What School Leaders Need to Know about Secondary Traumatic Stress

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Introduction

Many school leaders are well aware of the impact they can have on the climate of their school community. Caring and compassionate administrators work hard to influence the interpersonal atmosphere of their school, and value the health and wellness of their staff and students. Our culture's recent focus on school safety and bullying has contributed to a huge amount of literature that describes the factors that can support positive climate and thus safety, as well as factors that can contribute to individuals feeling disconnected, alienated, frustrated and potentially destructive. Not only are school leaders called upon to create safe and healthy schools for children, but administrators also have a critical role to play in the development of a healthy work climate for the staff that supports them.

Social changes in our society have contributed to a significant increase in children with many emotional/behavioural needs and many school districts have responded to the needs of these at-risk children by increasing staffing in areas such as counselling. Although school leaders are appreciative of the support provided to both students and staff by the school counsellor, many administrators are uncertain about the role of the counsellor, or how best to make use of the special skills they bring.

The development of the field of professional school counselling has emerged from the recognition of the need for well trained counsellors who are qualified and prepared to deal with the challenging situations often seen in schools today. Any school principal who has faced the extraordinary challenge of dealing with the sudden death of a student or staff member understands the value of a group of trained mental heath professionals who are available to support the emotional and psychological needs of the

school community. Situations such as abuse disclosures, suicide risk assessments, grief and loss, family break ups, conflict resolution and mental health crises are common in schools, and the administration may be relieved to have a counsellor available to refer to.

While school and district administration may recognize the intense and draining nature of the work facing school counsellors, they may not be aware of certain unique risks involved for helping professionals who are engaged with traumatized individuals. Many crisis situations faced by school counsellors involve trauma and traumatic events. Trauma can be defined as exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, to self or others' physical or psychological well-being (American Psychiatric Association, 2000). A traumatic event is an experience that causes physical, emotional, psychological distress or harm to an individual or to those close to an individual, or a perceived threat to one's safety or to the stability of one's world (Figley, 1995).

Individuals who are drawn to the field of counselling usually have a strong sense of empathy and a genuine desire to help others: as trained professionals, counsellors provide children and adolescents a safe, empathic environment to share their painful stories. What most counsellors do not know is how this process of empathic engagement with clients may be affecting them personally. Rothschild (2006) summarizes evidence that may explain the process by which counsellors can become affected by exposure to other people's emotional pain. According to Rothschild, empathy is rooted in the human central nervous system and involves the activation of specific brain cells called mirror neurons. Mirror neurons appear to be involved in the contagion of yawning and

laughter, and in the mimicry of facial expressions. These brain cells are now thought to be related to the concept of emotional contagion.

According to Rothschild (2006), all emotion is contagious through the process of empathy, which is rooted in the body and brain. Empathy, a foundational process in counselling, may be a 'double edged sword', acting as a tool to facilitate our understanding of clients while also threatening "our emotional well-being by making us a prisoner of someone else's nervous system" (Rothschild, 2006, p.3).

A growing body of theory and research exists that describes how counsellors can be affected by exposure to other people's trauma: the terms compassion fatigue (Figley, 1995), vicarious trauma (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1996), and secondary traumatic stress (Stamm, 1995) have all been used to describe the range of adverse effects often seen in helping professionals. In order to reduce the risks associated with caring for others in distress, counsellors and school leaders need to be made aware of this important issue. In particular, school and district administration require information about how they can support their counselling staff and assist in the prevention of such harmful stress and potential burnout.

This paper will provide school administrators information necessary to recognize the signs and conditions which may contribute to the development of compassion fatigue or secondary traumatic stress in counsellors and other staff. A discussion of the ethical implications will explain why school leaders should be made aware of this subject. Finally, suggestions for organizational practices and strategies known to prevent compassion fatigue will provide school leaders guidelines for developing a healthy work environment for counsellors and all staff. Awareness training, peer collaboration or

clinical supervision, and the need to encourage self care practices are three key areas emphasized in the research as foundational components of a professional wellness program. Although the term counsellors is used throughout this paper, it is important to realize that teachers, administrators, special education consultants and teaching assistants all have the potential to be affected by their work with troubled children and families.

