Heuristic Study of Trauma Therapists and Vicarious Trauma

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ABSTRACT

Trauma therapists are the recipients of client survivor stories. The ongoing exposure to survivor stories can lead to similar trauma symptoms as those experienced by the survivor themselves. This experience can be referred to as vicarious traumatization (VT). Ameliorating these affects is essential for the health of the therapist and for the future clients of the VT therapist. This study used a qualitative heuristic methodology. Five-trauma therapists were interviewed as to their experience of VT and helpful ways to ameliorate the affects.

Vicarious traumatization was identified as impacting all of the research participants. Alterations in world view schemas, specifically around the world being a safe place was noted as being vulnerable to VT. Research participants identified the trauma agency as having a substantial affect on their experience of VT. Personal history, resiliencies, spirituality, and self-care strategies also affected their experience of VT.

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Chapter 1: INTRODUCTION

Research on trauma has focused almost exclusively on the person who is directly traumatized. In the past few decades, however, research has begun to examine the effects on family, friends and therapists who experience the trauma secondarily. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) defines post *traumatic stress disorder* (PTSD) in these terms:

> The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves threatened death, actual or threatened serious injury, or other threat to one's physical integrity; 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 (American Psychological Association, 1994, criterion A1, p. 425).

Limited research has supported the notion that a trauma therapist who is empathically engaged with a client will become vicariously traumatized and experience symptomology similar to that of the trauma survivor. These effects have been tracked mostly through an examination of symptoms shared by trauma therapists. *Vicarious traumatization* (VT) is a term offered by McCann and Pearlman (1990) to describe this phenomenon and includes a personal transformation in cognitive schemas and belief system for the trauma therapists. This study focuses on the experience of (VT) by trauma

therapists and includes what they have found to be helpful in ameliorating the effects.

What internal and external resources are helpful to therapists exposed to secondary trauma? Why is it that some trauma therapists are able to continue working in this challenging field and others are not? How can trauma agencies and counsellor educators understand the phenomenon of VT and provide education and support for therapists? What can therapists personally do to ameliorate the effects? This study adds to the current knowledge by exploring the trauma therapist's needs, so that further support can be given to ameliorate the effects of VT.

The study was designed to address the phenomenon of VT as experienced by trauma therapists working at a specialized agency. It was an exploratory search, conducted by interviewing five participants. A heuristic, descriptive, qualitative methodological approach was employed throughout the study from conception to analysis and reporting of results.

Chapter 2: LITERATURE REVIEW

The Effects of Trauma on the Trauma Therapist

The experiences of traumatized persons have been investigated for a long time. In what way has the trauma changed their lives? How have the survivors made their way through the trauma? What was helpful in this process? What parts were especially challenging? These questions focus primarily on the traumatized person and exclude others who were traumatized indirectly or secondarily. "Yet, descriptions of what constitutes a traumatic event (i.e. category A [criterion] in the DSM-III and DSM-III-R[1] descriptions of PTSD clearly indicate that mere knowledge of another's traumatic experiences can be traumatizing" (Figley, 1995, p. 5). Therefore, working as a therapist with people who have been traumatized will eventually have an effect on that therapist. Consider Figley's (1995) assertion that, "there is a cost to caring" (p. 1). Accordingly, the cost of caring has been identified as secondary traumatic stress or compassion fatigue. Figley (1995) defines "secondary traumatic stress as the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). Figley also includes the concept of empathy in his explanation of

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[1]DSM-III = Diagnostic and Statistical Manual of Mental Disorders (3rd ed.); DSM-III-R= Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.)

secondary trauma. If we are not empathic with the trauma survivor, we will not understand the person's experience of being traumatized. Empathy opens a window from our experience to theirs, which in turn presents the opportunity to be traumatized (Figley, 1995). McCann and Pearlman (1990) also include empathy as central to their concept of VT.

Vicarious traumatization goes beyond the concept of secondary traumatization by also taking into account changes in cognitive schemas and belief systems. McCann and Pearlman (1990) present a comprehensive view of VT being the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material. The transformation includes "personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life" (Pearlman, 1995, p. 51). Increasingly, therapists are being called upon to assist survivors of trauma. Listening to reports of horror, human cruelty, and extreme loss can be overwhelming. Therapists may begin to experience feelings of fear, pain, and suffering similar to those of their clients, and to experience similar trauma symptoms, such as intrusive thoughts, nightmares, and avoidance, as well as changes in their relationships with their families, colleagues, and the wider community. They may themselves come to need help and assistance to cope with hearing about others' trauma experiences (Figley, 1995; Pearlman & Saakvitne, 1995; Sexton, 1999; Wilson & Lindy, 1994).

> The symptomologies of the trauma therapists are nearly identical to post traumatic stress disorder except that exposure to a traumatising event experienced by one person becomes a traumatising event for the

> second person. Thus, the secondary traumatic stress disorder symptoms are directly connected to the person experiencing primary traumatic stress (Figley, 1995, p. 11).

The client who has been originally traumatized is not being assigned blame for the traumatizing effects his story has on the trauma therapist. The secondary traumatizing effects are instead seen as an occupational hazard (Munroe et al., 1995; Pearlman & Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1995). "It [VT] reflects neither pathology in the therapist nor intentionality on the part of the survivor client" (Pearlman & Mac Ian, 1995, p. 558).

Exposure to children's trauma may be especially provocative for therapists and trauma workers (Figley, 1995). Dyregrov and Mitchell (1992) acknowledged several aspects of working with children that make it difficult for helpers. These challenging aspects include the powerful emotions elicited in work with child survivors, such as feelings of helplessness (Coppenhall, 1995), rage, desire for retaliation, and disbelief in humans' capacity for cruelty (Brady, Guy, Poelstra, & Brokaw, 1999). Intrusive imagery has been noted to be more prevalent in workers who are exposed to trauma experienced by a child. Identification with the victim might be stronger when working with children. This may occur because most helpers have personal relationships with children; they easily imagining their own children suffering the same fate (Dyregrov & Mitchell, 1992). Childhood trauma may also affect therapists to a greater degree because of our own memories of childhood. "Over identification may be a pitfall in working

with traumatized children because we can easily remember the intensity of our own childhood fears and vulnerabilities" (Brady et al., 1999, p. 387). In this study the McCann and Pearlman's (1990) concept of VT as a conceptual framework for understanding the impact of sexual abuse treatment on the therapist will be employed.

Burnout and Counter transference

When identifying VT it is helpful to know what it is not. *Burnout* is a term which some may view as encompassing the problems faced by workers with job stress. Definitions of burnout include it being a "syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people work of some kind" (Maslach, 1976, p. 3). According to Pines and Aronson (1988) burnout is a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations. Mental exhaustion is generally thought to signify burnout.

"From a social learning theory (Rotter, 1954) point of view, burnout might be conceptualized as the state in which one's minimal goals are too high and are not changed in response to feedback" (McCann & Pearlman, 1990). Symptoms of burnout have been described as depression, cynicism, boredom, loss of compassion, and discouragement (Freudenberger & Robbins, 1979).

Burnout refers to the psychological strain of working with difficult populations (McCann & Pearlman, 1990). Victims may be seen as more

challenging or "difficult" and produce symptoms of burnout in mental health professionals for a number of reasons. Victims of undisclosed trauma may require long-term therapy and be difficult to treat. Trauma victims may also avoid or be reluctant to focus on traumatic memories, which can cause potential frustration for the therapist. Finally, therapists who view victimization as a reflection of social and political problems may feel helpless and hopeless about the potential impact of individual psychotherapy upon the underlying causes of crime and violence (McCann & Pearlman, 1990). McCann and Pearlman (1990) believe that burnout may be the common pathway between the therapist's continual exposure to traumatic material that cannot be assimilated or worked through and the trauma survivor's numbing and avoidance patterns that reflect an inability to process the traumatic material.

Although the burnout literature is relevant to working with trauma victims, the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of suffering and cruelty that are characteristic of serious trauma (Danieli, 1981; Haley, 1974; McCann & Pearlman, 1990). Burnout is also different from secondary traumatic stress because burnout emerges gradually and is a result of emotional exhaustion, whereas secondary traumatic stress can emerge suddenly and without much warning (Figley, 1995). Sexton (1999) states that secondary traumatic stress also appears to have a faster recovery rate than burnout. McCann and Pearlman, who conceptualized VT, concluded that the effects on the therapist are pervasive, cumulative, and likely permanent. It is their

(McCann & Pearlman, 1990) belief that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on their feelings, relationships, and life.

In the context of psychotherapy *countertransference* can be regarded as the distortion of judgment on the part of the therapist due to her or his life experiences, and is associated with her or his unconscious neurotic reaction to the client's transference (Freud, 1959). The therapist's material becomes stimulated through the process of seeing oneself in the client, of overidentifying with the client, or of meeting needs through the client (Corey, 1991). According to Pearlman and Saakvitne (1995) countertransference is defined as:

> (1)The affective, ideational, physical responses a therapist has to a client, his clinical material, transference and re-enactments.
>
> (2)The therapist's conscious and unconscious defences against affects, intrapsychic conflicts and associations aroused in the former (p. 23).

The most comprehensive models of countertransference reactions among therapists who work with victims include those of Danieli (1981). She worked with therapists of Holocaust survivors, who found empirical validation for "themes of guilt, rage, dread, horror, grief and mourning, shame, inability to contain intense emotions, and utilization of defences such as numbing, denial, or avoidance" (McCann & Pearlman, 1990, p.135). Lindy (1988) identified a number of symptom patterns that emerged in therapists working with Vietnam veterans. "These symptoms included nightmares, intrusive images, re-enactments, amnesia, estrangement, alienation, irritability, psycho physiologic reactions, and survivor guilt"

(McCann & Pearlman, 1990). Figley (1983) discusses a concept of secondary victimization, which describes the experience of people close to the victims, such as family members, who may suffer signs and symptoms of traumatization similar to those of the victim. Overall, it appears that exposure to the traumatic experiences of victims may be hazardous to the mental health of people close to the victim, including the victim's therapist (McCann & Pearlman, 1990).

Countertransference is present in all therapies, representing the therapist's conscious and unconscious responses. It is specific to a given client and the particular therapist client dyad, and is related to personal conflicts and psychological needs within the therapist (Pearlman & Saakvitne, 1995, p. 33). Figley (1995) states that the secondary traumatic stress concept includes, but is not limited to, countertransference reactions. Vicarious traumatization is specific to trauma therapy and is the result of an accumulation of experiences across therapies (Pearlman & Saakvitne, 1995). Its effects are felt beyond a particular therapy relationship, both in other therapy relationships and in the therapist's personal and professional life. Vicarious Traumatization is permanently transformative, while counter transference is temporally and temporarily linked to a particular period, event, or issue in the therapy or in the therapist's inner or external life as it interacts with the therapy (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Sexton, 1999).

Vicarious Traumatization

The concept of VT (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) has similarities to countertransference and burnout. It is

also distinct, and is based on constructivist self-development theory. "The underlying premise is that people construct their own personal realities through the development of complex cognitive structures which are used to interpret events (e.g., Epstein, 1989; Mahoney, 1981; Mahoney & Lyddon, 1988)"(McCann & Pearlman, 1990, p. 137). This perspective is interactive in that it views the therapist's unique responses to client material as shaped by both characteristics of the situation and the therapist's individual psychological needs and existing cognitive schemas (McCann & Pearlman, 1990). Hollon and Garber (1988) have suggested that when an individual is confronted with a schema-discrepant event, the person can either change or reinterpret the event so that it is congruent with schemas, which is called *assimilation*, or alter schemata to incorporate the new information provided by the event, which is called *accommodation* (Astin, 1997). The process includes the likelihood of *overaccommodation*, or changing the belief system too much. An example of this is a therapist who has a change in cognition about others, especially regarding safety, trust, and esteem. Astin (1997) shares her personal experience as a trauma therapist who noticed changes in cognition only after she had changed the locks in her home for better ones, began to always lock the car doors when driving, and was more careful with whom she spoke in public. Astin found herself "wondering why that guy is walking toward me and clutches keys ready to strike out if I have to; questioning the motives of others much more readily and never assume they mean me no harm"(Astin, 1997, p.106). Astin (1997) sees a positive side to this change in cognitions', she has learned "that bad things can happen, there is danger out there, not everyone can be trusted"(p. 107). This

is accommodation. The danger is the insidious slide into overaccommodation in which the cognition changes to bad things always happen, there is no goodness in the world or in others, and no one merits trust.

Vicarious traumatization is a natural response to a very specialized kind of highly demanding work. Working with traumatized people can be distinguished from working with other people because of the clinician's exposure "to the emotionally shocking images of horror and suffering that are characteristic of serious trauma" (McCann & Pearlman, 1990, p. 134). "Our clients' vivid and sometimes graphic descriptions of their brutal victimization, while it is often essential to their healing for clients to share specific traumatic images, we can carry these with us and they may at times appear to us, unbidden, as clear as our own internal images" (Pearlman & Saakvitne, 1995, p. 32). As therapists repeatedly witness their traumatized clients' experience, they open themselves up to personal transformations. "Just as survivor clients have developed various ways of protecting themselves as a result of childhood victimization, so do therapists develop styles of protecting themselves from repeated exposure to trauma material in the work" (Pearlman & Saakvitne, 1995, p. 280). Unfortunately, these adaptations are not necessarily in the best long-term interest of the therapist, the therapy, or the client.

Frame of Reference

Identity

Pearlman and Saakvitne (1995) suggest, "the most disturbing and enduring alteration for the trauma therapist is the inevitable transformation in his identity, worldview, and spirituality" (p. 283). Therefore, how an individual views, experiences, and interprets the world will be altered due to continual exposure to clients' trauma material. Vicarious traumatization causes a disconnection to one's usual experience of self (Pearlman & Saakvitne, 1995). Examples of this are therapists who hear themselves making callous or cynical retorts to clients or colleagues, have dreams in which they engage in sadistic behavior towards clients' perpetrators or clients, or feel alienated from themselves (Pearlman & Saakvitne, 1995). Vicariously traumatized therapists may also find it too easy to move into one's head, to become a thinking rather than a sensing being. This may occur in order to manage the onslaught of emotions connected to trauma therapy (Pearlman & Saakvitne, 1995). Hearing about sexual abuse affects the therapist's sexual experience and integration of sexuality into personal identity. Trauma therapists might ask what it means to enjoy sexual intimacy when so many people have been terrorized and abused sexually (Pearlman & Saakvitne, 1995). Therapists may also feel isolated in social situations if people recoil from them when they answer the innocent question of what kind of work they do. Public identity as trauma therapists can also prevent them from taking a break from work (Pearlman & Saavitne, 1995). Although some people may recoil, others will share their own thoughts, or even disclose a history of sexual abuse.

