Introduction

Illinois Helping Everyone Access Linked Systems (HEALS) was a federally funded multi-year initiative that aimed to improve systems' responses to Illinois children, youth, and families impacted by violence. For a forthcoming report, ICJIA researchers conducted a process evaluation of the Illinois HEALS demonstration site.[1] The study sought to better understand the site's implementation of the Illinois HEALS Recognize, Connect, and Engage (RCE) framework. The Illinois HEALS RCE framework posits that strong linkages within a system involve *recognizing* victimization has occurred, *connecting* victims to resources, and providing services that meaningfully *engage* victims and their families. In the current study, researchers analyzed data gathered as part of that Illinois HEALS evaluation. They examined the interview data from five mental health professionals who provided services to children, youth, and families. Interviews were conducted in 2022, and no additional participants were recruited. Researchers focused specifically on data related to burnout and vicarious traumatization, including strategies used to mitigate negative impacts.

Defining Burnout and Vicarious Traumatization

Researchers and individuals who work in helping professions have used varied terms to refer to experiencing negative impacts due to exposure to others' trauma. Terms include burnout, compassion fatigue, and vicarious trauma. Literature suggests that burnout, compassion fatigue, and vicarious trauma exist on a continuum. When the effects of burnout are unaddressed symptoms may worsen and may progress to compassion fatigue and vicarious trauma.[2]

Burnout is emotional exhaustion and withdrawal due to a person's work or workplace.[3] Risk factors include a high workload and an unsupportive work environment.[4] Trauma exposure is not required for an individual to experience burnout.[5] Self-care related activities and supportive relationships and work environments can reduce burnout's negative effects.[6]

In contrast, compassion fatigue occurs either when individuals re-experience their own similar trauma upon hearing the trauma of others or when individuals empathetically experience another's trauma.[7] Those who are more emotionally responsive to a person's trauma may be more likely to experience compassion fatigue.[8] Similar to burnout, individuals experiencing compassion fatigue may feel less satisfied with their work and experience emotional withdrawal that hinders their ability to help others.[9]

Vicarious trauma refers to a negative change in one's outlook due to exposure to another person's traumatic experiences.[10] Over time this exposure can negatively impact a provider's ability to remain empathetic.[11] Additionally, researchers have found that the stress from working with traumatized clients can be compounded by administrative tasks and interactions with clients' interpersonal supports.[12] To mitigate the adverse effects of vicarious trauma, a supportive environment for providers is needed.[13] Organizational support for providers' well-being and uses of self-care can help address vicarious trauma and its effects.[14] Broadly, the Office for Victims of Crime refers to compassion fatigue and vicarious trauma as vicarious traumatization.[15] In this article, researchers adopt this same terminology to discuss study findings.

Impacts

Researchers have studied burnout and vicarious traumatization among mental health professionals, nurses, and other helping professions. Findings indicate that the impacts of burnout and vicarious traumatization overlap. The effects of burnout include physical exhaustion, headaches, withdrawal from work, an inability to connect with clients, lowered self-esteem, and feelings of inadequacy.[16] In addition to these symptoms, an individual experiencing compassion fatigue may reexperience the client's trauma, have intrusive thoughts or anxiety, and avoid discussion of symptoms or reminders of clients' trauma.[17] Similar to compassion fatigue, vicarious trauma symptoms include nightmares, intrusive thoughts, and anxiety.[18] However, vicarious trauma is also characterized by a negative change in an individual's worldview that extends beyond their work.

Mitigating Burnout and Vicarious Traumatization

Research has identified approaches for mitigating the negative effects of burnout and vicarious traumatization. Approaches include individual-level self-care and organization-level implementations of vicarious trauma-informed strategies.

Self-Care

Self-care can help individuals ameliorate the effects of burnout and vicarious traumatization. It refers to employee-initiated activities that benefit well-being, address employee needs, decrease feelings of isolation, or reduce stress.[19] Self-care activities include setting boundaries around work hours, developing and maintaining supportive interpersonal relationships, and seeking therapy.[20] Two additional self-care strategies include becoming more knowledgeable about trauma and engaging in professional development.[21] Additionally, some self-care activities, such as physical activity, spirituality, and increased socialization, have been shown to improve a person's ability to cope with burnout and vicarious traumatization.[22]