Theoretical Constructs

Compassion fatigue

Compassion fatigue is the most recent term used to describe the emotional reaction of a helper to another person's trauma. Figley (2002), used the term to describe the "cost of caring", or the range of adverse effects on caregivers due to their work with traumatized individuals (p.2). Compassion fatigue can affect professionals in any field who come into contact with people affected by extreme emotional pain or trauma (Figley, 1995). Individuals suffering from compassion fatigue may begin to notice they are not 'emotionally available' to themselves or to the important people in their personal lives. Some counsellors continue to work effectively but feel unable to give of themselves in their personal lives, as though their compassion is all used up. The condition is based upon the better known concept of secondary traumatic stress, and is similar to burnout, but each of these terms required more in-depth explanation to clarify the unique differences between them.

Secondary traumatic stress

Secondary traumatic stress (STS) is similar to post-traumatic stress (PTS) but the trauma is not experienced directly as a victim, but through secondary exposure to a victim's story or experience. The symptoms of STS and PTS involve three symptom

clusters: intrusion (intrusive thoughts, images and sensations), avoidance (of people, places, things and experiences that elicit memories of the traumatic event) and negative arousal (hypervigilance, sleep disturbances, irritability, startle reactions, anxiety) (American Psychiatric Association, 2000).

Affected counsellors may begin to take on symptoms or perspectives of their clients, and themselves become affected by intrusive imagery or flashbacks of the event. A counsellor may notice that they have recurrent flashbacks or a visual image of an event that did not happen to them, but to their client: For example, one school counsellor described a troubling image affecting her when she was driving through highway intersections. She was experiencing a recurrent image of a woman being T-boned in her car with her young child sitting next to her. Through introspection, the counsellor recognized that this image came from a client who, years previous, had shared with her that her mother had been killed in a car accident while she rode beside her in the car. Other common signs of STS may be an unusual preoccupation with a particular client and their circumstances, dreams or nightmares about a client or their experience, or a sudden fear associated with a client's traumatic experience.

Vicarious Traumatization

Vicarious traumatization (VT) was first described by McCann and Pearlman (1990a) as they noted the pervasive effects of doing trauma therapy on the identity, world view, psychological needs, beliefs and memory system of the therapist. They defined the concept of vicarious trauma as the transformation of inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material. "People who work with victims may experience profound psychological effects, effects that can

be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann & Pearlman, 1990a, p. 132). Vicarious trauma is a process rather than an event, and it occurs without warning over time and through repeated exposure to the verbal descriptions of all forms of life altering traumatic experiences of clients (McCann & Pearlman, 1990a).

Through a process of empathic engagement with clients, the counsellor may feel the client's emotional reactions and thus risk becoming traumatized vicariously (Pearlman & Saakvitne, 1995). As counsellors face the reality of hardship and loss daily via their supportive involvement with others, they are confronted with the potential for loss in their own lives, and those they love. Beliefs or schema about safety and control can become permanently altered by the involvement with people who have been hurt. Pearlman and Saakvitne (1995) suggest that we "do not blame our clients for our experience of vicarious traumatization but view it as an occupational hazard, an inevitable effect of trauma work" (p.31). These authors maintain that vicarious trauma is normal and inevitable result of our work and should not be perceived as a sign of illness, weakness or incompetence.

Burnout

Burnout is a more common term that is related to the concept of compassion fatigue and vicarious trauma, but refers specifically to a state of physical, mental and emotional exhaustion or dissatisfaction with one's work situation. Burnout usually emerges gradually under conditions of inadequate resources or by long term involvement with emotionally draining situations (Valent, 2002). In many cases, burnout involves frustration with a work situation, co-workers or supervisor, whereas compassion fatigue

is related to the clients. One's experience of burnout can often be immediately remedied by quitting a job whereas compassion fatigue and vicarious trauma do not disappear simply by changing circumstances (Figley, 2002).

