Development of an Art Therapy Method for the Prevention and Treatment of Vicarious Trauma

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Development of an Art Therapy Method for the Prevention and Treatment of Vicarious Trauma

Capstone Thesis

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Abstract

Modern developments in the field of mental health care have greatly increased understanding of vicarious trauma and its impacts on the helping professions. However, the prevalence of vicarious trauma symptoms highlights the need for additional research into prevention and treatment. First responders, critical healthcare workers, and mental health professionals are at particularly high risk for compassion fatigue, burn out, and other symptoms of vicarious trauma as they work closely with traumatized populations. The high incidence of vicarious trauma in individual helping professionals can have immense consequences that ultimately limit quality systems of care available to the general public. This thesis investigates vicarious trauma through an art therapy workshop that was created for staff at a domestic violence shelter in the southeastern U.S. The use of visual arts better engaged staff in conversations on vicarious trauma than verbal methods alone and facilitated deeper processing and freer professional sharing on this difficult topic. Specific considerations to tailor this method for other high risk helping professions is discussed.

Keywords: Vicarious trauma, compassion fatigue, burnout, art therapy interventions, helping professionals, first responders, critical healthcare workers, mental health professionals
The Role of Art in the Prevention and Treatment of Vicarious Trauma

Introduction

This thesis presents the development of an art therapy method. Recent developments in the field of mental health care have greatly increased available resources on the impacts of vicarious trauma on helping professions. However, these sources lack a succinct understanding of the unique needs of high risk helping professions, how prevention and treatment can be tailored to best serve each occupation, and how the creative arts can be used to facilitate processing and discussing difficult experiences in a professional setting.

The concepts surrounding vicarious trauma, including similar terms, such as compassion fatigue and secondary traumatic stress, are a generally recent development within the field of mental health counseling. Within the last 20 years, researchers have begun to recognize the toll that working with traumatized populations has on caregivers of all kinds. As detailed by Russell and Cowan (2018), connections between stress, trauma, and neurobiological changes have been studied since the early 1900s, mainly as a response to World War I. However, these concepts weren’t generalized to civilian life until the 1980s when children of Holocaust survivors began presenting similar trauma responses to those of their parents. The turn of the 21st century brought about a deeper understanding of trauma and the immense impact secondary exposure has on specific helping professions such as first responders, medical personnel, and mental health workers. While prevention and treatment efforts for vicarious trauma has begun, the most current research by Russell and Cowan (2018) points to neurobiological symptoms such as the activation of mirror neurons in empathic processes which have the potential to restructure the brain in the same way as direct exposure to trauma. This deep, neurobiological impact becomes highly concerning when paired with the current prevalence of vicarious trauma.
Just as the understanding of vicarious trauma came from the roots of trauma theories, trauma treatment can provide guidance in the treatment of vicarious trauma. Crenshaw stated in his 2006 book titled *Expressive and Creative Arts Methods for Trauma Survivors*, “…neuroimaging scans have shown that when people remember a traumatic event, the left frontal cortex shuts down— in particular the Broca’s area, the center of speech and language” (p. 25). Using the arts in therapy for this population enables us to bypass the speech and language center that may not be functioning properly. Hinz (2009) also indicated that art can help improve overall brain function and argued, “Creative experiences have the potential to integrate information from both hemispheres of the brain” (p. 7). The most unique benefit of the use of art in therapy, is aesthetic distance. Glass (2006) defined aesthetic distance as “the point at which the client can have access to his feelings and also maintain an observer stance” (p. 58). The arts allow the client to indirectly speak about their trauma. This indirect approach allowed clients to discuss their art while remaining separated from the trauma experience and avoiding an automatic trauma response. The art object itself acts as a container to hold the excessive affect of the trauma. This enables the client to remain an observer of the trauma while speaking about it and aids in professional sharing around difficult topics. Integrating the arts into vicarious trauma treatment is consistent with a holistic approach and honors the relationship between the mind and the body.

This thesis has considered the history and current research on the numerous symptoms of working with traumatized populations and how these symptoms vary based on the services of multiple helping professions. This research was then used to create an arts based workshop for staff at a domestic violence shelter in the southeast. The goals of this thesis and method are firstly to understand the symptoms specific to three types of helping professions; first responders,
medical personnel, and mental health care workers. And secondly, to use the arts to prevent and process vicarious trauma, reduce stress, increase positive feelings, facilitate professional sharing, and build a space for community and wellness.

