

# A vicarious trauma preventive approach. The Group Traumatic Episode Protocol EMDR and workplace affect in professionals who work with child abuse and neglect

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## Abstract

Workplaces that provide services and deal with abuse cases are often associated with high levels of work stress, burn out, and high expressed affect. The current intervention aimed at a more effective management of stress and affect in the workplace. EMDR therapy is an evidence-based treatment for PTSD and anxiety disorders. A Group EMDR protocol was applied to professionals working at "the House of the Child", an innovative specialized Mental Health Unit that provides multi-disciplinary assessment, diagnosis and treatment services for children and adolescents survivors of abuse and neglect operated by the Association "The Smile of the Child". The intervention included two sessions. The stabilization session took place for purposes of screening and preparation (self-regulation) and lasted 45 minutes. In the second session, which lasted 90 minutes, participants processed a recent stressful event that occurred in the workplace. The stressful event was not shared in the group. There were twenty participants and two facilitators, all of whom working at the unit. The Job Affect Scale, the Impact of Event Scale-R, the State-Trait Anxiety Inventory and the Subjective Units of Distress (SUD's) were administered. The dependent (paired) *t* test showed significant reduction of the SUDs related to the stressful event, decrease in the avoidance, intrusion and hyperarousal symptoms. Moreover, reduction in the negative affect in the workplace was noted. The current pilot intervention provided indications for the usefulness of workplace interventions aiming at more effective stress management and better communication among the members of the multi-disciplinary team. Further research is needed to evaluate the efficacy of Group EMDR in workplace stress management and the prevention or processing of vicarious/secondary trauma.

**Key words:** Group EMDR, workplace stress, vicarious trauma, multi-disciplinary team

## Introduction

It has long been recognised that professionals working with survivors of trauma are likely to be affected by the exposure to traumatic material<sup>1</sup>. Research data show that 6% to 26% of therapists working with traumatised populations and up to 50% of child welfare workers are at high risk of developing secondary traumatic stress or the related conditions of post-traumatic stress disorder and vicarious trauma<sup>2</sup>.

The therapists not only listen to clients' narrations of traumatic experiences but also engage in an empathic relationship with the client. Inevitably, trauma work requires the therapist to attune to the client's responses, and, as Siegel put it, "feel the feelings, not merely understand them conceptually"<sup>3</sup>. The emotional strain the therapist experiences due to the exposure to trauma and its multiple effects on the therapist have been addressed in the literature through the notions of secondary traumatic stress, compassion fatigue and vicarious trauma.

Secondary trauma has been described as the transfer and acquisition of negative affective, cognitive and behavioural states resulting from prolonged and close contact with traumatised individuals<sup>4</sup>. Secondary traumatic stress includes avoidance, intrusion and arousal symptoms<sup>5</sup>, such as hypervigilance, a sense of hopelessness, fear, guilt, anger, cynicism, physical ailments, sleep problems<sup>6</sup>. Compassion fatigue is a less stigmatising way to describe secondary traumatic stress<sup>5</sup>, and has been used in the literature interchangeably with the "secondary traumatic stress". Vicarious trauma refers to the changes in the therapist's beliefs and systems of meaning that result from the chronic engagement with traumatised individuals<sup>7</sup>.

The accumulative effect of the exposure to trauma can lead to burnout which has been described as a state of emotional and physical exhaustion the professional experiences<sup>8</sup>. Burnout has been associated with job dissatisfaction, absence from work, low levels of commitment, staff turnover<sup>9</sup>, low productivity and compromised quality of care to service users<sup>10</sup>.

## The House of the Child and the Smile of the Child

"The House of the Child" is a Mental Health Unit for the provision of individualized Mental Health Services to children and adolescents victims of abuse, neglect, domestic violence, victimized minors, children involved in bullying incidents and generally children who have recently or in the past have been exposed to severe psycho-traumatic experiences and suffering resulting to mental health, adaptation or behavioral problems. "The House of the Child" is operated by the domestic child protection civil society Association "The Smile of the Child" and constitutes a specialized service, unique in Greece and innovative both in Europe and internationally. "The House of the Child" is staffed by a specialized multidisciplinary team and provides free services to children and adolescent victims who live either with their family or within alternative models (foster family) or other sheltering frameworks (hostels, boarding schools, shelters, etc.). The multi-disciplinary therapeutic team of the "House of the Child" undertakes a holistic and comprehensive diagnostic evaluation and treatment of any kind of disorder that victimized children may suffer from.

