

MAINTAINING PHYSICAL AND  
EMOTIONAL SAFETY:

*A Primer for Social Workers*



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## Goals for Today

- Increase awareness of physical and emotional occupational risks that social workers face
- Understand steps you can take to prevent and/or reduce risks
- Develop a thoughtful learning approach to navigating your personal and professional risks and developing related protections

## Health Precautions

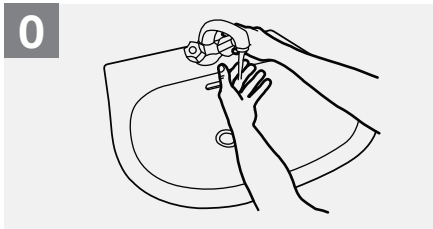
- Wash hands frequently, after *every* client visit
- Obtain annual PPD test
- Vaccinate: Measles, mumps, rubella, varicella; Hepatitis A and B; influenza
- Remain home if you have a fever, muscle aches, or other acute flu symptoms
- Cough or sneeze into your inner elbow
- Avoid contact with potentially infectious body fluids: blood, pus, feces, non-intact skin, and all body fluids except sweat
- Be alert to sharps or used needles in medical settings or on home/community visits
- Immediately report any potential infectious exposure

# How to Handwash?

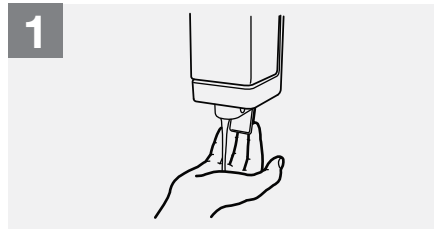
WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB



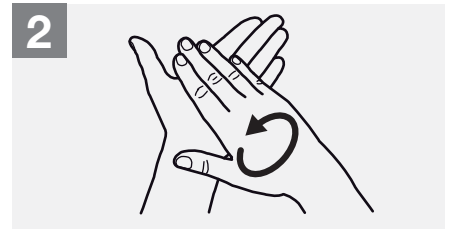
Duration of the entire procedure: 40-60 seconds



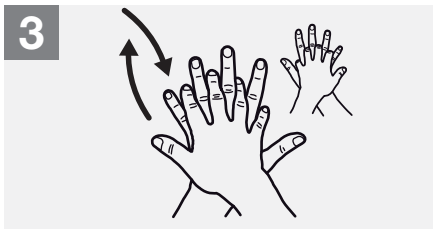
Wet hands with water;



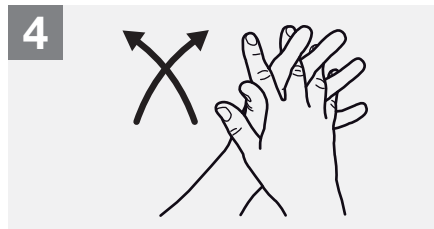
Apply enough soap to cover all hand surfaces;



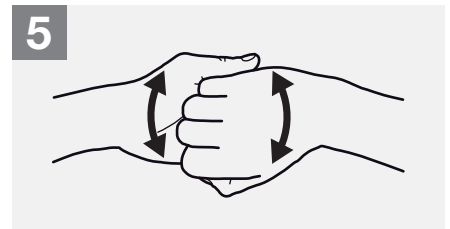
Rub hands palm to palm;



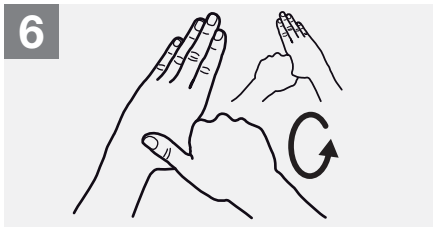
Right palm over left dorsum with interlaced fingers and vice versa;



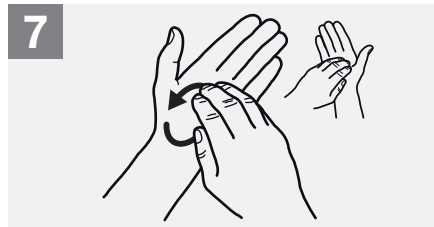
Palm to palm with fingers interlaced;



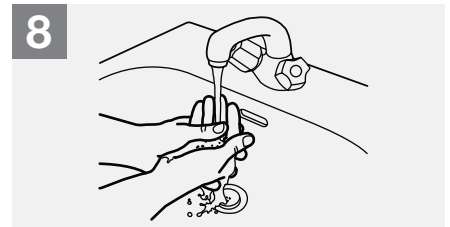
Backs of fingers to opposing palms with fingers interlocked;



