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Narratives of Secondary Traumatic Stress: Stories of Struggle and Hope

by

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Abstract

Even though posttraumatic stress theory has been extensively developed in the psychological and medical literature, development of secondary traumatic stress theory is still in its infancy. The traumatology literature reveals a focus on traumatized victims and, with few exceptions, excludes those who are secondarily traumatized (Figley, 1995). Secondary, or vicarious, trauma has become more topical over the past 7 years. Claims have recently been made that counselors working in the field of trauma are vulnerable and at risk for developing trauma symptoms similar to those experienced by their traumatized clients. Descriptors such as “compassion fatigue” (Figley, 1995), “traumatic countertransference” (Herman, 1992), and “contact victimization” (Courtois, 1988) are used in the trauma literature to capture the essence of this phenomenon, which is thought to be a natural consequence of knowing about a traumatizing event experienced by a significant other. For a trauma counselor, this significant other is the client with whom a caring and often long-term relationship has been established.

The American Psychiatric Association’s (1994) fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* refers to a secondary traumatic stress reaction, but omits discussion of the implications. Empirical research on secondary traumatic stress is minimal: Most focuses on survey data that report incidence levels and correlate demographic variables and symptoms. Qualitative research into the lived experience of counselors working in the field of trauma is absent from the literature.

This research study is an investigation into the meanings of experiences of struggling

with secondary traumatic stress. The researcher sought to answer the question, “What meanings do trauma counselors make of their struggles with secondary traumatic stress?” Four counselors working in the field of trauma co-constructed narratives on their struggles with secondary traumatic stress. Three conversations were held with each participant. A reflexive narrative method was designed for data collection and narrative analyses were conducted at three levels of interpretation: (a) textual interpretation of the research conversations, (b) interpretation of the research interactions, and (c) four collaborative interpretive readings of the narrative accounts. Narrative analyses generated the following salient aspects of the participants’ struggles with secondary traumatic stress: (a) struggling with changing beliefs, (b) intrapsychic struggles, (c) struggling with the therapeutic relationship, (d) work-related struggles, (e) struggling with social support, (f) struggling with power issues, and (g) struggling with physical illness. Implications for professional practice, research, and education were addressed.

Examiner

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Dedication

To the loving memory of

Margaret Ann Buchanan

whose spirit has been

a constant source of inspiration.

CHAPTER 1

The history of psychological trauma can be traced back to the late 1890s with Pierre Janet's pioneering work on hysteria that took as central the view that dissociation was the key organizing mechanism in response to psychological trauma. At the same time, Sigmund Freud was documenting that terrifying life events, especially those in early childhood, were a source of psychological pathology in later life. Freud made the causal link between childhood sexual abuse and hysteria. In 1893, Freud retracted his original claim due to the backlash from the medical profession. He stated that hysterical symptoms were actually due to childhood fantasies, and the study of trauma was abandoned for nearly 50 years (Herman, 1992).

In this century, the study of psychological trauma has brought to consciousness the human response to personal and collective catastrophe following major military events such as World War I and II, and the Korean and Vietnam conflicts. Interest in traumatic stress resurfaced in the late 1960s and 1970s with the advent of three key historical activities. First, the large number of psychologically distressed veterans returning from Vietnam and Cambodia and the associated influx of refugees into North America placed an enormous strain on the Veterans Administration system and mental health providers in the United States. The proactive veterans' movement was one of the main catalysts in securing government funding for research into the impact of war-related trauma.

The second impetus was the women's movement that brought to public awareness the shocking epidemiological evidence of the prevalence of sexual and domestic violence perpetrated against women and children in our society. In her random sample of over 900 women, Diane Russell (1984) documented that one in four women had been raped in

adulthood and one in three women had been sexually abused in childhood. The response to this report set in motion government funding for women's sexual assault centres and rape crisis lines throughout North America. The 1980s became the decade for research on the impact of childhood sexual abuse and war-related traumas.

The third political event that caused a surge in awareness of traumatic stress in North America was the human rights movement. Through organizations, for example, the NAACP, issues such as violence, poverty, and injustice directed toward minorities were brought under public scrutiny. Political activists brought attention to the mistreatment of minority groups in state mental health facilities. Groups such as Amnesty International contributed by making the Western world conscious of the violence and political torture experienced by survivors of terrorist regimes in other parts of the world. These three historical activities (the Vietnam War, the women's movement, and the human rights movement) were directly responsible for resurrecting awareness of the impact of traumatic events upon the human psyche.

In 1980, for the first time, the American Psychiatric Association (APA) included in their third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* a diagnostic category for the effects caused by "an event outside the range of usual human experience . . . that would be markedly distressing to almost anyone" (p. 250). This classification was labelled *Post-Traumatic Stress Disorder (PTSD)*. In their 1987 revision, the APA reassessed the category and included in *DSM-III-R* the criteria of Complex PTSD, for those survivors who have suffered long-term effects of traumatic stress, such as prisoners of war, people held in captivity, battered spouses, and incest and

other childhood sexual or physical abuse survivors. In 1994, the APA became more explicit in providing guidelines for diagnosis, by distinguishing between those directly and those indirectly exposed to traumatic stressors. According to the latest APA (1994) edition of the *DSM-IV*, a person diagnosed with PTSD must have “experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others” (p. 426). The new diagnostic category in the *DSM-IV* (1994) provides a key to understanding exposure to another’s experience as a traumatic stressor, by pointing to the inclusion of the following element in the criterion: “The person’s response involved intense fear, helplessness, or horror” (quoted in Stamm, 1995, p. xvi). Stamm states

No longer is pathological traumatic stress addressed from the event-only perspective. Instead, the new *DSM* rubrics suggest it is necessary to consider the ecology of the entire system and focus on the interaction *between the person and the event*. It is this bi-fold nature of the definition--if the caregiver reacts with intense fear, helplessness, or horror--then the possibility of caregiving as an etiology of pathology exists. (pp. xvi-xvii)

The body of literature focusing on psychotherapy with trauma survivors has flourished over the past 15 years, but little of that literature has addressed the impact of trauma work on the trauma counsellor. However, there is currently a growing interest in the deleterious effects of trauma work on mental health professionals (Arvay & Uhlemann, 1996; Figley, 1995; Follette, Polusny, & Milbeck, 1994; Munroe, 1995; Neumann & Gamble, 1994; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Evidence of this interest can now be found at international conferences on posttraumatic stress; in recently published articles and books (Pearlman & Saakvitne, 1995; Stamm, 1995; Wilson & Lindy, 1994); and at professional workshops and training seminars where

symposia on *vicarious traumatization*¹ and *secondary traumatization*² are beginning to flourish.

Although there is an increased interest in the topic of secondary traumatic stress, at the present time there exists only a handful of research studies (Arvay, 1993; Follette et al., 1994; Munroe, 1991; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). All of these studies have contributed significantly to our understanding of the demographic indices and levels of stress among mental health professionals working with survivor populations. Their research data have mainly been collected by using survey methods, incorporating standardized instruments, such as the Impact of Event Scale (IES, Horowitz, Wilner, & Alvarez, 1979), the Brief Symptom Checklist (BSI, Derogatis & Spencer, 1982), and the Trauma Symptom Checklist-40 (TSC-40, Elliott & Briere,

¹McCann and Pearlman (1990) first described *vicarious traumatization* as the cumulative transformative effects upon the trauma therapist from working with survivors of traumatic life events. Later, Pearlman and Saakvitne (1995) defined vicarious traumatization as “the transformation that occurs within the trauma counsellor as a result of empathic engagement with clients’ trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people’s cruelty to one another, and witnessing and participating in traumatic reenactments, either as a participant or a bystander in the therapy session. It is an occupational hazard and reflects neither pathology in the therapist nor intentionality on the part of the traumatized client” (p. 31).

²According to Figley (1995), secondary traumatization results from knowing about a traumatizing event experienced by a significant other; the stress results from helping or wanting to help a traumatized person. “Secondary Traumatic Stress Disorder (STSD) is a syndrome of symptoms nearly identical to PTSD (APA, *DSM-IV*, 1994), except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms directly connected to the sufferer, the person experiencing primary traumatic stress” (p. 8). The difference between secondary traumatization and vicarious traumatization is that the former is subsumed under the diagnostic criteria in the *DSM-IV* and the latter is a construct based on McCann & Pearlman’s (1990) constructivist self development theory.

1991). These studies have focused on common response patterns among subjects and have provided significant information on the general incidence of stress levels among those working in the field of trauma. (A description of each of these studies and a review of the findings is offered in the literature review in chapter 3.)

A review of the literature revealed a clear gap in qualitative understandings of secondary traumatic stress. To date, a narrative study focusing on the descriptive experiences of trauma counsellors struggling with secondary traumatic stress has not been published. This research study of narratives of secondary traumatic stress offers a significant contribution to the field of traumatology, and to the understanding of psychological trauma. In order to counter the impact of secondary traumatic stress, it is crucial to understand the toll that it takes on the trauma counsellor from the counsellor's own perspective. Much can be learned from the point of view of those whose lives have been impacted by their work with survivors of trauma. Instead of examining common response patterns across subjects, this study has been designed to focus on individual experiences of secondary trauma through the narratives that trauma counsellors construct as they make meaning of their struggles with this experience.

There are ethical and moral reasons for providing descriptions of the cost of caring to those involved in bearing witness to the aftermath of violence in our culture. The ethical imperative pertains to an obligation that mental health professionals have to provide appropriate and effective care and to "do no harm." If we in these professions do not recognize the personal impact of trauma work on the counsellor, we run the risk of not recognizing its effects on our work and the care we give our clients (Pearlman &

Saakvitne, 1995). Trauma counsellors often work in isolation, lacking social and work support and the conceptual background and practical training to do this work safely (Arvey & Uhlemann, 1996). To date, few counsellor graduate training programs in British Columbia offer education about psychological trauma, and even fewer address the risks involved for both the counsellor and client in doing this difficult work. Scholars in the field of trauma, such as Jacobs (1991), Yassen (1995), Pearlman and Saakvitne (1995), and Wilson and Lindy (1994), agree that the self of the counsellor is the fundamental tool in trauma work; therefore, counsellor educators, clinical supervisors, and trainers in trauma therapy have a duty to warn and protect trauma counsellors (Munroe, 1995), by providing proper education and effective support to minimize the vulnerability of counsellors working in the field of trauma. A response to these moral and ethical issues is provided in this narrative study.

The Purpose of the Study

My assumptions entering this research project were that participants of this study, all trauma counsellors, would be struggling with repeatedly painful and even horrific experiences that have been disruptive to their everyday notions of how the world should be. I anticipated that they would be confronting the difficult task of reconciling these disruptions to previously held core beliefs (e.g., good versus evil; hope versus despair; safety versus vulnerability) and would be struggling with physical, psychological, and social effects as well. My interest lies in the narrative constructions of struggling with shifting core beliefs and the ways in which the participants reconstitute their lives in order

to be psychologically and physically healthy. The research question is how do trauma counsellors manage to incorporate new conceptual shifts that contradict previously held core beliefs in a way that allows them to function as healthy, viable, and hopeful trauma counsellors? Through a reflexive³ narrative process, the researcher developed a collaborative research relationship with the participants in this study for the purpose of understanding the multiple meanings of struggling with secondary trauma.

The Researcher's Context

As a constructivist, I believe that there are multiple constructions of social reality; there is no “single truth” or “reality” that can be known. Constructivists state that knowledge and truth are not discovered but created or invented (Schwandt, 1994). Humberto Maturana (1980) calls reality “the search for a compelling argument” (p. 80). Since personal realities are socially constructed there is no observation independent of the observer (Efran & Fauber, 1995). The nature of reality, that is, what can be known about it, is formulated in both individual and group constructions. Constructions are local and specific, emerging from our personal experiences. The value or worth of a construction is dependent upon what knowledge is available at any given time (Guba & Lincoln, 1994).

Constructivists reject the picture of language as a tool to convey information.

³*Reflexive* refers to a bending back on itself or oneself. *Reflexivity* has been described as a turning-back of one's experiences upon oneself wherein the self to which this bending back refers is predicated and must also be understood as socially constructed. “This folding back may unfold as a spiraling, if we allow for multiple perspectives, and acknowledge that the same self may be different as a result of its own self-pointing” (Steier, 1991, p. 3).

Language is interactive; it is an action, a doing. Language is a form of social activity. Jay Efran calls language a choreography, a dance; “it is communal and personal and we all participate in it” (personal communication, July, 1997).

My epistemological approach to research is subjective, interactive, and dialogical. The participants and I construct what can be known as we actively engage through the discourses we create in doing research. I take an approach to knowledge construction that is interpretive, proactive, and subjective. We engage in creating meaning using Hans Vaihinger’s theory on the philosophy of “as if” -- as if there were an objective reality “out there” (cited in Mahoney, 1991, p. 15).

George Kelly (1955) instructs us that understanding or meaning-making is proactive and purposive. Further, meaning is constructed through contrasting differences and “linguaging” is the path to meaning construction. As Jacques Derrida (1987) posits, language is a self-referential system -- concepts are defined in terms of their similarity and differences to other concepts. Oscar Gonclaves (1997) states

It is in language that meaning is constructed. Increasingly, psychology is recognizing that language and discourse are both the means and the ends of meaning and knowing. . . . The hermeneutic and meaning nature of language results, above all, from the process by which words are combined with one another in the establishment of a narrative plot or matrix. It is within this narrative matrix that the individual proactively and creatively constructs a reality of meaning. We are talking here of a narrative of action, a narrative that exists only in the process of telling (Gergen & Kaye, 1992), a narrative as a speech act (Harre’ & Gillet, 1994). (p. xiv-xv)

It is with this understanding that I can state that meanings cannot be measured. “They are at heart relational, self-referent, and qualitative. They do not exist out there. They require both construction and interpretation. What is required is a fundamentally different kind of epistemology” (Efran & Heffner, 1997, p. 4). What is required is a constructivist

epistemology that is interpretive and hermeneutic. Both the researcher and the participant are embedded in a culture of symbols, rules, morals, and language. As Efran and Heffner (1997) and Derrida (1967) argue, the etiology of meaning is self-referential and relational. In this study, I construct knowledge by contrasting my personal knowledge and experiences of secondary traumatic stress with those of my participants. I move between being a constructivist to a social constructionist, depending upon the research activity that I am engaged in. Both contain the notion that reality is socially constructed and participatory, but the latter emphasizes the social contexts that shape meaning-making. I use the term *constructivist* throughout this text to refer to both constructivist and constructionist concepts.

Susan Krieger (1991) states that the self of the researcher cannot be disengaged from the research process; “rather, we need to understand the nature of our participation in what we know” (p. 30). In recent feminist postmodern literature (Hertz, 1997; Jipson & Paley, 1997; Reinhartz, 1997; Richardson, 1997), there has been a call for the visible inclusion of the author in our research texts, providing insight into how knowledge has been constructed and positioning the researcher as a “situated actor” (DeVault, 1990) in the research process. Based on my belief that I need to include myself in the research in discernible ways, in order that the reader might be able to comprehend my interpretive stance as the researcher, I have included this section as background highlighting my interests and experiences with the research topic.

For my master’s thesis I conducted a survey questionnaire on counsellor stress that was distributed to 250 counsellors working in the field of trauma throughout the province

of British Columbia. I compared test scores across subjects on three measures of stress: general life stress (Perceived Stress Scale, Cohen, Karmarck, & Mermelstein, 1983), burnout (Maslach Burnout Inventory, Maslach & Jackson, 1981), and traumatic stress (Impact of Event Scale, Horowitz, Wilner, & Alvarez, 1979). The return rate was 64%, and I found that 14% of those surveyed had high scores on all three measures. But what did scoring high on all three measures mean in the lives of these counsellors? Although I had learned a great deal by conducting the survey, I found upon completion that I was left with several unanswered questions: What were the respondents' personal experiences of this phenomenon? What meaning did they make of their struggles with secondary trauma? How did these experiences impact each individual's sense of self or identity? How did they reconcile the disruptions in their lives? I was also influenced by the passionate notes and letters that a few counsellors had included with their questionnaires, elaborating their struggles with their work. Their written responses were much more rich and emotional. I felt drawn into their personal experiences. There was a resonance with my own experiences in the field. Unfortunately, the emotionality reflected in their brief notes and letters was missing in the reported survey findings.

In 1993, I completed that thesis and enrolled in the doctoral program. Expanding my initial research on counsellor stress, I decided to develop a research project that would be congruent with my constructivist epistemology and my commitment to feminist research practices. I wanted to expand on the meaning of the experience of struggling with secondary traumatization from the perspectives of those experiencing it.

In terms of my personal experience in the field of trauma, I had spent 6 months

working at a centre for sexually abused children and a year working as a counsellor at the University of Victoria Counselling Centre. I started to attend the annual conference sponsored by the International Society for Traumatic Stress Studies, where I presented my master's research findings and enthusiastically conversed with other researchers (Charles Figley, Sarah Gamble, James Munroe, Laurie Anne Pearlman, and Bessel van der Kolk) on the topics of vicarious trauma and secondary traumatic stress.

In February 1996, I was invited to participate as a delegate to South Africa on a 3 week exchange led by Bessel van der Kolk. The purpose of this trip was to share clinical and research expertise with our South African counterparts. We visited many trauma centres, universities, and hospitals throughout the country and gave lectures on theoretical conceptualizations and treatment strategies for various types of traumatic events. It was in South Africa that I learned about multiple traumas and was inspired by the recovery process. We met with the Truth and Reconciliation Commission and heard testimony from the survivors of apartheid. We had the enormous pleasure of meeting Nelson Mandela and Desmond Tutu at a ceremony in Cape Town celebrating two historically significant events: the Inauguration of the Commissioners for the Truth and Reconciliation Commission and the 50th Anniversary of Mandela's incarceration on Robbin Island. Their words will be with me forever.

In South Africa, I was profoundly affected by the horrors of apartheid. The testimony of so many survivors weighed upon me. Each evening after dinner our contingency would meet for a debriefing session to deal with the vicarious effects of what we had heard and/or witnessed during the day. We became very close—connected in our knowledge of

the evil that exists in the world. I was also inspired by the hope and courage I saw in each person I met. For example, in Cape Town I met a minister, wearing an eye patch and using hooks for hands, who shared tea with me and told me what it meant to be a freedom fighter.

On my return home I faced a personal crisis of my own when my beliefs shifted and I struggled to restructure various shattered selves. I battled with the philosophical concepts I earnestly held as they clashed against my efforts to construct new beliefs. It was a transformative experience, in that core beliefs about myself and my world were disrupted. It took me months to recuperate and get back to the work of completing this dissertation. However, I reentered the field of trauma with a powerful personal experience that I believe has in many ways paralleled the experiences of the participants in this study. I also experienced the recovery process and have a greater appreciation of the struggles. Writing this dissertation has been an amazing process of self-discovery and self-construction.

Language Usage in the Text

Since the field of trauma may be new to some readers of this text, I explicate the frequently used psychological terms as well as words found in recent feminist postmodern writing by footnoting them (e.g., subjectivity, discourse, reflexivity). I use the term *client* instead of *patient*; *survivor* instead of *victim*; *counsellor* synonymously with *therapist*, in referring to other specialists such as social workers, psychologists, psychiatrists, emergency response workers, police officers, child care workers, the clergy, and other

persons working in helping professions who counsel traumatized individuals. In terms of pronoun usage, throughout this text, I subscribe to gender-fair language and because the participants in this research study are all female, I predominantly use the pronoun *her* and occasionally substitute *him*. When referring to other researchers in the text, I frequently give the author's first name. Using the author's first name, instead of leaving it out, identifies the author in gendered terms, which disrupts the hegemonic practice of assuming the writer is male. Finally, I write the text using Canadian spelling, except in the Abstract where I implement American spelling.

Overview of the Text

Although each chapter of this dissertation stands alone, I have given considerable thought to the organization of the chapters. I have written this overview as an explanatory note for the academic reader seeking standards and forms of writing found in traditional research texts. My desire is to proceed in a manner respectful to the participants in this study and to present the text in an understandable format for the reader. I do not offer the usual textual presentation found in traditional psychological research, but instead utilize a format that I believe is integral to this research process.

Chapter 2 presents the participants' narratives on secondary trauma, with a brief introduction that articulates how the narratives were constructed and provides an explanation for beginning with the participants' narrative accounts. Because the method of inquiry is narrative, this chapter replaces the Results section found in traditional research texts. Chapter 3 is divided into two sections: The first is a review of the

literature on narrative inquiry as human science research, and the second is a review of the literature on secondary traumatic stress. Chapter 4 focuses on the research method; a reflexive narrative method is presented. Chapter 5, typically the Discussion section in traditional research texts, is the final chapter of the dissertation. It interfaces and juxtaposes the perspectives of the researcher, the participants, and a traumatologist in the format of a fictional conversation. Within this conversation, the findings of the research project and implications for future research, education, and training are discussed.

In summary, I introduce the dissertation, present the participants' narrative accounts, review the literature on narrative inquiry as human science research and the literature on secondary traumatic stress, present in detail a reflexive narrative method used in this research project, and conclude with a three-way fictional conversation between the participants, the researcher, and a traumatologist.

When the great Rabbi Israel Baal Shem-Tov saw misfortune threatening the Jews, it was his custom to go into a certain part of the forest to meditate. There he would light a fire, say a special prayer, and the miracle would be accomplished and the misfortune averted.

Later, when his disciple, the celebrated Magid of Mezritch, had occasion to intercede with heaven for the same reason, he would go to the same place in the forest and say: "Master of the Universe, Listen! I do not know how to light the fire, but I am still able to say the prayer." And again the miracle would be accomplished.

Still later, Rabbi Moshe-Leib of Sasov, in order to save his people once more, would go into the forest and say: "I do not know how to light the fire and I do not know the prayer, but I know the place and this must be sufficient."

Then it fell to Rabbi Israel of Rizhyn to overcome misfortune. Sitting in his armchair, his head in his hands, he spoke to God: "I am unable to light the fire and I do not know the prayer; I cannot even find the place in the forest. All I can do is to tell the story, and this must be sufficient." And it was sufficient. God made men because He [She] loves stories. (Robert Murphy, 1960, quoted in Neimeyer & Mahoney, 1995, p. 195)

Inspired by a quote from Ruth Behar (1996), I offer this caveat: “If you don’t mind going places without a [traditional] map, follow me” (p. 33).

CHAPTER 2

NARRATIVES OF SECONDARY TRAUMA

Introduction

The purpose of this chapter is to present the narrative⁴ accounts of four trauma counsellors who have struggled with secondary traumatic stress. Traditionally, the Findings section of a research study follow the Literature Review and Methods sections. I have purposefully broken away from tradition for several reasons. By positioning the narrative accounts “up front,” I am privileging the participants’ experiences, recognizing personal, local knowledge⁵ as a valuable starting place. Each narrative account inherently conveys its own meaning of the experiences of struggling with secondary traumatic stress. By placing their narrative accounts first, I am honouring participatory and experiential knowledge construction over the dominant psychological discourse⁶ on trauma, which is reviewed in the last section of this chapter.

⁴Donald Polkinghorne (1988) states that *narrative* can refer to the process of making a story, to the cognitive scheme of the story, or to the result of the process, such as “stories,” “tales,” “histories,” and, in this research study, “accounts.” A distinction between *narrative account* and *story* is made in the literature review in chapter 3. I define narrative according to Norman Denzin’s (1997) definition, as a “performative process of making or telling a story” (p. 158). Narrative falls within both modernist and postmodernist conceptualizations.

⁵Clifford Geertz (1973) recommends that human scientists orient themselves to “local knowledges,” those aspects of human experience that are unique, individualized, and contextualized.

⁶*Discourse* refers to the relations between language and social reality. Discourse analysis is the study of patterns and rules controlling language and representations used in film, literature, pictures, and texts, for example. According to Michel Foucault, (Rabinow, 1984) discourse analysis is a study of power structures and assumptions underpinning language practices.

Beginning with the narrative accounts situates the reader in the experiences of those who have suffered with this phenomenon. Reading these narrative accounts and coming to your own understanding of the meaning of an individual's struggle with secondary traumatic stress is a useful position from which to comprehend the research process. Also, showing the struggles with secondary traumatic stress from the personal experiences of these four women before framing their accounts within the larger discourse of trauma is congruent with the collaborative, reflexive narrative method used in this study.

Narrative Construction

These narrative accounts were co-constructed. The women in this study individually told their stories, and the interactions between storyteller and researcher were recorded and transcribed. Transcripts were read, responded to, and discussed on several occasions by the four participants and myself, employing a reading guide (Table 2, chapter 4). Through this process, I wrote the final research narrative accounts after consulting with the participants for editorial approval.

A narrative account cannot re-present⁷ actual life because the telling of a story is after the event; it is a remembrance fashioned by both the storyteller's and researcher's context, desire, and personal interests. The interaction between the storyteller and

⁷ I have hyphenated the word *re-present* because I use the term in the postmodern sense. The world of real lived experience can never be captured or represented in research texts. There is no direct link between experience and text (Denzin, 1997). I am signifying that re-present means "to present again." To re-present Other narratively means to construct a textual interpretation.

researcher are interwoven into the text. In this way the narrative accounts presented here are blended texts: a construction of multiple voices, interwoven interpretations, and reflexive analyses. The narratives are constructions brought forth by a collaborative, interpretive research process. The final written text bears my authorial inscription. These narrative accounts tell as much about me as they do about the participants. Through the reflexive process of this research writing about the experiences of others, I came to a new understanding of my own subjectivity.⁸ As Laurel Richardson (1997) poignantly reminds us: “Surely as we write ‘social worlds’ into being, we write ourselves into being” (p. 137).

So Who Is Telling the Story?

The voices of Anna, Donna, Jesse, and Marie have been appropriated. I wrote the narratives as first-person accounts. These narratives are my own constructions, carefully crafted through a reflexive and collaborative research process. Unlike traditional psychological research where the author of the text is concealed and the lives of the participants are objectified by writing in the third person, I did not want to reduce my participants’ experiences to themes or categories. Acknowledging that we, academic authors, are always present in our writing no matter how hard we try to hide this fact, I write this introduction to the research narratives as a way of “coming clean.” My desire

⁸According to Christine Weedon (1987), *subjectivity* is used to refer to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world. It is precarious, contradictory, and in process, constantly being reconstituted in discourse each time we think or speak.

was to create embodied narrative accounts that value emotionality. I have attempted to craft narratives that would engage the reader and bring to life the multiple interpretations that inform the creation of these narrative accounts.

Each participant's narrative has been entitled "Lessons" because these are teaching stories full of instructions about the meaning of struggling with secondary traumatic stress and how counsellors survive in the field of trauma. Some of the narrative accounts are complete stories in the modernist sense: plot, sequential ordering of events leading to a critical point or crisis, and ending with a resolution. Others are not modernist tales. They present issues that are left unresolved, in a chaotic bombardment for the reader to disentangle. Some of the accounts are contradictory and ambiguous, like "real" life, life in process, a chapter not yet finished.

Anna: Lessons on Self-Care

I grew up in a large family, four girls and one boy, in a small, rural community in northern Alberta. I am a tall, large-set woman with dark features. Because of my stature I am often judged as being dominant. I can be assertive, yet at the same time, caring, and sensitive. I am in my 40s and work as a trauma counsellor in a clinic on the lower mainland of British Columbia. I have been working in the field of trauma for almost 12 years, with a few breaks to do other types of work. Several years ago I went back to university and completed a master's degree in counselling psychology. For a few years I worked as a sexual assault counsellor, but for the last 5 years I have been an administrator, clinical supervisor, and part-time counsellor at a centre for survivors of

political violence and torture.

At the centre, the dominating mother projections have become problematic. Because I am extroverted, assertive, and outspoken, people react to me as though my words or actions carry more weight or meaning than they should. My intentions are often misunderstood or misinterpreted because projections get mixed in with the messages. For example, if I am with a group of women deciding where to go for lunch, I'll usually offer a suggestion in my assertive, enthusiastic way and it will be interpreted by four out of six women as a demand. Yet, if a woman who is soft-spoken, shy and petite said the exact words in this group, she would be interpreted as offering a suggestion. So every day, in almost every interaction, I carry this cultural ascription and it's getting very tiresome.

About a year and a half ago, I "hit the wall." Like in a marathon race, the wall was that place, that moment in time, when both my mind and my body collapsed. Hitting the wall was a frightening, painful, and disorienting experience. The events leading up to this crash, tell the story of an out-of-control, workaholic trauma counsellor running a marathon race toward her own self-destruction. I realize as I approach the next part of this writing that I am starting to get flooded physically, remembering that large, black stain on my life. I also realize that this written account cannot possibly capture this complex experience as I struggle to articulate it.

For quite a long time I had been working anywhere from 12- to 15-hour workdays at the centre. I was dealing with a lot of heavy cases at that time, many survivors from Cambodia and Chile, as well as acting as clinical supervisor, which meant that I was continually debriefing my colleagues on their vicarious trauma. My strategy at that time

was to work myself to the point of exhaustion each day as a means of keeping the dogs at bay. I had put on weight, I wasn't getting any exercise and hardly any sleep, and I started to isolate myself socially. There were many nights when I didn't want to go home. I wished I could sleep in my office. I just couldn't face the drive home. I was conscious that my behaviour was insane. I knew that I was becoming a workaholic and I knew why.

Going home I would start to feel "it." It was like a large, heavy cloak slipping over me, weighing me down, and I became draped in despair. I felt grey, empty, and hopeless. Life felt hollow and meaningless. I couldn't find joy anywhere. I couldn't read, or watch television, or converse with a friend. Driving toward my house, I would feel the energy going out of my feet. It was a very physical and intense feeling, like I had been beaten up. And no matter what I did I couldn't shake that off. If I tried going for walks, I would feel like weeping. Moving my body was exhausting, like I was dragging it along behind me. I just couldn't see the point of being in the world if this was how people could be treated. Images of their tortured bodies would flash before my eyes. These feelings threatened to immobilize me and engulf me--I was starting to lose control. My only salvation was going to work and staying there for as long as I could each workday.

In my counselling sessions with traumatized clients, I would sometimes get swept up in feelings of helplessness. I would flip into a desperate state where I would feel that there was nothing I could do to help the client in front of me. And I just couldn't stop myself from going into that state. I would suddenly be transported back to the same place that I had felt as a young child: There's nothing I can do; I'm stuck. I've been screwed over by my family and by my sexual abuse, and now, by listening to all these trauma

stories, here I am. My life is going to be a piece of shit! So I started dissociating more and more. I was cut off from the neck down. I just lived in my head. I would fall into a numb depressing state. I plunged into my work, trying to fill the void, hoping to find a distraction--a way to stay away from my feelings, my body, and this overwhelming despair.

The crisis erupted one day as I was on my way to a conference on Vancouver Island. I was invited to speak on strategies for debriefing colleagues. I knew I wasn't well. I had this blinding headache that I couldn't get rid of, but it was too late to cancel. Getting off the airplane I collapsed. My body completely gave way; the pain in my head and face were excruciating. It was like somebody had hit me across the face with a two-by-four. Half of my face went into paralysis and my body was like a limp rag. It was like I got the wind punched out of me. They called an ambulance and took me to the hospital. I was tested several times over the next 2 weeks by various doctors, but they couldn't figure out what it was. In the final diagnosis they claimed that I had some strange virus. They didn't know where it came from, what it was called, whether or not it would get worse, or how long it would last. They just sent me home. I felt completely numb.

Recovery took a very long time. My body had virtually collapsed. At first, I couldn't get out of bed. My face hurt so much that listening to someone speak or hearing people laugh would cause the pain to spike. My headaches were so excruciating that I couldn't see straight. I couldn't read or write for about a week. I couldn't listen and I couldn't talk. All of my senses were screaming, "Shut it off!" No one could help me and I was afraid that I would never get better.

Over 3 or 4 months, I started to regain my energy. The paralysis and facial pain very gradually subsided. During this recovery period, I struggled with recognizing the seriousness of my illness. Unbelievably, I made plans during the first week of my illness to return to work. My head kept playing the same tape: "I'm making it up. I'm a wimp, and I should be back at work." My coping strategy of workaholism was no longer an option.

So I went to therapy. My therapist and I spent many sessions working on the metaphor of my physical illness--being slapped across the face. My body was saying, "Smarten up!" I realized that hitting the wall was an accumulation of three crises: being physically ill, being vicariously traumatized from my work, and having a professional identity crisis. I had been living according to a formula that I had devised in my head. I had allowed the impact of my job to eat away at my whole being and inevitably I got ill. I had to ask myself: Why am I doing it? Why am I listening to people's trauma stories over and over and over for years to the point of risking my own health? And a more urgent question I faced at that time was how would I ever be able to adequately protect myself when hearing and witnessing the atrocities of mankind? How would I ever be able to continue to do the work? And finally, why did I want to?

I realized the problem was complex. It was layered within the dynamics of work and intertwined with my own abuse history. Work was a double-edged sword. On one side there was the mission, a purpose in my life, something beyond myself that gave life meaning. On the opposite side I was working through my own trauma story, identifying with other survivors, and trying to make a difference in their lives. It cuts both ways: The mission side of the sword was cutting me to shreds while I was bleeding to death from

overidentifying with my clients.

After 8 months I returned to work—healthier and wiser. I no longer used workaholism as a coping strategy. My illness was a transformative experience. I learned that I was not invincible. I started to analyse my practices and became vigilant about self-care. Now I debrief regularly with someone who knows what I need and knows how to debrief properly. Trauma counsellors need to debrief regularly in order to buffer the effects of vicarious trauma. It is imperative to debrief with someone who knows how to do it. Some people try to actively listen and sympathize, but it seems that they are performing. Sometimes I am aware that they may be anxious because I am in a management position, and this may contaminate the debriefing process.

I believe debriefing has to be formal and structured. I have to be willing to come to my colleague and say, “Mary, do you have a minute for me to debrief?” or “Is this a good time for you?” If so, then we can go into another room, away from our colleagues so that they don’t have to hear it, because it is not necessary to burden them. In this private place we both prepare ourselves psychologically for what I’m going to share. In this way the role of the debriefer is delineated so the unexpected doesn’t come at you from nowhere. People just can’t be indiscriminate about their clients’ stories, because the workplace becomes toxic. It becomes unsafe to be anywhere, even in the halls or lunchroom. Debriefing can also be contained on two levels: 1) telling the debriefer all the sensory details resulting from the impact of the client’s trauma story or 2) discussing only the counsellor’s feelings about the client’s story. Then the impact of the trauma story is immediately dealt with and the feelings dissipate. The stress is not just diluted, it is

released.

There is a reason why I separate these two types of debriefings: I have learned that working in one sensory modality at a time offers a better chance of releasing the impact of the trauma story. I believe that taking an image, putting words to it, and articulating it makes the image more solid and more real. Therefore, not verbalizing it keeps the impact on the level of imagery--which is less concrete. Meanwhile, you are able to release the feelings more directly. I find that by remembering the images and then just discharging them by crying, or raging or drawing it--expressing it through feelings--you have a more direct path to releasing the impact. There is something about saying it, verbally theorizing about it, that invokes hearing it, and now other modalities are involved which concretizes the images you want to get rid of. So, careful, conscious debriefing is partially about protecting the debriefer (not wanting to lay something horrific on them), but it is also about not wanting to overwhelm yourself.

There is also one other major factor that impacts on many trauma counsellors: belonging to an agency that is an organization based on political idealism. Being part of a political organization that is run mostly by women, I find that women coming into the organization have higher expectations of other women than they do in a mixed gender, non-political environment. They expect really great things of other women, especially if they themselves are feminists, because they have feminist ideals about how women are suppose to interact. They tend to believe that there shouldn't be any power differences or power struggles in the workplace and of course, even if you're a feminist, you still are enmeshed in the dominant culture. You still have power struggles and hierarchical

thinking all around you. For example, you still have to deal with competitiveness, family of origin factors, and personal prejudices, and all this stuff gets acted out and people become disillusioned and disappointed. So they start blaming each other and start to turn on each other. It is a horrible thing to watch and it makes me very sad. People just have a hard time facing the reality that other women aren't perfect. There is a huge denial around this topic at work and it gets repressed and goes underground. It makes the job that much tougher.

Finally, the real lesson that I learned was that trauma work can be life threatening. If you don't have a self-care plan in place, this work can kill you. So I learned self-care is not theoretical. Just thinking about self-care or talking about it isn't enough. You have to have a concrete plan--something you do regularly.

I started by going back to work part-time. I am very selective about the cases I work with and I'm very concrete about time management. For example, I bought a smaller day planner and in this way I allow myself more space in the day. I started to think about things in a different way. I became vigilant about my own needs and levels of stress. I developed a built-in alarm system--any time I start to get overloaded my face starts to twinge or tingle and that immediately signals me to pay attention. I ask myself: Is this really the best thing for me? Is this going to make me feel good? Is this going to put a strain on me? I am more realistic and much more self-caring. I walk to work every day and back home. Power walking has become an end in itself. I watch what I eat and have lost 45 pounds over the last year. I monitor my caffeine intake and don't drink alcohol. I play more now. I finally realized how significant humour and good friendships are to

one's mental health. I've learned that having strong connections and healthy relationships is key to self-nurturance. You need to have people around who "get it," who are not offended by your assertiveness and protectiveness in your self-care management. It is about being selective in how you unwind, or relax. Now I limit the amount of television I watch, I don't isolate myself, I plan life in 4-month chunks, making sure that something fun is scheduled in like a trip or a concert, something to look forward to. Then I make sure that I have enough energy to do it and that is how I find hope. Playing the self-care game theoretically is like playing with fire--eventually you get burnt. These are some of the lessons I have learned from being in the field.

