SECONDARY TRAUMATIC STRESS AND VICARIOUS TRAUMATIZATION:
PROTECTIVE FACTORS AND THEIR UTILIZATION

A DISSERTATION
SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE
DOCTOR OF PHILOSOPHY

BY
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BALL STATE UNIVERSITY
MUNCIE, INDIANA
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Ball State University                                                                                      
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ABSTRACT

DISSEPTION PROJECT:  Secondary Traumatic Stress and Vicarious Traumatization: Protective Factors and Their Utilization

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This study examined the impact on psychotherapists who are repeatedly empathically exposed to their client’s traumatic content. Psychotherapists were asked to complete survey packets which included quantitative measures of Secondary Traumatic Stress (STS) and Vicarious Traumatization (VT), which are both theorized to be negative conditions which may develop after being exposed to other’s traumatic content. Some respondents were then interviewed, and the transcribed interviews were analyzed utilizing the qualitative technique of grounded theory. The results of this study suggested psychotherapists mediate the impact of traumatic exposure through a variety of factors, including personal characteristics, external support systems, and the use of a variety of self-care skills. These factors, along with psychotherapist’s responses to barriers interfering with accessing these factors, appear to change over time as therapists gain experience. Additionally, rather than developing negative symptoms as a result of their work, many therapists appear to develop positive outlooks, a deep respect for their client’s and human resiliency, and a sense of confidence that they can help their clients.
Dedication

This dissertation is dedicated to my wife Lori and my children Aaron and Erica, who tolerated long evenings away from home, high stress levels, and many weekends occupied by studying and writing. This work is also dedicated to Mary Schwendener-Holt, Gunnar Ingolfsson, and Katerina Psarropoulou, without whom this would not have been possible.
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Chapter 1: Introduction

Statement of the Problem

Many psychotherapists, as well as others involved in the helping professions, are routinely exposed to their client’s traumatic materials through their work. This exposure to other’s traumas, whether through counseling, interviewing, or otherwise helping to heal wounds associated with the victim’s traumas, has a cumulative impact upon those exposed to those traumas. Over the last two decades, there has been an increasing amount of attention paid to the impact of working with traumatized individuals upon therapists and others within the helping professions (Figley, 2001). Because of the realization that this valuable work does not come without cost to the individual therapist, a newer literature focuses on the costs of caring for therapists themselves. Terms used to describe this phenomenon are varied, but the most common include secondary traumatic stress and vicarious trauma. Although there is overlap between the concepts underlying these terms (Baird & Kracen, 2002), there are also specific differences. Secondary traumatic stress (STS) refers to a set of symptoms that parallel those of posttraumatic stress disorder (PTSD) as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2004). Vicarious traumatization refers to long-term internal changes, with a specific emphasis on cognitive schemas which become negatively altered due to repeated exposure to client’s traumatic imagery and traumatic content. Through repeated exposure to traumatic themes and imagery, psychotherapists experience disruptions in their views of self, others, and their over-arching worldviews (McCann & Pearlman, 1990; Sabin-Farrell & Turpin, 2003). Despite the variance in terms and definitions, there has been an increasing recognition that psychotherapists as well as other helpers often
pay a heavy price for choosing to engage in empathic relationships with individuals who have experienced traumatic events. The goal of the following study will be to help further elaborate upon the physical, emotional, and psychological costs associated with working with traumatized individuals, as well as to describe how these costs can be either reduced or prevented.

**Background**

The phrase “burnout” was originally coined by Maslach in 1982. Maslach proposed that burnout was a condition that can occur when an individual is chronically overworked or under-supported within the workplace environment. The syndrome was originally characterized by three principle domains: Cynicism, prolonged emotional exhaustion, and workplace inefficiency. Leiter (1991) reported that the three components of burnout had become widely re-classified as emotional exhaustion, depersonalization (from cynicism), and diminished personal accomplishment. The emotional exhaustion component refers to feeling over-extended and depletion of physical and emotional resources. Depersonalization (Cynicism) relates to negative perceptions, callousness, and detachment from aspects of the work environment, including emotional detachment from individuals in the workplace. Reduced personal accomplishment is characterized by dissatisfaction with one’s work, a low sense of efficacy in the workplace, and a perceived lack of opportunity and achievement (the original inefficiency component referred to personal beliefs that one is incompetent and/or lacks achievement, as well as a general lack of productivity).

The concept of burnout describes a collection of effects that can occur over-time when an individual’s workplace requirements chronically exceed their personal capacity to meet those requirements (Maslach, 1982). This concept served as a basis for the development of
related but separate concepts concerning individuals who work with traumatized individuals. Researchers began to recognize that Malach’s original concept of “burnout” did not sufficiently describe the collection of symptoms often experienced by individuals who worked closely with traumatized persons (Figley, 1995). These individuals exhibited symptoms that appeared to be more severe and longer lasting than those exhibited by those experiencing burnout (Every & Mitchell, 2003; Sabin-Farrell & Turpin 2003). Figley (1995) began to utilize the term “compassion fatigue,” to describe this more severe condition often experienced by mental health workers, social workers, and others in helping professions. Figley described secondary traumatic stress as a collection of symptoms that go beyond simple burnout; these symptoms are described as being more severe, longer lasting, and have a greater impact upon therapeutic/empathic relationships.

The DSM IV TR (2000) describes Post Traumatic Stress Disorder as a disorder that can only occur if an individual is either exposed to a traumatic stressor either directly or indirectly. Secondary traumatic stress describes the latter, and has been shown to occur in family members of individuals who have been traumatized (Figley, 1995). However, persons who work closely with traumatized individuals are also repeatedly exposed to traumatic material; the closer the individual works with the person and is exposed to the victim’s trauma, the more likely the individual is to develop symptoms of secondary traumatization (Figley, 2002). Figley (1995) described STS as a condition exhibiting many of the characteristics of PTSD, but is developed within individuals who work with others who have experienced trauma.

Figley (2002) stated these PTSD-like symptoms can include intrusive and recurrent recollections of traumatized clients and their traumas, feeling as if the traumatic events were
re-occurring, intense physiological or psychological distress when exposed to cues related to helping others or with the role of helper, and avoidance specifically related to attempts to avoid exposure or recollection of traumatized clients or their stories (as opposed to avoidance due to exhaustion). Figley reported other STS symptoms include irritability or anger outbursts, hypervigilence, difficulty concentrating, insomnia, and/or an exaggerated startle response. Individuals experiencing STS may experience a reduction in their compassion or empathy for those they work with and may become numb or cynical concerning the suffering of others through depersonalization (similarly to burnout). He asserted that individuals with STS may also lose hope in the ability of their client’s abilities to change and may begin to feel “scattered” or disorganized. Figley stated that individuals experiencing STS may believe they cannot meet professional obligations; their personal lives may suffer, and they may lash out at co-workers. In short, Figley’s conceptualization of STS expanded upon the concept of “burnout” and described the unique symptoms experienced by individuals who work closely with traumatized persons; although the symptoms of STS include many of the symptoms related to burnout, the STS construct included multiple symptoms not experienced within burnout. Figley argued that these symptoms were more congruent with persons who are experiencing post-traumatic stress disorder from directly experiencing trauma, then simple burnout.

However, Figley was not the only researcher who recognized that burnout insufficiently described the potential effects produced by working with traumatized persons. McCann and Pearlman (1990a) also argued that burnout did not adequately describe many of the symptoms that therapists working on an empathic level with traumatized individuals often experienced. These authors described a collection of symptoms associated with countertransference and
emotional/cognitive reactions stemming from being exposed to a client’s traumatic experiences over time, which they termed “vicarious traumatization.” Vicarious traumatization (VT) refers to the cumulative impact upon a therapist after being exposed to repeated empathic engagement with trauma survivors. McCann and Pearlman (1990b) described VT as being inevitable, pervasive, and cumulative in nature: They argued that all therapists working with trauma will eventually develop a degree of VT, and the more frequent the exposure to trauma the more powerful the effects of VT would be. Vicarious traumatization is also viewed as being a chronic condition, with those affected experiencing alterations to their core schemas relating to safety, trust, control, intimacy, and self-esteem. Therapists experiencing vicarious traumatization may begin to experience common trauma symptoms such as anxiety, dissociation, avoidance, and disconnection (Perlman & Saakvitne, 1995). They may also experience somatization, depression, judgmentalness towards themselves or others, and disrupted beliefs about themselves and the world around them. Pearlman (1990a) argued that VT was a separate concept from STS, with the principle difference being that VT is viewed as a chronic condition which principally impacts cognitive schemas, while STS is viewed as a (usually) shorter term condition characterized primarily by behavioral symptoms. In summary, VT describes a phenomenon through which therapists who work with traumatized individuals may develop a constellation of symptoms beyond those associated with burnout, with cognitive schemas being the principle areas affected.

**Secondary traumatic stress versus vicarious traumatization**

There is no clear consensus within the literature concerning which of these two concepts, STS and VT, more accurately describe the effects on helpers who work with trauma.
Additionally, there is no consensus concerning the relationship of burnout to VT and STS, or concerning how these three concepts inter-relate to, or overlap with, one another. Bell, Kulkarni, and Dalton (2003) argued that burnout and vicarious trauma share many similar factors. They stated:

Although some of the numbing symptoms of vicarious trauma bear some resemblance to burnout and may in fact result in burnout over time, research on therapists has also begun to establish vicarious trauma as a distinct concept...Thus, burnout alone does not appear to capture the effects of trauma as an occupational stressor. Although vicarious trauma may present with elements of emotional exhaustion, depersonalization, and reduced personal accomplishment, it also has effects that are unique and specific to trauma work (p. 464).

These authors illustrated the difficulty concerning the duel concepts of STS, and VT. There is an overlap between the constructs, with shared symptoms being a part of the conceptual definitions of all three constructs.

The author of this current work is in agreement with Bell et al (2003) that there is likely a significant overlap between these two concepts. McCann and Pearlman (1990a) stressed the impact of working closely with trauma on cognitive schemas, while Figley (1995) stressed the importance of physiological and behavioral reactions. However, it seems likely that these two competing constructs are actually measuring differing aspects of the same collective syndrome. Persons who have experienced trauma directly exhibit physiological and behavioral symptoms which are consistent with STS symptoms, as well as disruptions to cognitive schemas caused by trauma exposure which are consistent with VT (Shapiro, 1995; Matsukis, 1996). Both Figley and
Pearlman argued that exposure to traumatic material in turn can traumatize the therapist through this exposure. Both researchers described symptoms consistent with those experienced by individuals who had been directly traumatized. Therefore, it would seem consistent that STS and VT are both related to a single traumatic condition developed through secondary exposure to trauma. Because these constructs are likely describing components of a single phenomenon and are often used interchangeably within the literature, the author of this current work will generally refer to these constructs together (i.e., “STS and VT”) unless otherwise specified.

There has been one attempt to date to examine both STS and VT to determine which concept is better supported by research evidence. Baird and Kracen (2006) conducted a meta-analysis of STS and VT research in an attempt to clarify the constructs and determine convergence/divergence between the constructs. At the time this research was conducted, these authors reported they could only find 16 studies that examined either STS or VT, and nine of these were unpublished dissertations. Baird and Kracen stated this illustrated the newness of this area of research as well as the lack of empirical evidence supporting, refuting, or describing these concepts. The results of their meta-analysis suggested there was evidence supporting both constructs. Unfortunately, these authors focused solely on finding evidence to support VT and STS as separate constructs, and did not attempt to find evidence suggesting a convergence between these constructs.

Regardless the terms used, it has become increasingly clear that psychotherapists who are exposed to other’s traumatic experiences will likely find themselves impacted in one form or another (note: the terms “psychotherapist” and “therapist” will be used interchangeably
throughout this work; therapist refers specifically to a therapist engaged in psychotherapy).

Several studies have demonstrated a connection between working with traumatized individuals and the development of symptoms that could be characterized as either vicarious traumatization (Ben-Porat & Itzhaky, 2009; Cunningham, 2003; Pearlman & Maclan, 1995) or secondary traumatic stress (Nelson-Gardell & Harris, 2003; Schauben & Frazier, 1995). These studies highlight the importance of continuing to investigate STS and VT, as well as the importance of identifying which individuals are at increased or decreased risk and under what circumstances risk is exacerbated or mitigated.

**Overview of Risk and Protective Factors**

There are a number of factors that may place a therapist at greater or lesser risk of developing vicarious traumatization or secondary traumatic stress. These factors may be internal (biological, historical, psychological) or external (agency support or lack thereof, community stressors, community resources). The following section will identify several of these factors, although some of these suggested factors have supporting evidence that is inconclusive at the present time.

As many psychotherapists are exposed to traumatic material involving rape, sexual assault, sexual abuse, and domestic violence, gender has been examined as a potential risk or resiliency factor. Kassam-Adams (1999) suggested that gender may be related to an increased risk of developing secondary traumatic stress and vicarious traumatization. Although there has been some research supporting gender as a risk factor (Woodward-Meyers & Cornille, 2002), other researchers found no correlation between therapist gender and risk (Brady, Guy, Poelstra, & Brokaw, 1999, Nelson-Gardell & Harris, 2003). Interestingly, Linley and Joseph
discovered that gender (for females) might actually play a protective role in preventing STS or VT. There is an apparent need to continue to examine whether or not gender plays a role at all in developing STS or VT, or if there are gender interactions with the type of traumas or clients a therapist is exposed to.

A personal history of traumatization has also been examined as potentially being a risk or protective factor. Cunningham (2003) found that therapists who had been sexually abused appeared to be more vulnerable for developing vicarious traumatization; Vrklevski and Franklin likewise discovered that exposure to previous traumas was associated with higher levels of VT. Nelson-Gardell and Harris (2003) also found evidence that a history of emotional or sexual abuse contributed to the development of STS. However, there is also evidence suggesting that personal histories of trauma may actually serve as protective or resiliency factors rather than as risk factors, particularly when the psychotherapist had developed a sense of resolution or personal meaning related to their experiences. Follette, Polusny, and Milbeck (1994) found no evidence that a history of sexual abuse was associated with increased risk of VT: In fact, these researchers suggested such a history was associated with increased utilization of positive coping strategies and may develop a greater sense of meaning when working with traumatized individuals. Linley and Joseph (2005) also suggested that previously traumatized therapists gained a greater sense of meaning and were at decreased risk of developing VT, if these past traumas had been resolved through therapy. Once again, the current body of research has yielded contradictory evidence related to one's personal history of trauma as being a risk or preventative factor.
The workplace environment may serve as a risk factor or resiliency factor, depending upon multiple factors within the employment environment. Many factors have been identified as increasing the risk of developing STS or VT, including the level of workplace support (Schauben & Frazier, 1995; Vredensburgh, Carlozzi, & Stein, 1999), availability of resources (Cougle, Resnick, & Kilpatrick, 2009; Goldsmith R. E., Barlow, & Freyd, 2004), the psychotherapist’s workload (Vredensburgh, Carlozzi, & Stein, 1999), the typical clientele (Vredensburgh, Carlozzi, & Stein, 1999), or the number of traumatized persons per caseload (Boscarino, Figley, & Adams, 2004; Meyers & Cornille, 2002; Schauben & Frazier, 1995). However, supportive work environments have also been associated with a decreased risk of STS/VT (Boscarino et al., 2004; Coster & Scwebel, 1997; Ortlepp & Friedman, 2002), particularly if there is supportive supervision available (Linley & Joseph, 2005; Morrison, 2007). The current body of research presents a somewhat clearer picture for the workplace environment. Supportive environments appear to help prevent STS or VT, while non-supportive environments, high caseloads, limited resources, or high proportions of traumatized individuals per caseload appear to contribute to developing secondary traumatic stress or vicarious traumatization.

Experience, or the lack thereof, may also contribute to the development or prevention of VT or STS. Both the quantity of professional education (Abu-Bader, 2000) and years of experience (Pearlman & Maclan, 1995; Cunningham, 2003) have been associated with reduced risk for developing VT. Age also appears to be associated with lower levels of either STS or VT, although in these studies age is not differentiated from years of experience (Adams, Matto, & Harrington, 2001; Nelson-Gardell & Harris, 2003; Vrendenburgh et al, 1999). There appears to
be an interaction between age and/or experience and the development of STS or VT, with increased experience and/or age being associated with lower rates of STS or VT. Unfortunately, it is not known whether this is due to more experienced persons having gained skills offering resiliency, or whether this is simply due to attrition, wherein vulnerable persons simply leave the field of employment.

Harrison and Westwood (2009) found that individuals who have fostered personal, professional, and spiritual support systems outside of their work environment are less likely to experience burnout, compassion fatigue, or vicarious traumatization. Pearlman and Saakvitne (1995) argued for psychotherapists to develop spirituality to elicit “spiritual renewal” as a protection. Similarly to Harrison and Westwood, Pearlman and Saakvitne also stressed the importance of developing peer support groups to foster a system of support and emotional release with individuals experiencing similar challenges. Although Perlman and McCann (1990a) had conceptualized the development of VT as being a gradual and possibly inevitable development when working with traumatized individuals, the above named researchers argued that psychotherapists at risk of developing VT could delay or avoid the developing VT through the development and utilization of various support systems.

The above-mentioned study by Harrison and Westwood (2009) is indicative of a potential difficulty with the current body of research. These authors conducted a qualitative study of six self-proclaimed trauma therapists who had been working professionally as therapists for between ten and thirty years. These researchers examined what protective strategies these therapists were utilizing and reporting to be effective, as well as their personal experiences with VT. Harrison and Westwood reported that the interviewed therapists actively
challenged personal negative cognitions, embraced psychological complexity, utilized mindfulness and developed a sense of spirituality, engaged in “active optimism” (the belief that the world is generally good and that people can heal), and maintained clear boundaries between self and client. These therapists were aware of and respected their personal limits, practiced holistic self-care (mind, body, and spiritual self-care), worked at creating meaning for their work, and practiced “exquisite empathy” for their client-described as developing a deep, meaningful relationship while still maintaining boundaries. This study provides a rich amount of insight into what works for these particular therapists, and challenges other research that suggests empathic engagement might be a risk factor. However, there are obvious generalizability problems as this was a qualitative study with only six subjects; these generalizability concerns become even greater as these six subjects were therapists who were specifically selected due to their exceptionality. Examining a small number of exemplar psychotherapists, in this case highly experienced and skilled psychotherapists who specialized in trauma therapy (and were coping exceptionally well), provided detailed information that may not be applicable to the “average” psychotherapist at all.

In summary, researchers have identified several factors which may serve as protective or preventative factors concerning the development of STS or VT. Intriguingly, there is even a suggestion that working with traumatized individuals may enhance an individual’s personal growth (Tadeschi & Calhoun, 2004). Unfortunately, many of these suggested protective factors have been shown to be related to the occurrence of STS/VT, but there is insufficient empirical evidence to suggest causality. Additionally, there are generalizability concerns in that much of the existing research identifying protective factors has been derived from interviews with
exceptional therapists who were functioning well and not displaying symptoms of STS or VT (Haarrison & Westwood, 2009). These factors have not been proven to be truly preventative, but have been shown to be associated with lower rates of STS/VT; additionally, these factors may not be useful or applicable to the “average” therapist. The purpose of the current study will be to attempt to add to the body of knowledge regarding protective factors, but also to obtain evidence regarding the effectiveness of protective factors for preventing the development of STS or VT for a variety of therapists.

What becomes apparent from the current body of research is that multiple factors influence whether a helper is at increased or decreased risk of developing STS or VT. Some of these factors appear to be fairly straightforward and generally supported by research, such as the effectiveness of a supportive work environment and supervision in preventing STS or VT; however, many of these factors have little supportive evidence, or even contradictory evidence. Although there is evidence that there are factors which increase one’s vulnerabilities when exposed to another’s traumatic content and imagery, there is no clear agreement related to how these factors place a person at risk or even consistent agreement as to whether these are actually risk factors at all. There appears to be a strong need for more research to clarify whether or not specific factors put therapists who work with traumatized individuals at risk, what characteristics of individuals interact with these factors to increase risk, and what the specific mechanisms behind the risk increase truly are.

**Importance of the Current Study**

Secondary traumatic stress and vicarious traumatization can severely impact therapists who work with traumatized individuals, as well as the persons they are tasked to help (Figley,
1995; McCann & Pearlman 1990a). Therapists experiencing STS or VT may depersonalize their relationships with the persons they are assisting, will have a reduced capacity for empathy, and will likely provide a poorer quality of service (Pearlman & Saatviken, 1995). These therapists might experience symptoms associated with trauma exposure such as hypervigilence, nightmares, insomnia, intrusive memories, and intense reactions to the clients they work with, as well as potential lasting changes within cognitive schemas (Figley, 2002).

A therapist experiencing STS or VT will likely find their effectiveness as professionals compromised, sometimes to a great extent (McCann & Pearlman, 1990a). This raises ethical issues relating to that therapist conducting therapy in a compromised manner. Everall and Paulson (2004) stated, “It is an ethical imperative to deal with personal issues in order to maintain a high standard of practice and adhere to the principles of responsible caring and integrity of relationships” (p. 33). Ironically, it is likely that many therapists who pride themselves on their ethical standards do not consider the ramifications of conducting therapy while being compromised by these conditions. Based upon the research to date, it can be argued that it is a therapist’s duty to practice self-care and to be aware and honest about their personal risks associated with STS and VT. By caring for themselves, the therapist actually increases their capacity and ability to provide effective, caring, and empathic services for their clients.

The body of knowledge is fairly large concerning factors that are associated with STS and VT vulnerabilities which may help identify which therapists are at greater risk. There are also several studies which suggested possible protective factors and prevention techniques that may delay or prevent the development of STS or VT. Unfortunately, there is little experimental data
relating to these prevention/protective techniques to help determine which of these factors are efficacious, which specific techniques work better for specific individuals or types of trauma exposure, or if there are other unknown factors which interact with these protective factors.

One of the few research projects which attempted to discern which protective strategies actually were efficacious was conducted by Bober and Regehr (2006). These researchers surveyed 259 professional counselors to determine which STS/VT preventative factors these counselors believed to be important, which of these protective factors were actually utilized, and which protective factors appeared to be effective. These authors stated:

Many coping strategies are recommended by theorists and researchers in the areas of vicarious and secondary trauma, yet to our knowledge no research projects have evaluated the effectiveness of these strategies on reducing distress...participants generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities, and supervision, although supervisors were more likely to believe in the value of supervision than frontline workers. However, there was no association between the belief that leisure and self-care were useful and time allotted to engage in these activities. Those who believed in the value of supervision were more likely to devote time to it. Most importantly, there was no association between time devoted to leisure, self-care, research and development, or supervision and traumatic stress scores. Thus, there is no evidence that using recommended coping strategies is protective against symptoms of acute distress. (p.7).

Thus, there was not only no statistical evidence that protective factor utilization actually protected individuals from STS/VT, but there was evidence that counselor’s beliefs in which
protective factors worked did not translate into utilizing these protective strategies. The sole exception within Bober and Regehr’s study appeared to have been the number of trauma clients within a caseload, and based upon this, these authors recommended agencies monitor the number of trauma cases and spread these cases out amongst workers. The authors also found evidence that disrupted belief systems were correlated with significantly reduced rates of participating in leisure activities, suggesting that experiencing STS/VT can result in individuals being less likely to utilize necessary skills. This study illustrated the need for research not only examining whether or not protective skills are actually effective, but also research examining why these skills are not being utilized. It is clear more research is needed in this important area.

**Statement of Purpose**

The goal of the following study was to help clarify several issues related to how STS or VT is experienced within therapists, which protective or resiliency factors are perceived as being important or effective to prevent or delay the onset of STS or VT, and which of these are actually utilized by therapists. Additionally, barriers to utilizing these factors were explored, as well as how these skills are perceived and utilized over the course of a counselor’s development. Unlike previous research, this study did not limit its sample to therapists who work with specific traumatic themes (such as childhood sexual abuse), nor did the sample focus on exemplar or purely expert therapists. Due to the more expansive scope of this project, it was hoped that the data derived would provide insight into the development and evolution of therapist perceptions and skill utilization over the course of their development. The results would also provide evidence related to how a more typical therapist copes, or does not cope, with STS or VT when working with traumatized clients. This broader range of data would be
important to guide future research; the literature currently provided evidence primarily related
to how exceptional therapists cope, with limited evidence regarding whether or not less
developed therapists are aware of these factors or skills, utilize these skills, or face unique
barriers related to protecting themselves or incorporating skills into their daily lives.

Through this study, this author endeavored to provide evidence related to the following
questions:

1. What skills or behaviors are present in practicing psychotherapists who report good
coping or have few symptoms of VT/STS, and how do these therapists differ from
psychotherapists who are not coping well or have higher symptoms of VT/STS?

2. What skills or behaviors are viewed by practicing psychotherapists to be protective
factors related to the development of STS or VT?