The various terms and concepts described have in common the accumulation of negative psychological changes due to one's professional involvement with the emotional pain of others. For consistency, the term compassion fatigue will be used to convey the complete range of terms and conditions.

Ethical Implications

Why is it critical that counsellors and school administrators be aware of the risks of compassion fatigue? Perhaps most significant to this paper is the potential for harmful emotional effects in the counsellor. From an administrative point of view, it is expensive and inefficient to replace staff that may leave their jobs due to the effects of compassion fatigue; losing high quality, caring staff is clearly a significant loss to the organization. Monroe (1999) examined the ethical implications of secondary traumatic stress (STS) and believes there is a clear ethical need for organizations to provide their staff with training and information about STS: "Active preventative measures should be a part of the work environment" (p.216). However, it is important and necessary not only to protect the well-being of counsellors, but also to ensure high standards of care for the students being served.

The welfare of the students in counselling is clearly an important issue for school divisions, and administrators need to be aware of how counsellors who are unknowingly affected can damage vulnerable clients and cause harm (Monroe, 1999; Pearlman & Saakvitne, 1995). Counsellors affected by compassion fatigue may become intrusive and

aggressive with their clients (Pearlman & Saakvitne, 1996). Disturbed sleep, nightmares or heightened irritability may reduce a counsellor's attentiveness, patience or ability to focus and think clearly. Counsellors who have become overexposed to trauma may begin shutting down their own emotions to the point of numbness or dissociation, losing their ability to empathize effectively. Rescuing clients or becoming suspicious of other counsellors are also ways counsellors experiencing STS may behave (Munroe, 1999). Loss of empathy, de-personalization, unresponsiveness, cynicism, procrastination, boredom, loss of interest, forgetfulness and decreased effectiveness are possible cognitive and behavioural signs cited by Monroe (1999). Finally, many counsellors become so involved in the demands of their work and their efforts to help that they neglect their own needs, often skipping lunch, coffee breaks or working during time off. Munroe (1999) suggests that such behaviour can be harmful to clients who look to us as models: for clients learning to improve their own ability to maintain personal boundaries, a selfless approach to work is not helpful.

The research shows that awareness is the foundation for preparation and prevention of compassion fatigue (Figley, 2002; McCann & Pearlman, 1990a; Monroe, 1999). Therefore, educational institutions for counsellors should include training and education about the potential for permanent damaging effects of compassion fatigue (Arvay, 2001; Cunningham, 2004; O'Halloran & O'Halloran, 2001). As counsellors are made aware of the ethical need to gain informed consent from their clients, a similar process should be involved with individuals entering into the counselling field (Monroe, 1999). The ethical principles of duty to warn and to avoid harm should be applied to workers entering the field, and in addition, should include a "duty to train" counsellors in

specific strategies to cope with exposure to traumatic material (Monroe, 1999, p.217). Through awareness, helpers can be attuned to the signs of compassion fatigue in themselves as well as in colleagues, and must then be prepared to take adequate steps to address the issue.

Signs of Compassion Fatigue

The signs of compassion fatigue and secondary traumatic stress may overlap with symptoms of common stress, anxiety or depression, but a significant aspect of the problem involves the individual's professional role. Compassion fatigue often involves physical, behavioural, cognitive, psychological and spiritual changes and may include the Post Traumatic Stress Disorder symptoms of avoidance, intrusive experiences and negative arousal (American Psychiatric Association, 2000). Physical signs include exhaustion, insomnia, headaches, gastrointestinal complaints and increased susceptibility to illness. Behavioural signs may include increased substance use or abuse, anger and irritability, and absenteeism.