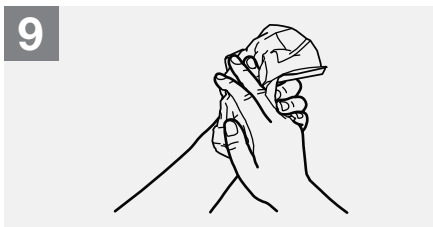
Rotational rubbing of left thumb clasped in right palm and vice versa;



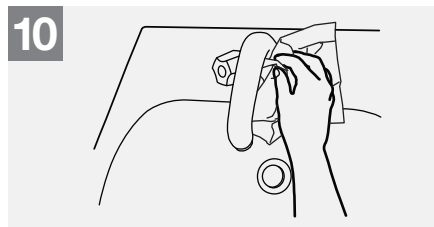
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



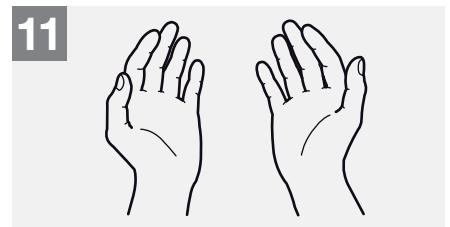
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES  
Clean Your Hands

## Incidence of Injury from Clients

### General Findings

- Bureau of Labor Statistics (2001) places injury incidence for social services at 15/10,000 workers (vs. 2/10,000 for private sector)
- About 20% of social workers report feeling “sometimes unsafe” with clients
- Less experienced workers may be at higher risk for assault and/or injury

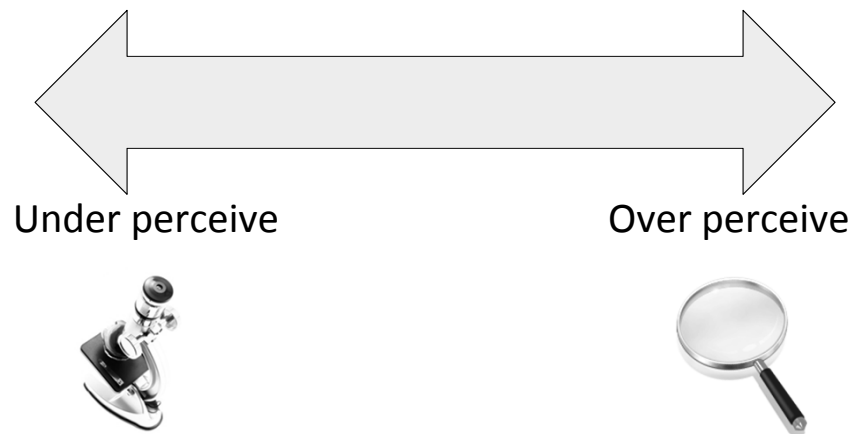
### Canadian Social Work Workplace Study (2005) (n=179)

Type of Violence	Last 2 years	Entire Career
Verbal Harassment	56%	88%
Verbal Threats	20%	64%
Stalking	5%	16%
Physical Assaults (no injury)	6%	29%
Physical Assaults (Injury)	<1%	8%

## Social Work Risk Factors

- We often work alone, in isolation
- We often conduct our work in community or home settings
- Deinstitutionalization may have resulted in more dangerous clients in the community
- The communities we respond to are often socially deprived, oppressed, and stressed
- As helpers, we may have a professional culture of avoiding discussing risk to ourselves

## Perception of and Threshold for Risk Vary Widely



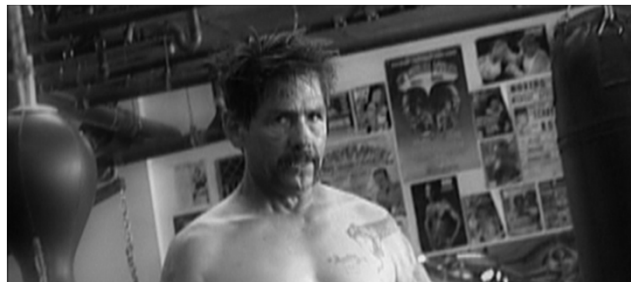
## Highest Clinical Risks of Assault

- Clients with a history of:
  - Prior aggressive or impulsive behavior
  - Drug and alcohol use
  - Mental disorders that include command hallucinations, irritability, perceptions of persecution, and emotional reactivity
  - Being mandated to attend services
- Clients currently facing situations that lead to feeling high levels of fear, frustration, loss of control

