and event-related factors that contribute to traumatic reactivity are discussed.

Articles

Alexander, David Alan; Klein, Susan. (2001). **Ambulance personnel and critical incidents: impact of accident and emergency work on mental health and emotional well-being.** *British Journal of Psychiatry*, v. 178, pp. 76-81.

Seeks to identify the prevalence of psychopathology among ambulance personnel and its relationship to personality and exposure to critical incidents. Data were gathered from ambulance personnel by means of an anonymous questionnaire and standardised measures. Approximately a third of the sample reported high levels of general psychopathology, burnout and posttraumatic symptoms. Burnout was associated with less job satisfaction, longer time in service, less recovery time between incidents, and more frequent exposure to incidents. Burnout and GHQ-28 caseness were more likely in those who had experienced a particularly disturbing incident in the previous 6 months. Concerns about confidentiality and career prospects deter staff from seeking personal help. Concludes that the mental health and emotional well-being of ambulance personnel appear to be compromised by accident and emergency work. [A]

Andersen, Henrik Steen; Christensen, Anders Korsgaard; Petersen, Gorm Odden (1991). **Post-traumatic stress reactions amongst rescue workers after a major rail accident.** *Anxiety Research*, v. 4 no. 3, pp. 245-251

Rescue tasks under heavy strain may act as traumatic events creating stress reactions among the rescue workers. After a major rail accident the rescue workers were examined by questionnaire at 3 and 7 months postaccident using the General Health Questionnaire-28 (GHQ), Impact of Event Scale (IES) and a structured questionnaire made for the purpose. 18 percent of the 77 rescue workers who participated in the study had GHQ-case-score and 10 percent had IES-case-score at 7 months using the usual GHQ-cut-off (4/5) and a low IES-cut-off (19/20). For the case-scorers there was a tendency towards increased GHQ- and IES-scores from 3 to 7 months. 5 (6 percent) had PTSD of low to moderate severity at 7 months.

[A]

Armstrong, Keith R; O'Callahan, William; Marmar, Charles R. (October 1991). **Debriefing Red Cross disaster personnel: the multiple stressor debriefing model.** *Journal of Traumatic Stress*, v. 4, no. 4, pp. 581-593.

During the 1989 San Francisco earthquake, Red Cross disaster personnel were involved in providing services which put them at risk for developing stress reactions including PTSD. This article describes the disaster relief efforts in San Francisco and Oakland made by Red Cross workers and the debriefing which was provided to these personnel. Mitchell's Model for Critical Incident Stress Debriefing (CISD) was modified to fit the broad spectrum of needs and stresses experienced by disaster relief personnel. The Multiple Stressor Debriefing Model (MSDM) which evolved from this experience is discussed with specific recommendations for mental health workers involved in Debriefing Red Cross and other emergency personnel who face multiple stressors over an extended period of relief operations [A]

Badger, James M (2001). **Understanding secondary traumatic stress.** *American Journal of Nursing* v. 101, no. 7, pp. 26-33

Military combat is not the only trigger of posttraumatic stress. To the nurse, a burn unit, emergency department, or neonatal intensive care unit can be a 'war zone.' Suggests ways of handling the extraordinary, as well as the ordinary, stresses of nursing. [T, Introduction]

Bamber, Martin (1994). **Providing support for emergency service staff.** *Nursing Times*, v. 90 no. 22, pp. 32-33.

This paper provides a comprehensive review of the literature focusing on PTSD related to the experience of involvement in major incidents. The structure, role and function of the staff support team set up by the South Tees Occupational Health Psychology Service is described. [A]

Bradford R, John AM. (1991). **The psychological effects of disaster work: implications for disaster planning.** *Journal of the Royal Society of Health*, vol. 111(3), 7-10

The paper focuses on the issue of identifying staff who may be more vulnerable to psychological distress and the need for services to plan psychological screening and support for staff who will be exposed to the trauma of dealing with the aftermath of disasters. Specifically, attention should be paid to staff selection, training, use of resources, supervision, debriefing, counseling and feedback [A]

Brandt, George T.; Fullerton, Carol S.; Saltzgaber, Lee; Ursano, Robert J.; et al (1995). **Disasters: Psychologic responses in health care providers and rescue workers.** *Nordic Journal of Psychiatry*. Vol 49(2) 89-94.

Reports and questionnaire responses from health care and rescue workers involved in an air show *disaster* in Germany were studied. There were three characteristic responses to worker stress: identification, a sense of helplessness and inadequacy, and psychological distancing. Exposure to the grotesque, identifying with the rescue work, feelings of helplessness and guilt, and psychological distancing were particularly stressful, as was *not* participating in relief efforts.

Brown, Jennifer M; Campbell, Elizabeth A. (1991). **Stress among emergency services personnel: progress and problems.** *Journal of the Society of Occupational Medicine* (ISSN: 0301-0023), v. 41, no. 4, pp. 149-150.

PTSD has been diagnosed in British emergency health professionals. This article examines some of the ways that management and organizational failures contribute to this stress and how it might be prevented

Brende, Joel Osler (1991). **When post traumatic stress "rubs off".** *Voices*, v. 27, no. 1-2, pp. 139-143.

Briefly outlines a 12-point outpatient program which initially developed in response to the needs of staff members of a Veterans Administration hospital who were suffering from various PTSD symptoms that their patients exhibited. Concludes that, "those of us who do this kind of work need to recognize that this is a widespread problem that we need not be ashamed of."