Worldview

Beliefs, expectations, and assumptions about the world are central to many current notions about the effects of victimization (McCann & Pearlman, 1990). Janoff-Bulman (1985) has said that victimizing life events challenge three basic assumptions about the self and the world. The first is the belief in personal invulnerability; the second is the view of oneself in a positive light; and the third is the belief in a meaningful, orderly world. Vicarious traumatization may lead to the same effects on therapists as those experienced by victims. *Just world theory,* as developed by Lerner (1980), states that most people have a belief or schema that the world is just and fair. "That means that good things happen to good people and bad things happen to bad people" (Astin, 1997, p.105).

> As the therapist listens repeatedly to tales of intentional abuse of children, he may feel overwhelmed by the scope and prevalence of child abuse and cruelty...the therapist may change his worldview, as he loses sight of the profound difference he and a single relationship can make. This change in worldview defeats the therapist's greatest therapeutic gift, the belief in the process and hope for healing (Pearlman & Saakvitne, 1995, p. 285).

A therapist with a disrupted worldview might believe that people are fundamentally self-serving or evil. This therapist might be suspicious of every parent seen with a child in a store or at a park (Pearlman & Saakvitne, 1995).

Spirituality

The work of trauma therapists continuous calls into question issues of meaning. Trauma therapists may easily enter into a state of hopelessness or despair, feeling profound existential isolation and loneliness (Moustakis, 1961). A therapist may experience emotional numbing as a response to painful feelings. Therapists' insight into their innermost thoughts and feelings and willingness to be open to all aspects of life can diminish as they pull back in order to protect themselves. "As a therapist comes to rely on denial, intellectualization, isolation of affect, dissociation, and projection, his capacity to connect to himself and others will diminish" (Pearlman & Saakvitne, 1995, p. 287).

Self Capacities and Ego Resources

Self-capacities allow an individual to maintain positive self-esteem and a consistent sense of identity. Self-capacities also help individuals manage and express strong affection. Vicarious traumatization may cause a therapist to be overwhelmed with extreme emotion, feel self critical, and be filled with anxiety (Pearlman & Saakvitne, 1995). A therapist who is vicariously traumatized may find it more difficult to tolerate, integrate, and be alone with intense feelings. Impairments in self-capacities result in difficulty in self-soothing. The traumatized therapist may turn to external sources of comfort, relief, or numbing, such as overeating, overspending, overwork, television, and increased alcohol consumption (Pearlman & Saakvitne, 1995).

A variety of maladaptive behaviours can emerge when ego resources are impaired. These include overwork, decision-making difficulties, a lack

of sensitivity to personal needs, and a lack of interest in others. A therapist who has impaired ego resources may make poor choices with regard to workload and achieving balance in life, be less introspective and have limited access to personal cognitive abilities, lose a sense of prospective, be unable to empathize with clients, and focus on content to the exclusion of process (Pearlman & Saakvitne, 1995).

Psychological Needs

The same psychological needs that are sensitive to disruption by trauma are susceptible to the effects of VT. These needs include safety, trust, esteem, intimacy, and control.

Safety

Images involving a loss of safety, including threats or harm to innocent people, may alter the therapist's schemas in the area of safety (McCann & Pearlman, 1990). Therapists who are repeatedly exposed to details of their clients' sexual abuse may begin to question the safety and benevolence of the world. The world may appear dangerous and threatening, especially for children: their own, children they know, or children in general (Cunningham, 1999; Pearlman & Saakvitne, 1995). Therapists often report having nightmares that reflect a loss of safety. A disrupted sense of safety can also lead to hypervigilance and an expectation of victimization (Pearlman & Saakvitne, 1995).

Trust

When trust in oneself is disrupted, the individual is less able to be independent. This person can no longer trust his perceptions of other people, social situations, or feelings. This individual may rely more heavily upon

others to meet his needs. A therapist whose trust schema has been affected may have a difficult time with boundaries, trusting too much or not at all. Behaviors include not going out, dropping community involvement, and disengaging from relationships (Pearlman & Saaakvitne, 1995).

Esteem

Vicarious traumatization can lead to a more negative sense of self-esteem. A therapist might ask, "If I can't help other people, then what good am I?" All the roles a person plays can be affected by this alteration of schema (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Impairment in esteem for others is likely caused by the work engaged in by trauma therapists. "Clinicians who work with sexually abused clients hear about terrible acts brought about by another human being, often one who is charged with the care, protection and nurturance of the child" (Cunningham, 1999, p. 281). Hearing story after story of people who acted cruelly, selfishly or neglectfully can cause a devaluation of others. Loss of self-esteem and of esteem for others decreases both the therapist's connection with self and with others (Pearlman & Saakvitne, 1995).

Intimacy

By working with sexual abuse trauma, therapists become aware of human cruelty. Trauma therapists working with survivors may experience a sense of alienation resulting from exposure to horrific imagery and cruel realities (McCann & Pearlman, 1990). Protecting oneself from cruelty can lead to emotional numbing. This in turn blocks feelings of intimacy with the self and others. Survivors may also feel stigmatized by their experiences. The therapist may share an uncomfortable sense of separateness from family

and/or friends. This sense of separateness is compounded by psychotherapy's requirement of confidentiality.

Control

Persons who have been victimized often find themselves in situations of extreme helplessness, vulnerability, or even paralysis. Exposure to these traumatic situations through the client's memories and stories may evoke concerns about the therapist's own sense of power or efficacy in the world (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Therapists who have a disruption in control schema may try to compensate for their clients' helplessness through an increase of control in their own lives, or conversely, may surrender control in situations where control is appropriate and possible. This may occur as therapists accept the helplessness in their clients' experiences of abuse (Pearlman & Saakvitne, 1995).

Sensory System

Therapists may experience disruptions in their own sensory systems. "A hallmark of Vicarious Traumatization is the intrusion of clients' violent sadistic imagery into the therapist's own inner life" (Pearlman & Saakvitne, 1995). Kassam-Adams' (1995) research documented therapists' reports that pictures of their clients' sexual abuse kept popping into their heads. It is not uncommon for trauma therapists to find their own sexual experience abruptly interrupted by the intrusive images or body sensations described by the client (Pearlman & Saakvitne, 1995). The intrusive imagery, often images of those scenes that survivor clients have described vividly, connects in some way with therapists' own psychology (McCann & Pearlman, 1990; Pearlman, 1995; Pearlman & Saakvitne, 1995). "Imagery that is the most

painful to therapists often centres around the schemas related to the therapist's salient need areas" (McCann & Pearlman, 1990). A therapist for whom safety is salient would likely recall those images that are associated with threat and personal vulnerability.

Therapists may also experience bodily sensations paralleling those described by clients. Therapists have described feeling genital pain, numbing of various body parts, and other strange physical sensations during sessions with sexual abuse survivors and dissociative individuals (Pearlman & Saakvitne, 1995). Trauma therapists may develop sensitivity to other sensory experiences, such as certain sounds or smells. These responses are more likely in people in whom these sensory modalities are more highly developed than the imagery system (Pearlman & Saakvitne, 1995).

It is clear that unaddressed VT can be hazardous to the trauma therapist, and all of his or her personal and professional relationships. Vicarious traumatization also provides the therapist with unparalleled opportunities for personal and spiritual growth. "When aware of the risks, therapists can work to minimize the deleterious effects and maximize the positive transformative effects of their profession on all aspects of their selves" (Pearlman & Saakvitne, 1995).

Research on the Effects of Trauma Work on the Therapist

It has only recently been acknowledging that it is not only the trauma survivor who is impacted by the trauma experienced. Figley (1986) wrote about survivor family members who were exhibiting symptoms of PTSD but had no direct exposure to the trauma. It appeared that the experience of being in a family with someone who was traumatized might be enough to

elicit post-traumatic stress symptoms in people. Danieli (1988) examined countertransference reactions of therapists working with very traumatized people, noting that there were common themes that emerged.

Danieli (1988) studied the countertransference reactions of therapists working with survivors of the Nazi Holocaust and the survivors' children. Danieli (1988) conducted in-depth interviews with 61 trauma therapists to examine the nature of their emotional responses and other problems experienced in connection with their work. Content analysis of the interviews resulted in 49 countertransference themes emerging. The most frequently reported themes included therapist defences (numbing, avoidance, denial, distancing), bystander guilt, rage, shame, horror, grief, privileged voyeurism, and casting the client as victim or alternatively as hero. Survivors and their children have frequently complained of neglect or avoidance of their Holocaust experiences by mental health professionals. The phrase *conspiracy of silence* has been used to describe this phenomenon (Danieli, 1988). Psychotherapists frequently reported feeling horror and dread. " I dread being drawn into a vortex of such blackness that I may never find clarity and may never recover my own stability so that I may be helpful to this patient" (Danieli, 1988, p. 229). Therapists reported deep sorrow and grief during and after sessions with survivors and their families. A few psychotherapists found themselves sharing the nightmares of the survivors they were treating, and some therapists attempted to avoid listening to pain and suffering by asking questions, that is moving away from the felt experience (Danieli, 1988). Therapists who were unable to contain these powerful, intensely painful feelings in themselves and in their patients

became intolerant or immobilized. "They were, therefore, unable to provide a holding environment in which survivors and/or their offspring could begin to grieve and mourn personal losses, a necessary healing process for them and their families" (Danieli, 1988, p. 230). Until similar research is replicated for therapists who work with other traumatized populations, it remains unclear as to how specific these countertransference themes are to working with Holocaust survivors, and how generalizable they are to working with other traumatized populations (Sexton, 1999).

Pearlman and Mac Ian (1995) gave a questionnaire to136 self-identified trauma therapists who volunteered to participate in a study investigating the effects of trauma work on therapists. This research examined trauma therapists' exposure to clients' traumatic material as well as the therapists' psychological well-being. Pearlman & Mac Ian (1995) found that those therapists who had a personal experience of trauma in their lives reported greater disruption than did those without a personal trauma history. Kassam-Adams (1995) also found a significant correlation between a therapist's personal history of trauma, particularly childhood trauma, and trauma symptoms. Therapists with a personal trauma history were also more adversely affected by a greater length of time doing the work and by the percentage of trauma survivors in their overall caseload. Of the sample, 60% reported a history of personal trauma. Pearlman and Saakvitne (1995) suggest that therapists with a history of trauma are attracted to working with trauma survivors. Although their own experiences may give them greater sensitivity and insight into the effects, needs, and defences of trauma clients, it may also make them more vulnerable to VT. Novice therapists in the

trauma history group experienced the most severe difficulties. Experienced therapists in the trauma history group had less disrupted schemas. Pearlman and Mac Ian (1995) wonder if this occurs through self-selection, that is, therapists with more disrupted schemas leave the field earlier, or because "survivor therapists who enter this field in order to find meaning in their own trauma actually accomplish this goal through their work, and then they demonstrate a resolution of previously disrupted schemas" (p. 563). Experienced therapists without a trauma history reported greater disconnection from their own inner experience. "This may be a therapist's way of not feeling as much pain related to the work" (Pearlman & Mac Ian, 1995, p. 563). Furthermore, they reported lower concern for others, probably due to constant exposure to the effects of human cruelty. Clearly, these effects are likely to have an undesirable impact on therapists' relationships with clients, with others, and on their own inner lives.

Chrestman (1995) used a survey methodology in which questionnaires were mailed to therapists belonging to the International Society for Traumatic Stress Studies, the International Society for the Study of Multiple Personality and Dissociation, and the American Association of Marital and Family Therapists. These questionnaires were designed to assess personal and professional history, psychological symptoms, cognitive schemata, coping behaviors, and behavior changes. Chrestman (1995) predicted that therapists reporting secondary exposure to trauma would show more distress symptoms, that is, more negatively valenced cognitions on measures of cognitive schemata, than therapists who do not report secondary exposure. It was also expected that relevant personal and contextual variables would

influence the relationship between secondary exposure and negative outcome. Results were mostly supportive of these expectations. " A predictable relationship between secondary exposure and psychological distress change was demonstrated" (Chrestman, 1995, p. 31). Secondary exposure to trauma was associated with increased symptoms of intrusion and avoidance on the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) as well as increased symptoms of dissociation and sleep disturbances. The scores indicated a level of distress significantly different from that of therapists who did not experience secondary exposure but were not reflective of symptomatology in the clinical range (Chrestman, 1995).

Chrestman (1995) found that therapists experiencing secondary exposure were more likely to report slight increases in trauma-related symptomatology and to report increased efforts to protect themselves and their families from harm. As professional experience, income, and post-graduate training increased, symptom reports decreased. Other risk factors associated with increased symptoms were higher ratios of clinical versus nonclinical activities and higher percentages of trauma clients in the caseload. Therefore, the increase in symptomatology appears to be related to both the percentage of time spent in clinical activities generally and time spent with trauma clients specifically.

Many therapists in this study reported episodes of extreme distress from which they recovered, but which were very intense and overwhelming to them for a short period of time. For most of these therapists, more extreme distress after secondary exposure to trauma appeared to be an acute rather than a chronic phenomena from which they were able to recover

(Chrestman, 1995), although some in the sample experienced extreme and enduring distress related to secondary exposure to trauma. This was reflected in higher levels of symptomatology and was described as extreme distress and debilitating anxiety, which necessitated treatment and in some cases resulted in career changes (Chrestman, 1995). Although such excessive and long-lasting responses were few, they document an extreme form of secondary stress response.

Kassam-Adams (1995) studied the relationship between therapists' level of exposure to sexually traumatized clients and the therapists' own report of PTSD symptoms or more general work stress symptoms. The participants in the study were 100 masters or doctoral level psychotherapists in outpatient agencies who completed and returned self-report questionnaires. Therapists were asked about their workload and use of clinical supervision. They were asked to rate the emotional and technical support available to them at work. Participants were also asked whether in childhood or in adulthood they had ever experienced any of the following six types of trauma: physical abuse and maltreatment; emotional abuse; sexual abuse or assault; death of an immediate family member; home destroyed by fire or other natural disaster; or another kind of traumatic experience (Kassam-Adams, 1995).

Two outcome measures were included in the study. The first was a measure of general work-related stress and psychological distress. The second measurement was of trauma symptoms commonly found in PTSD; the measurement tool was the Impact of Event Scale (Horowitz et al., 1979). The results of this study provided empirical support for the notion of VT.