Psychologically, a person may experience a need to distance oneself emotionally from family, clients and colleagues or may feel they have no compassion left for their 'real' life. A very common indicator of compassion fatigue is emotional numbness (Figley, 2002; McCann & Pearlman, 1990a; Yassen, 1995). Working with people in crisis requires counsellors to develop the ability to deny their own feelings and shut down their own reactions during the counselling session. Many professionals become very efficient in their ability to 'turn off' their feelings. Over time, this practice may result in dissociation, or the disconnection from the emotional domain. Depression, reduced

ability to feel empathy and sympathy, inability to tolerate strong feelings may occur. McCann and Pearlman (1990a) state:

> "Therapists may experience painful images and emotions associated with clients' traumatic memories and may, over time, incorporate these memories into their own memory systems. As a result, therapists may find themselves experiencing PTSD symptoms…The helper must be able to acknowledge, express, and work through these painful experiences in a supportive environment…if they are to ameliorate some of the potentially damaging effects of their work. If these feelings are not openly acknowledged and resolved, there is the risk that the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathic and responsive stance with clients." (p.144)

Heightened anxiety or irrational fears, intrusive images or flashbacks to client's trauma may be significant signs. A disruption of one's feelings of personal safety, control or competence, or an increased sense of vulnerability can occur (McCann & Pearlman, 1990a). For example, a counsellor working closely with clients who have lost a loved one in a car accident may become excessively fearful about highway driving. For some counsellors, a diminished sense of enjoyment of career and failure to nurture non-work related aspects of life are also common psychological effects (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Baranowsky (2002) describes another well documented sign of compassion fatigue, which is described as 'the silencing response'. Affected counsellors may begin to actively and passively avoid additional traumatic information with their clients. The silencing response may occur when counsellors change the subject, avoid a topic,

minimize, use humour or sarcasm with clients and fear what the client has to say. According to Baranowsky, the silencing response behaviours increase as compassion fatigue increases.

Assessment scales used to measure compassion fatigue have been developed: The Compassion Fatigue Self Test was developed by Figley (1995) to differentiate between burnout and secondary traumatic stress in psychotherapists. More recently, the Compassion Fatigue and Compassion Satisfaction Self Test for Helpers (Hudnall Stamm, 2002) improved upon the original scale by including positive measures of work satisfaction in addition to the compassion fatigue and burnout scales. These tests are available on-line (http://www.isu.edu/~bhstamm), and were intended for easy access, self scoring tools for helping professionals (Figley, 1995).

Risk and Protective Factors

The development of compassion fatigue appears to be determined by an interaction between the counsellor, the work situation and the client (Figley, 2002). Pearlman and Saakvitne (1995) examined aspects of a therapist's personality, personal history, current personal circumstances and place in one's professional development as potential factors that may contribute to the development of vicarious trauma.

Counsellors who find purpose and meaning in their work may be protected from compassion fatigue (Pearlman & Saakvitne, 1995). Recognizing and appreciating the positive aspects of the work can keep counsellors healthy. A counsellor's professional identity and positive feelings of competence are important: where they have a strong sense of themselves and their ability to help, they will be more resilient. Alternatively, the questioning of the counsellor's competence by students, parents or administration can

contribute to vulnerability (Pearlman & Saakvitne, 1995). Beliefs that make up the worldview of the counsellor are important factors: entering into the helping professions without a clear sense of purpose or beliefs about how therapy works or the limitations of counselling may put people more at risk to develop signs of despair and hopelessness.

Spirituality can be a significant protective factor because much of the damage of trauma is spiritual damage (Pearlman & Saakvitne, 1995). It is often the alteration of beliefs about meaning and hope that can contribute to permanent damage in helpers. Because connection to spirit or a higher power appears to be a significant protective factor, counsellors should be encouraged to nurture their spiritual development. Spirituality is tied to a sense of connection: connection with others, connection to a higher power, connection with community and with nature. Prayer, mediation, religion and yoga are examples of spiritual practices that can protect helpers.

Self awareness and introspection are important protective personality traits in counsellors as they are critical in maintaining self-protective behaviour and empathy (Pearlman & Saakvitne, 1995). Alternatively, counsellors who are limited in self awareness may lack the insight necessary to notice and deal with signs of secondary stress.