D'Andrea, Livia M; Waters, Charley (Winter 2000). **Predicting post-incident stress in emergency personnel: a guide for mental health professionals on critical incident stress management teams.** *International Journal of Emergency Mental Health*, v. 2, no. 1, pp. 33-41.

The role of the Mental Health Professional (MHP) on Critical Incident Stress Management (CISM) teams has been described as one of assess and refer. That is, to assess participants who are reacting strongly to a critical incident and refer them for additional psychological help. The purpose of this article is to present guidelines, from practice and from the research literature, for MHPs to use to help them predict which participants are likely to experience high-stress reactions following the critical incident. The stages of a CISD are briefly described and the predictive features associated with each stage are discussed. [A]

Durham, Thomas W; McCammon, Susan Lynn; Allison, E Jackson (1986). **Psychological impact of disaster on rescue personnel.** *Psychiatry Digest*, v. 1986, no. 4, pp. 27-29

79 rescue, fire, and medical personnel and police officers who treated victims of an apartment building explosion completed a questionnaire describing their emotional and coping responses to the disaster. 80 percent had at least one symptom of PTSD. 8 of 21 PTSD symptoms were present in at least 10 percent of respondents. The most frequently reported symptom, intrusive thoughts about the disaster, occurred in 74 percent of those working with or searching for victims at the disaster site. On-the-scene rescue workers had

significantly more PTSD symptoms than did in-hospital staff. 52 percent of the respondents reported that family members and coworkers were supportive or very supportive in meeting their emotional needs following the disaster; 36 percent noted that support networks were not helpful. The coping behaviors most frequently used were to remind oneself that things could be worse (57 percent) and to try to keep a realistic perspective on the situation (53 percent). 11 percent reported seeking emotional support from others or looking to others for direction. [A]

Everly, George S. (1995) **Familial psychotraumatology and emergency service personnel.** In Everly, George S (ed.). *Innovations in disaster and trauma psychology, volume one: applications in emergency services and disaster response*, pp. 42-50. Ellicott City, Maryland: Chevron.

Can the family of an emergency worker be the victim of traumatic stress? In this chapter speculation is offered into the biological and psychological roots of trauma-related familial discord. [T, p.3]

Hodgkinson, Peter E; Shepherd, Melanie A. (1994). **The impact of disaster support work.** *Journal of Traumatic Stress*, v. 7, no. 4, pp. 587-600.

Limited available evidence suggests that disaster support work may have negative effects. 67 social workers were surveyed, measures being taken of psychological symptomatology and wellbeing, personality variables, social support, life events, and various aspects of disaster support work. Comparison with normative data suggested that subjects were experiencing significant levels of stress. Two major sources of disaster-related stress were identified: role-related difficulties and contact with clients' distress. Approximately one third of the variance in helper response could be explained by variables reflecting coping style, prior life events and the aforementioned aspects of disaster support work. Follow-up data at 12 months demonstrated persisting high levels of stress. [A]

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Marmar, Charles R; Weiss, Daniel S; Metzler, Thomas J; Ronfeldt, Heidi Marie; Foreman, Clay (1996). **Stress responses of emergency services personnel to the Loma Prieta earthquake Interstate 880 freeway collapse and control traumatic incidents.** *Journal of Traumatic Stress*, v. 9, no. 1, pp. 63-85.

Contrasted the responses of rescue workers to the 1989 Loma Prieta earthquake Interstate 880 freeway collapse (n = 198) with responses to critical incident exposure of Bay Area Controls (n = 140) and San Diego Controls (n = 101). The 3 groups were strikingly similar with respect to demographics and years of emergency service. The I-880 group reported higher exposure, greater immediate threat appraisal, and more sick days. The 3 groups did not differ on current symptoms. For the sample as a whole EMT/Paramedics reported higher peritraumatic dissociation compared with Police. EMT/Paramedics and California road workers reported higher symptoms compared with Police and Fire personnel. 9 percent of the sample were characterized as having symptom levels typical of psychiatric outpatients. Compared with lower distress responders, those with greater distress reported greater exposure, greater peritraumatic emotional distress, greater peritraumatic dissociation, greater perceived threat, and less preparation for the critical incident. [A]

McCammon, Susan Lynn; Allison, E Jackson (1995). **Debriefing and treating emergency workers.** In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 115-130. New York: Brunner/Mazel.

Emphasizes the importance of promoting trauma resolution and healthy coping strategies in emergency workers. Strategies that can be implemented before, during, and after a traumatic event are summarized. Pretrauma interventions include the use of a stress audit, training regarding stress and its management, and policy development. During a traumatic event, interventions include orientation to the trauma site, on-scene support, demobilization, and debriefing. Common elements among the several debriefing models described include the structuring of opportunities to review the events of the traumatic situation and to ventilate feelings, the learning of skills for integrating and mastering the event, and obtaining assistance in identifying, enlisting, and accepting help from one's support system. Post-trauma activities include individual follow-up sessions, the use of experimental procedures such as eye movement desensitization and reprocessing, and attention to anniversaries of traumatic events. Anecdotal reports testify to the effectiveness of debriefing and provide helpful insights into working with emergency responders. [T, p. xix]

McCarroll, James E; Ursano, Robert Joseph; Wright, Kathleen M; Fullerton, Carol S. (1993). **Handling bodies after violent death: strategies for coping.** *American Journal of Orthopsychiatry* (ISSN: 0002-9432), v. 63 no. 2, pp. 209-214.