3. What are the barriers to utilizing these skills or activating these behaviors?

4. How do practicing psychotherapists respond to these barriers: How do they overcome
these barriers, if at all?

It was hypothesized that there would be differences between the usage of skills as well
as psychotherapist behaviors/characteristics between individuals who were coping well in
terms of having few symptoms of STS or VT and those with higher rates of symptoms. The
current body of literature suggested usage of skills and practicing behaviors related to resiliency
should prevent or slow the development of STS or VT (Figley, 1995, McCann & Pearlman,
1990a, Pearlman & Saatvitne, 1995), although the limited quantitative evidence currently
available suggested this may not be the case (Bober & Regehr, 2006). Based upon the larger
body of evidence, it is believed that the utilization of protective (in terms of preventing or
lessoning the development of STS or VT) skills and the presence of protective characteristics or behaviors would be more likely in therapists who were coping well or display fewer symptoms of STS or VT. Additionally, it was hypothesized that therapists working with traumatized individuals who had fewer symptoms of STS or VT would also be experiencing fewer barriers to accessing protective skills or behaviors when compared to individuals who are experiencing an increased number of STS or VT symptoms. Finally, it was hypothesized that the protective skills, behaviors, and characteristics utilized, as well as the barriers (and psychotherapist responses to these barriers), would differ according to the counselor’s level of development or years of experience. It was hoped that gathering information related to these research questions, as well as evidence supporting or disconfirming these hypotheses, would advance the body of knowledge and clarify what appears to work or not work in terms of developing STS or VT symptoms. Additionally, this study would endeavor to help clarify Bober and Regehr’s (2006) findings, which suggested that valued skills tended to not be used and when used tended not to be effective. Ultimately, this study would endeavor to provide evidence which may ultimately be helpful in preventing psychotherapists working with traumatized individuals developing symptoms which could create personal distress or compromise their therapeutic effectiveness.
Chapter 2: Review of the Literature

The Impact of Secondary Traumatic Stress and Vicarious Traumatization

As stated earlier, many therapists and other individuals working within the helping professions are routinely exposed to other’s traumatic experiences and stories. This exposure to other’s traumas, whether through counseling, interviewing, or physically healing the wounds caused by these traumas, has a cumulative impact upon those exposed to those traumas. The following literature review will attempt to describe the ways in which individuals are impacted by being exposed to those traumas, as well as what factors might put a person at greater or lesser risk of being effected. Finally, gaps within the literature will be reviewed, and the importance of conducting a study to address these gaps will be revisited.

As stated earlier, there exists an increasing body of evidence that suggests working with traumatized persons can negatively impact those that engage in this work, whether psychotherapist or other helper. Ben-Porat and Itzhaky (2009) conducted a mixed-methods study examining the incidence and symptoms of VT in psychotherapists who work with family violence issues. The qualitative results suggested therapists who work with family violence have higher rates of marital distress and more negative worldviews when compared to psychotherapists who are not exposed to family violence content. Their research suggested these therapists tended to view marital and family relationships (including their own) in terms of power and control, had “lost faith” in humanity, viewed the world as less safe and less just, and perceived their society to be malicious and aggressive. Schauben and Frazier (1995) surveyed 148 counselors and found that counselors who worked with sexually traumatized individuals felt “emotionally drained” after being exposed to the intense pain associated with
the victim’s stories. These counselors also reported experiencing severe disruptions in their belief systems relating to themselves and others, and viewed the world as being less safe and people in general as being less kind and more prone to pathological behaviors. Individuals who worked with a higher percentage of sexual violence survivors endorsed more symptoms consistent with post-traumatic stress disorder and greater disruptions in their beliefs about themselves and others.

**Secondary Traumatic Stress and Vicarious Traumatization Risk Factors**

Researchers have suggested a number of potential risk factors which could contribute to the development of vicarious traumatization or secondary traumatic stress disorder. As reported earlier, these factors can refer to internal or external characteristics, and can relate to an individual’s prior experiences, personality traits, demographical characteristics, or home/workplace environments. The following section will elaborate upon the factors which have been studied to the present, and will comment upon the current state of research relating to these factors.

Kassam-Adams (1999) found that female counselors appeared to be at greater risk of developing STS than male counselors. Woodward-Meyers and Cornille (2002) examined STS reactions in male and female child protection workers and found female workers tended to report higher rates of symptoms including increased anger, hypervigilence, intrusive thoughts, numbing, and the occurrence of nightmares. Sprang et. Al (2007) found higher rates of STS in female mental health providers in a rural Southern area when compared to male counterparts, speculating that female mental health workers might have experienced more gender-related barriers which increased their vulnerability to STS. Interestingly, Wee and Meyers (2002) found
evidence that male counselors tended to experience more symptoms of STS than female peers; significantly, these researchers studied an incident of mass terrorism (the Oklahoma City bombing), which might explain the differences in their findings. Despite these findings, several studies have examined the influence of gender and found no evidence that gender played a role in developing VT or STS (Brady, Guy, Poelstra, & Brokaw, 1999; Nelson-Gardell & Harris, 2003; Pearlman & Maclan, 1995). The current body of research would best be described as inconclusive, and it is likely that if gender is a risk factor, the degree of risk will vary according to the nature of the trauma exposure as well as other mediating factors.

In addition to gender, a history of prior traumatization may be a risk factor for mental health workers and/or counselors. Cunningham (2003) found a relationship between therapists having a reduced sense of personal safety and higher VT scores if they had experienced sexual abuse themselves. Nelson-Gardell and Harris (2003) examined multiple potential risk factors in child protection workers, and found that a history of emotional abuse and sexual abuse were both associated with an increased risk of developing STS. Vrklevski and Franklin (2008) studied criminal lawyers and found evidence that higher exposure to traumatic materials was associated with an increased risk for developing VT. Additionally, Vrklevski and Franklin suggested that individuals with a history of multiple traumas in their personal histories were at higher risk for developing symptoms.

The nature of the trauma an individual is exposed to may also determine their degree of risk for developing difficulties with STS or VT. Beaton and Murphy (1995) found that therapists who worked with traumatized children appeared to be at higher risk for developing VT than are those who worked with adult trauma victims. There is also evidence that individuals who
engaged in therapeutic relationships with victims of violent crime and sexual abuse were at higher risk when compared to individuals in a similar occupation who do not work with violent crime victims (Cunningham, 2003; Schauben & Frazier, 1995). However, Kadambi & Truscott (2004) compared mental health workers who worked with sexual abuse survivors, cancer patients, and therapists in “general practice” and found no differences in the degree of VT between these groups. It appears that specific populations who are perceived as highly vulnerable (or highly undeserving of being victimized) as well as the nature of the trauma dealt with might contribute to the degree of risk for therapists. However, as with other possible risk factors, there is limited evidence for this as well as contradictory evidence.

Proximity to traumatic events appears to increase the likelihood of developing STS or VT. Eidelson, D’Alessio, & Eidelson (2003) discovered that the closer geographically a mental health worker was to a disaster, the more likely that individual would be to develop these conditions when working with survivors. Musa and Hamid (2008) also tracked long-term and short-term crisis workers in Darfur. The results of their study suggest that therapists exposed to a disaster or traumatic event on a prolonged basis are much more likely to experience STS/VT than individuals who are exposed on a brief basis. These studies suggest that the closer the therapists are to a traumatic event (or are immersed in the event as they help others), the greater the impact will be upon the therapist.

The workplace environment has also been studied to determine if there are potential risk factors. Therapists employed in the public sector appeared to be at higher risk of developing STS or VT when compared to therapists who work in private or group practices (Vredensburgh, Carlozzi, & Stein, 1999). This appeared to be due to higher caseloads,
inadequate resources, and more “difficult” clients. The authors suggested these clients were more likely to experience multiple environmental stressors such as poverty, unemployment, and exposure to crime, as well as fewer social supports and higher rates of client co-morbidity.

Long work hours also appear to be risk factors for developing STS or VT, as are caseloads with higher numbers of traumatized individuals (Boscarino, Figley, & Adams, 2004; Meyers & Cornille, 2002; Schauben & Frazier, 1995). Working in the public sector is also associated with higher rates of client experienced trauma (Cougle, Resnick, & Kilpatrick, 2009; Goldsmith, Barlow, & Freyd, 2004), suggesting agency workers might also be exposed to an increased percentage of traumatized clients. Newell & MacNeil (2011) studied workers who were and were not exposed to the traumatic stories or traumatic of the patients at a veteran’s hospital. These researchers found that workers who worked directly with patients, and who were exposed to traumatic content, experienced higher compassion satisfaction but also experienced more compassion fatigue (STS) compared to workers who did not interact directly with patients. This study provided evidence that despite similar work hours and working conditions, the exposure to the trauma of the patients did appear to interact with workplace conditions to produce higher symptoms of compassion fatigue (STS), along with a greater sense of satisfaction. Unlike other factors, there appears to be consistent evidence that workplace factors can increase therapist risk of developing STS or VT.

Workplace factors have been examined in comparison to other potential risk factors. Kadambi and Truscott (2008) studied therapists who work with sexual abuse victims in Canada, utilizing cluster analysis methods to evaluate these therapists responses to brief open ended questions. These researchers reported that the most important factor contributing to the
therapist’s perceptions of being traumatized in their work were workplace factors; these included a lack of support, long work hours, high caseloads, and limited resources. Their study also found that exposure to details of the trauma, societal injustice, exposure to human cruelty, and counter-transference or highly emotional reactions within the therapist were other important factors. This study is significant not only due to highlighting the importance of the workplace in developing symptoms, but also in that although many of their results were consistent with what would be predicted by VT, these therapists did not score significantly differently on measures of VT compared with other Canadian therapists. These authors also suggested qualitative reports of VT may not be correlating with quantitative measures of the construct, suggesting the need for construct refinement.

Individuals who work in environments where they are likely to be confronted with actual, in-vivo traumatic events and other emergency situations are more likely to develop STS or VT (Beaton and Murphy, 1995; Follette, Polusney, & Milbeck, 1994). These positions would include employment with child protective services, crisis units within community mental health centers or hospitals, police departments or other emergency services, or disaster response teams. Although not mentioned specifically in the literature, these cases are particularly interesting as there is a blurring between what would be considered primary traumatization and secondary traumatization.

Finally, workplace cultural factors appear to play a role in the development of burnout, compassion fatigue, or vicarious traumatization. Schauben & Frazier (1995) suggested that a lack of larger support systems contributes to the development of trauma related problems for mental health workers. These authors argued that cultures that discourage the expression of
emotion, autonomy, and self-care place employees at increased risk of developing VT or STS through the establishment of a dysfunctional “norm.” These unhealthy cultural norms not only directly discourage self-care, but can discourage individuals within the cultures from helping one another. Ultimately, the individuals within these cultures can internalize these norms and invalidate their own need for self-protection or the personal impact they may be experiencing through being exposed to other’s traumas.

**Secondary traumatic stress/vicarious traumatization protective factors**

Researchers have attempted to identify factors which might provide a degree of resiliency or protection for those who work with traumatized persons. As described earlier, Harrison & Westwood (2009) suggested that individuals who have developed personal, professional, and spiritual support systems outside of their work environment appear to be less susceptible to developing STS or VT. Pearlman and Saakvitne (1995) also found that developing peer supports, particularly with others who worked with traumatized individuals, appeared to decrease the likelihood of developing Vicarious Traumatization. Pearlman and Saakvitne stressed the importance of emotional release within this peer context, as well as engaging in a shared experience with peers.

Specialized trauma training may serve as another resiliency factor. Ortlepp and Friedman (2002) discovered that individuals with specialized training were less likely to develop subsequent difficulties compared with individuals without specialized training. Eidelson, D’Allesio, and Eidelson (2003) found that individuals with general disaster relief training experienced less vicarious traumatization after the September 11th terrorist attacks on the world Trade Center than those who had no such training, such as emergency responders who
were not trained to cope with large-scale disaster events. These authors suggested that specialized training might serve to prevent some of the “shock” experienced when being exposed to traumatic content, as well as pre-loading the importance of self-care and utilizing preventative skills.

Increased years of education and experience also appear to serve as protective factors. Abu-Bader (2000) found that education served as a resiliency factor for developing STS. Pearlman and MacIan (1995) report that years of professional experience (rather than simply “age”) were associated with a reduced risk of developing VT. Cunningham (2003) also found evidence suggesting the number of years of professional experience with traumatized individuals reduced the risk of developing VT. Cunningham believed this was due to therapists learning the importance of self-care as part of a maturation process, although an alternative explanation could be that this finding simply represented the attrition of individuals who do not have specific characteristics amenable to practicing effective self-care. Several researchers have found that age is negatively correlated with the development of VT, although these findings are likely due to the development of professional experience and competency rather than simply “age” (Adams, Matto, & Harrington, 2001; Nelson-Gardell & Harris, 2003; Vrendenburgh et al, 1999). These findings suggest experience and training seems to serve as protections against developing STS or VT, although the mechanism(s) behind these possible protective effects is unclear, and an attrition effect cannot be ruled out.

Regardless of experience or training, there is evidence that supportive work environments and effective supervision can serve as protective factors for therapists. Adequate supervision, defined as being supportive and empathic in nature, has been identified as a factor
that may mitigate the development of STS or VTS (Boscarino et al., 2004; Ortlepp & Friedman, 2002). Linley and Joseph (2005) suggested that adequate supervision can actually help a therapist obtain a sense of meaning or purpose through their work. Morrison (2007) reported that allowing persons who work with traumatized individuals to express their feelings and fears to supervisors or colleagues served as a protective factor for STS. Additionally, Morrison advocated for organizations to offer the opportunity to debrief after particularly difficult sessions as a means of processing STS reactions. Morrison also argued that STS reactions should be normalized and discussed within agencies, and self-care should be promoted throughout an organization. Coster and Schwebel (1997) utilized questionnaires and therapist interviews to discern what self-care strategies therapists thought were useful. Their results suggest therapists view self-awareness and self-monitoring, support from friends, spouses, supervisors, and other therapist, and maintaining a balanced (utilizing vacations, engaging in stress management) life were important to prevent STS or VT. These authors also suggested the importance of normalizing STS in the workplace, particularly stressing employers and employees needed to be aware of the vulnerability psychotherapists face and how to recognize impairment.

Pearlman and Saakvitne (1995) stressed the importance of psychotherapists developing a personal sense of spirituality, both to buffer against the impact of being exposed to other’s traumas, as well as to develop a healthy sense of personal meaning. Brady, Guy, and Poelestra, (1999) studied spiritual well-being as a protective factor, and suggested that individuals with a higher sense of spiritual contentment are at decreased risk for developing secondary traumatic stress or vicarious traumatization. Interestingly, female therapists who treated more sexually abused individuals reported experiencing a more satisfying life in both spiritual and existential
terms when compared to female therapists who worked with a few or even no sexually abused clients. These researchers suggested that exposure to trauma might force some therapists to face issues of spirituality and meaning, resulting in a stronger sense of resilience and purpose within the therapist. However, this finding may simply be an indication that therapists with higher senses of spirituality and personal meaning (as measured by these authors) might be drawn to working with abuse survivors.

Follette, Polusny, and Milbeck (1994) found that therapists with a significant history of childhood physical or sexual abuse did not experience significantly more negative responses to child sexual abuse survivor clients than those without such a history. They also reported significantly more positive coping strategies within therapists with a trauma history. These authors suggested therapists may have access to specific resources that can serve as protective factors; through utilizing these coping strategies and resources, previously traumatized therapists might obtain a greater sense of meaning through their work. Linley and Joseph (2005) found that therapists who have engaged in therapy to address past traumatic events also appear to be resilient to vicarious traumatization. In fact, Linley and Joseph suggest that a history of prior traumatization may enhance a therapist’s ability to discover meaning in their current work with trauma victims, which will provide further resilience.

While many researchers have focused on preventative factors, some investigators argue that working with traumatized persons (or being exposed to trauma directly) might actually facilitate personal growth. Arnold, Calhoun, Tedeschi, and Cann (2005) formulated the concept of vicarious posttraumatic growth, wherein they assert that many individuals who experience traumatic events actually grow emotionally and spiritually from their experience. Additionally,
these individuals adopted new perspectives relating to their relationships, positively re-evaluated their lives, and developed a sense of meaning for their experiences. Follette, Polusney, and Milbeck (1994) argued that a therapist’s methods of coping with past traumas, as well as their ability to construct meaning for these past events, were greater determinants concerning the development of secondary trauma syndromes rather than the nature or extent of past traumatizations. Pearlman (1999) argued that many therapists experience positive growth from working with traumatized individuals, including developing deeper interpersonal relationships, enhanced awareness of their day-to-day experience, and an increased appreciation for their lives and their work with trauma survivors. Pearlman and Saakvitne (1995) reported:

Sharing in the growth and development of another person is an honor. Participating in the transformation of a client’s despair is a life-altering, spiritual experience for those therapists who are open to it. Our client’s resilience and capacity to heal and to grow are powerful antidotes to the creeping cynicism that characterizes vicarious traumatization (1995, p. 403).

Pearlman and Saatvitne asserted that if a therapist is capable of developing a sense of meaning in relationship to their work with traumatized persons, this sense of meaning will not only serve as a protection against developing VT but will also foster the potential for personal growth.

Steed and Downing (1998) examined the prospect of post-traumatic growth in therapists. These researchers discovered that many therapists do report obtaining a sense of personal growth through their work with traumatized individuals. The authors state “...many of the therapists experienced positive changes in their sense of identity, and beliefs about self and
others...there was evidence of positive alterations in their sense of meaning/spirituality, and world view, including re-evaluation of previously held beliefs, increased self-awareness, and the acquisition of new perspectives” (p.2). Bell (2003) surveyed domestic violence workers and found that 40% of those who responded reported being more grateful for their lives, more appreciative of their relationships with significant others, and were less judgmental towards people in general. Linley & Joseph (2005) argued that gender could actually be a protective factor for female therapists who were working with female sexual abuse and assault victims. These authors reported that these female therapists showed greater potential for self-growth and the ability to find meaning in their work. These researchers suggested this increased capacity for growth and gaining a sense of purpose from their work might help prevent STS as well as a sense of disillusionment or hopelessness.

Related to the concept of post-traumatic growth is a newer concept termed “vicarious resilience.” Vicarious resilience (VR) was a construct proposed by Hernandez, Gangsei, and Engstrom (2007) and was originally examined through qualitative methods with therapists working with political violence victims. These researchers conceptualized VR as being similar to VT, suggesting empathic exposure to traumatic content could instill changes to therapist’s core schemas and beliefs about self, humanity, and the world they live in. However, VR postulates these changes can be positive changes, with therapists developing an increased sense of hope, faith in humanity, or sense of compassion and connection with others. These researchers stated:

We advance the idea that a specific resilience process occurs as a result of psychotherapists’ work with trauma survivors: VR. This process is characterized by a
unique and positive effect that transforms therapists in response to client trauma survivors’ own resiliency. In other words, it refers to the transformations in the therapists’ inner experience resulting from empathetic engagement with the client’s trauma material. VR may be a unique consequence of trauma work. We argue that this process is a common and natural phenomenon illuminating further the complex potential of therapeutic work both to fatigue and to heal (P. 237).

This is an intriguing construct, as VR originates from the experiences of therapists and is related to an established concept which has some theoretical support (VT). Unlike post-traumatic growth, which originated from studies of trauma victims and has been somewhat transposed onto therapist’s experiences, VR is derived directly from studies of therapists. However, VR is still an exploratory concept, with only one other study, another qualitative study again by Engstrom, Hernandez, and Gangsei (2008), to support its validity. Additionally, the therapists studied were working internationally with victims of political and systemic violence, and may not be applicable to other therapists. Nevertheless, VR remains an intriguing construct and will be revisited later in this work.

In summary, researchers have identified several factors which may serve as protective or preventative factors concerning the development of STS or VT. Intriguingly, there is even a suggestion that working with traumatized individuals may enhance a therapist’s personal growth, or may positively impact their core schemas and result in their becoming increasingly resilient. Unfortunately, many of these suggested protective factors have been shown to be related to the occurrence of STS/VT, but there is insufficient empirical evidence to suggest causality. What this means is these factors have not been proven to be truly preventative, but
have been shown to be associated with lower rates of STS/VT. The purpose of the current study will be to attempt to add to the body of knowledge regarding protective factors, but also to obtain evidence regarding the effectiveness of selected protective factors.

**Secondary Traumatic Stress versus Vicarious Traumatization: Unanswered Questions**

Perhaps the principle complicating factors related to studying secondary traumatic stress or vicarious traumatization is the disagreement between proponents of STS and VT about which concept best describes the effects therapists often experience when working with traumatized individuals. Both constructs are defined as collections of symptoms which arise in individuals who work closely with traumatized individuals. Pearlman and McCann (1995) described vicarious traumatization as a condition arising from engaging in deeply empathic work with traumatized individuals. Figley (1995) described secondary traumatic stress disorder in many of the same terms, with less stress placed upon the importance of empathic engagement. When the respective symptom lists are examined for both VT and STS, it becomes apparent that there is a great deal of overlap between these constructs. Pearlman and McCann insisted their concept of vicarious traumatization is unique and described long-lasting changes to personality and cognitive schemas. However, therapists working with trauma survivors (and STS is nearly identical to PTSD, except the trauma exposure is secondary) would also report the presence of long-lasting changes to cognitive schemas and accompanying personality changes (Shapiro, 1995). Therefore, it is likely that VT and STS are stressing different symptoms of a single phenomenon.

Figley (1995) further complicates the matter when he utilized the term compassion fatigue interchangeably with the concept of secondary traumatic stress disorder. Figley later
stated “Compassion fatigue is a more user-friendly term for secondary traumatic stress disorder, which is nearly identical to PTSD, except that it applies to those emotionally affected by the trauma of another...” (2002, p.3). Other researchers view compassion fatigue as being on a continuum between burnout and secondary traumatic stress disorder or vicarious traumatization. For example, Sheehy-Carmel and Friedlander (2009), when describing how some impacted therapists might have left their field of work, stated “That is, it would not be surprising if secondary traumatization is less easily endured than compassion fatigue” (p. 466), implying a difference between the severity of these concepts. This statement was made despite their earlier quotation of Figley’s assertion that compassion fatigue is synonymous with STS. Mendenhall (2006, p. 360) described compassion fatigue as the following:

Although a variety of definitions for compassion fatigue exist, common themes relate to breaking-down processes in which one’s physical, emotional, and even spiritual resources are depleted...those experiencing compassion fatigue often struggle with a chronic sense of exhaustion and fatigue, insomnia, headaches, stomachaches, lack of appetite, physical agitation or retardation, and frequent bouts of sickness (e.g., colds, sore throats). Psychologically, they often feel irritable and are overwhelmed by the volume and content of their work. They sense a reduction in their baseline empathy for others, feel numb to patients’ and families’ pain, and are cynical regarding patients’ and families’ ability to change and/or perceive them as being responsible for many of their problems. They often report a sense of feeling scattered and unable to meet their professional (e.g., paperwork) and personal (e.g., calling home) obligations.
Mendenhall’s description would seem to be very similar to the concept of burnout rather than secondary traumatic stress, and certainly this description is very different from Figley’s descriptions of compassion fatigue.

A final issue complicating the research is the nebulous definitions of what constitutes a trauma therapist, or a therapist at risk for developing STS/VT. When examining STS and working alliance perceptions of therapists working with sexual offenders, Sheehy-Carmel and Friedlander (2009, p. 463) included “...therapists who worked in any therapeutic setting individually with male clients who have committed a sexual offense.” Total contact hours with clients per week ranged from 2 to 60, with the actual hours worked with sexual offenders never being specified. This appears to be a typical problem within the research literature, with investigators examining relationships between STS/VT and therapists who are exposed to secondary trauma, while not having specific criteria for what constitutes a “trauma therapist,” a “trauma caseload,” or even a “traumatized client.”

The great majority of studies have also examined associations relating to STS/VT and specified variables. Causality is often inferred from the discovered associations, without experimental work conducted to provide statistically sound evidence to the inferred causality. This is especially troublesome when there are prevention and protective recommendations made as part of a study, without having causal evidence justifying the recommendations.

**Research justification and proposal**

Secondary traumatic stress and vicarious traumatization can severely impact psychotherapists who work with traumatized individuals, as well as the persons they are tasked to help. Therapists experiencing STS or VT may depersonalize their relationships with the
persons they are assisting, will have a reduced capacity for empathy, and will likely provide a poorer quality of service. These psychotherapists might experience symptoms associated with trauma exposure such as hypervigilence, nightmares, insomnia, intrusive memories, and intense reactions to the clients they work with, as well as potential lasting changes within cognitive schemas. As stated previously, these psychotherapists will likely be compromised in performing their duties, potentially to the point where it may become unethical for them to practice (Everall & Paulson, 2004).

The purpose of the following study is to advance the knowledge base relating to vicarious traumatization and secondary traumatic stress, as experienced by therapists. This study will utilize a qualitative design, with the purpose of examining psychotherapists of varying experience and functioning levels who work with traumatized persons. These individuals will be interviewed to help determine what skills are being utilized or what resiliency characteristics are present. Differences between these individuals will be ascertained, as well as what general themes emerge. An emphasis will be on which specific skills/characteristics are present or employed, what characteristics/skills are viewed as being important by the participants, and how are these skills or qualities are actually utilized. Barriers to utilization will be examined, as well as how these individuals have worked to overcome these barriers. Different themes between those who experience higher symptoms verses lower levels of symptoms will be examined, as well as differences between those who value and/or utilize protective skills (or possess theoretically protective characteristics) and those who do not.