## Protective Factors

- Empathic engagement with client, emphasis on strengths, AND thorough assessment of safety and risk factors
- Friendly, Frank, and Firm discussion with client about expectations related to safety -- theirs and yours
- Advance agreements, when possible, that create respectful, exit plans for all
- Trusting and refining intuition
- Thoughtful agency protocols and supports

## Eddie from *The Empress*



## **Discussion Questions About Eddie**

- 1. What are Eddie's strengths?**
- 2. What factors seem to lead Eddie to aggressive behaviors?**
- 3. What further information would you seek from Eddie in order to identify potential safety risk and protective factors?**
- 4. What words would you use to build safety agreements between Eddie and you?**
- 5. If your internship assigned you to work with a client like Eddie, what would your honest thoughts, feelings, and/or reactions be?**

## **Scenario**

You are a social work intern for a support housing program whose mission it is to provide psychosocial assessment and intervention to residents of SRO (single room occupancy) hotel rooms to prevent, when possible, their eviction or being homeless again.

You have successfully engaged Eddie into a case management relationship, and specifically, you and he have agreed to work on his goals of reducing his use of alcohol and drugs and increasing his ability to get along with others (reducing conflicts and fighting). He has signed a release for you to speak to his building's management and they have recently called you to report that he is drinking heavily and has been very aggressive in the lobby with other residents and front desk staff.

Today, he drops into see you at your office. He appears as though he has an altered mental status. Specifically, he is pacing in an agitated manner, his body posture and facial gestures appear tense and intimidating, his eye contact is characterized by focused staring/glaring, he appears to be breathing in a shallow rapid fashion, and he is using a very loud voice in the reception area. As soon as you greet him in the waiting area, he approaches you at a close distance and loudly demands \$15 as a loan because he states he was "robbed" and "has not eaten."

### **Guiding Question:**

1. How would you respond to this scenario in a manner that balances your clinical duties and goals with your attention to his, your, and other members of the clinic's safety?



## **TIPSHEET: De-Escalating Agitated Clients in the Office**

1. Use observational data to recognize the signs of escalation including the client's posture, eye contact, facial expressions, physical gestures, muscle tone, voice and speech patterns etc.
2. Call for back-up assistance when possible which can include either a supervisor or another clinician to directly assist you or to simply stand back and observe discretely.
3. If client is overtly threatening, carrying a weapon of any kind, is assaulting property, or appears to be in acute medical distress, alert 911 immediately.
4. Choose the safest possible location to talk to the client. This may mean moving other clients out of the waiting room so you can talk with the client here; or it may mean stepping just outside the front door with assistance; or there may be a special room available in your clinic for circumstances such as these. You do not want you or your client to be or to feel trapped so easy access to exits, open doors, and windows are recommended.
5. Use your own physiology, whenever possible, to cue the client's physiology to calm and self-control. Examples include staying relaxed and empathic, keeping a reasonable distance, keeping yourself a bit lower than client, hands down and palm out, a sideward stance, relaxed breathing, meeting gaze but not staring down, lowered voice and slow speech and friendly, confident tone.
6. Identify what the client's immediate goal is by asking: *"I can tell you are really upset today. Thank you for coming in to see me. What can I do for you right now to help you feel safer?"* Or *"I'm worried about you, and I want to make sure that you and everyone else is safe right*

*now. Can you tell me what's going on please?"* Try to uncover what the real, underlying issue may be for this client today that has led them to be so activated.

7. Express a desire to help without making promises you can't keep. *"I appreciate you coming in today. I'd like to help you if I can."*
8. Avoid questions, statements, or information that may imply the client is to blame for his/her circumstance. While this conversation will need to happen, today is probably not the right time. The client needs to "save face" and feel in control right now.
9. Set firm limits in a compassionate, respectful manner. Use specific behavioral language. *"In order for me to be more able to help you today, I'm going to ask you to please lower your voice, stand back a bit from me, and take a few deep breaths."*
10. If verbal redirections do not succeed, then move to limit-setting in a firm but flexible manner, offering choices when possible. *"I still want to help you and I also need to keep everyone here feeling safe. I need you to either take a cool-down break right now or for you to leave and come back at another time. Which option do you prefer?" "I'm going to step out of the room for a moment and get some water. May I bring you some?" "We are unable to give you or any client cash. Is there some other way I can help you today?"*
11. Following resolution of the crisis, a debriefing with all involved clinical staff and supervisor is recommended. Clinical follow-up with client that does is sensitive not to induce shame but does help them to analyze what happened, reassess their coping, and revisit safety-related agreements can advance the therapeutic alliance, can help the client learn to self-regulate better, and can prevent or reduce future incidents.