Interviews with and observations of experienced and inexperienced personnel were conducted to determine their coping strategies before, during, and after their work with the bodies of people who had died violently. Avoidance, denial, and social support from the work group and spouse appeared to facilitate coping. The implications of these findings for therapeutic intervention are discussed. [A]

Miller, Laurence (1998). **Helping the helpers: psychotherapeutic strategies with law enforcement and emergency services personnel.** In Miller, Laurence. *Shocks to the system: psychotherapy of traumatic disability syndromes*, pp. 215-248. New York: Norton.

This chapter describes the types of stresses and problems experienced by police officers,

firefighters, paramedics, and other crisis workers and outlines the psychotherapeutic strategies that may prove most effective in helping these emergency responders. [T, p. 216]

Mitchell, Jeffrey T; Everly, George S. (1995). **Critical incident stress debriefing (CISD) and the prevention of work-related traumatic stress among high risk occupational groups.** In Everly, George S; Lating, Jeffrey M (ed.). *Psychotraumatology: key papers and core concepts in post-traumatic stress*, pp. 267-280. New York: Plenum Press.

In this chapter, Mitchell and Everly introduce the critical-incident stress debriefing (CISD) technology, an intervention technology used in response to accidents, homicides, suicides, community disruptions, and disasters in much of the world. CISD may be the most widely used formal group intervention for the prevention of post-traumatic stress within high-risk groups. [T, p. 265]

Myers, Diane Garaventa. (1995). **Worker stress during long term disaster recovery efforts: who are these people and what are they doing here?** In Everly, George S (ed.). *Innovations in disaster and trauma psychology, volume one: applications in emergency services and disaster response*, pp. 158-191. Ellicott City, Maryland: Chevron.

Topics treated include: Are disaster workers affected by their mission?; disaster response and disaster recovery: differences in worker tasks; roles and tasks of long-term recovery workers; key organizations in long-term recovery; review of the literature about these workers; sources of stress for long-term disaster workers; effects of stress on workers; stress mitigators for workers; a comprehensive stress management program for workers; recommendations for the future; innovations in intervention

Nocera, Antony. (2000). **Prior planning to avoid responders becoming "victims" during disasters.** *Prehospital and Disaster Medicine*, v. 15, no. 1, pp. 46-48.

Prior planning to meet the physical and mental needs of medical and emergency services responders is a practical measure to reduce staff stress. This has the potential to improve both the operational efficiency of a disaster response and reduce the incidence of PTSD in responders. Research is needed to define which interventions provide the greatest benefits to local responders. [A]

North, C. S., Tivis, L., McMillen, J.C., Pfefferbaum, B., Cox, J., Spitznagel, E.L., Bunch, K., Schorr, J., & Smith, E.M. (2002). **Coping, functioning, and adjustment of rescue workers after the Oklahoma City bombing.** *Journal of Traumatic Stress*, 15, pp. 171-175.

Firefighters who served as rescue and recovery workers were assessed. They had relatively low rates of PTSD and described little functional impairment, positive social adjustment, and high job satisfaction. PTSD was associated with reduced job satisfaction and functional impairment. Post disaster alcohol use and drinking to cope were associated with indicators of poorer functioning. Surveillance for problem drinking after disaster exposure may help identify those in need of intervention. (from authors' abstract)

Pieper, Georg; Maercker, Andreas. (1999). **Männlichkeit und Verleugnung von Hilfsbedürftigkeit nach berufsbedingten Traumata (Polizei, Feuerwehr, Rettungspersonal)** [Masculinity and avoidance of help-seeking after job-related trauma (police, firefighters, rescue teams)]. *Verhaltenstherapie*, v. 9, no. 4, pp. 222-229.

Persons in the predominately male domains of high-risk occupational groups (police, fire department, rescue teams, prison guards) often show difficulties in accepting psychological help after traumatization. The paper presents case reports and conceptual discussion of the relationship between masculinity and treatment motivation. Clinical experiences on male-specific complications of PTSD and a high risk profile of male work-related trauma victims ('alpha-man') are discussed. Theoretical discussion furthermore includes social cognitive theories of masculinity and of development of PTSD. The paper concludes with suggestions for interventions relevant to the outlined problems. [A]

Raphael, Beverley; Meldrum, Lenore; O'Toole, Brian I. (1991). **Rescuers' psychological responses to disasters**. *British Medical Journal*, v. 303, no. 6814, pp. 1346-1347.

Discusses the fact that valuable research has been done to clarify the impact of disasters (including PTSD) on rescue workers and suggests ways of preventing long term morbidity.

Raphael, Beverley; Wilson, John P (1994). **When disaster strikes: managing emotional reactions in rescue workers**. In Wilson, John P; Lindy, Jacob D (ed.). *Countertransference in the treatment of PTSD*, pp. 333-350. New York: Guilford Press.

The authors discuss nine dynamic themes common to rescue work: (1) force and destruction, (2) confrontation with death, (3) helplessness, (4) anger, (5) loss, (6) attachments, (7) elation, (8) survivor guilt, and (9) voyeurism. Disaster and rescue workers are not immune from developing psychiatric disorders; empirical studies that show that between 20 to over 80 percent of rescue workers show symptoms of prolonged stress response. This has implications for job performance as well as for the nature of clinical interventions necessary to provide care and an opportunity to work through the emotionally troublesome aspects of rescue work. [T, Introduction].