It is hoped that this study will help to contribute to the body of research related to these important issues, and to provide further evidence related to Bober and Regehr’s (2006)
findings, which suggested valued skills are both not utilized and do not appear to work when even they are used. This study will take an approach not previously utilized, to help examine not only the important issues related to what factors prevent STS or VT, but to compare these factors related to both constructs to help determine if these preventative factors apply to both constructs or if specific skills would be better suited for either STS or VT prevention. It is hoped that this research can both clarify the existing research, as well as add to the current field of knowledge; and in doing so, might lead to better identification of effective skills as well as different needs amongst psychotherapists who work with traumatized persons.
Chapter 3: Methods

Restatement of Purpose

The purpose of this study will be to obtain further evidence relating to how working with traumatized individuals impacts therapists, what skills or characteristics serve as protective or coping measures for these therapists, and what factors interfere with implementing these coping or protective factors. Unlike studies before this one, therapists of different experience levels will be interviewed to help determine which skills are utilized by novice versus more experienced therapists. This is of importance as the evidence within the literature suggested maturity and experience serve as protective factors (Adams, Matto, & Harrington, 2001; Nelson-Gardell & Harris, 2003; Vrendenburgh et al, 1999), yet there is no evidence explaining why this is so. Additionally, it has been suggested that protective skills likely develop over time (Perlman & McCann, 1995), yet this has not been verified and there is no evidence describing how these skills potentially develop. Finally, information will be gathered related to what barriers, whether practical or psychological, are present which might interfere with coping or protective factor activation or utilization, as well as how therapists attempt to overcome these barriers. This study will hopefully fill gaps within the literature as well as find further evidence to support/refute or explain Bober and Regehr’s (2006) findings that therapists who value skills often do not utilize these skills.

Method

Grounded theory (Glaser & Strauss, 1967) is a qualitative method used to develop theoretical explanations of human behavior “grounded” in data gathered from those displaying that behavior. Phenomenology is used to explore the meaning of a lived experience among a
based on this study’s research questions, grounded theory appeared to be a natural fit to help understand the
individual therapist’s experiences related to working with traumatized individuals, their
perceptions of what factors help to protect them from being impacted by this work, and how
these factors actually serve protect themselves or help them to cope. This method also allowed
the researcher to obtain detailed information related to why skills or protective factors might
not be utilized. Grounded theory allowed for the collection of deep and rich information which
is currently lacking related to skill utilization and protective coping, the development of these
skills and factors over time, and what interferes with utilization on a personal level.

The utilization of grounded theory can be particularly useful when an area has not been
sufficiently studied, or when there have been few studies conducted and those have been
primarily correlational in nature. In grounded theory studies, theory is not used at the front end
of a research study develop a research design and influence perspectives (Creswell, 1998).
Instead, theory is utilized at the back-end of the study to help interpret results and to place
these results within the current body of knowledge. In essence, the theory is generated from
the gathered data and compared to the current literature to determine the fit within that
literature or expand upon the current body of literature. This will be particularly useful in
studying the current topic, as theorists in the literature have suggested skills work and should
be utilized (Figley, 1995, Perlman & Saakvitne, 1995), yet there has been very limited research
conducted relating to these skills and the research that has been conducted suggests these
skills do not tend to work and are not utilized (Bober & Regehr, 2006). Grounded theory will
ideally elicit information which might help confirm the importance of skills, suggest that truly
skills are not as effective as assumed, or can suggest a new theoretical perspective related to what works and what does not.

**Participants**

**Sampling**

In qualitative research, information-rich cases are the basis for the logic and power of the method (Patton, 1990). Subjects were selected using purposive sampling (Bernard, 2002). To obtain the initial purposive sample, 120 surveys were mailed to therapists selected through the American Psychological Association’s trauma division, the EMDR Institute’s directory of trauma therapists (Note: EMDR is an acronym for eye movement desensitization and reprocessing therapy, a form of trauma therapy combining imagined exposure with bi-lateral physical stimulation-Shapiro, 1995). These surveys consisted of both the Professional Quality of Life survey (Stamm, 2010) and the Trauma and Attachment Belief Scale (Perlman, 2003).

The Professional Quality of Life (ProQOL) is a self-report measure utilizing 30 Likert scale items to obtain scores related to three constructs; Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (see Appendix B). The Professional Quality of Life Scale (ProQol) is currently in its fifth rendition, and consists of 30 Likert-scale items which measure three distinct constructs; Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm, 2010). The scale also measures the construct “compassion fatigue,” which is viewed as collective distress related to working with traumatized persons and encompasses both burnout and secondary traumatic stress. The Compassion Fatigue inter-scale correlations suggest a 2% shared variance ($r=-.23; \text{co-}\sigma = 5\%; n=1187$) with Secondary Traumatic Stress and 5% shared variance ($r=-.14; \text{co-}\sigma = 2\%; n=1187$) with Burnout. However, Stamm suggests this shared
variance (34%, \( r=.58; \) co-\( \sigma = 34\% ; n=1187 \)) is reflective of shared distress which would be experienced both by individuals experiencing burnout as well as secondary traumatic stress; burnout and secondary traumatic stress are unique constructs as measured by the ProQol. Specifically, the burnout scale does not measure symptoms associated with fear or anxiety stemming from working with traumatized persons. The current edition of this instrument was revised from four earlier editions, with a collected 1768 cases forming the normative sample across these editions (Stamm, 2010) The revised version (the ProQol) was designed to retain the strongest and most salient items while strengthening the subscales and the subscale ability to represent separate constructs. The alpha reliabilities for the subscales are: Compassion Satisfaction alpha = .87, Burnout alpha = .72, and Compassion Fatigue alpha = .80.

The Trauma and Attachment Belief Scale (Pearlman, 2003; see Appendix C) is a self-report measure designed to measure the five cognitive schemas conceptualized to be principally effected through therapist exposure to traumatic material. These scales correspond with the principle five constructs of vicarious trauma discussed earlier in this report: Trust, safety, control, intimacy, and self-esteem.

The Trauma and Attachment Belief Scale (TABS) contains 84 items, scored on a 6-point Likert scale with scores ranging from 1 (disagree strongly) to 6 (agree strongly). Higher scores on the TABS indicate a higher level of cognitive disruption. The TABS was derived from the Trauma Belief Scale, which also was designed to measure Vicarious Traumatization symptoms. Through extensive feedback from subjects, the scale was refined and the TABS was then developed based upon this feedback and data. Normative data for the TABS was obtained from a sample of 1,743 individuals aged 17-78. Pearlman (2003) reported the TABS demonstrated
good internal consistency, with scale scores as follows: self-safety (.83), other safety (.72), self-trust (.74), other trust (.84), self-esteem (.83), other esteem (.82), self-intimacy (.67), other intimacy (.87), self-control (.73), other control (.76), and total (.96). There is a test/retest reliability of .75, and internal consistency is .96. Additionally, subscale test/retest reliability varied between .60 and .79, with a median score of .72. Subscale test/retest internal consistency ranged between .67 and .87, with a median score of .79.

Respondents in the current study were also asked to report selected demographic information, including the number of traumatized individuals they have been working with both currently and on average over prior years, total years of experience as a therapist, and education level. This information will not only help to screen out individuals who may not be appropriate due to insufficient engagement with traumatized persons, as well as to provide additional qualitative information which may pertain to the results of this study.

The therapists receiving these surveys were asked to complete the enclosed instruments, and were also asked for their permission to be contacted for a brief interview via either telephone or Skype to ask further questions regarding their responses as well as their experiences with self-care, STS, or VT. The original goal was to have selected sufficient individuals from the initial surveys to ensure there would be saturation (see below) while also yielding a sufficient sample to study two distinct groups. These groups would be divided according to their scores on the ProQOL and/or the TABS. These two dichotomous groups were to be selected for follow-up interviews to provide a richness of data, with the goal of gathering information about the experience of individuals who are reported higher rates of symptoms suggesting the presence of VT or STS, as well as those who seem to be the least affected by
these syndromes. These two groups would also be evaluated by two separate coding teams, through a process which will be discussed shortly.

To be included in the study, therapists must have been working with an average of eight or more clients per week who meet one of the following criteria: Meet the DSM IV TR (APA, 2000) criteria for post-traumatic stress disorder, have a trauma-related concern as one of the primary focuses of therapy, or a primary focus of therapy stems from traumatic experiences and these experiences are examined within the therapy process (such as substance abuse which developed after the loss of a child). As stated earlier, these therapists were to be identified through agency supervisors or through organizations such as the APA trauma division of the EMDR online list service.

**Sample Size**

The sample selected was large enough to gain sufficient information to obtain a thorough account of therapist’s experiences. Lincoln and Guba (1985) asserted informational redundancy is the principle criterion to determine when a sample is sufficiently large to cease the sampling procedure. Using this criterion indicates that sampling is stopped when no new information is gathered from further data collection (Lincoln & Guba, 1985; Patton, 1990). Lincoln and Guba suggested that about 12 interviews are often sufficient to exhaust most available information, which they termed informational redundancy. Strauss and Corbin (1998) also advocated this approach, although they utilized the term “theoretical saturation.” Strauss and Corbin also asserted that information gathering should continue until no new information in relevant categories emerges, and there is sufficient data within categories to allow for thorough and in-depth analysis. The current study utilized 14 interviewees, with the few
additional interviewees added to include some individuals who practiced in settings different from the other interviewees; these were also added due to the study’s design of using two separate coding groups to determine if there were between-groups differences. More than 14 were not deemed to be necessary for the purposes of this study because theoretical saturation appeared to be reached around the twelfth interview, and additional interviews did not appear to yield significantly new information.

As stated earlier, the interviewees were separated into two groups for coding purposes, with this separation being completed based upon their scores on the ProQOL and the TABS. Individuals scoring higher on the TABS or the STS scale from the ProQOL were placed in the “higher scoring” (HS) group, with the others being evaluated within the “lower scoring” (LS) group. The sample achieved for this study was sufficient to achieve information saturation both in terms of commonalities amongst therapists working with traumatized persons, as well as differences between those who are experiencing more challenges related to STS and VT as well as those who report few symptoms.

**Study Recruitment**

Participants were initially recruited from The APA trauma division or from the EMDR Institute directory. Attempts were made to directly recruit participants from community mental health agencies, with this author leaving voicemail and email messages requesting further contact with four separate agencies without receiving any response. A fifth community mental health agency was later contacted with a direct referral from a study participant, but again there was no response to communication attempts despite the referral person giving recorded permission to use her name as a reference.
Therapists were mailed survey packets which included the ProQOL, the TABS, and requests for simple demographic information as well as the number and type of trauma cases they typically work with. A letter explaining the purpose of the study, confidentiality, risks and benefits, and contact information was also included. Included in the demographics sheet was a request for permission for the researcher to contact the respondent to conduct a brief (15-30 minute) interview to gather further information.

The first wave of surveys were mailed to 120 potential respondents, with 23 of 120 being returned with the surveys completed. Of these, eight individuals completed the ProQOL and the TABS but declined to be interviewed. This resulted in fifteen respondents who had initially indicated they would participate in an interview. However, of these individuals three were not be able to be scheduled for interviews, despite multiple attempts to contact them. Another respondent verbally refused the interview when she was contacted via telephone, and a second expressed some hesitation. This respondent and the author of this study exchanged several emails about the study and her concerns, with her ultimately deciding to not participate. A third respondent agreed to be interviewed, discussed an interview time with this author over the telephone, but then did not respond during the scheduled time and did not respond to further contact. Unfortunately, these three persons had all scored higher on the ProQOL STS scale and the TABS, and would have made good candidates for the higher scoring (HS) group. See Table 1 for a summary of respondent characteristics and participation status.
Table 1.

**Demographic characteristics of respondents**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Gender</th>
<th>Age</th>
<th>Years of Experience</th>
<th>History of prior trauma</th>
<th>Workplace setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>LS1</td>
<td>M</td>
<td>65</td>
<td>27</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS2</td>
<td>M</td>
<td>65</td>
<td>32</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS3</td>
<td>F</td>
<td>61</td>
<td>33</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS4</td>
<td>F</td>
<td>73</td>
<td>35</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS5</td>
<td>F</td>
<td>42</td>
<td>14</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS6</td>
<td>M</td>
<td>55</td>
<td>22</td>
<td>Suicide of family member</td>
<td>Private practice</td>
</tr>
<tr>
<td>LS7</td>
<td>F</td>
<td>47</td>
<td>13</td>
<td>N/A</td>
<td>College counseling center</td>
</tr>
<tr>
<td>HS1</td>
<td>F</td>
<td>57</td>
<td>31</td>
<td>Childhood abuse, domestic violence</td>
<td>Private practice</td>
</tr>
<tr>
<td>HS2</td>
<td>M</td>
<td>57</td>
<td>24</td>
<td>N/A</td>
<td>Veteran’s administration</td>
</tr>
<tr>
<td>HS3</td>
<td>F</td>
<td>68</td>
<td>16</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>HS4</td>
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<td>70</td>
<td>30</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>HS5</td>
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<td>15</td>
<td>Childhood abuse</td>
<td>Community mental health</td>
</tr>
<tr>
<td>HS6</td>
<td>F</td>
<td>49</td>
<td>25</td>
<td>N/A</td>
<td>Private Practice</td>
</tr>
<tr>
<td>HS7</td>
<td>M</td>
<td>29</td>
<td>1</td>
<td>N/A</td>
<td>College counseling center</td>
</tr>
<tr>
<td>INC1</td>
<td>F</td>
<td>71</td>
<td>27</td>
<td>Childhood abuse, natural disaster, life-threatening illness</td>
<td>Private practice</td>
</tr>
<tr>
<td>INC2</td>
<td>F</td>
<td>38</td>
<td>8</td>
<td>Childhood abuse (multiple forms)</td>
<td>Private practice</td>
</tr>
<tr>
<td>INC3</td>
<td>M</td>
<td>60</td>
<td>4</td>
<td>Car accident</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>INC4</td>
<td>F</td>
<td>34</td>
<td>10</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>INC5</td>
<td>F</td>
<td>60</td>
<td>23</td>
<td>Sexual assault, home invasion</td>
<td>Private practice</td>
</tr>
<tr>
<td>INC6</td>
<td>F</td>
<td>68</td>
<td>35</td>
<td>Childhood emotional abuse</td>
<td>Private practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>N1</td>
<td>F</td>
<td>47</td>
<td>20</td>
<td>Car accident, sexual assault, childhood abuse</td>
<td>Counseling agency</td>
</tr>
<tr>
<td>N2</td>
<td>F</td>
<td>64</td>
<td>18</td>
<td>Childhood sexual abuse</td>
<td>Private practice</td>
</tr>
<tr>
<td>N3</td>
<td>F</td>
<td>53</td>
<td>10</td>
<td>Childhood sexual abuse</td>
<td>Unknown</td>
</tr>
<tr>
<td>N4</td>
<td>F</td>
<td>63</td>
<td>37</td>
<td>N/A</td>
<td>Private Practice</td>
</tr>
<tr>
<td>N5</td>
<td>F</td>
<td>62</td>
<td>21</td>
<td>Car accident</td>
<td>Counseling agency</td>
</tr>
<tr>
<td>N6</td>
<td>M</td>
<td>54</td>
<td>20</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
<tr>
<td>N7</td>
<td>F</td>
<td>41</td>
<td>14</td>
<td>Sexual assault</td>
<td>Unknown</td>
</tr>
<tr>
<td>N8</td>
<td>F</td>
<td>58</td>
<td>24</td>
<td>N/A</td>
<td>Private practice</td>
</tr>
</tbody>
</table>

Note: LS indicates “low scoring” respondents, HS is “high scoring” respondents, INC indicates “interview not completed,” and N indicates interview initially refused.

This initial mailing yielded a decent response rate and several potential interviews, but a pattern also became apparent with this mailing. Those who responded, and particularly those who agreed to be interviewed tended to have many years of experience (26.89 years on average) and all except for one were working in private practice settings (the last working in a veteran’s hospital). These participants also tended to score lower on the TABS and ProQOL (this will be discussed later) when compared to those who declined to be interviewed. These persons appeared to be a fairly homogenous group, and there appeared to be a need to obtain interviews from therapists who worked in other settings and who were ideally not engaged in private practice. Another factor suggesting a different sampling approach was needed was that of the initial nine persons who were actively interviewed, seven of these identified themselves as primarily EMDR therapists; this suggested a need to also have increased representation from persons using other techniques to treat trauma. This does not imply this study adopted a “maximum variation” approach as discussed by Glaser and Strauss (1967), but there was a
recognition that increased variety would yield a model that would be more likely to fit with a broader range of therapists who work with trauma, rather than be limited to highly-experienced therapists who worked in private practice and largely utilized a specific technique.

Selective sampling was again engaged in at this point with the author of this study contacting colleagues at various agencies to enquire if they were aware of individuals who would meet study criteria whom might be contacted to have a survey packet mailed to them. There was a purposeful effort to recruit individuals working in community settings, hospitals, domestic violence shelters, the Veterans Administration, or college counseling Centers. There was also an effort to reach persons who had less experience compared to those who responded to the initial mailed surveys. This method of selective sampling yielded three additional interviews, including one person working at a community mental health center, one working with the Veterans Administration, and one with a college counseling center. The technique of “snowball sampling” (Patton, 2002) was also utilized at this point, with new interviewees being asked if they were aware of other therapists who worked with trauma who could be contacted. This yielded two more interviews, one with an individual in a college counseling center who only had one year of experience (and worked with sexual assault and sexual abuse cases), and an individual in private practice who was open about discussing a personal history of trauma. It should also be noted that this selective sampling and snowball sampling again led to several false leads, with five persons agreeing to receive a survey-and three expressing great interest in being interviewed-yet not responding to further attempts to contact them.

**Researcher Perspective**
Qualitative research differs from other research methodologies in that the investigator functions as both the primary mechanism for data collection, as well as the primary mechanism for data analysis. To ensure the researcher obtains data and analyzes data in a valid and reliable manner, the investigator should receive extensive training and guidance before engaging in the inquiry process (Patton, 1990; Strauss & Corbin, 1998). The researcher must make great efforts to avoid bringing their personal biases into their collection of the data, as well as the analysis of the data. However, qualitative research methods recognizes that no matter how carefully the investigator works to avoid bias, it is inescapable that a degree of bias will most likely be introduced into the study (Creswell, 1998; Strauss & Corbin). Because of the risk related to the introduction of bias, as well as the above-mentioned dual role of the investigator, there is a required high degree of personal self-awareness as well as a need to acknowledge personal theoretical assumptions and other factors which might influence the data collection and analysis processes.

Related to these requirements for awareness of personal biases is the importance of approaching this research with an open-minded perspective. In this study, the literature review had been conducted prior to the implementation of this research for the purpose of guiding the interview focus and question framework, as well as to prevent the possibility of replicating work previously completed. However, the qualitative process will demarcate from this literature review. In other words, this investigation was open to whatever themes and processes emerged whether or not these were related to the larger body of literature (Creswell, 1998; Strauss & Corbin, 1998). Through approaching the data collection and analysis process from an open-minded perspective, the risk of guiding the process in a way that “fit” a specific
construct was reduced. Approaching the process through this method will allow for the potential discovery of new relationships or paradigms which might have been missed if the researcher attempts to fit the data into an existing construct or theory.

Data Collection

Data was collected by conducting one-on-one, structured interviews via telephone or in-vivo with the author of this study. Eleven of these interviews were conducted via telephone at a time of the interviewee’s choosing; the interviews were recorded digitally after receiving the interviewee’s verbal permission to record. The remaining three interviews were conducted face-to-face with the interviewee, with all three occurring in the offices where they also conducted therapy. These sessions were also digitally recorded, after permission was obtained by the interviewee. The structured portion of the interview took between 15 minutes and an hour, with the majority of these interviews falling between 15 minutes and 20 minutes. The interviews were guided by the research questions (appendix A), but were conducted with a flexible approach to allow appropriate follow-up questions, gather elaboration on important points, and to allow for new information or discoveries to be sufficiently explored. The format was designed to provide sufficient structure to ensure all relevant information could be gathered and to help limit some researcher bias, while also being unstructured sufficiently to obtain all relevant data. As can be seen in Appendix A, the primary questions and follow-up questions were designed to gain information relating to the presence of STS or VT symptomology, as well as to examine protective or self-care skill utilization and barriers to utilizing these skills, while still being flexible enough to allow for the introduction of new themes or evidence not specifically related to prior findings and theories.
Field notes were taken during each interview, as well as immediately after the interviews. These notes included information relating to the interview time and any relevant environmental factors, participant verbal demeanor and non-verbal information, and (if in person) body language and other observable factors. Also noted were relevant factors such as interruptions, interviewee mentioned stressors, or any other factors which might impact the interview or the interviewer’s approach. These field notes then summarized the conversations as well as include any pertinent information which might be divulged before or after the formal recorded interview. A final piece of information included in the note was when the interviewee wished to have a donation made to (four declined to have donations made), and in three cases it was noted that the interviewees did not wish to review the transcript of the interview. These field notes have been stored in a locked and secure strongbox, and all identifying information has been removed where possible.

The interview guide was pilot tested through three interviews prior to being utilized with these recipients. This was done to address any concerns such as a lack of clarity, poor or inappropriate questions, or any unforeseen issues such as cultural inappropriateness. These pilot interviews were conducted with therapists who the author was familiar with, two of whom met criteria for this study and one of which was highly trained in multicultural and social justice issues. Prior to this step, the question guide was distributed to three experienced trauma therapists who would be considered to be experts based upon their experience and reputations. This step was taken to gather information concerning the appropriateness of the questions asked given the research topic, to refine the guide, and to inquire about the inclusion of other questions or information domains not already included. Another concern was any risk
of potentially triggering an individual with a history of trauma, with all three therapists agreeing this did not seem to be likely at all to occur. The structured questions, along with the demographic sheet and introductory letter, were then reviewed with this author’s dissertation chair, approved by the dissertation committee, and then submitted for IRB approval.

After the interviews and the transcriptions were completed, the transcripts were mailed or emailed (dependent upon interviewee preference) for review. As stated earlier, three interviewees declined to receive the transcript; of the others two provided clarification for sections which were transcribed as inaudible, one of these offered a clarification for another point, and a third offered three minor clarifications for comments they had made. One of these also asked if some comments in the transcript would be included in the study, and they were assured they would not be as there was a remote chance of this respondent being identified by the information. No interviewee expressed any major concerns about the interview process, and there did not appear to be any indication that any members disagree with the themes and information obtained through the interviews.

Data Management

As stated earlier, all interviews were audibly recorded using a digital recorder with the permission of the participants and transcribed verbatim. The permission of the participants was always obtained prior to the recorder being activated. These transcriptions were completed by the researcher, and were then reviewed again by the researcher to ensure accuracy of the transcription. Any references which might directly reveal the identity of the participants, colleagues, or specific agencies were then removed from the transcripts. Transcribed interviews were then provided to the participants for their review of the transcription accuracy, as well as
to allow the participants to verbalize any concerns raised by the transcription itself (see above for the exceptions to this). All materials, including the digital recorder and a flash drive containing copies of the recording and transcripts, are being kept in a locked fireproof box within a locked file cabinet.

*Protection of Human Subjects*

This study was reviewed by the Ball State University Institutional Review Board (IRB) for approval. Informed consent was obtained from all participants, and this informed consent listed any potential foreseeable risks which might have been incurred by participants. All interview information was (and continues to be) kept confidential, and participants have not and will not be identified by name or by any other characteristic which could break their anonymity. As stated earlier, all materials utilized for this study (transcripts, recordings, field notes, and other memos or communications) are kept in a secure location. These materials will be retained in a secure location for five years following the study conclusion; then these materials will be destroyed.

*Data Analysis*

Strauss and Corbin (1998) described the basic principles of grounded theory. One of these principles was that the analysis begins the moment the first data was collected. This, in turn, will guide future data collection processes. The interview guide was somewhat dynamic, in that this guide was reviewed for the need for revisions continuously during the interview process. The data analysis included initial transcripts, field notes, and coded interviews. Although initial analysis began with the first transcripts, a more thorough analysis was conducted with every three interviews to examine the need to revise the interview guide.
Through this process, data collection continued to be reviewed for adjustment to obtain the most relevant data as indicated through the active interviews.

Coding teams

A microanalysis was utilized for all interviews by trained coders who were divided into two teams, with one team analyzing the transcripts from the higher scoring (HS) group and one team analyzing the lower scoring (LS) group. For clarification purposes, the Higher Scoring (HS) group refers to individuals who scored higher on the ProQOL STS scale and/or the TABS global VT scale; in other words the HS group consists of individuals who are experiencing a greater negative impact from their exposure to trauma content than the LS group respondents. The code training was performed by the author of this study, and the coders were all volunteer doctoral students from the Ball State University Counseling Psychology department. Four of these coders were in their third year of their doctoral programs, and one was in her first year. All coders had completed master’s degrees (or equivalent) in counseling or clinical psychology, and all had several years of clinical experience working in a variety of practicum placements. Three students were international students, but were well versed in the English language and had spent several years in the United States at the time of this study. All had completed the CITI training program for researchers. Two coders were utilized for all analysis within the two groups, with the fifth coder utilized to resolve discrepancies between the initial coders when they could not reach agreement.

Coding process

The microanalysis consisted of a line-by-line analysis of the interview transcripts to generate initial data categories (Strauss & Corbin, 1998). These initial categories were
meticulously examined to determine potential relationships between the categories. With each new idea, a new code was created and attached to the corresponding lines of text. The codes were labeled, described and modified throughout this process. This dynamic processes of microanalysis and code generation then led to the next phase in the process, termed “open coding.”