Therapists reported intrusive and avoidance symptoms related to their work with clients, that is, "I had waves of strong feelings about it", "Pictures about it popped into my head" (Kassam-Adams, 1995, p. 41). It was found that exposure to trauma clients is related to therapist PTSD symptoms. The research also demonstrated that the measure of general occupational stress symptoms was not related to the stressor of exposure to sexually traumatized clients and that exposure to other difficult types of client diagnoses was not related to the intrusion and avoidance phenomena of PTSD. These results strengthen the argument for a model of vicarious or secondary traumatization rather than general occupational stress or burnout in accounting for therapists' responses to trauma clients (Kassam-Adams, 1995). The results of this study point out the need for further examination of the role of gender and the therapist's personal history of trauma (particularly childhood trauma) as factors in the development of PTSD symptoms related to the work of psychotherapy with trauma clients. It appeared likely that gender and trauma history might be related to a self-selection of trauma work, the therapist's perceived vulnerability to the type of trauma material presented by clients, and the ways in which the therapist experiences his or her working relationship with trauma clients (Kassam-Adams, 1995). The finding that therapists with personal histories of trauma may be more susceptible to VT because of the potential memories and intense empathic responses elicited by clients' pain has received a significant amount of attention (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Johnson and Hunter (1997) tested the concept of VT (McCann & Pearlman, 1990) and assessed how counselors cope with the stress they experience in their counseling role. The research included comparing questionnaire responses of 41 sexual assault counselors and 32 counselors working in other, more general problem areas (Mental Health Services, Child and Family Services, Marital Counseling, Adolescent Services, Palliative Care, Drug and Alcohol Counseling, Developmental Disability Services, and Community Health). The study used the Maslach Burnout Inventory to measure psychological burnout and stress (Maslach & Jackson, 1984). The study also sought to identify counsellors' coping strategies. The last instrument used was a Beliefs and Values Questionnaire developed by the authors. "This questionnaire consists of a series of items concerning attitudes and beliefs about safety, trust, power, intimacy and esteem in the context of the role of a counsellor" (Johnson & Hunter, 1997, p. 321).

The results of this study show a difference between the two groups on the subscale of Emotional Exhaustion in the Maslach Burnout Scale. Other variables such as differences in training and work practices may also have an influence on counselor stress. The results also provide some support for the theoretical model of VT as proposed by McCann and Pearlman (1990). The results demonstrated two significant relationships: one with the Intimacy factor and the other with the Power factor. A disruption in the intimacy schema supports the belief that personal relationship difficulties at home are linked to problems encountered at work. In examining the disruption in the power schema, it is noted that sexual assault counselors often play an advocacy role for the client with large government agencies including

Welfare Departments, Police, and the Legal Courts yet have no real power within them. From anecdotal reports, this lack of control can leave the counselor feeling powerless and frustrated. Sexual assault counselors perceived a more negative change in control schema with regard to their perceptions of personal powerlessness. Sexual assault counselors were also found to use escape-avoidance strategies more frequently than the control group counselors. These strategies, including eating, drinking, smoking, using drugs or medication, sleeping more than usual, denial, and isolating oneself from others, are generally considered less helpful than other possible strategies since they do not resolve a problem but instead put it on hold (Johnson & Hunter, 1997).

The last research study included is a national randomized sample of 1,000 psychotherapists by Brady, Guy, Poelstra and Brokaw (1999). This study included 446 returned questionnaires examining the VT of women psychotherapists attributable to their work with sexual abuse survivors. This survey used the Impact of Events Scale to assess subjective distress, particularly post-traumatic stress symptomatology, as a result of exposure to a life event (Horowitz et al., 1979). The Traumatic Stress Institute Belief Scale was also used to assess disruption in cognitive schemas, including therapists' beliefs in safety, trust, esteem, intimacy, and control. Schemas have a self and other dimension (Pearlman & Saakvitne, 1995).

The study indicated that women psychotherapists who have more sexual abuse clients in their caseloads or see a high number of survivors over the course of their careers are more likely to exhibit trauma symptoms themselves (Brady et al., 1999). The study found that although the

psychotherapists who treat survivors reported more trauma symptoms than their colleagues the intensity of these symptoms was not severe. It was also found that therapists' underlying assumptions and worldview were undisturbed, although some intrusion and avoidance symptoms were noticed. It was also noted that women psychotherapists who primarily treat child sexual abuse survivors do not appear to be more susceptible to developing VT than do their counterparts who treat primarily adult sexual abuse survivors (Brady et al., 1999).

This study found that therapists who treated more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients. Conducting psychotherapy with survivors of sexual abuse may force therapists to challenge their own constructs of meaning and faith. The heightened emphasis on spiritual issues found in trauma therapy may strengthen psychotherapists' spirituality. Perhaps by being confronted with clients' issues of meaning, hope, and spiritual understanding, female psychotherapists' own faith emerges stronger and more resilient (Brady et al., 1999). Brady et al., (1999) offer two explanations for this phenomenon. The first is that sexual abuse survivors serve as catalysts for therapists' personal growth. The exposure to the trauma material may produce a momentary spiritual crisis and cognitive dissonance, but can eventually result in a stronger, healthier sense of spiritual well-being. The second is that clinicians who feel particularly grounded in a clear philosophy of life are drawn to work with trauma survivors. These practitioners sense that they have the necessary spiritual and existential strength to conduct such challenging work.

Many therapists believe the positive aspects of treating sexual abuse survivors outweigh the negative. They are rewarded by "Witnessing the resilience of humanity and the courage of the human spirit, the joy in participating in the healing of another, and the personal growth that results from journeying with survivors of trauma (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995)" (Brady et al., 1999).

Self Care Strategies

Balancing work, play, and rest helps us to remain grounded in various aspects of our complex identities. This is important for all of us and especially important for therapists working with trauma survivors. "Practices that renew a cherished sense of identity or that expand one's identity beyond that of trauma therapist are helpful" (Pearlman, 1995, p. 54). Participating in activities that reconnect oneself with others as a friend, parent, child, partner, and sibling are helpful reminders to trauma therapists that they have other roles. Engaging in creative endeavors such as writing, playing music, art, and gardening; being physically active through exercise, dance, or hard physical work; and reconnecting with one's body through massage, dance or yoga, are all helpful in balancing the helper role played as a trauma therapists (Pearlman, 1995). Schauben and Frazier (1995) reported that 35% of their research participants (148 female sexual violence counselors and psychologists) engaged in leisure activities such as gardening, reading, listening to music, and going to movies to cope with work-related stress.

VT may affect worldview. Janoff-Bulman (1992) suggests that spending time with happy, healthy children, working for social justice,

building a sense of community, and travel expand worldview. Spirituality may also be affected by VT and can be mediated through meditation, yoga, writing in a journal, engagement with art and beauty, poetry, and nature (Pearlman, 1995). Pearlman and Mac Ian (1995) found that 44% of the trauma therapist sample developed a spiritual life helpful in coping with the demands of trauma work. Brady et al., (1999) also found that "Practitioners who treated more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients" (p. 391). The inner abilities that allow us to maintain a sense of positive self-esteem are sensitive to the impact of VT. Effective self-care strategies are those that reconnect us with internalized images of loving others (perhaps through letter writing, journal writing, meditation or prayer). Activities that increase our affect tolerance or reconnect us with our feelings are particularly helpful in this realm. They include obtaining emotional support from others, personal psychotherapy, meditation, yoga, and opportunities to experience and express the full range of human affect (Pearlman, 1995). Issues of self-awareness, peer support, and self-care are very important for trauma therapists (Brady et al., 1999). Schauben and Frazier (1995) found that trauma therapists who used social support as a coping mechanism had fewer trauma symptoms. Those inner abilities that allow us to meet our psychological needs and to manage interpersonal relationships can be impacted both by trauma and by doing trauma work. Resources such as self-examination, sense of humor, empathy, limit setting, and giving and receiving supervision are essential. Safety, trust, esteem, intimacy and control are schemas that are vulnerable for trauma therapists. Pearlman and

Mac Ian (1995) found that two thirds of trauma therapists reported the helpfulness of attending workshops, talking with colleagues between sessions, informal case discussions, and in the personal realm socializing and spending time with family. Group supervision can also promote connection. Trusted colleagues can help us examine our distortions (Pearlman, 1995).

The trauma therapist can experience intrusive imagery. Pearlman (1995) suggests that this occurs through a connection between the therapist's own psychology and vivid images described by the client. The self-care strategy that is most helpful here is for the therapist to identify personal salient theme in the material. Once the therapist has worked to integrate the material as it relates to his or her own issues, the material will cease to be intrusive (Pearlman, 1995). It is the therapist's feelings, not the survivor client's material, which must be processed. Balance is very useful here: a balance of one's caseload, balancing one's day to intersperse therapy, and supervision, and balancing clinical and nonclinical work (i.e. research, teaching, and supervision). It is also helpful to create time each day for self-care; this might involve a phone call home, yoga breathing between clients, or a walk outdoors. These strategies bring therapists back to their bodies and to their senses (Pearlman, 1995).

Examining structures within an organization can help to ameliorate VT. Organizations and agencies whose staff members treat a significant number of trauma survivors must take responsibility for reducing the impact of VT. Establishing an emotionally supportive, physically safe, and consistently respectful work environment is especially important when

trauma issues heighten intrapersonal and interpersonal stress (Brady et al., 1999). Pearlman (1995) reports that at the Traumatic Stress Institute they devote the first hour of a two-hour case conference each week to feeling time. Laughing and crying with colleagues normalized staff responses and renewed them for the week ahead. Other agencies are also allowing time and space to address VT. "Regular time set aside in clinical staff meetings to address feelings and concerns related to trauma work is one way to help prevent exacerbation of Vicarious Traumatization in the workplace" (Brady et al., 1999, p. 390). Prevention of potentially harmful effects from VT involves attention to both concrete issues, such as provision of supervision and adequate time off, as well as less tangible sources of support, such as the organization's attitude toward the impact of trauma on helpers. The tangible support of individual supervision, small group supervision, biweekly case conferences, biweekly seminars, and informal consultation whenever needed, is important. Chrestman (1995) notes that adequate pay is another tangible support helpful in ameliorating secondary trauma. Less tangible is the fact that supervision fosters an atmosphere of respect, safety, and control for the therapist exploring the difficult issues evoked by trauma therapy. Respect allows for maintenance of self-esteem and a sense of safety while a therapist examines mistakes or painful counter-transference issues (Rosenbloom et al., 1995).

Empathic engagement with client after client can be draining; one response is to shut down emotionally. Schauben and Frazier (1995) found that behavioral disengagement correlated positively with their measure of VT. One way to remain connected with the client while protecting oneself

emotionally is to purposefully remain aware of the broader context as the client is sharing his or her experience of abuse. That might mean remembering that the client has survived and that he or she now has access to helpful, caring others (Pearlman, 1995).

Summary and Purpose of Study

Research into the effects of trauma on people has been fairly extensive and centered around the survivor. In the past two decades there has been increased acknowledgement of people being secondarily traumatized by the survivors experiences. Figley (1983; 1986; 1995) examined the phenomenon of the survivors' family and friends exhibiting the same symptomology as survivors. Recently McCann and Pearlman (1990) focused on the experience of the trauma therapist. They reported trauma therapists were experiencing alterations in their schemas similar to the change experienced by trauma survivors. The purpose of this study is to use a qualitative heuristic methodology to examine the experience of Vicarious Trauma (VT) as reported by trauma therapists. This type of research design allows for the phenomenon of VT to be examined from the perspective of the trauma therapists. Examining the phenomenon of VT will illuminate the way's to ameliorate this experience. Understanding the impact of VT and the ways to ameliorate its effects will be helpful for trauma therapists, trauma agencies and educators.

Chapter 3: METHODOLOGY

Understanding the Human Experience

Arguments about the nature of human phenomena and the methods appropriate for studying them make up an extensive literature in human science. There has been successive corrosion of the belief that pure objective knowledge is possible (Polkinghorne, 1983). It has been concluded that observations do not produce "facts," because observations are dependent on the various theoretical and cultural schemes that the observer brings to the situation. "The present situation in the epistemological conversation is that there is no foundation which can assure that knowledge claims are accurate representations of the real" (Polkinghorne, 1986, p. 14). This transformation of belief signified a new beginning, the origin of a human science approach emphasizing human experience as its subject matter. The focus of this approach is to comprehend the meaningfulness of psychological life as it presents itself in the real world (Barell, Anstoos, Richard, & Arons, 1987). Barrell et al. (1987) suggests the following definition of human science research.

> Human science research can be defined as a systematic exploration and understanding of meaning, behavior, and interaction in the context of human experience. It represents an umbrella-like unity across different disciplines as well as across technical diversities at the level of approach. What unites the group is the recognition that human

> existence needs to be approached on its own terms rather than on conceptual foundations borrowed from the natural sciences (p. 452).

Rennie (1994) expanded on the belief that human science research approaches have a number of specifics in common.

> All characteristically use natural language both as data and in representation of results; all embrace reports on subjective experience as legitimate data; all typically work with a small number of selected data sources; all emphasize discovery more than verification; all recursively combine inquiry and analysis; and all are interpretive at root (p. 327).

Polkinghorne (1983) suggests that it is not our commitment to methods that matters, but our understanding that "human beings exist within an experience of meaning"(p. 48). Meaning is a subjective experience that is created by the individual dependent on their perception of themselves, and the world. The view that individual experiences are subjective and behaviour depends on the meaning they make of it, also defines qualitative research. Qualitative methodology attends to the uniqueness of each case; data collection in qualitative research is individualized; the researcher seeks to capture the coresearcher's experience; qualitative research establishes direct interpersonal contact in accepting, caring and non-judgemental ways; and there is concern for the whole person (Patton, 1990). Qualitative research is the type used in this human science study.

Conceptual Framework of Heuristic Research

Heuristic research is a philosophic and conceptual orientation within the framework of human science. Heuristics contains key ideas drawn from

existentialism and phenomenology (Douglass & Moustakas, 1985). Moustakas' concept of heuristic involved his search for a word that would meaningfully encompass the processes that he believed to be essential in investigations of human experience (Moustakas, 1990). Heuristic comes from the Greek word *heuriskein*, meaning to discover or to find; it refers to a process of internal search through which one discovers the nature and meaning of experience (Moustakas, 1990). "It is the focus on the person in experience and that person's reflective search, awareness, and discovery that constitutes the essential core of heuristic investigation" (Douglass &Moustakas, 1985, p. 42).