**Literature Review**

**Vicarious Trauma**

The terms vicarious trauma, secondary traumatic stress, burn out, and compassion fatigue are common terms that are often used interchangeably. However, the subtle differences provide a holistic understanding of the complexities of vicarious trauma. Compassion fatigue is defined as, “a state of tension and preoccupation with traumatized patients” which happens as a result of “re-experiencing” traumatic events with the client and is therefore seen as unavoidable in certain lines of work (Russell & Cowan, 2018, p. 4). Common symptoms of compassion fatigue include avoidance or numbing of reminders associated with the client and persistent arousal. Quite similarly, secondary traumatic stress is defined as “the stress from helping or wanting to help a traumatized person” and is also seen as an inherent quality of certain professions (Russell & Cowan, 2018, p. 4). These terms are most often used interchangeably as both include applications for populations outside of traditional helping professions, for example partners of veterans or family members who become caretakers of children with disabilities. Burn out is more specific to helping professionals and is characterized by emotional exhaustion, diminished feelings of accomplishment, and depersonalization (Russell & Cowan 2018). Burnout has often been associated with low job satisfaction and high staff turnover in multiple helping professions (Salloum, Kondrat, Johnco, & Olson, 2015; Elasher, Moustafa, Aiad, & Ramadan, 2017). Lastly, vicarious trauma describes the cumulative impacts of working with traumatized populations which entails both short-term and long-term effects. Helping professionals can experience
symptoms such as cynicism, loss of hope and a disruption of beliefs about self and the world. In addition, they may experience similar symptoms to those of their clients which often include heightened arousal, invasive thoughts or flashbacks, and a difficulty experiencing positive affect (Nen, Astbury, Subhi, Alavi, Lukman, Sarnon, Fauziah, Hoesni, & Mohamad, 2011). For the purposes of this paper, the term vicarious trauma will be used most often as this term best encompasses all of the aforementioned ideas and symptoms. The wording of vicarious trauma also highlights the similarity to the development and course of treatment of direct trauma which has been used as a guide to create therapeutic interventions for helping professionals.

The prevalence of vicarious trauma warrants further research into prevention and treatment. Lanza, Roysircar, and Rodgers (2018) detailed the prevalence of Post Traumatic Stress Disorder (PTSD) among first responders which is more than twice as high as deployed soldiers and ranges from 8% to 32% as compared to the average U.S. American’s range of 6.8%-7.8%. The authors also reported increased risk for acute stress, substance abuse, and major depression. Similarly, Elasher, Moustafa, Aiad, & Ramadan’s 2017 study found 80% of surveyed critical healthcare workers reported high levels of emotional exhaustion with 60% reporting some level of depersonalization, a common symptom of trauma survivors. Mental health care workers suffer comparable symptoms to their more medical counterparts as Salloum, Kondrat, Johnco, and Olson (2015) reported that 34%-50% of their sample of Child Welfare workers experienced high or very high levels of compassion fatigue. Additionally, Bearse, McMinn, Seegobin, and Free (2013) divulged that 61% of surveyed psychologists had experienced clinical depression and 42% had experiences of suicidal ideation both of which can be tied to trauma exposure. Perhaps even more telling, 59% of these clinical psychologists reported having experienced a time when they may have benefitted from personal therapy but did
not seek it out. The incidence of vicarious trauma is real and the impact is vast. Society at large has a great need for helping professions but if careers are not sustainable for providers, communities face a detrimental situation for all.

**Etiology of Vicarious Trauma**

Russell & Cowan (2018) have detailed the history and etiology of what they term as “compassion stress injury” and traced early trauma research to American Army psychiatrist Walter B. Cannon who first termed the phrase “fight or flight.” More specifically, the first reference to vicarious trauma was from British Army psychiatrist William H. R. Rivers in his creation of the phrase “shell shock by proxy.” The authors indicated that the information gathered about trauma and its secondary impacts during WWI was roundly ignored and a great deal of mental health treatment during WWII was spent relearning these lessons. During WWII the terms “old sergeant’s syndrome,” “old psychiatrist syndrome,” and “burn out” came into play. The stress placed on sergeants making constant life or death decisions as well as the stress on psychiatrists listening to endless numbers of traumatic stories became clear. These concepts were not generalized to civilian life until the 1970s-1980s. It was through transgenerational trauma seen in the families and children of survivors of the Holocaust that this more general understanding had begun to take place. The terms “vicarious traumatization” and “secondary traumatic stress” were created at this time and the ideas surrounding burn out were generalized and applied to civilians. Russell & Cowan coined the term “compassion stress injury.” The authors chose this terminology as they argued it best encompasses all the ideas behind compassion fatigue, burn out, vicarious traumatization, and others, while emphasizing, “an actual mind-body ‘wounding’ not dissimilar to physical injury versus mere fatigue” (p. 2). Current research related to treatment of vicarious trauma has called for greater exploration into
prevention and treatment. Most research has offered cognitively-based prevention methods to protect against any automatic trauma responses. (Klimecki & Singer, 2015; Klimecki, Leiberg, Richard, & Singer, 2014). However, Russell & Cowan disputed that these cognitively based approaches may not be able to address neurobiological reactions to trauma such as the activation of mirror neurons in empathic processes which have the potential to restructure the brain.