Strauss and Corbin (1998) described the process of open coding as an analysis through which concepts could be identified and their properties then defined. Conceptually similar themes, or themes which have connected meanings, are grouped together and in turn these concepts are given names. Codes identified early in the process were utilized to identify similar concepts garnered in later interviews, while newly identified concepts continued to expand the codex. Ultimately, this process allowed identification of codes unique to specific interviews as well as concepts which are shared across multiple interviews and are more global in nature.

Strauss and Corbin (1998) then described the next step in this process; axial coding. This is the process through which open codes are grouped into larger and more abstract conceptual categories. Through the process of axial coding, data which had been divided into small units through the initial open coding process is re-assembled. These larger coded units were analyzed according to their properties, and then these were compared to one another across categories. This microanalysis was conducted line-by-line upon the interview transcripts to identify the initial coded concepts. The notes and general themes identified through the interview process were then utilized to develop categories on the conceptual level. Codes and corresponding content themes, quoted from the transcripts, were used throughout this process to identify similarities and relationships across multiple levels of complexity. Ultimately code families or
“Super Codes” were identified to contain groupings of related codes. This coding was conducted by the coding teams, supervised by this researcher.

Once the open and axial coding processes were completed, the category’s quotations were reviewed utilizing a process termed “data cleaning” (Stauss & Corbin, 1998). This process was conducted by the coders after they received training in the principles of grounded theory and coding, the training again performed by the author of this study. The quotations within each category were then reviewed to determine the appropriateness for inclusion within a given category. In cases where a specific code or category was not included within a specific interview, the transcript for that specific interview was examined to ensure specific data was not overlooked.

Data was then coded and organized into distinct categories, or themes, and super-categories. Strauss and Corbin (1998) suggested utilizing a process termed “selective coding” through which the theory would be integrated and further refined. Selective coding allows for the construction of a larger explanatory framework, wherein the major categories are integrated with one another to form a larger theoretical scheme (Strauss & Corbin, 1998). This theoretical scheme then was utilized to help explain the main themes within the data, and also helped account for what variation was found. The proposed process, and frameworks derived from this process, was then used for comparisons with the current body of literature. This selective coding was performed by the researcher to determine the explanatory framework revealed by the selective coding process; the themes derived from this final step will be discussed in detail in the following section.
Reliability and Validity Criteria

Qualitative research differs from quantitative research in that the traditional statistical reliability and validity methods are not utilized. However, Lincoln and Guba (1985) provided a framework through which reliability and validity measures can be examined to help ensure study results are credible, transferable, and dependable. Credibility is considered to be the qualitative equivalent to internal validity, or how trustworthy or plausible the study’s results can be considered to be. Credibility can be established through peer debriefing, data verification, and member checking. Lincoln and Guba particularly stressed the peer debriefing aspect of credibility checking, stressing that presenting data and data analysis to peers will help to accurately explore interpretations, biases, and inconsistencies which might have been missed by the investigator. In this current study, sections of the analysis have been discussed with members of the dissertation committee, the coding teams, and therapists who work extensively with trauma throughout the data collection and analysis process to obtain feedback related to the interpretations of the data as well as to identify any unrecognized biases or errors committed by the investigator. In general, feedback has been generally positive-meaning that the structure if the questions and the approach has generally been seen as effective in obtaining the stated goals of this study.

Raw data verification refers to the process of comparing the theory against the raw data (Strauss & Corbin, 1998) after the collection process is completed. After the general framework/hypothetical model was completed and the key themes identified, this researcher thoroughly reviewed the transcripts to ensure the resultant findings are truly reflected within
the data. This process resulted in minor alterations to the model and structure of the themes to ensure the best “goodness of fit” with the information provided within the transcripts.

“Member checking” describes the process of presenting findings, interpretations and conclusions to the participants within the study (Lincoln and Guba, 1985). This step is conducted to confirm that the findings are representative of the participant’s experiences, and thus further establishes credibility. This process was conducted by mailing copies of the transcripts to the participants to allow them to verbalize any perceived errors. Additionally, all participants were engaged in conversation after the structured interview, where the interviewer gave them the opportunity to express any questions or concerns they might have, to provide any clarification concerning the interview or the research, and to discuss any of the purposes for the specific questions or themes discussed during the interview. These conversations were also transcribed and mailed to the interviewees (unless they declined this step) for further comment, although this information was not coded or included within this study.

Qualitative research sacrifices a degree of generalizability for the purposes of gaining richer data from a smaller sample of individuals. However, there is still a concern for external validity related to research results, and this parallel to external validity is termed “transferability” (Lincoln & Guba, 1985). In other words, transferability refers to the extent to which the results of the study can be applied to other contexts or larger themes. Clearly and adequately defining the sample and utilizing clear and explicit inclusion/exclusion criteria are methods of enhancing transferability. A second method is to provide rich or “thick” descriptions of the phenomena investigated, as well as structuring the interview process to obtain rich and
lengthy contextual responses from the participants. The process of modifying the guide over time in response to interview results and peer/participant feedback is another method of ensuring rich or thick descriptive responses throughout the data collection process. In this study, the inclusion of the ProQOL and the TABS not only provided information about the interviewees for descriptive and study purposes, but these instruments also better inform regarding the degree to which the results may be more or less generalizable. These instruments also offer data points to further check the validity of the interview results. For example, these offer a quantitative measure to compare to the transcriptions; if an individual scores high on these instruments, this should also be reflected to some extent in their transcription responses. The process utilized in this study ultimately appeared to be fairly robust in providing rich (thick) descriptions, which enhanced the richness of the descriptive data.

Dependability (Lincoln & Guba, 1985) is another qualitative factor which roughly parallels the quantitative construct known as reliability. Dependability refers to research process temporal consistency, which in this study generally refers to the degree by which the researcher is consistent across interviews and data analysis. This author worked to establish dependability by carefully documenting all aspects of the research processes across all stages of data collection. Additionally, data cleaning procedures were utilized to examine the extent to which codes were applied in a consistent manner within the data analysis procedure. Finally, openness and seeking out peer and participant feedback further helped to establish consistency by identifying areas where bias or error might have been introduced to create inconsistency within the process.
A final concern is conformability, which refers to the extent to which the study’s results are clearly based upon the participants experiences rather than researcher biases or theoretical leanings. Conformability was enhanced in this study through obtaining participant feedback (as mentioned above) by allowing participants to have a voice related to whether or not the findings accurately portray their experience and to express any thoughts or concerns about the interview process. The researcher also kept detailed notes throughout the process to help identify and reflect upon the researcher’s personal experience throughout the process, with one goal of these notes being to gain insight into areas where bias might be intruding into data collection or analysis.

After the data had been gathered, thoroughly analyzed to develop an encompassing framework, and all the previously mentioned validity and reliability checks conducted, the process of discussing the data and developing theoretical perspectives from the findings was engaged in. This will be thoroughly discussed in the next section of this work.

Chapter Four: Results

Restatement of purpose and methods

The purpose of this study was to examine the positive and/or negative impacts therapists experience when they work with traumatized individuals, as well as what factors might serve to mediate or ameliorate these potential impacts. This study utilized grounded theory to develop a hypothesis concerning this phenomenon, in an effort to better understand what factors appear to help therapists prevent or reduce any negative impacts, which may serve to promote positive impacts, and what factors interfere with skill utilization and whether
or not these processes evolve over time. In the following section, the results of this study will be organized and presented as recommended by Creswell (2007), with information being organized into seven distinct themes which correspond to a proposed theoretical model. Significant differences and similarities in coding between the two separate groups will also be reviewed within each section, and will be further discussed in the final section of this work.

As stated above, this section will be largely organized according to seven general themes derived from the axial codes. These themes were derived from a lengthy process which began with an initial evaluation of the information provided by the interview transcripts, which were then coded through the open coding process (Strauss & Corbin, 2008) into initial data points. Once there was agreement on these open codes within the coding teams, these teams worked to find commonalities between these codes to form larger code categories. This was done through the process of developing Axial codes, which were more abstract categories that were more encompassing of information and which organized information into larger and more usable themes (Creswell, 2007). These were then organized by the researcher through the selective-coding process and across the higher scoring and lower scoring groups (Creswell, 2007) into super-codes which form the model discussed later. Each step in this process produced codes which become increasingly more abstract and theoretical, with the final result being the development of a hypothetical model explaining the phenomena investigated.

In order to help organize this information in a coherent manner, the researcher again organized the categories derived from the Axial codes into seven distinct themes. The following discussion of results will largely be organized along these themes, with further discussion of a proposed model which will incorporate these themes into a coherent hypothetical model of the
phenomena studied. Each theme section will have quotes from the interviews incorporated in the discussion to provide the reader with evidence in support of the findings, as recommended by Merriam (2009). To provide further context for the reader, these quotations will typically be denoted as “HS” or “LS” so the reader will be aware of which group the quote originated from. After the themes are sufficiently discussed, a proposed hypothetical model will be presented to illustrate the central phenomenon studied; this model will also be explained in detail. A table will be presented prior to discussing the central themes; this table will illustrate the themes derived from the coding process and will illustrate examples of open codes which ultimately created the central themes.
Table 2

Themes and connected samples of corresponding open codes.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Open Code Samples:</th>
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<tr>
<td>Therapist Personal Characteristics</td>
<td>Strong sense of identity</td>
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<td>Sense of humor</td>
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<td>Awareness of own issues</td>
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<td>Empathy as a personal trait</td>
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<td>Awareness of own limitations</td>
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<td>Knowing own triggers</td>
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<td>Therapist development</td>
<td>Past lack of awareness and competence</td>
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<td>Developing coping skills</td>
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<td>Increasing ability to maintain boundaries</td>
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<td>Increased self-care over time</td>
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<td>Further training improved work</td>
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<td></td>
<td>Gaining experience</td>
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<td>Self-Care</td>
<td>Exercise as stress reliever</td>
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<td></td>
<td>Time with animals</td>
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<td>Family time</td>
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<td></td>
<td>Keep a balance in life</td>
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<td>Vacations for self-care</td>
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<td>Connecting with nature</td>
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<td>Personal and Professional Support</td>
<td>Peer consultation</td>
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<td></td>
<td>Consulting with peers or supervisors</td>
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<td>Caring peer group</td>
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<td>Peer supervision</td>
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<td></td>
<td>Importance of talking about difficulties</td>
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<td>Seeking supportive colleagues</td>
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<td>Empathic Exposure to Traumatic Content</td>
<td>Anger and sense of injustice</td>
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<td>Fatigue from trauma work</td>
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<td>Feeling brittle</td>
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<td>Trauma work increased compassion</td>
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<td>Trauma work helps clarify priorities</td>
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<td>Trauma work is rewarding</td>
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<tr>
<td>Hope, Resilience, and Therapist Effectiveness</td>
<td>Belief in clients’ ability to heal</td>
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<td>Belief in human resilience</td>
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<td>Confidence in client progress</td>
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<td>Belief in good world</td>
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<td>Touched/admiration</td>
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<td>Workplace and Personal Barriers</td>
<td>Pressure from agency/supervisors</td>
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<td>Monitoring of caseload</td>
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<td>Being overworked – too busy</td>
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<td>Work environment matters</td>
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<td>Community mental health has more pressure</td>
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<td>Harder when kids were younger</td>
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Discussion of central themes

Personal Characteristics

All respondents identified and discussed personal characteristics of trauma therapists which they either believed were important for these therapists to successfully engage in their work. Respondents discussed these characteristics either in reference to themselves or to therapists in general, but viewed these characteristics as being vital to work effectively with trauma victims, as being necessary to protect themselves psychologically when exposed to trauma material, or as simply being important for any therapist working under high stress. Some therapists also discussed some characteristics which they believed placed them or other therapists at increased risk when empathically engaging with traumatized persons, but the great majority of the response codes indicated statements which were viewed as positive in terms of being protective or enhancing effectiveness. Some of these characteristics were viewed as being intrinsic within the therapist, either being a part of their personality or at least a characteristic they possessed at the start of their career, while other traits were viewed as being developed or learned characteristics. The remainder of this section will discuss these reported personal characteristics in detail, while also providing sample statements from the transcribed interviews to provide detail and context for the reader.

Self-awareness was specifically mentioned by six therapists (four HS and two LS), and was viewed by these therapists as being vital when engaging in work with traumatized persons. Self-awareness was discussed as a therapist quality where they had the ability and willingness to actively engage in self-reflection, to be honest about their personal limits and vulnerabilities, and to monitor their distress levels and emotional states. Self-awareness also described
therapists who, as a result of self-examination, had a realistic sense of who they were as a person and as a therapist who worked with difficult content. One LS respondent stated “I believe a therapist must know and be in tune with themselves foremost in order to be safe to take care of someone else.” Another respondent remarked “To do the work that I do, I have to stay grounded in my own self and understanding my own self (HS).” These therapists not only stressed the importance of having an awareness of self, but viewed this as a vital pre-condition of being truly capable of helping another person work through the trauma they experienced.

Other therapists discussed the importance of personal awareness with a focus on the need for more specific awareness needs: For example, four respondents (three HS and one LS) reported it was important for trauma therapists to have an awareness of their personal needs or personal issues which might impact their work. One HS respondent stated “…so I think probably it’s pretty important for a therapist to be pretty open all the way around to not only understanding other people’s problems, but understanding your own.” Seven therapists (five HS and two LS) discussed the importance of a trauma therapist being aware of their personal limits, with an eighth respondent (HS) also stating there was a need for therapists to be accepting of their personal limitations. Connected to this was a therapist who discussed the need to have an awareness of personal vulnerabilities, and two other therapists who discussed the importance of therapists having an openness and willingness to deal with personal issues when they arise. One HS interviewee commented “I’m not an inexhaustible resource. I will burn out. I will crash and burn.” Another HS respondent stated:

Whatever relationship issues I’ve had, I’ve had to be able to work through them.

Whatever relationship issues with my kids, I’ve had to be able to work through those
and be open to my issues. So it’s never been like everybody else has problems and I don’t. I mean, you know, we’ve all got to work through our shit. That includes me. And so I think probably it’s pretty important for a therapist to be pretty open all the way around to not only understanding other people’s problems, but understanding your own; not only caring about other people, but caring about yourself; not only understanding where their limitations are, but understanding where your own are; all those things.

These respondents stressed the importance of therapists who work with trauma to be willing to examine what their limitations and vulnerabilities are, whether acute or chronic. To have an openness and awareness of these limits is viewed as being a necessary step in managing these factors; managing these factors appears to be necessary to prevent interference in the work of trauma therapy.

The importance of being aware of personal boundaries was reported by two therapists, with a third discussed the importance of being aware of personal vulnerabilities. A fourth cited the need to be aware of personal trauma triggers. One HS respondent succinctly stated “I have pretty good boundaries. It keeps me from, you know, being affected particularly.” Another HS respondent remarked “The actual content of the trauma that people might tell me about can, on some, not frequent, but some cases be upsetting. But for me personally, usually that does not bleed into my psyche that much. I have pretty good boundaries in that regard.” Although this statement also refers to empathic exposure to traumatic material, the therapist views their tendency to have good boundaries—this case referring to a psychologically protective mental boundary—serves to protect them when exposed to traumatic content. Another therapist
viewed having a good sense of boundaries was more related to being able to separate oneself psychologically from the client’s issues, or even from the client. This therapist remarked “I also have certain personal boundaries. So I know that their work is their work, and my work is my work, and I’m pretty good at keeping those two separate.”

Of note is the fact that all four of the therapists who mentioned boundaries were in the HS group. There appears to be between-groups differences when reporting the importance of self-awareness, with HS therapists being much more likely to have stated these characteristics were important compared to LS group respondents. This may be due to the reality that increased symptoms might demand increased self-monitoring to manage symptoms or that there were unidentified differences between the respondents which tended to elicit a greater focus from one group on these issues; differences which resulted in some individuals intrinsically being self-monitoring while others needed to be effortful to be aware. Another possible explanation could be due to differences in setting; perhaps the higher rate of private practice therapists in the LS might have led to less of a need to manage self-awareness. Regardless of these differences, it appears that therapists view self-awareness and an awareness of personal needs and boundaries to be instrumental when working with traumatized persons.

Connected to the importance of being aware of vulnerabilities, having boundaries, and knowing limits was the perceived importance of therapists having conducted their own therapy. This was mentioned by seven respondents (five HS and two LS), and was generally seen as important for two purposes: Developing self-awareness and resolving problematic issues which may generally interfere with conducting therapy, and working through past
traumatic experiences. Working through past traumas appeared to be seen as very valuable to prevent the therapist from being triggered by traumatic content similar to their own, by reducing the risk of counter-transference towards their client, and allowing the therapist to engage fully and effectively in the necessary work without interference from the therapist’s past trauma material. One HS therapist cautioned:

I know multiple people that I've worked with in the past and they go into a profession but they haven't done their own inner work and so whatever issues that have -- shame-based issues, unresolved issues they have can be acted out in transfers and counter-transfers in their own relationships with the patients. And that's not good for -- definitely not good for the patient because they're having to deal with a professional's personal issues and it's not good for the professional if they tend to just repeat whatever pattern that was unhealthy in their own family.

Clearly there is a strong concern that unresolved trauma on the part of the therapist can ultimately be harmful to both the client and the therapist themselves. An HS interviewee remarked “It’s okay to have had trauma experiences and work with this population, but it’s certainly knowing what your buttons are, knowing what area you might be kind of heading in towards that might be activating you in a way that you haven’t yet dealt with before.” Another therapist (LS) spoke of this in terms which suggested prior therapy would limit the risk of developing VT or STS, as well as would allow for effective therapy without interference from the therapist’s personal trauma history. This therapist reported:

I’m very adamant on this. If a therapist has not done their own historical glimpsing or processing, I think they are in danger of being overwhelmed, being frightened, and/or
being intimidated by stories that they might hear in their office. For example, I was severely traumatized as a child and I get extensive therapeutic work to facilitate myself. And now that I have done that, it doesn’t get in the way. My story doesn’t convolute with theirs. They don’t have something that overwhelms me. It doesn’t create any flashbacks and/or reverberations of my own stuff, my own therapeutic material. So I think the best thing that any therapist can do, regardless of whether they work with a trauma victim or not, is be sure that they have taken care of their own psychological material.

From these comments, it is clear that several of these therapists believed strongly in the importance of therapists having done their own therapeutic work, particularly in cases where therapists have experienced their own personal trauma.

Similar to being self-aware and aware of personal needs and vulnerabilities, respondents discussed the need for the therapist to have a clear identity as well as a comfort with that identity. Three of the HS respondents reported the need for therapists to have a “strong personal identity.” Another HS interviewee mentioned the need for a trauma therapist to have a degree of comfort with themselves as an individual, remarking “I think you have to be comfortable in your -- with -- in your own skin, around trauma...” Two additional respondents (LS and HS) stressed the need for therapists to value both themselves and their self-care needs. A second HS respondent stressed the importance of the therapist treating themselves as they would treat the client. Related to this was one HS respondent who stated the therapist should have a high degree of “self-compassion.”
In addition to the therapist being comfortable with oneself, it appeared that therapists should also be able to help the client become comfortable when working with them. Several respondents cited the importance of therapists possessing personal characteristics which would facilitate relationship building with the client, as well as characteristics which would be helpful in empathically connecting with a client and facilitating trauma processing. Some of these were also stated as being important for therapists in general, but were viewed as being particularly important when interacting with victims of trauma. Six therapists specifically mentioned the need for a therapist to have a high capacity for empathy (four HS and two LS), with another HS therapist stressing the importance of their being a very sensitive person. “I think that there are many really excellent therapists out there who have somehow either innately or through their own personal development have a strong capacity for empathy” reported one LS therapist. Three HS and one LS therapist specifically cited the desirability of a therapist who works with trauma to be either compassionate or caring, with two additional therapists stressing the need to have either an “openness” for their clients or to be an “open-hearted” person.

Other respondents focused on characteristics which would facilitate relationships with traumatized persons through acceptance of the client and by helping the client to build trust in the therapist. One therapist reported the importance of having “unconditional positive regard” for his clients, referring to an acceptance of them even in cases where they were victims who had also perpetrated on others. A second respondent echoed the need for acceptance of the client, despite the client’s presentation, including possibly difficult or abrasive characteristics. Non-judgmentalness was mentioned by both an HS and LS responder, and both an HS and LS responder also stressed the importance of the “genuiness” of the therapist. Genuiness was
seen as particularly important when working with clients who exhibited trust issues. One HS respondent, who worked for the Veteran’s Administration, stated “Being real, being genuine, and you know, people pick it up really quick whether you’re full of it and full of yourself and whether you’re there with them.” Another HS respondent stated “You have to have authenticity and tenderness to really -- to truly heal those places for people, and so, without that, it's -- you're not going to get very far in regards to trauma…”, with authenticity being viewed similarly to genuineness.

Protective characteristics such as the ability to appropriately detach oneself from others, set boundaries between self and client (mentioned above), or separate oneself from the process of trauma therapy were also frequently mentioned. One LS therapist remarked “I am pretty good at being detached. Their trauma tends not to get to me.” These characteristics were at times described within the context of actively preventing empathic exposure (will be discussed later in this section), but were more frequently coded as being a general characteristic of the therapist. “So I know that their work is their work, and my work is my work, and I’m pretty good at keeping those two separate (LS).” Two HS therapists mentioned separation as a protective characteristic, and two LS reported the ability to be detached from the client was protective.

Related to detachment or separation were codes related to the therapist being “cognitive” or analytical in their personality or approach. These codes referred to segments where therapists were discussing how cognitive or analytical approaches or personality characteristics serve as another protection from intense emotional content. One therapist remarked “I can be fairly, you know, analytical as well, and I think that’s protective as well as,
you know, I don't -- I think more, I can detach a little bit because my nature is to not be very reactive emotionally. I can do that if I need to, but I'm not basically that way.” One LS respondent described himself as being cognitive in nature, and a second LS responder described himself as being analytical; both viewed these characteristics as being helpful through limiting their empathic exposure to trauma content.

Being “Psychologically minded” was another characteristic reported by an LS interviewee, and this was described as being a trait which limited empathic exposure due to the therapists’ tendency to focus on the process of therapy rather than on the trauma content. This was also described as a trait which enhanced effective and intuitive work as a therapist, even when faced with complex cases or severely traumatized persons. Related to this characteristic was a responder who endorsed their “strong theoretical foundation,” and credited this for their effective work with trauma clients as well as their sense of confidence they can help. One responder (LS) cited “strong diagnostic skills,” and elaborated “I have pretty solid diagnostic skills, so most of the time I’m not surprised at what’s coming my way, which also facilitates it being a positive experience. So most of the time, ahead I will know whether or not I have the likelihood of being successful with them.” Another therapist (LS) endorsed the importance of therapists having a “clear understanding of trauma” to ensure their effectiveness. These responses suggest several therapists viewed clinical competence as being important traits, and through being competent the effective treatment provided helped to heal the client, provided a base of confidence for the therapist, and could minimize complications or failures in the therapy. It should be noted that similar responses were also coded and discussed in the Hope, Resilience, and Perceived Effectiveness theme. These codes were included in the personal
characteristics category if the code was in reference to a quality of the therapist, while other
codes referred to a developmental process where the therapist was acquiring skills,
competency, or developing the characteristic; or if the code was referring to a quality that
instilled hope and confidence that the therapist could be efficacious in the healing process with
the client.

Some therapists (three LS and two HS) reported valuing a strong sense of spirituality, and
believed this characteristic was useful when they engaged in therapy with traumatized persons.

One LS therapist reported:

I think there needs to be a spiritual dimension. I don’t think it needs to be an organized
spiritual directive, but I think there has to be some innate spiritual perception that says
life is bigger than I am, and I have access to that bigness, so I can share it with someone
who’s been traumatized. Otherwise, I’m going to feel limited when I’m up against what
is their terror.

Spirituality or a spiritual outlook was often viewed as a characteristic which could help the
therapist maintain a positive perspective, or could be utilized to provide a degree of hope for
clients. Having a sense of spirituality was viewed as a positive characteristic by these three
responders, but was mentioned by other responders in other contexts (as either a form of self-
care or as a mediator to help the therapist actively maintain a sense of hope or faith in
humanity). Thus, spirituality is another concept which bridged several categories dependent on
the context in which it was discussed.

Besides a sense of spirituality, other characteristics were seen as very positive as well as
viewed as facilitating therapy. Being characteristically optimistic was described by two
respondents as being an important factor when working with trauma. One of these therapist stated, “I have an overall sense of hope and some optimism that can I think carry me through dark times and I think that that can be reflected in my work with clients.” In addition to being hopeful or optimistic, another respondent described therapists who work with trauma as having “courage,” and another respondent stated their belief that being confident was a characteristic which also allowed therapists to engage in therapy with a hope and optimism which could be infused in the client as well. Two respondents added that a sense of curiosity in people was important, while another cited being dedicated to clients as important.

A final positive characteristic which was reported by five respondents was the importance of a sense of humor. Humor was viewed as important to help diffuse from stressful traumatic content, but was also seen as being instrumental in helping therapists maintain a healthy counter-balance to the frequent horrific content they are exposed to. One LS respondent stated “Humor, of course, is very important. Studies indicate that all the time, no matter who you’re working with. In any health professional, good humor is a very important relief.” Humor was also viewed as being a mechanism to be used outside of the therapy context, to help the therapist find a sense of enjoyment and positiveness in their everyday lives.