Donna: Lessons on Mirrors and Masks

As I contemplate what to include in my story, I feel anxious and vulnerable about sharing it. I write this story feeling that I am taking a risk, putting myself on the line. For these reasons, I am *only* willing to write about the struggles from being vicariously traumatized and how I have been able to make sense out of it. I have excluded details about my family of origin and information regarding my personal life. All I am willing to reveal is that I am in my early 50s and come from a White, middle-class background, and I recently separated from my husband. I live on one of the Gulf Islands off the coast of British Columbia. I work as a family counsellor in a transition house, a shelter for abused women and their children. I use to work in a large city at a sexual assault centre, but about 15 years ago I moved to this island, got married, raised my daughters from a previous marriage, and resumed counselling full-time about a year and a half ago.

It is probably very hard to understand my experience unless you have been a trauma counsellor. I am burdened by all the trauma stories and all the tormented lives that I have to embrace, day after day. All of my clients' trauma stories enter my being. I am left "holding their pain." I ask myself, "Why do these people have to suffer so much?" I am left depleted because there is no answer. Often I am flooded with the images and emotions that their stories leave behind and I am frustrated by wanting to "fix" it and make it all better. I want to rescue my clients, yet I know that I can't fix their problems--that's not how healing works. It takes courage to witness these trauma stories week after week, knowing that I am being impacted and realizing that even though I get supervision, the long-term effects are still going to be there.

I am constantly monitoring my intake of the amount of emotional material I can hear. It is like a shut-off valve. When I reach a certain point of being overloaded, I shut off the valve--it's my way of containing it. The only problem with this strategy is that I can't tell myself to shut it off until I have already heard it. But it does help prepare me for the next telling when the client and I revisit that part of the story. This may sound paradoxical, but I know that I do my best work when I am fully present. However, to be a grounded trauma counsellor I can't always be fully present because of the flooding effects of hearing the horrific details of clients' stories. To be able to stay there in the room with the client I have to monitor the intake of the information I am receiving. So there is this dilemma that I face: How open am I going to be and how will I know when I have to shut it off before I get impacted?

This work leaves me feeling isolated and alone a lot of the time because I can't share

the stories with anyone outside the shelter. There is a hopeless, sometimes pointless, attitude about finding support outside work. It would be nice to have a few close friends around to validate my feelings without having to go into any long explanations about what it is that I need. There is another dilemma for me in this issue around not being able to share the clients' stories outside of work. This relates to my belief that society needs to know about the details of abuse so that changes can be made in the prevention of abuse. Perhaps if society knew more about how much abuse occurs, people would be more proactive in protecting those who are powerless to protect themselves.

Another struggle for me has been the enormity and breadth of people's trauma and all the systems that their trauma impacts. There seems to be a web of systems involved: family, courts, police, schools, churches, and other social agencies. It isn't simply a matter of dealing with the client's abuse. As a counsellor I am overwhelmed with the magnitude of issues that I have to deal with in these other systems. I have devised my own self-care solution to this problem, which is "keep it simple"; this means one client, and one day, at a time. The problem with this solution is that I am still caught in the larger web, which leaves me feeling hopeless and trapped. Sometimes I just want to burst out.

A few of my fundamental beliefs about the world have been challenged by doing trauma work. The one that I struggle with the most is my sense of safety in the world--not just for myself but for everyone. I keep asking myself why it is that so many people have to suffer? Why isn't the world safer? Why do we allow abuse to happen? I struggle with what I yearn for--a safe world to live in. I also struggle with the masks that people

wear. I have learned that people are not always who they present themselves to be. So I also struggle with trust issues--wanting to believe that with certain givens I can trust the safety of my world. But some masks are very good.

I am confronted daily with the evil in the world and often I am left speechless in the face of it. My fear is that the ever-present evil is increasing. I think I have a primitive kind of fear about evil. If I don't name it, I don't give it power. I have to keep reminding myself that the slice of pie I see every day isn't the whole pie. As a society we need to learn to control our shadow side, because increasingly our individual barriers seem to be breaking down. It is the collectivity of this breaking down of barriers that I fear the most. This is the evil that I fear.

Perhaps linked to the evil I fear out there is the shadow side of myself that I fear as well. My shadow side is about my potential for anger and rage. I carry a lot of rage inside that has to do with the amount of injustice in the world, and I am afraid if I vent it or unleash it, I might be destroyed in the process. I am able to deal with some of this rage in clinical supervision, but only a portion of it gets released. Containing it and living with it I know is the source of the despair that I feel. What is under all the anger is my frustration and sadness around my belief that nothing will change. Sometimes I am overwhelmed by the hopelessness of it all. There are days when I just don't have my being to bring to this work.

The central paradox for me in doing this work is the fact that I need to have hope in order to continue in this field. You simply can't do this work unless you have hope and I am constantly struggling to find it. I am afraid that I will become cynical and fall forever

into despair. It is like pushing a huge boulder up a mountainside. The task is almost impossible, yet you keep trying. It is crazy making. You ask yourself, "Where is the goodness in the world?" and you just can't find it. I have learned that I need to stop intellectualizing about it because it just doesn't help. I have learned that you just have to say to yourself, "There is no solution. There is no answer. It just *is*." And that is all that you can do. Just accept that it is just the way it is.

So I ask myself how it is that I can continue to do this work and the answer is that I am a strong woman. I have learned how to protect myself--how to keep my soul pure. I monitor the amount of trauma I am exposed to so as not to corrupt my soul. When it gets beyond me I simply give it to God to take care of. It is about having a balance in your life--a mixture of work and fun. I need to get out there and have more fun, play more, get exercise. Often at work I will take a break after a session with a client and go outside to have a cigarette. Some of my colleagues judge this as an unhealthy activity, but for me it is the break of getting outside that I need. It's about having the ability to step outside of the trauma for a few minutes and find some relief. I actually joined a meditation group as a means of self-care, but having to report to the meditation leader on a weekly basis concerning my progress seemed too much like a test and that was the last thing I needed--adding another piece of pressure onto my plate--so I quit. I do like to get physical exercise and I have a hobby that I like to dabble in at home. I would like to get out more and have fun but I am usually too tired after work.

Finally, there is one major thing that I have learned in doing this trauma work and that is about the mirrors in life. One way that I am able to make sense out of all of this is

my ability to see that my work life often mirrors my personal life. Sometimes what I learn in my personal life helps me be a better counsellor. Sometimes the parallels make me feel insecure--perhaps I am not as grown as I should be--but most of the time they are great teachers. The struggle is about being able to stay aware of what aspect of the mirror you are looking through at any given time. Another piece is having the ability to see the masks that people wear. If you are able to keep these insights conscious you have a chance of surviving in this field.

[When Donna finished telling her first story, we sat together having a cup of tea. She said, "Now do you want to hear the real story?" After further discussion, we turned the tape recorder back on.]

It was a typical Friday night at home. We were both worn out from the week's wear and tear, relaxing in front of the television. I felt really restless, changing the channels on the television with the remote control. He suddenly grabbed the remote out of my hand and threw it across the room. Then he grabbed my hair and pulled me off the couch onto the floor. He was yelling, calling me names and kicking me. He proceeded to beat the hell out of me. I screamed, cried, begged him to stop, but he didn't. I don't know how long it went on. I woke up in the dark, lying on the floor in the middle of the living room. It was very late. I tried to get up but everything hurt, so I literally crawled down the hall to the bathroom, tears scalding my face. Every inch I crawled I wanted to scream in pain, but I was so scared he would come back at me again. I was terrified. I just knew if I could

reach the bathroom I might be safe. I'm sure I was in shock. I don't remember much about the rest of that night. I slept on and off, locked in the bathroom, huddled, shaking uncontrollably behind the bathroom door. I didn't know if he was in the house or not.

In the morning I crept into the kitchen and got some ice packs from the freezer and the large butcher's knife. I locked myself in the spare bedroom with the knife between the door jam, praying that it would hold. I stayed there for two days, terrified that he would come after me again. I could hear him creeping quietly around the house. A few times he yelled stuff like "You better stay in there, cause if I see you I just might kill you!" and then he would kick at the door.

I was completely numb, even though my body must have been in excruciating pain. I later discovered that I had a cracked rib and a badly bruised spleen. My whole body was black and blue from the kick marks. My lip was badly cut and one earlobe was torn. I remained in that room, held captive by my own husband, the man I loved and cared for all those 14 years of marriage. What was happening? How could this be happening to me? I couldn't grasp it. I was in total shock.

I actually went to work that week. I just put one foot in front of the other--it was sort of like shell shock. I isolated myself from my colleagues, tried to concentrate on my clients' lives, but I wasn't really there. My body sat in the chair but I was vacant. I just couldn't make any sense of it. He had always been good to me; he never did anything like this before. What had I done to cause this? How could we go on? How could I ever trust him again? I was terrified of him. When I went home at night he would verbally abuse me. He shouted at me, just 2 inches from my face, laying down the law about how I was

to behave, screaming at me, “Do you get that?” I had never heard him like that before. Those first few weeks seemed totally surreal. I was scared, confused, and alone with no one to tell. I believed no one could help me. I also believed that no one would believe me because he was a clergyman. No one would be able to see this side of him—even I was having a hard time believing it. I started to think that maybe I was going insane. My whole world was shattering in front of my eyes and I was helpless to stop it.

Eventually, after a few weeks, I told a colleague at work. She helped me name what happened. I was stunned when she said, “Donna, you’ve been abused. This is abuse.” I know it sounds simplistic, but I hadn’t been able to label the experience up until that moment. Her words hit me hard. I realized that I could no longer live with him. I struggled with the realization that in that single night, my marriage had been shattered. I felt that my life was over. I went into a depression. All my beliefs about what my life had meant to me, what my reality had been, and my own identity were shattered. I kept asking myself how can I believe anything anymore? How can I ever feel safe again? How can I trust myself? Why didn’t I see the abusive side of my husband before this? My god, I dealt with abuse on a daily basis in my job; how could I have missed the signals?

He finally moved out and I continued to go to work every day. In a way work was my sanctuary. I was able to delve into other people’s pain as a way of avoiding my own. But I wasn’t really there. I was completely numbed out. I felt like I was walking and talking and doing my job, but it was a shell of my former self doing all these things. As I stated earlier, I didn’t have my being there with me. The struggle at this point was just staying alive. I didn’t want to live, but didn’t have the courage to do anything about it. I

struggled with continuing to do the trauma work when I was hardly there for myself.

Finally, with the support of my colleagues, I went into therapy. I took antidepressants for a short while and worked on my personal trauma with my therapist. It is a long process, but I am starting to heal myself.

I learned a lot about trauma from my personal experience. My sense of self, my ability to trust my own judgments, my self-esteem, and my understanding of my own reality were all shattered that night. It was like my soul had been “punch-bagged.” My husband ripped me apart and ripped my world apart. Coming out of those therapy sessions I felt like a piece of shredded steak that had one of those hammers mincing it. I thought I was going to feel that raw and bloody forever. It was chaotic. I was fragmented and I didn’t know how to put my life back together. I didn’t have a framework for moving forward. I felt like I would never be able to feel happiness again. I was trying to learn how to be in the world while ripped to shreds.

Through therapy and the support of co-workers I was able to trace the emotional abuse and it started to make sense once I put it together with some family of origin material. I still have difficulty talking about this experience. There was a lot of shame and humiliation involved in naming the experience, so I started isolating myself. I wanted to work through my own pain first, before I sought support. This is just the way I did it. But I also wanted to be monitored at work because I knew that my personal trauma was leaking into sessions with my clients. I did get support and explained to my colleagues that if they found me withdrawn, it was just my way of reserving my energy. I had to learn how to monitor my own intake of my clients’ trauma stories. For a while, I would

block the trauma stories and collude with the clients for not telling it. I often struggled to be present in the room with them because I was overwhelmed and I had so few resources left to give. My pain container was full, yet their stories kept coming. It is interesting that before my own trauma I used to bring the clients' stories home with me. Now I was coming home and delving into my own trauma story. The clients' material fell into the background. It became a dance between personal trauma and vicarious trauma. At work, I was able to keep my personal trauma at bay, but when I came home my own pain would come forward and the vicarious trauma would recede.

Through my work I began to see the parallels between my life and my clients' lives. These are the mirrors that I alluded to in the first story. I began to see that the same dynamics that perpetrators use to silence their victims were being acted out in my own life. I didn't want to speak about the abuse because it would humiliate my husband, perhaps even ruin his reputation. I kept quiet. I was able to relate to the parents of the children that I was counselling in their struggles to speak about the abuse. There is a lot of shame from abuse that keeps us all silent. There was also a lot of guilt about not knowing what I shared with these parents. How could it be that I didn't see it coming when I knew the signals and patterns of abuse from my work as a trauma counsellor? The parents could feign ignorance but I couldn't.

There were also parallels between the controlling behaviours that my husband exhibited and the behaviours of the abusers in my clients' lives. I often felt like the yo-yo on the end of his string. He was always in control, manipulating me, pulling me in, and letting me go. One of the most painful experiences after we separated was the loss of

support from my extended family and many of our friends. No one could come to terms with this; no one was willing to see the abuse for what it was. The message was “Don’t disrupt things; just get on with your life.” When I told a mutual friend about the abuse he said that it was probably just a response to seeing abuse everywhere because of my work. This blame-the-victim syndrome, which I witnessed in my work with other survivors, was getting played out in my own life.

There was also a parallel between the grief and loss that I was feeling in losing my husband after 14 years of marriage and the grief and loss that my clients experience in the breakup of their families. I witnessed how my clients had great difficulty in letting their husbands or fathers go, how they would jump back and forth trying to find a way to stay in relationship with them, and finally how they would realize that it had to end for their own good.

My struggle was about reconceptualizing the former loved one to an abuser. It was complex. I still loved my husband on some level and asked myself, “What does it take to learn this in my soul?” I could see more than just an abuser—he was a friend, a lover, a father to my children. Where did this split between his actual self and his portrayed self come from? Why hadn’t I been able to see the masks that he wears? And more important, how was I suppose to move on? How could I let go of this marriage? I hoped that some of these answers might be shown to me through my work with other victims of abuse.

So underneath my skin I carry a lot of anger. This rage is about the injustice—who has the right to rip your life apart? It’s about being judged, blamed, dismissed, and shamed by other people’s ignorance. This rage is about being silenced and controlled. My

anger is about how I was fragmented, torn to pieces, and how I have had to learn to put myself back together. The pounding of my soul that symbolizes my abuse has taught me to open my eyes and to take a stronger stance. I have learned to be more assertive. Although this has been the biggest trauma in my life, I have been transformed by it. And even though I will never understand why abuse happens, I can be proud of how I am emerging out of the carnage. From my work and my own trauma, I have learned that a stronger, healthier individual comes forth to go out into the world, wiser because of meeting the challenge.

My personal trauma has made me a better counsellor. It has allowed me to reach places inside that I hadn't been able to reach until the event. This is a "knowing" that conveys itself. There is a shared knowledge between my clients and myself about the levels of suffering that victims experience. I have been able to use the mirror metaphor as a tool to help me be a better therapist. It has helped me to understand the issues on a deeper level and assisted me in helping my clients recover. I have been able to use this learning and apply it to my own situation. This helped me come back stronger. It has been a learning experience in terms of self-care and self-identity.

Donna's Verbatim Note Written on the Transcript After the Second Conversation

It was painful at first to read, to experience the struggle of trying to articulate my experience. I nearly gave up. I couldn't bear to see the lack of cohesion and felt very vulnerable and exposed. I thought I could summarize what I had said in a neat, cohesive way. People might think I am a babbling idiot if they read this. But then maybe that's just

a parallel to what dealing with trauma and trying to reintegrate it is like.

I experienced a miracle, something magic with a child today. At first I wanted to go and share with a colleague, but the session and experience was so profound that I was afraid to minimize it by sharing it . . . and yet I was so impacted by the glory of the event. The child, the mother, and myself . . . what we created and the momentum of the healing. The child took us there and instinctively I/we moved with him and for him. It's difficult to describe this experience, this one case.

Maybe the topic being so broad is why it is so difficult to talk about vicarious traumatization and its impact on me and how I struggle with the issues and stay healthy. It might have been easier if I'd thought of one case.

But in this part of the story lies the hope and transformation. Part of what I brought to today's event was my past being there with me in the struggle, affirming me, and out of my own affirmation/confirmation an intangible gift, I bring to some children sometimes, and the story we create heals. And maybe I couldn't have had that magic place today without absorbing his pain/the pain and deeply wanting life to be better for him and for me . . . the scalding tears come. The transformation for all of us . . . hope. A bent, twisted, awful, yes, evil, man began the story and the child led us out. It seems like the agony and the ecstasy. Perhaps the therapist has to be prepared to walk alone, in silence, in both empathizing with the trauma and the healing . . . to be present to the experience that evil has created in a child, to co-create the healing. I think working with children who have been abused is like experiencing the pain of the human condition and standing in awe of it

Jesse: Lessons Learned Along the Way

When I was 3 my mother and I moved back to Saskatchewan to the family farm. I grew up surrounded, for as far as the eye could see, by rows and rows of wheat and corn. The fields were my world then; my worldview blue and gold. We lived in a small house built for the hired hands by my Ukrainian grandfather. My aunt owned the farm then and lived in the big farmhouse with her husband and two daughters. My early years were warm and sheltered by my mother's love and protection. Our small, Ukrainian farming community lived by these time-honoured codes: Work hard, be strong, look on the bright side.

Everyone said I looked like Shirley Temple when I was little. Being so cute earned a lot of attention and adoration. So I learned at an early age that a smile goes a long way. I was just expected to be happy. I should have been nicknamed "Sunshine." My childhood however was a study in contrasts. I remember running through the wheat fields with my cousins or riding our bikes straight for miles without having to make a turn. Our world went on forever and as I marvelled at it, my cousin, black and blue from her father's beatings, saw it as inescapable--no end in sight--nothing but endless wheat fields. It was her prison.

Although I can't remember my father beating my mother, I do remember the anger the men carried and lashed out at the women and children in their care. I learned that men worked hard, played hard, prayed every Sunday, and were mostly mean the rest of the time. But my wise, loving mother protected me from all that. It is hard today to imagine what it was like for her, being a single parent by choice and raising a child by herself,

being divorced and Catholic as well! It must have been very difficult for her, with her personal history, to live in such an orthodox community.

I left the farm at 19 and enrolled in a small college in western Canada. I earned my B.S.W. and was lucky enough to get a job in a sexual abuse centre where I had done my practicum. I'm 40 now and still here 15 years later. My job at the centre is to process all the in-take calls, make initial assessments, and carry a part-time counselling caseload.

I think vicarious trauma is a common experience among trauma counsellors. For me, it came early in my counselling career. I was hearing a lot of trauma stories. The cases seemed to be piling up. I was young and inexperienced then. My first awareness of the impact of my job was very subtle. I started to notice a shift in my general outlook on life. Originally, I believed that basically everyone was good; next, I shifted to believing that perhaps a small portion of the population wasn't good; and, then, I believed that almost everyone abused children. If I went to the park and saw a couple with their child, I would make assumptions in my mind about what was really going on in that family. I fell into an irrational way of viewing the world because of the initial vulnerability I experienced from listening to so many stories of abuse on a daily basis. I saw abusers everywhere and I really struggled with this generalized negative worldview for quite a while.

What I remember most was this lingering, heavy feeling. My outlook was clouded. I felt submerged under something intangible, yet heavy and grey. I was very fatigued and felt physically weighed down like I was bearing an enormous weight. I began taking these feelings home with me. I was finding it more difficult to separate my work life from my home life. It was like being infused with a toxic substance.

In those early years, I was able to stay afloat through the support of my colleagues. We use to just spontaneously debrief, grabbing the first willing co-worker we could find, because we couldn't wait for clinical supervision. This camaraderie worked for me to a point. There was something about being in the trenches together that helped me continue on. Eventually, over time, I learned how not to be so vulnerable. I learned how to set boundaries for myself by not allowing myself to become overwhelmed by the trauma stories. I was able to compartmentalize my emotions by blocking my feelings until I was able to deal with them with a colleague or through clinical supervision. I never really got completely buried under the weight of vicarious trauma, but I certainly came close a few times in those early years. I think my maternity leave was a turning point for me--a saving grace. During my time off, I was able to reflect on the impact of my job counselling traumatized children. I was able to assess what I needed to do in order to be able to continue in this field. I learned that if I didn't take care of myself, I wouldn't be able to take care of anybody else.

Although the maternity leave renewed my resources as a counsellor, I was not prepared for the major shift in one of my core beliefs around trust that motherhood brought on. Being a mother put a totally new slant on my work with traumatized children. Motherhood made it harder to deal with stories about babies and small children because I now had a strong identification with these children. I was more protective and aware of a child's developmental needs. It impacted my heart, both for these abused children and their mothers. I was also struggling with child care issues for my own child because I became extremely anxious about leaving my child with a stranger. I was

obsessive about the screening process--checking references and doing police record checks on all the applicants. I finally decided to share child care with my co-worker who was even more protective than me. She had an unfortunately bad experience once with a babysitter and she was superparanoid about finding the right person. I guess I put a lot of faith in her judgment and underneath I knew I had very good intuitive skills and could trust my own judgment about people. But in the back of my mind was this little terror--what if? I couldn't completely trust my own instincts because the stakes were too high. There was always that unknowing and that unforeseeable element at play that made me really anxious. Later, I became less anxious and I realized that my fears were unwarranted. It really isn't a problem for me anymore.

I realize as I write this account that my beliefs about good and evil have been challenged, but my sense of trust in the world hasn't been shattered. I've learned that people are not born as perpetrators. There is always a reason why abuse happens. Having this understanding helps me continue doing the work. It gives me some concrete explanation that enables me to understand why abuse happens. Understanding the *why* allows me to go forward, to do the work, and to have hope.

Over time I have learned that vicarious trauma ebbs and flows. It is cyclical; it increases and decreases like the tide. The impact seems to be a result of a piling up of cases, which makes me believe that it's the accumulative effect of trauma counselling that makes the job hazardous. There isn't a single trigger. It isn't that single case, or single client. It is more a process of the wearing down of one's resources. There also seems to be a seasonal pattern to vicarious trauma in the workplace. There is a collective slump

that takes place in the winter months. Everyone gets sick more often, the caseloads seem to be overwhelming, and the families who seek counselling seem more vulnerable at this time of year. There's almost a feeling that the whole agency gets vicariously traumatized collectively. Neither clinical supervision nor management efforts seem to be able to prevent it. No one seems to have the energy or resources to cope. In the winter, I find myself shoring up for the onslaught. I inevitably get sick and have to take some time off. But I have learned that this too passes.

One aspect of doing trauma work that can impact on personal relationships is the isolating nature of the work. I am able to talk about my feelings with my colleagues because we have a shared knowledge and understanding about the impact of the work. Also, the confidential nature of this work prevents me from sharing it outside of the centre. When I go home and feel the need to talk about my feelings, I just say that I heard something really cruel or horrible today and my partner is supportive. But it is an understanding on a different level. That's why social support from friends or family can only go so far. I also think that the subject of child sexual abuse is a taboo in our society. It causes reactions in people who don't really understand the work. I often find myself explaining why I work in this field to other people when they ask, and I feel like an apologist. It really makes me angry and annoyed that I have to explain it to them and then deal with their reactions to my words, because child sexual abuse is seen as so hideous and unspeakable.

When I try to theorize about vicarious trauma I realize that there is a distinction between burnout and vicarious trauma. For me they are on a continuum. Vicarious

trauma starts at one end moving along the continuum in varying degrees of severity, until you get really traumatized and are unable to emotionally respond to your clients. At the other endpoint, when the vicarious trauma is at its peak, you have reached burnout. When I am experiencing vicarious trauma, I am very fatigued, I dream about my work, I feel emotionally depleted in my outside life, I have low tolerance for violence on television or in books, I am feeling that cloud coming over me, and this is my signal that I am not taking care of things. I have built my own self-regulatory system--like a Geiger counter that tells me how close I am to having everything shook up. I believe I have never personally experienced burnout because I am able to tell when I'm overloaded. I have never stopped caring for the work. I have never thought to myself, "I just can't hear anymore!" I never reached the point where I couldn't be emotionally responsive to my clients.

I think that it is really important to take care of the personal stressors in life if you do trauma counselling. I know when my mother was dying and I was caring for her, I had to get outside counselling and support in order to continue to work with clients. I couldn't carry it all. It is about taking care of your emotional life and having self-understanding about your own needs and resources. You have to also actively take care of yourself, like getting exercise, taking vitamins, getting enough sleep, and doing something meaningful or creative outside of work.

I see trauma work as hopeful, constantly renewing, and eternally positive. I get to see the recovery process unfold. There is a lot of healing that goes on with these children and their families. You get to witness amazing courage and resiliency in people. This

knowledge comes after being in the field long enough to weather the storms of vicarious trauma experienced in the early years of one's career. For me, it all comes down to what you learn along the way.

Marie: Lessons on Letting Go

I'm an easterner. I was born and raised in a small fishing port on the Bay of Fundy, Nova Scotia. I grew up in a large extended family because my parents were always taking in foster kids. Three of the foster kids lived with us for 14 years. I remember my mother telling me that their mother never recovered from postpartum depression after her last baby. You have to remember that in those days the neighbours took you in. We didn't have mental health agencies or social workers in our small village, and if you were in trouble somebody had to pitch in and help you out. That's the way it was.

So, early in life I understood that bad things happen to people in this world. I had firsthand knowledge that life could be difficult. My childhood experiences planted the seed in me that helping others was not only valuable but necessary. When I was 18 I left my home to go to a small Christian college in Ontario. It was located in a northern Ontario town, with limestone buildings and a downtown that consisted of four city blocks. It took me a while to adjust because I really missed my family and I longed for the sea. But the college community was very small and it didn't take long for it to become my new family. At first I thought I might like to be a doctor, then I changed my mind to a minister, and finally I thought that what I really enjoyed most was helping people with their problems, so I changed my focus to social work and counselling.

It was at this cloistered college that my worldview about good and evil started to get shaken up. An old childhood friend confided to me on a visit one weekend in my first year that she had been sexually assaulted by her uncle and cousins throughout her childhood. I didn't overreact. I just listened and tried to comfort her. I seemed to have an intuitive sense about hearing this story--where this sense came from I don't know. Later that year, in a small Bible study group, one of the women just blurted out that one of the board members of the church had sexually assaulted her. No one said anything; we all just sat there. I think we were in shock. Later I asked her what she wanted to do about it; shouldn't she report him to the pastor? But she said nothing. She said she felt so much better by just having told her story. I started getting angry inside and I didn't know what to do with it. I noticed a big change in this woman. Before the telling she wore really big clothes, never wore makeup, and acted very shy and distant, but after the telling she started to wear clothes that were in style, and she came out of herself more. I started to understand how sexual abuse affects self-esteem. The betrayal of trust, my anger toward this member of our church for abusing this woman, and my frustration with not knowing what to do about it ate away at me for months. Before summer break, a very close male friend confided in me that another male student at our Christian college--someone I was acquainted with--had sexually assaulted him. He was devastated by the experience and I left school that first year totally disillusioned, confused, and angry. What bothered me the most was the betrayal of trust by men in positions of authority in the church. I saw it as more of a betrayal than under ordinary circumstances, because these were men of God. It was worse than somebody who professes no faith. My sense of trust in religion had been

shattered and I couldn't wait to go home, back to the sea and to the safety of my family.

In my second year at college my own world was shattered. I was sexually assaulted by my boyfriend in my dorm. It is hard to describe all the feelings I still have about this. It represents my loss of innocence, loss of trust, loss of my personal sense of safety in the world, betrayal, and it shattered my self-esteem. It took me a long time to recover from it and I told no one. I didn't even have a label for it. You have to remember the historical context here. This was the early 1970s, in a Christian college, in a small northern Ontario farming community. Women didn't talk about sex, at least not openly, and the shame attached to being raped was huge. I knew that I would be blamed for it. It would get reframed: "You must have been asking for it." "What were you thinking when you let him into your room?" "You know it's hard for guys to control themselves." We were taught that self-control was the woman's responsibility. We hadn't yet coined the phrase "No means no!"

I continued to struggle with the dark side of the church. I began questioning everything. Why don't women hold positions of power within the church? Why does the church repress any discussion around topics dealing with sex? How can these men go on to become ministers and church leaders? How do they reconcile the contradictions between the teachings of the church, the ethics and morality that they professed, and their twisted, abusive, perpetrating behaviours? I began to see the failings of the church--that there was no place to voice one's hurtful experiences, there was no avenue to address the hypocrisy, and people were not made accountable for their actions. The church leaders should have made these men accountable in tangible ways. You just couldn't leave it up

to God to fix it. God doesn't wear clothes. God can't take you to jail. God is too abstract. I remember at that time I use to walk around wearing a big button that asked, "How far can I go and still go to heaven?" The church and the college have to take some responsibility for their oppressive practices and their willful blindness to the realities of abuse.

Today I can almost rationalize the fact that the man who assaulted me went on to become a minister, but I cannot accept the fact that the guy who assaulted my male friend later went on to be a minister, got married, had children, and eventually was in charge of a foster home in which he was charged with sexually assaulting many of the children in his care. There is something very twisted and sick about these men of God. It is not comprehensible. I still struggle with it and probably always will. Terry Kellogg said something once that really sums it up for me: "Every kind of abuse is a spiritual abuse." I have to agree because abuse has the effect of negating the soul.

After graduation I moved out west and did a graduate degree in counselling psychology at Simon Fraser University. During my practicum at the university I gained some experience in trauma work but I really didn't get trained until I volunteered for the crisis line at a women's sexual assault centre. I eventually worked for the centre part-time as a crisis line worker and part-time counselling individual clients. After a couple of years, I got a full-time position as a child sexual abuse counsellor at a mental health clinic for the Ministry of Social Services.

The first indicator that the trauma work was impacting me was that I started to question my own safety. I had been hearing a lot of horrific stories when I was doing the

crisis line work and suddenly I found myself making escape plans and safety plans everywhere I went. I was always checking out the atmosphere if I found myself alone with a man, even though on some level I knew my behaviour might be irrational. It was about this same time period that a rapist was on the loose at the university. He was reported as stalking women in the parking lots, then hiding under their cars, grabbing their legs when they returned, pulling them down to the ground, and raping them. Even if I wasn't at the university, I remember always looking under my car before getting in. One time I was on my way to the car with my boyfriend and I shouted at him, "Stop! You didn't look under the car!" He definitely thought I was nuts. I realized right then that his sense of safety was very different from mine and always would be. Until he could walk in a woman's shoes he would never understand my "nutty" behaviour. I remember feeling really angry that men don't even have to think about it--most of the time, their safety is a given. I was also angry that whenever I was with a man, an acquaintance or even an old friend, I was always making a safety plan in my head; I was never able to be fully engaged in whatever activity we were doing. I was always working on "the escape" in the back of my brain. The unfairness of it still ticks me off. But there is really nothing I can do about it. I'd rather be safe than sorry.

When I started working with ritual abuse cases, I was reminded of the spiritual nature of working with people. These experiences were consistent with my spiritual beliefs but not with my counsellor training. One experience in my office made me fearful about what I might be dealing with. I had been working with a woman who had been horribly, horribly abused. It was the third worst case I ever dealt with. It was after our usual office

hours, but I had agreed to meet this client after dinner. We were working through her story and when she got to the part where she was about to state that she believed her parents worshipped Satan, the lights went out. The lights had never gone out in our office before. I told her not to worry, this happens all the time. I went and switched on the breaker switch and the lights came back on. I could see that she was a little shaken by this, but she continued to tell her story. When she got to the part where she was about to state again that she thought her parents were Satan worshippers, the lights went out again. I was starting to get a little freaked out, but I knew however I was feeling, she must be feeling a hundred times over. I could see that she was shaking, eyes very wide, and she said perhaps she should just go. I told her not to worry, I would fix the lights and be right back. When I came back I was surprised to see that she had left, but then I heard this whimpering from behind the couch. She was completely freaked out by this and it took me the rest of the session just to calm her down. The next week, she returned to my office with an audiotape. I had asked her to try to tell her story in the safety of her own home and bring the tape in for us to listen to. When we replayed the tape, at that part where she talks about the abuse by her parents, there is a voice speaking over her voice in a strange language. For some reason I didn't feel afraid. I didn't sense that it was evil or threatening and neither did she. We listened and listened but couldn't figure it out. Perhaps the tape was just faulty, or perhaps not. I'll never know. All I do know is that sometimes when you do trauma work you push the edges of reality as we know it. Sometimes there's more than just a person's flesh and blood experiences. There's a spiritual aspect to this work and when you're that far out on the edge, life looks very

different. Different things happen out there.

Often the edges for the client are living or dying. Sometimes we are just tipping the edge between suicide or recovery. When you engage with a client you go to those places with them and you're impacted by the experience. In trying to make sense out of it, I struggle with the awful things that people do to other people. Sometimes they are just random acts of violence but most often they are perpetrated by the ones you know and trust. I remember asking myself on several occasions, "What could have happened to you in order for you to do such a thing to another human being?" I try to understand why abuse happens, but asking why can drive you insane. I think sometimes we ask why so that we don't have to have the feelings that go with the stories that we hear. But knowing why just doesn't take those feelings away. Some people use the "why" as a means to step over the pain and then repress that it exists and just move on. Rationalizing can be a great coping strategy, but eventually it catches up with you. Some of the cases really stay with you. I started thinking about my cases at home and when I went out with friends. I was carrying around a lot of stress in my body, my muscles were knotted. Often I would leave work and drive home with tremendous headaches. I was having nightmares about my clients' lives. On the night before I was suppose to go to do court work with a client, who had been brutally, violently, kidnapped, and raped, I dreamt that I was being raped and my partner, who was dreaming that a cougar was attacking him, tearing at his back, woke up to my scratching, pushing, and yelling, "Stop, stop!" I realized then that perhaps my work was getting to me.

I put limits on myself. I became conscious of my own boundaries. I remembered from

my early family experiences that life goes on. I believe that you can't save anyone; all you can do is teach them how to save themselves. I often wish that I could take their pain away, but I can't. All I can do is sit with them, witness their struggles. Over the years I've learned a lot about pain and struggling. In order to do trauma work, you have to know yourself, you have to be grounded or you can get lost in it. I remember one client whom I had worked with for a long time. I felt that we had really connected. We were just at that point in the therapy where she was about to open to her pain, and I was really ready to jump in. She got up and walked out. Didn't say a word, just left. I ran down the hall after her and out onto the street, my arms outstretched, calling to her, hoping that she would turn around and come back. When I got back inside the office, one of my colleagues said, "If you could have only seen yourself from up here, from my window." We started laughing. It was pretty bad, pretty pathetic.

But there are times in therapy when you do truly connect. Those moments when together you create something that can hold the pain so that later you can look at it and decide what to do with it. I believe that is the point of counselling--those connected moments--but they don't happen that often. It is like synchronized swimming; sometimes you and the client are really in sync. It is those times when I am truly myself, truly grounded, yet almost beyond myself. This is very difficult to articulate because it is metaphysical. There are definitely spiritual aspects to counselling work. This knowledge and ability to stay grounded came to me by trial and error over a long period of time. I feel really fortunate that I had a lot of grounding when I was growing up. My family taught me about balance. I learned that life goes on. It's about self-awareness: your

ability to monitor your stresses and resources, and the ability to know what balance means personally. I remember typing my friend's father's biography. He was a very religious man and every morning he would pray for an hour. He wrote that he was filling up his well. This metaphor has always resonated with me. If I find the well is getting pretty low, I know that it's time to replenish it.

Being vicariously traumatized was a gradual process. It was a combination of letting things slide in my own self-care and the accumulative effects of the job. My caseload was getting heavier and heavier. I was listening to some awful, gory details and more of the cases were becoming long-term. Things at work were starting to fall apart. I noticed that we were all gaining weight, everyone seemed depressed, and the manager was losing her ability to keep us afloat. We all seemed to be suffering from some group phenomenon. I started to think that there might be some truth to the idea that vicarious trauma is contagious. I remember at one group debriefing, the manager asked for feedback on the atmosphere at work and guess who she picked to go first. They all knew Marie would spill her guts while they watched. I started to emote, crying that we were all doing really good work and that it was just getting "pissed away" because of the lack of support from the management. Later the manager called me into her office and said she thought I was losing it. I said, "I'm just having my feelings. Isn't that what we teach people to do every day?" I was being stigmatized for crying, for being impacted by my clients. I didn't feel supported at work and things started to go downhill from there. I felt like I was bashing my head against a wall of indifference and I couldn't get through to the administration.