Rosser, Rachel M (1997). **Effects of disasters on helpers**. In Black, Dora; Newman, Martin C; Harris-Hendriks, Jean M; Mezey, Gillian C (ed.). *Psychological trauma: a developmental approach*, pp. 326-338. London: Gaskell.

The characteristics of traumatic reactions which are general to any helper and experiences more characteristic of helpers in specific roles are discussed. These include people involved in the physical act of rescue as professionals or as volunteers, such as fire officers, ambulance staff, police and those involved in the immediate aftermath, including religious leaders, those identifying the dead, accident and emergency staff, cleaners and mortuary attendants. Those with particular occupational hazards, especially transport workers, are also considered. Therapists' experiences and the timing of their interventions are explored. Role confusions, reversals and misunderstandings are described in relation to all helpers, victims,

expert witnesses and professionals in senior positions. This leads into two new notions of the 'wounded healer' and the multigenerational transmission of trauma. [A]

Stuhlmiller, Cynthia M. (1996). **Studying the rescuers** *Reflections*, v. 22, no. 1, pp. 18-19.

Argues that nurses can play a beneficial role in dealing with rescuers after a disaster, and warns that debriefings that focus on the potential for PTSD symptom formation may be counter-productive.

Summey, Jimmy Ray (2001). **The prevention, treatment and mitigation of secondary traumatic stress in emergency personnel dealing with disasters.** *Annals of the American Psychotherapy Assn.*, 18-21

Discusses pre-disaster, on-site and post-disaster interventions that have been successfully used to prevent or minimize the psychological and physical effects of the exposure of the disaster relief worker to a disaster or other traumatic event.

III. Resources on Burnout and Vicarious Traumatic Stress Among Therapists, Counselors, and Other Mental Health Workers

Books

Pearlman, L.A., & Saakvitne, K. (1995). **Trauma and the Therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.** New York: Norton. ISBN No.0393701832.

Stamm, B.H. (Ed.) (1995). **Secondary traumatic stress: self-care issues for clinicians, researchers, and educators** Lutherville, Maryland: Sidran Press. ISBN No.1886968071.

The articles in this book attempt to raise the question of stressful experiences in an ecological perspective so that we might learn to use what we know to prevent the pathology of PTSD and to enhance the possibility of positive developmental growth in the face of trauma. They address the psychological cost of doing trauma work, offer suggestions for ways in which therapists can create safe environments in which to work, and address ethical issues related to self care and vicarious traumatization.

Articles

Arvay, Marla Jean (2001). **Shattered beliefs: reconstituting the self of the trauma counselor.** In Neimeyer, Robert A (ed.). *Meaning reconstruction and the experience of loss*, 1st ed., pp. 213-230. Washington: American Psychological Association.

First describes the various definitions of secondary traumatic stress in order to locate it within the discourse on trauma; second, provides a discussion of the theoretical nexus between constructivism as an epistemology and narrative as a form of inquiry; and third, explains how the self is narratively configured and provide a brief description of the reflexive narrative method used in this study. After this theoretical prologue, the narrative accounts of two trauma counselors are presented followed by a discussion on how the self is reconstituted through traumatic loss. [T, p.214]

Berah EF, Jones HJ, Valent P. (1984). **The experience of a mental health team involved in the early phase of a disaster.** *The Australian and New Zealand Journal of Psychiatry*, vol.18(4), 354-358.

Reports on the reactions of a volunteer mental health team which convened in the aftermath of the 1983 Ash Wednesday bushfires. Sources of stress are discussed as are recommendations for their alleviation. [A]

Blair, D Thomas; Ramones, Valerie A. (1996). **Understanding vicarious traumatization.** *Journal of Psychosocial Nursing and Mental Health Service*, . 34, no. 11, pp. 24-30.

Close and prolonged work with victims of trauma and abuse can have serious psychological consequences for professionals, including development of anxiety, depression, intrusive thoughts, alienation, dissociative episodes, feeling of helplessness, paranoia, hypervigilance, and disrupted personal relationships. The concepts of cognitive processing models and investigation into memory dynamics can offer understanding of vicarious traumatization, and may help define preventive measures and treatment options for this condition. [A]

Blanchard, Ellen Arledge; Jones, Mirta (1997). **Care of clinicians doing trauma work.** In Harris, Maxine; Landis, Christine L (ed.). *Sexual abuse in the lives of women diagnosed with serious mental illness*, pp. 303-319. Amsterdam: Harwood Academic Publishers.

Topics treated include vicarious traumatization; countertransference; the clinician survivor; self-care.

Catherall, Donald R (1995). **Coping with secondary traumatic stress: the importance of the therapist's professional peer group.** In Stamm, Beth Hudnall (ed.). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 80-92. Lutherville, Maryland: Sidran Press. Suggests ways that trauma therapists can create safe environments in which to work. Argues that a carefully tended peer environment affords therapists the necessary objectivity to do the highly subjective work with trauma clients. Peer groups of trauma therapists set norms, provide support, help correct distortions, and generally offer opportunities to reframe the traumas. These peer-rich environments can be ripe for facilitating the ongoing work of self-care of healing secondary trauma. [T, Introduction]

Cerney, Mary S (1995). **Treating the "heroic treaters".** In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 131-149. New York: Brunner/Mazel.

