Position Paper of the IMHP Task Force on

Vicarious Trauma in the Workplace

SUPPORTING PRACTITIONER EFFECTIVENESS WITH YOUNG CHILDREN IN HIGH-RISK FAMILIES

The Serious Issue of Vicarious Trauma

Infant mental health practitioners are frequently confronted with serious family situations that leave them feeling helpless, hopeless and unsuccessful. In addition, the traumatic experiences of these families can trigger trauma in workers. Concerns about ability to ensure the well-being of both infant and parent, about being involved in legal issues, and about their own personal safety, can lead to practitioner anxiety, anger, withdrawal and/or burnout.

This is known as vicarious or secondary trauma. The ultimate result is that some highly trained practitioners withdraw from this kind of work or remain but become ineffective.

Staff turnover and withdrawal increase stress for the remaining workers and are costly to the service delivery system. Thus vicarious trauma has a negative impact on the effectiveness of practice with high-risk families who have young children.

Scope of Position Paper

This position paper addresses the issue of vicarious trauma when providing intervention for high-risk families and the supports needed to prevent or alleviate negative effects on individual practitioners and the service delivery system. The paper defines high risk and reviews literature on the features of high-risk families that create risks for young children living in them. It also summarizes the characteristics of effective interventions and the challenges of providing services to high-risk families. Finally, the paper makes recommendations for policies and practices needed to support practitioner effectiveness and staff retention.

IMHP's Vicarious Trauma Think Tank

To develop solutions to these challenging workplace issues, IMHP held a think tank in February 2003 with 60 invited management level representatives from sectors that provide care to infants and their families (Wolpert, 2003). The goals of the think tank were to:

- Learn more about the stresses of work with high-risk infants, young children and their families
- Discuss innovative ways to support staff, management and organizations
- Discuss strategies for getting the issue of workplace stress on the political agenda and creating a climate that recognizes what is needed to support work in this field
- Plan next steps for action.

The event included presentations on research related to secondary trauma and approaches to supporting frontline workers. As well, small groups defined the issues experienced in their work, proposed creative strategies to support staff (see pg. 10) and made recommendations for action.
Recommendations included:

- Develop organizational competencies for managing secondary trauma in the workplace and ensuring appropriate practitioner support and safety
- Develop a position paper to inform government and the public about the seriousness of vicarious trauma and to encourage action to address the issue
- Create awareness of vicarious trauma and its impact on workers in all systems, and develop appropriate training.

The Task Force on Vicarious Trauma in the Workplace

In order to implement these recommendations, IMHP formed a Task Force on Vicarious Trauma in the Workplace with the following goals:

1. To review evidence regarding effective interventions with young children in high-risk families.
2. To review literature on the impact of vicarious trauma when working with young children in high-risk families.
3. To develop a position paper and recommendations regarding organizational best practices for supporting practitioner effectiveness.
4. To develop and implement a dissemination strategy.

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Background

In February 2003, the Infant Mental Health Promotion Project (IMHP) held a "think tank" with 60 invited management-level representatives from sectors that provide care to infants and their families. The purpose was to address the serious issue of vicarious trauma when working work with young children in high-risk families (i.e. developing symptoms of trauma from repeated exposure to the suffering of others), and to propose strategies for creating the necessary support for working in this challenging field. To implement the recommendations, IMHP formed a Task Force on Vicarious Trauma in the Workplace (see pg. 10). The goals were to develop a position paper and recommendations for organizational best practices to support effectiveness of intervention with young children in high-risk families.

Challenges for Practitioners

Repeated exposure to the trauma, suffering and unjust circumstances of others can lead practitioners to develop symptoms such as fears for their own safety and that of their loved ones. Practitioners may begin to question their competence and to feel helpless to relieve the suffering of others particularly when they have received inadequate training for the interventions and assessments needed. In addition, they are burdened with high caseloads, overwhelming paperwork, and responsibility for high-risk families who can be difficult to engage, slow to show positive changes, have frequent crises, and may resist suggestions.

Increased public expectations of professionals coupled with a lack of adequate supports in the workplace create anxiety regarding harm to a child as a result of maltreatment or family violence. As well, practitioners have concerns about losing their jobs and careers in the current work climate of restrictive policy and cutbacks.

High-risk Families

The Task Force reviewed literature on factors that place young children at low, moderate and high risk. Risk factors included genetic or biological conditions of the child, parental psychiatric conditions, parental addiction to drugs or alcohol, environmental challenges such as extreme poverty, family violence, child abuse and neglect, and parental inability to provide adequate care for their children. The more risk factors and the fewer protective variables in a given situation, the greater the risk to the child.