The Association "The Smile of the Child" established in the January 1996. Since then, the organization has expanded to meet the serious problems of children in need living in Greece. Through its various services, "The Smile of the Child" protects children's rights and provides them with emotional and psychological support. Children who suffer from health problems or any type of abuse, neglect or abandonment, are within the organization's mandate<sup>11</sup>. Over the last 2 decades, "The Smile of the Child" has developed a variety of child centred activities in line with the national convention on children's rights, active on a 24-hour basis responding to personal and family needs where relevant and effective public services are lacking, which combined with economic crisis of recent years, has generated a dramatic increase in requests for help and referrals<sup>12</sup>.

## Eye Movement Desensitization and Reprocessing (EMDR) and the Group Traumatic Episode Protocol (G-TEP)

EMDR as a brief, effective approach for processing traumatic memories is suitable for Early Intervention<sup>13,14</sup>. The theoretical basis of EMDR Therapy is the Adaptive Information Processing (AIP) Model. According to the Adaptive Information Processing Model, stress symptoms are viewed as resulting from disturbing experiences that have not been adequately processed and have been encoded in state specific, dysfunctional form<sup>15-17</sup>. As suggested by Solomon and Shapiro<sup>18</sup>, the transformation of these dysfunctionally stored experiences into an adaptive resolution promotes psychological health.

The EMDR Recent Traumatic Episode Protocol (R-TEP) is an integrative recent trauma-focused protocol for Early EMDR Intervention and includes procedures and measures for containment and safety<sup>19</sup>. The EMDR R-TEP protocol introduced a focus on the trauma episode rather than only on the initial trauma event. During 2013, Shapiro<sup>20</sup> introduced a group application, the Group Traumatic Episode Protocol (G-TEP). It is adapted from EMDR R-TEP for using with different age groups and populations who have experienced traumatic experiences or adverse events with ongoing impact, not necessarily recent.

### This study

Research data on the vicarious/ secondary stress of professionals who are exposed to traumatic material, combined with the evidentiary basis of EMDR therapy informed the design of this intervention. Given that professionals working with child and adolescent victims of abuse and neglect are at risk for workplace stress and tend to experience high expressed emotion in the workplace, it was assumed that they could benefit from a trauma-informed intervention at a group level. On that basis, EMDR G-TEP, a cost and time effective and easily learned intervention, was applied to professionals working at “the House of the Child”, since it being a specialized mental health unit for children and adolescents who have been exposed to past and/or current experiences of abuse,

neglect, domestic violence and bullying and therefore a high risk working environment for secondary trauma exposure of personnel. Among others, EMDR G-TEP could help practitioners process stressful events and therefore respond to the combined effects of stressors in a trauma-exposed workplace more effectively. To our knowledge, EMDR G-TEP has not yet been applied in the field of workplace stress.

Preventive interventions that target vicarious/secondary trauma aim to modify cognitive distortions that arise from trauma experiences, decrease flooding and hypervigilance, help individuals to return to a previous level of adaptive functioning and promote safety for the future<sup>21-28</sup>. EMDR G-TEP intervention incorporates all these therapeutic elements.

The current study aimed to investigate the effectiveness of EMDR G-TEP in reducing the workplace stress of professionals working with traumatised children and prevent the complications of being exposed to trauma work. It also aimed at strengthening professionals’ resilience, thus ensuring effective and high quality delivery of care for children and adolescents victims of abuse and neglect.

## Method

### Design

This study is a single intervention on members of “the House of the Child” multidisciplinary team, who received two sessions of EMDR G-TEP intervention. The first session involved preparation, stabilisation and resource building and the second session, which took place one week later, focused on the processing of the stressful event.

### Participants and Procedure

Participants were recruited from the child and adolescent mental health unit “the House of the Child”. Two therapists administered the intervention. At all phases of the process, both therapists were present, the one as a leader and the second one as a co-facilitator, as suggested by Shapiro. Each G-TEP group was composed of five participants. Twenty therapists and members of the House of the Child multidisciplinary

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nary team (18 female, 2 male) participated in the intervention. Specifically, Clinical Psychologists, a Child Psychiatrist, a Speech Therapist, an Occupational Therapist, a Social Worker, a Special Education Teacher, Psychology graduate students and Administrative employees participated in the intervention. The main goal of the intervention was to process a stressful episode/ event that occurred in the workplace. The stabilization session took place for purposes of screening and preparation (self-regulation) and lasted 45 minutes. In the second session, which lasted 90 minutes, participants processed a recent stressful event that occurred in the workplace. The stressful event would not be shared in the group. The target event, which would not be shared among the members of the group, could be related to clients' traumas, interactions with other members of the multidisciplinary team or any experience in the workplace that evoked stress in the professionals. The participants were informed about their voluntary participation, and confidentiality issues were thoroughly explained.