Humour is another important factor that may protect counsellors from the effects of compassion fatigue (Moran, 2002). The physical effects of humour are similar to those of exercise, contributing to a reduction of physiological stress symptoms resulting in a relaxation effect. Research also indicates that humour can improve immune system functioning (Moran, 2002). Perhaps most significant for counsellors, humour encourages emotional expression and can contribute to a reframing of circumstances that can be

highly beneficial to wellness. Moran (2002) suggests humour "may help to deal with emotions at an individual level as well as contributing to a social understanding at a broader level" (Moran, 2002, p. 145). As most counsellors know from experience, laughing together about work situations enhances social bonding, and overall feelings of wellbeing.

A number of factors have been identified that may put a counsellor at increased risk for developing signs of compassion fatigue. One of the most well documented risk factors is the counsellor's own history of personal trauma (Figley, 1995; Pearlman and Saakvitne 1995; Pearlman & Mac Ian, 1990; Yassen, 1995). Hearing reports by clients about traumatic events, losses or dangerous experiences can activate memories of similar events in the counsellors own life. Helpers who are also 'survivors' must be extremely careful in attending to their own healing and self care needs. Healing must be viewed as a lifelong process which takes place on a continuum, so helpers with difficult histories themselves must be prepared to continually re-evaluate their own emotional health.

Current personal circumstances may contribute to the vulnerability of helpers. Life stressors, transition phases, losses, conflict and other interpersonal situations may undermine one's ability to maintain healthy perspective with clients. When undergoing personal crises or difficulties, staff must be particularly cautious about maintaining good self care.

Counsellors new to the field may be particularly vulnerable to compassion fatigue: in a study of vicarious trauma, Pearlman and Mac Ian (1990) found that the newest therapists with a history of trauma were experiencing the most difficulty. They indicate that this finding supports other literature showing that being younger or newer to

the work correlates with the highest levels of burnout. As well, working with traumatized children appears to be a significant risk factor (Meyers & Cornille, 2002). Figley (1995) reports that emergency responders are most vulnerable to compassion fatigue when they are working with the pain of children. This is particularly important for school counsellors who are working almost exclusively with children or adolescents. Because of the increased risk for new counsellors, school divisions may protect their new staff by providing mentors or arranging for peer supervision opportunities.

Prevention

Yassen (1995) describes secondary traumatic stress as a normal and inevitable result of working closely with other people's pain and thus cannot in itself be prevented, but suggests strategies that may prevent the stress from developing into a more serious disorder. As in other realms, prevention takes place on three levels: primary (through education, awareness workshops and self care plans), secondary (through support groups, supervision and consultation) and tertiary (through debriefings, interventions and personal therapy) (Yassen, 1995). As an overview of the literature on prevention, this paper will focus on suggestions relating to three key arenas for school divisions: awareness and training, strategies and structures that support self care at the professional group level and finally individual/personal self care.

Awareness

The research shows that awareness is the foundation for the prevention of compassion fatigue (Figley, 2002; McCann & Pearlman, 1990a; Monroe, 1999). Professional development opportunities such as workshops can provide education and training to both school leaders and school counsellors, ensuring that these professionals

are aware of the risks and are able to recognize and openly discuss the potential for occupational stress in all school staff.

Prevention begins with awareness and acknowledgment that the conditions exist (Saakvitne & Pearlman, 1995; Pearlman and Mac Ian, 1995; Yassen, 1995). At the organizational level, school divisions can ensure staff has training in recognizing their risk for compassion fatigue and preventative strategies. Because many school counsellors evolve from the teaching profession with limited formal education in counselling or mental heath, on-going professional development about work related stress is critical and training in treating trauma victims may be helpful (Pearlman & Saakvitne, 1995).