Not all characteristics described by therapist could be viewed as being helpful or positive; several respondents described personal characteristics which could be potentially detrimental, particularly when working with traumatized persons. One therapist (LS) mentioned being personally “high strung,” and referred to this within the context of an increased need to practice self-care and to set boundaries. Another therapist (LS) warned that therapists who could easily visualize descriptions could be at increased risk when being exposed to traumatic
material. Finally, two HS interviewees reported that the characteristic of being a “rescuer” could place therapists at risk if they were not cautious and aware of these tendencies. One of these interviewees stated “A lot of therapists are rescuers, including me, so having a real solid grounding of who you are and why you’re in the field and what your job can do and what your job can't do.” The other interviewee mentioning “rescuing” characteristics stated “I think people who are real rescuers and want to fix it all and to save them and that you’re going to probably be burned out.” Thus, although negative characteristics could place the therapist at increased risk when exposed to traumatic content, these respondents also express that an awareness of these traits can allow those at risk to modify their behavior to alleviate these negative effects.

**Therapist Development**

The therapist development theme includes codes referring to temporal processes connected to changes in therapist characteristics, therapist perspectives, efficacy in self-care, or perceived improvements in their effectiveness working with trauma clients. This theme also includes changes over time in the workplace setting, barriers to self-care, or use of support. The Axial codes which helped form this theme included reported changes in self-awareness and awareness of others, awareness of the impact trauma work was having on the therapist, recognition of the need for self-care, and becoming more skilled at engaging in self-care. Also included were codes referring to learning or obtaining heightened therapeutic skills which allowed for personal confidence and efficacious treatment, or new approaches which altered the degree of traumatic impact on the therapist. A final note is that in several instances, open codes which eventually formed this category were similar to codes included in other categories;
these were coded (and discussed) in the development category when these codes referred to a factor which changed or transformed over time. As noted earlier, the interview question “In what ways has the impact of working with traumatized persons changed over time? Has your view or use of self-care skills changed over the course of your career?” was added to the interview due to the initial two therapist interviews, where both respondents reported experiencing a personal developmental process which altered their use of self-care skills as well as their responses to trauma content. The inclusion of these questions, in response to information obtained in interviews, likely led to more and richer responses providing thicker descriptions related to change over time and developmental processes.

The development of self-awareness often occurred in response to therapists initially either having difficulty in the role of being a therapist, or in cases where therapists were being heavily impacted by being exposed to traumatic content. Several interviewees (four LS and four HS) reported initially being highly impacted by their work with trauma victims, and described experiencing a high degree of distressing symptoms during early portions of their careers. One LS therapist remarked “I think I used to be affected more, than I -- I've been in -- I've only been doing this since 1996, about 16 years, and I certainly think I, yeah, was affected more in the earlier years than now maybe because, see, I have been around it so much more. You know, it's not novelty anymore in that sense.” Another therapist described the process through which they discovered what form of self-care was ideal for them, due to the early impact of their work with trauma. This therapist stated:

I can remember way back when I used to work in the community mental health center and I was in private practice, I was getting a lot of headaches, I was getting a lot of body
aches. And I started to realize that I had to do physical things because otherwise -- you
know, I started to realize that I was holding too much in my body. And you know, so I
started doing runs and triathlons and to do things that were a good outlet for me.

This therapist describes a process of discovery in response to the recognition of the need due to
their negative symptoms.

Two HS respondents specifically described the developmental process they engaged in as
being “trial and error,” which occurred over an extended period of time. Again, this process was
engaged in in response to recognition of personal distress; or in these descriptions, a
perception of being “burned out” after working with traumatized persons. One respondent
described being “burned out” due to the number of clients she engaged with, and talked of the
process she engaged in to find a better fit for herself:

The first time actually -- the first time I was burnt out, I felt when I came out of graduate
school that like if you were working in a clinic, you should expect to work really close to
40 hours a week. And I’m not capable of that. My good -- probably my good number is
about 25 to 27. And we just kept like backing it off. I had a great secretary and she was
just back it off. But let’s see, a week or two of you know 29 to see if that works. Nope,
that’s not working. Let’s do a week of 27, see how that works. And we would just back
down, back down till we get to 23. And I would just finish till 23 which was nice.

This therapist describes utilizing a gradual process to discover the number of clients who could
be engaged with without the therapist experiencing negative consequences. Another HS
therapist describes a similar developmental process, again in response to distress early in her
career:
Yeah, I think I’ve got really much more self-protective. I think I thought I was an inexhaustible resource. I just burned. You know, I can do this, that, and the other. And burn the candle at both ends and I’ll be just fine. And I burned out pretty badly on three occasions early on. And then it was kind of like, you know what? This isn’t working. I can’t do this. And then I kind of had to stop. So yeah, I mean I think trial and error.

You’ll have to remember I’m 27 years into this now. So yeah, trial and error.

The common theme appears to be a recognition of being “burned out” or exhausted, and recognition of the need to form an effective response to manage these symptoms. In the cases of these therapists, they utilized a “trial and error” method to fine-tune what was appropriate and manageable for them.

Development of self-awareness in terms of personal perceived vulnerability or perceived weaknesses was also reported by nine respondents in total: four LS and five HS. One HS interviewee discussed this recognition of vulnerability as being an integral factor in their recognizing the need for self-care, stating: “Well, I think some of the self-care is realizing -- you know, I think there’s certain points in your career when you come to realize, you know, you’re just as vulnerable as anybody else is, you know.” Other responders described their transition from being insecure and vulnerable therapists to becoming confident and skilled both professionally and in terms of protecting themselves. One LS therapist talked of how difficult it can be early in a career to admit vulnerability; she also described the difficulty in letting others know of her perceived struggles when working with trauma. This therapist stated “I think sometimes initially maybe early on in my training as a young therapist, sometimes you’re kind of afraid to admit that you know, wow, I’m overwhelmed with that because you want to appear
you know, really competent and strong professional.” Therapists reported they were unsure of their skills, “eager to please” their supervisors, were initially full of self-doubt...but were able to overcome these characteristics over time and through obtaining experience and skill. Of note is that five of the seven HS respondents elicited coded statements suggesting vulnerable personal characteristics changed over time, while only two of the LS therapists reported similar statements. It is unclear of this is due to personality differences between the two groups, to differences in experiences/ settings which exposed earlier vulnerabilities, or if being less presently impacted by trauma work influences personal perceptions and reflective response content.

Several therapists reported they discovered the need for self-care skills, or were already aware of the need for skills but learned to practice these skills in a more effective or efficient manner. These respondents described a process which seemed to be connected to their development of self-awareness; specifically the recognition of the need to engage in self-care activities to manage their personal distress when they are exposed to client’s trauma content. In this case, however, the self-awareness became translated into action; the commitment to utilizing personal protective skills to manage their distress. One LS respondent stated “I didn't know initially how to practice them. And I only learned it over time, and, yeah, out of necessity and maturity and experience.” Another LS interviewee described not only recognizing the need to practice self-care activities, but also the need to make these an important part of their identity as a therapist. This interviewee stated “I -- the older I've gotten and the more experience I've gotten, I recognize the necessity for them, and I recognize the priority that they need to have, and so, yes, the more experience, I become -- I've made it more of a priority.”
Another respondent from the HS group specifically referred to this as an evolutionary process, reporting “So back then, I was working more, taking care of myself less, you know. So I would say that the evolution of self-care has been that I do more of it now. And you know, that’s just been more of a focus over time. It’s been more of a necessity.” Yet another HS interviewee discussed their recognition of the need for self-care, but in this individual’s case they specified the recognition for specifically individualized forms of self-care: “And I started to realize that I had to do physical things because otherwise -- you know, I started to realize that I was holding too much in my body.” These respondents provide evidence that developing self-care skills is often a dynamic process, initiated by their recognition of the need for self-care and continuing to evolve as the therapist gains experience. These therapists appear to not only recognize the value of these skills, but they also appear to increasingly prioritize these skills as they mature as therapists.

Another form of therapist development consisted of the evolution of therapeutic skills and techniques. In these cases, the development of therapeutic skills was coded differently from other references to skills or techniques if they were discussed as changing/evolving/or improving over time. In some cases, therapists talked of their approaches as being both static and dynamic over time; for example, one therapist stated “I think theoretically, I’ve kept the same approach over the years. Some of my techniques have altered over the years. I’ve honed and refined and integrated a lot of different tools.” Therapists discussed the importance of becoming increasingly competent in utilizing therapeutic techniques, and how this increased competence allowed them to become more efficient and confident in their work. One respondent (HS), discussing their rapid emersion into working with large numbers of
traumatized persons, stated “So I had to do a lot of kind of trial by fire. But I had to do a lot of learning really, really fast and really quick.” This therapist described being overwhelmed at first, but as they gained experience and competence they felt much less overwhelmed, much less distressed. When taken as a whole, these comments suggest that as therapists gain skills and experience, and as they add to their repertoire of techniques and refine their theoretical approaches, they become increasingly effective at their work as well as increasingly confident in their abilities.

Therapists also discussed development in relationship to personal characteristics; these were differentiated from open codes which helped build the personal characteristics theme alone due to therapists reporting their personal needs to learn or evolve important characteristics over the course of their work. For example, one therapist (LS) stated “I think a spiritual, some sort of spiritual foundation, which I have not always had, that's also something that I've grown into as I've aged. I think a spiritual connection is really important and only benefits the work that we do.” This therapist describes a characteristic of self, but one which has changed over time and has become beneficial to her work with traumatized persons. Another respondent (HS) reported “...you learn to have boundaries. I think you need to learn to do really good self-care,” indicating that these characteristics had to be developed over time. Others described becoming less judgmental individuals over time due to their work with traumatized persons; more realistic about recovery, more positive about their clients, etc. The common factor in these statements is that therapists reported recognizing that often the characteristics they value have become modified over time, either through their work with trauma or through a separate or partially connected personal maturation process.
The respondents in this study also reported experiencing changes in the personal impact when exposed to traumatic content through processes of either experience or desensitization. As referenced earlier, one LS therapist revealed “I think I used to be affected more, than I -- I've been in -- I've only been doing this since 1996, about 16 years, and I certainly think I, yeah, was affected more in the earlier years than now maybe because, see, I have been around it so much more. You know, it's not novelty anymore in that sense.” This therapist later repeated her assertion that the “novelty” of the traumatic exposure had decreased, but also provided comments about her perceived increased effectiveness. She reported “-- like I said, in the beginning, it was more of a novelty, and, I guess, at this point, I look at life and I know that, behind what you see, there's always something different than what you think is going on. And I guess maybe I see life more realistically or than I used to be.” This statement suggests that not only had desensitization occurred, but a degree of increased insight, or perhaps wisdom, had been obtained as experience was gained.

A result of the increased experience and competence appears to be a perceived increase in the therapist’s ability to instill change in the client, to help the client heal from the traumas they experienced. This sense of increased efficacy over time also appears to instill an increased sense of hope in the therapist, as they increasingly witness client recovery and healing. An LS therapist described this process as “So over this period of time, I can truly believe that people can go on to have healthy and happy lives and good relationships and not be defined by this bad thing that happened to them. Where earlier on I didn’t have as much evidence to base that on, so I think that’s been kind of nice to see.” This is evidence that as therapists gain skills and experience, they are likely to witnessed increased client improvement; they are also likely to
attribute this in part to their abilities as therapists. Witnessing increased improvement will likely lead to increases in positive perceptions concerning themselves, their clients, and the trauma work that is engaged in; this would likely then serve as a protection against possible negative consequences of this work, such as developing symptoms of STS or VT.

Taken as a whole, there is strong evidence that therapists develop in multiple realms over time; personal characteristics change, self-awareness may improve, and their recognition of personal risks and needs when doing trauma work develop or increase. Therapists also gain experience, knowledge of effective approaches and techniques, and knowledge of effective self-care, as they may simultaneously experience a decrease in reactivity to trauma through desensitization. The obtainment of skills and experiences also appears to decrease reactivity as therapists gain the confidence that they can help despite what the client has experienced, and the therapists becomes less anxious or apprehensive about the process of therapy with the traumatized person.

**Self-Care**

The therapists interviewed in this study almost universally reported utilizing self-care and protective activities and techniques and generally viewed these as being instrumental in coping with the stress of their work, maintaining balance in their lives, and defusing from the traumatic content they are exposed to. Thirteen of fourteen reported these skills being personally important, with the remaining LS therapist discussing these skills as being of importance to therapists in general but not necessarily important to himself. Additionally, these respondents not only viewed these techniques as being very important, they described how these skills were
often routinely practiced, as well as the fact that the majority of respondents made the use of these skills a priority in their lives.

Self-care was viewed as belonging to several distinct categories, and several therapists appeared to be particularly attuned to a specific category while others utilized a broad range of skills. The most common activities mentioned involved physical activities and exercise, with ten of fourteen respondents citing exercise as being very important and an additional two respondents citing activities involving a component of physical activity (gardening, yard work) as being important. Exercise was often discussed in terms of the stated activity being of value to the individual by itself, but more commonly activities were described in connection with the perceived benefits of the activity. For example, one interviewee (HS) commented “A lot of the stress that I might pick up during a course of a day, working with people, is taken care of if I can play tennis. My wife tells me, every once in a while, “It’s time for you to play tennis.” Another HS respondent asserted “Because I’m a very physical, my body is a very physical body, and so I have to do physical things. So I have to work out a lot. I’m a cyclist, so I have to ride my bike a lot. I have to -- I mean, it’s not really a choice. I have to attend to that.” It should be noted that some activities mentioned (such as the afore-mentioned tennis) would involve other persons; but when these activities were mentioned the respondents appeared to be focusing more on the value of the activity rather than the value of corresponding social activity. One HS respondent was very explicit about the importance of exercise in relation to his work as a therapist, explaining “I think what becomes very exhausting is just the containment piece, just being a witness to their stories and just being able to -- we contain so much of their affect a lot of times. I feel like working out is a balance for me and has helped me balance me out.”
respondent also mentions the importance of being in balance, which has already been mentioned in the context of being a valuable personal characteristic and will be discussed further in this section. From these comments, it is clear that physical exercise and activity is highly valued by many therapists and appears to be one of the key activities in regulating the impact and stress associated trauma work.

Two respondents mentioned yoga, which is an activity that could be viewed as bridging physical exercise and other activities such as mindfulness/meditation or even relaxation. One of the persons (LS) discussing yoga stated “Whatever that release is, so physical, for sure and for me it's yoga. I've been a practicer for five years, I am very high strung so that is vital, it's quiet and stillness and centering for me.” In this case, the respondent specifically mentions one realm of benefit for her, but it is likely there are additional unstated benefits (the physical exercise, stretching components). This is also likely to be occurring with other skills or practices in this discussion, where utilized skills or practices may have multiple varying benefits. For simplicity purposes, however, self-care factors will generally be discussed as somewhat distinct factors within this analysis.

Connected to physical activity were relaxation activities which respondents reported utilizing purposefully to decrease the amount of physiological stress they experienced. An interviewee discussed the importance of these activities for her reporting “Mindfulness. I think meditation, certainly, breathing, deep breathing, relaxation breathing, balance, like other activities, yeah.” One respondent reported engaging in frequent massage therapy as well as weekly pedicures; the main goals of these activities were primarily for relaxation purposes. Three other respondents (two HS, one LS) specifically reported actively using relaxation
techniques, or engaging in more general activities that produced relaxation for the purposes of managing the stress derived from their work.

Physical self-care was also discussed in terms of healthy living strategies aside from exercise. One HS respondent mentioned the importance of monitoring their nutrition, and stated they viewed this as being important in regulating their stress and reducing any negative impact of working with traumatic content. Proper nutrition was also stressed by a HS second respondent, who also stressed the importance of getting healthy sleep; a third HS respondent specifically mentioned the importance for themselves of receiving healthy sleep.

Many respondents reported that engaging in recreational activities was very important to them, particularly to maintain their sense of well-being and to cope with the difficulty of their work. Recreational activities were discussed as serving two general purposes; the first being as a distraction for the respondent, which allowed them to forget the stresses or worries of their work; or as activities which produced a sense of pleasure or enjoyment. Recreational activities could include reading (two LS respondents), watching movies (HS), listening to music (two HS) or playing music (HS). An LS interviewee reported engaging in distracting but engrossing activities, specifically mentioning Sudoku puzzles as being beneficial. Another LS respondent stated she found “intellectual and cultural activities” to be very important for her in terms of self-care, but did not elaborate on what some of these activities might be. One LS respondent discussed why she generally values “play and recreation,” stating “I think play and recreation is very important, creative play, whether it’s gardening, whether it’s a sports activity, or whatever that truly engages portions of their neurological systems and their spiritual and physiological systems so that the whole person can engage in other activities that are separate from the
trauma material.” In addition to naming specific activities, three respondents (all in the LS group) provided general remarks about the importance of a person “enjoying life” to help counter-act some of the difficulty of their work. For these respondents, recreation appeared to serve multiple purposes; as a vehicle to reduce distress, a method to elicit a sense of fun or positive emotion, or a distraction from distress or more troubling thoughts.

Several respondents discussed the importance of maintaining a general balance in one’s life, particularly in terms of having a balance between the work as a therapist and having a life outside of this work, or of balancing the workload itself. Five respondents mentioned the importance for themselves of maintaining a balance in their work; this is suggested to be a combination of having manageable caseloads (according to their personal preferences), the ability to engage in stress diffusion through breaks during the workday, and to have adequate time outside of work to participate in valued activities and self-care. One LS respondent stated “I’ve been able to, in a much better way, kind of regulate my own stress levels in terms of how I schedule clients, et cetera, et cetera, how I conduct my week. I work like Monday through Thursday, pretty long hours, pretty intensively, but then I have three days off so I balance out the work with time off and really getting away from the intensity.” Notably, of the five respondents discussing workload issues within the context of self-care, four were engaged in private practice and were in the LS group. It should also be noted that workplace and time demands were noted by other respondents, but their statements were often discussed in the context of these factors being barriers to self-care rather than factors they believed they actively and healthily managed. A sixth respondent (LS) discussed the importance of time management (without specifically referring to their workload), referring to the need to ensure
they had sufficient time to engage in valued activities. These statements provide evidence that balance in the workload is important, but obtaining this balance may be much easier if an individual is in certain settings such as private practice.

The theme of balance also included the need to have a “life outside of work,” and to engage in activities which provided a separation from their work with traumatized individuals. Five respondents specifically cited their need to have social contacts both outside of the workplace and who were not engaged in a related profession. These respondents viewed these contacts as persons they could healthily engage with in enjoyable activities who would also provide a separation from their identity as therapists. One (LS) therapist stressed the need to “Make sure you have a strong support group, good friends and you’re connected to good things going on in your life.” Another LS interviewee asserted “I have always felt that I needed to have friends that were not in the social work therapy business. So I love having people who I don’t talk about, you know, the trauma and we can talk about other kinds of things.” These persons were viewed (and coded) differently when compared to individuals discussed under the “supportive persons” theme, where persons maintained the roles of being professional supports or persons with shared therapeutic experiences who could help the respondent process issues. In other words, for self-care purposes several respondents cited the importance of having persons in their lives who served not as professional supports but instead persons they could engage in on a non-therapeutic level and whom could help them diffuse from the stress of their work.

Maintaining a balance in life also included the need to purposefully counter-act the impact of being exposed to trauma material, or to avoid unnecessarily exposing oneself to
negative material outside of the context of therapy. One HS respondent stated “When I’m really in the middle of some pretty dark trauma work, I tend to not watch darker movies, you know. I tend to lean more towards comedies and I need to laugh.” Another HS respondent stated they engaged in a strategy of purposefully avoiding stressful individuals or situations in their life when they recognized they were dealing with particularly difficult stress from their work with traumatized persons.

Some of the respondents specifically stressed the importance of activities which entailed solitude or a personal connection with nature. Two respondents from the LS group reported being actively engaged in nature was important for them to maintain a sense of relaxation or well-being. One of these LS respondents stated that “I live in the woods, we live in the woods, so I have -- I do have plenty of -- I have time by myself, which I need, and, you know, I enjoy nature and my birds, my plants.” Another LS interviewee echoed this, asserting “I’m a naturalist, so nature is very important to me. If I was sitting in a dark room without windows and couldn’t get outside in between each of my clients, I’d be far less effective than I am.” A third responder from the HS group stressed the importance of “alone time,” particularly when dealing with a very high stress-load or difficult clients. These responses highlight the variability and individuality of valued skills; for these responders, being able to isolate appeared to bring them a sense of calm or even serenity, while for other individuals (or even in other contexts for these responders) active and/or social activities would be more effective.

Five respondents (three LS, two HS) mentioned spirituality as being very important for them when engaging in work with traumatized persons. Spirituality was generally described as something respondents actively sought out when distressed; they reported engaging in spiritual
activities served to “ground” them, to reduce distress, or to keep their lives in perspective. Mindfulness or meditation were also mentioned by three respondents (one LS group and two HS group), and were discussed as serving a similar purpose to spirituality. All of these factors were also discussed as being essential for the therapists that valued them to maintain a sense of internal peacefulness. One respondent (LS) described the value for her in the following words: “As a meditation teacher, now I find for me to be able to observe myself and my thoughts, I think, is really important, so to be self-aware and then deal with things as things come up for myself.” Another respondent mentioned the value of spirituality for her in the context of a balanced life, asserting “At times in my life that I have had significant personal stress, my ability to concentrate and to focus is impaired, and so it’s really important to make sure that I continue to do what I can to reduce that kind of personal stress, which I think goes through activities but also spirituality and reliance on close friends and husband, family support, that kind of thing.” For these respondents, engaging in spiritual, meditation, or mindfulness activities seem to anchor them and restore a sense or equilibrium or peace.

Two respondents reported that vacations were very important to them. One respondent stated “I’ve always been a big advocate for vacations, big on vacations. And so, you know, I would always take my kids and go on vacation even though we didn’t have a lot of money. We’d go do something fun.” Another interviewee stated “And then every so often, I get really burnt out and then I just have to back off for a while. Going on vacation I think is key.” Based on these comments vacations appear to provide multiple self-care purposes; as recreation, as escape, and as social activities. Another LS respondent described her experience as “But time, freedom has always been paramount. And so being self-employed and self-directed in that
regard, I have pretty much orchestrated what I need to take care of myself...Now as an older person with grandchildren and some nice gardens, I take the liberty to say, “You know, I will in the summer take every fifth week off.” And that is self-care for me.” This suggests vacations, or “time off,” can also provide for relaxation as well as a sense of freedom (likely connected with the “escape” function).

The evidence provided by these respondents suggests that self-care skills are widely utilized and highly varied across individuals. Different skills appear to serve different purposes, from providing physical relief from body tension, helping the therapist to diffuse emotional distress or to distract from the distress, or to help increase a positive emotional state whether this is a sense of connection, joy, or calmness. These respondents indicated these skills and activities are viewed as both utilized and highly valued, as well as being perceived as an integral component of their general work with traumatized persons.

**Personal and Professional Support**

Several respondents discussed the importance of receiving personal or professional external support to maintain their personal effectiveness as trauma therapists. These sources of support were varied, and included peers, friends and family, supervisors or other organizational persons, or individuals functioning as consultants. Ten of the fourteen respondents discussed their perception that external support was a very important to their functioning effectively as well as coping with the impact of being exposed to traumatic content. Interestingly, all seven persons in the HS group discussed the importance of external personal and professional support, while only three respondents in the lower scoring group mentioned the need for such support. This disparity could indicate therapists seek out increased support when they are
experiencing more symptoms; that personality differences might lead to seeking external support and might make the therapist more at risk; or might be due to differences in workplace settings (approximately twice as many private practice therapists in the LS group). This will be further discussed in Chapter 5.

The most common open codes within this theme related to the importance of consultation. Consultation was mentioned by eight respondents (three LS and five HS), all of whom discussed the importance of having mechanism to engage in consultation as part of their work with trauma. Consultation could take on different forms for these respondents; a formal or informal consultation group, individual peers within or outside an agency, or consultation with a supervisor or administrator. One LS respondent stressed the value of consultation by stating “Peer consultation groups, to me, is one of the most important things that I've done to take care of myself in my practice.” An HS respondent discussed both the importance of consultation, but also stressed the importance of consultation in managing the impact of trauma work on the therapist. This respondent asserted “I think as a therapist especially working with trauma that you have someone that you could talk to another person that you can at least have that is aware of the cases that you’re working on and how what your reactions, that you can process reactions outside of therapy.” Another HS respondent echoed the importance of having access to consultation, again stressing the additional value of being able to debrief when exposed to particularly difficult trauma content:

I have not been in like an actual sort of therapist support group, but definitely I’ve always working in a facility where I’ve had colleagues to consult with, to even debrief with. I remember after some really tough sessions, needing to go into one my
coworker’s office and just cry, just let them say, “I cannot even believe that just to be connected to your humanness again” and have them bear witness to that a little bit. These therapists report that effective consultation appears to be vital for them to diffuse much of the stored emotional impact which can result from trauma exposure. Comments by these therapists also reported that consultation was viewed as being effective, and part of what made consultation effective was engaging in the process with others who shared similar experiences; others who had an idea of what the therapist was experiencing and what was needed by the therapist.