They were informed about the aims of the current study before they signed a specifically developed Consent Form. Prospective participants were also informed that they would have the right to withdraw from the study at any stage and in that case, their material would be destroyed. All questionnaires and measures were completed anonymously, and self-generated identification codes were used in order to match each response with the participant that submitted it.

## Measurements

The Impact of Events Scale-R, Job Affect Scale, State and Trait Anxiety Inventory were administered one day before the first session (stabilisation) and one week after the second session (processing). The Subjective Units of Distress was completed during the second session (pre-post).

**Impact of Events Scale (IES-R):** The Impact of Event Scale—Revised (IES-R), has 22 questions, 5 of which were added to the original IES to better capture the DSM-IV criteria for PTSD<sup>29</sup>. The validity of IES-R has been tested in different populations<sup>30</sup>. The Greek version of IES-R was developed by Giannopoulou et al.<sup>31</sup>.

**Job Affect Scale:** 12 items of the Job Affect Scale<sup>32</sup> were used in order to assess participants' experience of positive and negative affect at work during the previous week on a 5-point scale. The six positive items (JAS-PA) were: enthusiastic, elated, active, strong, happy, and excited. The six negative affective states (JAS-NA) were: hostile, scornful, fearful, sleepy, placid, and sad. The positive and negative affect parts of the scale had good internal consistency in Greek context<sup>33</sup>.

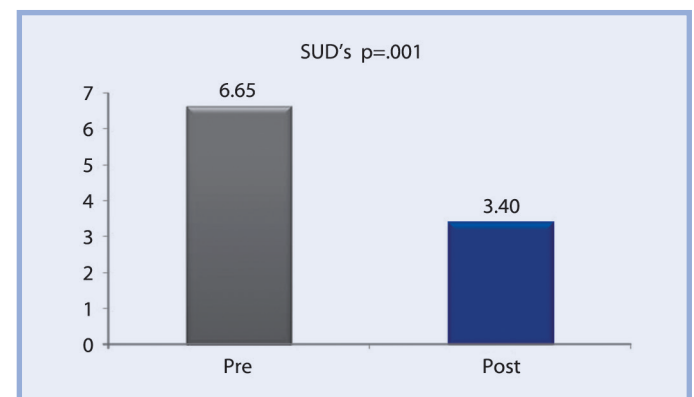
**State and Trait Anxiety Inventory:** The self-rated State and Trait Anxiety Inventory (STAI) has two separate components, the State Anxiety Inventory (SAI) and the Trait Anxiety Inventory (TAI), both of which are made up of 20 items<sup>34</sup>. The SAI measures how a person feels at the present time, while the TAI assesses a person's general disposition for anxiety.

**Subjective Units of Distress (SUD):** The Subjective Units of Distress is a one-item 11-point Likert-type subjective anxiety scale. Originally, it was defined as the self-rated current anxiety between 0 (a state of absolute calmness) and 100 (the worst anxiety ever experienced<sup>35</sup>). Later, Wolpe<sup>36</sup> proposed the use of a more compact scale ranging from 0 to 10.

## Results

### *Differences in the Subjective Units of Distress*

The dependent (paired) t test showed statistically significant reduction of the Subjective Units of Distress related to

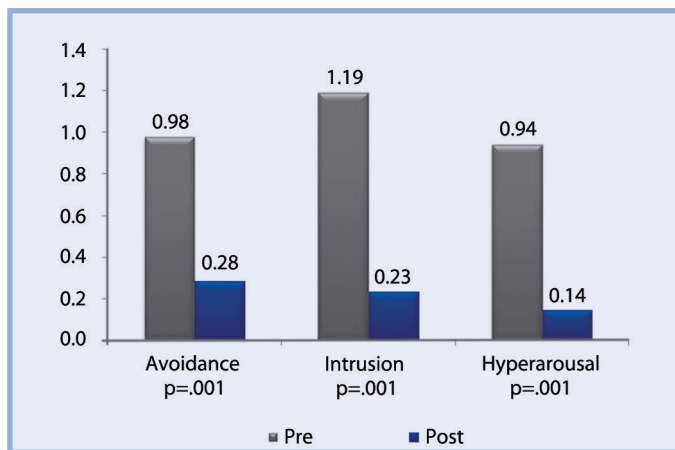


**Figure 1.** Differences in the Subjective Units of Distress pre and post processing (second meeting)

the stressful event at workplace ( $M_{pre} = 6.65$ ,  $SD_{pre} = 2.18$ ,  $M_{post} = 3.40$ ,  $SD_{post} = 2.44$ ,  $t(19) = 7.70$ ,  $p < .001$ ,  $d = 1.72$ ) (see Table 1 and Figure 1)