Vicarious Trauma-Informed Organizations

Organizations institute vicarious trauma-informed strategies when leadership takes steps to develop and implement workplace strategies that address risks of vicarious traumatization.[23] Some strategies include allowing for open communication, showing appreciation for staff, providing opportunities for staff to build supportive relationships, and incorporating self-care within organizational policies.[24] Strategies also include supporting staff in discussing their experiences during supervision (i.e., when a clinician receives regular support and guidance from a supervisor or more experienced provider).[25] Research shows that a vicarious trauma-informed organization can improve provider resiliency, productivity, retention, and organizational morale.[26]

Method

The present study provides insight into Illinois HEALS program affiliated mental health professionals' experiences with burnout and vicarious traumatization. The original study had five research questions:

- To what extent are the representatives from different collaboratives, coalitions, or organizations in the region collaborating?
- How and to what extent is the Illinois HEALS program strengthening the capacity of systems and communities to recognize child and youth victims?
- How and to what extent is the Illinois HEALS program supporting the connections of child and youth victims and their families to appropriate resources?
- How and to what extent is the Illinois HEALS program engaging child and youth victims and their families in appropriate services?
- Is the Illinois HEALS's Recognize, Connect, and Engage framework, as described in the proposed program design, being implemented with fidelity?

Through preliminary analysis of Illinois HEALS process evaluation data, burnout and vicarious traumatization emerged as an additional area of inquiry that should be explored in interviews with mental health professionals. Thus, this study had a separate research question that evolved from the initial study: How do mental health professionals experience and cope with burnout, compassion fatigue, and vicarious trauma when providing services to children, youth, and their families who have experienced victimization?

Data Source and Sample

The exact sample size of the larger Illinois HEALS project is unknown as researchers did not collect identifying information from survey respondents. Therefore, they could not determine if survey respondents were unique from those participating in either a focus group or interview. However, researchers were able to conclude that a minimum of 32 unique individuals participated in the evaluation. For this larger study, researchers recruited participants using convenience sampling. Eligible participants included licensed mental health professionals providing evidence-based services to children and youth through the Illinois HEALS enhanced reimbursement rate program,[27] the sample used for the current study. To recruit mental health professionals, researchers attempted to contact eligible participants directly, but their efforts resulted in only one interview. To increase participation, researchers asked leadership at the Illinois HEALS demonstration site to disseminate an email to eligible mental health professionals.

Researchers analyzed five interview transcripts, of a total of 39 interview transcripts,[28] from the larger Illinois HEALS study. The interview transcripts were from five clinical providers who served children, youth, and families who had experienced victimization. Participants included two clinical supervisors and three clinicians from two agencies located in Southern Illinois. They were trained or certified in one or more evidence-based practice used to address trauma symptoms. Researchers did not gather participant demographic data to protect confidentiality. Participants were assigned identification numbers as part of the larger Illinois HEALS study,

with that numbering being used in this report to refer to the subset of the participants quoted here.

Analytic Strategy

Interviews were semi-structured and included questions about providers' backgrounds, their experiences with burnout and vicarious traumatization, and barriers to service delivery and receipt. Interviews were conducted in person or virtually via Webex from July to September 2022 and averaged 40 minutes. Researchers audio- and/or video-recorded the interviews with participants' consent. Recordings were transcribed, and then a researcher analyzed interview transcripts using QSR NVivo 12. Interview transcripts were then analyzed using focused and open coding techniques. Focused coding was done to identify information relevant to the original study's research questions, and open coding subsequently was utilized to identify any additional, emerging themes. Across all five interviews there were a total of 10 codes developed, including barriers to service; benefits to clinicians; compassion fatigue, burnout, and vicarious trauma; linked systems; and work with children and youth. Researchers coded a total of 50 references related to burnout and vicarious traumatization.

Limitations

This study had a few limitations. First, due to the sample's small size the results cannot be generalized to other Illinois victim service providers; the findings are only applicable to providers working in Southern Illinois and serving children, youth, and their families that have experienced victimization. However, this study adds to the literature regarding the experiences of mental health professionals with burnout and vicarious trauma. Also, researchers did not gather participant demographic data to protect their confidentiality; therefore, participant demographic information could not be reported. Finally, due to project staffing, only one researcher coded interviews; therefore, inter-rater reliability, the extent to which two or more researchers agree in their application of codes, was not available. Inter-rater reliability ensures consistent data interpretation and reduces coding errors.[29]