Repeated stress of working with high-risk families experiencing such complex circumstances, the many crises that may occur and concerns about harm to a child can have a serious impact on practitioners.

Effectiveness of Interventions

Conclusions about the effectiveness of interventions in the literature included:

- Beginning intervention as early as possible in a child's life is more likely to be successful.
- Working directly with children who have identified delays or disorders or are at extreme psychosocial risk enhances outcomes probably because of the greater intensity of intervention.
- In-depth assessment is needed so as to focus on the most problematic areas.
- Families need assistance with concrete needs, crisis and supportive services, and help to overcome the effects of unresolved loss and trauma.
- A therapeutic parent-intervenor relationship with sensitivity to family structure, cultural, racial and ethnic differences is key.
- Home visiting may be essential to reach the most high-risk families.
- Long-term, high-intensity, family-centred interventions based on a variety of theoretical approaches may achieve the best outcomes.
- Interventions need to be staged and to address the hierarchy of needs of a family and the emotional well-being of both parents and young children.

Supports Needed for Work with High-risk Families

Government guidelines and funding and agency policies for assessment and intervention must take into account current research on effective practices and ensure a supportive structure for innovative approaches that meet the needs of high-risk families. This includes guidelines for assessment, intervention, professional roles and boundaries, confidentially, safety, team support and crisis response. Opportunities for reflection on casework must be made available through individual supervision with experienced professionals, team support and consultation with experts. Both frontline and supervisory staff need specialized training for the difficult work and ongoing continuing education as new information becomes available. Collaboration with other agencies is necessary as no one agency or professional can provide the multiple interventions needed to meet the needs of complex families.

Recommendations

1. Government at federal, provincial and municipal levels, and service organizations, managers and practitioners acknowledge:
   a) the complex needs of high-risk families with young children and the amount and kinds of resources and supports required to ensure the best possible outcomes for children
   b) the serious negative impact this work has on practitioners
   c) the supports needed by practitioners to provide effective services.

2. Organizations develop clear policies and strive towards practices that support the principles outlined in *Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health*.

3. Government at federal, provincial and municipal levels provide realistic service guidelines and allocate appropriate funding to ensure organizational support that enables practitioners to provide effective services for high-risk families with young children.

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Vicarious Trauma

It is now recognized that practitioners who are repeatedly exposed to the trauma and suffering of others can develop symptoms of trauma themselves. This reaction is known as vicarious or secondary trauma. When we listen to the story of another's pain and suffering, it is normal to be shocked and saddened, and to feel vulnerable. Hearing frequent descriptions of violent events and the cruel realities of the lives of many high-risk families, and being a helpless bystander to tragedy can have serious effects on practitioners (Figley, 1995; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). As well, empathy, which is essential to the process of treatment, places the worker at greater risk of secondary trauma (Figley, 1995) since the trauma of others can cause previously unresolved personal traumas to resurface and be re-experienced.

As a result, workers can experience symptoms similar to those of their clients, for example intrusive memories, nightmares, severe anxiety, irritability and emotional numbing (Regehr, 2003), and they may have difficulty listening to clients' accounts of events.

With repeated exposure, workers can incorporate an accumulation of traumatic material into their own view of self and the world (McCann & Pearlman, 1990) and develop increased fears for their own safety and that of their loved ones.

The intensity of work with clients in crisis situations of urgency and emotional reactivity can cause workers to begin to question their competence and to feel helpless to relieve the suffering of others.

In a recent study of traumatic stress arousal symptoms in fire fighters, paramedics and child protection workers, child protection workers, particularly managers, showed the highest number of symptoms and degree of traumatic stress (Regehr, 2003). There are many possible reasons for this, including the use of empathy by child protection workers to engage families and bring about change and their lack of specific training or support for dealing with traumatic stress. Emergency workers, on the other hand, may encounter horrific events, but are not required to deal with the anger, grief and despair of their clients on an ongoing basis.

Early interventionists are often idealistic about the effectiveness of their work. Having to come to terms with unjust circumstances in families can quickly make them chronically pessimistic about making a difference (Kauffman, 2002).

Workload, Job Responsibility and Policies

Significant workplace factors related to the development of vicarious trauma are high caseloads and responsibility for the welfare of others (Regehr, 2003). Practitioners with caseloads of almost exclusively high-risk families can experience a sense of failure that builds when positive changes are slow and crises are frequent. As well, if parents are difficult to engage and resistant to suggestions and interventions, a sense of powerless can result.