**Vicarious Post Traumatic Growth**

While many studies have focused on the negative impacts of working with trauma, there may be some benefits that are worth exploring in order to understand a more complex and realistic view of working with trauma. Edelkott, Engstrom, Hernandez-Wolfe, & Gangsei (2016) created a qualitative study to better define the term “vicarious resilience” which the authors noted was first coined in 2007 by Hernandez, Gangsei, and Engstrom. It was claimed that vicarious resilience and other positive effects of trauma work were discovered from unexpected findings in vicarious trauma research. Concepts of compassion fatigue, vicarious posttraumatic growth, and vicarious resilience all began taking form in the early 2000s. Twelve women and one man elected to participate all of which were qualified mental health professionals with at least one year of experience working with torture survivors. Four major themes were discovered; a change in the therapist’s self-perception and outlook, an altered spirituality, modified thoughts about self-care, and a new view on trauma work. The clinical implications of this study were significant. Almost all therapists underwent a change in self-perception which caused a reassessment of their therapeutic work. They adopted more strengths-based approaches and let their clients take the lead, making a more collaborative approach. Therapists also gained greater long-term motivation for their work and paid closer attention to self-care. Ultimately, the authors
argued that changes in all of these four major themes can improve therapeutic care and reduce burnout.

Cohen and Collens (2013) have also contributed to the understanding of vicarious post traumatic growth. The authors presented a metasynthesis of research from 20 different qualitative articles and four main themes were found which included emotional and somatic impact of trauma work, coping with that impact of trauma work, changes to inner schemas and behaviors, and the process of schematic change. The emotional and somatic impact of trauma work aligned with conceptualizations of vicarious trauma and included characteristics such as sadness, exhaustion, frustration, and numbness. Coping with the emotional effects of trauma work highlighted protective factors of organizational origin such as a managed and diversified workload and an inclusive style of working as impactful (p. 572). Personal protective factors of importance included self-care behaviors which were noted to be a common way to regulate emotions. The theme of changes to inner schemas and behavior noted a more complex picture than most trauma research on helping professions in that both negative and positive changes were catalogued. All in all, the authors claimed these positive changes were triggered by exposure to the client’s resilience and post traumatic growth. The most notable information found in the process of schematic change is that, “positive changes could co-occur alongside some of the negative emotional work” (p 576). This study determined that long-term, if intermittent, engagement with client can expose helping professionals to the client’s recovery and growth and allowed space for vicarious post traumatic growth to occur. Together these articles indicated positive outcomes for helping professionals working with individuals with a trauma background. While the field is aware of many risks and negative outcomes of working
with traumatized populations, the potential benefits require further research. Without this positive perspective, a holistic view of trauma work is incomplete.

**Specific Professional Concerns and Barriers: First Responders**

In order to tailor interventions for prevention and treatment of vicarious trauma, it is important to understand the nuances of demands on specific helping professions. Research noted workplace stigma as a large barrier to first responder mental healthcare (Kliem & Westphal, 2011). The myth or stereotype of an unshakable hero is compounded by worries of job discrimination or negative performance evaluations if mental health care is utilized. Due to the nature of the work, first responders may also fear the use of mental health resources will be obvious and may not remain confidential (Lanza, Roysircar, and Rodgers, 2018). This lack of privacy can manifest itself in multiple ways. Lanza, Roysicar, and Rodgers 2018, noted that the grief of first responders after a natural disaster or large scale crisis (i.e. the terror attack of 9/11) is often widely recorded and broadcasted to the public causing an invasion of privacy during times of great emotional turmoil. Additionally, most support and mental health care for first responders is often limited to short term care in direct relation these large scale crises (Rutkow, Gable, & Links, 2011).