Professional Self Care

Professional self care involves awareness of and conscious commitment to maintaining balance and healthy connections in one's work life. Limiting work hours and pacing the work day to provide opportunity for breaks allows for nutrition, connecting with colleagues as well as reflection. It is crucial that counsellors have access to regular time off, either as mental health (wellness) days or vacation days, as this time helps to provide balance by allowing for processing of emotion and refocusing on oneself as an individual (Pearlman & Saakvitne, 1995). Whenever possible, counsellors should be encouraged to experience a variety of work roles and types of clients. Setting limits is an important aspect of professional self care, as many helpers typically do not know how to say 'no', and as a result become overloaded with depleting activities.

Boundaries are another key aspect of self care (Pearlman & McCann, 1990; Saakvitne and Pearlman, 1996; Yassen, 1995). Time boundaries, personal boundaries

and professional boundaries all provide necessary structure to ensure separation between the counsellor and the client. Related to the concept of boundaries and balance is new research into the neuropsychology of empathy and autonomic nervous system (ANS) arousal: according to Rothschild (2006), "for therapists to minimize the risk to her emotional and physical wellbeing, she must find ways to balance her empathic engagement, regulate ANS arousal and maintain her ability to think clearly" (p.3). Practical strategies and exercises exist to teach helping professionals how to increase their control over empathic engagement and to learn to attend to and regulate their own bodily reactions to clients and their painful feelings.

Perhaps the greatest arena for professional self care involves connection with professional peers. The research literature points to the need for peer support and clinical supervision as the most critical aspects of professional self care (Catherall, 1995; Crutchfield & Borders, 1997; Monroe, 1995, Norcross, 2000). Peer support and supervision may involve some overlapping activities, but important distinctions require clarification. Peer support is less formally structured, often taking the form of a regular meeting, casual gathering or group debriefing. Telephone consultations with a trusted colleague or a session of black humour at a monthly meeting are examples of peer support. Supervision, however, is much more formal and structured, occurring at specific intervals with the intention of developing and improving clinical counselling skills and processing events and reactions that have affected the counsellor (Henderson & Lampe, 1992; Roberts & Borders, 1994).

Peer support is a key aspect of professional self care wherein workers have the opportunity to give and receive support from colleagues who are involved in similar work

tasks (Monroe, 1999; Pearlman &n Saakvitne, 1995; Valent, 2002; Yassen, 1995). Peer support can help build collegiality, reduce isolation and provide important opportunities to vent the difficult feelings often associated with helping others. Organizations such as school districts can reduce the risk of secondary stress in their employees by providing for and expecting peer support opportunities. McCann and Pearlman (1990) describe weekly two hour case conferencing meetings among workers in their organization; the first hour spent discussing difficult client cases (with consent) and the second hour discussing more personal reactions. Sharing coping strategies and holding colleagues accountable for their self care plans may be another important way peer support programs can be beneficial for helpers.

Clinical supervision. One of the most well established methods of professional self care for therapists and counsellors is the use of clinical supervision (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1996; Yassen, 1995). For most professional therapists, clinical supervision is mandated and considered an ethical responsibility; however, school counsellors appear to be the only professional group with no requirement (Sutton & Page, 1994).

Clinical supervision is defined by Crutchfield and Borders (1997) as a structured though varying set of activities that encourages counsellor self awareness and growth. Clinical supervision can focus on skill enhancement, professional identity development, case conceptualization or other aspects of the school counsellor's role in providing service to young clients. Similarly, Sutton and Page (1994) define clinical supervision as an intensive, interpersonal, focused relationship, in which the supervisor helps the counsellor as he or she learns to apply a wider variety of assessment and counselling

methods to increasingly difficult cases. Clinical supervision can take various forms; the most common models are individual or small group consultations with a trained mental health professional or peer supervision.

The type of supervision currently experienced by most school counsellors is referred to as administrative supervision and is most often provided by a school administrator with no counselling training. Administrative supervision is defined as "an ongoing process in which the supervisor oversees staff and staff communications, planning, implementation, and evaluation of individuals, programs or both" (Page et al., 2001, p. 144). Such supervision is concerned with counsellors' work ethics and habits, effectiveness in building professional relationships with others, and appropriate use of time (Henderson & Lampe, 1992). In a survey of school counsellors, Roberts and Borders (1994) found that 85% were receiving administrative supervision from the school principal, reflecting the current reality that most school counsellors are not provided access to a supervisor with mental heath training.