Findings

Experiences with Burnout and Vicarious Traumatization

Researchers found that all participants reported experiencing burnout or vicarious traumatization. In reporting their common experiences of burnout or vicarious traumatization, the service providers described various symptoms, such as nightmares, elevated stress levels, and a reliving of their own historic traumas. Providers gave examples of "[having] nightmares about clients within the past year" (P046) and described feeling "really burnt out…tired" (P065). In addition, one clinician reportedly began to experience vicarious trauma symptoms after starting their current position. This clinician's own trauma history had drawn them to the field, but hearing others' trauma stories resulted in them re-experiencing that history and needing to seek therapy to process it. In addition, a supervisor acknowledged that "anxiety with [their team] is very high" and that "[staff are] skipping meals…and having trouble sleeping" (P046), both of which indicate burnout and vicarious traumatization. Furthermore, one clinician reported making work-

related calls after work hours, potentially increasing their risk of burnout and vicarious traumatization.

Participants identified high caseloads and administrative paperwork as two risk factors for burnout and vicarious traumatization. One clinician reflected that their "[caseload] is probably too high" because one case is "not necessarily one individual client even though it shows one client on [their] caseload" (P065). That is, in addition to individual clients, clinicians must also interact with that client's family members, caseworkers, schools, and other supports. Additionally, this clinician noted that high caseloads had negatively affected their ability to provide services, stating "I have to pick and choose because I can't give all of myself to that many clients on an eight-hour day" (P065). In examining causes of burnout and vicarious traumatization, a clinical supervisor learned that paperwork could exacerbate symptoms. This supervisor reflected that some team members are "so stuck on thinking about [tough cases] that they're not getting to the paperwork, but then the thought of trying to do the paperwork for those clients just pushes them over the edge" (P046).

Importance of Supervision as an Organizational Strategy

Participants described their experiences with supervision, including its benefits. Specifically, one clinician noted that "trauma work can be hard" and that "supervision is a place to go with your own feelings…anything that you're struggling with or a case that you feel like you just kind of need to get off your chest" (P054). Similarly, a supervisor reflected that supervision was a space where staff could "talk about their stress level" (P046). Expanding on this sentiment, another clinician shared that having time with a supervisor had provided an opportunity to become more comfortable with the experience of providing a new therapeutic modality. This individual described the supervisor as being "extremely supportive" during weekly supervision meetings and being able to have "vulnerable conversations about why [they were] having a hard time with [the new modality]" (P069).

Findings suggest that the amount of time available for supervision may be insufficient to meet clinicians' needs. For example, a clinician described meeting with their supervisor regularly but not having enough time to talk about individual clients. This clinician reflected that the "[supervisor's] job should really be about two or three jobs" and that as a result staff do not receive the support needed because "[they] don't have access to [their supervisor]" (P065). Further compounding a lack of access is what one clinician described as a reluctance to "bother [their supervisor]" (P065). This clinician was hesitant to seek support despite recognizing that they were experiencing symptoms of vicarious traumatization.

Strategies for Ameliorating Burnout and Vicarious Traumatization

Interviews highlighted several strategies for mitigating symptoms of burnout and vicarious traumatization. These strategies can be implemented by staff, supervisors, and the organization.

Strategies for Clinical Staff

Participants identified therapy and self-care as two strategies that individual staff can employ to address burnout and vicarious traumatization. One clinician stated that "therapists need therapy" (P069) to help process their experiences working with children and youth impacted by violence. The provider further reflected that one benefit of therapy has been being better able to help their clients. Participants also described the importance of individual self-care. One clinician spoke of how, as an intern, they were required to have a self-care plan in which they identified ways to take care of themselves. This clinician has continued to implement that practice in their current role. In addition, this clinician detailed how agency leadership and colleagues encouraged self-care, for example, by asking "What have you done to take care of yourself?" or they may suggest, if someone looks stressed, "You need to take a few deep breaths. You need to go for a walk" (P069). In addition, a supervisor noted that staff developed self-care plans after an agency-wide assessment revealed a need for them.

Strategies for Supervisors and Organizations

Participants identified strategies that supervisors and organizations can utilize to ameliorate symptoms of burnout and vicarious traumatization. These included protected supervision time, peer mentoring, reminders, social activities, and increased pay. Providers asserted that interactions with supervisors should be protected, with enough "time built in" (P065) and enough "space where you can go and talk about [experiencing burnout]" (P054). One supervisor described two strategies they used to mitigate burnout and vicarious traumatization among their staff. The first was "protect[ing] supervision time very carefully" (P046). The second was introducing a peer mentoring program where individual staff could meet with at least two other colleagues monthly and mentor one another. These strategies provided clinicians with opportunities to discuss difficult cases and develop supportive workplace relationships. As an additional strategy, this supervisor advised clinicians to take care of themselves during particularly busy periods by reminding themselves that the influx of clients would eventually dissipate. Particularly busy periods included the beginning of a new school year or after the holidays.