The lack of ongoing mental health care supports is due in part to a lack of coverage from insurance which keeps mental health care inaccessible for first responders. Foels’ 2017 article detailed a legal issue using the case of a Florida police officer who was tasked with the clean up of the Pulse nightclub shooting. Officer Realin was not compensated for care once he developed PTSD from the incident. Worker’s compensation benefits in Florida only cover physical injuries or mental injuries which accompany a physical injury. While worker’s compensation benefits vary from state to state, Foels reported, “Currently, eighteen states, including Florida, refuse to
recognize purely psychological trauma unaccompanied by a physical injury as a compensable injury eligible for full workers’ compensation benefits” (p. 1444). This lack of insurance coverage is alarming when you consider that the prevalence of PTSD alone among first responders is almost five times higher than the general public, and more than twice as high as active duty soldiers; not to mention increased risk for depression, anxiety, vicarious trauma, compassion fatigue, and burn out (Lanza, Roysircar, and Rodgers, 2018).

**Critical Health Care Professionals**

Similar to first responders, critical care health professionals (i.e. end of life care, intensive care, or emergency department workers) often experience cumulative loss unique to their profession. Due to the nature of the job, critical health care workers have more frequent interactions with death than other helping professions. While many studies show that regular exposure to death can result in less death anxiety, this is impacted by multiple factors such as age, additional exposure to death in personal roles, and comfort with discussing mortality. Training to reduce death anxiety is somewhat common and has the additional benefit of reducing burnout in this population (Potash, Chan, Ho, Wang, & Cheng, 2015).

In addition to cumulative loss, burnout is also common for critical health care workers. In a study of critical health care workers by Elshaer, Moustafa, Aiad, and Ramadan (2017), 80% of those surveyed reported high emotional exhaustion and 76.8% reported quantitative overload (i.e. a skewed staff to patient ratio) which both have direct correlation burnout. This study found further evidence that lack of control at the work place in the form of reduced autonomy or decision making exacerbates the issue of emotional exhaustion.

**Mental Health Care Professionals**
Fortunately, mental health care workers face better workplace attitudes towards utilizing mental health resources for themselves. In a study by Bearse, McMinn, Seegobin, and Free (2013) which examined barriers to psychologists seeking mental health care, stigma was not reported as an issue. Instead, the factor with the biggest impact on whether or not a mental health care worker received mental health care services for themselves was difficulty finding a therapist. Main challenges in finding an acceptable therapist were lack of therapists of the same ethnicity, distance, and dual relationships; many practitioners in the same area considered each other colleagues and so a therapeutic relationship would be inappropriate.

**Systemic Considerations of Vicarious Trauma**

While all of these helping professions interact with traumatized individuals in unique ways, vicarious trauma has some common impacts on our systems of care. The largest common impact on systems of care is high staff turnover. Multiple sources in each of the helping professions noted a high turnover rate in association with vicarious trauma, particularly burnout, which had an overall negative impact on their organizations (Salloum, Kondrat, Johnco, & Olson, 2015; Tyler, 2012; Nen, Astbury, Subhi, Alavi, Lukman, Sarnon, Fauziah, Hoesni, & Mohamad, 2011; Elasher, Moustafa, Aiad, & Ramadan, 2017). Tyler (2012) explained, “…high turnover not only increases the costs of providing these services but also destabilizes the agencies and prevents them from creating a high functioning and cohesive work force” (p. 127). Resources of administrators can often be redirected as they scramble to find replacements and an increased workload placed on the remaining staff can cause quality and availability of services to drop drastically (Salloum, Kondrat, Johnco, & Olson, 2015).

Tosone, Nuttman-Shwartz, and Stephens (2016) also demonstrated a key point that helping professionals can often be called on to treat victims impacted by collective events. Even
though it is expected that helping professionals would work in the same communities where they live, there are times when this poses a complex problem. During a catastrophic event such as an extreme weather event or a terrorist attack, helping professionals will still be called on for aid even if they have been impacted in their personal lives. This creates a dual exposure to trauma as the event is experienced directly and compounded by interactions with other victims in need. The authors defined this as “shared trauma” (p. 233). Experiences of shared trauma can leave organizations short staffed and put additional strains on systems of care in times of dire need. Ultimately, a broken system can end up causing additional harm to traumatized individuals. Initial harm occurs during a traumatic experience and defenses may be built which make it difficult for individuals to receive care effectively. This initial harm can be aggravated or re-experienced by working with a system that is unintentionally neglectful or abusive due to gaps in care from insufficient staffing or trauma symptoms inherent in the system’s workers (Tyler, 2012). Because many individuals in helping professions are regularly exposed to trauma through their work environment and trauma symptoms are likely, there is a need for employers to own responsibility for the safety of their employees. Organizations that require their employees to be put in a position where vicarious trauma is likely should consider preventative measures a basic safety need and find ways to promote professional sharing around the matter. Appropriate help should always be accessible, even to those who provide it.