An issue of great concern and anxiety to workers is that a child on their caseload might be seriously injured or even die as a result of child abuse or family violence. Fortunately, such situations are rare. However, dramatic media scrutiny of the inquiry process makes practitioners more cautious in their attempts to help others (Regehr et al., 2003; Regehr et al., 2002). Concerns about job and career loss can produce significant anxiety.

Reduced funding and legislative changes have shifted working environments in sectors such as hospitals, child welfare and community-based health and mental health services. Workloads and pressures for services have increased while opportunities for adequate training, support and supervision have decreased. Policies and procedures in a number of early intervention agencies do not allow workers to provide the variety, length or type of services needed by high-risk families. Workplace strain depletes coping mechanisms and makes workers more vulnerable to vicarious trauma. Increased public expectations of accountability for professionals coupled with the lack of adequate supports in the work environment places practitioners at further risk.

WHICH FAMILIES ARE AT RISK?

High-risk families are those in which several conditions place a child at risk for compromised development. These risk factors may be categorized as follows (Landy & Menna, 2006):

1. Genetic or biological conditions of the child such as low birth weight, extreme prematurity, repeated hospitalizations or illness.
2. Psychiatric disorder, addiction, or significant developmental disability of a parent.
3. Sociological or environmental challenges, such as extreme poverty that compromise a parent's ability to provide a safe and secure environment for the child.
4. Parental inability to be adequately nurturing and responsive to a child due to unresolved loss and trauma. This may include neglect, the use of harsh or angry interactions and/or abusive discipline.

There is a complex interplay between risk factors and protective factors or mechanisms that protect a child against the consequences of risk and improve and enhance child functioning under conditions which would otherwise result in compromised development (Coie et al., 1993; Rutter, 1990).

Some examples of protective factors are having a supportive family network or community, having someone available to support a child during a mother's mental illness, promoting a parent's self esteem, and/ or creating opportunities for parents to improve their life skills and parenting skills.

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It has been difficult to determine the relative importance of different risk factors and the relative contribution of proximal and distal variables and biological and environmental factors to child outcome. Proximal variable are those closest to the child (e.g., negative mother-child interaction and relationship, high criticism of the child, maternal depression or other mental illness, parental alcoholism, harsh and punitive discipline). Distal variables are those that affect the child indirectly through their influence on parent-child interactions (e.g., minimal parental education, low socioeconomic status, overcrowding, single parent status) (Landy, 2002). The most important factors that have been found to differentiate low risk, moderate risk, and high-risk families are presented in Table 1.

Table 1: Determining Level of Risk*

* Adapted from Landy & Menna (2006)

LOW RISK	MODERATE RISK	HIGH RISK
• Less than 4 risk factors	• Between 4 and 8 risk factors	• More than 8 risk factors
• Several protective factors	• Few protective factors	• Protective factors rare
• Child responsive & content	• Child sometimes responsive & content	• Child is often unresponsive, withdrawn and unhappy
• Child seems to expect to be cared for	• Child sometimes seems to expect to be cared for	• Child seems to distrust parent, withdraw or act out for attention
• Parent(s) have good emotion regulation	• Parent(s) have difficulty with emotion regulation	• Parent(s) often lose control of emotions, and seem very depressed or anxious
• Can be self reflective	• Some self reflectivity except in certain areas	• Lacks capacity for self reflectivity
• A strong sense of self efficacy	• Some sense of self efficacy in certain situation	• Low sense of self efficacy
• Realistic self confidence about parenting	• Anxious and judges self to be a bad parent	• Very low or unrealistic high confidence about parenting
• Has positive attributions of the child	• Attributions of child distorted	• Attributions of child distorted & very negative/hostile
• Good capacity for empathy	• Only empathetic towards the child in certain situations	• No empathy for the child when s/he is upset and sad
• Average to above average intelligence	• May have some cognitive limitations	• Significant cognitive limitations, concrete thinking
• Cultural beliefs and practices protective of child	• Some distortions about child because of cultural beliefs but these are not destructive	• Cultural beliefs about the child could lead to harm
• Parent willing to use services & try suggestions, open to an intervenor	• Somewhat ambivalent about using services and the intervenor	• Rejecting of services and suspicious of the intervenor
• Interaction is warm, sensitive, and responsive	• Interaction is sometimes sensitive and responsive but can be rejecting	• Interaction is insensitive, ignores child's cues and is hostile
• Positive history of being parented or has resolved any trauma or loss	• At time issues from past history impede ability to respond to child	• Unresolved loss and trauma significantly impede ability to respond to child
• Good problem-solving and ability to plan and organize	• Some problem solving possible but can be impulsive	• Very impulsive, does not think things through and thus may place child and self at risk
• Family interactions seem to be warm and caring, have ways to deal with conflict	• Family interactions are questionable but manageable	• Very conflictual family relationships and no ways to deal with problems

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Parents in high-risk families show several characteristics and behaviours that interfere with their ability to care for children. In addition to creating risks for their children, these characteristics make establishing therapeutic relationships and providing effective interventions challenging. Some of these parental characteristics and behaviours are outlined below.