Participants also focused on strategies that organizations could employ to protect providers' well-being. Two of these were social activities and increased pay. To explain the benefit of social activities, one supervisor shared that doing team bonding activities during the workday had been a quick way to relieve stress. Another supervisor reported that their organization had established a committee to assist with incorporating more social activities, such as birthday and anniversary celebrations. Such social activities helped "to ensure that we're okay so that we can then provide services appropriately" (P069). Increased pay also advanced providers' well-being. Reportedly, it helped to make clinicians "feel valued in the work they're doing" (P068).

Recommendations

Study findings point to several recommendations for mitigating the impacts of burnout and vicarious traumatization among mental health professionals who provide services to children, youth, and families impacted by violence.

Reduce Work-Related Stressors

As the research literature suggests, addressing burnout among clinicians involves reducing workplace stressors, especially paperwork and high caseloads, and it involves strengthening supervisory and organizational supports.[30] From the HEALS interview transcripts, researchers learned from supervisors that indeed some clinicians delayed completing client paperwork because it reminded them of that client's trauma. Research also suggests that having providers complete paperwork for their peers can mitigate symptoms of burnout and vicarious traumatization as it allows providers to reduce interaction with traumatic cases.[31] Limiting and diversifying caseloads can also prevent or reduce burnout and vicarious traumatization.[32] Clinicians with smaller caseloads may have more time between clients to address case-related concerns or to ask for support with providing therapeutic modalities.[33] Additionally, encouraging the development of supportive relationships among staff can reduce work-related stressors and benefit providers' overall well-being.[34] Organizations can further prioritize providers' well-being by offering employee assistance programs, fostering supportive peer relationships, encouraging providers to take leave, and reminding them to only work during scheduled hours.[35]

Incorporate Protected Supervision Time

Protecting supervision time and using it for reflection can benefit those in the helping professions.[36] As mentioned earlier, participants described the importance of supervision but noted that the amount of supervision they received did not sufficiently meet their needs. They identified a lack of access to their supervisor and were concerned about their supervisor's capacity to provide supervision. Other studies have shown these same barriers to effective supervision.[37] Research suggests that supervision should occur regularly. Specifically, the Substance Abuse and Mental Health Service Administration recommends one hour of supervision for every 20-40 hours of service provision.[38] Furthermore, supervision should occur in a designated space and be used to discuss a provider's cases and their experiences with burnout and vicarious traumatization.[39]

Future Research on Providers' Experiences with Vicarious Traumatization

Future research is needed to overcome the limitations of this study in efforts to advance the field to more nuanced, generalizable findings and to more tailored recommendations. The data analyzed for this study were obtained as part of the larger Illinois HEALS process evaluation study that was focused on a demonstration site's implementation of that program for children, youth, and families impacted by violence in Illinois. The process evaluation gathered data only from mental health professionals about providers' experiences with burnout and vicarious traumatization or strategies that their organizations employed to mitigate effects. Other interview participants may have been at risk for vicarious traumatization but were not asked about this topic, such as individuals who provided case management services and those who supervised staff providing direct services. Thus, the interview responses extracted for this current study only reflect the experiences of a relatively small sample of mental health professionals serving a specific population. Future research should examine a larger sample of mental health

professionals serving victims or expand the sample to providers serving those exposed to other trauma types, such as natural disasters and housing or food insecurity. Such efforts would increase our understanding of burnout and vicarious traumatization prevalence in Illinois. Additionally, researchers should assess the efficacy of strategies for mitigating its effects, including individual strategies, such as self-care, and organizational strategies, like protected supervision time.

Conclusion

Clinicians and clinical supervisors providing services to children, youth, and families through the Illinois HEALS program experienced burnout and vicarious traumatization. These providers identified their symptoms, and they utilized strategies, such as therapy and team bonding activities, to mitigate its effects. While this study's sample was small, the experiences providers report highlighted the importance of prioritizing providers' well-being through organizational policies and practices to ensure high quality service provision. Thus, organizations that employ individuals in helping professions should take steps to better understand the extent of burnout and vicarious traumatization symptoms among their staff and should implement vicarious trauma-informed strategies that are responsive to providers' needs.

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