Despite the need for clinical supervision of counsellors and therapists, very little clinical supervision is being provided to practicing school counsellors (Borders & Usher, 1992; Roberts & Borders, 1994; Oberman, 2005; Crutchfield & Borders, 1997). Several studies indicate that the large majority of school counsellors would like to receive clinical supervision, but few are receiving it (Borders & Usher, 1992; Roberts & Borders, 1994, Sutton & Page, 1994). Sutton and Page (1994) found that 63% of school counsellors expressed a need for supervision but only 20% were currently receiving it. Page et al (2001) found that only 13% of school counsellors were receiving clinical supervision. Some literature indicates that the lack of supervision of school counsellors

may be a failure on the part of the counselling profession to communicate clearly the purpose and benefits of clinical supervision (AACD, 1989). Other authors suggest that "School administrators may be a force inhibiting appropriate supervision of counsellors because 80% of the counsellors seeking supervision reported their schools did not provide release time for supervision" (Sutton & Page, 1994, p. 4).

Various models exist for providing school counsellors the much needed support and development opportunities that clinical supervision can provide. Some school districts may endorse hiring the services of a qualified mental heath practitioner to provide one-on-one or group clinical supervision to their counselling staff. This consulting supervisor may provide opportunities for counsellors to increase their competence and confidence in advanced skill areas or may offer suggestions for handling particularly challenging cases. A clinical supervisor may also provide debriefing to the counsellors following critical incidents or difficult crisis situations. This service would indirectly improve the quality of counselling services offered to students and their families. An outside consulting supervisor may have additional benefits as their lack of administrative or evaluative involvement with the counsellor may increase the freedom for honest self disclosure (Pearlman & Saakvitne, 1996).

Another viable supervision alternative for school divisions is the use of peer supervision or peer collaboration (Agnew et al., 2000; Benshoff &Paisley, 1996; Borders & Usher, 1992; Crutchfield & Borders, 1997; Roberts & Borders, 1994). Recent trends in education have been towards recognizing the value of professional collaboration opportunities, and in this context, school leadership may be most supportive of the benefits of providing release time for counsellor peer collaboration. The powerful impact

of collaborative learning partnerships is due to the fact that they are based on a core of "an intense relationship centered on mutual goals… It is the social and psychological aspects of working together that are critical in understanding the concepts associated with partnered learning" (Saltiel, Sgroi, & Brockett, 1998, p.6). Counselling staff can use collaboration time to advance their own professional growth plans through learning from one another, while also addressing any personal or emotional issues they have encountered.

Benshoff and Paisley (1996) proposed a structured peer consultation model for school counsellors using dyads in a nine session program. Data collected indicates that the participants found this format to be very effective and beneficial in providing valuable support, generating ideas for working with difficult clients and in developing counselling skills. 100% of the school counsellors who participated in this study indicated that they would participate in peer consultation again, and would recommend it to other school counsellors. As well, all participants indicated that the experience had helped them in understanding and developing their consultation skills, counselling skills, concepts and techniques (Benshoff & Paisley, 1996).