### Differences in post-traumatic symptoms

The dependent (paired)  $t$  test showed statistically significant reduction on the avoidance ( $M_{pre} = 0.98$ ,  $SD_{pre} = 0.68$ ,  $M_{post} = 0.28$ ,  $SD_{post} = 0.34$ ,  $t(19) = 5.10$ ,  $p < .001$ ,  $d = 1.17$ ), intrusion ( $M_{pre} = 1.19$ ,  $SD_{pre} = 0.65$ ,  $M_{post} = 0.23$ ,  $SD_{post} = 0.28$ ,  $t(19) = 6.84$ ,  $p < .001$ ,  $d = 1.57$ ) and hyperarousal ( $M_{pre} = 0.94$ ,  $SD_{pre} = 0.72$ ,  $M_{post} = 0.14$ ,  $SD_{post} = 0.19$ ,  $t(19) = 5.57$ ,  $p < .001$ ,  $d = 1.28$ ) (see Table 1 and Figure 2).



**Figure 2.** Differences on the Subjective Units of Distress pre and post intervention

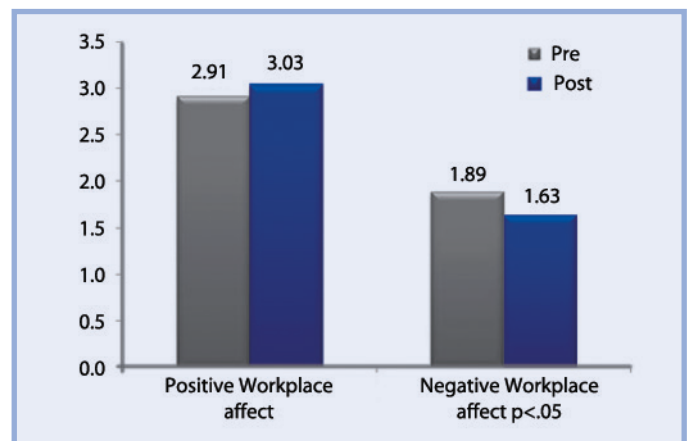
### Differences in State and Trait Anxiety

The dependent (paired)  $t$  test did not show differences in State ( $M_{pre} = 3.58$ ,  $SD_{pre} = 0.58$ ,  $M_{post} = 3.50$ ,  $SD_{post} = 0.40$ ,  $t(19) = 0.67$ ,  $p = .510$ ,  $d = 0.15$ ) and Trait Anxiety ( $M_{pre} = 3.42$ ,  $SD_{pre} = 0.16$ ,  $M_{post} = 3.39$ ,  $SD_{post} = 0.22$ ,  $t(19) = 0.80$ ,  $p = .436$ ,  $d = 0.18$ ) (see Table 1).

### Differences in the Workplace Affect

The dependent (paired)  $t$  test showed statistically significant reduction on the negative affect at workplace ( $M_{pre} = 1.89$ ,  $SD_{pre} = 0.66$ ,  $M_{post} = 1.63$ ,  $SD_{post} = 0.49$ ,  $t(19) = 2.51$ ,  $p = .022$ ,  $d = 0.58$ ). The dependent (paired)  $t$  test did not show differences in the positive affect at workplace ( $M_{pre} = 2.91$ ,  $SD_{pre} = 0.78$ ,  $M_{post} = 3.03$ ,  $SD_{post} = 0.66$ ,  $t(19) = -0.87$ ,  $p = .394$ ,  $d = -0.20$ ) (see Table 1 and Figure 3).

pre = 0.66,  $M_{post} = 1.63$ ,  $SD_{post} = 0.49$ ,  $t(19) = 2.51$ ,  $p = .022$ ,  $d = 0.58$ ). The dependent (paired)  $t$  test did not show differences in the positive affect at workplace ( $M_{pre} = 2.91$ ,  $SD_{pre} = 0.78$ ,  $M_{post} = 3.03$ ,  $SD_{post} = 0.66$ ,  $t(19) = -0.87$ ,  $p = .394$ ,  $d = -0.20$ ) (see Table 1 and Figure 3).