## Office De-Escalation Tips

- Use observational data
- Call for back-up and choose space to talk with client strategically
- Use own physiology to project calmness, empathy, confidence
- Offer empathy and options, when possible
- Ask directly and simply for most concerning behaviors to change
- Debrief

## Safer Home and Community Visits



## The Home Advantage

- Consistent with social work values and the history of our profession
- Engages clients who may not be active help-seekers but may be treatment-acceptors
- Allows for a fuller, more complete, person-in-environment, ecological assessment
- Creates access for homebound clients
- Involves day-to-day social supports

## Davis Home Visit Role Play

- The social worker needs to follow up on a report of child endangerment alleging that mother picked her teenage daughter up from school intoxicated.
- What worked well? What didn't?

# **SAFETY WHEN CONDUCTING A HOME OR COMMUNITY VISIT**

By Greg Merrill, LCSW  
UCSF Trauma Recovery Center

## **THE PRE-VISIT ASSESSMENT**

### **Of the Client:**

- Does the client have a history of assaultive, reckless, impulsive, and/or other dangerous behavior? How do use of substances affect this? How likely is it that the client will be actively using?
- How well do you know the client? How honest do you think they have been with you? (And remember: most clients are not forthcoming about potentially dangerous behaviors). What do available records reveal?
- Is the client an ongoing target for violence from others?
- Does the client own or keep guns or knives on his/her person or in his/her home?
- When you call the client to set or confirm a home visit, introduce the idea of your safety to them. *"I would appreciate your help finding where you live, parking, and entering your building safely. What should I be aware of?"* How does the client respond when you are upfront about needing to ensure the site is safe for you? Do they understand and respect your limits?

### **Of the Home or Community Site:**

- How likely is the assailant to know or discover where the client is staying or meeting you?
- How familiar are you with the neighborhood and location in which you plan to meet the client? Are there people you trust who may be more familiar with whom you can consult?
- Who else will be in the residence or at the site? Do these people have a history of assaultive, reckless, impulsive, and/or other dangerous behavior?
- What is the safest way to travel to the site (MUNI, BART, county car, your own car etc.)? Time of day? Day of week or month?
- Are there other safer sites where you could meet the client? Be creative!

## **Of Yourself:**

- How comfortable/uncomfortable are you about seeing this client outside of our office? If you are uncomfortable, are you talking about this with your supervisor? If not, do so before scheduling.
- Are you frequently overly anxious or cautious? Or, do you frequently minimize or deny risky situations?
- Are there categories of people who tend to make you more concerned about safety? Are your stereotypes creating a false sense of danger or security? Are you ignoring your gut because you are afraid others will think you are stereotyping or prejudiced?
- What does your gut honestly tell you?

## **Other Preparatory Steps You Can Take:**

- Discuss your concerns and fears about the visit honestly with your supervisor until mutual agreement can be reached about reasonable precautions;
- Arrange to complete the home or community visit before 1 p.m., preferably early in the a.m.; consider the day of the week or month as well;
- Arrange for someone to accompany you (research assistant, co-worker, supervisor);
- Together with supervisor decide that the client can only be safely seen in our office or on SFGH campus;
- Sign out a cell phone from the front desk and the visit log indicating where you are going, who you intend to see, what time you are departing and what time you intend to return;

## **AT THE TIME OF THE VISIT**

- Wear clothes that match professional roles but are comfortable and allow for easy movement;
- Upon arrival, park in an area where you can safely exit quickly, if needed; lock valuables in trunk before parking in that area;
- Observationally scan the environment for potential threats and resources;
- Walk with confidence and purpose, display friendliness and assertion, ask community members for help (*"Excuse me. I work with the Department of*

*Public Health and I am looking for unit 27B. Could you please point me in the right direction?”), and cross street discretely to avoid potential threats.*

- After client answers door, ask for permission to enter, exchange polite greetings (*“Thanks for inviting me into your home. I appreciate being your guest very much.”*), and eyeball the surroundings carefully.

### **If Danger Seems Present:**

- At the first sign of danger from the client or other household or community members, exit immediately. Common red flags include intoxication, verbal insults or escalations, intrusions upon your personal space or body, sexually suggestive remarks, unresponsiveness to limits, pleasure-taking in your anxiety, presence of any weapons, impulsivity or recklessness, etc.
- You do not have to explain why you are exiting. In fact, it may be helpful to lie (i.e. *“I was just paged and need to return to my office immediately”*);
- After exiting, get to a reasonably safe location and call 911 if appropriate or call Supervisor for consultation about how to proceed.
- Debrief with your supervisor as soon as possible.