**Art Therapy and Vicarious Trauma**

Contemporary research on treatment of vicarious trauma has found that the use of art interventions with helping professionals can be used as preventative measures to combat multiple symptoms of vicarious trauma. Art interventions have been noted to reduce stress, lessen feelings of isolation, and allow for freer professional sharing. Potash, Chan, Ho, Wang, & Cheng, 2015
argued, “art therapy may be particularly suitable for dealing with topics that are either too painful to discuss or in situations in which metaphor and symbol may allow for an expanded perspective” (p. 45). Similarly, Anderson & Gustavson (2016) studied the impact of a knitting education program on the compassion fatigue of oncology nurses. Although many nurses indicated that they did not have the time to participate as often as they would have liked, preintervention burnout scores were a mean of 24.72 with postintervention burnout scores at a mean of 22.91. The authors noted, “The nurses who reported the highest burnout scores preintervention had the most decrease in their burnout scores after the intervention. The same holds true for secondary traumatic stress scores…” (p. 103). Participants also reported bonding with fellow staff and gaining a creative skill to maintain. The community building aspects of a shared art making experience should not be overlooked. These facets reduce feelings of social isolation which are closely linked to burnout and compassion fatigue. (Elshar, N.S.M., Moustafa, M.S.A., Aiad, M.W., & Ramadan, M.I.E., 2018).

In a similar study, Ifrach & Miller (2016) explored the impact of a group peace pole intervention on the compassion fatigue of counselors working with domestic violence and sexual assault. Participants were in a group with their coworkers and given paint, markers, collage materials, and a four by four-inch canvas material to create a piece of art. Groups at three different sites were instructed that this art making is both for themselves and their clients as well as what they felt society needed to know in regards to domestic violence and sexual assault. Data was collected both pre- and postintervention via the Compassion Fatigue Self-test for Helpers and the Psychological Stress Measure-9. The pretest mean of stress was 31.78 and the posttest mean of stress was 23.9, a statistically significant difference. The authors also reported that the group setting added to a sense of belonging, safety, and well being.
Methods

An art therapy workshop on vicarious trauma was created for staff members at a domestic violence shelter in an urban city in the southeastern United States. An initial art therapy intervention was provided during a shelter staff meeting to introduce the new art therapy intern to the staff and to explain some theory behind this new approach being integrated into services at the shelter. The intervention was based off of Ifrach and Miller’s integration of social action art therapy into services for domestic violence and sexual assault workers. The intervention was so well received that administration asked if this service could be integrated on a more regular basis and thus this workshop was created. The purpose of this workshop was to determine if the use of art interventions would reduce stress within the staff and facilitate deeper processing and freer sharing around vicarious trauma than meetings including only verbal discussions on vicarious trauma.

The vicarious trauma prompts used in this workshop were modeled after Potash, Chan, Ho, Wang, and Cheng’s 2015 model for art therapy based supervision for end of life care workers in Hong Kong. The themes used in this model were intentionally put in order to allow a gradual exploration of more difficult and complex experiences. The topics included self-care and stress management, case sharing and clinical skills, and lastly grief and bereavement. The art therapy workshop created in conjunction with this thesis touched on similar topics in a similar order, as seen in Table 1. The topics began with less complex and more positive topics to give participants time to build confidence with art making before delving into deeper, more complex representations. Potash, Chan, Ho, Wang, and Cheng also noted mindfulness practices aid in increasing attention to emotions and reduce judgment and self-criticism. The mindfulness prompts focusing on positive emotions or reframing negative emotions were introduced as an
option for staff to choose. These prompts accompanied the vicarious trauma prompts in their level of depth and complexity as much as possible, as seen in Table 1.