Self care plans may be an effective preventative strategy for helpers. Just as many school divisions are requiring staff to submit annual professional growth plans, formalized self care plans for counsellors may be an important preventative strategy to ensure that counsellors understand the ethical as well as psychological need for balance and self care (Yassen, 1995). School divisions and clinical supervisors may request counselling staff to develop self care plans for coping with demands of their work on a daily, monthly and on-going basis, and to submit self care plans for review. In a recent study of 259

therapists, Bober & Regehr (2005) found that although participants believed in the usefulness of recommended coping strategies, these beliefs did not translate into time spent on these activities. This study demonstrates the need to ensure counsellors are actually 'walking the walk, not just talking the talk'. Some form of accountability for self care may appear to be a necessary step in ensuring it occurs, and formalized self care plans may be an important organizational practice for school division to adopt. *Debriefings* are an essential preventative service for counsellors and crisis teams following critical incidents (Mitchell & Everly, 1997; Valent, 2002). As much of the focus in school crisis response is on preventing long term stress reactions among affected students, the crisis team also is at risk for traumatic stress, and special consideration is required to ensure that counselling staff are not burned out as a result of their involvement. The importance of debriefing the response team is a well known step in traumatic events response, but one that may be underutilized. Following a critical incident, the crisis team may be tired and emotionally exhausted, preferring to go home. However, plans should be in place to follow up with all helpers to ensure traumatic images and personal reactions are addressed. Debriefings with a clinical supervisor following abuse disclosures, high risk suicide assessments or other emotionally charged incidents would also be helpful to school counsellors.

A final suggestion for preventing compassion fatigue is to encourage helpers to actively, frequently and consciously acknowledge and affirm the many positive experiences in our work and the rewards that come with supporting others through their pain (McCann and Pearlman, 1990). A well developed sense of purpose and meaning in this challenging work can protect counsellors from stress and burnout. Peer support

networks should devote a portion of time focusing on positive and hopeful experiences gained through our professional work (Pearlman & Saakvitne, 1995). Taking inventory of the success stories in our efforts to enrich the lives of others is an important factor that contributes to the resiliency of counsellors.

Personal Self Care

Personal self care is critical for all people working in demanding and stressful work environments. All school staff should be provided means and opportunity to develop routines that support self care; physical self care is comprised of proper exercise, nutrition, and sufficient sleep. Access to health benefits that cover body work such massage and other physical healing therapies would promote self care. Psychological self care strategies include maintaining life balance, relaxation exercises, contact with nature, creative expression, skill development (assertiveness, stress reduction), self awareness and using humour (Pearlman & Saakvitne, 1996). Personal self care also includes addressing social/interpersonal needs for connection with others. This may include evaluating and improving one's personal support network, increasing one's involvement with social activism and perhaps most importantly, getting help when needed (Pearlman & Mac Ian, 1990; Norcross, 2000; Pearlman & Saakvitne, 1996; Yassen 1995).

It appears that many counsellors enter into the field with a history of trauma themselves. Pearlman and Mac Ian (1995) surveyed 188 trauma therapists and found that 60% reported having their own trauma history, and that the "survivor" therapists showed more negative effects from their work than did those without a trauma history. This increased risk of vicarious trauma among helpers with their own trauma history

means that healing the healer is a common situation, and seeking professional help is and should be common among those in the helping professions. Mahoney (1997) reported that 90% of psychotherapists surveyed reported having experienced personal therapy themselves, and that more females than males make use of personal therapy. Yassen (1995) proposed the need for all professional helpers to engage in a process of evaluating one's own healing and suggests that establishing an attitude among helpers that getting help is a sign of personal strength would greatly improve the health of the profession. School division that can create an atmosphere that views seeking counselling as a healthy sign rather than a sign of weakness or incompetence will likely improve the climate and overall wellness of the organization.

Conclusion

The information presented in this article brings up a real and significant challenge for school leaders and all professionals working with people. Preventing compassion fatigue begins with education and awareness, as many people working in the helping professions do not know such risks are involved in human services. Personal and professional self care strategies have been suggested for assisting counsellors to develop specific, formal plans for caring for their own mental and emotional health.

School and district administration have an important leadership role in the development of a healthy work climate for all school staff. Their support and recognition of the psychological challenges involved for staff providing counselling services to affected students, parents and staff members is critical. The literature reviewed clearly indicates the need for a formally defined system of self care for counsellors, not only on the individual level, but at a group and organizational level as well. Awareness training,

peer support and clinical supervision are emphasized in the research as foundational components of a professional wellness program.

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