Bizarre things started happening at work. One of my clients called me in a panic and

asked me to help her talk a friend of hers out of committing suicide. I coached her over the phone and the guy didn't kill himself. Months later, this friend moved to town and brutally raped her. The irony of my saving his life, at the expense of her life, really hit me hard. Unexplainable, bizarre things like this were starting to happen around me.

I found I was taking the clients' stories home with me. I was starting to lose my consciousness about my own boundaries. I was really, really tired and having some physical symptoms as well: headaches, extreme fatigue, grinding my teeth, gaining weight, getting too many colds and flu symptoms, and feeling depressed. I went to my doctor and he prescribed an antidepressant. I screamed at him that I didn't want to take drugs. I just wanted a week off! After that I made a decision. I told the manager that I was taking a week's sick leave, then I had three weeks holidays coming to me. That meant that I would have one month off and one month back at work before I would resign and leave with my partner for a year to travel. It was a turning point. I knew I had to leave this kind of work for a while and regroup, get balanced. I managed to make it through that last month and I had a wonderful year off. Before I left to travel, I went back to Nova Scotia to visit my family. I started to reflect on what the heck had happened to me. My family affirmed me. They didn't see me as Marie, the trauma counsellor. They saw me just as Marie. I realized that I had allowed my trauma counsellor identity to consume my life. I forgot that I was more, much more than that. The trauma work had become a mission. The main problem for me was that I had let things expand and I got caught up in it. I was giving my life away to my work. I realized that I didn't have anything left to give and I needed time to heal.

My year away was my healing year. A year to myself, to reflect and rebuild. I realized while I was gone that I had held so many secrets--the painful secrets of many people's lives--and that was weighing me down. Little by little the psychological strain from holding these stories started to peel off. It was like they were just coming away and I was allowing myself to release them. I hadn't been aware of how burdened I had been with these secrets and how many I had accumulated. Being anonymous in a new country was freeing. It was a time and place where I didn't know anybody's secrets. I could just hold my own space and be with myself for a while.

As I look back now I can see the progression of my beliefs over time. I started by believing that generally the world is a safe place and sometimes bad or sad things happen to people. The next beliefs came after my crisis line training when I began to see that abuse happens everywhere. It is the random events that you can't account for that scared me, but I felt safe because I could trust those people that I let into my world. Finally, I ended up understanding that the random acts of violence are rare and actually it's the people you know who do most of the abusing. I was left with the fact that you are never really safe.

Today, I have come to a place of acceptance about random violent events because there are ways you can protect yourself. When I was in Europe I was assaulted by a stranger on the street. He drove up in his van and tried to force me into an alley, where he would have raped me. Fortunately, I struggled ferociously and was able to free myself and run to a neighbour's house to get help. I have often wondered why I always paid so much attention to those stranger stories in my trauma work, these random acts of

violence. Was my guardian angel there coaching me to pay attention to these stories because someday I would be facing such an event myself? I wonder.

What I think saved me over the 10 years of doing trauma work was my humour and my spirituality. I used a lot of black humour every day at work with my colleagues and sometimes, with care, with my clients. I never apologized for it. I would warn clients that this was part of who I am and it was also one of my self-care strategies. Sometimes the stuff you hear is really wild and so out of this world that you just have to laugh about it. Laughing together for me represents some of those connected moments in doing this work. It's about those moments when you feel really human; you're really touching each other. My spirituality is also who I am. It's a sort of consciousness that I carry all the time. Often I would turn to the Higher Power and express my frustration and pain and ask for help. I would perform cleansing rituals, like yelling out the window to God, screaming, "Why?" or "Just stop it! Stop it! I haven't caught up yet! No more abuse!" Sometimes the neighbours would be saying to themselves, "There she goes again, hanging out the window. What the hell is going on in there?" Doing that worked. It really helped me to release it.

As you've probably guessed by now I'm very imaginative and creative. I do community theatre and puppetry as an active, physical means of releasing the stress from my body. It is also a way of getting myself outside, out of the workplace, being out in the world physically. And because I am so visual, I use imagery in creative ways to express my feelings. With my visualizations, I am able to act out and release negative stuff and it has real meaning for me. I find that deep breathing exercises get me focused inwardly and

help me get centred. So for me it's about performing meaningful rituals.

I discovered a lot about myself over the 10 years I worked in this field. I learned a lot about how to do trauma work and how to stay balanced, safe. The older I get the more I realize how complex life is. There is always more to learn. I guess the lesson is about letting go of being able to know it all. It's about not having to be responsible for other people's secrets. It's also about being able to let go of your clients and allowing them to let go of you.

CHAPTER 3

PART I

A NARRATIVE APPROACH TO RESEARCH

Narrative as an approach for studying human existence is the focus of this chapter. Included are an overview of conceptualizations of narrative and the significance of narrative as a mode of inquiry. The concept of self as a narrative construction, issues of authorship, voice, and re-presentation within narrative research texts, along with a review of the diversity of criteria for the legitimization of narrative research, will be addressed.

What Is in a Story?

The narrative is present at all times, in all places, in all societies; the history of narrative begins with the history of mankind [sic]. There does not exist, and never has existed a people without narrative. (Roland Barthes, 1966, p. 14)

Roland Barthes (1966) claims the universality of narrative which is a central premise in narrative inquiry. Stories exist in every culture and are presented in a multitude of forms: novels, nursery rhymes, folktales, myths, newspapers, commercials, popular magazines, historical, educational, and scientific texts, cinema, and other literature and art. We make ourselves and the lives of others known through the stories we construct (Bruner, 1986, 1990; Connelly & Clandinin, 1990; Denzin, 1989; Josselson, 1995, 1996; Mishler, 1986; Polkinghorne, 1988, 1995; Richardson, 1990, 1994, 1997; Ricoeur, 1984, 1992; Riessman, 1993; Sarbin, 1986). Our stories reveal our purposes and intentions as human beings and the meanings we make of our experiences. Clarissa Pinkola-Estes (1992) contends that “stories are embedded with instructions which guide us about the

complexities of life” (p. 16). Narrative provides explanation of how the episodes and events in our lives are meaningfully linked.

Barthes (1966) maintains that narratives provide two significant rhetorical functions. At the individual level, stories are produced to explain one’s life in the past, present, and future; at the sociocultural level, stories serve to unify common cultural beliefs and values. Laurel Richardson (1990) extends Barthes’s explanation of narrative function to include a process of personal organization. She writes

Narrative functions at the autobiographical level to mark off one’s own individual existence from all others; it has its own finitude. One’s life is separable from others; it has its own beginning and its own ending. But, because of that separation, one can be an integrated whole—a being with its own unique past, present, and future. Narrative thus provides the opportunity for the individual to make existential sense of mortality, and, correlatively, through the narrative, the profound experience of mortality becomes sociologically accessible. (p. 23)

This sense of mortality is also accessible educationally and psychologically.

Narrative functions at the cultural level. Cultural tales are embedded with implicit instructions, values, and norms that influence the kinds of tales we tell. Examples of the cultural tales, or discourses, adopted by the participants in this study include mothering, spousal abuse, caregiver as volunteer, and trauma as a disorder or pathology.

Stories constructed by research participants open windows for narrative researchers to interpret the multiple meanings lived experience is given. Story construction provides endless opportunity for the re-authoring of our lives. In human science research, both the storyteller and the recipient of the story are involved in constructing meaning. It is a purposeful activity. Both the storyteller and the recipient of the story are situated in a larger cultural context. The multiple subjectivities of the storyteller, the recipient, and the

context within which they are situated influence the construction of their stories.

Narratively generated research texts can lead researchers to new insights that can inform self-understanding, professional practice, and human science in general.

What Counts As Narrative?

There is substantial disagreement about the exact definition of narrative (Riessman, 1993). There are many genres of narrative: Films, novels, personal essays, biographies, and plays are examples of narrative re-presentations. In the psychological literature, narrative is found in case studies, life histories, and clinical case reports. In human science research, we find narratives in transcriptions, case studies, field notes, autobiographical accounts, and in research manuscripts. Individuals relate experiences using a variety of narrative genres. For example, people write in journals, tell stories, tell jokes, write poetry and letters. Catherine Kohler Riessman (1993) reminds us that not all narratives in interviews are stories in the linguistic sense of the term.

Genres of narrative, with their distinctive styles and structures, are modes of representation that tellers choose. . . . Different genres persuade differently; they make us care about a situation to varying degrees as they pull us into the teller's point of view. (p. 18)

In reviewing the literature on narrative, one central point was continually being emphasized. Narrative is “both a process and product” (Polkinghorne, 1988); a “phenomenon and method” (Connelly & Clandinin, 1990); “a mode of reasoning and a mode of representation” (Bruner, 1986, 1990). Given the prominence of these distinctions, I will first describe narrative as product, phenomenon, or mode of re-presentation. I will then turn my attention to narrative as process, method, or mode of reasoning.

Narrative As Product

Narrative is a particular form of discourse production. Within the discourse of scientific research, narrative is one of three forms of data. The other two are numerical and short answer (Polkinghorne, 1995). Writers focusing on qualitative research (Bruner, 1990; Clandinin & Connelly, 1994; Denzin, 1997; Liebllich & Josselson, 1997; Mishler, 1990; Polkinghorne, 1995; Richardson, 1994; Riessman, 1993; Sarbin, 1986; van Manen, 1992) delineate the properties of narrative as they pertain to human science research. Informed by their writings, the following general description depicts what constitutes narrative as product, phenomenon, mode of re-presentation.

From a modernist perspective, narratives “represent” the various ways in which individuals relate to the world. Narratives are the primary schema by which humans render life meaningful. In human science stories, the narrator is the protagonist. As the teller of the tale, the protagonist reconstructs life and signifies its meaning. Stories are grounded in lived time and gain their credibility by relying on commonly held features embedded in the storyteller’s sociocultural context. The style of telling and the particular form of presentation are dependent upon the “historical conventions of time and place” (Scheibe, 1986, p. 131). Narrative construction is always influenced by the cultural conventions of telling, by the intersubjective context between the teller and receiver of the story, and by the historical context in which it is situated.

Plot is the central organizing system within narrative. The plot schema organizes lived events into a meaningful story, usually with a beginning, middle, and end. The plot renders individual events into a schematic whole, making a narrative more than a sequence of

events. Narratives are texts that are thematically organized by plot (Polkinghorne, 1995). Through emplotment, life events are construed and interconnected for the purpose of constructing meaning.

In postmodern texts, and often in research interviews, protagonists do not fashion their stories with the familiar sequence of beginning, middle, and end. Often research participants are in the middle of articulating their life stories. They may be struggling to understand how the past has influenced their lives or how a phenomenon began in their personal histories. Participants are in the process of “storying” their lives. As Donald Polkinghorne (1988) states, “Self is in the middle of its story and has to revise the plot constantly without knowing how the story will end” (p. 69).

A participant constructs meaning as she develops her account in the research interview. Therefore, the plot is not always developed in a comprehensible narrative fashion, as found in some novels, life histories, biographies, or autobiographical texts. The researcher is often actively engaged in the process of developing coherence by co-constructing the research text through an interactive dialogue. The sequencing of events in a narrative may be presented in a linear way through time, or may be given in a divergent stream-of-consciousness format by circling back on itself and placing events together or by signalling significance through devices such as flashback and flash-forward. Whatever sequencing format is developed, it cannot be changed without altering the story’s meaning. The plot and events within the plot interact, “each providing form for the other” (Polkinghorne, 1988, p. 19).

In narrative research, attention is given not only to what is said, but also to how the

story is told. It is in the telling that the story is rendered meaningful to the participant as well as the researcher. The plot is context bound and, because the contexts of our lives are always changing, research narratives are continually being rewritten or reconstructed. The implications for research are that our findings are not fixed. This point leads us to recognize that narratives are not only the products of research but are also emergent modes of knowledge that are constituted through the research process.

Narrative As Process

A strong argument for using narrative methods within the human sciences is based on the premise that humans are storytelling organisms (Connelly & Clandinin, 1990, Lincoln & Denzin, 1994; Ochberg, 1995; Polkinghorne, 1988). Narrative researchers maintain that narrative form is the primary way people make sense of experience (Bruner, 1986; Mishler, 1986; Polkinghorne, 1988). In this research context, narrative involves storytelling or story construction as a way of coming to know oneself and one's world. Narratives are the stories we tell ourselves about ourselves, as well as the stories we tell others about ourselves. How and what we tell in our stories becomes a means by which we make meaning.

Distinctions have been made between knowledge constructed through stories and the knowledge accredited to traditional science. Jerome Bruner's (1986) acclaimed criticism of formal scientific discourse that separates cognitive from emotional forms of knowledge is a cornerstone in the debate over what counts as science. According to Bruner, a scientific argument that is not established through rational discourse is relegated to the poetic or

literary realm. Bruner challenges this distinction by maintaining that “there are two modes of cognitive function, two modes of thought, each providing distinctive ways of ordering experience, of construing reality” (p. 11). The “logico-scientific mode” bases its claims on universal truths, whereas the “narrative mode” searches for meaning between events. The narrative mode is more than emotional expression. Bruner (1986) argues that the narrative mode “is a legitimate form of reasoned knowing” (p. 11). The logico-scientific mode of reasoning takes language to be transparent and believes it to be a medium that unambiguously reflects fixed, singular truths--the world as seen. This realist assumption is challenged by narrative scholars (Mishler, 1986; Polkinghorne, 1995; Richardson, 1990; Riessman, 1993) who argue that participants’ interviews do not mirror a world “out there.” The participants’ views of the world “are constructed, creatively authored, rhetorical, replete with assumptions, and interpretive” (Riessman, 1993, p. 5). As storytellers, participants are engaged in evaluating how and why events occur, and they are interpreting actions (Chase, 1996) and motives (Polanyi, 1985) through their story constructions. Their constructions are meaning-making endeavours jointly created with the researcher. In their storytelling, participants are not only creating a narrative, they are constructing themselves.

Self As Narrative Construction

A man [sic] is always a teller of tales; he lives surrounded by his stories and the stories of others; he sees everything that happens to him through them; and he tries to live his life as if he were telling a story. (Jean Paul Sartre, 1963, p. 39)

We achieve our personal identities and self-concept through the use of narrative configuration, and make our existence into a whole by understanding it as an

expression of a single unfolding and developing story. We are in the middle of our stories and cannot be sure how they will end; we are constantly having to revise the plot as new events are added to our lives. Self, then, is not a static thing nor a substance, but a configuring of personal events into a historical unity which includes not only what one has been but also anticipations of what one will be. (Donald Polkinghorne, 1988, p. 150)

Sartre (1963) and Polkinghorne (1988) offer a view of the self as a process, and in particular, a narrative process. However, this has not been the traditional view of the self offered by those using formal scientific methods. Until very recently, traditional theories presented the view of the self as a unitary, core, and cohesive entity (Kohut, 1977). The view of modernist theorists posits that, although we interact with the environment and are impacted by our relationships and culture, each of us has an essence, or core being, that is dependable, stable, and fixed over the life span. Postmodern writers (Hermans, Rijks, & Kempen, 1993; Peavy, 1993; Sampson, 1985) critique this view of the unitary self and claim that the traditional Western core self concept is culturally biased. They propose a theory of the self that is multifaceted, dynamic, and narrative in nature. Postmodern writers (Carlsen, 1988; Hoskins & Leseho, 1996; Kegan, 1982; Mahoney, 1991) also reject the traditional model of the self and offer a different view. They present a concept of self, not as fixed, or stable over time, but as a process, unfolding throughout one's life span. Donald Polkinghorne (1988) claims that the study of the self has "reemerged in research programs in the human disciplines, a 'rediscovery' due largely to the inability of formal science research to account for the unexplained variability in human behavior that has shown up in research using experimental designs" (p. 149). These new models portray the self as a dynamic process, a notion of self as agent, not as object or substance.

The idea of the self as a process was offered by William James at the turn of the

century (cited in Polkinghorne, 1988). James contended that the self was not an underlying substance to be discovered, but an idea that is constructed. He claimed that there were three constituents of being a self: the material self, the social self, and the spiritual self. Self-development, in James's view, is a continual process of synthesizing these three aspects of the self. James critiqued the Cartesian mind/body split. He argued that there are two distinct components of self. The "I" is self-as-knower, an interpreter of experience, and the "me" is an empirical self, the self known by the "I." He contended that the "I" can never be separated from the "me"; therefore, the "I" is not separate from the body (cited in Polkinghorne, 1988, p. 149). Theodore Sarbin (1986) extends James's theory of the self and frames it within the context of narrative. Sarbin presents the "I" as the author, and the "me" as an actor within the narrative. Thus, the "I" construes the story in which the "me" will be shown as one of the main characters, or actors.

Mikhail Bakhtin (1981, 1986) furthers Sarbin's notion of self-narrative by conceptualizing the self as a "polyphonic novel." Bakhtin views the self as a multiplicity of voices and a person's inner world as a network of intrasubjective relationships. He claims that in every conversational situation there were three parties within the speaker: the speaker who is speaking, the recipient (or the one who hears), and the "superaddressee," a third party who is presumed to understand what is being spoken (cited in Denzin, 1997, p. 36). In this view, there is no single author, but several authorial voices each constructing their own stories within a dialogically internal relationship.

Hermans and Kempen (1993) claim that this multiplicity of selves (or "I" positions) is not autonomous; rather, the self is seen as having a synthesizing role, a task of continually

attempting to make the self a coherent whole. According to Hermans and Kempen, this multifaceted dialogical self is developed through four elements: action, memory, imagination, and language. From birth we interact with our environment. Through memory we interpret life retrospectively; our imagination allows us to create and envision possibilities. Through language we demonstrate remembered pasts, articulate our current experiences, envision tomorrows, and share these understandings with others.

New metaphors of the self have emerged in the recent human science literature. Almost without exception, these new metaphors offer descriptions that point to a self-in-process. Examples are “the evolving self” (Kegan, 1982); “the dialogical self” (Hermans & Kempen, 1993); “possible selves” (Markus & Nurius, 1986); “the saturated self” (Gergen, 1991); “multiple selves” (Schwartz, 1987); “internalized selves” (Tomm, 1987); “the ideal or ‘ought’ self” (Higgins, 1987), and self as a “polyphonic novel” (Bakhtin, 1986; Hermans, Rijks, & Kempen, 1993). These metaphors of the self emphasize the notion that we are continually changing, engaging in internal and external dialogues, being influenced by culture, and are open to possibilities in our personal development.

Within these metaphors we find re-presentations of the self as narrative construction. Some theorists have conceptualized the self as an unfinished narrative (Howard, 1991; Josselson, 1995; Polkinghorne, 1988; Sarbin, 1986; White & Epston, 1990), depicting self as author, or storyteller, in a continual process of rewriting, reauthoring, or reconstituting oneself. A person constitutes herself by organizing events into a personal history or story that includes past experiences as well as envisioning a future self that she hopes to become. Self is a life-span developmental project whereby people compose their daily lives as stories

lived and share these stories with others. In each sharing they are constructing and reconstructing their identities. The self, in this sense, plots out the significance of everyday events based on stories told from the past and entertains new plots for the future.

At the same time, self is a product of cultural construction or cultural tales (Howard, 1991). Narrative as a form of inquiry provides human scientists with the means to interpret or locate a story within a larger discourse. Many cultural tales are adopted by individuals as part of their own narratives. The Christian tale and the psychoanalytic tale are examples from Western culture. What cultural tales depict stories of secondary trauma? Are they the traditional tragic tales in which the protagonist--usually a good person--is overwhelmed by crisis or tragedy, or are they the heroic tales where the protagonist struggles and finally overcomes a moral dilemma? Are stories of secondary trauma modernist tales, or are they postmodern constructions? Are participants aware of the kinds of tales they tell? Do their stories fall within the hegemonic, prescribed cultural tales of Western society? Or do they tell resistance tales? Perhaps participants tell both kinds of tales within one telling. If we attend to the cultural tales concerning psychological trauma within the discourse of psychology, do we find secondary trauma described mainly as a pathology?

Self in narrative research is construed through language. Attending not only to what is told, but how it is told, that is, the interaction between participant and researcher, is an essential focus in narrative research. It is in the activity of telling that narrative meaning is constructed. Through the construction of narratives, a storyteller is able to interpret the meaning of her life hermeneutically. Questions the narrative researcher might ask include: What self is being constructed in this narrative? Why? What does it mean to construct

oneself in this particular fashion? What cultural plots are at work within this storied life? What is not being told in this story? Narrative research is a dynamic process. Each telling will differ; each reading will render new interpretations.

Issues of Re-Presentation

Most researchers seek legitimation within the discourse of their disciplines with its explicit rules and traditions of re-presentation. Researchers are faced with ethical, rhetorical, and political dilemmas when their research narratives deviate from expected norms. How do we, the authors of research texts, re-present our participants and ourselves in relation to our participants? What do we include and exclude in our texts, and how do we decide? Do we write the participants' stories as complete accounts or do we thematize their stories into annotated segments as blocked quotes? Do we write their lives in the first person or third person? Do we literally write ourselves into the research text? How do we show our interpretations in the construction of the research text? These questions are both ethical and moral because decisions regarding re-presentation are influenced by the researcher's beliefs and by pressures within particular disciplines to conform to recognized standards. Re-presentational issues are daunting, but unavoidable. Many of the questions posed above will be addressed in chapter 4.

Vidich and Lyman (1994) claim that the history of interpretive inquiry can be divided into five moments. The fourth moment, the "crisis of representation," erupted in the 1980s with the publication of seminal works such as Clifford and Marcus's (1986) *Writing Culture* and Clifford Geertz's (1988) *Words and Lives*. These two works are part of the

disruption to traditional research writing and call into question issues of class, race, and gender, bringing attention to differences and incorporating reflexivity. Judith Stacey (1988) questions whether it is possible to have a feminist ethnography that can claim to be authentic, reciprocal, and intersubjective. She proposes that feminist ethnographers might be “masking a deeper, more dangerous form of exploitation” in their work.

The research product is ultimately that of the researcher. [However] with very rare exceptions it is the researcher who narrates, who “authors” the ethnography, . . . a written document structured primarily by a researcher’s purposes, offering a researcher’s interpretations, registered in a researcher’s voice. (p. 23)

Authority and authorship are issues in our human science research texts because writing the lives of others, or “inscribing others” (Fine, 1994), enacts values. Richard Rorty (1979) asks, “When we are engaged in constructing other, are we not on some level, through our interpretations, reconstructing ourselves through empathic identification?” (p.73). Michelle Fine and Lois Weis (1996) add to the discussion by suggesting that researchers need to “come clean at the hyphen,” meaning that we need to be reflexive in our work and question who we are as researchers. We have to talk about our own identities and how we, the researchers, are constructed in our research texts. What is reported and what is not reported? Who is protected and who is not protected in our research narratives? “Yes, we write the stories, we determine the questions, we hide some of the data, and we cry over interviews. But self-conscious insertion of self remains an exhilarating, problematic, sometimes narcissistic task” (p. 265).

In human science research, writers often narrate stories of particular groups or cultures to which they do not belong. This raises questions about authority and the author’s privileged position in relation to the text. Linda Alcoff (1991), writing about the problem of

speaking for others, argues that we cannot, even as a member, speak for the group. For example, should a particular White woman speak for other White women? We cannot transcend our own location and it is impudent and arrogant to speak for those less privileged or different. "A speaker's location has an epistemologically significant impact on that speaker's claims" (Alcoff, 1991, p. 9). "For whom do we speak, and to whom do we report, with what voice, to what end, using what criteria?" (Richardson, 1990, pp. 26-27).

Donna Haraway summarizes the issue of the embodied, situated researcher:

A progressive-postmodernist rewriting, however, proposes that, because all knowledge is partial and situated, it does not mean that there is no knowledge or that situated knowledge is bad. There is no view from "nowhere," the authorless text. There is no view from "everywhere," except for God. There is only a view from "somewhere," an embodied, historically and culturally situated speaker. (quoted in Richardson, 1990, p. 27)

Thus, there is no escape from interpretation, from our own subjectivity. Given that knowledge is always situated, partial, and subjective, it follows that knowledge claims have to be partial, limited, and contextual. As narrative researchers we are always working with life as told (Bruner, 1986). Life as told will always be problematic because stories always change. Stories are not stable, or fixed, over time. Many stories can be construed from any single account and new meanings will emerge at different places, at different times. All we can hope for are snapshots, because subjects cannot hold still for their portraits (Clifford & Marcus, 1986). It is imperative then that we recognize that our research texts have to be "plurivocal, open to several readings and to several constructions" (Rabinow & Sullivan, 1987, p. 12). As narrative researchers we have to be cautious and reflexive about the claims we make.

Issues of Legitimation

Issues of legitimation in narrative research are necessarily contentious. Hatch and Wizniewski (1995) surveyed twenty-two narrative and life history scholars and generated a list of criteria for judging the quality of narrative research. Their list includes the following seventeen standards: adequacy, aesthetic finality, accessibility, authenticity, believability, closure, credibility, compellingness, continuity, explanatory power, fidelity, moral persuasiveness, plausibility, resonance, sense of conviction, trustworthiness, and verisimilitude. The components of this list create a challenge for those narrative researchers who consider themselves constructivists, postmodernists, or poststructuralists. For example, the elements of trustworthiness and authenticity assume that the narrative is representative of “life as lived.” For the constructivist researcher, narratives are interpreted and jointly constructed as a “life as told.” The credibility and believability criteria listed above are not consistent with a constructivist research stance. They represent legitimation claims that are similar to positivistic criteria that require research findings be “truthful” to be credible and believable. These claims are founded on the belief that there is an exclusive, singular truth to be known and discovered in our narrative works.

Closure and aesthetic finality are two other criteria from Hatch and Wizniewski’s (1995) list that challenge the constructivist researcher because constructivist knowledge claims are always open to multiple readings; they are not fixed in time or place. Every reading will render new interpretations; therefore, closure, or finality, is not desirable or possible in a constructivist approach to narrative. Given some of these challenges to Hatch and Wizniewski’s criteria, how should a constructivist narrative researcher approach

questions of legitimation in her or his narrative productions? Which criteria are applicable and which aren't? And how should the appropriate criteria be applied?

Criteria for legitimation in narrative research are also dependent on additional complex factors. Included in these are the type of research design; the method of data collection (e.g., interviews, participant observation, focus groups, personal journals, biographies, autobiographies); the purpose of the study and the research paradigm in which the study is situated (e.g., modernist tales, poststructuralist accounts, feminist critiques, literary criticisms); the epistemological assumptions held by the narrative researcher (i.e., Is the researcher a feminist, a positivist, a postpositivist, a constructivist, a poststructuralist, or a combination of these?); the context and sequence of data generation (i.e., researchers and data are influenced and changed as data are collected); and lastly the type of data generated in the narrative project (e.g., audiotapes, videotapes, or both; interviews, focus groups, or both; film, journals).

Donald Polkinghorne (1995) holds that narratives reveal two distinctive types of knowledge claims depending upon whether the researcher has performed an analysis of the narrative data or has written a narrative analysis. The former yields common themes and involves a recursive stance, moving in and out of the data "looking for the best fit to a categorical scheme for the data set" (p. 10). The latter yields knowledge that is located in the research interaction by means of "emplotted stories." Analysis of narrative data employs "paradigmatic reasoning," whereas narrative analysis uses "narrative reasoning." Therefore, depending upon the type of narrative analysis performed, different criteria for legitimation are required. There is no hard-and-fast formula for what counts as legitimate

narrative research. Each study must be judged on its own merits according to a variety of factors. In the end, it is the researcher's responsibility to present the work honestly, ethically, and earnestly. In this study, narrative analysis by way of narrative reasoning was employed. I chose four evaluative criteria (persuasiveness, resonance, coherence, and pragmatic usefulness) that are described in depth in chapter 4.

PART II

A REVIEW OF THE LITERATURE ON SECONDARY TRAUMATIC STRESS

Introduction

The etiology of the word *trauma* comes from the Greek word meaning injury. McCann and Pearlman (1990) define psychological trauma as “an experience that is (1) sudden, unexpected, or non-normative, (2) exceeds the individual’s perceived ability to meet its demands, and (3) disrupts the individual’s frame of reference and other central psychological needs and related schemes” (p. 10). Scholars in the field of trauma generally agree that a traumatic event is one in which the individual is flooded with intense stimulation that he or she cannot control.

The participants in this study, whose narrative accounts were presented in the second chapter, are suffering from what Charles Figley (1995) considers “compassion fatigue,” which the trauma literature elaborates as Secondary Traumatic Stress Disorder (STSD). The symptoms seem to arise without warning and are nearly identical to Posttraumatic Stress Disorder (PTSD), except that the development of the former disorder is due to exposure to knowledge about a traumatizing event experienced by a significant other, instead of actually experiencing the traumatic event oneself, as in the case of PTSD.

The purpose of this part of chapter 3 is to review the literature on secondary traumatic stress, to explain the different conceptualizations, categories, and descriptors of the syndrome, and to review the research in this area. To begin, I will outline the history of traumatic stress in order to provide a foundation upon which current theories of trauma rest. Then, I will provide the most recent conceptualizations of posttraumatic stress and

secondary traumatic stress, leading the reader to an overview of the current research findings on secondary traumatic stress. Finally, the significance of studying secondary traumatic stress will be addressed.

Historical Overview of Posttraumatic Stress Disorder

As Judith Herman (1992) points out, psychological trauma has a curious history: “Periods of active investigation have alternated with periods of oblivion” (p. 7). For example, during World War II, there was an enormous amount of interest in the effects of war upon veterans. Surprisingly, following the war, interest in the study of psychological trauma practically vanished from the literature until the Korean and Vietnam Wars erupted. Nor were questions about the trauma experienced by Holocaust survivors asked. Why didn’t theories of psychological trauma evolve from interest in these experiences? Was the world engaged in mass denial? Could it be that without a supportive social environment, theories of psychological trauma became invisible (Herman, 1992)? Notwithstanding the rapidly expanding literature describing the effects of traumatic events upon human beings, questions of criteria and credibility are currently being debated (Brabin & Berah, 1995; Hacking, 1995; Powell & Boer, 1995).

Herman’s (1992) historical account illustrates three separate periods in which “a particular form of psychological trauma surfaced into public consciousness” (p. 9). The first era of psychological trauma was the development of the theory of hysteria, a psychological disorder characterizing women at the turn of the century; the second was the discovery of war-related traumas; and the third is our recent era, beginning in the 1970s

when knowledge of the effects of psychological trauma emerged due to increasing public awareness of sexual and domestic violence, as well as from the aftermath of traumas related to natural disasters. A brief description of each historical period follows, leading to the current definition of Posttraumatic Stress Disorder. An understanding of the historical development of PTSD is necessary because our current understanding of secondary traumatic stress lies within it.

The Concept of Hysteria

With the influential work of Sigmund Freud, at the turn of the century, the concept of *anxiety neurosis* gained acceptance. Hysteria became the chief explanatory principle for traumatic reactions and was commonly believed to be a woman's ailment, originating in the uterus, hence the name "hysteria." The study of hysteria "grew out of the republican, anti-clerical psychological political movement of the late nineteenth century in France" (Herman, 1992, p. 10).

Jean-Martin Charcot, the French neurologist, was the master architect of the study of hysteria. Many renowned physicians (e.g., William James, Pierre Janet, and Sigmund Freud) travelled to France to study under his tutelage. Charcot's Tuesday lectures were theatrical events in which he would hypnotize women and demonstrate his findings on the "Great Neurosis." He developed a classification system for the symptoms of neurosis, but paid little attention to the patient's inner world. Charcot died before he was able to determine the cause of hysteria, and the task was taken up by his followers, Pierre Janet and Sigmund Freud.

By the mid-1890s, both Janet and Freud came to the same conclusion: Hysteria was a condition caused by psychological trauma. However, it was Freud who revealed that hysteria was caused by childhood sexual abuse. Unfortunately, public reaction to Freud's (1896/1953) publication of this theory in *The Aetiology of Hysteria* was extremely hostile. His theory stated that abuse was endemic and he described it as perverted acts against children. Considering that most of his patients came from rich families in Paris and Vienna, there was strong political backlash against his publication. Disillusioned, Freud reformulated his theory, stating that the original analysis was the result of his patients' childhood fantasies and misinterpretations of childhood events. The theory of neurosis as a form of psychological trauma induced by childhood sexual abuse was lost for almost a century. "To hold fast to this theory would have been to recognize the depths of sexual oppression of women and children" (Herman, 1992, p. 19). The world was not ready to reflect on this painful truth.

War and Posttraumatic Stress

Posttraumatic stress as a disorder was not officially recognized by the American Psychiatric Association until 1980 when it was inscribed in the *DSM-III*, even though the problem had been known for over a hundred years. One of the earlier accounts of the disorder was found in Samuel Pepys's diary of the effects of the Great Fire of London (cited in Trimble, 1985). Near the turn of the century two great events, the American Civil War and World War I, mobilized a flood of interest and literature on the concept of posttraumatic stress. Dr. Jacob Mendes DaCosta, in 1871, was the first to study Civil War

veterans suffering from war-related trauma. DaCosta spoke of the condition as “irritable heart” and it became known in medicine as DaCosta Syndrome (Wooley, 1982, cited in Scrignar, 1988). Sir Thomas Lewis, in 1919, was the first to observe trauma symptoms in World War I veterans and he referred to these symptoms as “soldier’s heart” (Scrignar, 1988). The year before, his colleague Oppenheimer had coined “Neurocirculatory Asthenia” to characterize the same illness (Dalessio, 1978). However, Mott, in 1919, was the first to call the malady afflicting soldiers “shell shock,” which he attributed to exposure to carbon monoxide and changes in atmospheric pressure (Trimble, 1985).

In 1940, during World War II, Myers diagnosed 2,000 cases of shell shock and concluded that the condition had little to do with carbon monoxide or atmospheric pressure, but more to do with damage to the patient’s fragile psyche, caused by horror and fright (Trimble, 1985). In 1947, Kardiner and Spiegel finally argued for the conceptualization of one syndrome, traumatic neurosis, replacing shell shock, battle fatigue, and combat exhaustion, because they claimed that these terms all described the same syndrome (cited in Scrignar, 1988). Although Kardiner and Spiegel recognized the similarities between traumatic neurosis and Janet’s conceptualization of hysteria, they chose not to associate their findings with this derogatory label because they felt that it would discredit their patients (Herman, 1992).

After World War II, the disorder was literally ignored. There was no mention of any type of trauma-related phenomena, not even traumatic neurosis or combat neurosis in the *DSM-I* (APA, 1952) or the *DSM-II* (APA, 1968). With the reengagement in battle due to the Korean and Vietnam Wars, the trauma of soldiers was again a concern of the medical

establishment. Charles Figley (1978) claims that the disorder was not restricted to the battlefield or even close proximity to action, but that chronic and delayed sequelae were being reported in the VA hospitals across North America. Up until this time, traumatic neurosis was thought to be caused by the ego's deficiency in dealing with the stress of battle. The conceptualization of trauma was shifting to a theory of a posttraumatic neurosis resulting from "failed adaptations to change in the environment" (Figley, 1985). Thousands of veterans suffering from the stresses of the Vietnam War provided the necessary "subjects" with which to study and theorize the phenomenon. Vietnam veterans who refused to be forgotten pressured government, and the Veterans Administration commissioned an extensive study on the impact of wartime experiences. "A five-volume study on the legacies of Vietnam delineated the syndrome of Posttraumatic Stress Disorder and demonstrated beyond any reasonable doubt its direct relationship to combat exposure" (Herman, 1992, p. 27). Posttraumatic stress finally gained acceptance as an official disorder and first appeared in the *DSM-III* (APA, 1980), bearing an uncanny resemblance to the long-forgotten, earlier descriptions of traumatic neurosis delineated by Kardiner and Spiegel (1947) almost half a century before.

I am reminded of the horror of war and the remnants of its aftermath each Remembrance Day when I watch elderly war vets trembling and often crying as they recount their experiences in the evening news. It makes me realize that traumatic events have a profound effect upon our lives: Memories of traumatic experiences never actually disappear; they just move from foreground to background.

Victimization and Natural Disasters

For most of the twentieth century, it was the study of combat veterans that led to the development of a body of knowledge about traumatic disorders. “Not until the women’s liberation movement of the 1970s was it recognized that the most common posttraumatic disorders are those not of men in war but of women in civilian life” (Herman, 1992, p. 28).

The women’s movement and the advent of consciousness-raising groups led to the study of psychological trauma in women’s lives. Women brought their personal stories forth into the public arena and ignited a flurry of research centred on women’s issues. The formation of women’s centres that flourished in the early 1970s stimulated women researching women’s lives (Chodorow, 1978; Gilligan, 1982; Miller, 1976). It was Diana Russell’s (1984) extensive survey of 900 women (selected by random sample) that brought the striking incidence of sexual assault against women to public awareness and demonstrated how endemic it is in our society: One woman in four had been raped and one woman in three had been sexually abused as a child.

In 1983, Burgess and Holmstrom reported their findings on the psychological effects of rape. They labelled the phenomenon *rape trauma syndrome* and noted that the victim’s symptoms resembled symptoms described by combat veterans. Thus, a link between the trauma of victimization by rape, battery, and incest and the trauma of war was established. Researchers in traumatology began to question whether there were other victim populations with similar symptoms.

