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The Solution within the Work: A Scoping Review on Vicarious Resilience

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There are no known conflicts of interest to disclose.

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Abstract
The occurrence of burnout amongst healthcare workers and other helping professionals is a persistent problem, despite efforts made by individuals and organizations to prevent countertransference and the accompanying negative personal experiences. Vicarious resilience is a relatively new concept, highlighting the benefits one may experience from professional encounters with those who have survived trauma or other difficult life circumstances. Previous research detailing the personal effects of trauma work is predominantly negative, warning of vicarious trauma, secondary traumatic stress and compassion fatigue. This scoping review examines emerging evidence on vicarious resilience, featuring a more hopeful outlook for helping professionals. Recommendations from the research guiding professionals to experience vicarious resilience for themselves is included. Two original vicarious resilience practices are introduced.

Keywords: vicarious resilience, resilience, vicarious trauma, secondary traumatic stress, compassion fatigue, burnout, empathy, posttraumatic growth, compassion satisfaction
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I would like to thank my parents, Mark and Kelly Sova, for believing in me through every twist and turn of life. The countless hours spent with you on phone calls always brought peace and encouragement. Thank you to my siblings, Curt Sova and Kate Parillo, for your constant support and excitement and your grace as I ducked away during family trips to complete schoolwork. And to my partner, Tyler Munroe, thank you for your undying patience and love. Your sincere belief in my ability to accomplish any dream is what motivated me to pursue this degree. Finally, I would like to acknowledge my grandpa, Richard Sova, for instilling the importance of education in me from a young age. Your love of learning is something I have always admired and, perhaps, even acquired vicariously from you.
The occurrence of burnout amongst helping professions has been studied at length. Solutions have been offered, trainings created, and recommendations applied, yet the prevalence of burnout persists, especially within the healthcare setting. A study by Han et al. (2019) suggested that medical organizations across the United States spend a cumulative 4.6 billion dollars on burnout-related turnover and reduced clinical hours of physicians alone (Han et al., 2019). Another study found that turnover costs each healthcare facility more than five percent of their total operating budget every year (Waldman et al., 2010). And the medical companies aren’t the only victims of this occurrence. A study by Zhao et al. (2019) analyzed the effect of burnout on the cost of healthcare for patients in a remote community in Australia. Researchers found that cost differentials between clinics were directly proportional to staff turnover. An increase in rate of turnover by 10 percent equated to an extra $6.12 per consultation (Zhao et al., 2019). In addition to the fiscal damage caused by turnover, there is the unfortunate impact on patient care and clinical outcomes (Webster & Flint, 2014). For example, a study by Bae et al. (2010) found that high levels of workgroup learning, or the transfer of knowledge from senior level staff to newer staff, amongst nurses directly reduced the occurrence of severe medical errors. As turnover increased, workgroup learning decreased, demonstrating the dangerous side effect of turnover in the healthcare environment (Bae et al., 2010).

In an article by Cummings et al. (2018), researchers explain that turnover is likely due to helping professionals’ “indirect exposure to clients’ trauma [which] increases the likelihood of experiencing negative psychological responses including vicarious trauma, secondary traumatic stress and burnout” (Cummings et al., 2018). Definitions of these and related terms can be found in the “Objectives” section (pg. 9). Vicarious trauma has appeared as the topic of research in a variety of fields including, but not limited to music therapy, social work, psychiatry, child welfare, and dentistry (Arseneault, n.d.; Blome & Safadi, 2016; Bride, 2007; Gooding, 2019; Kochi et al., 2017; Martinez, 2016; Thomas, 2016; Uziel et al.,
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2019). The body of research brings to light a need for increased resilience amongst helping professionals.