Heuristic research involves researchers being a part of their work, acknowledging and embracing it (Moustakas, 1990). The researcher must go where the phenomena leads, pursuing "an original path that has its origins within the self and that discovers its direction and meaning within the self" (Douglas & Moustakas, 1985, p. 53). Heuristics encourage the researcher to be open and to energetically embrace the many ways of knowing.

Once the researcher is immersed in the phenomenon to be illuminated, the researcher seeks coresearchers to share their experience of the phenomenon, helping to move the researcher along the path to understanding. Knowledge may be revealed most authentically through metaphor, description, poetry, song, dance, art, or dialogue (Douglas & Moustakas, 1985).

Method

The methodological design for this study is a qualitative, human science approach, using a descriptive, heuristic style. I followed the six stages of heuristic research design suggested by Moustakas (1990) to connect with the process of the research. A qualitative inquiring, descriptive approach was used to engage with the participants and analyzing their experience is the manner of presentation to the professional community.

The first phase of the heuristic research design is initial engagement with the topic under investigation. "Within each researcher exists a topic, theme, problem, or question that represents a critical interest and area of search" (Moustakas, 1990, p. 27). The challenge of this first phase is to discover this intense interest that is passionate, important to the researcher, and contains meaning for others. The researcher "reaches inward for tacit awareness and knowledge, permits intuition to run freely, and elucidates the context from which the question takes form and significance" (Moustakas, 1990, p. 27).

The second phase is called *immersion*. Once the question has been discovered and defined, the researcher "lives the question in waking, sleeping, and even dream states" (Moustakas, 1990, p. 28). The researcher is immersed in the question. "Primary concepts for facilitating the immersion process include spontaneous self-dialogue and self-searching, pursuing intuitive clues or hunches, and drawing from the mystery and sources of energy and knowledge within the tacit dimension" (Moustakas, 1990, p. 28).

Incubation is the third phase and is the process in which the researcher moves away from intense focus on the question. The researcher is no longer

absorbed in the topic in any direct way. "The period of incubation allows the inner workings of the tacit dimension and intuition to continue to clarify and extend understanding on levels outside the immediate awareness" (Moustakas, 1990, p. 29).

The fourth phase of heuristic research is *illumination.* Illumination is a "breakthrough into conscious awareness of qualities and a clustering of qualities into themes inherent in the question" (Moustakas, 1990, p. 29). Illumination is the knowing on many different levels of what was previously unavailable to the researcher. It is an appropriate time for data collection because the researcher has a deep knowledge of the question and will be able to recognize the meaning in others' experience.

The fifth phase is that of *explication.* At this stage the purpose is to fully examine what has awakened in consciousness. Meaning can be understood in its layers of understanding (Moustakas, 1990). The ultimate result of explication is that "a comprehensive depiction of the core or dominant themes develop... as the researcher brings together discovery of meaning and organizes them into a comprehensive depiction of the essence of the experience" (Moustakas, 1990, p. 31).

Personal Presuppositions

Qualitative research involves the researcher in the process and acknowledges that involvement. Giorgi asks the researcher to "make explicit whatever one can" (1967, p. 162). Allowing opportunity for the researcher's presuppositions to be acknowledged is important because "as a researcher repeatedly pores over protocols in order to understand the structure of a phenomenon, his or her attitude regarding that phenomenon inevitably

changes" (Walsh, 1995, p. 339). This is especially helpful in evaluating the completed work. Giorgi suggested that the way to compare and evaluate research is by "trying to get the presuppositions that any psychologist holds out into the open so that their relative merits can be assessed" (1970, p. 162).

The presuppositions of this study were:

1.Participants would benefit from the interview process as an opportunity to express their insights, challenges and personal experience of the phenomenon.

2.Trauma therapists experience VT to some degree or another.

3.Trauma therapists have resiliencies and coping mechanisms that help with their experience of VT.

4.What participants' report on their experience will be an accurate reflection of VT.

5.A qualitative methodology using heuristics as a conceptual framework is the most appropriate way to discover the nature of VT and to illuminate it as it exists in human experience.

Data Collection

The data collection involved interviews with participants. The interviews were dialogues, allowing for curiosity and openness. The interviews included five questions, asked as the opportunity presented itself, within the free flow of information. The openness and flexibility of the interviews allowed for the phenomenon to emerge spontaneously. There was a guideline of two hours for the structure of the interview process, although this was open for review and if opportunity allowed the time was flexible.

This flexibility allowed the participants to open themselves up to the phenomenon and fully express themselves.

The participants were identified as trauma therapists who at the time of the interviews were working at an agency where they counsel children who had been abused. The participants were all therapists with masters degrees or equivalent. They were between the ages of 33 and 59, with four of the participants being female and one of them being male. The parameters of the participants' selection were based on the conceptual framework of heuristic research. Heuristic research starts with the premise that the phenomenon being studied is of passionate significance to the researcher. "Self-experience is the single most important guideline in pursuing heuristic research" (Douglass & Moustakas, 1985, p. 47). The experience of VT is a phenomenon that the researcher has experienced. The work began with this experience of the phenomenon and has moved to include other trauma therapists' experience in order to illuminate VT.

The research was supported by an agency whose mandate is to help children who have been abused. Trauma therapists working at the agency were invited to participate. A letter outlining the research was put into each trauma therapist's mailbox. Trauma therapists who did not want to participate were asked to communicate this to the researcher. All participants were contacted by telephone and appointments were made to conduct the interviews. Prior to the interviews participants were given consent forms to sign and were reminded that they could withdraw from the research at any time. One of the interviews was conducted in the participant's home and four of the interviews were conducted at the agency.

Questions Explored in Interviews

1. Have you experienced Secondary trauma while working as a trauma therapist? Tell me about this experience. Where in your body have you experienced this phenomenon?

2. What are your personal resiliencies or traits that help you cope as a trauma therapist?

3. Describe the things you do to help you cope and take care of yourself as a trauma therapist.

4. How do you manage your work as a trauma therapist when you are experiencing a personal, stressful life situation?

5. Does the agency you work for have adequate support to help you deal with secondary trauma?

Interview Format

Moustakas (1990) states that Patton's (1990) approach to interviewing and collecting qualitative data is appropriate for heuristic research. The general interview guide outlines "a set of issues or topics to be explored that might be shared with co-researchers as the interview unfolds, thus focusing on common information to be sought from all co-researchers" (Moustakas, 1990, p. 47). The questions were used as a general guideline within an open dialogue between the participant and the researcher. This open dialogue included a...

> high value on the depth and sensitivity of interchange, on the promise of I-Thou moments, and on the steady movement towards a true intersubjectivity... Intersubjectivity is drawn from existentialism and refers to a communal flow from the depths of one self to another self,

and to qualities of purity and loving integrity in interactions with others (Douglas & Moustakas, 1985, p. 50).

The researcher knew from her own experience the meaning expressed by the coresearcher; this allowed for the mutuality of discovery. "Common or universal elements imbue certain experiences in such a way that they are unmistakable" (Douglass & Moustakas, 1985, p. 51).

The purpose of the interviews was to uncover the experiences of the coresearcher and to illuminate and explore commonality and themes. In heuristic interviewing it is important for the researcher to use accurate, empathic listening; to be open in the conversation; to be flexible and free to shift and respond to what is emerging in the flow of dialogue; and to be skillful in creating a climate that encourages the coresearcher to respond comfortably, accurately, comprehensively and honestly about the phenomenon (Moustakas, 1990). The interview process is very compatible with Rogers' person-centered therapy, In which therapists immediately show respect for clients; thereby allowing them to proceed in whatever way is comfortable for them. The therapist listens without prejudice, and is open to either positive or negative feelings, speech, or silence. There is a willingness to stay with the client and their experience in the moment. Person-centered therapists attempt to establish themselves as authentically caring and listening (Corsini & Wedding, 1995).

The interview process involves "cooperative sharing in which co-researchers and primary researchers open pathways to each other for explicating phenomenon being investigated" (Moustakas, 1990, p. 47). The researcher and the coresearcher work together, accepting and affirming the

other. It is essential to establish a feeling of safety, allowing the willingness of the participants to say freely what they think and feel in relation to the phenomenon being investigated (Moustakas, 1990). The researcher uses empathy, reflective listening, personal disclosure, and unconditional positive regard to build the foundation of the interview. Once the foundation is built, the coresearcher is able to reflect and share experience of the phenomenon being studied. The researcher needs to be receptive and listening at all levels to what the coresearcher is saying.

> The researcher must keep in mind throughout the process that the material collected must depict the experience in accurate, comprehensive, rich, and vivid terms...depictions are often presented in stories, examples, conversations, metaphors, and analogies (Moustakas, 1990, p. 49).

Data Analysis

Immediately after each interview notes were made on thoughts, themes, and meanings that arose. Participants were asked if there were any personal journals, poetry, or art which might be helpful in illuminating their experiences of VT. This is important in heuristic research to satisfy different ways of knowing the phenomenon as well as satisfying a component of validity through triangulation. The interviews were transcribed verbatim.

The transcriptions, notes, and personal documents were then gathered together and separated for each participant. The stages of immersion and incubation followed with each of the participant's experience. The verbatim

transcripts were read repeatedly, themes and patterns were highlighted. The tapes were listened to while reading the transcripts; notes of themes and patterns were taken. "Essential to the process of heuristic analysis is comprehensive knowledge of all materials for each participant and for the group of participants collectively" (Moustakas, 1990, p. 49). The transcripts were then read again one by one to capture a sense of the collective experience of the participants. The data collected through self-reflection and coresearching was coded according to subject, and then analyzed and separated in terms of descriptive meanings, core themes, and creative illustrations and renderings of the individual's experience. The challenge of heuristic research is to examine all of the collected data in creative combinations and recombinations, sifting and sorting, moving rhythmically in and out of appearance, looking and listening carefully for the meanings within meanings, attempting to identify the overarching qualities that are inherent in the data (Moustakas, 1990). Throughout the sorting process it was important to return to the original transcribed interviews to comprehend the full meaning and context of a statement. This was important to ensure that what was actually said was what the participant meant.

Once the data were examined apart and as a whole, each person's information was reconstructed into a picture of their experience. The reconstructions were then brought back to the participants to read and they were asked for feedback. This was a check to ensure that nothing was added or omitted that was important in understanding the experience of the participant. It was also a check for validity.

The next step involved rereading the raw data and the participants' experience reconstruction in order to delineate commonality in themes among participants. The themes were then examined as a whole and those that appeared most important were included. Their importance was examined through commonality or number of times mentioned by participants, through metaphors, through voice tone and emotional weight, and through tacit knowledge. Polanyi (1966) described tacit knowledge as the direct manner, simply by virtue of being human and being alive, in which we experience the everyday world. The data was separated according to themes and colour coded according to research participant. The themes were then broken down and examined in the context of all of the participants. The material was reconstructed as a synthesis to illuminate the meaning of the experience.

Validity

Heuristic inquiry uses qualitative methodology to arrive at themes and essences of experience. Validity in heuristic research is one of meaning (Moustakas, 1990). "Does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately describe the meanings and essences of the experience?" (Moustakas, 1990, p. 32). Validity in human science research is that which makes the experience of being human what it is; the ability to make meaning out of experience.

The reason the human sciences cannot become theoretical sciences and the reason the notion of validity for tests and measuring instruments is

> limited is because of the human capacity to make meaningful and personally valid conceptual distinctions that incorporate the ever-changing contextual dimension of experience (Polkinghorne, 1986, p.147).
>
> Validity in heuristic research is also connected to replication of results. The validity of heuristic research is inherent, insofar as it pursues the truth, to the extent that it is conducted through authentic self-processes, and to the degree that after repeated examinations of the data, the same essences are revealed with the same degree of plausibility (Douglass & Moustakas, 1985, p. 44).

The validity of heuristic research is obtained through personal meaning; through the ability to replicate and still reveal the same essence; and the phenomenon's context. Understanding the phenomenon and its place within the fabric of society is important in human science research.

> For human science research to be valid, the researcher must demonstrate cognizance of his or her position within this context as one small thread in the large tapestry of on-going conversation and debate that shapes the social matrix defining a community. The human science researcher must take responsibility for connecting the 'story' that he or she is creating as a result of inquiry (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985, p. 302).

Verification can be achieved through understanding. It is self-verification where a sense a certain harmony or response between an evolving formulation and its felt meaning, the bodily aftermath of the experience as lived. This kind of check is readily available and can be applied to the

implications of the study. Another person can test the formulation for its response against his or her experience of the phenomenon under study. While understanding as a form of verification in the final analysis is personal, it is open to an intersubjective check. All people are embedded in and both constitute and are constituted by a complex of shared cultural forms, a living language, and a history. By and large, people share and creatively evolve a common experience, a common world (Shapiro, 1984).

Chapter 4: RESULTS

The purpose of this research was to examine the experience of VT. Specifically that includes understanding the experience of VT, its impact on trauma therapists, influences on the experience of VT, and ways to ameliorate its affects.

First there will be a description of the variables that influence the experience of VT for the participants. This will be followed by an analysis of the restructured stories using referencing to help illuminate the experience of the research participants.

These are the stories of five trauma therapists. They range in age from 33 to 59. All of these therapists work at an agency that counsel's traumatized children exclusively. Names, identifying features and events used in the stories have been randomly chosen to protect the identity of the subjects. Here are their stories.

Interview Summaries

Julie

Julie is a trauma therapist who works with children who have been abused. She works at an agency that is entirely devoted to counselling children who have been sexually or physically abused, and their families. This is a story of Julie's experience of VT.

> I was working with one little girl, I worked with her for three years, and it was a situation where she was so traumatized she wouldn't tell

> anybody what was happening, and the courts and the child advocate didn't get what was going on and I felt helpless to protect her. I felt that I was seeing this child every week, I had a strong therapeutic bond with her but I couldn't do anything for her. I think I felt the helplessness that she felt. I was trying to go to people without knowing the way. I think that I felt the confusion. There was a lot of signals and a lot of information. I couldn't put anything together that would help her in a coherent way. I think she must have been feeling that internally as she must have been getting conflicting information from both her parents. The father was the alleged offender and he would try to get at her and this was traumatizing for the children. He had told the children that he was going to kill the mother, that she was bad. He had asked the children to kill her. He had said all sorts of things like he was going to let her rot on the door step and then he would throw her into the ocean and she would poison the fishes.

Julie shared her feelings of identifying with the mother and her experience of helplessness.