Closely related to consultation were peer support groups, either formal or informal. Based upon the respondent’s statements, there is likely significant overlap between the function of consultation and peer support groups; the differences primarily being that consultation seemed to involve more formality or structure, particularly when occurring within an agency. Peer support groups, however, tended to be informal meetings, often involving peers who shared a degree of friendship; these groups seemed to be generally more open to discussions of emotional content and personal challenges occurring outside of the therapeutic realm. Four respondents (three LS and one HS) reported belonging to a support group, and these were seen as being important both to receive professional advice from in an informal setting as well as to be able to express one-self to with individuals with similar experiences. One respondent described in detail the formation and function of a valued peer support group:

I was doing a survivors group, so people knew, people were referring people to me, and stuff like that. So people knew that I did that kind of work, so they were calling me, having lunch. We were consulting about cases and things like that. So after a while, I got
this idea that I would just pull these people together and we would have a peer group.

So we did that, and we used to have meetings for like 20 years. And that’s been helpful too because we talk about cases, but we also talk about practice issues, we talk about personal issues, taking care of ourselves issues. You know, we’ve gotten to be very good friends, of course. But friends about -- friends who know about things in work, which is different than other friends. So that’s been really, really helpful.

As can be seen in this statement, these groups can be very strong sources of support, and can provide functions far beyond what would typically be provided in simple consultation. Another respondent added that they valued the peer support group they belonged to because it provided a safe environment to discuss personal challenges and to discover “blind spots” they did not recognize were present.

In addition to the importance of consultation, five individuals reported they found the ability to debrief to be very important. As mentioned above, debriefing was described as an activity where therapists were able to process their emotional reactions or as a mechanism of releasing contained emotional distress through a supportive outlet. One respondent stated “We would just bring some of that stuff up too and just basically just air it and usually you know, there was a sense of yeah, I hear what you’re saying.” Another respondent discussed the value of being able to debrief on a daily basis, due to the presence of another therapist she had daily contact with. Three LS therapists and two HS therapists reported debriefing (by itself) was important, with an additional four statements about the importance of debriefing being coupled with other contexts (such as debriefing as part of a support group). Debriefing appears
to be seen as an important tool to prevent distressing content becoming chronic (such as in STS or VT).

Two HS respondents did not specifically report the need to debrief, but verbalized the importance of having persons they could engage with to either express their emotions or to receive emotional support from. These individuals were discussed as being “supportive peers,” and were discussed as persons close to the individual who also worked as therapists. Four additional respondents reported the desire to have someone they could talk to who understood the challenges they experienced. Another two mentioned the presence of “supportive peers,” and stated these relationships were very helpful to manage their experiences when working with trauma. One of these respondents described this dynamic as “I would pretty well talk to the people that were around me. I mean, I would -- we were -- a lot of the things about -- we were really open. You know, we had a real caring for the caregiver attitude.” One of these reporters also stated supportive peers served an important function by recognizing when she needed to practice self-care skills. A final two respondents discussed the importance of having supportive persons in their lives who had similar or shared experiences to the therapist. These therapists believed persons who were also exposed to traumatic content had a better understanding of their experience, their struggles, and what would be helpful for the therapist. Based upon the evidence the respondents provided, it appears peer and collegial support is very valuable to help process distressing content as well as to support self-care and recognize when a therapist is experiencing difficulties. It also appears to be important for these support persons to be accessible, to have a sense of what the therapist is experiencing, and ideally to have had experiences similar to the therapist.
Supervision or leadership was mentioned by three respondents (two HS and one LS), with these persons expressing the importance of having effective organizational personnel who could help to reduce the impact of traumatic exposure. These respondents viewed effective leadership or supervision as fostering a supportive work environment, recognizing what the needs of the therapists were, and providing a structure where therapists felt they were safe to express their needs. Strong or effective organizational support was also mentioned by two persons in the HS group, and was described in similar terms. One important note is that four respondents also mentioned supervision as being detrimental to their self-care and work with trauma; several more mentioned workplace stressors as detrimental (these are discussed below in the barriers themes). What these comments suggest is that supervision and the workplace culture play important roles in preventing VT or STS, but can also be factors that increase the risks for therapists.

Although social support was often discussed within the realm of the workplace or therapist community, support from outside these spheres was also expressed as being important. Four respondents (two each of the HS and LS groups) discussed the importance of having strong friendships or family support. An additional respondent simply stressed the need for “strong social support” outside the workplace, and another respondent stressed the importance of having different friends outside of the therapy profession. These respondents viewed these connections as being important and serving some similar function as the debriefing with colleagues or peers: However, these external support persons were seen as individuals who could be connected with and who could provide a different experience.
compared to work peers or other professionals. These were persons who could ensure the therapist had a “life outside of therapy,” and who were not associated with trauma.

What is clear from the evidence provided is that external support is viewed by the majority of responders as being very important. Not only does external support often serve the purpose of consultation or discussing therapeutic issues such as treatment challenges or countertransference, but varying forms of external support appear to be invaluable for debriefing or diffusing the emotional energy accumulated from working with traumatic material. The role of debriefing or “having someone to talk to” may be even more effective when the external support has shared or similar experiences. External support may also be of value if the support is not connected with the psychotherapy profession; in these cases the external support may still provide a form of diffusion, but also serves as a means whereby the therapist can connect with positive persons not associated with their trauma work; these persons seem to help the therapist connect with a different community, and perhaps allow a form of positive escape.

**Empathic Exposure to Traumatic Content**

Perlman and McCann (1995a) discussed the risks of empathic exposure to traumatic material, stressing that the nature of psychotherapy-the need to empathically connect with the traumatized client-puts therapists at particular risk when they are exposed to traumatic content. This risk is largely due to the nature of the exposure, which occurs on a deeply emotional level, and opens-up the therapist somewhat to the experience of the client.

The respondents in this study largely appeared to have a different perspective when compared to Perlman and McCann’s perspective on empathic exposure to traumatic content.
Several members reported experiencing symptoms similar after repeated exposure to traumatic content which could fall under the conceptualization of VT. However, these therapists also tended to describe the dual presence of positive symptoms were not consistent with VT or STS. In fact, several therapists credited empathic exposure with improving themselves as therapists and human beings, with instilling positive schemas or beliefs about the world, and generally with helping them become more positive or connected with others. This collective evidence will be discussed in detail within this theme.

One important clarification regarding this theme is that many of the open codes which led to the eventual creation of this theme were similar to open codes included in the therapist sense of hope, optimism, and effectiveness theme. Items were coded (and now described) under this category when the information referenced was related directly to exposure to trauma content, the positive or negative impact of such exposure, or a reference to a characteristic immediately connected to trauma exposure, rather than a less direct statement concerning the generalities of working with traumatized persons. For example, a statement such as “when I hear about what they have been through, I feel great compassion for them” is referring to a status triggered directly by exposure to traumatic content, while “I believe my work has made me a more compassionate person” refers to a characteristic obtained through the experience of working with trauma.

Several therapists reported they had experienced strong emotional reactions when exposed to traumatic content. Five therapists in the HS group reported being personally impacted, while two from the LS group reported this. The words used to describe this immediate emotional impact were quite varied and often powerful: Disgusted, anger, upset,
disbelief, difficult to hear, helplessness, amongst others. One HS interviewee, who had only had one year of experience working with traumatized persons, stated:

It’s really hard to separate myself out and to sometimes keep firm kind of boundaries with my countertransference, especially like feelings of you know, just feeling angry. I’ve felt myself just really -- just kind of in shock and disbelief about some of the things you hear. And also just upsetting as well. I mean, sometimes you just hear stories that are so upsetting that it’s really difficult just to put into words.

Another HS respondent described his sense of anger and injustice when working with traumatized combat veterans. He reported:

I could almost only shut it off. I could almost always leave work and shut it off. But there were times where I would just kind of feel you know, just kind of a sense of maybe fatigue myself and in combination of anger and felt like things weren’t maybe fair and just, you know, for what some of these guys were going through. So there were sometimes some kind of an anger, that kind of being just of all the stuff they had to face.

These respondents effectively articulate the emotional impact which can occur when bearing witness to traumatic material; they also illustrate that this impact occurs not only in the moment, but can also linger with the therapist over time. The impacted therapists sometimes experience this on an even more visceral level, such as through intense bodily sensations. One HS therapist commented “I mean there was times -- there would be times when I would be listening to someone’s story or so and out of you know, out of almost no reason, I would find myself crying.” One HS respondent vividly described experiencing symptoms suggesting STS
was present (and even self-identified STS). This respondent reported “...a few years ago, I would just get these pictures in my head and they would like keep me up at night. It was almost like a trauma happened to me but it didn’t. It was that secondary trauma stuff that it was just crazy how upset I could get with my own picture I didn’t see there.” Clearly, many of the respondents recognized being personally impacted on a deeply emotional level through being exposed to traumatic content.

One impact of this exposure, particularly if the emotional exposure stays with the therapist, appeared to be a sense of exhaustion or fatigue. Three HS respondents described this, using various descriptive words including feeling fatigued, exhausted, or drained. Another HS respondent stated she used to feel “brittle” after being exposed to particularly horrific trauma content. Another HS interviewee reported that particularly difficult cases would sometimes create a lingering sense of hopelessness, which she would have to work through using colleagues and self-care skills.

The unique roles therapists have in their work, the fact that their role—their responsibility—is to help another human being heal from experiences which have been horrific, also appears to contribute to some of the impact intensity. One HS respondent described experiencing a sense of fear at times that they would not be capable of helping the client; that they “can’t fix” the person due to what they have been through. This therapist described placing a high degree of responsibility on themselves for “repairing” the client, and reported this increased their distress when engaging in their work. Another therapist asserted that the intense emotionality was in part due to their being in a position where they were privileged with the client’s story; that they were often the first person the client had opened up to about what had occurred. This therapist
explained “It’s an emotional piece for me that’s been most difficult for me to -- and just hearing some of the stories and knowing that a lot of other people don’t hear their stories and that we’re the sometimes the first person to hear some of their stories and bear witness to them the first time.” Yet another HS interviewee reported that they often experienced realistic concerns about their client’s safety, such as in cases of domestic battery or where the client was still at some degree of victimization risk. Not only was the therapist exposed to the traumatic content of past events, but they found the actual possibility of present danger interfered with their ability to let go of the distress from the exposure. A fourth HS respondent described the lingering impact which was particularly present when he worked with female clients, stating “I think there’s a little bit of trauma that you take away with you particularly with the women because they’re -- a lot of the traumas happen when they were children, much younger and so hearing those stories and, you know, I think you feel a sense of helplessness.” Based upon the comments of these therapists, it appears that the unique position therapists find themselves in might contribute to the intensity of the empathic exposure. The sheer fact that therapists are in a position of great responsibility, that they are privileged to information which has often been “locked up” by the client or been kept secretive; and the perception of client vulnerability seem to contribute to an increased risk of lingering therapist distress.

Several therapists (two LS and four HS) reported therapist qualities could place them at increased risk of developing negative symptoms when exposed to traumatic content. The primary characteristic, a high capacity for empathy, was discussed by one LS and three HS respondents. High degrees of empathy appeared to be seen as positive in terms of forming effective relationships with clients and being an effective therapist: However high empathy was
also viewed by some as putting the therapist at increased risk. One interviewee (LS) asserted “I think that there are many really excellent therapists out there who have somehow, either innately or through their own personal development, a strong capacity for empathy. And I guess it’s a double-edged sword when you’re working with trauma. And I think those people have to be very careful.” Another respondent (HS) stated “I think being a really compassionate, empathic person who loves people, it totally opens you up to burning out, to being traumatized, to you know, really having this stuff get under your skin.” This, again, is the “double-edged sword” alluded to by the earlier respondent; the very factors which might make a therapist effective in their work may also increase their risk of developing STS or VT. Another therapist expanded on this concern, arguing “But that capacity to empathize, also sometimes people have an innate capacity to visualize, and they may see things that are distressing and very, very vividly. And they may not be able to -- like sometimes you can’t get a song out of your mind, you know, going around in your head, you know, that visual imagery may not just go away when they leave, go home, and so forth.” Thus, these respondents caution that individuals who have a higher capacity to connect with another’s experience, on an emotionally empathic level or even on an imaginatory level, might be impacted more intensely by the material they allow themselves to connect with.

Other therapists mentioned characteristics they believed would place a therapist at increased risk of negative symptoms. Related to empathy, one HS respondent discussed general therapist qualities which she believed increased risk. This therapist stated:

I actually think that most of the stuff that draws us into counseling is really counter-perceptive. I mean, like the care giving, the people pleasing, the lack of boundaries and
all this stuff that, you know, because we’re such people lovers...It’s good because it makes you a really good and caring therapist. But at the same time, it also I think that all that stuff really opens you up to burn out in a big, bad way.

This respondent suggests that there are other qualities, in addition to empathy and compassion, which can “open up” a therapist to experiencing increased distress or negative impact when working with trauma. Another LS therapist stressed the importance Therapists engaging in their own therapy, cautioning “If a therapist has not done their own historical glimpsing or processing, I think they are in danger of being overwhelmed, being frightened, and/or being intimidated by stories that they might hear in their office.” Although already discussed in the Personal Characteristics theme, this therapist discusses how the failure to resolve one’s own trauma can directly interact with traumatic content exposure in a very detrimental manner.

Interestingly, several therapists credited their therapeutic approach with limiting the degree of empathic exposure they are subjected to. Four of the LS respondents specifically credited the use of Eye Movement Desensitization and Reprocessing (EMDR) as being helpful in limiting the impact of their exposure. One respondent remarked “So you know, I’ve always used EMDR pretty much with trauma cases. And that really helps to contain a lot of what we’re talking about here.” Another respondent described this perspective in more detail, stating:

... when you’re doing EMDR, it’s not necessary for the client to describe or go over all the details of trauma. Sometimes they spontaneously will because it’s helpful, therapeutic for them. But part of the instructions that you give to the client when you’re doing EMDR is that you can describe it as much as you need to, but it’s not necessary to
talk about all the details if it elicits feelings of shame or other things. So that helps to contain some of the kind of imagery and the vicarious traumatization that might happen to the therapist.

This therapist suggests this technique, through limiting the content or descriptive degree of exposure on the therapist, might reduce any potential negative impact. A third therapist reported a similar perception, asserting “I would have to acknowledge that early on in my practice, I did learn how to do EMDR therapy, which I think has been a very, very helpful means for me to be able to maintain boundaries.” In this context, “boundaries” was referring to psychological boundaries between the therapist and the visceral content of any presented traumatic material.

Several respondents did report having their world views changed due to their work with traumatized individuals. Two members of the LS group described becoming more aware of trauma in the world, with one reporting questioning “And I think I felt like, oh my gosh, how could there be such evil out there? Who could ever, ever do that? And I think it was more overwhelming initially.” Another HS therapist interviewed reported becoming concerned about both client safety and her personal safety due to her work. One member of the HS group stated “I’m not near as trusting and naïve.” This same respondent also described how their outlook had changed over the course of their work, asserting “And I guess when you first start out, which is probably going to be okay to start out that way, kind of idealistic about everything, you know. And then trusting the system and -- but I would say later on in my -- I still trust the system to some extent, but I don’t trust every judgment.” Another LS interviewee shared “I think it’s just made me a lot more aware of the horrible things that people do to each other.
And I think that there’s been times that it made me question humanity and human beings and faith and I’ll say that.” Of interest here is that the world-view, or cognitive schema changes, these therapists discuss tended to be viewed as either changes that had occurred in their past, or as being changes which were not necessarily negative, but instead more realistic viewpoints.

In fact, an equal number of therapists (two LS, three HS) specifically described their obtaining what they perceived as more positive, or healthfully balanced, worldviews or schemas through their work. Despite their exposure to painful and sometimes horrific narratives from their clients, these interviewees have been able to gain a form of positive perspective they view as being beneficial for themselves. One LS interviewee summarized this as:

You know, I think we sometimes like to think that there’s ways to protect ourselves from bad things happening. And I think over the course of my work, I recognize that bad things happen to good people all the time and yet it has not made me feel like well then what’s the point of living. I feel like in some ways that even though bad things happen to good people, there’s also good things that happen to people too. You know, there’s goodness in the world and there’s evil in the world. So I think it’s helped me to become a more balanced person.

This respondent has been able to balance the awareness of “bad” events with the awareness that “good” events also occur, and this is viewed as being a healthy perspective for this person. A second interviewee (HS) described in detail a similar perspective obtained through her work with trauma victims:
I think having a sense that even though the world is not a safe place, that we don’t get stuck with that. That again, having a belief that there is also goodness. And so whether that’s your religious belief, whether that’s a sense that people can also be good and that you can have positive relationships and not stay, I guess, stuck in the fear that oh my gosh, bad things are going to happen to everyone, so why even get connected? So I think my own belief that there can be pain in life and there can also be incredible joy and wonderful connections and we live this life knowing that we probably are going to have both.

Again, the exposure to traumatic content brought an increased awareness of pain and danger in the world, yet unlike what VT would predict the therapist obtains a healthy, balanced, and more realistic outlook on life. Yet another interviewee (LS) credited being exposed to traumatic content with making them become less judgmental, stating “And really also it’s helped me not be judgmental. I mean, this happens to all people across all races, social classes, no fault of their own.” The information provided by these respondents appears to both confirm and refute the predictions of VT that therapists’ world-views would be inevitably changed in a negative manner. These respondents recognized changes in their schemas, but the highly negative changes tended to be viewed as transitory, and the over-all changes were perceived as being balanced, more realistic, or even healthier perspectives.

The perspectives therapists adopted appear to be highly influential in how they interpret their exposure to traumatic content. While STS and VT predict empathic exposure places therapists at risk as part of their work, several therapists in this study reported experiencing exposure differently. One LS respondent described this as “…the feelings that were there and
that came I never really interpreted them as a negative thing. So it wasn’t like in fact if anything, it was interpreted maybe being able to connect and have some empathy, you know, for what people went through.” Intense emotion was viewed as connection with client, rather than as a negative event for the therapist. Another HS respondent discussed the importance of connecting with the client’s experience “despite the pain,” but ultimately viewed the power of the human connection as outweighing any cost associated with trauma exposure. One HS interviewee also acknowledged exposure to traumatic content was emotionally intense, but reported the positive impact of the process served to greatly mediate any negative impact. Three other HS therapists reported either achieving positive change, witnessing healing, or having a spiritual outlook mediated any negative impact on the therapist. One LS therapist succinctly summarized their perception of their work, remarking “I would say if there’s any impact, it’s a positive impact. It is not negative.”

As stated earlier, the evidence provided from these therapists in some part corresponds with symptoms predicted by STS or VT. However, several of the remarks provided by these therapists referred to symptoms they had experienced in the past, rather than current symptoms. The frequent mentioning of positive symptoms, or perceived healthy changes to schemas resulting directly from exposure to their client’s trauma, suggests another process may be occurring which is different from the processes leading to STS or VT. This will be discussed in further detail the following chapter of this work.

Hope, Resilience, and Therapist Effectiveness

Thirteen of fourteen therapists interviewed discussed experiencing positive factors which have derived from their work with traumatized persons. The perceived benefits or positives
these therapists reported often appeared to be in contrast to what Pearlman and McCann predicted, as discussed in the *empathic exposure* themes. These beneficial factors also suggested symptoms of STS were unlikely to be developing. Respondents reported not only were components of their empathic exposure to traumatic content actually protective, but this exposure could also produce positive changes in their schemas or worldviews. These therapists spoke of the transformation of clients, the resiliency of the traumatized individuals they worked with, and a belief that change was both possible and likely. They viewed themselves as being effective in instituting this change, felt honored or rewarded by having the opportunity to participate in this process of change with their clients, and often viewed themselves as experiencing personal growth through this process. Once again, the evidence provided through their comments, discussed in detail in this theme, is at times in stark contrast to the predicted symptoms or predicted development of both VT and STS. In fact, the evidence provided by these respondents suggests therapists may become energized, hopeful, and possibly positively transformed through their work with traumatized clients rather than becoming damaged through their work.

Several therapists reported their work with traumatized persons strengthened their belief that clients were capable of change, as well as capable of largely healing from the traumatic experiences they had endured. Three therapists reported the importance of their belief that individuals can heal from their traumas, and also reported repeatedly witnessing this change occur in their sessions with clients. One therapist summarized the potential power of this, with the following statement:
I have seen miracles, and that’s just life-changing to see somebody move from, you know, my life is ruined because this happened to me to like, you know, I can be okay. I can handle this. Being able to see people change and get through their trauma is just -- I think it’s amazing and I think that’s just really had a huge good effect on me.

One LS therapist discussed their belief that people in general were capable of change, and another two reported they often were able to discover the resilience in others through their witnessing change in their traumatized clients. Another LS interviewee also asserted that the change they typically witnessed was usually a sustained change; the interviewee felt strengthened in their work due to their confidence that the change that occurred would be long-lasting for the client. This therapists stated “…over time as I have seen people go on to not just be a survivor but really thrive in their life and make wonderful connections. And I’ve seen that maintained over a period of years.” An LS therapist also described their work with traumatized clients engaged as being “life changing,” referring to the client and explaining that the change which occurred would often be beyond simply recovering from the trauma(s) but would instead transform the individual on a global level. One LS therapist referred to the ability of the client to transcend their traumatic experiences, while another HS respondent utilized the term “transformation” to describe the global changes they often witnessed within clients. Yet another HS respondent discussed the ability of the client to obtain a degree of happiness in their life through their trauma work, with another LS reporting with confidence the client would be able to add joy to their life despite their current pain. These final two respondents believed not only in the client’s capacity to change, but to be capable of moving from an experience where they largely felt pain, to living a life which could contain happiness and contentment.
Related to witnessing change, several therapists reported their work had resulted in their viewing either clients or humans in general as being very resilient in the face of pain or suffering. Four HS therapists and three LS therapists specifically mentioned witnessing or even discovering a remarkable level of resilience in their clients. One respondent stated “I’m touched by the resilience of many people, of most of my clients, their resilience and desire to want to heal.” Two LS and two HS interviewees also remarked upon their belief in people’s resilience in general, and often credited their being able to work with traumatized persons as helping them develop this belief. One therapist, when discussing their thoughts on the inevitability of tragic events, reported “And like I will be -- because I have seen that people -- we can't stop it. And you know, there’s no necessarily predicting, but we’ll be resilient. We’ll make connections.” The respondents often reported that witnessing or discovering this resilience in their clients had a beneficial impact upon them, either in the immediacy of their work, or in their personal schemas about humanity or the world they live in. One HS remarked “I think you learn about human resilience. I think that’s incredibly important and the more you realize like how courageous, resilient, amazing people are, I think you can’t help but be affected by that.” Another LS therapist stated “I mean, sure I’ve seen people who have come into treatment and they describe some of the things that they went through. And I can’t believe that they’re still here. You know, so I think a lot of that speaks to the resiliency of the human condition.” An HS stated “And it’s been really gratifying to see how resilient people are even in the face of really bad things that have happened to them, the strength that comes from them, to me, is exciting to see and rewarding.” These interviewees continue to provide statements suggesting that rather than being either neutral or detrimental to the therapist, empathic exposure to
traumatic content, at least in cases where clients show improvement or resilience, therapists perceive they obtain positive personal gains through their work.

Several therapists reported the sense of confidence in their ability to help instill client change was a factor which provided the therapist with a sense of optimism and/or confidence. These interviewees reported they brought this perspective into their sessions with traumatized persons, and this perspective helped protect them because whatever the nature of the trauma, the therapist generally believed “I can help you.” One of the commenting LS therapists stated:

Number one, through experience I’ve learned that it can, provided effectively, can help a person actually get better, you know, and to be either greatly helped or even free of the PTSD symptoms and other trauma, emotions, and problems that come with trauma. And so that overlay of sort of optimism that I can help you, I feel efficacious in working with you, and that’s helpful to convey to the client, but it’s also very helpful to know that, to feel that when you’re approaching work with somebody like this. So that’s a very helpful thing from the beginning.

This and other therapists remarked on their perspective that they could help clients with both speed and efficiency; this further helped the therapist’s positive outlook because they were confident change could occur relatively rapidly, alleviating the client’s pain in a short amount of time. The above-quoted therapist explained this perspective, reporting:

...when you’re doing EMDR, when it’s working, the trauma imagery, all the various ways in which it is remembered begin to shift rather quickly. And that then obviously feels good to the client. And you feel like, “Okay, this is going to be changed. What this guy is telling me is actually happening.” And also you don’t end up dwelling on that and
repeating that looping, we would say, over and over again. And that, of course, helps a lot.

An HS respondent remarked “And then it’s also really important and helpful to know that you can help a person who’s had these bad experiences work through them in a fairly expeditious way, and that also puts sort of a positive overlay to what you’re hearing from the person.” In all, three respondents in the LS group specifically reported the change they witnessed in their work tended to occur at a fairly rapid rate; this was echoed by the quoted respondent in the HS group who reported this rapid change energized the therapist and created a sense of hope and optimism. Three HS and four LS respondents referred to their confidence in themselves or the techniques they utilized to help clients recover or heal; of these all but one LS respondent specifically mentioned this perspective in their effectiveness in the role of being a therapist gave them a sense of hope or optimism.