Once the medical field became aware of psychological trauma, reports of trauma-related events began to surface. The Aberfan disaster (Lacey, 1972) in Wales, in which a

slag heap hurtled down a mountainside and destroyed the mining town's elementary school, and the Chowchilla (Terr, 1990) kidnapping of a busload of school children in 1976 are two studies that focused on childhood trauma. Also C. Janet Newman's (1976) study on the Buffalo Creek disaster provided evidence that even adults and children who had only witnessed the flood--along with others who had lost a family member or friend in the torrent--experienced symptoms of trauma long after the event. A new definition had to be developed to encompass these experiences of traumatic stress, because it had become clear that traumatic stress could develop vicariously. Studies on natural disasters, man-made disasters, terrorism, torture, sexual assault, physical assault, childhood trauma, life-threatening illnesses, and incarceration in a prisoner of war camp or concentration camp and continued studies on combat veterans brought forth a multitude of publications, both in books and journals, on the topic of trauma. Several traumatic stress societies formed and some continue to meet annually to discuss recent advances in the field, and governments are funding research, training, and assessment in this field of inquiry. The media covers topics on trauma every day; whether through a talk show or a news event, traumatic stress has become part of our lives.

Clinical Definitions of PTSD and STSD

What exactly do Posttraumatic Stress Disorder and Secondary Traumatic Stress Disorder mean? How does posttraumatic stress differ from secondary traumatic stress? To quote the *DSM-IV* (APA, 1994), Posttraumatic Stress Disorder is defined by six criteria:

- A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criterion B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.
(pp. 427-28)

It is important to include these criteria of Posttraumatic Stress Disorder because they are important to the discussion of secondary traumatization.

What Is Secondary Traumatic Stress?

Charles Figley (1995) claims that secondary traumatic stress is a disorder and its definition is found within the description of PTSD in the *DSM-IV* (APA, 1994). Figley has italicized portions of the PTSD description to highlight how an individual may become traumatized without actually being physically harmed or threatened with harm.

The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone: a serious threat to his or her life or physical integrity; serious threat or harm *to his children, spouse, or other close relatives or friends*; sudden destruction of his home or community; or *seeing another person seriously injured or killed in an accident or by physical violence*. (1995, p. xv)

Criterion A1, in the APA (1994) specifies that the essential feature of the disorder is the development of characteristic symptoms following exposure to or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning

about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates (APA, 1994, p. 424).

The fundamental difference between the two disorders seems to be the position of the stressor: In Posttraumatic Stress Disorder, the stressor may directly harm or threaten people (primary stressor), and in Secondary Traumatic Stress Disorder, the stressor is the traumatized individual who has been exposed to harm (secondary traumatic stressor) (Figley, 1995). Just as posttraumatic stress is a natural consequence to a markedly distressing and unusual human event, secondary traumatic stress is a natural consequence resulting from knowing about or witnessing a traumatizing event that has been experienced by a significant other. The significant other in the case of the counsellor is the client. We can assume that it is not only the trauma counsellor who is at risk, but also family members and friends of the traumatized person.

Although there is mention of a secondary traumatic stress reaction in the *DSM-IV* (APA, 1994) no elaboration is given to the implications. It is also interesting to note that there is very little literature on the topic. Two books (Figley, 1995; Stamm, 1995) and less than a half-dozen articles (including one of my own) actually address this reaction among helping professionals. Figley (1995), suggesting that the incidence of PTSD may be “grossly underestimated,” because these figures do not take into account those who emotionally support trauma victims, states, “It is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress” (p. 7).

Theoretical Conceptualizations of Secondary Traumatic Stress

The phenomenon of secondary traumatic stress has been described as “secondary victimization” by Figley (1988), who noticed the deleterious effects on family members exposed to a traumatized member; as “traumatic countertransference” by Herman (1992); and as “contact victimization” by Courtois (1988), who warns that PTSD could be contagious. McCann and Pearlman (1990) call the phenomenon “vicarious traumatization” and claim that through vicarious traumatization therapists may find themselves experiencing PTSD symptoms. In *Compassion Fatigue*, Charles Figley (1995) discusses secondary traumatic stress in terms of “compassion stress” and “compassion fatigue.” Eth and Pynoos (1985) and Terr (1990) found that symptoms experienced by traumatized children were “contagious” to non-traumatized children who played with them. Mollica (1988) suggests that therapists become “infected” with their clients’ hopelessness, and Danieli (1984) reports, in a study on countertransference, that therapists dealing with Holocaust survivors shared the nightmares of the survivors they were treating. The predominant metaphor used by these traumatologists suggests that secondary traumatic stress is like a disease. The stress reaction of trauma counsellors is not treated as a relational or socially driven construct.⁹ The multiple labels, or constructs, point to the same phenomenon, but how does it work? What are the current theoretical explanations for secondary traumatic stress?

In the following sections, I present three current theoretical models that provide possible explanations for the development of secondary traumatic stress among trauma

⁹The use of the word *construct* is intentional in that I believe that names for diseases and symptoms and medical jargon are socially constructed labels that reinforce the disease metaphor utilized in psychological and medical discourse.

counsellors. The first model is Dutton and Rubinstein's (1995), based on a factorial model in which they provide a list of possible factors underlying the phenomenon of secondary traumatic stress. The second model is Cerney's (1995) psychodynamic model that describes four psychodynamic dimensions from which to understand secondary traumatic stress reactions, and the third model, developed by McCann and Pearlman (1990), is the constructivist self development model: a model developed from synthesizing aspects of cognitive theory, self psychology, and developmental theory.

Dutton and Rubinstein's Theoretical Model

Dutton and Rubinstein's (1995) model, explaining secondary traumatic stress reactions, involves the following conceptualizations:

1. A trauma worker's exposure to traumatic events, even if it is exposure to a single retelling of graphic details of a serious or devastating traumatic event, needs to be examined in terms of the trauma worker's response to it. It is the exposure to trauma (often repeatedly and over a long period of time), wherein therapists become aware of the possibility of a traumatic event occurring and maybe being repeated, which causes secondary traumatic stress. Exposure is inevitable when therapists typically facilitate recall of traumatic events in therapy sessions.
2. The trauma counsellor's posttraumatic stress reactions may be dependent on several issues such as: the perceived unpredictability of traumatic events; the source of the traumatic experience; the relationship with the perpetrator (whether the perpetrator is known to the counsellor or not); the extent to which the trauma involved the violation of

the trauma counsellor's assumptions about the world and others; the level of death threat to the client; the level of professional development and developmental age of the trauma counsellor at the time of exposure to the retelling of the traumatic event; the continuation of any form of threat to the client in the present; the presence of "mind control" as a component of the recalled traumatic experience; whether the trauma counsellor works as a solo practitioner or as part of a group; the presence of the trauma counsellor as a witness to or having knowledge of a traumatic event happening to someone else or being a direct survivor; and finally, the level of intimacy of the traumatic experience (e.g. sexual versus non-sexual).

3. The trauma worker's personal and professional coping strategies for responding to the traumatic situation and any psychological sequelae are important for self-protection when exposed to others' traumatic stories.

4. The individual factors (e.g., inner strengths, personal vulnerabilities, countertransference issues, level of burnout being experienced) and environmental mediators (e.g., personal and professional social support, additional stressors such as divorce, death of a loved one, financial or legal difficulties, institutional support, and the social, political, and economic context in which the trauma worker lives and works) figure in the susceptibility and the development of secondary traumatic stress reactions.

The authors also add that the influences of the social and cultural factors on how emotions are expressed, specifically in terms of gender, ethnicity, culture, and age, must be taken into account in the study of secondary traumatic stress.

Cerney's Psychodynamic Model of Secondary Traumatic Stress

Cerney (1995) postulates that four psychodynamic concepts are foundational to an understanding of secondary traumatic stress. She identifies *transference*, *countertransference*, *projective identification*, and *identification* as the four main explanations for the development of secondary traumatic stress.

1. Transference: The traditional meanings of *transference* refers to the client responding to the therapist as if the therapist were a parent figure, a spouse, or some other significant other. A negative transference is the typical response in trauma therapy. Frequently, the therapist, in the client's view, takes on the characteristics of the abuser. Working in this mode, for example with techniques such as role reversal or dealing with alters in multiple personality cases, may cause feelings of despair, depression, horror, helplessness, and fear in the therapists "as they become the victim[s] and the clients assume the roles of cruel tormentors and persecutors" (p. 134).

2. Countertransference: Feelings of inadequacy and incompetency are frequently experienced by therapists who do not attend to their own countertransference reactions in the therapy session. *Countertransference* is defined as the eruption of unresolved conflicts within the life of the therapist that are triggered by the client's story, overtake the therapist in the therapy session, and make it difficult for the therapist to remain empathic. If countertransference reactions go unattended, they can cause psychic harm to the therapist, putting the therapist at risk, especially if he or she is reliving the trauma of a previous personal experience.

3. Projective Identification: A description of projective identification is given by Cerney.

In the course of the therapy, a patient will often experience feelings of being persecuted by even the gentlest of therapists. When these persecutory feelings become unbearable, the patient tends to project them outward, often with such intensity that the therapist internalizes the feelings to the point of identifying with them, and then acts accordingly, as a persecutor, even though that is not his or her usual style. Both suffer: the patient again undergoes the trauma of being victimized, and the therapist's self-perception of being a kind, understanding person may be severely damaged. (p. 136)

4. Identification: This is really a problem of overidentification with the trauma client. It is understandable to have feelings of rage and desires for revenge along with the client in situations where the client's life has been terribly wronged, and justice has not prevailed. But in actuality identification with the client intensifies the client's feelings instead of helping him resolve them. Such enmeshment with the client may cause the therapist to violate therapist-client boundaries. Feelings of inadequacy and resentment may eventually intensify to the point of developing trauma symptoms similar to the client's.

McCann and Pearlman's Constructivist Self Development Model

A third conceptual framework for understanding secondary traumatic stress is McCann and Pearlman's (1990) constructivist self development theory. These authors state that this theory is based on a synthesis of other cognitive theories (Mahoney, 1991; Piaget, 1970), Kohut's (1977) self psychology, and Mahler's (1975) developmental theory. They also adopted ideas regarding trauma theory from Horowitz (1983) and Janoff-Bulman (1992).

Pearlman and Saakvitne (1995) utilize the constructivist self development theory as a conceptual model from which to understand secondary traumatic stress, or vicarious traumatization, the term they prefer and define as:

a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material. That is, through exposure to

clients' graphic accounts of sexual abuse experiences and to the realities of people's intentional cruelty to one another, and through the inevitable participation in traumatic reenactments in the therapy relationship, the therapist is vulnerable through his or her empathic openness to the emotional and spiritual effects of vicarious traumatization. These effects are cumulative and permanent, and evident in both a therapist's professional and personal life. (p. 151)

Pearlman and Saakvitne (1995) differentiate vicarious traumatization from secondary traumatic stress, stating that, although the two concepts overlap, they "differ in focus and emphasis" (p. 151). Vicarious traumatization includes the symptomatology of secondary traumatic stress within the context of "profound changes in the therapist's sense of meaning, identity, world view, and beliefs about self and others" (p. 151). But, Pearlman and Saakvitne claim, because the construct of secondary traumatic stress is derived from the diagnostic criteria given for Posttraumatic Stress Disorder in the *DSM-IV* (APA, 1994), which is based on observable symptoms, the *DSM-IV* gives secondary traumatic stress less elaboration.

These two conceptualizations are not orthogonal to one another; the STS approach focuses primarily on the symptoms, while the vicarious traumatization approach focuses on the individual as a whole, placing observable symptoms in the larger context of human adaptation and quest for meaning. (p. 153)

The theory of vicarious traumatization posited by McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) proposes that trauma disrupts the self in the following ways:

1. Frame of Reference: The trauma therapist experiences disruptions in one's sense of identity, in central beliefs about the world, and in spirituality. Counsellors may question their roles as therapists, parents, or spouses, and may question their own life histories. Their beliefs about justice, morality, good, and evil may be challenged. They may even lose a sense of meaning in life, a loss of hope and connection.

2. **Disruption in Self-Capacities:** These capacities include the ability to maintain a positive sense of self, the ability to modulate strong affect, and the ability to maintain an inner sense of connection with others. In vicarious traumatization, these capacities are disturbed. Signs include overextending oneself, increased self-criticism, hypersensitivity, a sense of isolation, and disconnection.

3. **Disruptions in Needs, Beliefs, and Relationships:** Basic needs such as safety, trust, esteem, control, and intimacy are susceptible to change. Cognitive shifts in core beliefs and negative thoughts about self and others are the result of vicarious trauma.

4. **Effects on Interpersonal Relationships:** Signs that vicarious traumatization may be affecting a therapist's relationships include social withdrawal, the inability to tolerate the wide range of feelings necessary to maintain intimate relationships, feeling alienated, and the inability to enjoy common forms of entertainment.

5. **Ego Resources:** The trauma therapist is unable to meet his or her own psychological needs and is unable to relate to others. For example, maintaining appropriate professional and personal boundaries may become very difficult or being able to make accurate judgments about self- protection.

6. **Imagery:** Trauma therapists may experience disruptions in memory in the form of intrusive thoughts or images wherein they are experiencing the clients' traumatic experiences as their own.

McCann and Pearlman (1990) state that the cost of vicarious traumatization is difficult to measure and more research is needed to explicate the factors which underlie the phenomenon. However, Pearlman and Saakvitne (1995) claim "widespread confirmation of

the clinical validity of the construct from hundreds of clinicians to whom we presented these ideas in workshops and talks, as well as some early research findings” (p.158) that have not yet been published.

In conceptualizing their constructivist self development theory, the construct of *burnout* is described by Pearlman and Saakvitne (1995) as a separate and different concept from vicarious traumatization. Burnout is described as a combination of emotional exhaustion, feelings of depersonalization toward clients, and having a sense of low personal accomplishment in one’s work. Burnout is related to the job site, whereas vicarious traumatization “incorporates the interaction of the situation with the individual” (p. 153). That is, vicarious traumatization focuses on the intrapsychic and interpersonal factors related to the individual (in this case, the therapist) experiencing stress.

Vicarious traumatization has also been distinguished from therapists’ countertransference reactions. *Countertransference* refers to the resurgence of a counsellor’s own unresolved or unconscious internal conflicts during the therapy session. “In the field of trauma, countertransference has been labelled ‘traumatic countertransference’ or ‘destructive countertransference’ and involves feelings of being overwhelmed by painful images and thoughts presented by survivors of trauma which obstruct the counsellor’s ability to be objective or present” (Arvay, 1993, p. 18). McCann and Pearlman (1990) differentiate countertransference from vicarious trauma by explaining that in vicarious traumatization the impact on the therapist is based on a cumulative effect across clients, not a single case response. However, they concede that vicarious traumatization may increase the counsellor’s vulnerability to countertransference reactions.

These three theoretical models of secondary traumatic stress are all that are currently available. Each represents a different view of the mechanisms at work. Dutton and Rubinstein (1995) offer a factorial model in which they describe all the factors they believe are determinants of secondary traumatic stress. These factors may or may not be representative of the problem, and it is most likely that individual variations will be experienced. Their model is supported in the limited research we have to date, and many of their factors overlap with McCann and Pearlman's (1990) conceptualizations. In researching secondary traumatic stress, it is helpful to have an understanding of what factors have been found to influence its development.

The psychodynamic model presented by Cerney (1995) is another framework from which to view secondary traumatic stress. Although the mechanisms of projection, countertransference, identification, and projective identification may be components of secondary traumatic stress, for me the model is incomplete. I would not adopt this model as the theory of secondary traumatic stress because reducing the therapists' experiences of secondary traumatic stress to one or more of these four components may result in an incomplete analysis. For example, trauma therapists may recount their experiences of secondary traumatic stress as a countertransference reaction, but that reaction may be just a small piece of the puzzle. Also, Cerney's model excludes several of the environmental mediators discussed by Dutton and Rubinstein (1995). There may be more at work here than the psychodynamic model can provide.

McCann and Pearlman's (1990) constructivist self development model offers a cognitive approach to their theory of vicarious traumatization. Although they portray a

model built on constructivist concepts such as frame of reference (identity and worldview) and cognitive schemas, their theory supports a view of self that is core, or fixed. A traumatized self has an identity and worldview that is shattered or disrupted. Vicarious traumatization is a phenomenon which is marked by profound changes in the core aspects of the therapist's self, or psychological foundations. "These effects are cumulative and permanent, and evident in both a therapist's professional and personal life" (p. 151).

Although I agree with many of their theoretical assumptions concerning the disruptions to one's frame of reference, the ability to manage strong feelings, the need for positive connections to self and others, and awareness of self-capacities, I cannot adopt a view that utilizes a core-self perspective. I do not view the world this way. However, it is important to understand that others may view the world in this manner, and to be open to other perspectives, particularly if the participants explain their experiences from this framework.

In summary, these three theories offer different conceptualizations of secondary traumatic stress. One perspective is not better than any other, and none are the only or "true" perspective on secondary traumatic stress. They are offered here as possibilities. In my research, I co-construct the theoretical perspectives of those who know the phenomenon firsthand, those who have had the experience of being vicariously traumatized by their work with trauma survivors.

Empirical Research on Secondary Traumatic Stress

To date there are only a few published articles that represent empirical research on the topic of secondary traumatic stress, one of which is my master's thesis. All of these offer

quantitative perspectives on secondary traumatic stress, using survey questionnaires to obtain data and statistical measures to illustrate their findings. Given that the construct of secondary traumatic stress was only recently defined (McCann & Pearlman, 1990), there is still very little research regarding its prevalence among counsellors in the field of trauma. We do not yet know all the factors contributing to the development of secondary traumatic stress, nor do we know the conditions that protect trauma counsellors from becoming traumatized. However, the following studies (three published and three unpublished) do provide information concerning incidence levels, correlations regarding symptoms and demographic variables, and, more importantly, pose questions that need to be addressed in future research.

In a study on the effects on female counsellors working with sexual violence survivors, Schauben and Frazier (1995) found that, among counsellors who completed their questionnaire, those having a higher percentage of trauma survivors in their caseload reported more disrupted beliefs, more symptoms of Posttraumatic Stress Disorder, and more self-reported vicarious trauma. Symptomatology was not related to these counsellors' own history of victimization. In addition, counsellors working with victims of violence experienced emotional distress and changes in their beliefs. Their main coping strategies were described as "active coping"--actively doing something about the problem, seeking emotional support, making a plan of action, seeking instrumental social support, and humour. The least common coping strategies were using alcohol or drugs, denial, and disengagement in the counselling process.

Follette, Polusny, and Milbeck (1994) studied general and trauma symptoms in mental

health and law enforcement professionals. They found that trauma symptoms correlated with the level of personal stress experienced by these professionals; negative use of coping strategies; and negative clinical responses to their sexual abuse cases. It appears that high levels of personal stress and inability to find positive support or engage in self-protection result in the development of traumatic stress symptoms and negative clinical practices, thereby, putting therapeutic relationships at risk.

In my master's thesis, "Counsellor Impairment in the Field of Trauma" (Arvay, 1993; Arvay & Uhlemann, 1996), a survey research design was used to study levels of stress among a random sample of counsellors ($N = 161$) working in the field of trauma in British Columbia. It was proposed that counsellors working with survivors of trauma are at risk for developing stress symptoms similar to those experienced by their clients. Counsellors were assessed on measures of general life stress, burnout, and traumatic stress. Twenty-four percent perceived their lives as being stressful, 16% reported high levels of emotional exhaustion, 4% were experiencing high levels of depersonalization, 26% felt ineffective in terms of personal accomplishment at work, and 14% were experiencing high traumatic stress levels similar to clients with Posttraumatic Stress Disorder.

A profile of the impaired counsellor emerged from the demographic variables and the measures of stress used in this study. Counsellors experiencing high levels of stress will most likely be in their early 40s, with education at less than a master's degree. They most likely will be employed in a community agency, as opposed to private practice, with less than 10 years experience and a client caseload between 10 to 26 survivors per week. They perceive that they have personal and work-related support that comes mainly from friends,

family, and peers at work. They find their work “challenging” and “somewhat manageable.” However, they state that they have “too many” traumatized clients and feel that their caseloads are “very intense.” They frequently experience being affected by their clients’ traumatic material. Many in this group reported experiencing countertransference issues in their sessions with traumatized clients, suggesting that there may be a link between being frequently affected by their clients’ traumatic material and dealing with their own countertransference issues. For self-care, they participate in exercise or activities with friends or family, rather than seek supervision or personal therapy. The self-care activities of this group do not appear to be an adequate buffer against stress.

In *Dissertation Abstracts International*, I found a dissertation by Munroe (1991) entitled “Therapist Traumatization From Exposure to Clients With Combat-Related Posttraumatic Stress Disorder.” Munroe investigated whether therapists themselves were subject to traumatic exposure by the nature of their work. In his findings, he reports that exposure to combat-related PTSD clients is related to therapist symptoms and he provides evidence that the effects of therapist exposure are distinct from burnout. He further reports that history of assaults and threats do not account for the obtained results. Apparently age, experience, or social support do not buffer the effects, but education and training in psychology at the doctoral level provide some protection. Munroe points out that professionals at the administrative, supervisory, training, and practitioner levels have an ethical duty to address this problem.

According to Pearlman, her work in progress with Gamble, Lucca, and Allen in 1995 distinguishes burnout from secondary traumatic stress. In another article with Mac Ian,

Pearlman (1995) reports a variety of behaviours that correlate significantly with overall schema disruptions experienced by trauma therapists. She also states that this study illustrated “significantly disrupted beliefs about self and others, one hallmark of vicarious traumatization, as well as psychophysiological symptoms and experiences of intrusion and avoidance of clients’ trauma material” (p. 158).

Two other unpublished studies that were poster presentations at an international conference on traumatic stress studies provide additional information on secondary traumatic stress. “The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists,” presented by Nancy Kassam-Adams (1994), University of Virginia, reports that therapists’ level of PTSD symptoms were significantly predicted by level of exposure to sexually traumatized clients. In her study of 100 masters- or doctoral-level psychotherapists in the Virginia and Maryland area, who completed self-report questionnaires consisting of three measures (Impact of Event Scale, a measure of traumatic stress; Personal Strain Questionnaire, a more general work stress measure; Occupational Stress Inventory), the researcher found trauma symptoms were not related to exposure to any other client problems or diagnoses, were not related to number of client hours, supervision, or other forms of support in the workplace, and that age of therapist or years of clinical experience were not related to therapists’ level of posttraumatic stress symptoms. However, Kassam-Adams did find that both gender and personal trauma history were correlated with traumatic stress symptoms and were significant predictors in therapists treating sexually traumatized clients. In particular, only therapists reporting childhood incidences of trauma (as opposed to adult incidence or abuse versus non-abuse trauma)

were strongly associated with posttraumatic stress symptoms.

Kassam-Adams, (personal communication, November, 1994), states that secondary traumatization poses a risk to therapists and is distinct from burnout and other forms of occupation stress. She suggests that there is a need for further examination of the role of gender and therapists' personal histories of trauma as factors in the development of secondary traumatic stress. Kassam-Adams's findings support Schauben and Frazier's (1995) and Pearlman and Mac Ian's (1995) claims that burnout is a separate and distinct construct from secondary traumatic stress. However, her statement that the therapist's personal trauma history is a factor in predicting level of traumatic stress contradicts the findings of Schauben and Frazier.

A team of researchers from the National Center for PTSD, in Boston (Chrestman, Duncan-Davis, Sullivan, and Kamen, 1995) who presented the second poster presentation, mailed out 2,000 questionnaire packets to psychotherapists containing (a) Personal and Professional History Questionnaire (Chrestman, unpublished); (b) Modified Mac Ian Trauma Therapist Behavior Change Checklist (Mac Ian & Pearlman, 1992); (c) World Assumptions Scale (WAS, Janoff-Bulman, 1989); (d) Trauma Symptom Checklist-40 (TSC-40, Elliot & Briere, 1991); (e) Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960); and (f) Impact of Event Scale (IES, Horowitz, Wilner, & Alvarez, 1979).

They report the following results: Therapists reporting historical trauma endorsed more distress/symptoms on the TSC-40 and the IES (Impact of Event Scale, a trauma symptom checklist) than those without a history of trauma. Therapists reporting secondary exposure to trauma endorsed more distress/symptoms on the TSC-40 and the IES than those without

secondary exposure to trauma. Symptom report was mediated by years of professional experience, increased income, percentage of trauma clients in caseload, and participation in research activities. Personal therapy, whether trauma or nontrauma in focus, and similarity of client trauma to therapist trauma were not significant mediators of symptom response. Cognitive schema as measured by WAS, did not change in relationship to trauma caseload or historical trauma. And finally, behaviours related to personal safety became more conservative as percentage of trauma clients in caseload increased.

Here, again, we see a contradiction to the findings of Schauben and Frazier (1995), who report that there is no relationship between prior personal trauma history and level of traumatic stress symptoms reported by trauma therapists. However, their report does supports Kassam-Adams's (1994) findings regarding exposure to secondary traumatic stress: Those therapists not exposed to traumatized clients do not develop secondary traumatic stress symptoms to the same degree as therapists working with trauma survivors. In addition, Schauben and Frazier's (1995) findings support the National Center for PTSD team's (1994) conclusion that percentage of survivors in the therapists' caseload is related to increased symptoms of traumatic stress among therapists.

The only qualitative component in all these research studies is found in Schauben and Frazier's (1995) study. They asked counsellors to provide open-ended descriptions of the most difficult and enjoyable aspects of working with sexual violence survivors. The respondents' reports that their work caused emotional distress and changes in core beliefs led the authors to conclude that counsellors who work with survivors report more PTSD symptoms and disruption in beliefs. To summarize the findings of the research studies

reported here, I have developed a table (see Table 1) using the factors related to the development of secondary traumatic stress among trauma counsellors with either a confirmation or disconfirmation of findings by researchers.

Summary of the Empirical Research

There is a consensus in the quantitative research on secondary traumatic stress that this phenomenon is a distinct construct from burnout. It also appears that the number of traumatized clients in the therapist's caseload is a factor related to secondary traumatic stress. The research is equivocal concerning the issue of the therapist's personal history of trauma as a factor in the development of secondary traumatic stress. Three research studies (Chrestman, et al., 1994; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995) found that it is a factor and three other research studies (Follette, et al., 1994; Munroe, 1991; Schauben & Frazier, 1995) claimed that it is not. Four studies (Chrestman et al., 1994; Gamble, Pearlman, Lucca, & Allen, 1995; Kassam-Adams, 1994; Pearlman & Mac Ian, 1995) investigated whether being exposed to only trauma clients as opposed to other types of clients was a factor and they found a positive correlation between this factor and the development of traumatic stress symptoms. Four studies (Arvay & Uhlemann, 1996; Chrestman et al., 1994; Munroe, 1991; Pearlman & Mac Ian, 1995) found that the number of years of experience in the counselling profession was related to levels of traumatic stress among counsellors. Three studies (Arvay & Uhlemann, 1996; Follette et al., 1994; Pearlman & Mac Ian, 1995) confirmed that the counsellor's level of education was related to secondary traumatic stress, that is, those with less than a master's degree were more

vulnerable. The age of the counsellor was also a factor in two of the research studies (Arvey & Uhlemann, 1996; Munroe, 1991), indicating that those who were younger were more vulnerable.

In terms of support and self-care, there does not appear to be a great deal of research in this area. Out of the five research studies that examined support and self-care, two (Arvey & Uhlemann, 1996; Chrestman et al., 1994) claimed that being in personal therapy was not a buffer against the effects of secondary trauma. Seeking supervision was found to be effective in two research studies (Follette et al., 1994; Pearlman & Mac Ian, 1995), and only one research study (Follette et al., 1994) found work-related support to be effective. However, social support was found to be a factor in two of the studies (Arvey & Uhlemann, 1996; Munroe, 1991). The type of work setting (e.g., private practice versus community agency) was also confirmed as a factor in two research studies (Arvey & Uhlemann, 1996; Pearlman & Mac Ian, 1995). Table 1 is illustrative of the gaps in our understanding of this phenomenon. Although important factors in the development of secondary traumatic stress have been examined, there appears to be an absence of agreement in the research findings to date.

Table 1

A Comparison of Research Findings on Secondary Traumatic Stress

	Schauben & Frazier	Follette, Polusny & Milbeck	Arvay & Uhlemann	Pearlman & Mac Ian	Munroe	Gamble Pearlman Lucca & Allen	Kassam- Adams	Chrestman Duncan Sullivan & Kamen
Distinct From Burnout	YES		YES	YES	YES	YES	YES	
Trauma Caseload	YES	NO	YES	YES	YES		NO	YES
Trauma History	NO	NO		YES	NO		YES	YES
Exposure				YES		YES	YES	YES
Experience			YES	YES	YES		NO	YES
Age			YES		YES		NO	
Personal Therapy			NO	YES				NO
Supervision		YES	NO	YES	NO		NO	
Work Support		YES	NO				NO	
Social Support			YES		YES			
Work Place			YES	YES				
Education		YES	YES	YES				

CHAPTER 4

A REFLEXIVE NARRATIVE METHOD

The method used in this study for researching the meanings constructed by trauma counsellors of their experiences with secondary traumatic stress will be addressed in detail in this chapter. The basic premise upon which this research project rests is the belief that meaning is dialogically and discursively located in the interaction between the researcher and the participant. Neimeyer (1995) supports this viewpoint by describing research praxis as “forming an intersubjective bridge between phenomenal worlds” (p. 2). Maturana and Varela (1987) point out that this interactive approach to inquiry requires the cultivation of new research practices (hermeneutic, deconstructionist, discursive, and narrative) that aim for the production of knowledges, while remembering that constructed knowledge is always partial, fragmentary, and shifting.

The method for this research project is a reflexive narrative method guided by a constructivist epistemology. The following assumptions outline the epistemological basis upon which the research design is founded:

1. Knowledge is socially constructed; knowledge is local, partial and co-constructed through dialogue. People participate in the creation of the knowledge they claim.
2. Language is a social activity; it is communal and personal. Human beings exist in language and meaning is constituted through language.
3. Human beings create their own identities through the stories they tell; we tell or write ourselves into being through our storytelling endeavours.
4. Construing is intentional: Human beings are meaning-makers; we impose

meaning on our own constructions and those of others.

5. Reflexivity, the act of turning back on one's experiences by means of conscious reflection, is an important element in the interpretation of human science research.

6. Understanding Other is an act of interpretation.

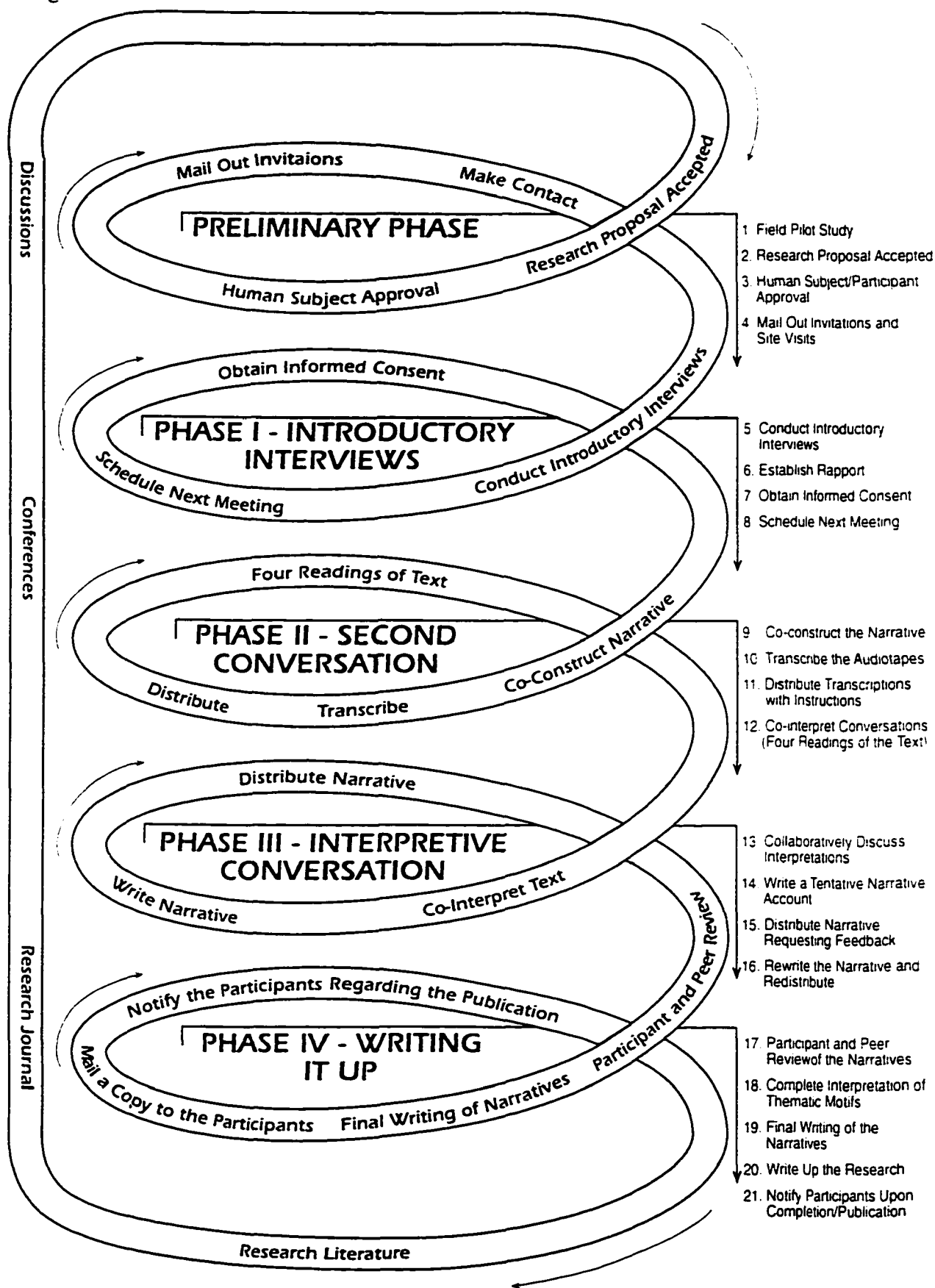
7. The research relationship is always influenced by power differences. Researchers should strive to create nonhierarchical, collaborative research designs.

8. Narrative researchers should include themselves in the texts that they write in order for the reader to gain a better understanding of how interpretations were constructed.

9. There is no universal reader of texts. Reading is always an act of interpretation.

10. Research texts are human constructions written by situated authors with vested interests.

This research project encompassed five phases as illustrated in Figure 1. These phases were (a) a preliminary phase; (b) first conversations, an introductory phase; (c) second conversations, co-constructing the narratives; (d) third conversations, an interpretive phase; and (e) the final phase of writing up the research project. Three levels of interpretation were employed in this narrative method (see Figure 2) as a means to construct the narratives on secondary trauma and to delineate narrative themes across participants, concerning the meanings of their struggles with secondary traumatic stress. These three levels are (a) textual, an interpretation of the text for plot, temporality, and sequentiality; (b) interactional, an interpretation of the interaction between the researcher and the participants, and (c) cultural, an interpretation through purposeful readings of the narratives



for the constructed self of the narrator, the struggles within the narrative accounts, and the power and gender issues within the transcribed text. I now turn to explicating the research process in detail.

The Research Journal

I began keeping a research journal during my time as a doctoral candidate and continued making journal entries until the final stages of the research process. My research journal included field notes, methodological considerations, and my personal experiences. It was a tool for generating insights, overcoming obstacles, illuminating preconceptions, posing further questions, and developing self-knowledge. My research journal served as a way to push forward issues that required examination. This self-dialogue, conducted through the process of writing, enabled me to examine my underlying beliefs and assumptions. The journal proved invaluable during the analysis stage of the research project in that it provided both a record of my previous thoughts, actions, and intentions, and a map showing the route that the research process had followed. In addition, I used a pocket dictating machine to record my thoughts on the research project as it progressed. Both my research journal and the use of a dictating machine provided a means for recording intuitive knowledge of what was going on throughout the research process and, thus, were reflexive acts on my part as the researcher.

The Pilot Study

As Steinar Kvale (1996) asserts, "Learning to become an interviewer takes place

through interviewing. . . . An interviewer's self-confidence is acquired through practice; conducting several pilot interviews before the actual project interviews will increase his or her ability to create safe and stimulating interactions" (p. 147). My decision to begin the research process with a pilot study rested upon several factors:

1. An opportunity for me to practice research interviewing.
2. The possibility of incorporating feedback from the pilot study volunteers into the research process.
3. My belief that knowledge regarding the research process informs a reflexive research stance.
4. A recommendation by committee members that a pilot study would act as a means to explore the proposed research questions.

Although I certainly wanted the interviews to be "safe and stimulating" for the participant volunteers, my main concern was technique. How would I foster interactive, meaningful conversations? How would I "invite stories" (Chase, 1995) on secondary trauma? In particular, I wanted to explore how I could invite reflexive stories, access tacit knowledge (Polanyi, 1985), and engage the participants in a project that would have meaning. To explore these issues further, prior to the research project itself, I invited two women to investigate these concepts with me through a pilot study.