Table 1
Outline of Art Therapy Workshop on Vicarious Trauma

<table>
<thead>
<tr>
<th>Week</th>
<th>Vicarious Trauma Prompt</th>
<th>Mindfulness Prompt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Self Care</td>
<td>Compassionate Letter to Self</td>
</tr>
<tr>
<td>Week 2</td>
<td>Vicarious Post Traumatic Growth</td>
<td>Mindfulness Drawing</td>
</tr>
<tr>
<td>Week 3</td>
<td>Unplanned Transition</td>
<td>Recreating Stress</td>
</tr>
<tr>
<td>Week 4</td>
<td>Vicarious Trauma</td>
<td>Mandala</td>
</tr>
<tr>
<td>Week 5</td>
<td>Reflection</td>
<td>Reflection</td>
</tr>
</tbody>
</table>

Participants

Staff from all departments of the shelter (i.e. social workers, mental health counselors, interns, front desk/intake staff, kitchen staff, volunteer coordinators, etc.) were invited to participate. The workshop was part of an ongoing effort by the agency to provide staff multiple opportunities to develop coping skills and address symptoms of vicarious trauma. Of 35 potential staff members, 14 were able to participate. Eight additional staff members expressed a desire to attend but were unable to schedule the time. The final participants included four social workers, one social work intern, four mental health counselors, two mental health counseling interns, one mental health counseling supervisor, and two intake staff.

Materials

Staff were provided with a variety of art materials including watercolor and acrylic paint, a variety of paintbrushes, oil pastels, markers, pencils, colored pencils, scissors, construction paper, regular paper, and watercolor paper. Written copies of prompts were also provided on each table in order to accommodate those who may need to come into session after we had already begun.

Procedures
Participants engaged in a five-week workshop style group session. In order to accommodate as many staff as possible, two sessions were provided on different days each week for five weeks. These times were intentionally scheduled not to interfere with current programming for the clients so that all staff could be available for either the workshop or coverage duties. The shelter provides 24/7 services to residents and mans a domestic violence and sexual assault hotline. Due to these circumstances, providing multiple sessions was the only way to maintain the coverage needed for critical staff members to step away. Sessions were an hour long and held in the pre-existing art therapy room. Each week the art therapy intern facilitated the group by beginning with a short meditation lasting 5-10 minutes. After this, staff were invited to choose from two art therapy prompts which are listed above in Table 1. 35-40 minutes were allotted for art making and the last 10-15 minutes of each session were set aside for participants to share if they chose to do so. Each week responses to the vicarious trauma prompt were created and documented during the workshop along with a journal of unsolicited responses and general themes. Journal entries were completed after each workshop session.

Results

The results have been broken down into general observations followed by specific responses to each theme. Significant qualitative observations were noted as a result of the workshop. Staff meetings with the topic of vicarious trauma being addressed through only verbal channels were characterized by bouts of silence as very few people are willing to share on such a deep topic in a professional space. The use of art facilitated easier, more light hearted discussion of difficult topics. It was originally planned that participants would share in small groups at their table in order to relieve some of the pressure of sharing with a large group in a professional space. However, multiple participants on multiple days quickly jumped to stand and share their artwork
with the entire room without being prompted as the group transitioned from art making to sharing. This sharing was not limited to the sessions as all participants chose to display their art in public spaces. Eleven staff chose to display their artwork at their desk, two staff work at shared spaces and asked that their work be displayed in the art room, and one participant chose to gift her artwork to another staff member after each session. Displaying the art in this public way prompted conversation throughout the week both among participants as well as with staff who were unable to attend, raising an overall awareness of vicarious trauma topics and the ways visual art can be used as a processing tool.

**Self Care**

After starting the first session with a short meditation, one staff declared, “We should do this before every meeting!” When the prompt on self care was approached, about half of the participants created images alluding to growth or building as seen in Figure 1. This figure was created by the workshop facilitator in conjunction with the staff art making time and represented an idea of building along with a changed/broaden perspective as self care increases. The second approach observed was a more literal representation showing a collage of types created from images of self care objects or activities and words.

Figure 1: _Self-Care_
All participants chose watercolor which was unexpected. Furthermore, all staff that attended the first week chose the self-care prompt but asked to take the prompts with them so that they would be able to do the mindfulness prompt on their own time.