1. Psychological characteristics of parents that interfere with their ability to be effective parents and make intervention challenging include (Landy & Menna, 2006):

• Inability to consider their own mental state and that of others, and therefore lack of empathy, sensitivity and responsiveness for their child.

• Inability to regulate emotions in themselves and therefore in their child.

• Negative attributions (i.e. beliefs or views) of the child (e.g. "that baby is crying just to make me mad").

• Poor sense of competence and inability to plan and problem solve.

2. Unresolved loss and trauma. Unprocessed memories of trauma or loss that are dissociated and stored as sensory and emotional fragments of the experience are easily triggered by situations reminiscent of the original trauma and re-lived in vivid flashbacks or nightmares that interfere with parenting (Briere & Conte, 1993; Herman & Shatzow, 1987; van der Kolk & van der Hart, 1991). As well, a number of physiological (e.g. chronic hyper-reactivity to stress, increased susceptibility to infection) and psychological consequences of unresolved loss and trauma (e.g. difficulty regulating emotions, loss of trust, withdrawal, detachment, hypervigilance, anger, fear) can negatively impact parent-child interactions. Some atypical behaviours of traumatized parents are associated with a disorganized pattern of early attachment which is known to be a potent risk for later psychopathology (Goldberg, 2000). These behaviours include frightened and frightening behaviour, inability to meet the emotional needs of their children, and sexualized and self referential behaviour (Bronfman, Parsons & Lyons-Ruth, 2000). All of these characteristics also make intervention challenging.

3. Psychiatric conditions that interfere with a parent's ability to be responsive to a child and place children at risk include:

• **Schizophrenia** (Seifer & Dickstein, 2000). Reasons for this vulnerability include increased genetic vulnerability, environmental strain caused by the illness (e.g., lack of employment, loss of income, hospitalizations), and parent-child interactions that tend to lack sensitivity, synchrony or mutuality, and fail to meet the emotional needs of children.

• **Maternal depression** (Cohn & Campbell, 1992; Lyons-Ruth, Connell, Grunebaum & Botein, 1990). Because they have low feelings of self efficacy, depressed mothers are likely to be less responsive to their young children and to alternate between being helpless and hostile or critical, thus creating disorganization in the child (Cutrona & Troutman, 1986; DeMulder & Radke-Yarrow, 1991; Teti, Gelfand, Messinger & Isabella, 1995). As a result, their young children have difficulties with self-regulation and mirror their mothers' anxiety and depressive symptoms, for example lethargy, sadness, and extreme distress on separation (Jameson et al., 1997).

• **Borderline Personality Disorder** symptoms (i.e. instability, impulsivity, fear of abandonment and uncontained rage) make it difficult to provide the nurturing, stimulation, consistency, and warm structure that infants and young children require.
As these parents experience terror of abandonment and perceive their child's efforts towards independence as rejection, parent and child can be locked in ongoing conflict without ways for resolution (Landy & Menna, 2006). The borderline parent expects to be taken care of but frequently criticizes any help a child (or intervenor) offers. Discipline is often inconsistent, rigid and extremely punitive. Many children of borderline parents have disorganized attachments because of inconsistent parenting and failure to receive adequate emotion regulation, and, as they grow up, they become controlling, oppositional, non-compliant or assume inappropriate role reversal and caretaking behaviour (Paris, 2003).

4. Use of drugs or alcohol exposes children to effects of the substance in utero and to later chaotic environmental conditions and difficulties in parent-child interactions (Freir, 1994; Weston, Ivins, Zuckerman, Jones & Lopez, 1989). Many of these mothers have histories of trauma, loss, abuse, and parental substance abuse (Brooks, Zuckerman, Bamforth, Cole & Kaplan- Sanoff, 1994). They may have become addicted to overcome low self-esteem and their own difficulties with affect control and self regulation make it difficult to meet their infant's regulatory needs (Brooks et al., 1994) particularly when their infants show withdrawal symptoms such as irritability, difficulty settling, and feeding and sleeping problems.