Resilience is considered to be the antidote to burnout; the ability to persevere despite seriously difficult life experiences. In his critical review of resilience theory and its relevance for social workers, van Breda describes resilience as “The multilevel process that systems engage in to obtain better-than-expected outcomes in the face or wake of adversity” (van Breda, 2018). The “better-than-expected outcomes” van Breda describes are assumably desirable for any professional, so how does one embody resilience? A new phenomenon sheds light on a solution. The term vicarious resilience (VR) was first published in 2007 by Hernández (referred to later as Hernández-Wolfe due to name change), Gangsei and Engstrom when the team discovered that a sample of trauma psychotherapists (n=12) increased their own ability to cope with adversity as a direct result of their work with resilient clients. In the article, VR is described as being “characterized by a unique and positive effect that transforms therapists in response to client trauma survivors’ own resiliency ... it refers to the transformations in therapists’ inner experience resulting from empathic engagement of trauma work” (Hernández et al., 2007). Hernández and her colleagues have supported their initial findings with an array of qualitative and quantitative evidence. Included in their publications are a validated scale to measure VR and a framework for a VR training course (Hernández et al., 2010; Killian et al., 2017). Their efforts to authenticate VR have been supported by teams of researchers from around the globe, all with the goal to build evidence for and promote VR amongst helping professionals.

Rationale

Vicarious Trauma

Surpassing VR in its depth and history of evidence is the occurrence of vicarious trauma. Revisions to the diagnostic criteria for posttraumatic stress disorder were made in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to include that secondary exposure to
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trauma can lead to impairing symptoms requiring treatment (Hensel et al., 2015). Though studies in vicarious trauma began specifically with trauma therapists, it has expanded to include helping professionals of many kinds. As there are many types of helping professionals, there are also many types of clients and many types of trauma. For example, pediatric medical trauma or “the psychological and physical response experienced by children and their families as a result of encountering pain, injury, serious illness and invasive medical procedures” is a more recently recognized form of trauma (McGarry et al., 2013). Considering this, staff at pediatric medical centers may each be subjected to feelings of vicarious trauma through their experiences with the patients and their families.

Research in the field of music therapy reveals clinicians have an increased risk for vicarious trauma due to a high prevalence of pain, anxiety, distress and trauma experienced amongst their clientele. A survey of music therapists (n=1,023) revealed that more than one third reported working with clients who were “distressed and/or traumatized” (Hearns, 2017). Another study found that, out of a sample of 68 music therapists who had worked for five or more years, 52 scored “moderate” and 29 scored “high” for degree of burnout in at least one of the subscales of the Maslach Burnout Inventory (MBI) (Maslach, 1986; Oppenheim, 1987). Additionally, an integrative review revealed that music therapists scored higher in levels of emotional exhaustion when compared to other mental health professionals (Gooding, 2019). Since music can be a gateway to suppressed emotions and memories, music therapists may be at an increased risk for experiencing vicarious trauma. This gateway effect means they are regularly privy to their clients’ experiences, good or bad (Hearns, 2017). Plus, music therapy is a bachelor’s level entry field, so new professionals may be younger and less experienced than helping professionals from other fields.

A survey of 294 social workers found that 45 (15.2%) met the core criteria for a diagnosis of posttraumatic stress disorder, which was nearly two times the US general population’s prevalence, 7.8% (Bride, 2007). A sample of Palestinian social workers (n=25) reported that their symptoms negatively
impacted their ability to complete tasks, serve clients, and manage the stress of their surroundings (Blome & Safadi, 2016). Within the field of dentistry, levels of vicarious trauma in dentists ($n=250$) were found to be positively correlated with number of working hours per week and negatively correlated with empathy (Uziel et al., 2019). And within the field of child welfare, a study found that rates of vicarious trauma amongst workers were being reported at rates between 26 and 34% (Dombo & Blome, 2016).