**Figure 3.** Differences in the workplace (positive and negative) affect pre and post intervention

	Pre intervention		Post intervention		t	d
	M	SD	M	SD		
SUD's	6.65	2.18	3.40	2.44	7.70***	1.72
Avoidance	0.98	0.68	0.28	0.34	5.10***	1.17
Intrusion	1.19	0.65	0.23	0.28	6.84***	1.57
Hyperarousal	0.94	0.72	0.14	0.19	5.57***	1.28
State Anxiety	3.58	0.58	3.50	0.40	0.67	0.15
Trait Anxiety	3.42	0.16	3.39	0.22	0.80	0.18
Workplace Positive Affect	2.91	0.78	3.03	0.66	-0.87	-0.20
Workplace Negative Affect	1.89	0.66	1.63	0.49	2.51*	0.58

Note: \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ .

**Table 1.** Paired samples  $t$  test (pre vs post) on the scores of the Subjective Units of Distress (SUD's), factors of the Impact of Events Scale-R, State and Trait Anxiety and Job Positive and Negative Affect



## Discussion

Our study attempted to explore whether EMDR G-TEP might be an effective intervention for professionals who are exposed to trauma vicariously. Our results demonstrated that the participants processed traumatic memories related to stressful events in the workplace and gained a sense of control. In addition, the participants had the opportunity to learn stabilization skills through grounding, relaxation and visualization exercises taught and practiced in the first session. It was found that IES-R scores improved significantly, which means that participants' symptoms of intrusion, avoidance, and hyperarousal were reduced. Moreover, their subjective units of distress in relation to the stressful events the participants processed decreased. These findings are consistent with the findings of Yurtsever et al.<sup>37</sup> and Lehnung et al.<sup>38</sup> on the effectiveness of G-TEP in reducing posttraumatic stress symptoms.

Our study found that EMDR G-TEP was effective in reducing trauma practitioners' distress in relation to stressful events at workplace. A similar pattern of results was obtained in a recent study of Behnammoghadam et al.<sup>39</sup>, which demonstrated the efficacy of EMDR on reducing stress intensity experienced by emergency medical staff, a group of professionals also susceptible to stress and anxiety.

Moreover, Snisar et al.<sup>40</sup> conducted a study in Ukraine which examined the effectiveness of EMDR G-TEP in treating and preventing trauma among mental health professionals working in war zones. The preliminary findings presented by the researchers demonstrated the effectiveness of sustained sessions of G-TEP in reducing the risk of trauma in professionals working in military action zone. Findings of the current study are consistent with the above findings, revealing that EMDR G-TEP can be effective in improving stress levels of professionals working in trauma-exposed environments. However, the current study focused on the prevention of vicarious traumatization of professionals working in the field of child abuse while the Ukrainian study focused on trauma prevention in mental health specialists working in war zones.

An interesting finding of our study was the participants reported the workplace negative affect reduced after the inter-

vention. This indicates a change related to workplace contextual factors rather than the specific stressful event that was processed with EMDR G-TEP. This finding that has the potential to cast new light on the effects of the adaptive processing of stressful events at work on the workplace affect and professional quality of life.

According to the Affective Events Theory<sup>41</sup>, the cumulative affective experiences at workplace in combination with other intrapersonal and interpersonal factors form professionals' job-related attitudes. Affect is a subjective feeling state with a hedonic tone and differs from discrete emotions and moods in that it has a specific contextual element but not a particular target<sup>42</sup>. Therefore, work affect is a crucial aspect of the work experience.

## Limitations and recommendations for research

Our study included a small number of participants, and therefore, our results cannot be generalized to other professionals or teams working with trauma.

Factors that may influence the stress and affect in the workplace, such as personality traits, years of experience, special training on trauma, and supervision, were not taken into consideration. Furthermore, a control group was not used. Since there has not been previous research on applications of EMDR G-TEP to professionals, it is not possible to compare our findings to previous ones. In the current study, measures used demonstrate changes in professionals' symptoms but not their overall level of functioning and quality of life. Moreover, follow up measures need to be administered in three-month time to ensure the results maintain in the long term.

Further research should be conducted to explore the effectiveness of EMDR G-TEP with other groups of professionals who are vulnerable to work stress or at risk of developing vicarious/secondary trauma at workplace. It will be important that future research further develop and confirm these initial findings measuring vicarious trauma (e.g. VTS<sup>43</sup>, STSS<sup>44</sup>), coping strategies (e.g. CSI<sup>45</sup>), professional and global quality of life (e.g. ProQOL<sup>46</sup>, WHOQOL-BREF<sup>47</sup>).

Our data indicate that professionals working with child

abuse and neglect report improved affect in the workplace following the intervention. This is an important finding that suggests that further research could investigate the interconnectedness of personal and workplace contextual factors variables and their association with workplace stress and affect.

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