5. Family violence has a serious impact on children both when they witness domestic violence and when they suffer physical, sexual, and emotional abuse and neglect from a parent. Indirect effects of spousal abuse occur through the mother's lack of emotional availability, harsh discipline from either or both parents, and being blamed for the fights. Infants of mothers who experience a partner violence are more likely to have a disorganized attachment (Zeanah, Danis, Hirshberg, Benoit, Miller & Heller, 1999). Many of these children develop aggressive behavior and other conduct problems (Bell, 1995), depression and anxiety, lower social competence and self-esteem, and lower social academic performance (Graham-Bermann & Levendosky, 1998; Sudermann & Jaffe, 1999), as well as symptoms of Post Traumatic Stress Disorder (Osofsky, 1995).

6. Effects of parental abuse and neglect include affect regulation difficulties (Cummings et al., 1994; Shields, Cicchetti & Ryan, 1994) hyperactivity, distractibility and a high level of anger (Erickson, Egeland & Pianta, 1989). Eventually some of these children become aggressive themselves (Cummings, Hennessy, Rabideau & Cicchetti, 1994). Some are more hypervigilant, anxious, withdrawn or depressed (Rieder & Cicchetti, 1989) whereas those who are sexually abused also show more sexuality problems (Wolfe, Gentile & Wolfe, 1989).

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Children exposed to various forms of neglect and/or abuse Cicchetti, Barnett & Braunwald, 1989; Cicchetti & Toth, 1995) frequently have insecure disorganized attachments (Carlson, more difficulty recognizing the emotions of others (Camras, Grow & Ribordy, 1983), lower scores on measures of self esteem (Egeland, Sroufe & Erickson, 1983), and elevated levels of psychopathology (Cicchetti & Toth, 1995). Child maltreatment has been linked to childhood depression, conduct disorder and delinquency, antisocial personality disorder, substance abuse, suicidal and self-injurious behaviour, anxiety, and dissociation (Luntz & Widom, 1994; Malinosky-Rummell & Hansen, 1993).

7. Teenage parenting can also place infants at risk. Infants of teenage parents are more likely to be avoidantly attached and to meet criteria for disorganized attachment to their mother (Hann, Castino, Jarosinski & Britton, 1991; Spieker, 1989).

Like all mothers, teenage parents have a wide range of parenting ability. However, as a group they are less sensitive, responsive, and emotionally positive with their infants and young children (Landy, Montgomery, Schubert, Cleland & Clark, 1983; Osofsky & Eberhart-Wright, 1992; Zeanah, Keener, Anders & Vieira- Baker, 1987). Teenage parents also misread their infants' cues (Lester, 1992) and have less realistic expectations for young children, underestimating abilities in some areas and overestimating in others (Osofsky, Hann & Peebles, 1993; Fodi, Grolnick, Bridges & Berko, 1990). Toddlerhood is challenging for teenage mothers who experience their child's increasing independence as rejection (Crockenberg, 1987). Thus infants of teenage mothers are less likely to experience empathetic responsiveness and nurturing when upset and distressed (Hann, Osofsky, Barnard & Leonard, 1994).

The repeated stress of working with high-risk families experiencing any of the above complex circumstances and the many crises and risks to young children that may occur can have a serious impact on practitioners. Therefore, a variety of strategies are needed to support those who work in early intervention programs with such families.

EFFECTIVENESS OF INTERVENTIONS WITH HIGH-RISK FAMILIES

It is difficult to determine how successful early intervention is in enhancing the outcomes of infants and young children because intervention programs are diverse and complex as are the populations served. As pointed out by Guralnick (1999), we need a "second generation" of research to inform us about what works, with whom, and at what stage of a child's development. Also we must be more precise about "what" works. When an intervention is successful, we need to know how it can be replicated with integrity in other similar situations.

At the current time, some general conclusions can be made about the efficacy of interventions (Gomby et al., 1995; Karoly et al.,1998; Landy, 2001; Landy & Menna, 2006). A few of these are highlighted below:

• Beginning earlier in a child's life, either during pregnancy or at birth, is more likely to be successful than intervention that begins after a child is one or two years of age. Early plasticity of the brain allows opportunity to optimize brain structure and biochemistry. Interventions provided early can avoid negative interactional patterns between parent and child and prevent negative parental attributions of a child becoming firmly entrenched.

• When children already have developmental delays or other disorders, or have been abused or neglected, or are at extreme psychosocial risk, child outcomes are best enhanced by interventions that include working directly with a child, probably because of the greater intensity that direct child treatment can provide. Such interventions include educational centre-based childcare or specialized specialized individual treatments adapted to the child's specific problem areas and needs.