This book chapter focuses on treaters who work with psychologically and physically traumatized patients. Cerney notes that these therapists are especially vulnerable to secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD), as the assault on their sense of personal integrity and belief in humanity can be so shattering that it places them in a special group of traumatized individuals who are similar in many ways to the individuals they treat, although each trauma victim, whether patient or therapist, is different. The author assesses the reactions of therapists who experience compassion stress and compassion fatigue, including issues of transference, countertransference, projective identification, and identification. She also describes factors that influence the experience and consequences of compassion stress/fatigue, preventive measures to minimize or prevent its occurrence, and ways to help the therapist who has suffered compassion fatigue. [T, p. xix]

Lahad, Mooli **Darkness over the abyss: supervising crisis intervention teams following disaster.** (2000). *Traumatology*, v. 6, no. 4, pp. 273-293.

This article suggests another way of understanding the experience of the victim and the

helper and the fantasy of omnipotence related to the "magic touch" of parenting evoked by the interrelationship of helper - parent; victim - child. Understanding the experience of the encounter with the "darkness in the face of abyss" may help to explain the powerful psychological effect on the helper, once they get in contact with the abyss and the dark. This in turn may be a partial explanation of compassion fatigue. [A]

Lansen, Johan (1993). **Vicarious traumatization in therapists treating victims of torture and persecution.** *Torture*, v. 3, no. 4, pp. 138-140.

It has become clear during recent years that therapists exposed to traumatic "material" run the risk of becoming traumatized themselves: vicarious traumatization. It is not yet known what risks are involved in this respect for therapists treating victims of torture and persecution. In order to get an impression of the extent of this phenomenon, a questionnaire was sent to many centers in the world involved with this work. An inventory was made of the casualties involved and the measures that are taken to prevent this phenomenon. About 10 percent of the therapists seem to be affected. Supervision by an experienced senior staff member, peer group supervision, and monitoring case-load are considered to be important preventive measures. [A]

Lesaca, Timothy (1996). **Symptoms of stress disorder and depression among trauma counselors after an airline disaster.** *Psychiatric Services*, v. 47, no. 4, pp. 424-426

Psychological symptoms of 21 therapists who provided counseling to individuals affected by the crash of a commercial airliner were compared with those of 20 therapists from the same mental health center who did not participate in the disaster relief efforts. At 4 and 8 weeks, the trauma counselors experienced significantly more symptoms of PTSD and depression than the therapists in the control group. At 12 weeks the only significantly increased symptom among the trauma counselors was avoidance behavior. [A]

Meichenbaum, Donald **Helping the helpers.** In Scott, Michael J; Palmer, Stephen (ed.). *Trauma and post-traumatic stress disorder*, pp. 117-121. New York: Cassell.

Counselors working with traumatized clients are particularly walking a tightrope between a lack of empathy, in order to protect themselves, and over involvement. This chapter flags the warning signs and steps that can be taken to ensure that the counselor does not fall off the 'rope'. [T, Introduction]

Munroe, James Franklin; Shay, Jonathan; Fisher, Lisa M; Makary, Christine; Rapperport, Kathryn; Zimering, Rose Theresa (1995). **Preventing compassion fatigue: a team treatment model.** In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 209-231. New York: Brunner/Mazel.

Suggests that isomorphic characteristics of compassion fatigue and PTSD, and the intensity and duration of exposure by clients, is predictive of responses. The authors assert that no therapists are immune to these effects. The chapter deals with the thorny ethical questions in

traumatology: the duty to inform, educate, and act in connection with compassion fatigue among colleague therapists. This team of authors suggests that therapists working alone may be unable to identify their own responses. A team approach is described that prevents secondary trauma and enhances client treatment by actively modeling appropriate coping strategies. Recognizing the effects of secondary trauma, the authors argue, gives therapists not only a means of prevention for themselves, but also a window of understanding and an opportunity to intervene actively with their clients. They offer several examples of client patterns and team responses, and outline several specific practices for therapists. The ideas presented here are derived primarily from work with the Veterans Improvement Program which provides treatment for Vietnam combat veterans diagnosed with PTSD. [T, p. xx, 209]

Ortlepp, K., & Friedman, M. (2002). **Prevalence and correlates of secondary traumatic stress in workplace lay counselors.** *Journal of Traumatic Stress, 15*, pp. 213-222.

Data were collected to explore the experiences of nonprofessional trauma counselors in the workplace. Most of the counselors did not experience symptoms of secondary traumatic stress requiring clinical intervention. Changes to cognitive schemata regarding counselors' world views were found. Program coordination, self-efficacy, stakeholder commitment, sense of coherence, and perceived social support were significantly related to counselor's experience of secondary traumatic stress and role satisfaction. (from author's abstract)

Ostodic, Edita (1999). **Some pitfalls for effective caregiving in a war region** *Women and Therapy, v. 22*, no. 1, pp. 161-165.

This article presents an overview of issues and concerns which can negatively impact the effectiveness of caregiving in a war zone by traumatization of caregivers, and conflicting agendas and prejudice of foreign mental health organizers and trainers. [A]

Pearlman, Laurie Anne; Saakvitne, Karen W. (1995). **What contributes to vicarious traumatization?** In Pearlman, Laurie Anne & Saakvitne, Karen W. *Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors*, pp. 295-316. New York: Norton.