### **If it Seems Safe to Proceed:**

- When sitting down, look carefully for signs of drug paraphernalia or sharps that could inadvertently cause injury;
- Call the office in front of the client as soon as you arrive and state your location, his/her name, and your estimated time back in the office
- Early on you can start with friendly but assertive gestures (e.g., asking the client if they could please turn the TV or radio down or off; asking them if it would be all right to put the dog in a back room; asking the client if he minds putting a shirt on etc.) and set limits as needed, being careful not to be overly passive or overly aggressive;
- Confirm upon arrival that the client does not have a knife or gun in their possession and that others in the residence do not;
- At completion of visit, ask the client how the meeting went for them and what, if anything, was helpful. Also provide them with reinforcement of any of their behaviors that you think made the visit effective and also ask for future cooperation as needed (*“I really appreciate that you were waiting for me and looking out for me when I arrived. Thank you. The only*

*thing I'd recommend for next visit is that the television be off since I couldn't always listen to you the way I usually like to. How do you feel about that?")*

- Set next visit time and revisit the best and safest day and time; ask about alternate locations, if feasible or indicated, including office visits.
- Upon departure, call the office again in front of client to state you are departing and again give your estimated time of arrival.
- *"Thank you so much. I really enjoyed seeing you today and want to thank you again for having me as your guest."*

### **AFTER THE VISIT**

- Pay attention to any discomfort you feel as you think back on your visit and try to discern if it was based on your lack of familiarity with the client, client's family, or the client's social environment or based on risks
- Particularly consider whether there were any boundary violations that may lead to a future unsafe situation
- Debrief the visit fully with your field instructor to determine if home visits are appropriate and to develop additional precautions, if needed

### **PLEASE REMEMBER:**

**YOUR SAFETY ALWAYS COMES FIRST. PERIOD. NO EXCEPTIONS. REPEAT: YOUR SAFETY ALWAYS COMES FIRST. YOU CAN'T BE EFFECTIVE IF YOU DON'T FEEL SAFE.**

**YOU WILL NOT DISAPPOINT A SUPERVISOR BY EXITING A SITUATION. YOUR COMMITMENT TO THIS PROFESSION, WORK, AND YOUR CLIENTS WILL NOT BE QUESTIONED. WE APPRECIATE YOUR HONESTY.**

**YOU ARE HELPING YOUR CLIENT BY MODELING SAFETY CONSCIOUSNESS. CLIENTS WILL EVENTUALLY BE ABLE TO INTERNALIZE YOUR MODELED BEHAVIOR OF RESPECTING YOURSELF AND OTHERS EVEN IF IN THE MOMENT THEY THINK YOU ARE OVERREACTING.**

**OVERREACTING IS ALWAYS SAFER THAN UNDERREACTING.**



## **DAVIS FAMILY HOME VISIT**

You are a social work intern following up on a non-emergency, 10-day referral related to suspect child endangerment. The reportee is from a high school and reports that the mother, Mrs. Davis, was seen picking up her 16 yo daughter from school intoxicated and driving off with her daughter in the car. There are no prior reports on this family that have been filed and the school reports the 16 yo is a great student. Mrs. Davis is thought to be about 40 years old.

You called Mrs. Davis to introduce yourself and let her know about the referral and your need to speak with her and her daughter. Mrs. Davis became very annoyed, stated “mind your own damn business,” and hung up. You decided not to call back but to make an announced visit with a partner within the next few days.

You are now going out to the home to see if you can engage Mrs. Davis in a conversation, interview her daughter, and complete follow-up on this referral. Your main goal is to assess the safety of the child and any other children or fragile adults in the home and to see if there are resources or supports that might assist the family.

## Vicarious Trauma (VT)

- *Vicarious Trauma is the process of change that happens because you care about people who have been subject to trauma and injustice. Over time, this can lead to changes in your psychological, physical, and spiritual life that also affect your family, your organization, and your patients/clients.*

Pearlman, L.A. & McKay, L. (2008). Understanding and addressing vicarious trauma. [www.heading-institute.org](http://www.heading-institute.org)



## Vicarious Risk Factors

- Early career and later career risks may vary
- Greater similarity to patients served and/or personal trauma history
- Volume and severity of client presentations
- Personal temperament
- Higher levels of life stress
- Not yet fully developed personal coping repertoire, support systems, and spiritual beliefs
- Organizational context unsupportive