> I was feeling the mother's traumatization as well. The mother was feeling not believed. She was being reported by the father all the time and was continually investigated. When I started to see her I knew I could be taken in so I reserved my judgment until I could view her in multiple situations with her child. I subsequently ended up feeling the same way when I put my information to the child advocate, and the information to the courts… I felt helpless as well. I was experiencing the lack of credibility that she was experiencing.

In this particular case the emotional abuse was particularly troublesome.

> The element of emotional abuse was the most horrible. I've heard more horrible stories. How someone who was so ill and basically incestuous could use this power to terrorize huge numbers of the professionals as well as the system. And the child, if we felt terrorized what did that parent and child feel?

Julie described how working with this case made her quite ill. " I actually think when I did get ill and had major surgery, it was partly because of the long-term effects of this particular case. The stress was huge." Julie's bodily reaction to this case included "a feeling in my gut and in my heart. More than that it was a sick feeling in my stomach and an agitated feeling. My head felt muddled and confused. Every time I tried to write something down, I felt like I wasn't making any sense." Julie experienced other symptoms including memory problems, flashbacks, and the inability to focus.

Personally, Julie was having relationship difficulties with her sister at the same time all of this was happening at work. The difficulties were confusing to Julie and mirrored the confusion she was feeling with this case. "I felt completely at a loss to understand what the problem with my sister was. It was filtering through the rest of the family and I got completely isolated for a while... The sense of confusion compounded, as it mirrored the confusion that was going on with this case." At the agency Julie experienced similar feelings of confusion. Julie was challenged by the management style. "It was a murky environment, I never knew what the hell was going on. I never knew information and again that mirrored what was

happening with the client." Julie talked about the unpredictability of that environment. " I can't deal with ambiguity within the context of threats. It was a very threatening environment ... it was unpredictable." The feeling of being threatened was similar to Julie's experience with her case. "There was a fear that this person (the alleged offender) might be violent. I was never sure whether he had his eye on me. It was pretty awful, a pretty awful situation."

Julie's self-identified resiliencies include her ability to play, fantasize, and create with art. Other resiliencies include a "sense of humour, the ability to really laugh at stuff." Julie's spirituality is what gives her a context to see what she's doing and her part in it.

> With suffering, why do people cause suffering... A lot of events happen to people. It's what we do with that experience, and what you think about yourself. Spirituality is a tool to pick yourself up with, to keep your mind clear, a tool to recover. You might think that life isn't fair but you have the tools, the path through that. You don't have to make it all right to keep going.

Julie's ability to make meaning out of experience has been helpful for her in her work as a trauma therapist. "The ability to try and make some meaning...I think we're all tested and we have to look inside ourselves. You have to trust your own judgment."

> Julie identified her colleagues as a large part of her support system. We have the most wonderful group of people here. I had good supervision, individually and in-group. People who understood the dynamics, who were clear, who were supportive of my observational

skills, who were supportive of the work I was doing with the child, made me feel like I was giving something to this child.

Julie's coping mechanisms included taking care of herself with good food, exercise, art and meditation. Julie talked about her reliance on being challenged by undertaking new training, gaining new clinical tools, and making contacts with other practitioners and community contacts. Julie's physical environment was also helpful. "Two huge old fir trees are framed by the windows in my house. I really felt like they were holding their arms up to me. I felt like they were these big towers of strength, they were very supportive." At this particular time Julie's other supports, her sister, her massage therapist, doctor, and hairdresser, were all unavailable for one reason or another. This gave Julie the opportunity to search internally for personal meaning.

Julie and another counsellor facilitated a therapy group, which included her client and the client's mother. Working with the client and her family allowed Julie to feel hopeful.

> We watched her feel permission to be with her mother. She walled herself off from her in the beginning. She was able to be with her and be nurtured. It was wonderful. I watched her mother cry at being shut out by her. I then watched her go through the process and learn how to trust her mother and then at the end, seeing the tangible objects that they made together and the insight that they had into each other. My client's confidence grew incredibly by the end of the group. To watch her grow and relax was wonderful.

Analysis of Experience

Julie's experience of VT was especially difficult because of compounding personal and agency struggles that were occurring at the same time. Julie's confusion about the conflict with her sister not only mirrored her experience of working with her client but also meant she had lost a huge personal support. Julie mentioned feeling traumatized by the environment of the agency in which she worked. This experience added another major stressor. Julie was also having health problems, which was a definitely a strain. Therapists should be aware that other major life stressors will make them more vulnerable to the effects of secondary traumatic stress (Figley, 1995).

One of Julie's themes was not feeling credible in the work she was doing with her client. This theme was repeated in her experience in the court system, in working with other professionals, and with the agency management. Julie may have experienced this theme in the past and this made it resonate even more powerfully because of that connection. Julie identified the support she received from her peers at the agency as very helpful in validating her experience and clinical expertise in working with the child, in the courts and with other professionals involved in the case. Rosenbloom et al., (1995) discuss changes that might occur to therapists' self-esteem through the process of doing trauma work and ways to ameliorate these changes.

> The inner abilities that allow us to maintain a sense of positive self-esteem are sensitive to the impact of trauma and of doing trauma work. Effective self-care strategies in this realm are those that reconnect us

> with our internalized images of loving others and reinforce a positive sense of self. Activities that increase our affect tolerance or reconnect us with our feelings are particularly helpful in this realm (p. 58).

Julie's ability to move through her experience of VT, make meaning of her experience, and delight in her clients' progress is likely the reason she feels so suited to doing trauma work. "For the therapist, an important aspect of self-care and nurturance is to remember why one chooses to do trauma work and to appreciate the inherent rewards it offers. To be part of the healing process can be transforming, inspiring and rewarding for the therapist" (Sexton, 1999, p. 401).

Sophie

Sophie is a trauma therapist working at an agency that specializes in counselling children who have been abused. When asked if she had any experience with VT, Sophie discussed one particular example that was significant for her.

> One of the main times that I think about when this [VT] comes up was when I was seeing a client whose grandfather was bringing this client to see me and the disclosure ended up being against grandpa. This was after about six months of seeing her that the girl disclosed sexual abuse by her grandfather who was sitting outside the office door. That was a time that it was really hard to let it go. I thought about it all the time. I had trouble sleeping. I would wake up at night and think about her and him I knew I was way too emotionally involved.

This particular client was very significant to Sophie; while she was talking about this client emotion was present in her voice and posture. When asked if she felt this experience in her body Sophie replied that she "felt it in my chest and stomach... felt it was being eaten away at." Sophie described her experience with this case.

> It was a long time ago... I think that I would see mostly images of him coming in. I was under the impression that he was this great grandfather who always had a treat and a new outfit and they seemed really close... and when I worked with her here it was a huge thing, she was really mad that she told as she thought she had lost all that good stuff. I think another thing that helped was continuing to work with her for another year and a half until she was actually finished counselling... that was helpful to continue on so that it wasn't just ending. I could feel hope for her... I would see visions of him... I would feel angry and betrayed, and then see her little face... my first session with her when she was six years old and she just sat there... her first words were 'fuck you, I'm not answering your fucking questions. She has a special place in my heart... she taught me a lot.

Sophie shared her personal trauma experience and connected it with this case. Sophie talked about how her grandfather was her safe haven when she was a little girl.

> I was close to him, he was the greatest, for that little girl to be abused by her grandpa was difficult to handle for grandpa was my safe person. When I saw them together he treated her very special. To me that was how grandpas were, and that grandparents are special for

> me because of my own history. So there were a lot of similarities with that little girl. It was so huge to me I couldn't let it go… Because I keep thinking what if my grandpa did this… and I didn't have my safe place.

Sophie said that talking to the clinical coordinator was helpful. Sophie was working closely with the case social worker and they both found it helpful to debrief their feelings about the case. Sophie said she had talked to another supervisor who had made the experience more difficult. "She said you guys need to get a lawyer and why didn't you see the red flags." Sophie said the experience was especially challenging as it took a long time to resolve. "It would come up and I would get upset again, it took a long time to get through."

"Going to the beach, throwing rocks, running around…. just the salt air and the sounds of the waves," are helpful coping strategies for Sophie. Sophie discussed her use of rituals to help with VT.

> Sometimes when work is really having a bad day, and lots of stuff is happening, I know that my mind is doing that racing thing and thinking have I gotten these notes done, etc.… sometimes I'll light a candle and I'll just take a couple minutes and say good bye to my clients and blow out the candle and that just seems to help as a kind of ritual. And sometimes I'll do it at home… I cover them with light and send them off and I blow out the candle, which helps me to center.

Sophie also takes care of herself, going to bed early, eating healthy foods, and getting regular exercise.

The use of humour is a huge resiliency in this work. Sophie also said that she is quite creative. "There is something about doing crochet and crafts, I can actually sit at something and it's done. Unlike this type of work which isn't like that, so it helps being able to complete." The ability to work on something and see its completion is helpful because many times therapists do not have the opportunity to see the results of their work.

Sophie talked about how her work has affected her personal life. "I definitely think my work affects how I look at things. I may be more suspicious than other people, I don't know. I know definitely after that happened I don't look at grandfathers in the same way. Everyone is more suspect to me." With children I know I am more watchful around them. "I am always looking... I don't have nieces or nephews but with my friend's kids... I'm always watching and I'm listening for dysfunctions and what is really going on."

Analysis of Experience

Sophie's VT experience encapsulated itself in a case that was extremely difficult to move through, because it was a case that resonated for her personally. It involved a child whose grandfather appeared to be a support but in actuality was the alleged abuser. The relationship this child had with her grandfather appeared familiar to Sophie because she had a grandfather who was essential to her when she grew up. Sophie's history may have given her a frame of reference in which to make judgments about her client's relationship with her grandfather. Unfortunately, her client's grandfather was not what he seemed to be. This case may have also brought up painful memories of Sophie's own trauma. As each therapist brings her

unique personal history to the therapy relationship, it can be especially challenging when that history includes traumatic life experiences. The trauma material will stir not only empathy, but also memory and personal pain (Pearlman and Saakvitne, 1995).

A helpful piece in this story was the ability to work with the client for quite a length of time. Sophie's work with her client allowed the opportunity for hope. "Hoping with and for our clients is an essential part of their healing. Allowing ourselves to notice when things go well, when our clients do better, when our work feels useful can be restorative to an assaulted sense of hope" (Pearlman & Saakvitne, 1995, p. 392).

Sophie found the use of rituals helpful in ameliorating VT. Sophie talked about her use of visualization in order to separate herself from her client. It is very important to be able to leave clients at work in order to achieve healthy boundaries. Pearlman and Saakvitne (1995) suggest using creative endeavours after a session or at the end of the day to leave the clients' traumatic imagery behind.

The ability to leave clients' experiences behind and move into your personal life is essential in order to create balance in your life. Having balance allows the opportunity to experience life in many different roles. "Balancing work, play, and rest helps us to remain grounded in various aspects of our complex identities" (Rosenbloom et al., 1995, p. 54).

James

James is a trauma therapist who works at an agency that counsels children who have been abused. His caseload consists of children who have

been either sexually or physically abused. James describes the following example of his experience with VT.

> I have a client who is a First Nation's child who was physically abused by the father, sexually and physically abused by an older sibling, and the mother did not support this child at all. When I first saw him he presented like a dishrag. It just got to me. The life had just been stomped out of this child. That feeling I could still feel, now I mean.

James' client reminded him of his own experience. James shared his personal history of feeling overpowered and controlled by one of his parents and mostly unprotected by the other. James felt that his older sibling received the bulk of attention and that he was just along for the ride. He felt that the world did not revolve around him but rather around his older sibling. James talked about "not being heard, then that sense of powerlessness that I had chronically growing up, you know there was this huge boulder to push" in his family of origin. James expressed a connection with the child whose experience resonated with his own; he felt he was not special in my family, although his experience was not of the magnitude of that of the client. James believes that "as human beings on a basic level we get devastated when we see that level of abuse." When we hear or read about horrific abuse "There is a universal feeling of being overwhelmed at that cruelty and that kind of secondary trauma. How can that be?"

James would like to do less trauma work in order to decrease the effects of VT. "One cannot hear after a while, cannot take in information because of the volume. I think this adds to the vulnerability for secondary

trauma, and even becomes a metaphor for being overwhelmed." James talks about being flooded with information about his clients as well as about other trauma therapists' cases. The flooding of information from other therapists is more difficult to process, because he...

> doesn't have the child in front of me to be hopeful about, and I can't dialogue with the parent either and clarify anything. So, all I can be is a recipient of crap. And yes, my colleagues are working to help this child heal, but in some experiential way, I feel this sense of powerlessness, via a via, that information and that to me just reinforces that sense of powerlessness that the child has.

The bodily sensations that accompany these feelings of secondary trauma include "a tightness and a feeling of shortness of breath and restriction, like losing the breath, a powerlessness sensation in my solar plexus to throat."

James said that his personal life impacts his work. An example is when he is sensitive about his role as a parent; it does affects his work, by humbling him. James also believes being a trauma therapist affects his personal life, including being overprotective of his children.

> My older child tells me I'm overprotective and I'm always reminding her about safety and feel weird if it's a dad that's looking after her and their child or when my kids have a friend over, I purposely stay detached. I don't want to be too friendly or physical with their friends because I fear that something will be misinterpreted.

James was sensitive to accusations of abuse and to supervision issues with his children and his children's friends. He said it was hard to answer the question of how trauma work affects his life.

> Because trauma work colours one's general attitude about society, I think. And one becomes more cynical. I personally grapple with negativity... It goes back to a [parent] who was very negative about life and told me I was too good and the world out there will eat you up. In some ways this job reinforces the view that the world will eat you up and that the world is in a decrepit state... spiritually I am an informal Buddhist, I would say. Because Buddhism starts off by saying that life is suffering, let's take it from there. Let's build positivity from starting with the recognition that life is suffering... and I can relate say to being Jewish, again sometimes in terms of the suffering that the Jews have endured ... That predates my work here, but the work can reinforce that kind of outlook and it can build on it... In order to take care of myself, I have to consciously cultivate positive things... In a sense I've got to find an answer to why there is suffering in life, we've got to resolve this question... how can you not have a view that there is a lot of suffering in life, how can you not have that view and do this work?... But we have to come here, day after day, with the knowledge that we've got more bullshit, see I am getting emotional about this, more bullshit on the doorstep to deal with. And to have the patience to keep facing bullshit on doorsteps.