Each therapist brings his own personal history, current circumstances, and empathy to the therapy relationship. In addition, the trauma material and the nature of the clientele contribute to the possibility of vicarious traumatization. This chapter discusses these aspects of psychotherapy.

Pearlman, Laurie Anne; Saakvitne, Karen W. (1995). **Supervision and consultation for trauma therapies.** In Pearlman, Laurie Anne & Saakvitne, Karen W. *Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors*, pp. 359-381. New York: Norton.

This chapter will address the techniques and practice of supervision and consultation for trauma therapies, identify essential components for a trauma therapy supervision, and

discuss some broader training and educational needs. [T, p 360]

Pearlman Laurie Anne (1995). **Self-care for trauma therapists: ameliorating vicarious traumatization.** In Stamm, Beth Hudnall (ed.). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 51-64. Lutherville, Maryland: Sidran Press.

This chapter outlines the areas impacted by vicarious traumatization and suggests self-care strategies that apply to each area of disruption.

Ratliff, Nancy (1988). **Stress and burnout in the helping professions.** *Social Casework, Vol 69(3)*, 147-154

Reviews the literature on stress and burnout in human services professionals. Most of the literature consists of common sense advice, personal anecdotes, and case studies; empirical evidence for what actually prevents stress is scant. Empirical studies are difficult to evaluate because of differing definitions of stress and burnout, weak controls, and failure to use a control group.

Rosenbloom, Dena J; Pratt, Anne C; Pearlman, Laurie Anne (1995). **Helpers' responses to trauma work: understanding and intervening in an organization.** In Stamm, Beth Hudnall (ed.). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 65-79. Lutherville, Maryland: Sidran Press.

Describes policies and programs employed by the Traumatic Stress Institute to prevent and alleviate vicarious traumatization among members of its professional staff.

Smith, A J M; Kleijn, Wim Chr; Stevens, J A. (2001). **De posttraumatische stressstoornis: bedrijfsrisico voor behandelers?: een onderzoek naar werkstress bij traumatherapeuten= (Posttraumatic stress disorder: an occupational risk for therapists?: research findings of workstress in trauma therapists).** *Tijdschrift voor Psychiatrie*, v. 43 no. 1, pp. 7-19.

Research questions were, how burdening are trauma therapies for the therapists, and, does the emotional burden relate to the characteristics of the patients? The contribution of organizational factors was also analysed. A questionnaire was distributed among 129 employees of a trauma institute. A high level of experienced emotional burden was related to the treatment of traumatized patients. Emotional burden was related to therapist-anxiety and acuteness and severity of the PTSD-symptoms. Role clarity (tasks and responsibility) was a stress-reducing factor. Other factors seemed to play a part in burnout: here the relationship of the therapist with the organization as a whole emerged as an important factor. [A]

Van der Veer, Guus. (1992). **The consequences of working with refugees for the helping professional.** In Van der Veer, Guus. *Counselling and therapy with refugees: psychological problems of victims of war, torture and repression*, pp. 241-248. Chichester, England:

Wiley.

This chapter advises therapists on how to avoid negative consequences of counseling victims of civil warfare and rape.

Vicary, Dave; Searle, Grey; Andrews, Henry (2000). **Assessment and intervention with Kosovar refugees: Design and management of a therapeutic team.** *Australasian Journal of Disaster and Trauma Studies*. Vol 4(2)..

The Western Australian Department for Family and Children's Services (FCS) were invited to assist in providing services to the Kosovar refugees relocated to Australia in 1999. The department's involvement centered on needs assessment of the Kosovar and the provision of family and individual support and advocacy. Family and Children's Services made an early decision to develop support infrastructure for staff prior to commencing work with the Kosovar. The management of staff was designed to reduce levels of tension related to the counsellors' work, build a strong and supportive team, reduce the possibility of worker burnout, and facilitate re-entry into the workplace upon completion of the Team's work. This article reviews the assessment methodology and subsequent interventions undertaken with the Kosovar by FCS team members. It also examines the management strategies utilized to maintain the health and functionality of the Team so that they in turn could provide quality services to the refugees.

White GD. (1998). **Trauma treatment training for Bosnian and Croatian mental health workers.** *American Journal of Orthopsychiatry*, Vol. 68(1), 58-62.

Describes trauma treatment training programs in the former Yugoslavia for Bosnian and Croatian mental health workers. Compassion fatigue and burnout among the trainees was measured and evaluated and a system of international supervision and consultation was implemented. Plans for development of this system to support future training and consultation programs are discussed. [A]

Williams, Mary Beth; Sommer, John F. (1995). **Self-care and the vulnerable therapist.** In Stamm, Beth Hudnall (ed.). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 230-246. Lutherville, Maryland: Sidran Press.

Discusses the vulnerabilities experienced by therapists within a framework of ethics and standards of practice, and examines the importance of addressing these issues on both an individual and collective basis. [T, p. 131]

Yassen, Janet (1995) **Preventing secondary traumatic stress disorder.** In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 178-208. New York: Brunner/Mazel.