As mentioned beforehand, several of the therapists interviewed credited the techniques they utilized with being effective at instilling change in their clients. Several therapists particularly mentioning EMDR, and reported they viewed this approach as providing them with the ability to create fast change in a high number of clients. Three LS therapists in lesser or greater extent credited EMDR techniques for their success with clients, with two HS therapists echoing this view. Two LS respondents either reported they believed this success kept them motivated in their work or was instrumental in their extending their careers. One HS therapist reported:

...when I'm doing EMDR, I feel energized. I see transformation. I see an integration on a deeper level, even, if I might use the word, spiritual level, where people have -- and I
don’t mean religion, but I mean I think they have a -- it integrates on a deeper level. So that's what has, I think, enabled me to do this work longer and not be affected by it because of the modality that I'm using.

Two of these therapists also reported their prior experience using exposure techniques was detrimental either to themselves or the clients they worked with. Interestingly, other therapists with different therapeutic approaches did not specifically credit the techniques utilized as being instrumental in their success, but rather either spoke of their general effectiveness as a therapist or did not discuss therapeutic effectiveness in the interview.

Several therapists discussed their perspective that working with traumatized persons, and being exposed to traumatic content, has either instilled them with positive emotions or beliefs about their work or has made them a better person in general. One respondent (LS) simply stated “It’s probably made me a very compassionate person, to sum it up,” while another HS respondent echoed “I think it's made me much more compassionate, more understanding.” This sense of developing compassion through their work with trauma survivors was also reported by another HS respondent, who stated “Well, I think it has -- it sensitized me, it's made me more compassionate to people and to appreciate the kinds of strengths that people have that have survived in many of the ways I see people surviving.” Witnessing success and resiliency in their clients had positive impacts on themselves as a person. One HS therapist reported when their clients progressed they felt good about themselves both as a person and as a therapist. Another HS respondent asserted that seeing positive change within the client had positive impacts upon the therapist, helping to instill a heightened sense of hope in the
therapist, served to energize the therapist, and counter-acted some of the potential negative impact of their work.

Connected with this observed success is the confidence therapists develop as they do achieve success in their work and witness clients healing. One LS respondent reported they had a sense that clients would be highly likely to recover based upon their prior success; this served to bring hope and optimism into sessions with current clients or new clients. Another reported being honored that they could be the catalyst for client change, and viewed themselves as being both hopeful and empowered due to recognizing they were instrumental in helping others heal. Yet another stated they believed they were highly successful in helping others heal, and they found this to be greatly beneficial for both the client and the therapist. This respondent stated “I find great satisfaction in my work with these people, and I’m generally 85-95% successful with them. And so there’s a natural reward when I service someone. So that kind of prevents a negative impact.” A history of success appears to help therapists keep a sense of hope and confidence when they conducted therapy with traumatized persons. One therapist stressed “the client will cope with help,” again stating with confidence that people can (and in this perspective will) change when provided the therapeutic assistance they need. Another summarized this as “I feel much more competent when I'm working with people because I've seen people that I've work with get better. And that helps -- that gives me a sense of -- what's the word, encouragement.” The evidenced provided by these respondents suggests that not only does witnessing change or resiliency lead to reduced impact of traumatic content, but when the therapist perceives they are themselves skilled and competent, they gain additional positive benefit and the impact of trauma exposure is reduced further still. This
appears to occur partially from the positive emotions the therapist experiences as they witness the client improve and gain relief; but the therapist also has the satisfaction of being a part of this recovery process. The competence the therapist experiences likely allows them to also have increased hope that clients can change by working with themselves or other competent professionals, even in cases where clients may have complex difficulties or very severe trauma histories. Finally, these respondents appeared to experience decreased uncertainty or distress due to not feeling overwhelmed or unsure of themselves, and due to the confidence they have in self and client; this confidence is likely bolstered from many past experiences which the therapist can draw on to maintain their belief in client change and their personal sense of efficacy.

Several therapists (three HS and three LS) reported having developed strongly positive emotions connected to the clients they work with, or with trauma victims in general. One of these HS therapists reported having a great admiration for her clients, and in a later statement described being “in awe of their resilience”. Three therapists specifically reported being honored to participate in their client’s recovery, with another HS therapist discussing the excitement they felt at being allowed to assist the client to heal. One HS respondent reported:

I mean, I just think it’s such an honor and privilege to sometimes work with people who have been traumatized, especially people who have been like sexually abused and things like that, because a lot of times they won’t have an opportunity to even tell other people and no one believes them. And so just being that voice for them and for them to finally feel acknowledged and validated and be accepted, to me I just get so much reward in seeing people.
Another described being deeply and positively “touched” emotionally by engaging in the process of healing with their clients. Four therapists (three HS and one LS) stated they found the experience of engaging in trauma work to be personally highly emotionally rewarding, with another two reporting they felt “privileged” to be doing the work they do. A final therapist (LS) discussed not only experiencing a sense that her work was rewarding, but also described experiencing a sense of human connection to those she worked with:

You know, but to me, you can’t sort of stop living. We don’t really have a choice. This is where we’re -- the world we’re born into. So anyway, no I think I do feel like my work, especially with those clients. I mean, those are probably the ones who I get the most connected to. And while it can feel emotionally draining, it also can feel incredibly rewarding.

The evidence provided by these respondents stands in sharp contrast to symptoms of STS or VT; rather than being exhausted, dispirited, avoidant, saddened, etc., these respondents largely reported experiencing many positive emotions and cognitions about their work, themselves, and the clients they engage with.

For some therapists, what they reported experiencing as part of their work seemed to go beyond simply developing positive emotions or attachments with their clients and experiencing a sense of being privileged, honored, or rewarded. For these therapists, the experience of helping others heal from their traumas was seen as an almost existential experience, providing a sense of meaning or purpose for the therapist. One LS therapist described the work she engaged in as “I would say that to be able to work with people that have all these problems, my place in all of it is a spiritual endeavor. I mean, I don’t go around thinking about that all the
time, but now that I think about it, I’d say that’s what it is.” Another respondent described her working with traumatized persons as being an activity which brought meaning and purpose to her life, stating:

…it gives meaning to your life. I think that -- also the other part of my world belief is that I feel like we’re put on this earth to make it better, you know, or something to good with what we’re given in whatever way that is. If we’re a great businessman, do good in business. But I feel like if I can help instill a sense of hope for people or help them to see themselves in a way I can see them, and then I grow from that too. It’s definitely not just oh, me being this good person to them. I mean, I really feel like I gain from those relationships too.

From these comments, it is clear that for at least some of these respondents trauma work is something which they see as not only highly valued, but an activity which provides a sense of purpose for them. One other LS therapist also described her work with traumatized persons as being a spiritual endeavor, along with another HS respondent.

Still other respondents discussed positive transformations in their personal worldview, again in contrast to what would be predicted by Vicarious Traumatization. Two respondents reported strengthening their belief that the world is good (both HS), with a third (LS) stating they have a belief that people are generally good. Another therapist reported developing an increased sense of optimism about humanity after repeatedly witnessing the resiliency of the clients she worked with. Yet another described developing a broad sense of hope as a worldview through witnessing the remarkable change within clients.
These respondents appeared to view their work with traumatized persons as being positive and transformative, both for themselves as well as for the individuals they work with. The factors contributing to this sense of optimism, hope, and confidence in change appear to be witnessing individuals recover from traumatic experiences and witnessing many individuals move beyond simply recovering to developing a meaningful life experience. These therapists were able to view individuals as being resilient and capable of change, and they also viewed themselves as being a vital part of this change. Several expressed the importance of their personal sense of confidence in this process; their confidence that they were capable of helping the client, and in many cases were in possession of effective techniques which would facilitate the process of healing. As a result, these therapists were able to experience positive emotions and experiences about the work they engaged with and the persons they engaged in their work with; in many cases they even recognized their work with trauma as positively altering their personal views of the humanity or the world, and believed they had become better persons through this work.

Workplace and Personal Barriers

Several respondents reported they had experienced barriers to either practicing self-care or to successfully managing distress after being exposed to traumatic material. All therapists discussed having experienced barriers to their ability to engage in effective work with clients, their ability to manage symptoms of distress when exposed to traumatic content, or their ability to engage in valuable self-care activities. However, the interviewees in this study tended to discuss these barriers largely as factors which had occurred in their past, and also reported they had often been able to work through or overcome these barriers. The individuals in the HS
group, however, were more likely to discuss barriers as being events which were presently occurring (three of the seven reported this); these respondents also tended to be the respondents who had scored the highest on the ProQOL or TABS. This will be further examined in the discussion chapter of this work.

Nine of fourteen respondents verbalized both time and workplace demands were barriers to managing distress when engaging in trauma work. Excessive workplace requirements (generally described as high case-loads or productivity requirements) were discussed as being either being barriers due to the stress on the therapist these requirements produced, to the perceived difficulty of doing effective work given time and caseload demands, and/or the resultant difficulty of making time to engage in important self-care activities. Two LS therapists specifically mentioned the general workplace setting as being a barrier to practicing skills, with both of these therapists referring to their past work at a community mental health agency as being the difficult setting. Therapists often described working in settings such as community mental health agencies as being more difficult to manage personal distress, or as having more barriers to regulating the impact of trauma exposure. One HS therapist who had spent several years in a community mental health agency remarked:

“...the nature of private practice versus Community Mental Health, it's less traumatic, the people are less damaged, I think, generally, the ones I see now in private, working in private agencies than they were in Community Mental Health. It's a whole combination of things, more time, fewer clients, maybe less severely ill, less severely traumatized. The other therapist who had worked in a community agency echoed these statements, stressing the lack of flexibility, less motivated and more severe clients, and a perceived callous
attitude of administrators. Other respondents cited general workplace factors, not necessarily connected to a particular work setting, as placing them at increased risk of developing distress or decreasing their ability to manage symptoms stemming from trauma exposure. Three therapists in the HS group cited lack of workplace resources as interfering with their ability to manage their distress, with another referring to high caseloads in past employment and scheduling pressures due to high demand.

Workplace limitations were also described as either being a lack of peer support, lack of supervision, or ineffective supervision. The lack of peer support or supervision often resulted in an inability to process difficult or complex therapy sessions, or a lack of opportunity to decompress from intense emotions with another therapist. One respondent stated the lack of peer support created a sense of isolation, which demoralized them and made them more vulnerable to distress. Four of the HS respondents also discussed difficulties with supervision or leadership, and reported this increasing their distress, their vulnerability to STS or VT symptoms, or at least interfered with their ability to conduct effective work with clients. One HS therapist recounted the lack of support she received from her supervisor after a client took his life, stating “...one of my clients killed himself, and that was just -- I was just so upset. And people just told me -- well just my boss told me if I didn’t care so much, it wouldn’t hurt so much.” Another HS therapist shared her inability to seek out help, partially due to own insecurity but also because of the lack of a supportive supervisory relationship. She stated “I think sometimes initially maybe early on in my training as a young therapist, sometimes you’re kind of afraid to admit that you know, wow, I’m overwhelmed with that because you want to appear you know, really competent and strong professional.” These respondents provided strong evidence that both the lack of effective supervision/leadership, or
ineffective/damaging supervision seems to contribute to increased distress and vulnerability to developing STS or VT symptoms.

Several respondents discussed external stressors related to their personal lives as contributing to their distress and making them more vulnerable when exposed to traumatic content. One LS therapist discussed family crises as being a barrier to managing stress, stating “Family in the past, my daughter is now older, so it's less of an issue. I have more flexibility in terms of scheduling, but, yeah, sometimes that, depending upon things, that issues that arise, sickness actually, when she was sick. And I would say, also, because I'm aging, I've had to deal with other family crises. A second HS respondent citing relationship issues outside of work would increase their vulnerability to work-related stress, and a third HS respondent reporting grief and loss as interfering with their ability to manage work-related distress. Three therapists described family demands as interfering with their ability to engage in self-care, each of these therapists specifically reporting the presence of children and the responsibilities associated with having children as being the reason for this distress. One therapist specifically mentioned gender, stating she believed her functioning “in the role of mother” increased her demands and thus increased her stress while limiting her ability to engage in self-care. This respondent stated:

Yeah, when my kids were younger, it was much harder for me to carve that out, and so I find it's much easier just they're older and they're teenagers. And it's, you know, when you have children, I think you're even more involved as a woman anyway, still just a part of having -- being a mother, period, and so it's much easier, but once they're older, to be
able to sort of carve out some self-care that I wasn't so good at doing when they were littler.

Although the other two therapists discussing children as limiting their ability to engage in self-care did not specifically mention gender, they were both female. This suggests female therapists may experience increased family demands or child-rearing responsibilities compared to male therapists.

The theme of one's life being in balance, first discussed within the self-care theme, emerged again when examining barriers. Unlike balance as a self-care skill, however, in the current theme therapists were reporting a life out-of-balance was a risk factor when working with traumatic content. Three therapists specifically mentioned having a life “out of balance” increased distress and could make a person vulnerable to negative symptoms. One HS therapist succinctly described her personal barriers as being “Just time and work-life balance, that's all. Yeah, I have two kids.” Three additional therapists cited the need to have personal boundaries as being instrumental to protect the therapist, and discussed a lack of boundaries as placing them at risk. Two respondents discussed boundaries in terms of the need to have separation between work and home, while a third therapist discussed the need to have emotional boundaries between work and “life outside of work.” All three of these respondents mentioned experiencing increased distress during times when they were not able to maintain these balances or protective separations.

Personal emotional states were also described as being barriers to therapists being effective at protecting themselves when engaging with traumatized persons. One therapist cited personal stress (without assigning a cause to this stress) as being detrimental, while
another therapist discussed apathy and fatigue as placing them at risk. Fear was mentioned as being detrimental by two therapists, although for very different reasons: One therapist cited the fear that a difficult client would commit suicide increased their distress, while another therapist reported the fear of failing a client created doubt in them-self, which then increased their distress. One HS respondent described the difficulty their personal apathy and fatigue created-and described the effect this ultimately created on practicing self-care. This respondent reported “Apathy. There's not really -- there's really no -- it's just more of a discipline thing. If I were to discipline myself when I got home from work -- maybe fatigue sometimes. I think that’s like the paradox . Like the more stressed we are, the less likely we are to use some of those things.” Another LS therapist discussed how emotional stress, which she perceived as connected to a biological cycle (difficult menses), increased her distress. This therapist reported that in private practice she stopped seeing clients during her menses due to the increased difficulty she experienced in managing her intense emotions with clients. She also reported she would be unable to do this if she was not in private practice. These respondents provided significant evidence that therapist intense emotional states can be barriers either to managing their distress when working with trauma, or in being able to engage in therapy in a highly effective manner.

Characteristics of clients were also viewed as potentially being barriers to successful treatment; client characteristics were also described as potential factors which could increase the distress of therapists who engage with these clients. Six of fourteen respondents (three each from LS and HS) cited client diagnoses or client presentation as being barriers. One LS
therapist mentioned work with “addicts” as being particularly difficult, and later described clients with attachment disorders as being difficult to engage with. This therapist reported:

You know, some of the people who have been just chronic trauma they just don’t trust anyone. Those are the ones that are the hardest. No matter how much I encourage some of those ways, they’re just so betrayed they can’t really -- they don’t really take the risk.

This respondent focuses on the difficulty some clients have of trusting or connecting to others as being the principle barrier to conducting effective therapy; therapy which is ineffective or unsuccessful can then become more emotionally draining for the therapist. Another interviewee described highly distressed or unstable clients as being problematic, describing:

...sometimes If the person is unstable, if the person for example might be suicidal, if the person has had a very difficult time regulating their emotions, that can be pretty stressful because then that requires a lot more care and follow-up on the therapist’s part. And that can extend the hours of your week professionally. It might also require contacting -- being contacted outside of normal therapy work hours. So that certainly can be very stressful.

Not only does the emotional instability and degree of risk produce increased stress for the client, but this respondent emphasizes the potential for these clients to involve more investment in time and energy, possibly with less probability of trauma being successfully resolved. Other therapists (two HS and one LS) reported clients with comorbid disorders, borderline personality disorder, or dissociative identity disorders all made their work much more challenging and difficult. These therapists also described these clients as being barriers in
part due to the difficulty of working with these challenging clients, but also due to the higher emotional toll aid by the therapist due to the volatility or severity of these clients. Two other LS respondents concurred that clients presentation could be a potential barrier when clients demonstrated difficulty forming trust; these therapists, along with two additional HS respondents, also reported difficulty when they felt they could not connect with a client, or when clients appeared to be “stuck” or were making no progress (regardless of the cause). These characteristics were cited by four therapists, and appeared to be related to the aforementioned more severe clients in diagnostic terms. What is clear from these responses is that several therapists viewed “difficult” clients to be likely to increase therapist distress, while also demanding the therapist invest more emotional or practical resources in the therapy process.
Based upon the evidence presented in this section, it becomes clear that the impact of being exposed on an empathic level to traumatic content is dependent on several factors. Among these are the personal characteristics of the therapist, the degree and nature of the traumatic exposure, the ability of the therapist to utilize support systems to manage distressing symptoms of exposure, and the presence of therapist challenges and barriers. The potential impact of trauma exposure may also dependent on the therapist’s belief that clients can change, their belief that they can effectively assist in helping clients change despite the degree of their trauma, and their use of effective self-protective or self-care skills. All of these factors
are likely to be influenced by the development of the therapist over time, as well as life experiences such as personally experienced traumatic events. In regards to therapist development, there appears to be a tendency for therapists to become more skilled at managing the various factors over the course of their careers. The result of this is that through empathic exposure to the traumatic material of their clients, therapists who work with these clients are likely to experience consequences. However, these consequences can be either positive (such as post-traumatic growth/vicarious resilience) or negative (as explained by STS or VT), dependent upon the interplay between these varied factors.

The model presented is an attempt to concisely illustrate the findings of this study in an understandable and cohesive manner. This model is presented in a layered manner to represent both internal factors (factors within the therapist), external factors (such as workplace variables and the presence or absence of available support), and the reality that these factors influence one another (indicated by the arrows connecting internal and external factors). The largest arrow indicates the developmental process as well as temporal factors; therapists bring into therapy personal experiences which influence their responses to traumatic content as well as their use of support, self-care skills, view of clients, reactions to workplace variables, etc. The dynamic interplay between these various factors results in whether therapists are likely to experience either positive or negative personal outcomes (VT, STS, VR) when empathically engaging with the traumatic content of their clients. The presented model illustrates the complexity of these various processes, as well as how multiple variables play a role in mediating other variables; the model also highlights there are multiple points where interventions can result in differing positive (or negative) outcomes.
As an additional validity check, the currently presented working model was emailed to the fourteen interview respondents along with the accompanying description. These emails requested the interviewees review this model and respond either via email or telephone contact (the researcher again included telephone contact information) if they had concerns or disagreement with the model, or if they required further clarification. As these individuals are quite busy and had already contributed significant personal time, the accompanying email informed the participants that a response was only requested if they had the above-mentioned concerns or desire to discuss aspects of the model for clarification. Eight interviewees did respond, with six reporting they agreed with the model, one respondent asking for minor clarification about the “life experiences” track (and then agreeing they thought the model was a good fit), and one respondent questioning whether differences in font sizes (internal versus external factors specifically) suggested differing levels of importance. This respondent reported agreement with the model when it was explained that all factors varied in importance for individuals and the font size or other wording characteristics was not intended to suggest one factor is generally more important than other factors. In sum, the response from these interviewees appeared to corroborate the validity of the current model in succinctly illustrating the various factors (and relationships between these factors) which influence the impact therapists experience when working with traumatized persons.

**Quantitative scores of survey respondents**

The final section of this chapter presents the quantitative scores for the ProQol and the TABS for all respondents, as well as the averages for the various groups of respondents who
completed surveys for this study. The STS and VT t-scores for group members and average t-scores of these groups are included in the following table:

Table 3.

List of STS and VT t-scores for respondents.

<table>
<thead>
<tr>
<th>Respondent</th>
<th>STS t-score</th>
<th>TABS total t-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>LS1</td>
<td>51</td>
<td>35</td>
</tr>
<tr>
<td>LS2</td>
<td>51</td>
<td>33</td>
</tr>
<tr>
<td>LS3</td>
<td>61</td>
<td>36</td>
</tr>
<tr>
<td>LS4</td>
<td>55</td>
<td>33</td>
</tr>
<tr>
<td>LS5</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>LS6</td>
<td>52</td>
<td>35</td>
</tr>
<tr>
<td>LS7</td>
<td>51</td>
<td>33</td>
</tr>
<tr>
<td>Average LS t-scores</td>
<td>52.85</td>
<td>34.43</td>
</tr>
<tr>
<td>HS1</td>
<td>58</td>
<td>40</td>
</tr>
<tr>
<td>HS2</td>
<td>49</td>
<td>47</td>
</tr>
<tr>
<td>HS3</td>
<td>55</td>
<td>40</td>
</tr>
<tr>
<td>HS4</td>
<td>62</td>
<td>47</td>
</tr>
<tr>
<td>HS5</td>
<td>51</td>
<td>39</td>
</tr>
<tr>
<td>HS6</td>
<td>77</td>
<td>42</td>
</tr>
<tr>
<td>HS7</td>
<td>55</td>
<td>36</td>
</tr>
<tr>
<td>Average HS t-scores</td>
<td>58.14</td>
<td>41.57</td>
</tr>
<tr>
<td>INC1</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>INC2</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>INC3</td>
<td>60</td>
<td>45</td>
</tr>
<tr>
<td>INC4</td>
<td>67</td>
<td>51</td>
</tr>
<tr>
<td>INC5</td>
<td>65</td>
<td>39</td>
</tr>
<tr>
<td>INC6</td>
<td>58</td>
<td>44</td>
</tr>
<tr>
<td>Average RNI group</td>
<td>60.67</td>
<td>41.67</td>
</tr>
<tr>
<td>NI1</td>
<td>67</td>
<td>51</td>
</tr>
<tr>
<td>NI2</td>
<td>62</td>
<td>39</td>
</tr>
<tr>
<td>NI3</td>
<td>58</td>
<td>53</td>
</tr>
<tr>
<td>NI4</td>
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<tr>
<td>NI5</td>
<td>75</td>
<td>35</td>
</tr>
<tr>
<td>NI6</td>
<td>58</td>
<td>42</td>
</tr>
<tr>
<td>NI7</td>
<td>64</td>
<td>45</td>
</tr>
<tr>
<td>NI8</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td>Average NI group</td>
<td>63.25</td>
<td>44.5</td>
</tr>
</tbody>
</table>
The over-all t-scores for the TABS (measuring VT) for the LS group was 34.43, with a range from 33-36. The HS group average was 41.57 with a range of 39-47. The individuals who responded and had indicated they would agree to be interviewed, but who either later refused or did not respond to efforts to contact them (“interview-not-completed,” or INC respondents), scored an average of $T = 41.67$, range 31-51: Therapists who completed the surveys but declined to be interviewed scored an average of 44.5, range of 35-53. Although the small sample suggests these differences could be due to randomness, there does appear to be a pattern where persons scoring lower tended to agree to be interviewed while those who scored higher tended to decline. Measures of STS from the ProQOL showed this pattern even clearer, with LS respondents averaging T-scores of 52.85, HS scores of 58.14, INC persons scoring 60.67, and responded but declined to be interviewed scoring 63.25. These results suggest there would likely be differences in the way this study’s participants responded compared to how other therapists may have responded. As stated earlier, the average therapist who responded at all to this survey scored below-average on the global measure of VT, suggesting there is likely a large group of individuals who either were not successfully reached or individuals who scored average or higher for VT may be highly unlikely to respond to surveys at all, much less agree to be interviewed. This will be further discussed in the following chapter, and the implications of this quantitative data will be discussed in further detail.
Chapter 5: Discussion

The purpose of this study was to clarify the degree to which symptoms of STS or VT were experienced by therapists who work with traumatized individuals, to identify which protective self-care skills were utilized by these therapists and were perceived as effective, and to examine what barriers therapists may experience in utilizing protective factors. Therapist development was to be explored as part of this study, along with an examination of the interplay between therapist development and self-care utilization and effectiveness, symptoms of STS, and symptoms of VT. This study utilized quantitative measurements to provide additional supportive data for discussion purposes, as well as to examine differences between therapists who scored higher and lower on these quantitative measurements. The following chapter will discuss the results of this study, as well as limitations and implications.

Important findings

Vicarious traumatization (VT) predicts that therapists will develop core disruptions to personal schemas and worldviews over time. At best, these negative disruptions can be halted or delayed through vigilant use of self-care and protective skills, but for many therapists these negative consequences may be inevitable (Dunkley & Whelan, 2006). However, the results of the current study found no supportive evidence for this assertion. Contrary to what VT would predict, the majority of respondents (thirteen of fourteen) specifically reported personal growth through their work with traumatized persons. This growth often involved developing and maintaining positive views of their clients, recognizing a human capacity for resilience or goodness, and increasing positive views of the world these therapists live in. Therapists in this study reported a belief that individuals can heal and recover from their traumas, developed a
sense of hope and optimism when interacting with traumatized persons, and often gained a
sense of personal efficacy and confidence that they could help trauma victims to heal. Not only
was this evidence derived from in-depth interviews, but the TABS provides corroborating
quantitative information to support the perceptions of the therapists: The average t-scores on
the TABS total score for the LS group were 34.43, and the average for the HS group were 41.57:
the total average was a t-score of 38. This indicates that the average respondent was over one
standard deviation below the mean for TABS respondents; the HS group average fell well below
the mean, although still within one standard deviation. These scores support the therapist’s
perceived sense that negative consequences in terms of long lasting schema disruption had
largely been avoided or limited, while positive growth and alterations of schemas had
developed.