**Vicarious Post Traumatic Growth**

The prompt on vicarious post traumatic growth included a definition of the concept and related terminology in the event that participants were unfamiliar with the idea. Participants agreed there are benefits to working with traumatized populations but that due to the short term nature of the shelter, these benefits could be few and far between. Overall, the themes had an emphasis on positivity. One participant noted that clients can present negatively and be increasingly disrespectful to staff but sometimes you get a client that reminds you why you do the work. She commented, “don’t forget its about peace, hope, and love.” Another participant likened vicarious post traumatic growth to fire and noted how some clients can “reignite passion” for the work. Most participants included some kind of pairing in their artwork as seen in the image Figure 2 created by the workshop facilitator. In addition, participants could identify two or three relationships which encompassed the occurrence of vicarious post traumatic growth rather
than drawing inspiration from a single experience. In this way, many artworks created in response to this prompt were abstract representations.

Figure 2: *Vicarious Post Traumatic Growth/Resilience*

Unplanned Transitions

The topic “unplanned transitions” was substituted in place of a cumulative loss or bereavement topic as this is specific to the shelter’s language around the high rates of turnover of clients. Many staff invest deeply in the clients at the shelter who may leave without warning and not return. Clients may also break certain rules deemed “deal breakers” and the same staff members who have advocated for the client’s shelter and well being may be forced to exit them. In these cases, closure for the client and the staff can be difficult. As one participant noted, “We are still grieving a loss of the client as well. Grief and loss is not just death.” Participants were asked to create a postcard for a client who may have had a bad transition or who may have transitioned successfully but did so while the staff was away. An example can be seen in Figures 3a and 3b, the front and back of a postcard. All participants had specific wishes for multiple clients which usually centered around a hope for the clients’ continued growth beyond their time
at the shelter. Participants hoped regardless of how the clients’ transitions went that they would be able to hold on to skills and positive memories they gained from their time at the shelter and build on those.

Figure 3a: Unplanned Transitions

Figure 3b: Unplanned Transitions, back

Vicarious Trauma

The images created in response to the vicarious trauma prompt varied widely which confirms a statement made by a participant, “[Vicarious trauma] is different for each person. We all experience it in a unique way.” One participant noted what she sees while working at the shelter versus what she needs to take care of herself. Another participant felt the process is “cyclical”; as the client escalates she takes time to help them regulate which in turn regulates herself before the cycle repeats. Yet another participant created art with a theme of empathy noting the different stages clients go through as they choose to leave their abuser and enter shelter through to after they exit the shelter. Figure 4a was created during the planning stages of this workshop in order to provide an example representation for staff who may be inexperienced with visually representing such a complex topic. Figure 4b was then created during the workshop. These figures represent the fluid nature of vicarious trauma in that even one individual can experience vicarious trauma in different ways at different times.

Figure 4a: Vicarious Trauma

Figure 4b: Vicarious Trauma Revisited
Reflection

The last week of the workshop was used as a time to reflect on what this process has been like and what participants felt they gained from this experience. Common themes included growth, happiness, and peace. Two participants also included thoughts on how much more comfortable they have become with the art making process. One of them noted, “This [way of making art] is more process rather than product oriented. This image came from my relaxed mind which is crazy to think about compared to where I started.” Overall this session was characterized by a sense of community and completion as seen in the encompassed circular shape of Figure 5.

Figure 5: Reflection on the Process
Discussion

The most important observation noted during the workshop was the eagerness of the participants to share their artwork. This enthusiasm confirms statements made by Ifrach & Miller (2016) who argued, “Counselors may have fears or shame in discussing compassion fatigue verbally. Using the expressive therapies offers a non-verbal means to communicate can reduce the feelings of stress and stigma around this kind of professional sharing” (p.35). Aesthetic distance was key. Rather than sharing about emotions or experiences directly, sharing became about the clever ways that participants could represent this emotional experience. Viewed in this light, it was easy for staff to celebrate each artwork even if the content was difficult. The artwork also appeared to lessen the formality in the room and reduced the pressure to present perceived weaknesses in front of supervisors. One participant claimed, “The art evens the playing field. No matter our position we can all be impacted by vicarious trauma.”

The main choice of materials was watercolor on watercolor paper which was unexpected by the facilitator. Hinz (2009) classified watercolor as a “fluid” material as it has less inherent structure and flows quickly during art making. This choice was unanticipated as according to Hinz, fluid media is more likely to elicit emotional responses. Due to the emotional nature of the regular work day it was believed that staff would gravitate towards more resistive media but this was not the case.