This chapter presents an understanding of the concept of prevention and offers an ecological model as a framework for planning for the impact of secondary traumatic stress (STS). It is based on the premise that STS in itself cannot be prevented since it is a normal and universal

response to abnormal (violence induced) or unusual events (disasters). The enduring or negative effects of this response, however, can be prevented from developing into a disorder, secondary traumatic stress disorder (STSD). This chapter emphasizes the various components of a comprehensive prevention program including the individual and environmental aspects of self-care. It assumes that unless we prepare, plan, or attend to the effects of STS, we can cause harm to ourselves, to those who are close to us, or to those who are in our professional care. The second section of this chapter discusses implementation of a prevention plan. It identifies factors that influence successful prevention planning and makes suggestions for combating resistance to prevention planning. [T, p. 178]

IV. Resources on Burnout and Vicarious Traumatic Stress: Miscellaneous

Books

Figley, Charles R (ed.) (1995). **Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized**. New York: Brunner/Mazel. ISBN No.0876307594.

Discusses the vulnerability of caregivers to “compassion fatigue,” distinctions between compassion fatigue, burnout, countertransference, and PTSD.

Raphael, Beverley; Wilson, John P (Eds.) (2000). **Psychological debriefing: theory, practice and evidence**. Cambridge: Cambridge University Press. ISBN No.0521647002.

This book discusses the current state of the vigorous debate over the effectiveness of debriefing, explores circumstances in which debriefing may or may not be useful, and suggests directions for future research.

Articles

Catherall, Donald R. (1995). **Preventing institutional secondary traumatic stress disorder**. In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 232-247. New York: Brunner/Mazel.

In this book chapter, institutions are the central point of interest, especially those that are vulnerable to acts of violence or other sources of traumatic stress. The author argues that well-prepared institutions establish ongoing mechanisms to deal with PTSD and compassion fatigue among their workers, including therapists. He maintains that the first step is to evaluate the degree of exposure and assign responsibility for prevention activities before incidents actually occur. The institution must then work to establish an atmosphere that acknowledges the normality of reactions to compassion stress and facilitates the processing of exposure to secondary stressors. This healthy atmosphere, according to Catherall, is similar to that in families that cope functionally with primary trauma (i.e., they identify the stressor as a problem for the entire group, and not just the affected individual) and that approach the problem in an open, supportive, nonblaming fashion. In addition, Catherall notes that institutions must attend to aspects of the institutional environment that affect the workers' abilities to function as a closely knit group. These elements include the hierarchical structure of most institutions, the impersonal and disempowering atmosphere of many bureaucracies, and the influence of the institutional mission. Finally, Catherall points out that institutions must attend to the dynamics of the group and ensure that affected workers are not viewed as having something wrong with them, but, rather, as having had something happen to them. [T, p. xxi]

Figley, Charles R. (1995) **Compassion fatigue: toward a new understanding of the costs of caring.** In Stamm, Beth Hudnall (ed.). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*, pp. 3-28. Lutherville, Maryland: Sidran Press.

Topics treated include: conceptual clarity; identification of trauma; why are there so few reports of secondary trauma?; why STSD?; definition of secondary traumatic stress and stress disorder; contrasts between STS and other concepts; countertransference and secondary stress; burnout and secondary stress; why compassion stress and compassion fatigue?; implications for training and educating the next generation of professionals.

Figley, Charles R; Kleber, Rolf J. (1995). **Beyond the "victim": secondary traumatic stress.** In Kleber, Rolf J; Figley, Charles R; Gersons, Berthold P R (ed.). *Beyond trauma: cultural and societal dynamics*, pp. 75-98. New York: Plenum Press.

This chapter focuses on these secondary victims: the victim's spouse and/or children, friends and neighbors, colleagues at work, and helping professionals such as rescue workers, emergency personnel and psychotherapists. These people are in some way close to the victim or survivor. Secondary traumatic stress refers to the stress symptoms resulting from hearing about an extreme event experienced by a friend or loved one or from attempting to help the traumatized or suffering person. This exposure may be a confrontation with powerlessness and disruption as well. The authors review the scientific literature associated with secondary effects of traumatic stress and describe the various groups of people indirectly influenced and touched by trauma. [T, p.15]

Figley, Charles R. (1995). **Compassion fatigue as secondary traumatic stress disorder: an overview.** In Figley, Charles R (ed.). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*, pp. 1-20. New York: Brunner/Maze.

The purpose of this chapter is fivefold: (a) to introduce the designation compassion fatigue to describe the result of working with traumatized people; (b) to provide a rationale for the stress-producing potential of these secondary traumatic stressors, which is equal to or greater than that of more conventional, direct traumatic stressors; (c) to discuss the advantages of separating out secondary stress reactions (compassion stress) and stress disorders (compassion fatigue) in the DSM from direct stress reactions and stress disorders; (d) to describe a theoretical model that accounts for and predicts the emergence of compassion stress and compassion fatigue among professionals working with traumatized people; and (e) to explicate the principles associated with accurate diagnosis, assessment, research, treatment, and prevention of compassion fatigue. [T, p. xvi]

Maslach, Christina; Leiter, Michael P. (1997). **The truth about burnout: How organizations cause personal stress and what to do about it.** San Francisco, CA, US: Jossey-Bass/Pfeiffer xi, 186 pp.

This book focuses on the organizational sources of job burnout. Guidelines for eliminating

the underlying problems that cause burnout are discussed.

Urquiza, Anthony J; Wyatt, Gail Elizabeth; Goodlin-Jones, Beth L. (1997). **Clinical interviewing with trauma victims: managing interviewer risk.** *Journal of Interpersonal Violence*, v. 12 no. 5, pp. 759-772.