The findings of this study seemed to be congruent with Hernandez et al (2007), who
proposed the construct vicarious resilience (VR) to explain positive personal growth they
observed in therapists working with trauma. These researchers suggested exposure to the
traumatic content of clients could actually result in developing positive schemas about
themselves and their clients, an increased sense of hope for victims and for humanity, a strong
belief in human resilience, and an increased sense of compassion and connection with others.
Responses within the current study often echoed the findings of Hernandez et al, with the
addition of respondents in this current study reporting greater senses of efficacy as therapists
as well as developing healthier and more balanced perspectives about themselves through their
work. Importantly, the current study evaluated a varied therapist sample (rather than
therapists working largely with political violence) providing evidence that VR is likely to be present in a variety of therapists who work with traumatized persons.

While this study provided little evidence supporting the development of VT, the results were less clear regarding the potential development of STS symptoms. Few STS symptoms were reported or discussed by therapists in this study, although some respondents did mention experiencing symptoms such as intrusive memories, hypervigilence or avoidance, or increased anxiety as a result of working with traumatized persons. The respondents who reported these symptoms were not only a minority of respondents, but often discussed these as symptoms which had occurred in the past. However, the ProQOL administration yielded t-scores which were higher than the average VT t-scores. On the ProQOL, the LS group averaged t-scores of 52.85, and the HS group averaged 58.14 (total average was 55.50). Thus, both groups scored within one standard deviation from the norm for persons administered the ProQOL; however both groups were above the mean score. This may suggest symptoms of STS may be more subtle, and thus less likely to be discussed, stress related to trauma work may be more likely to be impacting these respondents in emotional or behavioral ways rather than impacting core schemas, or the respondents likely to participate in studies such as this might have a unique pattern which results in discrepancies between VT and STS measures. As noted earlier, Baird and Kracen (2006) found evidence that STS and VT overlapped one-another as constructs but were also both valid; perhaps individuals who have developed strong self-care skills and protective factors might tend to develop vicarious resiliency while still being somewhat impacted on a more immediate emotional or physical level by their work.
Another important finding of this study was strong evidence that self-care and other protective skills were highly valued by participants, were actively engaged in, and appeared to be effective. Contrary to what Bober and Regehr (2006) found, the results of this current study suggest that therapists who work with traumatized persons can protect themselves from potential harmful impacts from this work through active utilization of self-care and protective skills. Therapists also appear to become more effective at utilizing skills over time, and may obtain more access to using skills as barriers change or decrease over time. Not only are these skills and protective factors perceived as being effective by therapists, but (as mentioned before) quantitative data from the TABS and ProQOL supports their views that these skills work to reduce negative impacts. Thus, the current study supports the use of protective skills and activities as being viable techniques which can protect therapists who work with traumatized persons.

Gender has been suggested to be a risk factor for developing STS of VT by Kassan-Adams (1990) Woodward-Meyers & Cornille, 2002. The current study did not find specific evidence directly supporting this, but did reveal some evidence suggesting one possible explanation as to why gender may be a variable factor. Two female therapists mentioned the need to care for children as being barriers to practicing self-care, while a third mentioned family emergencies. Although evidence was not found suggesting gender differences were related to selecting or valuing self-care strategies, experiences related to empathy, use of support, etc., it may be that female therapists are more likely to have additional caretaking pressures outside of therapy when compared to male therapists. These responsibilities may require increased emotional
investment while also limited the time available to access personal self-care activities. This is a possible finding which merits further investigation.

The current study provided strong support for prior research findings suggesting workplace settings could contribute to developing symptoms of STS or VT (Cougle, Resnick, & Kilpatrick, 2009; Goldsmith R. E., Barlow, & Freyd, 2004; Schauben & Frazier, 1995; Vredensburgh, Carozzi, & Stein, 1999). Public settings and community agencies were described as being associated with more time constraints on therapists, decreased therapist and client resources, and more severe or difficult (such as addicted or borderline personality disordered) clients. The workload of the therapist, as well as the number of trauma clients, also appeared to increase therapist emotional fatigue and distress while simultaneously limiting their ability to utilize self-care activities. This finding is also consistent with the findings of Boscarino, Figley, & Adams (2004), Meyers & Cornille (2002), Schauben & Frazier (1995), and Vredensburgh, Carozzi, & Stein (1999). The results of this study also concur with earlier research findings that supportive workplace environments were associated with decreased STS or VT symptoms (Boscarino, Figley, & Adams, 2004; Linley & Joseph, 2005; Meyers & Cornille, 2002; Morrison, 2007; Schauben & Frazier, 1995). Although mentioned as possible causes for decreased STS/VT in prior study discussions, the current study provided direct evidence suggesting how the workplace environment can decrease STS or VT; time flexibility, a sense of being supported, opportunities to consult, opportunities to process intense emotional content, and a degree of control over one’s caseload all appear to be directly beneficial to the therapist.

There was substantial reported evidence that there was a perceived increased risk of developing STS or VT for therapists who have a personal history of trauma, as suggested by
prior researchers (Cunningham, 2003; Nelson-Gardell & Harris, 2003; Vrkleveksi & Franklin, 2008). This may also be reflected in differences between persons who agreed or declined to be interviewed, as well as the average scores of these individuals four of fourteen agreeing to be interviewed reported trauma histories, while ten of fourteen who declined to be interviewed or initially agreed and were unable to be interviewed reported trauma histories. However, the results of this study also supported the findings of other studies (Follette, Polusny, & Milbeck, 1994; Linley & Joseph, 2005) which found either no evidence that a prior trauma history led to increased risk for the therapist. In fact, the respondents often reported they believed prior histories of trauma could contribute to personal growth in the therapist. They key difference appears to be the importance of the therapist having engaged in their own therapy to address prior trauma. Respondents consistently reported that therapists who had successfully dealt with their past personal traumas, often reportedly through their own therapy, were not perceived as being at increased risk and could use the act of helping others as a further method of maintaining or enhancing their personal growth and recovery.

New findings

The results of this study support the pursuit of several new directions for future research. The first of these new findings stems from strong evidence that the majority of therapists move through a developmental process as they engage in work with traumatized individuals. Prior research has suggested therapist experience (Cunningham, 2003; Pearlman & Maclan, 1995), years of education (Abu-Bader, 2000), or age (Adams, Matto, & Harrington, 2001; Nelson-Gardell & Harris, 2003; Vrendenburgh et al, 1999) were associated with a decreased risk of developing STS or VT; many of these authors discussed the possibility of
therapist personal development as a factor, but alternate explanations (such as therapist attrition) could not be ruled out. The current study not only found evidence that therapists who work with trauma do engage in a development process (which allows them to better cope when exposed to traumatic content), but this development occurs across multiple areas. The therapist themselves appears to be changed by their work, along with their awareness of the need for self-care, their utilization of self-care, their perceptions of their clients, and their sense of hope and resiliency in clients.

What is not known is whether this developmental process would be a normal process for therapists working with trauma in general, or if there were unique characteristics possessed by the individuals who had agreed to be interviewed (many of whom had been engaging in trauma work for many years or even decades). It is not known if therapists without a similar capacity for personal development might simply become too severely impacted and might either leave the profession or might seek out positions where they are less empathically exposed to trauma content. The fact that respondents scored as being less severe than average on the TABS suggests there are differences between these therapists and the “average” therapist. However, the therapists in this study did score slightly above average on the ProQOL STS scale, suggesting they were “average” in the amount of secondary traumatic stress symptoms they experienced. They also tended to describe similar developmental processes regardless of their scoring higher or lower on these instruments, as well as the number of years of experience (27 years average for LS group, 20.29 years average for HS group; over-all range of 1-35 years of experience with median years of experience being 25). Despite the potential
limitations, it appears likely that therapists do engage in a developmental process which occurs across multiple dimensions.

The question of therapist development needs to be further explored to identify if there are personality or other trait differences in therapists which influence their course of development, or could even inhibit the developmental process. Another important area of study would be to examine how other factors, such as a supportive or non-supportive workplace, can mediate therapist development. In what ways could this process be fostered, and could training programs begin this process more effectively before new therapists fully enter the workforce—where they might be exposed to high numbers of traumatized persons? Finally, could simple awareness that therapists often advance through a developmental process when engaging with trauma provide benefit to a new therapist, possibly by educating them about the normalcy of being impacted by traumatic content with the added awareness this impact will likely positively change over time if there is a willingness to develop skills and utilize resources.

Another unique finding was the importance of techniques and therapeutic approaches when working with traumatized persons. Several respondents discussed their perception that becoming skilled in conceptualizing clients, learning specific trauma therapy techniques, or being competent in an approach was protective. Developing these competencies enabled the therapist to be effective in instilling client change and recovery as well as provided the therapist with a sense of hope and optimism in their effectiveness regardless of the severity of the client’s trauma. Although likely connected with therapist age or experience, these therapists specifically mentioned competence and expertise in effective approaches providing them with
confidence in themselves and their abilities to help clients improve or heal. This also seemed to allow therapists to enter work with traumatized clients with less initial emotional distress, as well as reducing the general distress of their work throughout the therapeutic process. This finding suggests employers and/or training programs should ensure newer therapists be well-versed in an effective set of skills prior to being thrown into a difficult workplace setting or a position with a high caseload of trauma cases.

Another important and unique result was the finding that certain techniques could protect the therapist from more intense empathic exposure. One therapist specifically mentioned EMDR, which is psychotherapy technique in which the client only provides limited details of their trauma (as necessary) to the therapist and through which much of the client’s exposure is through mental visualization rather than verbal or written description (Shapiro, 1995). In other words, the therapist receives less exposure to traumatic content than they might if they were utilizing other approaches. As stated earlier, seven of the therapists responding to this study utilized EMDR as their primary technique: Of these therapists, six were in the LS group. Respondents also cited EMDR as leading to rapid change, which further bolstered the therapist’s sense of confidence and limited the length of time before clients achieved relief. Further research should focus on how different trauma techniques might impact the development of STS or VT. Techniques which limit traumatic exposure should specifically be explored, with a potential decrease in therapist risk being evaluated in addition to other efficacy factors. In the end, in cases where approaches are equally effective for clients, an approach which has less exposure for the therapist may be preferable.
Limitations

As mentioned previously, the sample of respondents interviewed for this study may limit the applicability of the results to therapists in general. The use of professional organizations for the initial mailings may have resulted in a sample which may have different qualities compared to the average therapists engaging in high levels of trauma work. The high number of individuals in private practice settings in this study may also be reflective of this, as these therapists may have been more likely to join these organizations. Therapists in private practice may also have simply had more time or flexibility to complete surveys or to be interviewed.

This researcher recognized the importance of having a more diverse (in terms of experience, workplace setting, and levels of STS/VT) sample compared to other previously cited studies of VT or STS. As discussed earlier, efforts were made to reach these individuals through selective sampling and snowball sampling (which also can introduce sampling bias), but these yielded limited success; the sample did bring a greater degree of respondent diversity, but highly experienced, private practice, lower VT respondents were still over-represented. As prior research has consistently suggested community and other public settings offer unique challenges and risks for trauma therapists, future studies should attempt to reach these therapists to determine how their experiences may be different. Of note in the current study was the fact that two private practice respondents reported they had worked in community settings in the past, and verbalized that they did experience increased barriers due to those experiences.
One advantage to the design of this study was the use of quantitative measures to provide data related to the current level of STS and VT the respondents were experiencing. Not only did inclusion provide the basic split used to group respondents, but valuable data was obtained to inform both the discussion and results of this study. One additional benefit is that this inclusion provided information concerning another limitation of this study, through providing quantitative information suggesting those who agreed to be interviewed were somewhat outside the norm for the typical respondents measured by these instruments.

One possible explanation for the differences between those who responded and those who did not could be concerns about confidentiality, or practical concerns about practicing ethically. Although this researcher made clear the importance and commitment to safeguarding confidentiality, the respondent’s identity would still be known to the researcher, and the reality is that there could be a risk of inadvertent contact with the researcher at some point in the future. Respondents would likely be aware that they may be struggling with issues of STS or VT, and there may have been professional concerns about this becoming known to others in the profession. This survey would also be examining issues related to the respondent’s career and professional work as a therapist, and some might have wondered if there was a perceived risk in participating, particularly if there was a fear their functioning was impacted by STS or VT to the point there may have been ethical concerns. Another trend appeared to be that higher scoring respondents did appear to be more likely to endorse a history of trauma than lower-scoring persons. There is a possibility that these persons might have feared the interviewer would ask questions about their history, or they might be inclined to discuss this history as part of an interview response, and they may have been reluctant to share this information. Other
possible explanations could include simply that these individuals would be less likely to be part of professional organizations, would be less likely to have been recommended by peers or contact persons for selective or snowball sampling, or may have felt too overwhelmed by their work or distress to take the time to complete surveys. Regardless, the results of this study may be limited in the application to the trauma therapist population as a whole.

Potential researcher bias is another limiting factor in this study. Qualitative research acknowledges that researchers will inevitably bring personal biases to their studies; therefore great efforts are made to limit these biases (Creswell, 1998). Although the author of this study attempted to limit any personal biases, the potential that biases would still be present is inescapable. The current author has worked extensively with traumatized persons, and there is the possibility that the author’s prior experiences may have influenced the interview process, possibly even in subtle and unintended ways such as through voice tone or other non-verbal signals. Two respondents, who were questioning their selection for this research prior to the interview beginning, were informed of the interviewer’s experience as a therapist, and there is a possibility this knowledge may have influenced some of the content of their responses. Efforts to limit bias were engaged in through having questions and forms reviewed by the dissertation chair and through pilot testing the instruments-thus receiving feedback about any potential bias. Coding teams were also utilized to prevent researcher bias in the coding process, but the author trained these teams and supervised the coding process (although strove to remain as neutral as possible when supervising the teams). Nevertheless, bias of some degree is still likely to be present within this work.
Another limitation could have occurred due to the two-group design of this study. There may have been differences between the coding teams which may also have affected the open codes and axial codes. Both teams received the same instructions and training, and shared the third coder (the “tie-breaker”), but individual differences may have influenced the coding process as well.

**Recommended Future Research**

1. Efforts should be made in future studies to study therapists who have more elevated levels of STS and VT, for the purposes of discovering how applicable the results of this study are to those populations, or how higher-scoring therapists might be experiencing different developmental processes, barriers, and impacts.

2. Research should focus on personal characteristics of therapists to better determine which characteristics are protective, which characteristics put the therapist at risk, and which seem to be innate versus developed characteristics. Of particular interest is the role of high empathy in mediating positive or negative impacts on the therapist. Also of particular interest are characteristics which can be developed through experience or training, to form interventions to enhance or decrease these characteristics.

3. Vicarious resilience (VR) should be further explored and defined, and should begin to be examined using both qualitative and quantitative methodology. Ideally, a measurement of VR should be constructed for facilitation of this study. The relationship between VR and VT should also be further examined, to determine if there are factors which could result in developing either construct given a similar exposure to traumatic content.
4. Longitudinal studies should be designed to obtain a better sense of the process of development therapists undergo when working with traumatized persons. Such a study could also provide insight into how STS or VT symptoms might develop or change over the course of a therapist’s career.

5. Therapy techniques for effectively treating traumatized persons should be researched to determine if the technique utilized may reduce or increase the risks of developing STS or VT.

Significance for the field

The current study is significant in that a hypothetical model has been created which describes the various factors contributing to developing either positive or negative impacts when a therapist is empathically exposed to traumatic content. Additionally, evidence has been gathered refuting the conclusions of Bober and Regehr (2006), who suggested that not only did therapists generally not use valued self-protective skills, but even when utilized these skills appeared to be ineffective. Evidence in this study was also gathered to support or clarify prior research, including some possible developmental processes suggested but not supported by prior research. The data generated from this work, supported by quantitative measures (ProQOL and TABS), provided further evidence that VT does not appear to be a syndrome which inevitably occurs over time due to empathic exposure to trauma. Additionally, the evidence from this study suggests a form of personal growth is occurring, with the hypothetical construct Vicarious Resilience appearing to be a possible explanation for what therapists reported. Finally, this study introduced some new factors which may influence the development of STS or VT. These factors include evidence that specific therapy techniques might decrease exposure to
trauma content; the role of personally perceived therapist competence and efficacy as a protective factor; various personal characteristics of therapists which appear to mediate the impact of traumatic exposure; and descriptions of how various factors might interact with one another to mediate the impact of trauma exposure. Finally, strong evidence was gathered suggesting therapists effectively modify their use of protective skills over time, as well as evolve in general as therapists through their exposure to traumatized clients. These developmental processes result in therapists not only becoming increasingly able to avoid negative impacts of STS or VT, but may facilitate positive outlooks or the development of VR. As a result of this last finding, interventions or trainings might be developed which facilitate these developmental processes.

**Current Recommendations**

1. Training programs and employers ensure therapists and (particularly) therapists in training are made aware of STS and VT, as well as what can be done to guard against these syndromes. This will be particularly important when a trainee plans to engage in a career where there is a high likelihood they will be exposed to traumatic content, or in agencies with high proportions of traumatized clients.

2. Training programs and employers ensure therapists and (particularly) therapists in training are made aware of vicarious resilience, as well as the fact that therapists often go through a developmental process where the negative impact of traumatic exposure can positively change over time due to changes initiated by the therapist.

3. Therapists who experience healing in their clients begin to build a sense of hope, witness human resiliency, and form a sense of personal efficacy. Inexperienced
therapists should be “eased” into work with trauma at first and should receive frequent and effective support to help them develop these characteristics; sending inexperienced therapists into situations where they have limited support, high caseloads with several traumatized persons, or highly difficult trauma clients should be avoided.

4. Therapists should be educated on the importance of self-care and external support, as well as potential barriers to their practicing self-care or accessing support. The need or usefulness of these should be explained and normalized. Therapists who have limited access to collegial support or consultation should be educated on the usefulness or need to connect with peers or colleagues to obtain informal support.

Conclusion

The results of this study suggest that therapists appear to be able to protect themselves from negative impacts when empathically engaging with trauma survivors. Therapists can reduce or ameliorate potential negative impact through the use of self-care skills and strategies, through accessing various forms of external support, or by otherwise mediating the nature of the traumatic exposure’s impact: Personal characteristics of the therapist may also play a role in mediating any potential impact on the therapist. As therapists gain experience, they appear to not only become more aware of the need to protect themselves from negative impacts, but become more versed at utilizing self-care skills and other protective techniques. Additionally, rather than being negatively impacted therapists may develop a sense of personal growth and fulfillment as part of their work, along with an increased sense of hope and confidence that their clients can change; the therapist also gains a sense of personal efficacy in their ability to instill change in their clients, which further increases their sense of hope and
decreases their emotional stress even when faced with very difficult traumatic content.

Therapists appear to be active agents in this process, and not only value self-care skills and other supportive factors, but actively seek to engage in incorporating these skills into their work as therapists.
References


Appendix A

Interview Questions

In what ways has working with traumatized individuals affected you personally?

What activities do you think are helpful for therapists to use to reduce the emotional impact of working with traumatized persons?

Which of these activities do you use, and how often do you use them?

What have some of your barriers or challenges been to utilizing self-care activities or coping skills?

How do you overcome those barriers?

What (if any) personal characteristics or outlooks do you believe are helpful in reducing the impact related to working with traumatized individuals?

Addendum to Appendix A:

In what ways has the impact of working with traumatized persons changed over time? Has your view or use of self-care skills changed over the course of your career?
Appendix B

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

<table>
<thead>
<tr>
<th>1=Never</th>
<th>2=Rarely</th>
<th>3=Sometimes</th>
<th>4=Often</th>
<th>5=Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am happy.</td>
<td>2. I am preoccupied with more than one person I [help].</td>
<td>3. I get satisfaction from being able to [help] people.</td>
<td>4. I feel connected to others.</td>
<td>5. I jump or am startled by unexpected sounds.</td>
</tr>
<tr>
<td>6. I feel invigorated after working with those I [help].</td>
<td>7. I find it difficult to separate my personal life from my life as a [helper].</td>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
<td>9. I think that I might have been affected by the traumatic stress of those I [help].</td>
<td>10. I feel trapped by my job as a [helper].</td>
</tr>
<tr>
<td>11. Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
<td>12. I like my work as a [helper].</td>
<td>13. I feel depressed because of the traumatic experiences of the people I [help].</td>
<td>14. I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td>15. I have beliefs that sustain me.</td>
</tr>
<tr>
<td>16. I am pleased with how I am able to keep up with [helping] techniques and protocols.</td>
<td>17. I am the person I always wanted to be.</td>
<td>18. My work makes me feel satisfied.</td>
<td>19. I feel worn out because of my work as a [helper].</td>
<td>20. I have happy thoughts and feelings about those I [help] and how I could help them.</td>
</tr>
<tr>
<td>21. I feel overwhelmed because my case [work] load seems endless.</td>
<td>22. I believe I can make a difference through my work.</td>
<td>23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
<td>24. I am proud of what I can do to [help].</td>
<td>25. As a result of my [helping], I have intrusive, frightening thoughts.</td>
</tr>
<tr>
<td>26. I feel &quot;bogged down&quot; by the system.</td>
<td>27. I have thoughts that I am a &quot;success&quot; as a [helper].</td>
<td>28. I can't recall important parts of my work with trauma victims.</td>
<td>29. I am a very caring person.</td>
<td>30. I am happy that I chose to do this work.</td>
</tr>
<tr>
<td>43.</td>
<td>I worry about what other people will do to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44.</td>
<td>I like people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.</td>
<td>I must be in control of myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.</td>
<td>I feel helpless around adults.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.</td>
<td>Even if I think about hurting myself, I won't do it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48.</td>
<td>I don't feel much love from anyone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49.</td>
<td>I have good judgment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50.</td>
<td>Strong people don't need to ask for help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51.</td>
<td>I am a good person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52.</td>
<td>People don't keep their promises.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53.</td>
<td>I hate to be alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54.</td>
<td>I feel threatened by others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55.</td>
<td>When I am with people, I feel alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56.</td>
<td>I have problems with self-control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57.</td>
<td>The world is full of people with mental problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58.</td>
<td>I can make good decisions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59.</td>
<td>I often feel people are trying to control me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60.</td>
<td>I am afraid of what I might do to myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61.</td>
<td>People who trust others are stupid.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62.</td>
<td>I am my own best friend.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>63.</td>
<td>When people I can't trust me, I believe they are in danger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>64.</td>
<td>Bad things happen to me because I am a bad person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>65.</td>
<td>I feel sad when I am alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>66.</td>
<td>I feel angry when I see people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>67.</td>
<td>I often doubt myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>68.</td>
<td>Most people are good at heart.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>69.</td>
<td>I feel sad about myself when I need help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>70.</td>
<td>My friends are those when I need them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>71.</td>
<td>I believe that someone is going to hurt me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>72.</td>
<td>I do things that put other people in danger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>73.</td>
<td>There is an evil force inside of me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>74.</td>
<td>No one really knows me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>75.</td>
<td>When I am alone, it's as if there's no one there, but even me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76.</td>
<td>I don't respect the people I know best.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>77.</td>
<td>I can't figure out what's going on with people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>78.</td>
<td>I can't do good work unless I am the leader.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>79.</td>
<td>I can't relax.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>80.</td>
<td>I have physically hurt people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>81.</td>
<td>I am afraid I will harm myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>82.</td>
<td>I feel left out everywhere.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>83.</td>
<td>If people really knew me, they wouldn't like me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>84.</td>
<td>I look forward to time I spend alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix D: Demographics sheet

Please fill out the following brief questionnaire. This information will be used for the purposes of better understanding our findings. This demographic information might also be considered when selecting individuals for an optional follow-up brief telephone or internet interview. You may choose to leave parts of this blank if you feel certain questions are too personal.

Gender: ___ Male ______ Female

Age: ___________ Years of experience as a therapist: _______

Estimated current weekly number of clients you work with who you would consider to be “trauma cases.” These would include individuals who fit criteria for PTSD, are being treated for trauma related issues (substance abuse, personality disorders), or have significant history of traumatic experiences which you have addressed clinically (complex grief, childhood abuse or neglect): __________

Years of experience working with traumatized persons at this level: ______

Have you experienced any of the following personal traumatic events in your lifetime?

☐ Serious car accident
☐ Domestic violence
☐ Sexual Assault
☐ Physical Assault
☐ Childhood sexual abuse (victim)
☐ Childhood physical abuse (victim)
☐ Childhood emotional abuse/neglect (victim)
☐ Combat
☐ Natural disaster
☐ Other: _______________________________________________________________________

The researcher will be contacting a limited number of respondents for a brief follow-up interview. This interview would take between 15-30 minutes, and would be conducted by either telephone or via the internet (preferably Skype). All information within this interview would be confidential, and $10.00 will be donated to a charity of the respondent’s choice for each interview.

Would you be willing to participate in a brief follow-up interview? Yes______ No______

If you would be willing to be contacted for a brief interview, what would be your preferred method of contact to arrange an interview time (please list your email address or telephone number in front of your preference)?

_________________________________________ Email _________________________________ Telephone