• Since interventions are most successful when focused on areas in which there are most difficulties, the first stage should be an assessment of risk and protective factors and family needs in order to choose the most suitable approaches. Ongoing monitoring and assessment are also necessary to determine adjustments needed, for example when change occurs, some risks or difficulties are overcome, and/or new patterns of need arise.

• High-risk families need a range of services including assistance with concrete needs, crisis intervention, supportive services, short-term interventions, and long-term interventions that help overcome the effects of unresolved loss and trauma.

• As well as being sensitive to the individual needs of children and parents, interventions must be attuned to differences in family structure, roles and patterns of relating including cultural, racial and ethnic differences.

• Home visiting may be essential for the most high-risk families who otherwise are unlikely to access programs. It may also be necessary to develop creative strategies to keep parents involved so as to reduce drop-outs. Home visitors from the same cultural background as families and who are able to speak the language of parents may be essential for immigrant families.

• In general, when parents in high-risk families have a history of trauma or loss, interventions need to be of high intensity and over a long period of time, and the development of a therapeutic parent-intervenor relationship is key. However, brief focused interventions within the framework of ongoing availability of service providers are effective in changing specific aspects of functioning or providing parents with understanding and strategies to alter parent-child interactions and attachment.

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• Families at highest risk may need a mental health approach that is less didactic and follows the parent's lead, taking into account parental goals. This approach makes the parent an active participant and avoids parental perception of powerlessness in a hierarchical relationship. Providing a sense of partnership between parents and intervenor needs to be a focus of the intervention. This is particularly important when parents have experienced loss and trauma.

Interventions need to be based on a variety of theoretical approaches and to be staged to address the hierarchy of needs of a family and the emotional well-being of both parents and young children. The challenge for practitioners is first to engage high-risk families and establish a trusting therapeutic relationship.

For many children, it is critical to stabilize the family situation by enhancing the family's support systems. In extreme cases such as parental mental illness, violence in the family, or drug and alcohol use that significantly impair parenting or place a child at risk for abuse or neglect, reporting to child welfare and removal of the child may be necessary at least until the situation can be stabilized.

Often practitioners do not have adequate training in the variety of interventions needed and the assessments necessary to decide on appropriate interventions. As a result, they struggle with feelings of incompetence and hopelessness and they require a variety of supports to prevent vicarious trauma and enable them to remain effective in their work.

SUPPORTS NEEDED FOR EFFECTIVE INTERVENTIONS WITH HIGH-RISK FAMILIES

Appropriate Government Guidelines and Organizational Policies

Government guidelines and funding and agency policies need to take into account current research on effective practices and ensure that a structure is in place to support innovative approaches and interventions to meet the needs of high-risk families (Landy & Menna, 2006). For example, policies that allow only brief interventions are not appropriate.

Guidelines are necessary for referrals, assessments, intervention decisions and outcomes for evaluation (e.g., characteristics of child, parent, and parent-child relationship). As well, protocols are needed for recording service and assessments.

Policies are essential for maintaining reasonable caseloads and appropriate role definitions and boundaries. Policies about boundaries with families assist in establishing therapeutic relationships that are supportive and open but maintain professional roles and functions. These policies should include guidance on issues such as giving and accepting gifts, attending events (e.g., christenings, funerals), lending money, and sharing of personal information (e.g., strategies that worked with their own children but not personal details other than training and experience).

Policies are also needed about confidentiality, safety, acceptable team behaviour, crisis responses and managing critical incidents (Howe & Milstein, 2003). Health benefits and disability coverage should allow time off to recover from serious work-related events or burnout and to help workers maintain a balance between work and family time. It is important to note that a worker's personal supports and outside interests can serve as a buffer against secondary trauma (Regehr & Cadell, 1999).

Reflective Supervision

Supervision that is reflective is one way that has been found to help overcome some of the symptoms of vicarious trauma that may result from this work and avoid burnout (Bernstein, 2002; Fenichel, 1992; Landy, 2003; Parlakian, 2001, 2002).

The four main components of reflective supervision are:

• It is available regularly, preferably on a weekly or at least bi-weekly basis, and as far as possible without interruptions such as phone calls.

• It is a collaborative and supportive relationship between supervisor and supervisee that encourages open discussion of difficult feelings, disappointments and frustrations, that acknowledges success when a parent and child make valuable gains, and that respects each person's expertise.

• It has a sound theoretical basis that is accepted and understood within the agency and offers a common understanding of what is occurring in the treatment. Such theory can make what may seem on the surface like random, disconnected or incoherent behavior into something that is understandable and more coherent. Theoretical understanding is needed in several areas (see *Competencies for Practice in the Field of Infant Mental Health*).