James has ways of coping with trauma work. "I have to have a philosophical mindset to do this work. And in the mornings, if I don't do some meditation or prayer, I feel more exposed, I feel raw. I feel like I don't have the protection to do this job." Exercise is important to James', he exercises in the morning and sometimes throughout the day. Other ways of

coping include allowing for rest throughout the day and processing traumatic material with colleagues. Laughter and a sense of humour are also helpful. James discussed his preference for working with children as opposed to adults and his ability to maintain boundaries more readily with children. "We may relate to our clients with our hearts, but the parental heart is different from the heart that relates on an equal level." This difference helps to maintain boundaries. James does not feel that he takes his work home with him. "Occasionally a client may turn up in a dream but to me it is a warning sign that I'm working too hard and not leaving it at work."

James' resiliencies include a sense of humour, insight, a Buddhist attitude (which allows him to accept that these things happen, that this is what God has presented us with), perspective and the ability to see resiliency in a child.

James believes that the most difficult and stressful part of the job "is when I'm dealing with children who are in a situation that is not safe. That is the most difficult. Where one can see hope and resiliency, safety in the present moment, it really relieves the secondary trauma or the potential for secondary trauma considerably lessens."

Analysis of Experience

James' experience of VT is a client with whom he felt a connection. The experience of his client was similar to his own life experience. This connection made the trauma more challenging to move through. James examined his past, identified his experience of not feeling valued, and drew

parallels with the client who had been so abused and looked like the life had been stomped out of him. The ability to be self-aware and introspective are tools essential to the trauma therapist. A therapist whose self-attunement is limited or inhibited will be more vulnerable to the effects of VT (Pearlman & Saakvitne, 1995).

James found it hard to accept that people could be so cruel to a child. Intentional cruelty inflicted on a child can be very devastating to a therapist. "Clinicians who work with sexually abused clients hear about terrible acts brought about by another human being, often one who is charged with the care, protection and nurturance of the child" (Cunnningham, 1999, p. 281). James' mother expressed a belief that James was too good for this world. This rather negative belief about others may be a way of seeing the world that is helpful when doing trauma work. Pearlman and Mac Ian (1995) suggest that therapists with negative other-esteem schemas might remain in the trauma field longer as they do not experience a conflict between the stories they hear and their pre-existing negative beliefs about others. The search for meaning and understanding permeates James' experience of working with traumatized children. Being faced day after day with trauma reinforces the need for spirituality or of a larger context in which to make meaning of life experiences.

Kate

Kate is a child and family counsellor working at an agency that specializes in trauma work with children who have been abused and their families. Her entire caseload consists of children who have been sexually or

physically abused. Kate described two events to illuminate her experience of secondary trauma. Kate shared that both stories involved First Nations clients who died after she finished her work with them. Kate detailed one of these stories, her experience with a child whom she had been seeing for alleged abuse and who subsequently died from health problems a couple of years after they had completed their work together. Kate expressed "feelings of not having done enough, of maybe not having taken enough action." " The death of a child is so sad and the death of this former client continues to bring up some feelings of grief." In addition to Kate's work with the client and family, numerous other professionals were involved. This client was differently because in addition to being seen during regular office sessions, there were also home visits. The home setting provided a less structured and more personal environment. Sessions there were longer because there were activities with the client such as dancing and walking on the beach as well as talks with the client and family. "Once the family insisted on giving me a bottle of home canned salmon... so there were some compromises to the standard boundaries one has in the office setting." There were commonalities between client and personal life. Salmon has been a theme for Kate personally and this connected with the offering of salmon by the child's family. The death of the child may have resonated with Kate's personal losses.

Kate relates her experience of going to the local salmon run one year and looking at the "tiny bones of the salmon that died and that washed up on the shore." Kate said that she continued driving and ended up on a reserve at the First Nations salmon hatchery. She spontaneously entered and saw

female salmon hanging from hooks and the eggs streaming from their bodies. Kate had a strong reaction to the unanticipated view of the salmon "gutted and the life force being dispersed in that grim kind of setting of steel and hooks." Kate described her next connection with salmon and First Nations people, which involved festivities at the big house. Kate read the myths connected with the twin salmon dance, which she witnessed. This was important to Kate, because the first salmon of the season are referred to as the twin salmon. These are killed and their bones are saved and thrown back into the river. "The twins are very special and the parents of twins are very special... and the spirit of the twins goes to their home under the ocean where they return from... this sustains the return of the salmon." These connections were an "emotional door opening, which was a perfect fit to my own experience of losing twins." Kate talked about her sadness and the process of healing after the death of her first children. She spoke of her hospital experience of receiving a huge amount of medication and not being able to touch either of her first two babies. She draws a parallel with First Nations people who "sustained their culture by going underground and pretending that it had disappeared and with safety it comes up again, which parallels one's own personal pain going underground...and so I keep finding First Nations culture as an avenue for my own process."

Kate's said that she had been away on sick leave and when she returned she found out that the child had died. "It affected me so I had a rush of emotion and tried to get more information and was able to discharge and voice the anguish." What was helpful was a staff member who had First Nations connections and intuitively knew what to do. She brought out a

plant that needed replanting and suggested they do it together. "I felt a connection with her and with the earth and burying a child. It was a learning experience for me of how ritual is so important and so simple the everyday things that we can do to acknowledge the inner process of emotions."

Kate related that talking about the death of her former client brought forth a sensation in her "belly and somewhere in my heart and I feel something up here a little higher, and a slight presence of tears just in there."

Kate talked about what she does to cope with working with trauma survivors.

> One of the things I do, I realize, sometimes on Friday nights or Saturdays, I plunk myself down and I let come what comes... and stay with my feelings and if I'm stirring my porridge and if the tears are pouring I'm letting that happen... I have a profound acceptance for an advocate for tears... So I find that it is a gateway to consciousness, a permission to myself for crying from the build-up of the week. So there is crying and imaging and visualization and images to emerge.

Kate shared other coping devices, which included painting, drawing, writing, and dancing. Kate has matched up with another counsellor and they take turns counselling each other. This is an opportunity to explore issues, relieve stress, an discharge emotion. Kate also finds reading First Nations material and spirituality important for her healing. Kate talked about the legend of Dzunaqua. "I encountered Dzunaqua when I was reading myths and so on in the archives. First Nations legends about Dzunaqua include the story of children wandering into forests and being captured by Dzunaqua.

This was a caution to parents to look after their children. These children might get taken by Dzunaqua and carried in her basket, which she had strapped to her back. Dzunaqua was said to eat children although she never was able to as the basket had a hole in it so the children could escape and run away. Kate felt a connection with Dzunaqua. "The fact that Dzunaqua carries children in a basket parallels for me pregnancy. So that is a projection for me of my own lost children." Dzunaqua was special to Kate as "the mask performed ritual in the context of healing and providing safety and protection for children."

Trauma therapy affects some therapists in a more profound way than others. Personal resilience relates to the impact of trauma work. Self-identified resiliencies included Kate's personal experiences and her awareness and use of countertransference to assist in emotional discharge and recovery. Kate said that for her commonality with client experiences is a wealth of usefulness. Humour, the ability to self reflect, and emotional discharge, are other resiliencies for Kate. Having a child in her life has impacted her experience of VT.

> When I hear horrifying things happening to children I flash it happening to her, so I pull back in horror... it can be very confusing and distressing... yet at the same time it is wonderful having a little child in my life because it also gives me a sense of joy and of the wholeness of children.

Analysis of Experience

Kate's experience of VT included the connection she felt with a particular client and how that client resonated with her own personal

experiences. Having a child you know die, especially one you have worked closely with for a long period of time, can be traumatic. Compounding that experience with personal losses, including the death of your own babies, and any unresolved grief and loss issues can make the experience even more challenging to move through. The therapist's own trauma can intensify the experiences of their clients.

> Each therapist brings his own unique personal history to the therapy relationship; when that history includes traumatic life experiences, he may be more susceptible to Vicarious Traumatization. The material a therapist hears from clients will stir not only empathy, but also memory and personal pain. The membrane between his personal and professional selves will be stretched and he will have to work more vigilantly at times to remain clear, protected and have boundaries intact" (Pearlman & Saakvitne, 1995, p. 309).

Seeking out opportunities to grieve for her client also allowed Kate to grieve for her lost babies. The ritual of symbolically burying the child allowed for the concrete acceptance of the loss.

Kate's resiliencies include her way of honouring the body's mechanisms to strive for healing and balance. The acceptance of tears for the release of emotions accumulated through the workweek was helpful for discharging residual material. McCann and Pearlman (1990) discuss coping strategies that help us ameliorate some of the potential hazards of trauma work, they include giving ourselves permission to experience fully any emotional reactions we are experiencing. Embracing emotional reactions to

VT allows the therapist to be present and empathic with the client's traumatic material as well as permits the necessary discharge of affect.

Stephanie

Stephanie a trauma therapist working with children who have been abused, discussed her experience with secondary trauma. "There have been a few really horrible experiences, but these are usually quite brief. Letting it out with tears, emotions, and reading have moved it through quite fast." Stephanie also described a challenging experience with VT that was different from most others because it was more difficult to move through emotionally.

> Probably the clearest one I have is with one client I worked with, with a huge abuse history, very violent, probably would call it ritualistic abuse... When dealing with the client and family we had built a solid relationship but where secondary trauma came in was when I shared information with agency supervisors. The supervisor wanted to know about the offender, about safety. Does the family really need to be on the lookout? Was there anything this family would need to do? It was at this point where a series of actions occurred. I was asked to produce the files for supervisors and felt ethically conflicted as I had been asked by the client to be absolutely confidential about their history. Whenever the child would come to the agency, he would go through extreme stress and anxiety; he was terrified the abuser would see him. The supervisor wanted to open the case up on the police files. The supervisor wanted the family to be asked to release this information. I

> said they wouldn't do this. My clinical role as therapist for the family was being undermined. The family felt I was questioning if the abuse actually happened.

Stephanie pulled all the paperwork on the case given to her by a family member on events of abuse as told by the child after it occurred. This material hadn't previously been read to completion. She felt she needed to make sure she was on the right path. [After reading the file]

> I started getting flashbacks and nightmares; flashbacks of material and it was grotesque. I started to experience fear as I learned what went on and how extreme it was...there just couldn't be anyone that vicious. I then felt some of the client's paranoia. I was picking up their fear and wondering if the abuser (who was a computer whiz) could find them from the police computers. I think part of it was that the story was real and it was such grotesque material like from a book but this wasn't a book these were real people.

Stephanie found her usual ways of coping were not working. She was not able to continue with the rest of her work as effectively as usual. Stephanie found "going into meetings was very stressful and her heart rate and everything started to go up." She said she felt the same helplessness and hopelessness as the client did. She was also feeling controlled by someone not in clinical relationship with the client telling her what to do. "It was me taking on, me experiencing a little of what it may have been like for them; loss of control, loss of being able to keep things safe, paranoia. I was hyperalert. Would he be able to find them through computer files?"

The part that resonated for Stephanie was the feeling of being unsupported by the supervisor. "The experience really picked at the ground of authority that I have. I have a great respect for authority. I follow the rules, for there are reasons for the rules. What really came up for me was my ethics; my ethics with my client had been jeopardized." The parallel between her client's experience and her experience within the agency became clear. "This was a place where we are supposed to be supported. This was a place where trust and respect that I know what I am doing; don't undermine my abilities." Client confidentiality was being jeopardized, "hierarchy would do something despite me saying, 'No that is not okay. No I don't want to do that.' Stephanie's powerlessness reflected her client's powerlessness to stop the abuse and control safety.

The safety issue was the most essential for Stephanie. "It really felt like we jeopardized his safety and if he died, if this guy had found him through our agency. I would have had a really hard time because I would have felt that we were responsible." The client and his family were so disturbed by the possibility of the police pulling their file on the computer that the boy would only come to the agency in disguise. The family did not feel that this was a safe place for the boy to be, but because of the connection the boy and his mother had with Stephanie they did continue for a while. The trauma for the boy was tremendous; he felt very anxious in an insecure environment. "The boy's anxiety was so high he was sick and couldn't sleep when he came in for counselling. As safety was undermined the file had to be terminated. I had a good farewell with the family. They still come and visit and say hi. I still think about it."

Stephanie's personal resiliencies, which help in dealing with VT, include judging and intuiting.

> I think that is really true with my clients, it's a real sensing. I feel that just go in and just do it. Just see what happens, kind of a trusting. But the other part is that I evaluate it as it happens. And I am like that in everything that I am doing. It's not that I am planning and thinking along a certain level, but a part of me is evaluating what's happening, what's taking place. I think to some degree that helps to create a little bit of a screen, so I'm not just feeling things.

The evaluative process creates a screen, which is helpful for Stephanie in maintaining an empathic connection while simultaneously keeping healthy boundaries with her client.

Stephanie described an experience she had with a little girl with attachment issues. This very angry girl was difficult to be with because she responded negatively to keep people away.

> As the little girl was talking about how she hated babies and they were stupid and that she never wanted a baby, they were really dumb... And here I was forming a mom holding a child...I wasn't actually consciously thinking at the time, but then it became conscious and then it was, yeah go with that. For me it was a way of saying yes I'm hearing you but there is also something else. And this was also a way of counteracting whatever that negativity was.

Stephanie identified her positive attitude as resilience. "I have been positive in my work. I always have been positive. That is a characteristic that

allows me to work sometimes in a negative environment." Stephanie noted that her belief system and spirituality are also personal resiliencies.

> I do believe in change. But I think that the faith for me has been more about learning how to let go. Doing the best that you can and then letting go and trusting in and really trying to trust that it will be okay, because there are times when it is sorely tested. I keep faith that change will come in those positive ways I crave. It just may not come how I expected. I always marvel when I pray very specifically about things and allow for transformation here for I have done as much as I can do here. And I am prepared to let it go for it is beyond me, and I hand it off to higher powers. I can maintain my stance then and I think with optimism that there will be transformation, and even if the event doesn't transform me, that it will be okay. There will be a peacefulness that it will come back.

Stephanie included "keeping humour and camaraderie in the workplace" as very important in having good connections with people. "The people who didn't work well here (staff members) are those who didn't feel a sense of camaraderie and trust with other workers." She also includes energy to move fast and be very organized, as traits that have helped her remain balanced in her workplace.

Stephanie believes her environment is very important in helping her stay as relaxed as possible.