## A Student Perspective: Loma Prieta



## Student Journal Entry, SW 400, Fall 2009

### Free Topic: What's on your heart and mind?

What's on *my* heart and mind? They are cluttered with so many things. And sometimes I feel so wiped out that it feels like there is nothing left in either. I just finished watching a news special on the Loma Prieta earthquake that was produced to commemorate its 20th anniversary. On October 17, 1989 at approximately 5:04pm, the big quake hit the Bay Area. Whenever there is a major event like that that happens, people like to talk about where they were at that particular point in time. It was inevitable that I searched my memories to think about where I was on October 17, 1989 at 5:04pm. I was 6 years old at that time, at my home in Oakland watching TV with my sisters when the shaking started that cut off our power for hours. Then, it occurred to me that it was 2 months later that our mom passed away when the rest of my life shook – because 2 months after that, my dad also started his 10 year-long alcohol and child abuse. Obviously '89 was not the best year for me. I can call it the year that my entire world shook. Fortunately though, the shaking caught me but I didn't fall down (ha-ha)<sup>1</sup>.

It felt a little eerie watching the news special that presented video footage of the crisis that ensued afterwards. I was too young to be aware of everything that was going on back then; and during every interview and structural damage that was shown, I wondered what I was doing and what my family I were feeling. It was probably the last time we all bonded together as one normal and perhaps scared-yet-happy family. It was definitely "the" opportunity to do so. I have now become obsessed with Loma Prieta, Wikipedia-ing for more information and YouTube-ing for more video footage. I think I am hoping to somehow re-connect with my 6 year old self that I have unconsciously shut out for so many years. I have never reflected that far back probably because the memories are hard to find. And when found, they are hard to keep. I am cherishing this moment of investigation and discovery.

I chose to share this in my journal entry not as a random thought and unrelated piece to Social Welfare. My 26 year old self today shows me that even when everything seems to be against you, it is not time to give up. In fact, it's a time for action and resilience. When life seems to be at its worst, we tend not be able to see past the crisis. Loma Prieta caused a ton of damage in the homes and lives of many Bay Areas. Fire started where the water supply eventually ran out and firemen could only stand there to watch the fire; a critical section broke off of the Bay Bridge, the expansive Cypress section of the 880 freeway collapsed. Many buildings and homes collapsed. Sixty-three people were killed, thousands injured, and thousands more were left homeless. People panicked, people worried, people lost optimism. If I had been able to comprehend the extent of the injuries done to the state of the Bay Area, I would have probably felt it was the beginning of the end of the world. Yet, it's not the end of the world. Buildings, homes, structures...and my own life have been rebuilt. Reflection of public and private events helps to fuel my desire to take action against the unfortunate realities that occur in life. Social workers are builders of strength and resources for people who have been shaken and fallen down. Support is what keeps us up when we run against our own Loma Prietas.

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<sup>1</sup> A reference to Anne Fadiman's book [The Spirit Catches You and You Fall Down](#) (1998) which we were reading in class.

## Common Adverse Effects

### ■ Body/Physiological

- Insomnia
- Fatigue, exhaustion
- Numbness, body disconnection
- Appetite and weight changes
- General somatic distress and poor health
- Hypervigilance: constantly on-guard for danger

### ■ Emotional/Feeling

- Feelings of shock, horror
- Persistent unwanted emotional overwhelm including sadness, anxiety, irritability
- Numbness and emotional overdetachment
- Absence of positive emotions: happiness, humor, enjoyment.

### ■ Thoughts/Beliefs:

- Repetitive, obsessive thoughts or images
- Distracted, forgetful
- Rigid, black-or-white thinking
- Loss of ideals can lead to depression, despair
- Negatively-altered beliefs about the self, others, and the world (themes: meaninglessness, fear, distrust).

### ■ Behavior:

- Isolate professionally and/or personally
- Avoid reminders of what is painful or uncomfortable
- Inflexibility or “over-flexibility” of boundaries
- Conflicts with others where attributions and anger may be displaced
- Imbalanced work contribution: over or under.

## ✓ SIGNS AND SYMPTOMS OF DISTRESS

*Every human being has stress and will accordingly suffer from signs and symptoms. When these signs and symptoms, however, become so severe and/or chronic that they interfere in your ability to enjoy your work, your relationships, and your life, it's time to evaluate.*

### Physical

Chronic feelings of fatigue  
Chronic aches and pains  
Gastrointestinal distress  
Profound muscle tension  
Teeth grinding  
Poor nutrition or eating habits  
No or limited exercise  
Excessive weight loss or gain  
Insomnia or Oversleeping  
Unhappy in and with your body

### Emotional

High levels of depression, anxiety  
High levels of anger, frustration, irritability  
Emotionally numb or vacant  
Lack of happiness, satisfaction  
Feels Overwhelmed