During the past decade, research methodology in the area of child and adult violence has increasingly utilized a clinical interview methodology. Although this methodology promises a more reliable and clinically rich set of data, it also carries higher degree of risk of emotional distress to the interview participants. Thus far, most of the focus on risk has been directed toward the respondent or subject; however, this article describes differing aspects of risk for the interviewer and presents clinical examples. Approaches to minimizing and managing emotional distress on the part of the interviewer are presented, with an emphasis on recruitment of research personnel, initial and ongoing training, and structuring regular interviewer team meetings. It is proposed that the safety and emotional health of both the respondent and the interviewer should always take priority over data collection. [A]

Van der Velden, Peter G; Hazen, Koos H M; Kleber, Rolf J. (1999). **Traumazorg in organisaties (Trauma care within organizations).** *Gedrag en Organisatie*, v. 12, no. 6, pp. 397-412.

Various organization and professions are at risk for acute stress situations and traumatic events. Due to the nature of their services and products they are confronted with aggression, robberies, sudden deaths, traffic accidents, calamities and disasters. When acute stress situations accumulate and occur frequently they become part of chronic work stress. To prevent incident-related and persistent coping disturbances, absentee's leave, and diminished work performance, three forms of trauma care are described and discussed, which are based on a social-cognitive approach to coping with (traumatic) stress. The central element of these forms of trauma care is the structured provision of informative, cognitive, social, and emotional support. First, an outline is given of a structured short term cognitive oriented assistance program, designed for single acute stress situations like a robbery and sudden death of a colleague. Second, a structured supportive behavioral counseling program is described for employees who in the aftermath of the event are confronted with new stressors which negatively affect the coping process, such as reorganizations, medical problems, and formal investigations. Third, a structured work meeting program is described and discussed, which is designed for organizations where acute stress situations accumulate. The advantage of these forms of trauma care is that they can be realized within organizations. [A]

V. **Coping With Catastrophe: Responding to the Psychosocial Effects of War, Natural Disasters, and other Humanitarian Emergencies**

General Manuals

Ehrenreich, J.H. (2001). **Coping With Disaster: A Guidebook to Psychosocial Intervention** (Rev. Ed.). Old Westbury, NY: Center for Psychology and Society. (Also available online, in English and Spanish, at <http://www.mhwwb.org/disasters.htm>).

Hodgkinson, P.E., & Stewart, M. (1998). **Coping with catastrophe: A handbook of post-disaster psychosocial aftercare** (2nd Edition). London: Routledge. ISBN No.0415168538.

Raphael, B. (1986) **When disaster strikes: How individuals and communities cope with catastrophe**. New York: Basic Books. ISBN No.0465091687.

Roberts, A.R. (Editor). (1990). **Crisis intervention handbook**. Belmont, CA: Wadsworth. ISBN No.019513365A.

World Health Organization, (1996). **Mental Health of Refugees**. Geneva: World Health Organization. ISBN No.9241544864.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). **Disaster mental health services: A guidebook for clinicians and administrators**. White River Junction, VT: National Center for PTSD. (Also available on-line at <http://www.ncptsd.org>).

Additional Resources: Books

Danieli, Y., Rodley, N.S., & Weisaeth, L. (Editors). (1996). **International responses to traumatic stress**. Amityville, NY: Baywood. ISBN No.0895031329.

Enarson, E., & Morrow, B.H. (Editors) (1996). **The gendered terrain of disaster through women's eyes**. Westport, CT: Greenwood Publishing Company. ISBN No.0275961109.

Everly, G.S., & Lating, J.M. (Editors). (1995). **Psychotraumatology: Key papers and core concepts on post traumatic stress**. New York and London: Routledge. ISBN No. 0306447827.

Ladrado-Ignacio, L., & Perlas, A.P. (1995). **From victims to survivors: Psychosocial intervention in disaster management in the Philippines**. *International Journal of Mental Health*, 24, 3-51.

Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (1996). **Ethnocultural aspects of posttraumatic stress disorder**. Washington, D.C.: American Psychological Association. ISBN No.1557989087.

Walker, B. (Ed.) (1995). **Women and Emergencies**. Oxford: Oxfam.

Additional Resources: Internet

David Baldwin's Trauma Pages, <http://www.trauma-pages.com>. A wide variety of articles and resources can be accessed at this site.

Health and Human Rights Info: <http://www.ishhr.org>. "Health and Human Rights Info" is a project aimed at making practical information and materials on health and human rights more easily accessible to health workers in the field. The focus will be on psychosocial intervention and psychological care in areas affected by gross human rights violations and catastrophic events. For this purpose we will establish a website with selected texts and information. The website will be launched by the end of 2002.

National Center for PTSD, <http://www.ncptsd.org>. The PILOTS Database, a database on traumatic stress, is available at this site.

National Hazard Center, <http://www.colorado.edu/hazard>. The Search-HazLit database, a database on disasters of all kinds, is available at this site.

Psychosocial Working Group Inventory of Key Resources:
<http://earlybird.qeh.ox.ac.uk/psychosocial/>. This inventory is a collection of grey (unpublished) literature that allows ready access to project-related documentation exemplifying key methods and principles of psychosocial interventions. The Refugee Studies Centre, University of Oxford, on behalf of the Psychosocial Working Group, has developed this collection as a resource for academics and practitioners with the help of the Forced Migration Online team. The collection will be added to as materials become available.