The first volunteer was a doctoral colleague who shared an interest in my research project and was willing to offer her personal experiences. She had experienced secondary trauma when she first started working as a trauma counsellor. I approached the second participant during a workshop on secondary traumatization and invited her to be a part of

the pilot study. Her stated motivation in participating in the pilot study was twofold: She was interested in my research topic and she felt that maybe she would learn something about herself.

Both pilot study interviews were one hour in length. The pilot study interviews began with an explanation of the purpose of the pilot project. Both participant volunteers signed the Pilot Study Participant Consent Form (see Appendix A) that defined the purpose of the pilot study, explained the voluntary nature of participation, and outlined the researcher's commitment to confidentiality. The interviews were audiotaped with the participant volunteers' consent. I informed the pilot study volunteers that their audiotapes would be used only as information guides for the research process, and that upon completion of the pilot study the audiotapes would be destroyed. They were asked to take a metaperspective during the interview. Following each pilot study interview, the participant volunteers and I discussed and reflected on the interview process for approximately one hour. This debriefing session was also audiotaped.

Over a period of several days, I listened to the audiotapes of each of the interviews and the debriefing sessions in order to achieve several goals. I wished to note the development of the participant volunteers' narratives, to gain awareness of myself as the researcher in the research interaction, to understand how meanings were construed by myself and the participant volunteers, and to develop strategies for future interpretive analysis. Journal entries were made to record these new insights for use in the research project. These new insights, resulting from the pilot study, are summarized in the following five substantive areas:

1. The pilot study allowed me to reflect on myself as the researcher. I gained confidence in trusting my own style as an interviewer and in following my hunches. Referring to those places in the pilot study interviews where the volunteer and I felt a strong connection was confirmed by reference to the audiotapes, the debriefing session, and the research journal. The feedback from both participants was very useful in terms of how they experienced my presence, my style of interacting, my use of questioning strategies, the amount of interruption that occurred, and my influence in directing the flow of the interview. One participant volunteer stated, "It was like an ordinary conversation. . . . You were earnest, empathic. . . . I knew you were listening very carefully and I felt understood." The other participant volunteer stated, "You only interrupted me a couple of times to ask me a question, but it didn't sidetrack me, and I understood that I wasn't being very clear about that part of the story." and she continued, "I felt respected. You have a very sincere and gentle manner about listening and when you probed for what I meant, I knew what you were pointing to, but sometimes I just couldn't explain it better. I agree, though, that there is something more there that needs to be looked at." I was satisfied by these comments that both participant volunteers had experienced "safe and stimulating interactions" and I trusted that I would be able to create similarly safe and stimulating interactions during the research project.

2. The pilot study enabled me to reflect on how to invite stories of secondary trauma. Being empathic, open, flexible, and curious was confirmed as valuable researcher characteristics. The deliberate creation of a trusting atmosphere produced valuable results because a participant is more responsive when the interview atmosphere is relaxed. The use

of a pilot study to practice research interviewing, prior to the research project itself, was helpful in making me confident that the communication skills I had learned in counsellor training were transferable.

3. The pilot study made it possible for me to explore ways to access tacit knowledge (Polanyi, 1985). It became apparent that the process employed in the research project needed to incorporate a reflexive component in order to uncover deeper levels of meaning not readily apparent in the telling of the story. The telling of the story of secondary trauma is one level of meaning-making. Reflecting on the story is a second level of meaning-making that may point to underlying beliefs and enable the interpreters to see what is at work behind the narratives. A third level of meaning-making points to the conversational interaction between the speakers. How do they construct the narratives on secondary trauma and how do they fashion their own identities in the process?

4. The pilot study enabled me to experiment with narrative analysis prior to the research project. Upon reflecting on the process of interpretation, I decided to ask the participants in the future research project to write their own narratives on struggling with secondary trauma. I believed that writing an autobiographical account as a self-reflexive act constitutes self-understanding. Written accounts provide a direct pathway to the participants' interpretations of their own experiences. Having the participants write their own narratives, instead of telling them in a research interview, bypasses that first level of researcher interpretation wherein accounts are sieved through the filter of the researcher who is actively co-constructing the telling of the story. I wondered whether the participants would be willing to write their own narratives and whether it would be appropriate to ask.

5. I discovered, in consultation with Dr. Oberg, that the site of the research would be the research participants' struggles. In the research project, I would need to take into account how the participants construed their experiences of these struggles. The pilot study allowed new questions to emerge other than those already posed: What meanings are construed in the telling of their struggles with secondary trauma? How is language used? How is the self of the narrator portrayed? How are the struggles culturally embedded? How does the researcher develop through the research process? What meanings are constructed in the research interactions?

For all these reasons, the pilot study was an informative experiment in research process and influenced the research project by broadening my understanding of the influence of the researcher in the development of the interviews and in adding depth to the content of the questions offered to the participants.

Inviting Participation

A letter was distributed to 20 trauma centres in British Columbia (see Appendix B), inviting participation in this research project. These trauma centres included 4 transition houses, 4 rape crisis centres, 4 women's sexual assault centres, 4 child sexual abuse centres, 3 provincial mental health clinics, and 1 association for the survivors of torture. In addition, I delivered oral presentations at 2 trauma centres, explaining the purpose of the research project, with a request for participation. Five women and 1 man initially volunteered. Three volunteered to be interviewed as a result of the oral presentations, 2 volunteered as a result of the letters sent to their workplaces, and another volunteered after hearing about the

research project from a friend. All of the volunteers contacted me by telephone and introductory interviews were scheduled.

The First Conversation: Introductory Interviews

A good informant is one who has the knowledge and experiences the researcher requires, has the ability to reflect, is articulate, has the time to be interviewed, and is willing to participate in the study. . . . Participants are representative of the same experience or knowledge; they are not selected because of their demographic reflection of the general population. (Janice Morse, 1994, pp. 228-229)

Individual introductory research conversations were conducted for the following reasons: (a) to introduce the research project by giving a detailed description of the purpose, an explanation of my research questions, and a detailed account of my expectations of participants and their role in the research process; (b) to introduce myself and my role and responsibilities in the research process; (c) to assess the knowledge level and appropriateness of each potential participant, which Patton (1990) refers to as “purposeful sampling” and, more specifically, as “critical case sampling;” and (d) to build rapport with these potential participants. Five of the introductory conversations took place in a casual, non-threatening atmosphere over lunch. One volunteer was interviewed over the telephone.

All six volunteers met the selection criteria for participation in the research project. Each person briefly described his or her experiences of secondary traumatization and, based on the selection criteria described by Janice Morse (1994) in the epigraph, I was satisfied that rich, descriptive, informative narratives would be generated.

Reflecting on the First Conversations

Reviewing entries in my research journal and reflecting on the recruitment interviews, it was apparent that some concerns were already becoming clear to me about the research process. For example, despite his assurances, one participant might not have the time that would be required to complete the research project. More important, the emotional stability of one of the participants was also a concern. This raised questions for me as the researcher: Is it ethical to encourage someone to participate in a research project that may make them extremely vulnerable? Can this dilemma be avoided considering this research project must necessarily explore past (or even present) wounds?

I decided to approach all of the participants with these concerns before the start of data collection. I was reassured by them that their participation would not pose a problem for them. One participant stated that she would let me know if she felt that she needed counselling to help her deal with some of the issues that may come up during the research. Their reassurances did not answer these ethical issues--other than on an individual level--but were sufficient to allow me to feel that the research project could proceed. In fact, both of the participants triggering my concerns did not continue to the end of the research project. The one male who volunteered to participate in the study withdrew after three attempts were made to meet. He stated that he was unaware at the time of his volunteering how busy he had become and that he needed to "guard his time" by not overextending himself. Of the five remaining participants, one withdrew after our second conversation. Her psychiatrist contacted me, stating that she had been hospitalized, and indicated that she would be unable to participate in the study. My immediate concern was whether her participation in the

research had any effect on her current condition, but her psychiatrist indicated that it had not. I was reminded of what Michael Patton (1990) meant when he wrote that “interviews are interventions. They affect people. A good interview lays open thoughts, feelings, knowledge, and experience not only to the interviewer, but also to the interviewee” (p. 353). Her audiotaped conversation and her participant consent form were both destroyed.

One of my conclusions from the pilot study was the desirability of an individually written narrative from each of the participants. However, not one of the participants was willing to write her own narrative. Each participant preferred an audiotaped interview. Reluctance to write their own narratives of experiences with secondary trauma was ostensibly due to pressures of work and family obligations, that is, lack of time to produce such narratives. Because this element of the research project had been added as a result of the pilot study and was not integral to the research project itself, I did not feel it was necessary to abandon these participants and attempt to locate participants who would agree to produce written narrative accounts. However, I questioned the reasons given for their repeats. Is the process of writing in itself intimidating? Is the risk of self-exposure too great and the ability to self-censor too tempting? At this point I struggled with other questions: What impact will this have on the research design? What impact will it have on the research process? How do I deal with transcripts as narrative texts? How do I analyze transcripts as narratives? Would I have to look for new participants or would I overcome this obstacle by changing the research design?

After discussions with my supervisor and committee members and reviewing the literature on narrative analysis, it was apparent that audiotaped conversations would

generate participant accounts and that the subsequent interpretive process would not be unduly hampered. If the focus of the conversations would be on the interaction between the speaker and the listener and between the interpreters and the texts, then narrative accounts, co-constructed through our conversations, but authored by myself, would provide the necessary research text.

The Second Conversation: Constructing the Narrative Accounts

There were several reasons governing my choice to engage in research conversations instead of other forms of data collection. First, studies focusing on posttraumatic stress among trauma counsellors have taken a predominantly quantitative approach. My master's research (Arvay, 1993; Arvay & Uhlemann, 1996) was one of these studies. I decided, at that time, not to add another survey questionnaire to the research pool or devise a structured interview schedule that would predetermine the data to be collected by the questions posed. Ann Oakley (1981) states in her critique of traditional interviewing methods that (a) interviews are traditionally viewed as a one-way process in which the interviewer elicits and receives, but does not give information, (b) the interviewees are seen essentially as passive respondents and objectified as data producers, (c) interviews are not viewed as social interactions where meaning is co-constructed, and (d) meaning is reduced to statistical comparability with other interviews and the measurable data they produce. These traditional research methods restrict trauma counsellors from expressing in their own words their understandings of secondary trauma.

Second, I wanted to provide the participants with opportunities to express and give

meaning to their personal experiences with secondary trauma. Because I believe that people both make sense of their experiences through narration and communicate the meanings of their experiences through narration, I decided to “invite stories” through conversation (Polanyi, 1985).

For these reasons I chose not to use traditional interviewing methods. I also chose to view my participants as “co-investigators” (Hermans, 1992). They were not to be “respondents” who are limited to responding upon request, nor “informants” who merely impart information. As participants, they would be actively engaged in the process of constructing the meanings of their experiences. By eschewing the traditional methods used in psychology to study secondary traumatic stress, I am making explicit my assumptions about research and about how knowledge is produced.

Assumptions and Concerns Guiding Method

Several assumptions and concerns guided this method. The underlying premise came from Elliot Mishler’s (1986) definition of interviewing as a method for gathering data in the human sciences:

I propose a reformulation of interviewing, one that attempts to redress the problems engendered by the standard approach. At its heart is the proposition that an interview is a form of discourse. Its particular features reflect the distinctive structure and aims of interviewing, namely, that it is a discourse shaped and organized by asking and answering questions. An interview is a joint production of what interviewees and interviewers talk about together and how they talk to each other. The record of an interview that we researchers make and then use in our work of analysis and interpretation is a representation of that talk. How we make that representation and the analytic procedures we apply to it reveal our theoretical assumptions and presuppositions about relations between discourse and meaning. (p. vii)

My preference for the term *conversation* instead of *interview* points to the interactive,

interrelational, dialogically shifting, communicative style that underscored my approach during this research project. Steinar Kvale (1996) explicated the original Latin meaning of conversation as “wandering together with” (p. 4). This metaphor illustrates my efforts in co-constructing the research narratives with my participants.

Because my belief is that knowledge is socially constructed, research conversations necessarily become reciprocal exchanges in which each person presents a perspective that is responded to by the other through acknowledgment and questioning. A response is offered in return and thus anticipates the next exchange. Research conversations are complex and contextual interactions. There are interactive shifts between the various possible selves of the researcher responding to the selves of the participant and vice versa (Markus & Nurius, 1986). Both the researcher and the participant hold multiple “I” positions in the exchange (Hermans, Rijks, & Kempen, 1993). A research conversation is a reciprocal exchange of ideas, beliefs, and hunches and illustrates the way in which knowledge is socially constructed.

Another assumption that informs this method is the belief that research should strive to be collaborative and non-hierarchical (Hermans, 1992; Mies, 1983; Reinharz, 1992). Although I do acknowledge that there are always inequities inherent in any research relationship, given that the topic of study, the research method, authorship, and the interpretation of the final text remain in the domain of the researcher, I attempted to address these inequities by including the following elements.

The participants determined where and when the interviews would take place. They decided the length of each interview and how much information they wished to disclose. Six

conversations were scheduled at mutually agreeable times. The length of each conversation varied from 1½ hours to 3 hours. At the discretion of the participants, they were encouraged to create the narrative accounts in their own way, by being encouraged to tell stories of their own struggles with secondary trauma. I deliberately and consciously took an open, gentle, respectful, empathic stance during the conversations, asking a few questions for clarification of sequencing, word usage, or significance of an episode, while restricting my probing for information. I also engaged offering authentic responses and by self-disclosing parallel experiences when it seemed appropriate to do so. The participants consented to audiotaped conversations (see Appendix C) and knew that the tape recorder would be turned off at any time upon request. The participants also knew that their participation was voluntary and could be withdrawn at any time. Every effort was made to conceal their identities. Each participant chose her own pseudonym for the narrative text. At each stage of the research process, the participants were kept informed, given opportunities for input, and invited to share in the construction and interpretation of the findings.

My final concern at this early stage of the research project was directed towards the practice of “inviting stories” (Chase, 1995; Polanyi, 1985). How would I be able to generate “thick descriptions” (Denzin, 1989) from my participants? I decided to begin each conversation with a “starter statement,” reiterating the purpose of the study and my interest in the topic. The following is the starter statement with which I began the research conversations:

I am interested in exploring the different meanings counsellors construct from their experiences of working with trauma survivors. My assumptions going into this research are that trauma counsellors struggle with their clients’ stories and that these stories are disruptive to their everyday notions of how the world should be. I anticipate

that trauma counsellors confront the difficult task of reconciling disruptions to previously held core beliefs about themselves and the world in which they live. My interest in this research topic lies within that struggle. What have the struggles been like for you, and what meaning have you made out of your experiences with these struggles?

Clearly something more than just a good starter statement was needed. Because the purpose of the conversation was to co-construct narratives on secondary trauma, I would also have to actively engage in the meaning-making process. I felt that our mutual skills, as trained and experienced counsellors, would facilitate an in-depth, reflexive conversation. I was also aware that inviting the Other's story was more than just opening up the conversation or asking good questions. It would entail my attending to the narrative account at both the micro-level of the individual experience of the narrator, and at the macro-level of cultural practices. Susan Chase (1995) has described what it means to invite the Other's story:

In listening to the other tell her story, we need to remain attentive to the ways in which its culturally problematic character may produce silences, gaps, disruptions, or contradictions. Thus, inviting the other's story requires more than a good life story question, it also requires reiterating the invitation throughout the interview. This means that we may need to ask questions that will encourage her to fill in what she has left out or to articulate more fully her contradictory feelings. (p. 14)

Thus, the participants and I would have to be engaged at both an experiential level and reflexive level.

My treatment of the first and subsequent research conversations followed a pattern. After audiotaping a conversation I would (a) immediately reflect on the conversation by orally dictating my thoughts on the process; (b) listen to the audiotapes several times and write down insights, thoughts, and reflections in my research journal; (c) transcribe the audiotapes; and (d) write a tentative summary account, using the transcription of the

audiotape and my research journal as references. This part of the research project took approximately 3 months to complete.

Reflecting on the Second Conversations

After the second conversations were audiotaped, transcribed, and reflected upon, I was inundated with volumes of researcher process notes. From these, a few insights will be highlighted in this section; several others relating to methodological considerations will be addressed in the final chapter.

Constructing research identities. Schwandt (1996), like many other human science researchers (e.g., Fontana & Frey, 1994; Guba, 1996; Heshusius, 1996; Reinhartz, 1992; Smith, 1996), has struggled with an essential question: “How shall I *be* toward those people I am studying?” (p. 156). Reflecting on this question and the second conversations, I was struck by the ways in which the participants and I fashioned research identities that fell into the traditional research paradigm of researcher as the receiver of knowledge and participant as the one who offers knowledge while trying to guess what the researcher wants. The participants made beginning statements, such as “Well, I’m not sure if this is what you want but . . .” and “Well, I’m not sure where you want me to start” and “I hope this is useful.” These tentative overtures indicated that there was a prescribed format that should be adhered to and that the function of the participant was to provide me with a certain kind of information. Three of the participants made statements about being careful not to overwhelm me with their experiences, asking if they should continue to give me explicit, emotional details that were contained in their stories. There was a clear but unspoken desire

to be cooperative, useful participants. However, the very skills that I shared with the participants as fellow counsellors meant that as the conversations progressed, these skills came into play to surpass the traditional paradigm as we participated in the kind of conversations I had envisioned.

I found myself being dethroned from the researcher/expert perch when a participant asked me a question during our conversation. I was so surprised by her question--asking me what I meant when I said, "Oh, that's interesting"--that I was taken off guard because *she* was asking *me* to explain myself! She felt that she was being judged and she "called me" on it. I began to grow into my new role as co-participant, or using Michelle Fine's (1994) phrase, I began to "work the hyphen" between self and Other, calling into question my privileged position as the researcher.

Self-disclosure during the conversations. Researcher self-disclosure, when carefully and appropriately offered, initiates authentic dialogue. It is a way of sharing the self of the researcher, exposing beliefs and feelings, and contributing to the construction of the research narrative. As a feminist practice it supports the notion of nonhierarchical research (Josselson, 1996; Oakley, 1981; Reinhartz, 1992). These presuppositions about researcher self-disclosure influenced the communicative interactions between myself and the participants. There were several instances where I offered an anecdote, shared my feelings about the participant's story, or told my own parallel story. We mutually explored the meanings of our shared experiences. We laughed together, cried together, held hands, and struggled to understand what it all meant.

Shulamit Reinhartz (1992) states that "researchers who self-disclose are reformulating

the researcher's role in a way that maximizes engagement of the self but also increases the researcher's vulnerability to criticism, both for what is revealed and for the very act of self-disclosure" (p. 34). What this criticism suggests is the traditional paradigm's insistence on being "objective." I am not alone in my approach to research as conversation. There are many human science scholars who are taking a holistic, reflexive approach to science and who are investigating the moral and emotional aspects of their work (Behar, 1996; Denzin, 1997; Fontana & Frey, 1994; Guba, 1996; Heshusius & Ballard, 1996; Josselson & Lieblich, 1996; Richardson, 1994). There needs to be a place in research for somatic and emotive ways of knowing in the construction of knowledge. Reflecting on the process of self-disclosure and its impact on knowledge production during the research encounter is a starting place.

Researcher vulnerability. What is the by-product of conducting research that is emotive, engaged, and revealing? There has been some mention in the literature on the stressful moments researchers encounter doing such research. Examples are Margaret Gordon and Stephanie Riger's (1989) painful rape interviews, Becky Thompson's (cited in Reinharz, 1992, p. 35) dissertation on eating problems which left her feeling anxious and depressed and Diane Russell's (1989) *Lives of Courage: Women for a New South Africa*. I anticipated before commencing this research project that the stories of secondary trauma might be difficult for me to hear. However, I was not prepared to be seriously affected by them. To my surprise, I was affected. Each conversation was an emotional encounter. Although I felt encouraged and hopeful after we concluded the second conversations, I was also impacted by the pain of the participants. Their stories, which I revisited repeatedly by

listening to the audiotapes and re-reading the texts, left me feeling depressed at times. There may be a tertiary level to traumatic stress. This might be a future research project for those interested in the implications of trauma research on the researcher.

The Transcription Process

The approach that I took in transcribing the research conversations rests upon the assumption that qualitative research is not replicable. Therefore, the practice of explaining how texts are produced via the transcription process is not directed to the purpose of replication, but rather to show the reader the researcher's approach to the text. From such an explanation, the reader might ascertain the merits of the researcher's interpretation.

If feminist interview researchers carefully describe exactly what occurs during the interviews and during the analysis process, we are likely to discover additional methodological and ethical dilemmas that can be clarified and perhaps resolved. In my view, the emerging norm of self-reflexive reporting of the interview process and the experiments in exact reproduction of people's speech are steps in this direction. (Reinharz, 1992, p. 45)

Although I agree with Reinharz (1992) that attempts of this sort must be made, I do not believe that "exact reproduction of people's speech" is possible. All that we can do as researchers is attempt to reproduce the communicative events as closely as possible--they will never be exact. Second, we cannot reproduce past events. Our stories (and transcriptions of these stories) do not mirror the world as lived because our stories are constructed retrospectively. We can only attempt to reconstruct life events and hope that there will be some degree of verisimilitude. As an analogy, there are qualitative and interpretive differences between being an actor in a play, watching the play, or reading the play.

Transcription is an interpretive practice. A researcher's approach to transcription underscores her or his individual theoretical and epistemological assumptions about research. The method of transcription for this research project was designed utilizing models of transcription procedures described by Susan Chase (1995), James Gee (1991), Elliot Mishler (1992), and Catherine Kohler Riessman (1993).

Each audiotape was transcribed twice. The first transcription was produced as a rough draft. (I personally transcribed all but one of the audiotapes.) For the first rough draft, I carefully listened to the speech events to record each aspect of the speech produced (e.g. laughter, pauses, silences and gaps, hedging, crying, yelling). I noted any aspect of the speech act that was not audible on the audiotape, but was recorded in written form in my field notes (e.g., body language, movement, facial expressions, positioning, environmental influences).

For the second draft, I followed a listening method suggested by James Gee (1991). I re-transcribed the conversation by displaying the text of the rough draft in stanza form, where each episode of the narrative was kept together in a series of lines and the tone of speech and pace were marked. Each episode that was conceptualized as a story within the larger narrative was marked at its beginning and ending by double-spacing. The tone of the speaker was marked by using a bold font to indicate emphasis, and italics to emphasize emotional expression followed by a bracketed word indicating my interpretation of the emotion (e.g., "This grey cloud would come over me." [sad]), and capital letters to mark raised voices. The phrasing of the speaker was marked by using ellipses (" . . .") to indicate interruptions in speech, followed by "[P]" to indicate a long pause and "[p]" to indicate a

pause under three seconds, and quotation marks were used when the speaker was referring to someone else's comments. All hesitations were written into the text (e.g., "um hmm," "tch," "um," "ya know"). Both speakers were included in the transcription and when speech overlapped the researcher's speech was bracketed with "{}" to show it had been spoken simultaneously.

In the first rough draft, I numbered the lines by transcribing the whole text into AQUAD, a computer software program for analyzing qualitative data. However, reducing the text to codes was contrary to the spirit and intent of the research project. I found as I reviewed the columns printed out from the AQUAD program that I felt a loss of the contextual cues. I felt distanced from the participants' stories. Deciding to approach the transcripts in a holistic manner, I scrapped the computer-generated data.

The last transcription task--before I turned my attention to the interpretative process--was to identify narrative episodes: places in the text where stories began and concluded or were taken up again later, that is, "listening for entrance and exit talk" (Riessman, 1993). I was attempting to identify stories within stories in order to understand the temporal sequencing of the story line and to determine the unfolding of the plot.

Finally, it must be noted that transcriptions are always partial; in any specified notation system, some aspects of speech are included while others are excluded (Mishler, 1986). The inclusion/exclusion dimension of transcription practices only points to the assumptions held by the interpreter. Catherine Kohler Riessman (1993) summarizes my view of the transcription process:

Transcribing discourse, like photographing reality, is an interpretive practice. Decisions about how to transcribe, like decisions about telling and listening, are theory driven

(Ochs, 1979) and rhetorical. . . . Different transcription conventions lead to and support different interpretations and ideological positions, and they ultimately create different worlds. Meaning is constituted in very different ways with alternative transcriptions of the same stretch of talk. (p. 13)

The Interpretive Process

It is I who put the themes there. I did not find them, discover them, or uncover them; I imposed them. (Wolcott, 1994, p. 108)

Interpretation is guided by the interpreter's assumptions about discourse. The interpretive approach a researcher takes is grounded in her or his epistemological beliefs. The act of interpretation is to render "it" meaningful. It could be a text, a person, an object, an action, or an interaction. Often in human science research, it is a process.

Acts of interpretation, grounded in epistemological beliefs, raise difficult questions: How do we study meaning when it is a process? How do we show an interpretation without distorting another's experience? Is distortion an inevitable result of interpretation (Fine, 1994)? From a constructivist viewpoint, interpretation is never transparent, because researchers are engaged in reconstituting the other from their own perspectives. Von Glasersfeld (1991) states, "If the constructivist movement has done anything at all, it has dismantled the image of language as a means of transferring thoughts, meanings, knowledge, or 'information' from one speaker to another" (p. 23). Interpretation is always in terms of concepts and conceptual structures that the interpreter has formed out of elements from her or his own subjective field of experience. For this reason, a reflexive approach to analysis is imperative, and the interpreter must acknowledge her presence in the interpretation. I am moved by the words of bell hooks (1990) and reminded of the responsibility interpreters

must bear when reconstituting the stories of Others.

No need to hear your voice when I can talk about you better than you can speak about yourself . . . Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. . . . I am still author, authority. I am still colonizer. (pp. 151-152)

Interpretation is multiperspectival: It is not static or fixed, and it is “context sensitive” (Denzin, 1997; Mishler, 1990; Polkinghorne, 1988). Acts of interpretation take place through all the stages of research (Kvale, 1996). Interpretation underscores every research task, from formulating the questions, to keeping a research journal, to transcribing the text, to doing the analysis, to writing the report. As an attempt to come to terms with my own interpretations throughout this research project, I kept two questions in mind: What does this mean and why do I choose *this* meaning over others?

Methods of Interpretation in Narrative Research

There can be no single method of interpretation in narrative research. Narrative analysis is multidisciplinary (Riessman, 1993), and approaches to narrative analysis differ depending upon the discipline where it is situated and the researcher’s theory about discourse and meaning. An approach located in sociolinguistics takes language as representing reality. For example, Labov and Waletzky (1967) used structural analysis to reduce the particular content of personal narratives to a general structure that was then contrasted to other stories with a similar structure. Their view of narrative posits that stories are about past events and have common properties to other stories.

In anthropology, Agar and Hobbs (1982) employed structural analysis to show how components in a story are linked together through various coherence devices that provide

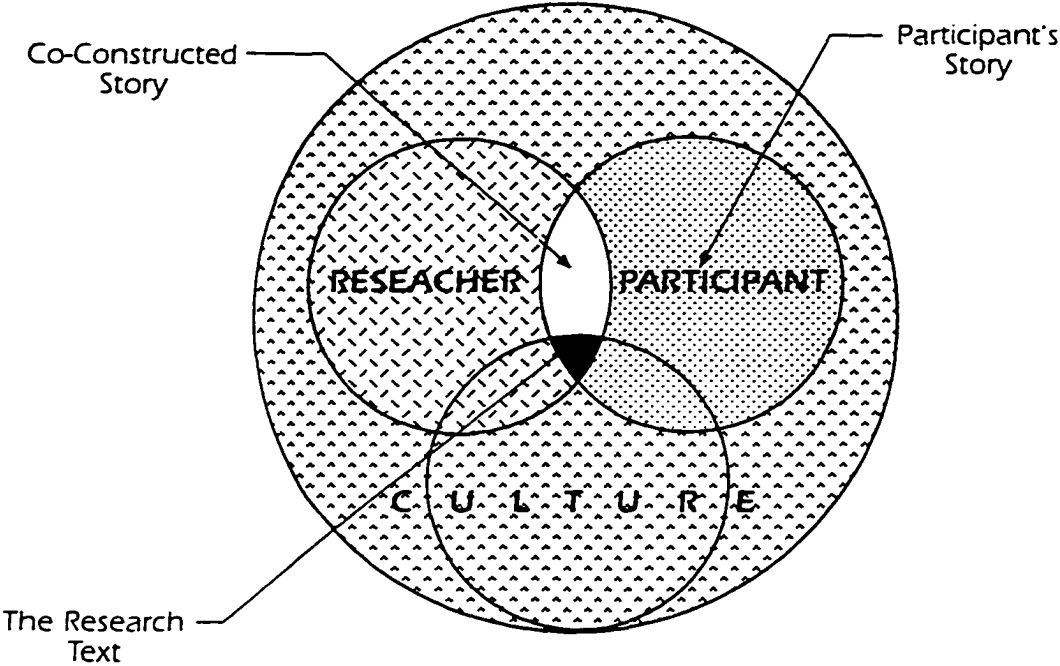
the researcher with an understanding of the structure and content of the participant's cognitive world (Mishler, 1986). Van Dijk (1980) focused on narratives as a means to assess cognitive processing and claimed that readers and listeners assume that texts have thematic coherence. Usually, stories do not make sense if the main topic or theme is missing. Gee (1985), located in the field of literary criticism, has argued that attention should be paid to how a narrative is told. He proposed a model for narrative analysis built on the poetic structures in speech. These approaches to narrative analysis look to the structure of speech for their interpretation and fail to attend to the interaction between the speaker and listener. They exclude the influence that the researcher has on the knowledge produced. In recognizing the limitations of these approaches, the method of interpretation developed for this research project explores the meaning of narrative at three different levels: as a text, as an interaction, and as a cultural product.

Three Levels of Interpretation

The interpretive methods employed in this research project were designed to incorporate not only the narrative as a text, but also to focus on the interaction between the participant and the researcher, and to explicate the cultural stories embedded within the context of the narratives. Three dimensions of interpretation were designed for these purposes. Figure 2 illustrates the three levels of interpretation applied in this research project.

Level 1: Textual interpretation of the participants' narrative constructions. The first level of interpretation was designed to answer the questions: What is this story about?

LEVELS OF INTERPRETATION



Three Levels of interpretation

Level of Interpretation	Interpretive Task	Outcome
Textual	Interpreting the text for plot, temporality and sequentiality	The Participant's Story
Interactional	Interpreting the interaction between researcher and participant	The Co-constructed Story
Cultural	Reading for the self of the narrator, the struggle, and power and gender issues	Narrative Themes in Research Text

How is this story construed? How is the self of the narrator constructed in the telling of her story? What does the way in which the story is constructed reveal about the participant's experience of secondary trauma? Three levels of narrative construction were examined: plot, temporality, and sequentiality. A set of questions were designed to address each level of narrative construction.

1. Plot: How is the plot developed in this account? What are the subplots and how are they connected to the narrative as a whole? Is there one story with related episodes or are there a series of different stories being told? How does the protagonist portray herself? What is hinted at, left incomplete, or omitted from the story? What interpretations can be made from these omissions, gaps, or hints? How does the narrator use different tropes in her account and what purpose do they serve? Is there a crisis point or an epiphany? How is it resolved, accounted for, or both?

2. Temporality: What are the temporal elements in the story? How are the verb tenses significant in relating present, past, and future constructions? What do the shifts in the self of the narrator from the "I" position to third person indicate?

3. Sequentiality: How is the story ordered through time? How does the narrator link subplots or episodes together to create a coherent, meaningful narrative? How does the narrator use flashbacks and other devices to create movement over time? How does she re-enter the flow of the story? Where is she taking the interpreter and why is it important to her?

Each conversation was interpreted using these questions as a guide. Story maps were drawn for each conversation in an attempt to make a visual re-presentation of the plot

development as well as the temporality and sequencing of events. The use of metaphors, paradoxes, and ambiguities were drawn out for future examination with the participants. Character sketches and summary accounts were developed for each participant. Upon completion of the textual interpretation, a first rough draft of each participant's narrative account was written. Notations were made on the transcript in the form of interpretive questions that were to be reflected upon with each participant during the third conversation. Although this level of interpretation is reductionistic, it did provide the researcher with an interpretive account to take back to the participant for discussion. The outcome at this stage of the research, based on the second conversation, was a tentative interpreted narrative text portraying the researcher's view of the participant's story.

Level 2: Interpretation of the research interaction. The purpose of the second level of interpretation was to focus on the research interaction. How was the construction of the narrative affected by the interaction between the researcher and the participant? Polkinghorne (1988) and others (Josselson, 1996; Mishler, 1986; Shotter, 1993) argue that narratives are interactions that take place in specific contexts. In order to understand how the narrative was constructed, I had to retrospectively explore the ways in which the co-investigators (myself and the participant) constructed the research interaction.

John Heritage's (1989) work on conversational analysis informed my method of interpretation. According to Heritage, conversational analysis is based on three premises: (a) interactive talk is structurally organized, (b) all interactive talk is contextually produced and reflects its situatedness, and (c) the first two points are present in all conversations. Holstein and Gubrium (1994) state that "no order of detail can be dismissed as disorderly, accidental,

or irrelevant” (p. 266). In addition to Heritage’s model, two questions developed by Steinar Kvale (1996) frame my approach in analyzing the interactive conversation. First, what is the role of the researcher in how a participant’s narrative is constructed and what does it mean in the research interaction? Second, how do the researcher’s questions, assessments, silences, interruptions, and responses enter into the narrative’s production?

Each conversation was reflexively interpreted with the guidance of these questions and the interactions between the participants and myself were traced. Places where I interrupted, redirected, showed an emotion, theorized, or made a comment were analyzed for their implications in the narrative’s construction. John Shotter (1993) has advised the reader to look at the gaps in conversation because that is where we notice the interaction at work. A commentary on the interpretation of the interaction was written with page references from the transcript. Also, notations were made on the transcript as a cross-reference, in order to gain clarification and input from the participants during the third conversation, the interpretive interview.

Level 3: Four collaborative interpretive readings of the text. The third interpretive stage involved a collaborative effort between the participant and the researcher. The purpose of this level of interpretation was to intentionally read the narrative to determine how the narrative evolved as a cultural product. Because we are all embedded in the stock of cultural stories available (Polkinghorne, 1988), this may not be possible given that speech is never isolated or ahistorical (Bakhtin, 1986).

An instruction sheet (see Appendix E) and a reading guide were produced for the participants. Two copies of each transcript were photocopied onto 11 x 17 inch paper and

four columns were drawn on the right-hand side of each page. A copy of the transcript was returned to each participant with four coloured pens and instructions on how to approach the text for interpretation. The participants were asked to interpret the text during four separate readings. A summary of the general instructions were stated as follows:

The following is a guide to assist you in interpreting the text. This process entails at least four readings of the text and perhaps more as the research process unfolds. I am asking you to be the interpreter of your own transcript. The purpose of each reading is to approach the text from a different standpoint. . . . If there are other readings that you would like to engage in, please call me in order that I may do the same so that our interpretive processes coincide.

Table 2 shows the instructions for each of the four readings: content, self, the struggle, and power and gender issues.

The participants were given their transcripts with the instructions the middle week of December and asked to return them in January. I completed all four readings of each participant's transcript while I waited for the transcripts to be returned. All the transcripts were returned by February. All the transcripts had been interpreted except for one. This participant stated that she did not have the time to do all four readings, but she would be willing to spend "extra" time with me "flushing out her own ideas" at our next scheduled conversation.

The Third Conversation: Reconstructing Texts and Negotiating Meanings

The third conversations, the interpretive interviews, were audiotaped sessions held in the participants' homes (except for one session in a participant's office) and lasted 2 to 3 hours. Each participant retrospectively and reflexively discussed their interpretations of the four readings, then listened to and responded in turn to my interpretations. Our

Table 2

Instructions to the Participants for the Four Interpretive Readings

Reading for Content Use Blue Pen	Reading for Self Use Pink Pen	Reading for the Struggle Use Green Pen	Reading for Power/Gender Use Orange Pen
Read the transcript all the way through in one reading. You are looking for the "whole picture" or the story line. Note any questions or comments in the first column marked on the right. Does the text need to be changed so that confidentiality is not breeched? Are there any typos? Does the text need clarification or further explanation? Complete the summary section in the first column at the end of the text. Please summarize your thoughts on the story line or the contents of the text.	Here we are trying to locate the "self" of the narrator which is really you, the participant. As the reader or interpreter, read the text for the narrator's "I" positions. Ask: Who is this person telling this story? How is she situated in this story? What is she feeling? What are her struggles? What does she mean? How does she present herself? What parts of self does she choose to portray and what parts are hidden? This reading entails an empathic interpretation of the narrator's actions, beliefs, choices, self-representations. Summarize your interpretation of the person of the narrator at the end of this reading in the second column.	The emphasis in this reading is on the struggle with secondary traumatic stress. What meaning does the narrator make of this struggle? How does she make sense out of her experiences? What is not said-what is implied? What are the contradictions between her words and actions or interpretations? What are the paradoxes? What metaphors does she use? How do they help with the meaning beneath the words? Take time to reflect on this reading. There will be places where you know something is there, yet you can't quite name it-make a note of these places. Write a summary of the struggles and what they mean at the end of this reading.	The last reading involves two related yet distinct issues: power and gender. As you reread the text look for suggestions of gender issues and power imbalances. In what ways does the narrator struggle with issues regarding gender and power? Where is she silenced? When does she silence herself? When does she use her voice? Is she conscious of the power or political imbalances in her life and of the influences of culture? How do you understand her socialization process? How is her "reality" challenged? Summarize your notes at the end of this reading on power and gender issues in the narrator's life.

conversations were very moving and informative for both researcher and participant as we explored the meanings of metaphors, attempted to comprehend ambiguous parts of the narrative account, and struggled to see the cultural implications of our interpretations. Questions asked during the third conversations included, “What do you think this means?” “Where do you think you learned that?” “What were your feelings about that?” “What do you think you were trying to say here?” “Is there anything more here that needs to be said?” “Why do you think you felt that way?” “What do you think is underneath this?” “What do you think should have been done about that?” “What do you wish could have happened?” “What did you learn from this experience?” “Here is something that I see in this piece, what do you think?” “How does my interpretation of this fit with your experience?” And at the end I asked, “Is there anything more you would like to add to this interpretation?”