> I have pictures that feel really good to me. They are partly for the client, I want them to be relaxing but they bring out good places in me when I look around. I hold reminders of the work I do that I have done

> in clay or the things that people have given me. Some plants, anything that can just remind me of positive things. Things like birds, flowers, music, and coffee. Beauty around me keeps me focused on what beauty there is – seeing beauty in people and seeing growth and change.

Stephanie's garden is therapy. "Here in the garden you don't know what is going to happen, you just use everything you have to nurture the garden and hope that beauty will unfold." This is also a metaphor for her clients. "You use everything you have and hope that beauty will happen and there will be the flowering and blossoming of clients and they will finally come into their full beauty and be able to leave." For Stephanie her garden is a peaceful oasis. "Every year it is a constant reminder of change and growth. It's okay to go through a barren time. If you put in hard work, if you look after things, generally they do pretty well. Everything slows down being there, using all my senses." Other ways of coping include her love of painting and music.

Connecting with her family and child is another way to maintain balance.

> Having a child really helps you connect with children's needs, the stages they go through, a very magical place of being. It's wonderful to feel that very close connection. As a therapist we walk this path that we walk, only we don't hold on to the child, we let go. It is really nice to have that balance of the relationship with a child where there is the opportunity to be in that fuller state. The act of working with difficult relationships between parent and child at work helps focus on the

> knowledge of what you want to bring into your own family... Some of the healthy ones will get to that positive relationship with their children as they just want to have that really great place in time with their kids. It's really nice to help others make that close connection with their own child, and for me to appreciate and value my relationship with my child.

The impact of doing trauma work on Stephanie's personal life is evident in her worldview of safety.

> There are some repercussions of it. I think of children, of my child anyway, in terms of my changed consciousness of knowing things about parents that make you question the idea of relative safety for children, i.e., safety in general. All of it is a balancing act in terms of learning when to promote independence with my child and then when to hold back on it until I know the change is safely handled.

Stephanie said she needed stability at home in order to continue with trauma work. "A lot depends on the security at home, whether it is safe and has a lot of support and peace. When something is going on something major like a death, the combination of work and home stress will destabilize life as you know it."

Analysis of Experience

Stephanie's experience of VT was amplified by her dealings with her supervisor. Stephanie felt she lacked control of the direction in which her supervisor was taking the case. A perceived or actual lack of control can be a factor in VT.

> In our study of trauma therapists, those working in clinic and hospital settings showed higher levels of distress... If the therapist cannot limit his caseload, choose which clients he will work with, obtain adequate resources for the work, and make clinical decisions in the client's best interest, he will feel thwarted clinically, inadequate, resentful, or neglectful. These feelings feed into vicarious traumatization (Pearlman & Saakvitne, 1995, p. 313).

Stephanie felt her client's safety was being violated and her expertise and ethical obligation was not being respected.

Stephanie described reading about the intentional cruelty her client endured. Reading about the

> Undeniable realities of people's cruelty to one another; the horrific abuse, misuse, and neglect of children; and the vulnerability of children to untrustworthy adults overwhelm our defences... If a therapist has the courage not to deny his client's truth, these facts will invariably lead to disruptions in his frame of reference, and change therapists' safety schemas (Pearlman and Saakvitne, 1995, p. 299).

Stephanie reported facing the undeniable realities of people's cruelty to children and its repercussions on her own life. She experienced a change in her frame of reference that was reflected in her safety schemas. She has had more of a challenge balancing her child's need for independence with her questioning of the idea of relative safety for children.

Stephanie's resilience and ways of coping with VT are comprehensive. Having a beautiful, relaxing environment is very helpful in reminding her of the beauty within all people. A positive environment is helpful in feeling

connected with others and remembering the context in which trauma work is done. Stephanie's ability to be present and empathic with a client and maintain a healthy distance is another way of coping with VT. Pearlman & Saakvitne (1995) suggest hearing the traumatic stories told by clients in the context that the client has survived and that there are people that are helping them. This cognition helps the therapist separate from the effect as well as contextualize the incoming information.

Chapter 5:DISCUSSION

This study explore the experience of VT in trauma therapists working entirely with children who had been abused and their families. The research participants or coresearchers were five trauma therapists working at an agency concerned entirely with counseling children who had been abused. Moustakas (1990) used to term coresearcher to describe research participants in a heuristic study. Coresearcher was identified as being an appropriate term as the experience of the research participants and the researcher includes mutual discovery through the illumination of the phenomenon. This chapter is organized into themes common to the coresearchers. Each of the themes is examined and meaning is made of the coresearchers experience of VT. The meaning of the phenomenon is the synthesis of the information collected. The researcher's personal reflection on VT is introduced after the coresearchers synthesized meaning is presented.

Impact on Trauma Therapists

All five of the therapists spoke of bodily experience of VT. Talking about VT caused the therapists to remember bodily sensations. "Yes, even talking about it now I feel it in my belly, and in here somewhere in my heart, and I feel something up here higher, a presence of tears just in there." Three of the therapists connected the bodily sensations with their hearts. One found her heart beating faster and connected it to the client's feelings of helplessness and hopelessness. The sensation of tightness and restriction was another bodily experience. This tightness was a feeling of losing breath and feeling powerlessness. "It is not uncommon for therapists to experience bodily sensations, which parallel those described by their survivor clients"

(Pearlman & Saakvitne, 1995). These bodily sensations were most often linked to feelings like powerlessness, helplessness and hopelessness. These are also feelings, which the coresearchers used to describe their client's experience of trauma.

The coresearchers all mentioned feelings of helplessness, hopelessness, loss of control, powerlessness, lack of credibility, paranoia, and being overwhelmed and flooded when relating their experiences of VT. Four of the coresearchers connected their feelings with those of their clients. "I was experiencing the lack of credibility that she [client's mother] was experiencing. So feeling her helplessness, and feeling the child's helplessness." The experience was framed as mirroring the client's experience. "The symptoms, issues and conflicts experienced by trauma therapists and organisations parallel the traumatic sequelae experienced by survivors" (Sexton, 1999, p. 402).

Four of the therapists mentioned intrusive imagery. The images were "flashbacks", except that they had never experienced the situations they visualized. The images were associated with their client's experience. The imagery system of memory is most likely to be altered in vicarious traumatization. Like the trauma victim, therapists may experience their clients' traumatic imagery returning as fragments, without context or meaning. These fragments may take the form of flashbacks, dreams, or intrusive thoughts (McCann & Pearlman, 1990, p. 142).

"When I hear of horrifying things happening to children I flash it happening to my child, so I pull back in horror. It is a real living experience about feelings, it can be very confusing and distressing." Another therapist

said she was "getting flashbacks and nightmares, flashbacks of material and it was grotesque. I started to experience fear really as I learned what went on (with the child abuse) and how extreme it was." Having difficulty sleeping was an experience that was shared by three of the trauma therapists. "I thought about it all the time. I was thinking about my client. I had trouble sleeping. I would wake up at night and think about her and him [alleged abuser]." A coresearcher shared her experience of being unable to focus. "You carry things around in your head and think about them. I was unable to focus, to concentrate. I was afraid to put anything down on paper." Figley (1995) indicates that the mere knowledge of another's traumatic experiences can be traumatizing resulting in symptoms of PTSD.

All five of the coresearchers stated that their usual ways of coping with work- related stress were not always enough to amelioratize the affects of VT. Three of the therapists discussed feelings of mental exhaustion and the challenge of continuous trauma work. "This kind of work is innately imbalanced, innately we are not meant to deal with other people's problems of this sort day in and day out."

Change in World View

As the therapist listens repeatedly to tales of intentional abuse of children, he may feel overwhelmed by the scope and prevalence of child abuse and cruelty... A change in world-view might include the questioning of how people can be so cruel to one another, are people fundamentally self-serving or evil? He may feel suspicious of every parent he sees with a child in a store or at a park...this worldview disruption also leads us to experience what was once ordinary in new ways. Listening to a parent harshly chastise

his child in the grocery story, once an annoyance, becomes painful and perhaps even terrifying for the vicariously traumatized therapist who may wonder what this child will endure when alone with her parent (Pearlman & Saakvitne, 1995, p. 285).

Three of the coresearchers had children and they all noted a change in the way they viewed safety for their children or for other children they know.

My older child tells me I'm overprotective and I'm always reminding her about safety and feel weird it it's a dad that's looking after her and their child or when my kids have a friend over, I purposely stay detached. I don't want to get too friendly... but I wonder if I'm overreacting. I don't know it's always there.

It is challenging to know whether this change in worldview is an overaccommodation, given their work as trauma therapists, or if it indicates a realistic knowledge that the world is often not a safe place. "A disrupted sense of safety implies increased fearfulness, a sense of personal vulnerability to harm, and increased fears for our children and other loved ones" (Pearlman & Saakvitne, 1995, p. 289). A change in worldview may also be defined as a change in levels of trust. Therapists who have a disruption in their trust schema may, like their clients, be unable to trust external resources (Pearlman & Saakvitne, 1995). Three coresearchers found they viewed people in a more suspicious way. "I definitely think that this work affects how I look at things. I may be more suspicious than other people. I don't know. I am definitely always looking. Everyone is more suspect to me. I'm always watching and I'm listening for dysfunctions and what is really going on." Similarly, two of the coresearchers found trauma

therapy had altered their positive outlook. "Trauma work colors one's general attitude about society, I think. One becomes more cynical and I personally grapple with negativity... so I am very weary and in some ways this job reinforces the view that the world is in a decrepit state."

Personal History

Four of the research participants said that their personal history impacted on their experience of vicarious trauma. "It seems like the [client] material triggers some vestige-thread about my history of pain that I have not resolved and that is what creates images in my head and allows the tears to come." Another research participant identified closely with a client whose experience was similar to his own trauma history. "Because of my own trauma history, there were a lot of similarities with that client. It was so huge to me I couldn't let it go... because I kept thinking what if my family member did this... and I didn't have my safe place." When a trauma therapist's history includes a traumatic experience, he or she might be more susceptible to VT (Pearlman & Saakvitne, 1995). Two of the coresearchers said their personal history impacted their experience of VT but did not disclose their trauma history. The impact of VT was more intense for the trauma therapists when they felt a connection with the client. "The life had just been stomped out of this little boy. That feeling I could still feel, now I mean, maybe I could argue that in my own history I wasn't made to be special enough in my family, I had nothing of the magnitude that this boy had." It was also evident that having a trauma history was also an opportunity for introspection and self-reflection.

Therapists who have personal trauma histories may, to some degree, contribute to their own healing as they share in their clients' growth and change (Pearlman & Mac Ian, 1995). Witnessing a client's healing as they progress can be helpful and hopeful for the trauma therapist. One of the coresearcher's expressed the connection between personal trauma history and resilience. "I know what it is like to be a foster child...and so it gives me a feeling of strength too. Part of my strengths and resiliencies for me is having this experience and it is a wealth of usefulness."

Self-Care, Resilience, and Spirituality

Taking care of yourself is always important, and is essential for a trauma therapist. "Probably the most important recommendation we make to our colleagues about their personal lives is to have one. Balance work with place and rest" (Pearlman & Saakvitne, 1995, p. 394). All of the research participants identified many ways they take care themselves mentally, physically, and spiritually. All five coresearchers have been able to create and maintain helpful ways of coping with the work of trauma therapy. Four of the research participants included taking care of themselves with healthy food, exercise, and rest. "I am really good at taking care of myself. I go to bed early, eat healthy foods, get regular exercise. I'm not a workout person but I walk lots." All five of the coresearchers saw some type of art or creative endeavor as important. The creative activities mentioned included playing music, creating art, gardening, crafts, crocheting, sewing, and being physically active through exercise or dance. Each of these activities in its own way balances with some aspect of the helper, listener, nurturer roles

played in work as trauma therapists (Rosenbloom et al., 1995). One research participant used her garden as a metaphor for the work done at the agency.

I think the garden is a metaphor. Here at work I am not able to choose who I am going to see. I am getting them off a list. I am working with them the best that I can. In my garden I have some control over it and some I have to let go. I do get to choose what I put into the garden; knowing it has characteristics but if I don't know enough about it, then I experience the absolute delight of something unfolding. It's a constant reminder of change and growth.

All five coresearchers performed activities such as yoga, meditation, visualization, and crying, obtained emotional support from others, and practiced their own personal psychotherapy. These habits increase our affection tolerance or reconnect us with our feelings, allowing opportunities to experience and express the full range of human affection (Rosenbloom et al., 1995). One coresearcher discussed self-care through imaging and tears. "After work I will plunk myself down and let come what comes... I stay with my feelings and let the tears pour. I have a profound acceptance for and am an advocate for tears. So I find that it is a gateway to consciousness. So there is crying and imaging and visualization." All five of the research participants said spending time with their family was important in reconnecting with loved ones. Spending time with happy, healthy children can be helpful in rebuilding shattered assumptions about worldview (Rosenbloom et al., 1995).

Three of the participants used filling up of their senses in self care. "Walking on the beach is kind of like things going through... letting it go as

I'm walking... there is something about filling up with the salt air, the sounds at the beach." Two participants mentioned beauty in the environment, reminders of work that is done, positive smells and music.

All of the researchers thought humor was very important for resilience in trauma therapy. It was used extensively at their workplace. "Laughter is a powerful antidote to the gravity of our work, the use of humour is a kind of restorative exercise in perspective taking (Pearlman & Saakvitne, 1995, p. 394). Four coresearchers said being able to connect and interact with colleagues provided resilience. "I think the thing that really supported me was my colleagues, thank God. This would be very difficult if I was doing it in private practice... we have the most wonderful group of people here.

Three of the research participants mentioned having a positive attitude and finding personal meaning as helpful resiliencies for themselves as trauma therapists. Maintaining optimism and hopefulness in the face of human cruelty and tragedy is an essential component in making work with survivors possible (McCann & Pearlman, 1990). A therapist talks about staying positive while working as a trauma therapist. "I can hear and feel the negative, what I try to do is transform it, if I can, because it does take a toll on me. Positive energy re-energizes me. When positive things happen it's like an adrenalin rush." Another coresearcher took a Buddhist attitude that begins with the recognition that there is a lot of pain in life.

> I think that allows me to be resilient because okay those things happen, this is what God has presented us with, and maybe it's what is on our plate. Maybe on a relative level, this is what we have to deal with and

so, not that nothing is able to shock me, but I'm doing this job and that's what I'm going to see, if I were a doctor I'd see blood and guts.

Expectation has aided this coresearcher in the reduction of feeling overwhelmed by the trauma work. Two other research participants mentioned that seeing the child's [clients] resiliency was a positive trait they possessed.