There are some specific facets of the workshop that may need to be adjusted to be more effective if used with first responders. As first responders hear, smell, and feel a great deal of information as they navigate a scene, it is important to avoid sounds, smells, and tactile experiences that may remind participants of a traumatic experience and trigger a trauma
response. Van der Kolk described this process in his 2014 book *The Body Keeps the Score* as stated, “Long after a traumatic experience is over, it may be reactivated at the slightest hint of danger and mobilize disturbed brain circuits and secrete massive amounts of stress hormones” (p. 2). Art materials that have a strong smell are not advised and materials such as clay that involve a tactile response should be approached with caution. Ideally the workshop would also take place out of earshot of sirens or radio calls to avoid audible triggers. Protocols around sharing bring up another point of interest. While the staff at the shelter elected to keep their art in public view, this may not be recommended for first responders. Confidentiality is a main concern for first responders receiving services, as previously detailed, and therefore an expectation of complete privacy should be set from the start to establish safety among the group. Considerations around triggers and confidentiality are critical as they deal with perceived safety of the group space. Crenshaw (2006) claimed, “Nothing is more essential in the treatment of trauma survivors than creating safety in the therapeutic relationship and therapeutic context” (p. 25). Once individuals receiving care feel safe and can deem those around them trustworthy, they can deactivate the fight or flight response that accompanies trauma. Only after this deactivation happens can they begin to engage in beneficial behaviors that aid social engagement and positive attachment.

Critical health care workers may also benefit from accommodations. As stated above in Potash, Chan, Ho, Wang, and Cheng’s (2015) article, a bereavement topic may be more helpful for medical professionals than thoughts on unplanned transitions. It is not uncommon for medical personnel working with populations with physical trauma to have patients pass away and this common experience often causes cumulative grief. Kapoor, Morgan, Siddique, Guntupalli (2018) explained, “The fast-paced ICU environment and workload limit the time available to the ICU staff to grieve and emotionally process the death of their patient, often leading to their feelings
going unrecognized. Also, there is no formal training for critical care professionals regarding strategies to deal with grief” (p.1337). In light of this information, art interventions can be provided for bereavement in a number of ways. Strom-Gottfried and Mowbray (2006) indicated five measures to aid professionals in grieving the death of a patient: self-care, institutional support, review and debriefing, and mourning or memorial rituals. It would be best to choose one or more of these touchstones to include in a vicarious trauma workshop for critical health care workers according to the greatest need seen in the particular group of participants. Furthermore, the location of the workshop for critical health care workers should be taken into consideration. Similar to accommodations for first responders, the location of the workshop should be able to function as a safe space separate from potential triggers typical of the hospital setting. It may be best to address this with proper staff before beginning a workshop with critical health care workers in order to locate an appropriate space.

It became clear during the planning of this workshop that scheduling is a significant barrier. This barrier should be expected with first responders, critical healthcare workers, and mental health workers as all fields are typically required to be on call at all times while at work. First responders may have down time but could receive a call at any moment, and critical health care services and mental health services for traumatized populations often require staffing 24/7. However, multiple sources argue it is best to incorporate services into the regular work day rather than requiring the staff to seek their own resources outside of the organization (Anderson & Gustavson, 2016; Strom-Gottfried & Mowbray, 2006). The location of the workshop was also an unforeseen advantage. The art room was easily seen as a separate and safe space for the staff as very few staff run programming out of this room. There was also a mural of a sunset over water taking up most of the wall space that helped set the space as participants noted it was
calming and many used it for inspiration. Conversely, there were limitations to this workshop as services were not available for the night shift or weekend staff at the shelter. It was also not possible to provide coverage for some specialized staff like our kitchen staff, handyman, and the administrative staff and therefore it was more difficult for those staff to have the chance to attend. This study would also benefit from the inclusion of more specific pre and post data collection.

Future steps for this study would include replicating this workshop with first responders and critical healthcare workers. It would be advantageous to determine the usefulness of predicted accommodations for these populations. The hope is this research can encourage organizations operating in helping professions to take the consequences of vicarious trauma seriously. These organizations need to work towards preventative measures and best practices for treatment of vicarious trauma in order to protect employees from numerous negative impacts of trauma exposure. The ability to determine effective methods of prevention and treatment for vicarious trauma will help fight stigma for those seeking treatment and create more sustainable careers within the helping professions. These considerations for support of helping professions are critical as they will allow the general public greater access to services. The creation of best practices for prevention and treatment of vicarious trauma means society can facilitate approaches to helping professions that are healing not only for those receiving services but for those providing the services as well.
References


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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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