Each discussion was a collaborative effort to clarify my interpretation of the meanings within the text. We also discussed the construction of the narrative as a fictionalized account. Pseudonyms were created for each participant. Any identifying facts in the narrative were changed in ways that did not affect the outcome of the plot or intended meaning of the story, as far as we could discern. The participants were thanked for their efforts and were informed that the narratives would be sent to them for editorial review before inclusion in the dissertation. I explained that their feedback was important to me because I wanted to construct a narrative that they felt resonated with the accounts that they had told. At the same time, I acknowledged that the construction of the narrative was a joint venture, which was continually evolving and that the final writing was the research author’s responsibility. I could not guarantee that the changes would be incorporated, if these

changes drastically opposed my interpretation of the text. However, I did state that I would be willing to re-negotiate the meanings and writing of the text in an attempt to find consensus and move toward “shared” meanings if possible. Fortunately, re-negotiation was not an issue. Only a few descriptive words were changed in each transcript.

The next step in the research process involved two separate activities: re-constructing the edited individual narrative accounts on secondary trauma and developing an appropriate format for re-presenting the multiple perspectives within the research texts.

Writing the Narratives

The first task before writing the narratives was to summarize the four interpretive readings for each participant by jointly blending my interpretation with theirs. It is important to note that the second level of analysis (the interaction between the researcher and the participant) was collapsed into the interpretive conversation, since my questions on the interaction were re-inscribed on the text for further exploration. The next task was to rewrite their narratives using the information from the interpretive conversations and the story maps (the outcome of level one analysis) as guides. I wrote each participant’s narrative in the first person using a pseudonym for each. Changes were made in naming specific people and places in order to maintain anonymity for others and the participants. The narratives were delivered to the participants. All of the narratives were returned. One narrative was not changed in any way; a second narrative was amended by changing the introductory paragraph, toning down some of the adjectives, and re-wording three other sentences; the third and fourth narratives had minor alterations such as clarifying the

sequence of events, and altering some of the vocabulary. None of the changes transformed the interpretation of the text to any extent.

One participant and I met over lunch because I wanted to talk to her in person about my interpretation before returning the narrative account to her. I wondered how she would react to seeing her narrative in print. My fear of her reaction was based on my insertion of a fictional piece into the text that described in graphic detail the abuse scene. How would she respond? Did I go too far? She stated that the account was fine. I asked her to take the narrative home to read and reflect. Afterward, she changed only two words in the text and stated:

How did you know? That's exactly the way it happened. It's uncanny; my reaction is "Bang on!" I realize that the amount of fracturing doesn't have to be proportionate to the amount of or intensity of the violence. This is a really wild form of validation. It is an inspiration; it has really changed my awareness.

Another participant wrote:

There are some places where I've made suggestions about the content--erased a word or a phrase or suggested rewording. It's good work. An interesting way to do the story. I found it helpful to look at it this way; even gained new insight. It was very useful and a healing process to do this, so thanks!

A third participant stated that she didn't like the introductory paragraph which presented a fictionalized caricature of the narrator. She also asked me to change a few adjectives by toning them down. She stated, "It seems one sided. You haven't shown my compassionate side. Make it more sympathetic." I explained to her that my own projections and perceptions had influenced my description of her and that it was interesting to note the parallels between my original perceptions of her and her own acknowledgement that others are always projecting the "dominant mother figure" on to her. It became apparent to me that my

interpretation of this participant was too strong in her opinion. This is not how she wanted to be portrayed even anonymously. I decided to “soften” the text by changing the few words that were offensive to her.

The fourth participant stated:

I really thought it was great. I didn't return it to you right away because you said that I should return it if I wanted to make changes, but I didn't have any changes to make. I really liked it. I think it is very relevant and will be useful for other counsellors to read. Would you be willing to do a presentation on your findings at our centre?

The second task involved reading each narrative for themes regarding the meaning of the participants' struggles with secondary trauma. I started this task in a traditional fashion by completing a thematic analysis on the narratives, using van Manen's (1990) guiding question, “What statements or phrases seem particularly essential or revealing about the experience being described?” (p. 93) This analysis was done for each participant and led to the generation of 28 separate themes on their struggles with secondary trauma. The themes were then examined to see if there were any obvious groupings (Table 3). The thematic groupings on secondary trauma were descriptively composed and will be presented in the following chapter on the research findings. The reader is reminded that the participants' narratives were presented in the first chapter. You may want to revisit these narratives before reading the next chapter.

The final task before writing the dissertation consisted of distributing the narratives to colleagues for peer review. Two professors, who in addition to teaching are involved in private practice counselling traumatized clients, were asked for their reactions to the narratives. Two trauma counsellors in the field were also consulted. Of these reviewers, two have their doctorates, and two were doctoral candidates at the time of their reading. All

Table 3

Conceptual Groupings on Struggling with Secondary Traumatic Stress

Struggling With Changing Beliefs	Changes to one's worldviews Knowledge of the specifics of evil Issues regarding trust Changes to one's sense of safety Changes regarding beliefs about one's identity Grief and loss pertaining to one's beliefs Challenges to one's spiritual beliefs
Intrapsychic Struggles	Intrusive thoughts Depression and despair A mind/body split Feelings of shame, guilt, fear Containing one's feelings Conflictual internal voices Sense of self
Struggling With the Therapeutic Relationship	Countertransference issues Boundary Issues: Rescuing, giving self away, letting go Burdened with trauma stories
Work-Related Struggles	Being inexperienced Amount of work and/or caseload Non-supportive work environment Co-workers' perceptions and judgments Ineffective debriefing process Struggling with self-care
Struggling With Social Support	People's misperceptions about trauma counsellors Isolating nature of trauma work Lack of social support
Struggling With Power Issues	Powerlessness, oppression, silencing, and disillusionment
Struggling With Physical Illness	Developing a severe illness or frequently becoming ill

four peer reviewers were asked, “Please read the narrative to see if it resonates with your experience as a trauma counsellor. Is the story convincing? Is it coherent? Does the narrative account have pragmatic usefulness?” One peer reviewer wrote:

The story is particularly credible in the development of her belief system. She tracks her beliefs and experiences in a believable way. I found the descriptions of sometimes being “out on the edges” when doing therapy, striking. I have those times and it is at such times I have the strongest “hangover” from the sessions. Entering my client’s life-world and creating our space in their world does open up some strange energies sometimes. I got a sense of her abilities as a therapist—I liked that she reassured her client when the lights went out. I have strong values around maintaining a client-centered approach. I resonated with her learning around self-care, boundaries, and caring.

The second peer reviewer stated:

This story was very amazing. I really like the way you wrote it in the first person. That took a lot of guts, but it really makes it come alive. I was right in there with her. I have certainly had similar experiences (child care issues, client overload, depression, needing holidays, etc.) and can see how she resolved them. It took a lot of courage for her to tell her story and for you to write it. Great job.

The third peer reviewer commented in note form throughout the text as follows:

A very interesting thesis, especially the second part because Donna moved much more into the authenticity of her experience. I have made a few connections with this story. Take what might be helpful. An interesting concept of masks and mirror metaphors--will you be expanding on these concepts? There are many implications for counselling practice here, letting the client’s story fall into the background when the counsellor’s own crisis is at hand. The difficulty of letting the fathers and husbands go are inferences to the socialization process and the difficulty that women have with this. There is some commonality for women at midlife in coming to terms with their aging bodies--a much more subtle form of trauma perhaps? Thanks for sharing.

The last peer reviewer stated:

A novel way of presenting data. This narrative method has a much stronger impact than reading themes in the chapter that reveals the findings. I do see connections to counsellors in the field; although I have never personally experienced this phenomenon, I certainly have witnessed it at our centre. This study is really going to be helpful for those struggling with this, particularly if you stress the coping

strategies counsellors can use to prevent secondary trauma. There are a lot of implications for practice here.

Issues Regarding Legitimation and Authority of the Text

By what criteria do we judge the quality of a research study? There are differences of opinion regarding legitimation in the constructivist paradigm and as well as within narrative research methodologies. In a constructivist paradigm, unlike the positivist criteria of internal validity and reliability, there are two sets of criteria (Guba & Lincoln, 1994). First, the trustworthiness criteria of credibility, transferability, dependability, and confirmability and, second, the authenticity criteria of fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity. These criteria for judging the worth of a research study are not unproblematic for constructivists. The problems stem from the various constructivist positions one could adopt and from the parallelism of these constructs to positivist criteria; in other words, the trustworthiness criteria responds to the critique of positivists regarding validity and reliability claims. Some constructivists reject the comparison model as a legitimate model from which to make judgments regarding the evaluation of research.

I agree with these criticisms and tend to side with the authenticity component used by constructivists for evaluating research. This criteria forces the evaluator to make judgments regarding the fairness of an account. Are the voices in the account fairly interpreted and portrayed? A constructivist (Guba & Lincoln, 1994) looks at the ontological assumptions in the text: Does the text expand personal constructions? Does it educate or improve our understanding regarding the meaning-making processes of

others? Do the findings inspire action on the part of the participants in the research process? Does the account portray tactical authenticity (i.e., empower action)?

Greg Neimeyer and Michael Mahoney (1995) state that although criteria for the adequacy of personal and local knowledges vary from one constructivist to another, these do include “the degree to which knowledges provide for meaningful anticipation of events (Kelly, 1955), promote a sense of agency and participation in one’s life (White & Epston, 1990), or provide programmatically useful organizing schemes for guiding human action (Polkinghorne, 1992)” (p. 15). In this sense, usefulness seems to be a criterion for hermeneutic explanation.

For the purposes of this research project, I am adopting the criteria presented by Catherine Kohler Riessman (1993) in her book on narrative analysis that are consistent with a constructivist ontology and epistemology. I am concerned with two questions: First, how can the reader ascertain the worth of this study? Second, how does the research text claim its authority? Believing that truth claims are multiple and that there is no one authority, I propose the following guidelines for evaluating the worth of this project. These guidelines were developed to address issues of evaluation; they were not created to address issues of replication. Replication of a study of this nature from a constructivist viewpoint is never possible (replication, validity, and reliability are constructs from the positivist paradigm). Jim Denison (1996) states that “to evaluate the authority and determine the ‘truth’ of the results in narrative studies, the standard used to judge fiction should be employed” (p. 357). In the end, it is up to the interpreter to come to grips with the integrity of his or her study. I now turn to the four criteria used

to evaluate this study.

Persuasiveness

According to Riessman (1993), the persuasiveness of a narrative account answers the questions of whether the interpretation is convincing. Denzin (1994) and Polkinghorne (1988) claim that if the reader can resonate with the experience being portrayed in the narrative account, or can imagine having experienced the phenomenon under study, then the text has verisimilitude. In human science research, one cannot expect a perfect fit because meaning is partial and located between language and experience. It will always be an imperfect fit (Altheide & Johnson, 1994). In this research study, attempts to make a “good fit” (Guba & Lincoln, 1994) were accomplished by designing a reflexive method and by collaboratively including the participants in the editorial process. In order to report that the research project was persuasive and convincing, the narratives were judged by peer review. The oral and written reports by the peer reviewers do support the claim that the research texts are persuasive.

Resonance

Neimeyer and Mahoney (1995) remind us that

although we cannot aspire to a universally valid knowledge that corresponds in any direct sense with the real world external to us, we can and must draw on the symbolic resources of our place and time in formulating viable theories or useful fictions that enable us to negotiate our social world. (p. 15)

Riessman (1993) terms this criterion *correspondence*. However, I am reluctant to

use her term. It signals positivism, although Riessman did not intend this connotation. I prefer the term *resonance*, pointing to the “good fit” criterion that Guba and Lincoln (1994) have developed within the constructivist paradigm.

The issue of correspondence is very tricky because stories continue to change; people continue to change perspectives and gain new insights. Participants tell their stories and attempt to reveal to the researcher the “truth” of their experiences. Yet it is not a truth in the objective sense. As researchers, we cannot know the objective truth of their stories because we can only understand their stories through interpretation, narrative interpretation. Although the narrative text does not claim to be an exact representation of the participants’ experiences, I believe it is the ethical responsibility of the researcher to find out whether the constructed research text has adequate resonance from the viewpoint of the participant. Is the final research text faithful to the experiences constructed by the participants in this study?

I conducted member checks, not to confirm my findings, but to offer back (maybe even defend) my construction and to open up further dialogue. All of the participants supported the final re-constructed narratives of their struggles with secondary trauma.

Coherence

A coherence criterion has been developed by Agar and Hobbs (1982). They describe three types of narrative criterion for claiming coherence within research texts: global, local, and themal. *Global coherence* refers “to the overall goals a narrator is trying to accomplish by speaking . . . to justify an action” (Riessman, 1993, p. 67). *Local*

coherence refers to how the narrator uses linguistic devices to demonstrate how the different parts of the story are related; it is a “bottom-up-view” (Agar & Hobbs, 1982, p. 7). *Thematic coherence* concerns the recurrence of significant topics within the text. Coherence points to how the narrator’s speech expresses his or her beliefs, assumptions, or goals in the text. Catherine Kohler Riessman (1993) has pointed out that Agar and Hobb’s framework is difficult to apply to the interaction between researcher and participant and that their model connotes that there is a rational speaker in the interaction.

Coherence is a subjective criterion, based on one’s rendering of the text, one’s interpretive stance. Coherence is a difficult criterion to apply in the evaluation of narrative research because of its dependence on the abilities and sensibilities of the reader. What prejudgments does the reader bring to the text? Is the reader expecting a certain type of tale, a modernist tale? Is the reader an informed reader, has she or he had similar life experiences? How do narrative researchers ascertain a coherence criterion given these subjective differences?

For the purpose of this research project, a criterion of coherence was developed by means of member checks (the participants were able to claim whether or not the constructed narratives were coherent), peer review (the reviewers had experience as trauma counsellors), and feedback from committee members. The responses received through these three groups indicate that the narratives were coherent.

Pragmatic Usefulness

The pragmatic criterion underscores the usefulness of the research both in terms of the process and the findings. Nel Noddings (1984) states that educational research must have “fidelity to persons”; it should “counsel us to choose our problems in such a way that the knowledge gained will promote individual growth and maintain the caring community” (p. 506). A pragmatic criterion was established by the participants themselves in their comments on the process of being engaged in the research project. One participant suggested that for future research it would be easier to approach the research question if asked to develop their narratives around a particular incident in their trauma practice. The participants stated that they found the project useful, insightful, important for counsellor development, critical in the development of preventative measures, and meaningful. Three participants asked if I might share the research findings with their colleagues at their workplaces. I was also asked by two participants to ensure that the findings go to publication so that other trauma counsellors might benefit from their insights. The peer reviewers also supported these suggestions in their comments on the research narratives.

CHAPTER 5

MY STORY/HER STORY/THEIR STORIES

The purpose of this chapter is to bring together a discussion of secondary trauma from three standpoints: the voices of the participants in this study, the voices from the dominant discourse on traumatology, and the voice of the researcher. Originally, this chapter was written in a traditional format with the main themes from the research findings being displayed by subtitles and a description of these themes written with a commentary on how the themes matched or mismatched the current literature on secondary traumatic stress.

After reading the original chapter, I realized that my participants' voices were overshadowed by the voices of authority and my personal voice was missing from the account altogether. I struggled to find a way to present and discuss the findings without losing the multiple views contributing to the research. The solution I sought was to have a conversation between three different standpoints whereby the reader could enter a dialogue with my story, her story (each participant's), and their stories (the traumatologists). In order to achieve this juxtaposition of voices, the reader is asked to be imaginative and to envision this last chapter as a fictional conversation.

I have titled this fictional conversation "What Freud Didn't Tell Us: Tales from the Other Side of the Couch." It is presented as a focus group discussion between five trauma counsellors and a psychiatrist. Each of my participants has a role in this conversation and I have included myself as the fifth trauma counsellor in the group. The focus group has been organized by the psychiatrist for the purpose of gathering data for her research study on secondary traumatic stress. The psychiatrist has asked each individual to write a narrative

account of her experience struggling with secondary trauma and these accounts have been distributed to all members to read.

As the author of this fictional conversation, I have woven pieces of the participants' narratives into the conversation to illuminate the research findings and position them as discussion topics. The format of this fictional conversation does not follow APA style because fictional conversations are not usually found in psychological dissertations. I have taken the liberty of writing this last chapter in my own style, which I believe is easier to read and is consistent with the reflexive method used in this study. I have utilized endnotes, instead of footnotes, to cite reference material within this text. Implications for education, research, and counselling practice are addressed in the last section of this chapter.

Conversants

ANNA: Anna is a trauma counsellor and clinical supervisor at a centre for survivors of political violence and torture. The story of her struggle with secondary trauma depicts episodes of workaholism where she fell into a numb, depressed state and finally "hit the wall." She developed excruciating facial pain and was unable to get out of bed. "It was like being slapped across the face. My body was saying smarten up!" Anna reveals that the lesson she learned was that playing the self-care game can be like playing with fire--it can kill you.

DONNA: Donna works at a transition house for physically abused women and their children. Donna struggles simultaneously with secondary trauma from her work and primary trauma from being physically abused by her spouse. She sees parallels between her

life and her clients' lives. Donna uses her "shut-off valve" as a main strategy to prevent being overwhelmed by her clients' painful stories. She describes some lessons she has learned about mirrors and masks. She is able to make sense out of her experiences by seeing the mirrors between her work life and her personal life, and by being able to detect when people are wearing masks.

JESSE: Jesse grew up in rural Saskatchewan on her Ukrainian grandfather's farm. She works as a trauma counsellor and intake worker at a child sexual abuse centre. She describes struggling with her beliefs around her child's safety and theorizes about vicarious trauma as cyclical—"It ebbs and flows." For Jesse it's important to stay balanced both in your personal life and your work life. It's about what you learn along the way that helps prevent vicarious trauma.

MARIE: Marie moved to Ontario from Nova Scotia in her teens to attend a Christian college. She was sexually assaulted at college along with another friend. Marie struggled with the disillusionment caused by the abusive behaviour of men who have authority in the church. She finally had to quit her job and go away for a year on sabbatical. Marie discusses the spiritual aspects of doing trauma work. She believes that it's about learning to let go and allowing your clients to let go of you.

RUBY: Ruby's character in this fictional conversation re-presents my voice, the voice of the researcher. I chose the name Ruby simply because I like the name. Not using my real name should not be construed as an attempt to hide my identity.

DR. FELDMAN: Dr. Feldman is the psychiatrist who has organized this focus group for two purposes: to develop a support group for the conversants who are sharing their

experiences and to collect data for her research project on secondary traumatic stress. In this fictional conversation, Dr. Feldman re-presents the voices of authority, those traumatologists who write about secondary trauma. As the researcher in this fictional conversation, Dr. Feldman's character presents one of my voices, exemplifying my multiple positions within this text.

The Setting

These conversations are set in a heritage home, located on a quiet street in a small town in British Columbia. As we go inside, we enter a large vestibule and proceed through a long hallway, past the receptionist's desk, and enter a quaintly decorated office, which at one time must have been the solarium of this old home. The main wall was oak panel, but now is painted a pale shade of yellow. An enormous mahogany desk, cluttered with papers and family pictures, is situated in one corner of the room. The room is surrounded on three sides by large windows that allow us to view the quiet, gracious gardens encompassing this grand old house. Seated in the room are five women. Three are sitting on an overstuffed, floral-patterned couch against the wall, and the other two are reclined in matching chairs on either side of the couch. They form a semicircle. Standing before them is the psychiatrist. She is pointing to five large charts that are taped to the wall. Each chart is a summary of each of these women's experiences of secondary trauma.

**WHAT FREUD DIDN'T TELL US: TALES FROM THE OTHER
SIDE OF THE COUCH**

PART 1: STRUGGLING WITH CHANGING BELIEFS

DR. FELDMAN

First, I want to thank you all for having the courage to share your stories with each other. Now that you've read each other's stories and have contemplated how we should spend these five sessions together, I'm excited to hear from each of you.

[stands up and walks over to a chart stand that supports a white board, picks up a large black marker, writes the numerals 1, 2, 3, 4, 5, and turns around to face the women sitting in a semicircle]

We need to decide what the main topics will be for each session. Who would like to start?

RUBY

Well, what struck me the most from reading all the stories was the existential crisis we all seemed to experience regarding changes to our worldviews and beliefs about ourselves and our relationships. I think this is an important topic that we need to talk about.

MARIE

I agree. I think that is one of the main struggles for all of us.

DR. FELDMAN

[reads out loud as she writes on the white board]

Struggling with changing beliefs. Okay. What else?

DONNA

Well, for me, the main struggle seemed to be about managing the feelings and the intrapsychic struggles that came with doing the trauma work and everyone here has her

own take on this. I think this topic really needs to be addressed. You know, like how do we get a grip on this?

DR. FELDMAN

Okay.

[reads out loud as she writes on the white board]

Intrapsychic struggles.

JESSE

Hmm. I think one obvious topic is the effects of secondary trauma on the therapeutic relationship. For example, how do we maintain safe boundaries? How do we know if we're being effective and what are the signs to warn us that we may be crossing over some ethical line and doing harm to our clients?

DR. FELDMAN

Good one?

[everybody nods in agreement]

Okay. Struggling with the therapeutic relationship. Anna, we haven't heard from you yet. Is there any topic you feel we might want to cover in our time together?

ANNA

Yeah, well . . . I think we need to look at the support systems that need to be in place to do this work, like what are the struggles with finding work support and social support from our families and friends?

DONNA

Yes, that's an important one for me too.

DR. FELDMAN

Alright.

[reads out loud as she writes on the white board]

Struggling with work and social support. Well, we have four excellent topics and I agree that they cover the issues raised in all of your stories, but if I might make a suggestion.

[pauses to see if anyone objects]

I think we should end our time together talking about coping mechanisms and preventative strategies--you know, sharing what works with each other.

RUBY

Yes, I think that's a good idea, but I personally would like to come away from these sessions with a handle on what it all means.

DR. FELDMAN

Well, I think through our discussions together you will all be actively working on your own meaning-making. I believe that juxtaposing your own experiences up against one another's is a very beneficial way of seeing where you stand. It's a way to broaden and deepen your own understanding because you may want to defend your position, or expand on it, or change it altogether. Okay? *[sits down with the group]* Let's start today with number 1, "Struggling With Changing Beliefs."

MARIE

Could I start? *[no one objects]* The struggle for me is that my worldview keeps changing the more I do this work. Maybe part of it was my naivete coming into this job, but it wasn't like I didn't know that bad things happen to people. It seemed like the more stories I heard about the horrific acts people commit against others, and the fact that there's a never-ending stream of new ways people can hurt others, overwhelmed me and the clincher was learning about the random acts of violence that I couldn't protect myself against. I mean, I knew that I was safe in my family relationships and friendships, but I stood in the same

danger as my clients when it came to random acts of violence. I don't know . . . for a while there I was always checking under my car to see if the campus rapist was there and then in Europe when I was attacked by that stranger, it was like my work in this field had been preparing me all along to fend off this attacker. I knew exactly what to do, and it saved me. But I mean the struggle here for me is about having to learn to live with the certainty that life is unpredictable or maybe it's living with the certainty that I can never have complete control over my own safety in this world.

JESSE

I totally agree. That's exactly it for me too. I started in this field believing that sometimes bad things happen to a few people, to going to the other extreme in believing that abuse was epidemic. I started seeing abuse everywhere. Every time I saw a man with a child, in the park, or at the grocery store, or stopped in a car at a light, I would think I know what you're doing. You don't fool me. I was getting really warped. Everything was distorted and negative. I hated being infused with the toxicity of evil that existed in the world.

DR. FELDMAN

So, it's about a loss of innocence, a change in beliefs about goodness in the world and the amount of evil that exists?

RUBY

Well, it's difficult to find hope or see goodness in the world when you're bombarded daily with the knowledge that evil exists in real tangible ways in the lives of your clients. I too started to distort or generalize a suspicious belief that everyone was abusing children, during my time at the child sexual abuse clinic, even though I knew it was irrational. There are so many client stories that will always be with me. Our clients' lives have touched us in profound ways. I knew what it meant to do trauma work, but I didn't know how my worldview would be so significantly altered. Now that I've had my beliefs shattered I can't rebuild them without the cracks showing--the fault lines eventually show up. Still I have to

construct a sufficient version of my worldview in order to go on living or start all over with something new.

JESSE

I think having your worldview altered has to do with being inexperienced. In the beginning you are only able to see all the pain because you and your clients haven't worked long enough in the recovery process to see the healing unfold. But I remember that feeling, like I was being infused with a toxic substance . . . Now when I get that feeling of despair, or if I start to see the world in such a negative way, I know that it's a signal that I'm vulnerable to becoming vicariously traumatized. I have learned to monitor these shifts in beliefs or this taking on of such a negative worldview, and I've also learned to live with the shifting ground on which I've planted my beliefs.

DONNA

For me . . . I still struggle to maintain a balanced worldview. Sometimes I've been left speechless in the face of it, the evil that exists in the world. It's been really hard for me at times to find the goodness in people. I have to put the concept of evil on a continuum, so that I am able to see the balance and limit the judgments I make about others. Thinking about perpetrators this way has made it easier for me to deal with it.

MARIE

One of the hardest acknowledgments for me was coming to grips with the dark side of those who profess to be men of God. How could they commit such evil acts and continue to profess their faith? All I can think is, good lord, what could have happened to you in order for you, a man of God, to do something as evil as that? I can only imagine it. But you know asking why--being stuck in always trying to figure out why abuse happens-- keeps you, the counsellor, in a conceptual place. It means you step over the pain by theorizing about it. It allows you to stay out of the feelings, but eventually you have to recognize the emotional impact of hearing stories of trauma.

DR. FELDMAN

So, Anna, we haven't heard from you yet. Have any of your core beliefs been shattered by doing this work?

ANNA

Well, I can't say I've been surprised by the trauma stories clients tell me. I mean I always seemed to know about the awful things that can happen. So, it wasn't a real shock to me or my beliefs about the world. I've always lived with this knowledge, but it doesn't mean I don't struggle like everyone else with the despair concerning the amount of violence that exists in the world. Doing trauma work is a meaningful proactive way to counterbalance the negative impact that traumatic experiences have on people in our communities. The main difference between their stories and mine is that I've always lived with shifting beliefs. I never counted on my beliefs to be permanent. I learned that early on through my own abuse history.

DR. FELDMAN

So, counsellors who have a personal history of trauma may experience a shift in core beliefs in a different way than counsellors with no trauma histories?

ANNA

Perhaps . . . probably [*pauses, pondering*].

RUBY

Well, Dr. Feldman, I don't think you can categorize trauma counsellors' experiences of struggling with changing beliefs based on the criterion of whether or not they have a personal history of trauma. I mean I've read the research and they haven't conclusively linked a personal trauma history of the therapist to the experience of secondary trauma. I think in some cases a personal trauma history may be beneficial to the therapy and in other cases it may be detrimental to both the counsellor and the therapeutic relationship. And

furthermore, in my view, our beliefs are unique, personal, and related to our lived experiences. We may share certain beliefs about the world and ourselves, but we can't depend on having similar beliefs simply because we have been traumatized in the past. Don't you agree that it would depend on any number of factors such as the type of trauma, the age of impact, whether the trauma was man-made or caused by natural occurrences? There are so many variables at work here. And, even if all the trauma variables were similar, there is no certainty that our interpretation of our experiences would be similar. Each of us interprets and constructs meaning within a unique context influenced by biological, interpersonal, and cultural conditions. So, even though we have all had our belief systems affected by doing trauma work, we all have different experiences of how these beliefs have shifted.

DR. FELDMAN

Ronnie Janoff-Bulman¹ recognizes, in her work with trauma survivors, that three core beliefs are shattered. These beliefs are (a) the world is benevolent, (b) the world is meaningful, and (c) the self is worthy. Pearlman and Saakvitne,² the authors of *Trauma and the Therapist*, argue that trauma impacts an individual's frame of reference in three ways: First, one's worldview, meaning one's beliefs about benevolence and malevolence in the world, justice and injustice, and the randomness and predictability of living in today's culture are altered. Second, they claim that trauma affects one's identity, one's sense of self, and how one relates to others, and third, a traumatic event affects one's spirituality, one's capacity to make meaning out of one's life and make connections beyond oneself. What do you think about these two theories in relation to your own experiences?

RUBY

I think we would all agree that these two theories represent a framework from which to speak about the disruption to our belief systems.

[checks with the others who nod, gesture agreement, saying "um hmm"]

What is missing for me in the literature is the personal meanings of struggling with

secondary traumatic stress. By reading the stories shared here I could relate to what it meant to have your beliefs shattered in concrete ways. It resonated with me on a personal level. In other words, I not only got the theory underscoring secondary trauma, I felt it. These stories [*pointing to the five charts on the wall*] moved me. I'll remember them when I do this work, not the three or four constructs listed in the textbook under "Countertransference." As a practitioner, it's the personal, contextualized, local knowledge that helps me the most when I'm struggling with secondary trauma.

ANNA

Well, I agree with both of you. I think both perspectives are useful. We need both the theoretical and the personal ways of knowing to inform our practice. What I found interesting as I read through all the stories was that we were all concerned at some point with our own sense of safety. I personally feel a sense of loss around feelings of safety in the world. I used to be foolhardy before I recognized the amount of danger there is for women out there and now I'm reasonably cautious. So, this belief around safety shifted for me.

MARIE

Yes. I certainly became more vigilant around my personal safety after working on the rape crisis line. But I don't feel sad about it. I'm more resentful of the fact that men can have a taken-for-granted sense of safety in the world, whereas women always have to be on guard. I've learned a lot from my clients and I don't take chances anymore. I'm always devising escape plans or defense strategies, just in case. I don't think I'm paranoid about it--just cautious. I'm aware of the amount of violence that exists in our culture and I can't change it, and I'm just glad I know how to be reasonably safe. I'm just mad that the victims are usually women, children, or the elderly.

DONNA

I agree with Anna too. I am concerned with my own safety. I have fears for my own safety

not only with strangers but with those I'm intimately involved with. My sense of trust has been shattered because my rights to safety were violated by someone I should have been able to trust, my protector. So, for me, it's a double assault—both safety and trust were shattered for me. And I see this every day in my work. The questions that I struggle with are: How can I live in a world that I know is unsafe without being consumed by my own fears? What kind of society do we live in if we can't guarantee the basic need of safety? I don't know how to find the answers or reconcile this struggle. I am left feeling angry and I'm often filled with despair.

JESSE

Trust and safety were also a struggle for me. It wasn't until I had my baby that the safety and trust issues hit home for me. Like Donna the trust issue was about trusting others, but also about trusting my own judgments around who could be trusted, because my child's safety was at stake. There's always that little terror . . . that what if . . . Is this caregiver a possible child abuser? I use to trust my own judgment, but after hearing so many horror stories about babysitters and child abuse, I started to question my own perceptions of reality, my own judgments concerning the character of others and who I could really trust. This wasn't about seeing abuse everywhere. It was about being able to keep a balance in my own views about others and when I lost my perspective or balance, I was afraid--scared for my child's safety. So, there's a lot of fear driving all these beliefs.

DR. FELDMAN

If you're not safe, then the fear response kicks in. If you can't trust others, you're in a constant state of anxiety. As Bessel van der Kolk³ reminds us, when the safety of relationships is threatened, we resort to the emergency responses of fight or flight.

RUBY

Yes, we've all experienced this primitive response of fight or flight at some time in our lives, but there's another response to having our sense of trust and safety shattered and that

is a grief and loss response. For me, I actually had to mourn the loss of previously held beliefs and, like a death, I experienced a period of “nothingness,” an existential crisis caused by the disequilibrium of not having a belief I could count on. It was a time when I had no sense of self, or at least a former self, or any place that was knowable in the world.

ANNA

I guess I felt a sense of loss or grief around not feeling safe, because I used to feel a lot freer in the world than I do now. Still I’m glad that I know about the violence that exists. I’d rather have the knowledge and protect myself, than innocently go about my life like a sitting duck, waiting to be victimized.

DONNA

Well, for me, the loss is linked to the loss of security that comes with self-trust and the trust of authentic relationships. There is a parallel here to our clients’ sense of loss when they struggle with losing a loved one. Even though the loved one is their abuser, the survivor is in a complex relationship with the perpetrator because the perpetrator has a double identity in the eyes of the client. The betrayal by a loved one dismantles your sense of trust and security. There have been times when I have wondered if I could believe in anything anymore.

RUBY

[showing excitement]

Exactly! And, if you can’t believe in anything anymore, where are you? It seems like a place of nothingness--a “no-beliefs” place. How do we reconcile this? How do we rebuild our beliefs? How do we go on, knowing now that beliefs are transitory? How do we live in this ambiguity?

JESSE

You learn to carry on. You learn through your traumatic experiences and those of your

clients that life goes on, that life is about the challenges, the ambiguity, the despair, and the hope. That is what life is really about. And you come to see that life will continue whether you like it or not.

DR. FELDMAN

So, it's about choosing how you wish to construct your beliefs? Is that it?

JESSE

Yeah. It's about living long enough to know that this is yet one more of life's challenges and that it too will pass, that you'll be transformed by it in some profound way and that you'll find a way eventually to keep going. And eventually happiness and hope slip back into your life.

DR. FELDMAN

I think we should end this session on that hopeful note from Jesse. So, the struggles with changing beliefs, whether they are issues of trust, safety, or one's worldview, are about living with the knowledge that beliefs shift--they're malleable. It's a recognition that there is no guarantee that what you hold true today will necessarily be tomorrow's truth.

PART 2: INTRAPSYCHIC STRUGGLES

[one week later, the group reassembles]

DONNA

[nervously not looking at the others]

I almost didn't come today.

DR. FELDMAN

Oh, why is that, Donna?

DONNA

Because I knew we would be discussing our deepest feelings about doing this work and how it has impacted us, and I feel a lot of shame about some of these feelings.

DR. FELDMAN

Are you worried about being judged by the others?

DONNA

Yes, in some ways. I know that you all have more experience than I do, and I'm a little concerned that you'll think that I am unprofessional or something.

DR. FELDMAN

Donna, I don't think you are alone in your worries about feeling judged or feeling ashamed at times in your work. I think this might be a good place to start today. Perhaps some of you would be willing to discuss these personal feelings?

ANNA

[looking reassuringly at Donna]

I have certainly had times when I felt ashamed that I was overidentifying with a client. There was one client in particular who had a similar story to my own, and I felt like I was reliving the experience. I was really ashamed to debrief these feelings with my co-worker but I had to risk being judged in order to get the support I needed. I still feel vulnerable when I think about this person.

DONNA

For me, the sudden recognition that I too was a victim like my clients and realizing that

their stories were also now my story created self-doubt and negative feelings within myself. I felt ashamed to tell my friends or co-workers about my own abuse. I was really humiliated. And, on one level, I could relate to how the parents or significant others of the victims felt when their loved ones were abused and they didn't want anyone to know about it, because there I was in the same situation. For me, under the shame and humiliation was guilt. A voice inside said that I should have known, I should have seen the signs--after all I am a trauma counsellor. I should have recognized the behaviours of a perpetrator, but I was blind to the dynamics of abuse in my own life. The dynamics of abuse are very powerful. So, as a counsellor, I carried a lot of shame and guilt.

ANNA

[voice raised]

God, I just can't stand this. I just get so angry about how unfair this is. I just want to burst out.

DONNA

Well, I *am* angry. I'm so angry that at times I think I'll do some real damage. And I get angry that I'm angry *[tears well up in her eyes]*.

RUBY

I think the anger is really healthy. We are socialized not to feel our anger. I think we need to harness our anger in really proactive ways to do something about the amount of violence that exists in the world. Donna's story points to the conspiracy of silence. By not telling our shame or revealing our anger and by hiding our abuse we are protecting the perpetrators, and the cycle of violence continues.

MARIE

I too have had a hard time dealing with my anger. I still carry a lot of anger about the abusive practices of men in the church. I had to learn to live with the hypocrisy and I buried

my own abuse story because I was sure I would be blamed for it. You know, the blame the victim tactic, "She was asking for it." In those days you just didn't tell. There wasn't the awareness about the amount of abuse that actually went on, that we know about today. So, things are starting to change.