• It is reflective and allows practitioners to step back to consider their cases and work situations and to learn from their personal reactions that may be clouding their judgement. This may mean learning to set limits or boundaries without feeling guilty, not giving up on a family too soon, balancing the needs of a child with that of a parent, and developing new ways of working.

Supervision is also needed to review management and evaluation functions such as the type and number of cases, agency recording requirements, policies and procedures, and annual performance evaluations. Optimally, reflective supervision is provided individually by someone other than the supervisor responsible for these management and evaluation functions. When time constraints and budget do not allow individual supervision, peer or group supervision with a variety of disciplines can be helpful as well as bi-weekly or monthly clinical consultations from outside experts (e.g. Levkoe, 2002; Manio-Dimagio, 2002; Moher, 2002).

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Training

Specialized ongoing training is needed to work effectively with high-risk families. It is common for practitioners to feel a lack of skills and knowledge when working with a particular parent or family. New understanding and ideas for intervention strategies can build morale and enhance interventions. Team discussions of complex cases can provide excellent training as well as a sense of support. It is important that all staff members receive information and training related to relevant legislation such as child abuse and neglect reporting protocols and how to proceed if abuse is suspected. Opportunities are also needed to attend outside training such as conferences or workshops offered by IMHP and the *Certificate in Infant Mental Health* that IMHP offers in collaboration with York University, Division of Continuing Education (Moran, 2003).

Consultation, Collaboration and Service Coordination

Service providers in this field come from a variety of professional disciplines, including nursing, social work, medicine, psychology, early childhood education, occupational therapy, speech and language pathology. Paraprofessionals or lay home visitors trained on-the-job also provide support to families and interventions with parents and children. The competencies needed by practitioners from all backgrounds to work in the field were specified by IMHP in 2002, in *Competencies for Practice in the Field of Infant Mental Health*. This document acknowledged that the level of knowledge and skills would differ by discipline and area of practice, and that no individual service provider is expected to have all the competencies. Instead the document recommended that all practitioners have access to consultation and collaboration through individual supervision, other team members or experts from other agencies in the system in order to meet the variety of needs of high-risk families and children.

No one can do this work alone. Teams blending professionals and paraprofessionals are needed to work with high-risk families and hiring criteria need to consider personal aspects such as self-reflectivity, capacity for empathy, and ability to work both independently and as part of a team. Integrating teams of professionals and paraprofessionals who have passion for this work, ensuring training and supervision for all, and consultation from experts allows for the provision of the variety of the intervention strategies needed by high-risk families.

Because it is often not possible for one program to provide all of the services required by high-risk families, a coordinated system is needed with established arrangements for interagency cooperation. In Ontario, guidelines have been specified for service coordination (Office of Integrated Services for Children, 2000). These guidelines make it necessary for every high-risk family to have a designated service coordinator responsible for planning and coordinating services in collaboration with the family and other service partners. Although this has potential to be a valuable contribution to care, the process will be challenging because of the variety and number of components that may be involved (e.g., child protection, infant and child mental health, health care, infant development, child care). Bringing different disciplines and agencies with different philosophies, goals and vested interests together is time consuming. There may also be interagency rivalry and attempts to pass the most high-risk families on to others.

However, the benefits include increased continuity, consistency and coordination of service, reduced duplication of services and more efficient use of limited resources (Bain, 2003-04).

Maintaining a Positive and Realistic Perspective

Progress with high-risk families can be limited. To maintain a realistic but hopeful view of the possibilities for change, it is important to establish small, obtainable goals and to recognize the achievement of small gains. Qualititative feedback from families on helpful therapists' attitudes and caring (Norcross & Arkowitz, 1992) can be encouraging. Sometimes, progress in children is seen without progress in their parents (e.g., cognitive growth, socioemotional development, reduction difficult behaviours). In some cases the best that can be accomplished may be to assure the safety of the child and family. This achievement too needs to be recognized.

Support for Self Care

Often professionals who care for others find it difficult to acknowledge their own need to balance personal lifestyles and deal with stress. Organizations need to create a climate that encourages staff well-being in four areas: mental energy (e.g. learning something new, pursuing a hobby), spiritual energy (e.g. pleasure in nature, organized religion), emotional energy (e.g. connecting with family and friends) and physical energy (e.g. nutrition, exercise, and rest). Discussion and fun exercises about these strategies at a retreat or team meeting can facilitate meaningful interpersonal encounters and positive attitudinal changes (Peters, 2003).