Spirituality was identified in one form or another as important in trauma therapy. All five coresearchers discussed spirituality in a way that was meaningful to them.

Spirituality may be viewed as the meeting place of identity and worldview. Spirituality is an inherent human capacity for awareness of an elusive aspect of experience. It refers to the creation of meaning about self in the larger world... for some, this connection may take the form of a connection with a god or a higher power. For others, the connection may be with nature, with community or humanity, or with some other larger entity or force (Pearlman & Saakvitne, 1995, p. 63).

One research participants talked about the connection she feels with the environment. "I feel an incredible bond with the environment. For that is always there, it doesn't go away... I have these two huge fir trees, I really felt like they were holding their arms up to me. I felt like they were these big towers of strength, they were very supportive." Another participant discussed spirituality.

> I think my faith has been more about learning how to let go. Doing the best that you can and then letting go and trusting it, because there are times when it is sorely tested. I always marvel when I pray very

> specific about things and allow transformation here for I have done as much as I can do. I am prepared to let it go for it is beyond me, I hand it off. There will be this peacefulness that it will come back.

The ability to release control to a higher power releases the trauma therapist. "Practitioners who treated more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients" (Brady et al., 1999, p. 391). One coresearcher talked about how spirituality shapes meaning out of experiences.

> Life is a pretty messy process, both on a physical and psychological level. We can get caught in the negative or we can use these experiences and move through them. Spirituality gives me a context to find meaning. I think spirituality gives my life more meaning. What is meaningful to me is to have some creativity in my life, to be able to have a creative experience and in my relationship with someone and in a way that is meaningful in their lives. So I can deal with their trauma, you can't run away from it.

Trauma brings issues of meaning to the forefront and conducting therapy with survivors of sexual abuse may force therapists to challenge their views of meaning and faith (Brady et al., 1999; Pearlman & Saakvitne, 1990). The ability to extract meaning out of your client's trauma may be helpful in ameliorating the affects of VT.

> "Sexual abuse survivors may serve as a catalyst for therapists' personal growth. This exposure to disturbing material may produce a momentary spiritual crisis and cognitive dissonance but, evidently can eventually result in a stronger, healthier sense of spiritual well-

> being... Also clinicians who feel particularly grounded in a clear philosophy of life may be drawn to work with trauma survivors" (Brady et al., 1999, p. 392).

Spirituality in whatever form is meaningful to the trauma therapist is challenged by the trauma work and may come out stronger because of this examination. Having a context to view the world is a helpful way to work through the challenge of trauma therapy.

The Trauma Agency

All five coresearchers worked at an agency that specialized in counselling children who had been abused. The environment that supports trauma work is very important and impacts the therapist's experience of VT. The structure of the agency was discussed by three of the coresearchers. The agency has a hierarchical structure with a volunteer board of directors. One coresearcher said that the agency structure was a major stressor. "To my mind there is so much internalized oppression that we all deal with all the time and hierarchical structure confuses those patterns and fears." Another research participant was concerned with the volunteer board of directors. "I think it's a problem having a volunteer board of directors. They never really know what it's like to do this work. Only the group of you know, because it's confidential and it's also experiential. Unless you've done it you can't really know." A further comment involved the difficulty in intragency changes.

> I think that the challenging part is when there are intragency changes. When there is a lot of stress due to changes or maybe something happening causing distress within the workplace. I think that's the

most difficult part for therapists looking after themselves and secondary traumatic stress.

The structure and lack of stability of the agency can add to the workplace stress, which can increase the intensity of VT. On the other hand, the structure of the agency and the people who are in authority can help to decrease the impact of VT and are essential pieces to the health of the organization.

> Organizations and agencies whose staff members treat a significant number of trauma survivors also must take responsibility for reducing the likelihood of vicarious traumatization in the workplace. Establishing an emotionally supportive, physically safe, and consistently respectful work environment is especially important when trauma-related issues heighten intrapersonal and interpersonal stress. Regular time set aside in clinical staff meetings to address feelings and concerns related to trauma work is one way to help prevent exacerbation of vicarious traumatization. Furthermore, an organization's willingness to regularly examine systemic issues that may contribute to vicarious trauma is vital to both the organization's and the individual clinician's health" (Brady et al . , 1999, p. 390).

All the coresearchers complained about the previous supervisor at the trauma agency. "It hits me over and over that in the end the workers (trauma therapists) get exploited, disempowered and harmed environmentally and emotionally by the person in charge not making the workplace work to the optimum." The five trauma therapists used the following words to describe their experience in the agency: lack of

mindfulness, distress, anxiety, unsupported, hurtful, reactive, unpredictable, threatening environment, emotionally abusive. All the coresearchers gave examples that typified their emotional reaction. "A big piece of the secondary trauma for me was the agency. This was a place where we are suppose to be supported. This was a place where trust and respect of I know what I am doing; don't undermine my abilities. That is not helpful." The impact the supervisor has on the agency is immense. Organizations have a powerful influence on therapists they employ and on the therapeutic relationships that exist within the organization. Sensitivity on the part of members, and particularly leaders, of the organization to times when organizational dynamics call for change is essential (Pearlman & Saakvitne, 1990). The agency needs to be a container for the strong affect that may emerge through VT.

Communication was a theme mentioned by three coresearchers, who felt it was important to know what was going on in the agency and to feel connected. "The biggest thing that has helped me is just talking about it, communication, it feels like all the lines have just been opened up." Encouraging communication helps to flatten the hierarchical structure of organizations. A research participant cited helpful qualities in an agency supervisor. "A straightforward person who tries to include and elicit everyone's opinion, and give them a place to grow beyond the therapeutic hour with the client. I feel respected, I feel like I have grown several feet." Balancing clinical work with other types of work is helpful in managing VT. Activities and giving a sense of contribution at a broader level than the individual therapy and fostering a sense that of reaching out and helping

more people include teaching, writing, supervising, and conducting research (Pearlman & Saakvitne, 1995). Balance is essential in all areas of life, and especially so when it comes to trauma work. Balancing client load, organizing a schedule so there is a break between challenging clients, and breaking the day with walks, rest, and healthy food, are all important.

Self-care for trauma therapists also includes supervision and consultation. All five of the research participants discussed supervision.

> Here at the agency I find supervision really helpful as far as what I am doing with my clients and debriefing. But when my own stuff is triggered this isn't the place where I want to explore that. It's not that I don't feel comfortable, I just don't want to do that here in this building. To me there is a boundary here, I need to do this on my own.

The type of supervision determines its helpfulness.

> There is a movement in the field of clinical supervision away from an authoritarian, expert-based model of supervision toward a more relational interactive model. This model enables the supervisor to participate with the clinician in an examination of the process (Pearlman & Saakvitne, 1995, p. 374).

All of the coresearchers mentioned group supervision as being very important for ameliorating the affects of VT.

> I find it helpful to talk in groups and hear other people's struggles and issues and so I don't feel alone...that we are all in it together. So it is that group experience, I find that helpful. Sometimes it's really nice to be able to be in a group and have other people's idea and thoughts on what's happening...it would be helpful to look more at the issues and

> how they relate to your own life and the triggers. That is something we don't do a lot of.

The difficulty with group supervision is that there is less time to focus on any one individual's issues, and that it can be more difficult to establish trust within a group than in one-to-one supervision (Sexton, 1999). Three coresearchers acknowledged the time it takes to establish trust within group supervision and suggested groups remain intact for over a year to accommodate this. One coresearcher offered a suggestion to heighten the experience of supervision groups.

> I would like to be bold enough so that I could somehow get people to come to that emotional place where they can accept that I am in charge I am not falling apart when I cry. If the group would be totally delighted that I was crying, that could be more of a general approach and attitude by people at the agency and could be great to release stress for everybody involved.

Another coresearcher noted the importance of a different sensory experience as a way of expressing affection. The contained environment in supervision could be used to freely express VT through song or movement.

Four of the coresearchers discussed the helpfulness of an external psychological consultant. The personality of the consultant appeared to be a factor in whether the trauma therapist felt comfortable using that person as a resource. The agency and its resources have a tremendous impact on the trauma therapists. The impact of VT on trauma therapists is unavoidable, and it can be ameliorated by proactive strategies implemented by trauma treatment agencies and by individual therapists. Helpful strategies include an

organizational culture that acknowledges and normalizes VT reactions and offers practical support, providing opportunities for therapists to process the impact of their clients' traumatic material. It is also recommended that therapists maintain a range of supportive professional relationships, such as supervisors, colleagues, and team members with whom they can discuss and process their reactions (Sexton, 1999).

Recommendations for the agency

The trauma agency is the container for the therapists and their work with people who have been traumatized. The impact of the trauma agency was reflected by all of the participants. Common themes identified by the coresearchers are included in the following recommendations:

1. Open communication and inclusive involvement in agency direction.
2. Supervisors who are able to foster awareness and acceptance of VT.
3. Enabling therapists to balance clinical work with other types of clinical and non-clinical activity. I.e. Student supervision; presentations and education; writing and conducting research; imput into client load; organizing daily schedule to allow for breaks between challenging clients, and break's for self care.
4. Group and individual supervision and consultation that is relational, interactive, creative, and personally meaningful for therapists.

Brady et al., (1999) stresses the importance of establishing an emotionally supportive, physically safe, and consistently respectful work environment especially when trauma issues heighten intrapersonal and interpersonal stress.

Personal Reflections

Vicarious traumatization came into my awareness when I had my first child. When my first beautiful baby was born the awareness of personal safety came to the forefront. How could anyone hurt these vulnerable children? Children should be protected and cherished. I knew I was experiencing some type of transformation, I felt overwhelmed with tears for clients. I feel a profound sadness for the cruelty inflicted on children, I know the world is not always a good or safe place. I am made aware of countertransference and VT especially when I have a client who reminds me of my boys. After I heard one particularly horrifying story about a client I had a dream that night. The child was not in a safe place and that theme was evident in my dream. This is my recount of my dream:

> I was in a local grocery store with my two year old son. I noticed he was playing peek-a-boo with a young good looking man at the store. I felt uncomfortable and so we quickly left. I was then outside of my home, in my dream we lived in cooperative housing. A good friend came to me and said that this particular man had applied to live in the co-op. He was going to be allowed to move in as they said we couldn't not let him, at least not until he did something wrong. I remember feeling so angry that someone was going to get hurt before we could do something. I was then in a playground with my son, I knew it was going to blow up, and so I hurried my son away from there. Unfortunately I died in the explosion at the playground. In my dream I came down from heaven to see my son. I was at my son's baseball game. I remember thinking that nobody could see me as I was

invisible. I was wondering if I would recognize my son as he would be nine or ten by then. I remember seeing his beautiful face, I then looked over and saw the coach. It was the same young man who gave me that uncomfortable feeling in the grocery store. I knew that man was abusing my son and that I couldn't save him.

I still feel the sorrow when I tell this story.

I wrote a poem one day at work as I was sitting looking at a poster of a little boy. I was feeling accumulative work stress and my son was again on my mind.

Sitting at Work

Sitting at work
Looking at a picture of a child sitting with his back towards me
Little knees bent
His small feel facing me
I've seen Ethan sitting that way
He looks so tender and vulnerable
The smallness of his body, the curve of his neck and curl of his hair
It says 'It shouldn't hurt to be a child'
I feel the pain and sadness in my heart
My eyes filling
I'm overwhelmed and over filled by grief the loss of innocence causes
My face aches from crying for children who are so vulnerable
Their pain at not being cherished
The gift that they are, not being recognised.

Implication of Research

Trauma therapists, educational institutions, and trauma therapy organizations, must acknowledge the impact of VT and to examine helpful ways to ameliorate its effects. Acknowledging that secondary exposure to traumatic material will over time lead to symptoms similar to those experienced by the trauma survivor is the first step in creating an acceptance of the phenomenon. Educational institutions that train therapists need to include information about VT and how to lessen its effects. Trauma therapist who are not aware of the life changing effects their work has on them will not know about the possible damage they could unwittingly do to future clients. Organizations that work extensively with traumatized people have a responsibility to provide a safe, supportive place to process effect and cognition related to their client's traumatic material.

Limitations

One limitation of this study is that the results reflect the opinions and experience of trauma therapists from a single agency in Western society. Therefore, the findings cannot be generalized beyond these parameters. Another limitation is the minimal use of triangulation. Further insight may have been obtained through the use of quantitative measurement using the Traumatic Stress Institute Belief Scale. This scale measures disrupted cognitive schemas of trauma therapists.

Recommendations for Further Research

I recommend a study comparing male and female trauma therapists, to see if there is a difference in their experiences and whether there are

different ways to ameliorate their experiences of VT. In this or other research it would be helpful to examine culturally diverse trauma therapists and their experiences of VT. Further research might include examining the type of trauma therapists are working with, and comparing VT for these therapists. These suggestions might lead to more helpful ways to support trauma therapists in reducing the effects of VT.

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Appendix A

Heuristic Study of Trauma Therapists and Secondary Traumatic Stress

Date: June 26, 2000

Dear:

Thank you for your interest in my thesis research on the experience of Secondary Traumatic Stress. I value the unique contribution that you can make to my study and am excited about the possibility of your participation in it. The purpose of this letter is to reiterate some of the things that we have already discussed and to secure your signature on the participation release form that you will find attached.

The research model I am using is a qualitative one through which I am seeking comprehensive depictions or descriptions of your experience. In this way I hope to illuminate or answer my question: *What are trauma therapists doing to minimize Secondary Traumatic Stress?* This question includes interest in personal resiliencies or coping skills the individual may have as well as external self care strategies. Another area of interest involves the impact personal life changes (i.e. Marriages, separations, children, work changes etc.) have for trauma therapists and their experience of secondary trauma.

Through your participation as a coresearcher, I hope to understand the phenomenon as it reveals itself in your experience. You will be asked to recall specific episodes or events in your life in which you experienced the phenomenon we are investigating. I am seeking vivid, accurate, and comprehensive portrayals of what these experiences were like for you: your thoughts, feelings, and behaviours, as well as situations, events, places, and people connected with your experience. You may

also wish to share personal logs or journals with me or other ways in which you have recorded your experience- for example, in letters, poems, or artwork.

I value your participation and thank you for the commitment of time, energy, and effort. If you have any further questions before signing the release form or it there is a problem with the date and time of our meeting, I can be reached at 361-3653.

Sincerely,

Leisa Dauncey

VITA

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Title of Thesis:

Heuristic Study of Trauma Therapists and Vicarious Trauma

Author 

Leisa Michelle Dauncey

July 30, 2001