### Relational

Angry conflicts with patients and families  
Angry conflicts with other team members  
Isolates, No positive interactions  
Stops sharing with others and participating  
    In the group or team process  
Stops asking for what she/he needs or wants  
Feels misunderstood, unappreciated by others  
May begin to blame others or hold strong  
    Resentments toward others  
Transmits negative attitude and energy to others  
Either has no outside life or outside life that  
    Is the focus even during work time

### Mental

Unable to concentrate  
Inattentive and forgetful  
Disorganized  
Obsessive thinking  
Preoccupied by disturbing  
    thoughts or images  
All-or-Nothing Thinking  
Rigid or reflexive problem solving  
Unable to prioritize  
Overwhelmed by complex problems

### Behavioral

Chronically overworks or  
    overextends  
Loses professional standard  
Hostile, irritable, defensive  
Avoids work  
Decreased effectiveness

### Spiritual

Feels no positive meaning from work  
Feels powerless to make change  
Does not feel it is "worth it"  
Despair, doubt  
Negative worldview  
Guilt  
Surrenders ideals, hopes, vision

## ✓ SIGNS AND SYMPTOMS OF HEALTH

### **Physical**

Reasonably good energy level  
Makes efforts to eat healthful foods  
at regular intervals  
Exercises 3-4x per week  
Sleeping regularly  
Takes care of health problems  
Overall satisfaction with and in body

### **Emotional**

Mostly happy and satisfied  
Emotionally present  
Takes care of self when feeling overwhelmed  
by negative emotions  
Compassionate

### **Relational**

Builds excellent rapport with patients and families  
Maintains excellent rapport with team members  
Many positive and mutually fulfilling interactions  
Participates in team processes constructively  
Asks for what he/she wants or needs  
Feels basically understood and appreciated  
Handles conflicts with others professionally  
When doesn't, reflects and learns from it  
Does not blame or harbor resentments long-term  
Has a fulfilling outside life

### **Mental**

Good enough concentration  
Attentive, Good enough memory  
Reasonably organized  
Can mentally move on when needed  
When preoccupied by disturbing  
thoughts or images, cares for self  
Clear, rational thinking  
Creative problem solver  
Stimulated by Mental challenges

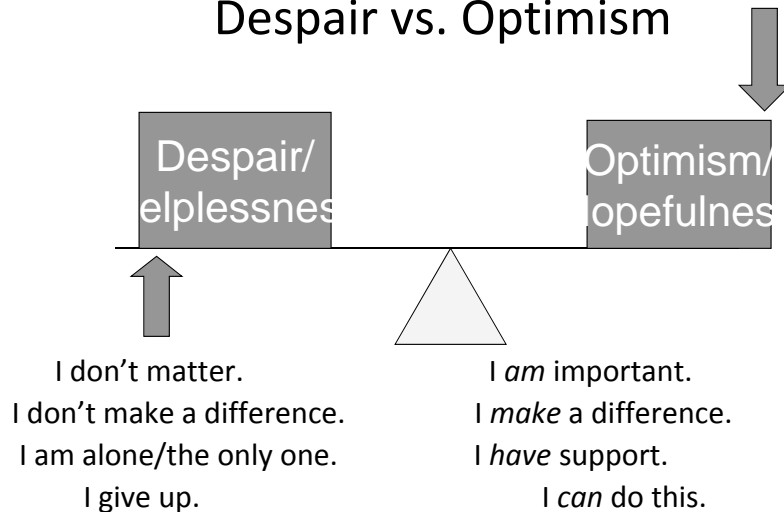
### **Behavioral**

Balances working hard with  
boundaries/self-care  
Holds consistent professional  
standard  
Remains effective in position

### **Spiritual**

Feels his/her work has meaning  
Knows when changes can be made  
and accepts when they can't  
Still finds value in the work  
Realistically optimistic  
"Lets go"/surrenders to higher power  
Renewed or refreshed by beliefs

## The Struggle for Meaning: Despair vs. Optimism



## Critical Incident Stress Debriefing

- We encourage you to initiate debriefings with your field instructor and/or your field consultant about adverse events you may witness or be a part of
- Seminar discussions can be helpful but may require veiling certain details so as not to unintentionally transmit trauma impact to peers



## Vicarious Resilience Happens, too

- Absorbing Client Strengths
- Feeling more grateful about your own life
- Learning to be more comfortable suffering and bearing witness, seeing this as an important part of life
- Strengthening your ability to balance remaining empathic and detaching

## The Best Coping Plans . . .

- Respect your temperament, preferences, reactions, and lifestyle, all of which change over time.
- Involve active strategies that require investment of your time and energy even when you feel you have neither.
- Balance:
  - **Escape**: Simply getting away physically, mentally
  - **Rest**: Activities with no goal or timeline
  - **Play**: Fun, creative, positive energy.