COMPETENCIES FOR ORGANIZATIONAL SUPPORT

Based on the research outlined above and opinions expressed at the "think tank" (see pg. 10), The IMHP Task Force developed a document entitled ***Organizational Policies & Practices To Support High Quality Services in the Field of Infant Mental Health*** in order to raise awareness of the challenges faced in this field and the responsibilities of organizations to provide appropriate supports that help retain experienced practitioners so that families receive continuity of care.

A third draft of this document was circulated for feedback and evaluation to participants at IMHP's Vicarious Trauma "Think Tank" and to members of IMHP committees and revised accordingly. A final draft was refined and approved by the IMHP Executive and Steering Committees.

(see also pg. 12, Supporting Resources)

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Issues

Participants at IMP's February 2003 "Think Tank" identified several stressors for frontline practitioners serving high-risk families (Wolpert, 2003) including:

• Increased workload demands including high caseloads, more complicated cases, overwhelming documentation requirements, and the time and energy involved in collaboration and service coordination.

• The emotional burden of listening repeatedly to difficult family stories and trying to engage and establish trust with many burdened clients affecting personal life and reawakening personal trauma histories.

• Concerns about personal safety being alone in the home with families, and the risk of liability and lawsuits in situations that place a child or parent at risk for harm.

• Increased expectations and accountability in the workplace, fear of failure, and job insecurity due to budget cuts or inadequate funding.

• Inadequate training and support for the difficult work.

Stressors for managers included:

• Being "sandwiched" by pressure from administration above and from staff who they are responsible for below.

• Making decisions without support, and enforcing policies they may not believe in.

• The drain of increased liability and accountability, high waiting lists, demands to justify funding, never-ending statistical reports and grant proposals, time constraints, personality conflicts and media involvement.

• Necessary administrative tasks interfering with needed supervision for large numbers of staff.

• Repeated training of new staff members due to high turnover.

As well, participants highlighted that organizations are challenged by systemic pressures including large mergers without adequate infrastructure, and poor funding not allowing for necessary supervision nor salary increases for workers who face increasing caseloads and often see little or no change in many high-risk clients.

Solutions

Several approaches were recommended by Think Tank participants to support staff and prevent burnout. Some of these solutions had been used successfully by agencies represented.

• Creating an atmosphere of appreciation and support that recognizes accomplishments, encourages a balance for mental, physical, spiritual and emotional well-being, and ensures training to understand and respond meaningfully to the reality of secondary trauma when working with high-risk families.

• Proactive management that provides support and information during organizational change and encourages ownership and investment.

• Flexibile work arrangements that provide opportunities to accommodate individual strengths and vary the type of work (e.g. service delivery, research, education, community meetings), and allow work hours that accommodate personal situations.

• Team building that ensures formal debriefing in stressful situations, the regular exchange of ideas, case presentations, and clinical consultation from different disciplines. Time away from the office for team building and visioning was suggested as a promising strategy.

• Funding commitment to meet specialized training needs for the challenging work with high-risk families and for advancing personal careers.

• Appropriate supervisor-staff ratios that allow regularly scheduled reflective supervision to ensure the nurturing and case support needed for this work, and that this clinical supervision be distinct from administration supervision.

• Ensuring safe working environments.

IMHP TASK FORCE ON VICARIOUS TRAUMA IN THE WORKPLACE (2004)

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Infant Mental Health Promotion (IMHP) is a coalition of professional representatives from service agencies dedicated to promoting optimal outcomes for infants (prenatal to 36 months) in collaboration with families and other caregivers.

IMHP's mission is to develop and support best practices for enhancing infant mental health through education, dissemination of information, networking, and advocacy.

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SUPPORTING RESOURCES

Infant Mental Health Promotion has developed a series of documents and practice guidelines relevant for program managers, child care and front-line service providers, and organizational staff to support high quality services in the field of infant and young child mental health.

These documents address the following topics:

Competencies for Practice in the Field of Infant Mental Health

Core Prevention and Intervention for the Early Years

Organizational Policies & Practices to Support High Quality Services in the Field of Infant and Young Child Mental Health

Vicarious Trauma in the Workplace - Supporting Practitioner Effectiveness with Young Children in High Risk Families

Interactive Learning Modules

Each *Best Practice Guidelines* document has an accompanying web-based Interactive Learning Module which presents the information in an interactive and accessible format that can be used for trainings and individual learning.

Visit the IMHP website at **www.IMHPromotion.ca** to access these and other resources or contact **imp.mail@sickkids.ca** for more details.

Supporting the social, emotional & cognitive well being of infants and young children

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