RUBY

I too was assaulted at university by one of my professors. I wonder still to this day how many other victims suffered under his tutelage. You know, Marie, perhaps if we had come forward at the time, perhaps if many more of us had come forward, things would have been different a lot sooner. It would have taken courage to bear the shame that came with speaking out. Yet, I think we can only blame our socialization to a point. Yes, there was a conspiracy of silence, and, yes, we were socialized to be "nice girls" and not show our anger, not tell our truths because society wasn't ready to hear it. I knew all too well that there was a price to pay for speaking out. But I do regret that I did nothing and I still have guilt about not having the courage to name my abuser.

ANNA

We live with a lot of cultural ascriptions. Women are labelled as being too emotional, too sensitive. So, as trauma counsellors, we have had to fight against these ascriptions. Doing trauma work means you have to face your emotions daily and you have to teach other women that having their emotions, in particular their anger, is okay. I learned early on through my family dynamics to endure the pain. This lesson got played out in my experience of secondary trauma. It wasn't until my body actually collapsed that I recognized that I was burying the pain of doing this work. So, how many of us have been taught to bury the pain, endure the burden, and are suffering because of it? We have to find ways to confront this cultural ascription because it's not serving us well as women, and it contributes to the conspiracy of silence and the cycle of violence that exists in society.

DR. FELDMAN

Jesse, we haven't heard from you.

JESSE

[somewhat hesitant]

I can't say I have felt ashamed or guilty . . . probably because I have never been traumatized in my personal life. But there are times when I do feel guilty when I'm with clients, because I have never had to endure their struggles. I've been fortunate in having a relatively good life.

DR. FELDMAN

Judith Herman⁴ calls this "witness guilt." It's similar to bystander guilt, where a witness to a traumatic event feels guilty that the trauma happened to someone else and luckily not to him or her. Christine Courtois⁵ writes about therapists who feel guilty because of the helpless feelings they get about not being able to undo the harm or pain and about not being able to make it better, and for bringing up the past traumatic experiences and all the pain that goes with it into the therapy sessions. Do any of you share these guilty feelings?

[long pause, no one immediately responds]

MARIE

The only time I remember feeling guilty is the time I talked a client's male friend out of committing suicide and he returned to town shortly after and brutally raped her. It was a really bizarre situation, but I did feel a little guilty about saving this guy's life. Maybe it's not really the same concept that you're referring to, Jesse, or that you're alluding to, Dr. Feldman.

ANNA

I can't say I've really felt that guilty about my work--at least, not that I can remember.

RUBY

No, neither have I. But, Dr. Feldman, I have a different take on Judith Herman's idea of bystander guilt. Didn't she use this term in an attempt to move us out of our complacency?

She writes:

[reads from a page of her well-worn copy of Trauma and Recovery, marked by a yellow post-it note]

To study psychological trauma means bearing witness to horrible events. When the events are natural disasters or "acts of God," those who bear witness sympathize readily with the victim. But when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides. It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering. . . . In order to escape accountability for his crime, the perpetrator does everything in his power to promote forgetting. If secrecy fails, the perpetrator attacks the credibility of his victim. If he cannot silence her absolutely, he tries to make sure that no one listens. . . . The more powerful the perpetrator, the greater is his prerogative to name and define reality, and the more completely his arguments prevail.⁶

So, I think the issue for counsellors regarding bystander guilt has to do with the dilemma of having to bear the burden of knowing about the moral issues at stake and also knowing that repression, denial, and avoidance are not just client issues but are enacted on a larger scale within our society. In this sense, bystander guilt is more complex than just witnessing the traumatic lives of our clients. It's about the helplessness and frustration that counsellors experience in not being able to change the social forces that contribute to trauma.

ANNA

Still, I don't have that kind of guilt. I consider my work to be very proactive in educating and combating the violence against women in society. I have always thought about my work in terms of having a mission, you know, giving something back. It helps me maintain a positive outlook on life.

DONNA

There have been times when I have felt bad about not being able to contain my feelings. I'm not sure if it's guilt, or just that I'm overwhelmed by the work and can't contain it anymore.

MARIE

Yeah, I can relate to that. I have had a hard time containing my feelings at different times during this work, and I learned eventually to create a container for them. I actually visualize a container that I put the feelings that I'm having about my client's experience into, so that I can step outside of them and view the feelings from a distance. In this way, I'm able to deal with the trauma story yet not get overwhelmed. But sometimes I have felt that the container was just getting too full, it was overflowing, and I knew during those times that I had to do something to rejuvenate myself because my container was full.

ANNA

As you speak about being overwhelmed, Marie, and your container overflowing, I am reminded of my own experiences, especially with this one client, where I felt that I couldn't prevent myself from going into a state of . . . of being swept up in feelings of helplessness. For me, there is that fear of losing control. There is something here about being overwhelmed by emotions at times during this work, that a fear creeps in that you're going to lose yourself in doing this work.

DR. FELDMAN

Like you're going to get lost in it?

[Anna nods yes]

Maybe we should talk about how we struggle to maintain a sense of self in this work. Do any of you share Anna's feelings that you might get lost doing this work or that you might lose your sense of identity?

ANNA

Well, could I just explain what I mean further? My sense of self was being challenged on two levels. First my personal sense of self was being undermined by the misunderstood projections being placed upon me by my colleagues at work--as I stated in my story, I always get this dominant mother-figure projection placed on me because of my stature and the fact that I am management. It's really frustrating and irritating. The second struggle with a sense of self has to do with a professional identity. Before my illness with my facial paralysis, I had become used to wearing the professional identity of a counsellor who was in control of her life. I took this professional identity with me everywhere, even into my social life, so that I was always in work mode. I discovered soon after my illness that the self that kept me going was a pattern I had developed in childhood as a way of surviving my dysfunctional family. In my illness, I was suddenly losing my sense of self as a strong woman, totally in charge of my life. My personal power was being challenged. In a way, I had to totally lose control in order to find myself again. Then I had to learn to grieve the loss of a former sense of self, as the professional, always in charge. Living that life just about killed me. I had to re-evaluate my own identity in order to gain balance and remain healthy.

DONNA

I can really resonate with Anna's story because I too have struggled with a shattered sense of self while doing this work. My identity changed over night from being married, to being separated and a battered wife, from being the counsellor to being the victim. This was a very painful transformation for me to deal with. It wasn't a transformation that I had initiated or even wanted. I had to accept that I, like my clients, was an abused woman. My self-esteem started to erode. I felt somehow that my sense of self was not great, but it was good enough. It kept me going. So, from the experience, now I can see that I must be a strong woman and that it took courage and inner strength to survive my personal trauma and still be able to do the counselling work. I didn't know at the time how I would get through it, but I did.

RUBY

I can see how a personal trauma would make you very vulnerable to having an identity crisis. I think we define ourselves often through our relationships. We construct a sense of self based on the responses and interactions we share with others. If our primary relationships are altered, then our sense of self is also altered. These disruptions can be very disconcerting, until we can fashion new identities that serve us. Trauma is transformative. Often a new self emerges out of the rubble.

MARIE

I think that this discussion relates to the loss of self that you experience when you are going through a depression. I think all trauma counsellors face depression at some point in this job. Depression, to me, is a by-product of trauma work. At work, at one point, I noticed that everyone was depressed. It was even suggested to me that I go on antidepressants. I knew then that I needed to get out of this job for a while. I had to get my "self" back, so I took a year off.

DR. FELDMAN

All of you did speak about being depressed, even if you didn't use that word. In the literature on secondary trauma,⁷ it's reported that general anxiety and depression are the two most common symptoms experienced among trauma counsellors. In your stories you spoke about feeling heavy, tired, hopeless, and seeing everything sort of grey. Three of you mentioned being on antidepressants for a limited period of time. You also spoke about life feeling hollow and meaningless.

ANNA

Yes, I do remember feeling like I was living in this grey, empty, despairing place. I remember driving home from work and it would slip over me like a cloak. At one point I was so tired that I think I may have even thought about suicide. The despair of hearing the trauma stories was really getting me down so much so that I was losing my sense of control

over my life. So, yeah, depression and loss of sense of self and a lost sense of control seem to be related in this experience.

DONNA

My experience of depression was felt as an overwhelming sadness. I just didn't have my "being" with me to bring to this work. I could almost feel my being dragged along the floor behind, hoping that it would somehow get up and get in there. It was flattened out on the floor. As I reflect on it, I just couldn't find the goodness in the world. The enormity of abuse in the world left me feeling helpless and hopeless, and then my personal confirmation of this just added to the depression. So, under my rage and anger about the injustice in the world, sit my despair and sadness.

RUBY

I have also struggled with periods of depression after having my beliefs disrupted. I remember contemplating suicide for a split second. I carry a lot of guilt and shame around these memories. I remember at the time reading a research article that reviewed the literature on depression.⁸ There is a gender difference cross-culturally regarding the occurrence of depression and it is generally agreed that the female to male ratio is 2:1. So, considering that we are all women counsellors here and that we have all experienced depression, don't you think we should be asking ourselves why women experience depression twice as frequently as men? What social, economic, political, and biological factors are at work here? Given these findings, the nature of our jobs, and the fact that we are female, it's no wonder that we have all experienced episodes of depression.

DR. FELDMAN

Good point, Ruby. Jesse, we haven't heard from you.

JESSE

Well, for me the depression was about having a bleak outlook. I guess I wouldn't call it a

full-fledged depression. The experience was more like being weighed down or overloaded. There would be this heaviness and I felt very weary. I felt like there was just this little cloud sitting right there [*points over her shoulder*]. It colours your worldview and it's depressing.

DR. FELDMAN

When you felt like that, Jesse, what colour would that worldview be?

JESSE

Grey . . . definitely grey.

DR. FELDMAN

Are there any other trauma symptoms besides feelings of depression that you would like to talk about?

RUBY

Well, one of the core symptoms of trauma in the trauma literature is the re-experiencing of intrusive thoughts or imagery. Other therapists have told me about dreaming their clients' trauma stories or imagining that a client's perpetrator is watching them or following them. One disaster relief worker told me that he dreamed about dying in a plane crash for weeks after he was involved in recovering the bodies from an airline disaster. He called them "night terrors." Lenore Terr⁹ writes about siblings of trauma survivors being vicariously traumatized and reliving their brother's or sister's trauma through their own nightmares.

MARIE

I have dreamed about my clients. This one client in particular who was brutally attacked really affected me. I use to dream [*very animated, lots of hand motion*] about her trauma story, but I was the one being attacked. On one occasion my nightmare woke my partner up. I was screaming and clawing and kicking so fiercely that he dreamt that he was being attacked by a cougar [*everyone laughs*]. Other times, images of my clients' trauma stories

would enter my head. I had a hard time letting some of these images go. I knew that my reluctance to return home from Europe after my year off had to do with confronting all the dark secrets again, all the terrible stories associated with where I lived that I had left behind. While I was away I was able to let the images go. When I returned I had to face them again.

JESSE

I've dreamt about my clients too. For me the impact of intrusive thoughts is a signal that I am overloaded. As the intake person in our clinic, I hear a lot of traumatic material, and it's a great deal of information to process on a daily basis. So, I have to work hard to leave these traumatic stories at work. It has taken me a long time, but now I'm pretty good at keeping clear boundaries between work and my home life.

DONNA

I found an interesting switch in my intrusive thoughts after my personal trauma experience. Before my abuse I found it difficult to shut off the impact of the trauma stories when I got home from work. After the abuse, the intrusive thoughts about my clients slipped into the background and my own trauma experience occupied my thoughts once I got home. I guess the most emotional or traumatic events in one's life take precedence and the other traumatic feelings become second order. I sometimes wish I could monitor the amount that I can hear and shut it off if it gets to be too much and triggers an emotional response. Unfortunately, I can't turn it off before I hear it. Sometimes it just leaves me speechless in the face of it.

DR. FELDMAN

So, like Jesse and Marie, you have a difficult time maintaining boundaries when you are emotionally impacted. Is there a difference between your experience and Jesse's experience in terms of intrusive thoughts?

DONNA

I think Jesse's experience is completely different in terms of not having to deal with the personal trauma on top of the secondary trauma from work. To me, the personal trauma added to the impact of dealing with the stress from work and it placed me at a much greater risk for developing secondary traumatic stress. The work is difficult enough when your personal life is healthy and secure. I see my experience as a double whammy.

ANNA

Before I actually crashed with my illness, I frequently found myself bringing my clients' stories home with me. I would stay at work as long as I could in order to avoid going home where I would be invaded with these desperate, negative thoughts and feelings. My strategy was to keep really busy at work to the point of exhaustion, go home and collapse, and that way I could control the intrusive thoughts. This coping strategy could have killed me. I'm lucky I didn't have a stroke or heart attack.

DR. FELDMAN

Anna, you and Donna describe being "in your head" during the most difficult times with these intrapsychic struggles. Would you describe your experience as a sort of mind/body split?

ANNA

Well, I remember that I was totally living by a formula that I had planned in my head, and I was overloading myself with work in order to keep myself out of my feelings. I just seemed to be cut off from the neck down until I got sick and my body was screaming for me to pay attention. I was always manipulating my energy level by telling myself that I was just lazy. Now I have learned to live more in my body than in my head. I recognize that it's a balancing act and I feel lucky that now I have this built-in stress regulator. Whenever I get overloaded my face starts to tingle or spike and an alarm goes off inside, signaling me to pay attention to my body. It's really about keeping a balance and knowing your own levels

of stress tolerance.

DONNA

For me the split is more about a mind/soul split. I consciously shut off the details of abuse because I don't want to corrupt my soul. I want to guard my inner being. Paradoxically, though, I feel the impact of the trauma stories in my body, mostly my gut. So, when I refer to the shut-off valve, I'm trying to regulate my tolerance level by blocking some of the cognitions in order to not be overwhelmed physically and emotionally.

DR. FELDMAN

Is your soul separate from your mind and body, or is your soul a part of your body, say your gut for instance?

DONNA

I think my soul is something separate from my mind and body.

DR. FELDMAN

So, when you say the trauma work impacts your soul, you mean it impacts both your mind and your body? So, when you shut off the valve, you are shutting off both cognition and felt emotions. You're guarding your soul?

DONNA

Yes.

DR. FELDMAN

Well, we are running out of time for this session. In terms of intrapsychic struggles we talked about struggling with shame and guilt, struggling with fear and feelings of losing control, struggles with containing the overwhelming feelings we get when we do this work, struggling with depression and despair, struggling with an identity crisis or changed sense of self, and finally we talked about struggling with intrusive thoughts and the experience of a

mind/body split as a means to cope with the impact of the work. Ruby, you are the only one who didn't say anything about experiencing intrusive thoughts. Did you want to add anything to the discussion before we end for the day?

RUBY

I can't say that I have experienced intrusive thoughts in the way that I believe they represent a traumatic symptom. There are some stories that will probably always stay with me, particularly the stories told to me in South Africa by the victims of apartheid. But even then there seemed to be another story, a transformative story juxtaposing the apartheid story. The people I spoke with also had great hopes and were so courageous that I left the country not feeling despair but inspiration. I got to see the other side of trauma, the transformative, inspiring stories of survival. I am not trying to diminish the intrapsychic struggles we are talking about, but there is the other side of trauma that keeps us doing this work, the capacity of the human spirit to heal and recover from traumatic events.

PART 3: STRUGGLING WITH THE THERAPEUTIC RELATIONSHIP

DR. FELDMAN

[the following week, standing in front of the group]

I would like to try a different format today. From my experience working therapeutically with trauma counsellors, I have learned that our topic today can be very volatile. Some people do not feel safe disclosing the difficulties they have experienced with their clients to other group members. Their fears are about being judged as incompetent, inexperienced, or inappropriate. So, to ease our discussion today, I would like to present some of the research findings on issues pertaining to our topic, "Struggling With the Therapeutic Relationship." I think my short presentation will aid in normalizing the difficulties you may have experienced working with traumatized clients, and it may make it easier for you to share your own experiences with each other. How do you feel about starting today's session in this way?

[the group seems to approve; no one speaks in opposition to this idea]

Okay, then I'll start with the theory. Traumatologists offer different reasons why counsellors are vulnerable to developing secondary trauma. Figley¹⁰ states that it's a combination of exposure and empathy. Stamm¹¹ claims that it's due to factors associated with lack of control and questions of competency, and Herman¹² states that trauma is contagious. The major consensus in the literature points to countertransference responses as the key to understanding disruptions to the therapeutic relationship. Wilson and Lindy¹³ write that the "primary cause of treatment failure" with the traumatized is unresolved countertransference reactions of the counsellors.

If we believe that the self of the therapist is the fundamental tool of trauma work as Jacobs¹⁴ suggests, and if we further contend that the building of the therapeutic relationship *is* the therapy with trauma survivors,¹⁵ then we have to attend to the experiences of the therapist within that relationship in order to ensure that the self of the therapist is not impaired.

Pearlman and Saakvitne offer the following statement about the fundamental truth of trauma therapy: "Traumatic material is difficult to hear and both parties will be affected by it. Clients know this, but therapists often feel they must deny it."¹⁶ Working with traumatized individuals who suffer from symptoms of PTSD can evoke powerful emotions and stress reactions within the person of the therapist. Our responsibility as trauma counsellors is to provide a safe and supportive environment within which healing and recovery can take place. It requires that we be attuned to the client's pain and be able to establish trust. Given that the trauma therapist is continually confronted with intense emotions and imagery during the process of treatment, it's inevitable and predictable that trauma work will cause *empathic strain*, a term coined by Wilson and Lindy.¹⁷

There are two major comprehensive and highly regarded sources in the literature on countertransference responses to traumatic material in working with clients. The first is the work of Wilson and Lindy and the second is the work of Pearlman and Saakvitne.¹⁸

Wilson and Lindy¹⁹ (1994) write that if we put countertransference responses on a continuum, at one end point we would have avoidance reactions and at the other end over-identification. By *avoidance* they are referring to behaviours such as distancing, or being detached, during sessions with clients and by *overidentification* they mean being enmeshed in the lives of our clients, being an excessive advocate for the client, or over-idealizing the client. They state that these reactions to trauma work are “expectable, indigenous, reactive processes in PTSD therapy.”²⁰ They also document four modes of empathic strain: (a) empathic withdrawal, (b) empathic repression, (c) empathic enmeshment, and (d) empathic disequilibrium. If a break in empathy occurs, there may be five different disruptions to the therapeutic relationship: Treatment could end abruptly; a certain phase in the recovery process could become fixated; there could be an increased intensity of trauma-specific transference; therapy, the client, or both could regress; and finally, there may be various acting-out behaviours. So, according to Wilson and Lindy, successful integration of the client’s traumatic experiences requires that the trauma counsellor be attuned to empathic strain and their countertransference responses. Let me finish this first theory with a quote from Wilson and Lindy’s book *Countertransference in the Treatment of PTSD*:

Countertransference is a multidimensional/interactive process. Clients disclose stories that are laden with affective intensity and descriptions of human experiences that so often exceed the boundaries of a just, equitable, and fair world, that cause the therapist to be taken aback and temporarily dislodged from an empathic, objective and nurturing professional role. . . . Powerful emotions are evoked that bruise the soul.²¹

I will end this talk now with a theoretical piece from Pearlman and Saakvitne,²² which I think is a relevant source for our session today because you all work with victims of abuse. They list six factors that contribute to a countertransference response in work with survivors of sexual abuse: (a) the therapist’s response to the reality of abuse, (b) the therapist’s response to the client’s transference, (c) the therapist’s response to the client’s posttraumatic adaptations (such as numbing, flooding, dissociating, suicide ideation, hyper-arousal, etc.), (d) the therapist’s history, personality, coping style, and transference to the client, (e) the therapist’s response to his/her own vicarious traumatization, and (f) the therapist’s theoretical perspective.

In this theory, Pearlman and Saakvitne describe a countertransference-vicarious trauma cycle. As vicarious trauma increases, countertransference responses become stronger and are usually less available to consciousness. Because vicarious trauma depletes the therapist of physical, emotional, and cognitive energy, it substantially contributes to therapeutic impasse.

[reads the following quote from an index card]

When the therapist is impaired by the work, he/she inevitably, and instinctively, moves to withdrawal or some other action to protect himself/herself. To the extent that this action is organized around the therapist's needs and does not consider the client's experience, the result is a disconnection and abandonment of the client and the relationship. . . . The client may also withdraw to protect herself. If the pair cannot sort out the reasons for withdrawal, the therapy will be stalemated.²³

They suggest that one way of countering the effects of the vicarious trauma-countertransference cycle is to judiciously disclose countertransference responses both in supervision and when appropriate in the therapy session with the client.

Well, that covers the theory. Would anyone like to respond?

MARIE

I know I have struggled with boundary issues in the past. The one incidence which clearly sticks out for me is the time I ran after my client down the street. We were just at that point in the therapy where she was approaching the emotionally difficult stuff. I was really ready to get at it, but I guess she wasn't. She just got up and quit. I felt really hurt and betrayed. I had worked with this client for a long time and felt that we were really getting close to integrating the trauma. But as I look back on it now I can see that I was the one doing all the work in this relationship and I wasn't aware that my client just wasn't prepared to face it yet. Before I realized that I was vicariously traumatized, I used to listen to clients complain about headaches, stomach aches, feeling horrible, and when the clients left I would be the one with the headache, stomach ache, and feeling horrible. There's something definitely wrong with this picture!

[everyone laughs with Marie]

ANNA

Just before my illness I know I was being impacted more and more by clients' stories. One client in particular whose history was similar to my own really overwhelmed me. Sometimes I felt like I was being swallowed up. It was difficult maintaining boundaries for my own protection.

DR. FELDMAN

What was it about this trauma story that was making you lose your boundaries with this particular client?

ANNA

I saw her life going down the tubes, and I remembered being that out of control at one time in my own life. I felt desperate that there was nothing I could do to help her. I was being swept away and my own painful past was being revisited. So, as far as the theory goes regarding countertransference responses being a part of secondary traumatization, I would have to agree. I do see my own trauma history playing a role in being affected so powerfully by this client. Also there were other factors as well, but the countertransference really pushed it to a head.

DONNA

I think many therapists have faced issues that are paralleled in the lives of their clients. I know by using my mirror metaphor in my story I was trying to explain how my personal life was reflected in my professional life through the lives and stories of my clients. One struggle is to stay aware of the parallels. I am noticing my own stuff and if something is happening and it's difficult for me to stay there I just take notice of it and try to stay present with the client. But after my personal traumatic incident, I have to admit, it was very hard to be there. I just didn't have my being to bring to the work and I was struggling

to stay present in the face of trauma.

DR. FELDMAN

Do you think your clients were aware of your struggle?

DONNA

I'm not sure. I see this time period on a continuum, from being grounded to being triggered by the client's material. I was aware of this, so I tried to stay cued to the triggers. But I remember some days being completely burdened by it. All their lives seemed to be resting on my shoulders--the women, the children, their families. I felt like I was carrying all these people and that I was entangled in a web of systems. I felt caught in wanting to fix their lives, feeling responsible for fixing it, and yet knowing that I can't fix it. That isn't how healing works. So, I really felt trapped in my own belief systems.

DR. FELDMAN

What about you, Jesse? Have you struggled with boundary issues or countertransference responses in your work?

JESSE

Well, I can't say I ever reached the point of burnout. I have always been able to be empathically responsive in my work with traumatized clients. Like everyone else though I have felt overloaded with my caseload and I know I have needed breaks, but I am usually able to put the trauma material aside until I am able to debrief it with a colleague or clinical supervisor. I guess I have developed a self-monitoring system that has evolved over the years that I have been counselling.

DR. FELDMAN

Do you think the difference between your experience and the others is that you haven't had a traumatized past? In other words, the countertransference reactions are different for you-

-not so personal.

JESSE

Perhaps the fact that I have not been traumatized means I can be more objective. I'm not sure. I do know that in the beginning of my career I nearly reached burnout because of the caseload and because I hadn't yet learned how to monitor the intake of the trauma stories. It has taken me a long time to learn how to do this work and many times I had to revitalize myself and take breaks to regroup.

DR. FELDMAN

It appears that countertransference is an inevitable aspect of trauma work, just as being secondarily traumatized is a "normal" response when countertransference reactions are out of control. I like the way McCann and Colletti²⁴ describe the "circular reciprocity" that occurs in the therapeutic relationship. They call it the "dance of empathy" where a process of "being with," or moving closer to, a client occurs and then is countered by a moving away from the material in order to maintain an appropriate empathic stance. They describe it as a choreography, or dance, that is determined by the counsellor's awareness and management of countertransference responses.

RUBY

I agree. I think it's a dance. But I also think that countertransference usually has a negative meaning in psychotherapy. I think this is a cultural myth. Countertransference within the helping professions usually means that the therapist has a traumatized past, or an unresolved past experience, usually associated with a traumatic experience if you're working in the field of trauma. The myth presupposes that those with traumatic histories will be more susceptible to negative countertransference reactions. But the research is contradictory on this point and, as yet, has not proven this to be the case.

Pearlman and Saakvitne²⁵ broaden the definition of countertransference and they normalize

countertransference experiences. A countertransference reaction could be an empathic understanding generated by just being a human being in this culture at this time. It can be a response that anyone would have to the horror that they are listening to. It doesn't have to be some dark, unresolved mystery from one's past that is being repressed or denied. Listening to the atrocities that people perpetrate onto others is toxic. Herman²⁶ claims trauma is contagious, so why should trauma counsellors be immune? Countertransference responses are the normal by-product of trauma work and this needs to be recognized as such by the profession. Living in a violent society means that we have all been exposed to violence and all have reactions to it. These feelings, cognitions, and responses to violence cannot be escaped. So, in my opinion, it's about not denying its effects.

DONNA

I think that having my personal traumatic experience actually makes me a better counsellor. It allowed me to reach places inside that I hadn't been able to reach before, and now I have this piece of experience to share with my clients. It's a knowing that conveys itself. I also need to admit that the work during that time period really helped me to survive. I was able to allow someone else's pain to fill the life space for a while.

DR. FELDMAN

Do you think that there is a thin line between your healing and your client's healing?

DONNA

Well, I think that it's about being balanced and knowing when you are crossing over the line of being too enmeshed or overidentified with the client. It's about always having to be aware of what is going on and giving yourself the space to have your feelings about the work that you are doing. Like you said, it's a dance of empathy.

RUBY

I believe that is true. I think countertransference responses can be both helpful to therapy and hinder therapy. As Wilson and Lindy state, “A therapist’s response to the trauma material can enhance or disrupt therapeutic engagement; countertransference responses can be complementary or concordant and they stimulate reactions in *both* the person of the therapist and the client.”²⁷ Maroda²⁸ describes this process as a “dual unfolding” between the person of the client and the person of the therapist, moving between transference and countertransference responses. This is the work of trauma therapy. If it’s not well attended to, it can be detrimental to the therapeutic relationship.

DR. FELDMAN

It is the counsellor’s responsibility to maintain awareness concerning his/her countertransference reactions, because these can lead to empathic strain and may cause a therapeutic impasse or even termination of treatment. We must remember that we are to *do no harm*. It’s our responsibility to provide a safe therapeutic environment in which counsellors can keep clear boundaries and maintain an empathic stance and at the same time be aware of the dual unfolding that Ruby refers to, in order that the client can successfully move through the stages of recovery and integrate the traumatic experience.

ANNA

But the question is: How do we as trauma counsellors know when we are in trouble? It’s not always possible to be aware of the impact of the work because of the subtle and complex coping strategies that we have adopted. I know that my workaholism was a coping strategy that proved to be lethal. At the time, when you are in that stressful state, you are not always aware of what is happening to you, especially if you are living in your head and not your body.

DR. FELDMAN

It’s important to have effective and reliable supervision and peer debriefing so that others

can help you become aware of your countertransference difficulties and also signal you that the stress you are experiencing may indicate secondary traumatization. As Herman²⁹ warns, you can't do this work in isolation. So, not only do you need to be keeping track of how you are doing, but your clinical supervisor should also be monitoring your stress level. We need to constantly be asking ourselves: In what ways are my clients' needs and interests being enhanced or jeopardized? It's a matter of professional ethics.

JESSE

I guess if we believe the metaphor that the therapeutic relationship is the tool of therapy then we have to keep that tool sharp.

RUBY

I like the way Lindy describes that relationship. He states that the therapist must become the "trauma membrane--the person who personifies predictability and safety, as well as the person with whom the dimensions of control and ambivalence can be worked through."³⁰ I think it's important to explore the countertransference responses in the therapy session when appropriate. It seems more authentic and helps break down the idealized images that clients project onto us. As Danieli³¹ observes in psychotherapists working with survivors of the Holocaust, if counsellors do not share their responses to the trauma stories then they may be seen by the survivors as colluding in the conspiracy of silence. Privacy may be misconstrued as secrecy. Trauma therapy requires that the counsellor use countertransference responses authentically and appropriately in the interest of a genuine therapeutic relationship. It's about reflexivity and conscious awareness. It means that we have to actively engage in bringing to light our unconscious, and often "unspeakable," feelings and cognitions. If we avoid them, ignore them and hide them from our consciousness, then they lay festering until we become sick, and that illness is secondary traumatization.

DR. FELDMAN

Well, we're out of time again. Let's pick up this conversation next week when we talk about struggling with work and social support.

PART 4: STRUGGLING WITH WORK AND SOCIAL SUPPORT

DR. FELDMAN

For the first three sessions we concentrated on the internal struggles you have experienced with beliefs, intrapsychic struggles, and experiences in the therapeutic relationship. Now we turn our attention to those we interact with at work and in our social lives. As I read through your stories I noted five main themes around your struggles in the work environment.

[points to a chart where she has listed the five themes]

They were (a) struggling with being inexperienced, (b) struggling with the amount of work or caseload you handle, (c) struggling with a non-supportive work environment, (d) struggling with co-workers perceptions and judgments, and (e) struggling with the debriefing process. Let's talk about work environment struggles, then move into struggles with social support.

ANNA

I mentioned in my story that I experienced burnout three years after I started working in the area of trauma. As I look back on it now, I know it was due to being inexperienced, and I really think I was vicariously traumatized.

JESSE

Yes, I thought I was burned out too in the early part of my career, but it was because I was young and inexperienced. I think inexperienced counsellors are most at risk for developing

vicarious trauma.

RUBY

We called it “burnout” because at that time we didn’t have any other word for it. We hadn’t yet spoken about the aftermath of hearing trauma story after trauma story. We hadn’t yet labelled our experiences *vicarious trauma* or *secondary trauma*. And the research does not yet demonstrate that experience or education can buffer the effects of secondary trauma.³² I really think counsellors are unaware of the dangers inherent in this work.

MARIE

[pointing to the second item on Dr. Feldman's list]

For me the workload had a great deal to do with becoming secondarily traumatized. At one point in my career--just before I quit--I was trying to do it all. It was a form of workaholism, I suppose. I got over-involved because I was committed to the organization and I felt that what I was doing was really worthwhile. It became sort of a mission. Later I realized that I needed to be more assertive about what I needed and I wished I had stronger boundaries regarding my workload. I think I was constantly giving myself away. Eventually I just got depleted.

ANNA

I was the same way. At one point I couldn’t keep track of it all. I know that most of my workload was self-imposed, at least the managerial aspects of it. And for me too my work had become a mission. I was trying to give back to the lives of women who shared similar experiences to my own abuse. I was trying to make a difference. I still see it as very worthwhile work. But I became a workaholic in order to avoid my feelings about how this work was impacting upon me. Just before I became physically ill, my client caseload was very heavy. I think it was the compounding factor that tipped me over the edge.

JESSE

I agree with Anna about the caseload being a factor underlying the vicarious trauma. I felt the impact as heavy and burdensome, and later I used this feeling as a signal to myself that I was overloaded and needed to take a break. I was able to recognize that place before I fell into it. So, I have learned to speak up and slow it down when I need to. I also think doing a variety of different tasks during the workday helps keep the vicarious trauma at bay.

DONNA

I have already described my workload as a web of systems. I have struggled with being engulfed by my work and getting caught up in a whole web of systems--the legal system, school systems, the family system, political systems. I feel burdened by all their lives--the clients, the children, the parents, the families and friends. My solution is to keep it simple.

RUBY

[looking at Donna; states in a gentle manner]

But, Donna, your solution is a bit ambiguous. How do you keep it simple when you are immersed in such complex, all-encompassing structures and relationships? It seems to be like a no-win situation.

DONNA

I know. The amount of work and the anger, rage, and sadness that I carry for my clients sometimes flattens me and leaves me on the floor.

DR. FELDMAN

[moving away from the emotional material]

What about support? Was there anyone at work who could support any of you and help you through this?

JESSE

When the agency where I work was in transition, I felt that the level of support was lacking by the administration. Everyone was feeling vulnerable and the leadership wasn't consistent. This caused a lot of added stress to the lives of all the counsellors, not just mine. I wish that there was more diversity at work. I need new challenges and see this as a healthy strategy to combat vicarious trauma. Unfortunately the creativity is just not there. It would take a great deal of energy and time to put something different in place, and right now I just don't have either.

MARIE

I remember when I worked at the counselling centre at one of the universities. It was short-term counselling, you know, five or six sessions and then they are out the door. This adds an extra strain on counsellors because they don't get to see the recovery process unfold. Another problem is lack of proper training. When I worked at the sexual assault centre I had to get training elsewhere, like at the Justice Institute or at conferences and workshops. The clinics can't provide the training, yet without it you're at risk for developing secondary trauma. The lack of work support really hit home for me when I was working as a child sexual abuse counsellor for one of the mental health clinics. I needed much more support structured into the job than management had in place. I became very frustrated with management because they were just "pissing away" all our good work by not being more supportive.

DR. FELDMAN

Did you want to do something about it? Did you try to change things?

MARIE

Yes, I finally did speak up. When I brought it to their attention I was accused of "losing it." So, I was silenced. It definitely wasn't supportive. I remember saying to them that I was just having my feelings and isn't that what we teach our clients to do every day? Couldn't

they see the contradictions between their administrative expectations and their actual practices? I decided then that I would have to quit and I did about a month or so later.

RUBY

[posing a question to the whole group]

So, having a supportive work environment is only available if there is the will on the part of the administration to create it?

ANNA

Well, I am a part of the management team where I work, and I too wish that it was more of a supportive work environment. In my workplace there is a political focus that may not be present in other trauma agencies. I believe that the political agenda of some of the counsellors may have compounded the vicarious trauma because there was a lot of anger and frustration for me. Sometimes I got embroiled in it. I didn't know the solution to the problem but I did notice how it added to the pressures of work and seemed to make the workplace toxic. Just when counsellors are in need of compassion and kindness, people get into a critical mode and attack. They put each other down. It's a compounding factor in a lot of political or feminist-oriented organizations. My organization, being mostly female counsellors, tends to embrace feminist ideals. Therefore, some counsellors become disillusioned when the management and co-workers don't live up to their feminist ideals. Having to live up to other peoples' ideals adds more stress to the already present pressures felt in the trauma work. It just isn't realistic. We are more than just feminists. We are human, just like everybody else, with all the same character flaws.

DONNA

I found that work was supportive in most instances. There are only two points about work that are non-supportive in my opinion: the low pay and the overemphasis on accountability. Counsellors are typically women and receive an income that is considered low on the pay scale compared to other trauma workers, such as fire persons, the police, or ambulance

workers. I believe that there is a general expectation that counsellors do this work because it's a "mission" or a "calling." Even if this is true, should a person be paid less for it? In terms of accountability, I struggle with the pressures to keep up the statistical records on my clients. I feel that these requirements for statistics are driven by the board members who need the numbers for funding purposes. Unfortunately, this record keeping part of my job keeps me from my clients and interferes with my role as a counsellor. They forget that I'm human, which is the downside of the agency's focus on accountability. I feel at times that I may be betraying my professional integrity for institutional regulations.

JESSE

I agree with some of that, Donna. I too think that there is a generalized tendency for people outside of counselling to view it as a form of volunteerism, instead of a real tough job that deserves appropriate compensation. I have struggled with other peoples' perceptions of what motivates people to become trauma workers. Often the board members who administer our agency project a sense of volunteerism, in that they think that counsellors are selfless. This can be very problematic for counsellors during contract negotiations. They expect you to do the trauma work for the love of it.

RUBY

The issues of pay equity, being female in a male-dominated society, and having biased attitudes underscoring the policies and practices in mental health institutions speaks to the power differentials in our culture. The status quo, or the expected practice, is that women should be doing this work for free--much like the attitudes generally held toward mothering and parenting. These practices are in most instances devalued in society, and yet look at the cost of caring: the mental health of the mental health professional, low economic status, professional discrimination, and a culture riddled with traumatized individuals who without counselling would likely turn up sooner or later in our hospitals, courts, jails, and morgues.

DONNA

Well, there's another side to work support that we haven't discussed. It isn't always lacking or insufficient. I know when I was going through my personal crisis, I was feeling very fragile. I explained to my co-workers that I was withdrawn because I had to conserve my energy. Although I wasn't judged for this, I was worried about my co-workers' reactions to my withdrawal. I also felt that it was risky to share the enormous rage I was feeling during our peer group sessions. But I was supported and offered regular clinical supervision. However, I am afraid that only a portion of this anger got dealt with through supervision. The struggle is the knowledge that I know that my stress gets added to each day that I do the work. But most of the time I feel really supported. The only time lately it has bothered me are times when I go outside to have a cigarette when my clients leave. I just need to step outside for a while. I think my co-workers may misunderstand this as needing to smoke when in fact it's about needing a break.