## Best Organizational Practices

- Clear policies and procedures
- Forms that standardize inquire about risks
- Thoughtful configuration of offices
- Culture of talking about emotional and physical safety, respect for threshold variance
- Debriefing Incidents Fully
- Ongoing analysis of threats and protections
- Staff and management partnership

## Transforming Vicarious Trauma: Tips for Social Workers

Developed by Greg Merrill, LCSW

1. ***Be Mindful.*** Because you are empathically connected to traumatized patients, you may be “infected” by their traumatic stress symptoms. As a result, you are likely to experience disruptions in memory, feeling, your body, behaviors, and relationships that are both acute and cumulative.
2. ***Invest in a Regular Coping Routine.*** Engage yourself with a regular, active, and intentional routine of self-care activities. Include a range of activities that replenish or restore your body, your mind, your heart, your spirit, and your social connections. Think *escape, rest, play*.
3. ***Avoid Excessive Inactivity.*** Although it may seem desirable to spend the evening silently watching television, chronic inactivity is not restorative. That being said, activities that explicitly have no goal orientation may be an important part of your overall coping plan.
4. ***Know and Respect Your Style.*** Learn, respect, and nurture your own style. When overwhelmed, you may want to go deep into your emotions and talk in depth; you might instead prefer a healthy distraction such as a period of intense exercise; or you might prefer other strategies altogether. Try a variety of activities over time to discover what combination is most potent for you.
5. ***Conduct Daily Rituals.*** Short rituals at the beginning and end of your workday can signal your body, mind, and heart about the transition between your professional and personal life. For example, consider starting or ending your workday with a cup of tea, a moment of silence, or a brief visualization; when arriving home, consider changing your clothes and showering to signal a new beginning.

6. ***Plan Ahead for Occasional Acute Episodes of Overwhelm.*** Certain stories or patients can overwhelm even the most resilient caregiver. These more acute episodes can last hours to days. Recognizing these symptoms and enacting a more intensive self-care plan will help restore your sense of control. To combat physiological arousal, intensive aerobic activity is usually recommended.
  
7. ***Increase Your Emotional Management.*** When emotionally overwhelmed, simply accepting your overwhelm, tolerating the unwanted feelings, and knowing that they will naturally reduce over time can be helpful. These are called “tolerance” or “acceptance” strategies, and they prevent your self-judgments from adding to your distress. Balance these strategies with more active “change” strategies in which you engage in activities (such as exercise, meditation, prayer, and/or seeking support) to reduce your negative feelings and increase positive feelings.
  
8. ***Discover The Positive Meaning.*** To counterbalance feelings of despair and hopelessness, intentionally cultivate an appreciation of strengths and resilience, look for small signs that you’ve made a difference, and praise yourself and others for the amazing daily efforts you make. *You are an everyday hero.*
  
9. ***Cultivate Creativity.*** The opposite of destruction is creation. When you engage yourself in creative activities (such as art, music, dance, writing, cooking, gardening, and even spontaneous acts of humor or improvisation), you actively restore balance to your world
  
10. ***Know When to Ask For Help.*** Although many people prefer privacy, when your reactions begin to negatively affect your personal and professional life, it is time to accept that you may need outside help. As a caregiver, you have a right to receive care, too. Accepting help doesn’t mean you aren’t strong or professional. Rather, it means you are strong and ethical enough to care for yourself so you can continue to provide care to others.

## **School and Campus Resources for Social Work Students**

### **Courses:**

SW 400, Field Seminars  
SW 210A, Stress and Coping  
SW 250X, Domestic Violence

### **Faculty:**

Your Field Consultants

### **Student-Led Support Groups:**

Chase Finney, [chasef@berkeley.edu](mailto:chasef@berkeley.edu)

### **University Health Services, Counseling and Psychological Services:**

510-642-9494

### **Books:**

Van Dernoot Lipsky, L. & Burk, C. (2009). Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others. Berret-Koehler Publishers: San Francisco, CA.

Kabat-Zinn, John (2011). Mindfulness for Beginners: Reclaiming the Present Moment – And Your Life. Sounds True: Boulder, CO.

### **Website:**

Free online module for understanding and addressing vicarious trauma

<http://headington-institute.org/Default.aspx?tabid=2646>