ANNA

I have struggled with my co-workers' judgments, which stem from their projection of the dominant mother-figure that they constantly cast upon me. I think it's easy for people to project authority issues or power issues onto me because of my stature and because of my managerial position. So, I'm a sitting duck for mother projections. I feel that I am often misunderstood by co-workers because people assume that they have to do what I say even though I may be just expressing an opinion. I'm not really dominant, my style is more assertive. I'm an idea generator and I have a clear, articulate, strong voice. People mix this up with aggression. I also think that I need to set firmer boundaries between myself and my supervisees and I need to say "no" more often in my supervisory role because sometimes I end up getting abused at times by my co-workers.

DR. FELDMAN

The only topic left that we haven't discussed yet concerning struggling with the work environment are the struggles you experienced with the debriefing process.

DONNA

As I mentioned earlier, I have had difficulty expressing my feelings about the amount of anger I carry around. I eventually risked sharing these feelings at a debriefing group. At first I felt judged by my peers for opening up and exposing my rage. Later I was supported by my colleagues and clinical supervision was put in place for me. But supervision is only a partial solution. I still feel frustrated because only part of my anger gets released through clinical supervision and I know that in this work secondary trauma is cumulative. It gets added to each day. So, for me, there seems to be some feelings of hopelessness in this struggle.

JESSE

The only issue I have about the debriefing process is that I wish it could be more spontaneous. I liked it better in our other location, where we were all on one floor and we could come out of our offices and chat together, support each other, laugh some of it off.

DR. FELDMAN

So, are you feeling somewhat isolated in your new location?

JESSE

No, I don't feel isolated. The peer support is just not as spontaneous as it use to be.

ANNA

My struggle with the debriefing process is finding the right person to debrief with. There are times when a peer debriefer is able to actively listen and sympathize with me, but I feel that at other times the debriefer is performing. Perhaps some of my colleagues become anxious debriefing me because I am management, you know, a person in a position of authority at the centre. This power difference could contaminate the debriefing process. So, I've decided I would rather wait for the right person to debrief with and process the feelings inwardly until I am able to debrief them, than have an unsatisfactory debriefing

session with a defensive or anxious colleague.

MARIE

Early on in my career at the rape crisis line training I was required to write down my feelings and reactions after each and every call, so that the clinical supervisor could debrief me right away at the end of my shift. This was extremely therapeutic. Later in my career, I have struggled to find an appropriate debriefing partner. The time restraints on myself and my colleagues and the heavy caseloads make it difficult to engage in spontaneous debriefing, which I regret. I remember an incident in peer debriefing where my feelings were being judged. So, there are times when the debriefing process makes you vulnerable to other people's judgments.

DR. FELDMAN

[moving the group out of the topic of work environment struggles]

What about social support? What are some of the struggles that you have experienced with social support?

JESSE

When I think about my struggles with social support I am reminded of the many, many times that I have been in social situations where someone comes up to me and asks "What do you do for a living?" and I reply, "I'm a child sexual abuse counsellor." The typical response is "ooh"--meaning "yuck"--or "How could you do that work?" "Why would you ever want a job like that?" The implication is that the trauma counsellor's job, particularly with abused children, is horrific and the counsellor must be some kind of voyeur or sadomasochist to want to work with sexual abuse survivors.

DONNA

It's difficult to explain the benefits of doing trauma work to someone outside of

counselling. They just don't understand.

RUBY

They pass on these judgments because they don't get to see the power of healing, or the courage that our clients have and the resiliency that we get to witness every day. There are two sides to abuse, and most people only recognize the horror. They don't acknowledge the transformative aspects of trauma recovery.

DONNA

Jesse, I once asked someone why he had asked me that question. The person's response was one of empathizing with me and not a judgment as you have experienced. I was a little surprised but appreciated the supportive response.

JESSE

Well, I was finally able to get to a place where I realized that it was the "outsider's" problem if he/she couldn't understand the healing process or the benefits in helping someone recover from a traumatic experience. There is enough stress to deal with without having to take on an outsider's misconceptions!

DR. FELDMAN

I think that is a good strategy, Jesse. Why should you have to take on someone else's projections!

JESSE

When I re-read my story I realized how isolating the work was. I think that the isolating nature of this work contributes significantly to secondary trauma. Doing trauma counselling and not being able to talk about it outside of work because of the confidential nature of the job creates a burden. If you are only able to present a censored or restricted view of

yourself in your social interactions, then how are you able to develop authentic relationships?

RUBY

[turning toward Jesse]

I noticed that everyone mentioned this, Jesse, in one way or another. I think the struggle here is twofold: (a) not being able to reveal yourselves in your totality, and (b) bearing the burden if you unleash the horrors of your work onto your family and friends. But the problem as I see it is that if we don't inform those outside of our work about the difficulties that we face, then how will anything ever change? Aren't we colluding in the conspiracy of silence by hiding what we know from the public? Shouldn't we be looking for effective ways to disseminate the information we have about the amount of violence we see every day? I too have struggled to keep my home free from the toxicity of abuse. But at what cost? What are the social costs of not telling others about the work we do?

JESSE

The boundaries for me are pretty clear. I don't need to have my friends know about my struggles with my work. I am supported by my colleagues who really understand the stress and can offer me the support that I need. I have a self-imposed rule to keep work at work and not to take any of my work home with me. I guess I am concerned about making my home life toxic with stories of trauma.

DR. FELDMAN

So, home is more of a haven, a place where you can retreat from trauma?

JESSE

Yes.

MARIE

I think I have the same philosophy, Jesse. I take my own advice about keeping boundaries at work and home. I've developed strategies to keep work at work. I've been able to separate these two spheres of my life. As far as social support goes, I can't say I have felt isolated or that I have lacked social support. I have a lot of interests other than my work that keep me busy and out there in the world.

ANNA

My way of dealing with secondary trauma was to stay in work mode through my workaholism and the effect was that I started to isolate myself socially. I was living with a good friend during my crisis period but I didn't feel that I could burden her with my struggle. I tried to deal with some of it with her but it was just too much. Anyway, she really couldn't do anything to make it better. She would listen to me but she would get sick of it. Upon reflection on my story, I remembered that even though I was socializing with friends I just couldn't step out of the work mode. I was always wearing my counsellor hat.

DR. FELDMAN

Why do you think you kept yourself in that counsellor role all the time?

ANNA

Because it kept me safe, I felt less vulnerable. I know this sounds strange because I am usually very extroverted and sociable. But I started to withdraw. I didn't want to leave work and I didn't want to relate to anybody. I didn't want to talk to anyone. I didn't want to socialize. I was more and more isolating myself socially . . . which was very strange. I was unconsciously losing part of myself--my social self. It wasn't a matter of social support not being available to me, it was more that I couldn't find the energy or drive to engage myself socially.

DR. FELDMAN

Why do you think you were safe at work? What were you safe from?

ANNA

I was safe from my feelings, from being overwhelmed. I just didn't dare open up those feelings because I knew I might drown in them. If I kept myself really busy I could stay away from the feelings underneath. But eventually it all came to the top when I got sick and I had to face it. There's that pun again!

[everyone laughs with Anna]

DONNA

After my personal crisis, I felt abandoned by a few family members. The people in my life seemed to take sides and were supportive to a point. I felt that they didn't totally believe me and I compared this behaviour to the dynamics of abuse that my clients experienced, the "blame the victim syndrome." The message from my family was: "Don't disrupt. Let us get on with our lives." This belief was exemplified when I approached a family counsellor who was also a good friend to both my husband and myself. After I told my story of abuse to this person, he diminished my experience by stating that because I was a trauma counsellor I was seeing abuse everywhere. I really felt judged and humiliated. The injustice again was fueling up inside of me. I felt a sense of loss and loneliness in not having the appropriate social support that I needed.

DR. FELDMAN

[speaking to the group]

Does this loneliness or sense of isolation leave you feeling depleted? What do you think some of the side effects of these feelings might be?

RUBY

Well, I noticed that we all got physically ill at one time or another due to the stress of working with traumatized clients. In the stories, we all described periods when we were extremely fatigued, feeling run down physically, and getting colds and the flu when our caseloads were heavy. But aren't these ordinary stress reactions to doing a difficult job, and therefore not particularly unique to secondary traumatization?

JESSE

Well, half-jokingly, I suggested in my story that perhaps the counsellors at my centre were suffering from a seasonal disorder because we all get sick in February each year. [*chuckling to herself*]. It's always raining in February and everyone tends to get a little down. Even the families of the clients I counsel seem to be worse off in the month of February. Who knows? Maybe it's just my worldview at that time of year--seeing everything as negative.

ANNA

It was my debilitating physical illness that paradoxically turned this whole secondary trauma experience around for me. I was out of commission for four months. It truly was a transformative experience. So, I think we need to pay attention to the physical signals of being overloaded. I take it as a warning sign to reassess my self-care plan.

DR. FELDMAN

I think you all at one time or other in your stories mentioned having headaches or feeling nauseous during some of the therapy sessions with your clients. Generally, this seems to be a common response to hearing stories of abuse day in, day out.

MARIE

I was surprised how I changed physically when I went away for that year. I lost weight and didn't get ill the whole time I was away. I felt the stress in my body just peeling away. I think the problem for all of us was that we were living mostly in our heads and not in our

bodies. To do this work you have to be connected and keep a balance in your life.

DR. FELDMAN

I agree, Marie, and I think this is a good place to stop for today. The next session is our last. I would like all of you to read over your stories and summarize the coping strategies that you used. Make a list of the effective strategies and the non-effective strategies and we will discuss ways to do this work and stay healthy. I would also like to look at what this experience has meant to all of you and come up with what you think those in education, clinical supervision, and research should be concentrating on to combat the deleterious effects of secondary trauma.

PART 5: WAYS OF COPING, PREVENTATIVE STRATEGIES, AND IMPLICATIONS FOR EDUCATION, SUPERVISION, AND RESEARCH

DR. FELDMAN

[for the last session, shows the group Table 4]

Here's the list of effective and non-effective coping strategies that you used to deal with the effects of being secondarily traumatized. I've put them in alphabetical order. But we don't have to go down the list and discuss them in that order. Which one do you want to start with?

JESSE

[points to "avoidance behaviours" on the list taped to the wall]

Perhaps leaving my feelings about work at work is an inappropriate coping strategy. I mean it could be, if they don't get debriefed before I go home. By avoiding them, they tend to pile up and this could leave you feeling really heavy, burdened. For me, I like to keep it at the conceptual level. I try to keep the images of trauma out of my head. I've never really articulated this before. I'm not sure if this is a self-care strategy or a resistance to acknowledging the effects of STS. One definite avoidance strategy that I do use which I

Table 4

Effective and Ineffective Strategies To Cope With Secondary Traumatic Stress

Effective Strategies	Ineffective Strategies
Avoidance of violence in media Clinical supervision Creative activities Education and training in trauma Exercise Healthy work environment Learning to let go Peer debriefing Personal therapy Political action Self-agency/self-knowledge Sense of humour Sleep Social support Spirituality Taking vitamins Theorizing about the work Vacations/sabbaticals/time off Visualizations/stress release	Avoidance behaviours Being silenced and self-silencing Denial of effects Ineffective self-care plan Isolating self Lack of self-monitoring Mind/body splitting Numbing out Overidentifying with clients Theorizing to stay out of feelings Workaholism

think is effective is to avoid anything violent in my social life, like violence on TV, at the movies, or in the news. I consciously avoid this stuff. I monitor my intake.

DR. FELDMAN

In your opinion, Jesse, then avoidance behaviours can be both positive and negative depending upon how they are being enacted? Monitoring your intake of trauma-related material is imperative?

JESSE

Yes. I think so.

RUBY

It's about that dance of empathy³³ we talked about earlier. It's sort of an approach-avoidance movement. Sometimes it's appropriate. At other times, when the interests of our clients are not served by avoiding the traumatic material, it is not appropriate. I think that the only way through this dilemma is to engage in self-monitoring and processing of traumatic material through clinical supervision. We need to be aware of what we are or aren't doing in therapy sessions with traumatized clients. I also think that disclosing our avoidance tendencies to our clients and providing an explanation of the process of this dance of empathy would help clients understand the dual unfolding that often occurs in trauma therapy. Of course picking the appropriate time to disclose this information is very important because you wouldn't want the client to switch roles and attempt to rescue the counsellor. It's a very difficult dance to choreograph.

Donna

My use of the shut-off valve metaphor is an example of an avoidance strategy. Sometimes I have to turn it off in order to remain present and keep myself from being pulled under. Sometimes it's effective. Other times it isn't. If I'm turning the valve off

too often then my avoidance strategy is ineffective. Another problem for me is that sometimes I feel like a zombie, especially during my personal crisis. I just had to numb out because I didn't have my being there with me to give to the work. I guess I was also in denial about the impact of my own abuse on my person as a therapist. I may have even overidentified with some of my clients because I spoke a lot about seeing the parallels between my life and theirs. So, I may have colluded with my clients about avoiding the trauma stories because I just couldn't handle it at that point. Sometimes I found that I was overwhelmed and at other times I was affirmed. For me it's about monitoring my intake and always being aware of how I'm being affected.

RUBY

I think this is a real problem for trauma counsellors because therapists are usually not aware of times when they are being drawn into re-enactments and becoming secondarily traumatized.³⁴ So, how do we know when we are ineffective? We say that we self-monitor, but how do we know when we are at risk, because there are times when our behaviours are unconscious and denial can be a very powerful coping strategy.

ANNA

Well, I may have combined avoidance and denial in my ineffective coping strategies. My workaholism was a means of avoidance. It kept me busy so that I could stay out of my feelings. But I think denial also played a large role in the development of secondary trauma in my case. I was in denial about the effects of my workaholism. There was also a mind/body split happening to me, where I was living in my head. So, I suppose this is also an example of avoidance and denial. Eventually, my body blew the whistle on me and I had no choice but to face it. I'd have to say that out of this list, I've used avoidance, workaholism, denial, and numbing out most frequently as ineffective coping strategies.

MARIE

I don't think I used avoidance as much as denial. I became over-involved in a couple of cases as I illustrated earlier and I was in denial about the impact that the work was having on me. But the centre where I worked supported this denial. There wasn't a means to come to grips with the emotions that I was having about the work. I was somewhat of a workaholic, like Anna, but I don't think I was numbing out. If anything, I was having too many feelings about it all. There was some aspect of self-silencing related to my early history about the abuse in the Christian college I attended, but, again, there is also the fact that there was no forum for my story to be heard at that time. I think some of these ineffective coping strategies are mirrored in the culture and the clinics where we work. I know, in my case, there was workaholism, avoidance, denial, silencing, and numbing out going on all around me.

JESSE

I think these issues are part of the experience of working at any trauma clinic or centre. I also think that we all at some point experience vicarious trauma doing this work. You just have to take care of it before it gets out of control. I also think vicarious trauma is a collective slump. Everyone at my centre has experienced being depressed, gaining weight, getting sick, feeling fragile and vulnerable, and experiencing work as non-supportive. These are the side effects of being a trauma counsellor.

DR. FELDMAN

There has to be the will on the part of mental health care management to become aware of their own non-supportive and ineffective practices that place their counsellors at risk. Alright. Well, let's move on now to strategies that you have found to be effective.

JESSE

Well, I've always valued my ability to have a sense of humour about the work. I think

it's a great stress releaser. I also think you need to be educated about trauma work and have knowledge about your personal processes. A lot of this personal awareness can be brought about through clinical supervision, peer debriefing, or with your own therapist. You have to take care of all the stressors in your life and stay on top of it because, if you don't take care of yourself, you can't take care of anybody else.

DR. FELDMAN

What specific things do you do to take care of yourself?

JESSE

Exercising regularly is important, getting enough sleep, taking vitamins, monitoring your stress load, getting peer support, and doing something else that is meaningful to you. I like to do stuff that is creative, like quilt-making, pottery, or taking a course in creative arts or learning something new. You also need to take regular breaks, like long weekends or vacations, in order to rejuvenate. And, I think as I look at the list we have here, theorizing about why abuse happens has helped me work through the disruptions to my own belief systems.

DR. FELDMAN

Can you tell us about your theory about why abuse happens?

JESSE

Well, I have two theories: The first one is about why secondary trauma happens and the second is an explanation I have developed that helps me continue to do the work. The first is that I believe that there isn't a single trigger or single case that causes secondary trauma. I believe that it's more a wearing down of one's resources. I also think that secondary trauma is cumulative. As we develop large caseloads we get weary and people become less able to cope with taking in the trauma material, and if you're

becoming affected by the work, then you are not able to handle the stress of the job. It's about taking care of all the stressors in your life and at work simultaneously and never letting it get out of hand. You have to stay on top of it. This I learned along the way. The second theory I have that helps me cope is my belief that people are not born as perpetrators. There is always some reason why abuse happens. Something really awful must have happened to these people in order for them to do the harmful things they have done. So, for me, it's about stopping the cycle of violence. Helping those who are abused today may prevent abuse from happening tomorrow.

MARIE

I think that my rationalizations or theories have helped me as well, and I can see the progression of my beliefs over time. I think that doing this work can make you develop a twisted view, and I often reminded myself of the statistics in order to stay balanced. I also believe that you can't save anyone and that the healing is the client's responsibility. I also think that I learned that I have control over my own life. I have control over who I allow into my life, I have choices about what kind of work I want to do, and I have control about how much I am willing to give and take in doing trauma work.

As well, my spirituality has been a great source of strength for me. Some of the unbelievable phenomena I have witnessed in doing trauma work has pushed the edges of my own spirituality, and although I cannot explain some of this, I know that it has great significance to me. I believe that there are ways that God steps in that we may be unaware of. Having a theory about abuse gives me hope, and yet I'm cautious not to use the theory to step over the feelings I have about this work. It's a combination of being aware of the theory and your own feelings about the trauma material that you have to integrate. Just like the clients, we have to make meaning.

I also use my craft as a puppeteer as a form of self-care. It's a creative release for me. I

also do acting, using my whole body, because being in my body helps me be aware of the amount of stress I am carrying and I am able to release it. I do healing visualization exercises and deep-breathing relaxation techniques. So, to me, it's about performing meaningful rituals and actively being responsible for your own self-care. It comes about with trial and error. It's about learning over time. Other parts of my self-care plan include peer support. I attended group therapy and art therapy and found them both to be very supportive. I keep a journal. It's important to know your personal process and to work at being self-reflective about where you are and how you are doing. My family has also been a great source of support to me over the years. One other important concern is training and education. I think that you have to be properly trained and well educated in trauma therapy in order to do this work. Seeing how others have managed in the field, becoming informed, and learning different strategies that work is extremely important. It also helps to normalize what is happening to you at work. And, like Jesse, I take time off, and I use my sense of humour a lot--black humour as a means to express some of the feelings and absurdity of it all. For me, it has been about learning to let go. It's about learning about the balance. It doesn't happen over night. It takes a lot of soul-searching and self-awareness but you can learn personal ways to stay safe doing trauma work.

DONNA

I do monitor the intake. That's what I mean by my metaphor of the shut-off valve. My solution is to get supervision and support at work. I have a motto--"Keep it simple"--as a self-reminder when I'm feeling overloaded, and that seems to help. I also believe it's dangerous to do this work in isolation, so securing a support system is really important. It's not always easy to surround yourself with people who understand what you are going through or what kind of stress you are under, but I think it's very helpful if you can. I would recommend engaging in personal therapy because I don't think clinical supervision and peer debriefing are enough. Seeing the mirrors between my work and

my personal life and recognizing the masks that people wear has been useful in helping me understand my own trauma experience. I guess I do theorize as well. I remind myself that the slice of pie I see everyday isn't the whole pie. You also have to be able to see the process through to recovery. It's imperative that you experience success and see the hope or you could drown in cynicism and despair. And, in a similar vein with Marie, I've also learned that theorizing can be an ineffective strategy, because often there is no justifiable answer. Sometimes there just is no solution. It's just the way it is and you have to accept that. You have to learn to live with the no-answer place. Spirituality has also been a source of strength for me. When it gets beyond me I simply give it to God to take care of. And you need to develop a daily plan, like exercising, having fun, developing a hobby. It's about keeping a balance in your life.

ANNA

For me it's about being vigilant about self-care. You have to debrief regularly with someone who is capable and able to be effective in reducing your stress. I think the theory I have developed about the debriefing process is beneficial to other trauma counsellors. Work environment stress also has to be evaluated in terms of its contribution to counsellor stress. Frequent constructive open-ended discussions about how work is or isn't supportive needs to be incorporated in the debriefing sessions or staff meetings. Issues such as denial, defensiveness, criticisms, blaming behaviours, competitiveness, backstabbing, and other non-helpful, non-supportive behaviours or attitudes have to be addressed openly. In terms of self-care, I am more realistic and vigilant now. I power walk, monitor my caffeine intake. I don't drink alcohol. I try to have more fun by connecting more with my friends, limit my television watching, don't isolate myself, and I make concrete future plans to take trips, do something different so that I have something to look forward to. The most important thing I learned from this experience is that trauma work can be life-threatening. Playing at the self-care game can be like playing Russian roulette. You have to actually do the plan, not just talk about it.

RUBY

A discussion on prevention needs to begin with the acknowledgment that experiences of secondary trauma are normal responses to abnormal and unusual life events. Therefore, a preventative plan doesn't pathologize the experiences of counsellors working through the difficult experience of being secondarily traumatized. A preventative plan needs to include a recognition of the ethics of professional practice. Unless we take care of the effects of secondary trauma, we are in jeopardy of causing harm to our clients, ourselves, and our profession. A preventative plan is required at both the personal and professional level.

DR. FELDMAN

This is very true, Ruby. Most of the coping strategies discussed by all of you have appeared in the literature on preventative measures in dealing with secondary trauma. Janet Yassen's³⁵ personal prevention model includes physical wellness, psychological awareness through strategies that foster self-awareness, social factors by developing a social support network, and social activism that increases social responsibility and alleviates feelings of powerlessness. The second component in Yassen's model addresses professional situations or workplace prevention. Her suggestions include having a balanced pace at work; keeping client caseloads manageable and work hours reasonable; setting boundaries in terms of time and keeping track of the amount of self-disclosure and personal investment in one's cases; dealing with multiple roles at work, for example, switching clinical and non-clinical activities, but being wary of the number of responsibilities that you place upon yourself; ensuring the availability of supervision, having peer support or personal therapy on a regular basis; obtaining the professional training needed to do the job; avoiding isolation when working with trauma survivors; being aware of boundaries by limiting the amount of overtime, taking tasks home, and receiving calls at home; replenishing professional skills and personal development by attending conferences, workshops, and professional retreats; attending to the physical setting because it's part of one's self-care (comfort, safety, and privacy); and finally, it is

important to be realistic about trauma work and necessary for trauma counsellors to believe that their efforts make a difference.

RUBY

But there is something about this plan that places the responsibility totally upon the trauma counsellor. Often problems originate within the institutions or agencies in which trauma counsellors work that are not always within the counsellors' control. Don't trauma agencies have a duty to warn trauma counsellors about the occupational hazards involved in doing this work?³⁶ It's not sufficient for employers to just instruct therapists to do self-care practices. There has to be the will on the part of the employer to support the trauma counsellor by providing the necessary buffers to keep the counsellor as safe as possible. When you consider the fact that trauma counsellors do not enter into emotional re-enactments of the trauma story with the client until the client has thoroughly organized a safety plan and backup support, shouldn't the same safety precaution be provided for the counsellor, because we now know about the deleterious effects of doing this work? And shouldn't we expect that counsellor training programs also have a duty to warn? The most alarming piece of evidence that points to the lack of concern by educators is the fact that at present there are few opportunities within counsellor training programs to properly train counsellors in trauma work--let alone inform them of the hazards of this type of counselling. This is very surprising considering that over one-third of our population is traumatized³⁷ and according to the findings of Pope and Feldman-Summers,³⁸ one-third of all mental health professionals have had experiences of childhood abuse.

Training has to include a solid theoretical foundation that includes an understanding of the effects of psychological trauma, the impact on the therapeutic relationship, an explanation of the countertransference-transference cycle, a thorough explanation of the effects of secondary trauma, instruction on how to cope personally and professionally--actually having the counsellors begin building an effective preventative plan--and finally,

exploring the problematic issues at the heart of the relationship between trauma counsellors and their agencies and how these may be addressed both individually and collectively.

DR. FELDMAN

I couldn't agree with you more, Ruby. There is both a personal and an institutional ethic that needs to be addressed in trauma-related work. Do you [*addressing other four*] have any recommendations for clinical supervisors or counsellor educators?

ANNA

I think counsellor educators and researchers need to go deeper by asking questions such as: What are the dominating principles that lock us into trauma as the approach to so many of the problems in life? What do we gain by labelling someone "traumatized"? Counsellor training needs to address these types of philosophical questions and train counsellors to be reflexive about their counselling practices.

RUBY

Dr. Feldman, isn't it true that with the *Diagnostic and Statistical Manual of Mental Disorders* categories a whole new discourse came into being? Using acronyms such as PTSD for Posttraumatic Stress Disorder and DID for Dissociative Identity Disorder, for example, creates an illusion of reality or permanence.³⁹ Studying secondary trauma, and naming it "STS," gives it legitimacy within medicine and science. But what is behind the move to document, revise, and categorize human experience? As Jesse asked, "Who benefits from labeling someone traumatized?"

DR. FELDMAN

Well, I think both clients and practitioners do. The *DSM* assists practitioners in diagnoses and treatment.

RUBY

But how does naming our experiences “STS” help us? Don’t psychiatrists use the *DSM* as a symptom checklist? Should our personal experiences of STS be understood in this way? Doesn’t the development of measures of STS bring the phenomenon into being and doesn’t STS then become legitimized because it has been documented by empirical science? And, more importantly, who benefits from this label, this diagnosis? Medical science and insurance companies benefit. Psychiatrists and other mental health professionals are compensated by insurance companies, billing hours must be documented and diagnoses must be given according to the *DSM* in order to get reimbursed for treatment delivery. Also, developing theories on STS benefit scientists as they gain legitimacy within the medical field through book publications and speaking engagements. So, there is a systemic benefit in naming the experience “a disorder.” Are you not contributing to this with your own research study, Dr. Feldman?

DR. FELDMAN

Yes, I am Ruby. I have earned a degree and recognition in traumatology. And, yes, I am colluding with the psychiatric discourse by considering your experiences STS. However, I believe my research offers a different view from a positivist, medical model. By using narrative as a form of inquiry, I hope that this study will be more personal, collaborative, and reflexive. I have not tried to present a universal view on STS. I am not saying that there is one experience here, the STS experience. I have not tried to give a definitive account as to causation. I think I pose as many questions as I do answers. I am trying to show that knowledge is local, situated, partial, and shifting. My hope is that this research will bring a personal, experiential component to the existing literature because of the construction of your stories. But let me throw these questions out to the group. Where should the research go from here? What do you think should be addressed in future research?

DONNA

As I mentioned in my story, I think participants should be asked to describe their experiences of being secondarily traumatized by concentrating on one particular case or one critical incident. Perhaps future research could be developed through a critical incident framework. I think it would be much easier for the participant.

ANNA

I think future researchers need to include diversity in their narrative accounts. What stories would be told if the researcher attended to differences in gender, race, economic class, sexual orientation, age, and ableism?

MARIE

[not acknowledging being part of a focus group already]

Well, I am interested in the collective story. I wonder what types of stories would be constructed if you conducted focus groups. It would be interesting to find out both the commonalities and differences in experience among a group of trauma counsellors. How does the collective story differ from the individual story? This type of research could also have practical applications if conducted as action research by studying a single work site where work environment factors could be included in the research.

JESSE

I wonder if secondary trauma exists in other fields of counselling. Do school counsellors, career counsellors, grief and loss counsellors, and family counsellors, for example, become secondarily traumatized in their work? How do they experience job stress? Do they tell similar or different stories? Is this phenomenon, secondary traumatic stress, exclusively experienced by trauma counsellors?

DONNA

I would like to see more research on the resiliency side of trauma recovery. When

trauma counsellors are not secondarily traumatized, what kinds of stories do they narrate? What are the resiliency stories about?

RUBY

I have wondered about the existence of a tertiary level of trauma. If we believe that trauma is contagious, then isn't it possible that the researcher may become traumatized from listening to participants tell stories about their secondary trauma? Does a tertiary form of trauma exist? Perhaps we should also be studying the effects on trauma researchers in the field. This idea could also be extended to trial lawyers and judges who listen to secondhand accounts of trauma stories from witnesses, such as psychiatrists.

DR. FELDMAN

Well, I am afraid we have run out of time and we must end here. I love the line from Mary and Kenneth Gergen who write about ending qualitative research studies: "In principle the spiral knows no boundaries; with socially reflexive research, one need never say goodbye."⁴⁰ I thank each of you for your time, your openness, your courage, and your generosity in sharing your lives with me and each other. I sincerely appreciate your participation in this research project.

After the women have left her office, Dr. Feldman writes a final entry in her research journal, dated October 1, 1997:

Well, it's finished. I wonder how these women benefitted from this study? Perhaps by telling their stories they were confirmed and affirmed. I believe that telling this story--both their stories and my story--is a way to construct meaning through the reflexive demands of the research. I'm left here still wondering about some of the difficult questions. Why do children have to suffer? Why can't we prevent violence? What does it all mean? I have come to realize through their stories and my own that it seems to be about living in the paradox, living with ambiguity. At some point, we

arrive at an acceptance that it just *is*. Life goes on.

Being involved in this research project was also a study about self—the researcher self. Butting up against my participants' lives gave new form to my own. I came to understand what *being* a constructivist actually means in my life. If we are constantly creating ourselves, then notions of morality and ethics are not fixed, not stable, but are in constant motion and flux. I do have a choice about what beliefs I hang on to. Reconstituting ourselves is never an easy task. It requires reflexive vigilance, self-knowledge, honesty, courage, and desire.

ENDNOTES

1. Janoff-Bulman., 1992.
2. Pearlman & Saakvitne, 1995.
3. Van der Kolk, 1994.
4. Herman, 1992.
5. Courtois, 1988.
6. Herman, 1992, pp. 7-8.
7. Figley, 1995.
8. Culbertson, 1997.
9. Terr, 1992.
10. Figley, 1995.
11. Stamm, 1995.
12. Herman, 1992.
13. Wilson & Lindy, 1994.
14. Jacobs, 1991.
15. Yassen, 1995.
16. Pearlman & Saakvitne, 1995, p. 17.
17. Wilson & Lindy, 1994.
18. Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995.
19. Wilson & Lindy, 1994.
20. Wilson & Lindy, 1994, p. 2.
21. Wilson & Lindy, 1994, p. 12.

22. Pearlman & Saakvitne, 1995.
23. Pearlman & Saakvitne, 1995, p. 335.
24. McCann & Colletti, 1994.
25. Pearlman & Saakvitne, 1995.
26. Herman, 1992.
27. Wilson & Lindy, 1994, p. 11.
28. Maroda, 1991.
29. Herman, 1992.
30. van der Kolk, 1994, p. ix.
31. Danieli, 1984.
32. Chrestman et al., 1994; Kassam-Adams, 1994; Munroe, 1995.
33. McCann & Colletti, 1994.
34. Munroe, 1995.
35. Yassen, 1995.
36. Munroe, 1995.
37. Finkelhor, et al., 1990.
38. Pope & Feldman-Summers, 1992.
39. Hacking, 1995.
40. Gergen & Gergen, 1991, p. 93.

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APPENDICES

Appendix A: Pilot Study Participant Consent Form

I, _____, voluntarily consent to participate in a pilot study examining trauma counsellors' experiences of being secondarily traumatized by their work with trauma survivors.

I understand that this interview will be approximately two hours in length and will be audiotaped.

I understand that the information on the audiotape is confidential and that my identity will not be made know and will remain anonymous.

I understand that the information gained from the interview is for the researcher's use only and that the material from this interview **will not be used** in the actual research study without my permission.

I also understand that I can stop the audiotape at any time, that I can withdraw my participation voluntarily at any time, and that confidentiality and my anonymity will be preserved.

It is my understanding that the audiotapes and any transcriptions of this audiotape will be destroyed upon completion of the pilot study.

Therefore, I give my permission to the researcher, Marla Arvay, to audiotape my conversation with her and give permission to her to use this audiotape to help develop her research study on secondary traumatization.

Signature of Pilot Study Participant: _____

Date: _____

Signature of Researcher: _____

University of Victoria
Department of Psychological Foundations
Supervisors: Dr. R. V. Peavy
Dr. B. Harvey

Appendix B: An Invitation to Participate**AN: INVITATION**

September 18, 1997

TO: Trauma Counsellors**FROM:** Marla Arvay, Doctoral Candidate, University of Victoria**RE:** Secondary Traumatic Stress Among Trauma Counsellors

You are invited to participate in a doctoral research project entitled, "Secondary Traumatic Stress Among Trauma Counsellors." Over the next few months, I will be interviewing counsellors working in the field of trauma from different parts of British Columbia. The purpose of this project is to gain a better understanding of secondary or vicarious trauma from those who experience it first hand.

You may be asking yourself: "Why should I participate in this study?" Your participation is essential because right now there is very little research that helps guide the training of counsellors in the field of trauma and we need this information to inform our practices and to help develop preventative measures. It is time to speak directly to those most affected by this work. Participants involved in this research will be interviewed 2 or 3 times for approximately one to two hours, and will be asked to carefully read their transcripts with a maximum commitment of eight hours. Your anonymity will be guaranteed and confidentiality will be strictly maintained. Participation is also voluntary and you may withdraw at any time.

Please seriously consider this invitation and the important contribution you could make to the field of trauma. I look forward to hearing from you and discussing this topic with you should you decide to volunteer.

Sincerely,

Marla Arvay, Doctoral Candidate
Department of Psychological Foundations
University of Victoria
Telephone: (250) 721-7211

Appendix C: Participant Consent Form**CONSENT TO PARTICIPATE FORM**

I, _____, consent to participate in a study examining trauma counsellor's experiences of being secondarily traumatized by their work with trauma survivors.

I understand that my participation in this study is completely voluntary and that I can withdraw from the study at any time without explanation. I also have the right to refuse to answer any questions that I do not wish to answer.

I am aware that I will be interviewed three times for approximately 1 to 2 hours by the researcher and I will be asked open-ended questions regarding my story about my struggles with being secondarily traumatized in my work with trauma survivors. I also understand that I will be asked to read the transcriptions from these interviews and will be asked to make notes and comments in order to assist the researcher in developing narratives on secondary trauma.

I understand that these interviews will be audiotaped and transcribed and that any data collected in this study will remain confidential and the transcriptions and notes will be kept in a locked filing cabinet in the researcher's office. Only the researcher will have access to the data and my name will not be attached to any published results, and anonymity will be protected by using a code number to identify results obtained from my participation. I understand that this signed consent form will be stored separately from the research data in order to protect my anonymity. On completion of this study, I understand that any identifying information will be destroyed. In addition, the results of this study, published or unpublished, will in no way identify me.

Signature of Participant _____

Date _____

Signature of Researcher _____

University of Victoria

Department of Psychological Foundations

Supervisors: Dr. R. V. Peavy

Dr. B. Harvey

Appendix D: Audiotaping Consent Form**AUDIOTAPING CONSENT FORM**

I, _____, voluntarily agree to the audiotaping of my discussion with Marla Arvay on the topic of secondary traumatic stress. I understand that the purpose of the research project is to understand the lived experiences of trauma counsellors who have struggled with being secondarily traumatized by their work with survivors of traumatic life events. I understand that the information on the audiotape is confidential and that my identity will not be made known to the readers or other participants of this research project. I understand that the excerpts of the conversations may be reviewed by persons other than the principal researcher and I give my permission to audiotape my conversations and give permission to use these audiotapes as research data on the understanding that my participation is voluntary, that I can stop the audiotape at any time, and that anonymity and confidentiality will be preserved.

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

Appendix E: Instructions to Participants

TO THE PARTICIPANTS

Attached you will find your transcript from our first interview. The next step in this research process is to interpret the transcript--our audiotaped conversation on secondary trauma. I will refer to the transcript as "text," "script," and "narrative" interchangeably throughout these instructions.

The following is a guide to assist you in interpreting the text. This process entails at least four readings of the text and perhaps more as the research process unfolds. I am asking you to be the interpreter of your own transcript. The purpose of each reading is to approach the text from a different standpoint.

Read the instructions carefully and if you have any questions please call me. It would be helpful to me if you could return the interpreted text to me within the next month [mid-January would be great] but this is a guideline; feel free to work at your own pace. If there are other readings that you would like to engage in, please call me in order that I may do the same so that our interpretive processes coincide.

Upon completion of the interpretive process we will meet again for the second interview to compare our interpretations and to develop the final narrative for the dissertation.

Thank you for your generous time and commitment to this project. I hope you have some rest and relaxation over the holidays and I look forward to getting together again in the New Year.

Sincerely,

Marla Arvay