Resilience

The evidence spanning across professions depicts a gloomy outlook for helping professionals. However, the possibility for resiliency is also revealed. For instance, in the study by Bride (2007) during which 15.2% of social workers met criteria for a PTSD diagnosis, about 30% of the sample reported no secondary traumatic stress symptoms (Bride, 2007). So, how is it possible that people can have similar experiences, yet respond differently? A meta-analysis revealed that personal trauma history was significantly correlated with secondary traumatic stress and may be a risk factor for developing it (Hensel et al., 2015). Similarly, a study by Nurius et al. (2014) found that amongst a sample of adults ($n=13,593$), adverse childhood experiences (ACEs) had a significant positive effect on missed days at work (Nurius et al., 2015). On the other hand, it is also believed that adversity may strengthen resistance to stress later in life (Rutter, 2006; Werner 1996). For example, a longitudinal study followed infants born in 1920 and 1921 ($n=167$) through adulthood. It was discovered that many of the participants displayed exceptional psychological strengths, despite being exposed to the social and economic deprivations of the Great Depression during their adolescent and young adult years (Elder, 1975).

There is also evidence that genetics may play a role in one’s capacity for resilience. The serotonin transporter gene (5-HTTLPR) is the most likely subject for a genetic indicator of resilience. The naturally occurring, genetically transferred, short allele of 5-HTTLPR results in lower reuptake of serotonin and has been associated with depression after exposure to childhood maltreatment. It is suggested that this genetic factor may be a determinant of resilience (Southwick & Charney, 2012).
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Southwick and Charney also present an explanation for the contradictory evidence on how a history of traumatic experiences may affect resilience. They conclude that repeated exposure to uncontrollable stress during infancy and childhood may lead to “learned helplessness” which can cause exaggerated emotional and behavioral responses to stressors. However, “mild-to-moderate stressors that are controlled and mastered can have a ‘steeling’ or stress-inoculating effect, where the child develops an adaptive stress response and becomes more resilient than normal” (Southwick & Charney, 2012).

While trauma early in life may make it harder for adults to manage stressors, it may also motivate them to become helping professionals. One study found that a sample of students enrolled in a Master of Social Work program (n=79) had a significantly higher occurrence of ACEs when compared to samples of the general population, university students, and child welfare workers. Out of the sample of social work students, 41.8% reported at least four or more ACEs, which is more than three times the rate of the university students (12.4%) (Thomas, 2016). The occurrence of personal trauma history amongst trauma workers is a befitting asset, allowing a deeper understanding of their clients. So, how can these individuals and other helping professionals increase their resilience to remain in their essential roles? This scoping review aims to bring awareness to a body of evidence in support of VR and empower helping professionals to realize the positive effect that their work can have on their own resilience. The purpose of a scoping review is to provide a “preliminary assessment of the size and scope of the available research literature” (Grant & Booth, 2009). Though a comprehensive review of VR literature was conducted in 2018, new research has emerged, increasing the diversity amongst participants beyond what was previously limited to mostly trauma therapists (Hernández-Wolfe, 2018).

Objective

The research question presented with this scoping review is: How can helping professionals experience the benefits of vicarious resilience to combat the effects of vicarious trauma and burnout? In the context of this review, a helping professional is defined as someone who “provide[s] health and
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education services to individuals and groups” (APA dictionary of psychology, n.d.). This includes healthcare professionals such as nurses, physicians, social workers, music therapists, and psychologists and other professionals such as law enforcement officers, teachers and childcare providers. As a reference, commonly utilized terms found in the literature are included below.

- **Vicarious resilience**: the “unique and positive effect that transforms therapists in response to client trauma survivors’ own resiliency” (Hernández et al., 2007).
- **Vicarious trauma**: “the profound psychological effects ... that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons” (McCann & Pearlman, 1990).
- **Burnout**: “a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity” (Maslach et al., 1986).
- **Compassion satisfaction**: “the satisfaction/gratification that results from being able to aid others” (Cummings et al., 2018).
- **Compassion fatigue**: “a result of indirect and often repeated exposure to the trauma of others—sometimes referred to as ‘the cost of caring’” (Thomas, 2016).
- **Posttraumatic growth**: “a significant positive psychological change following a major life crisis/trauma” (Cohen & Collens, 2013).
- **Empathy**: “the capacity to be aware of, understand, and vicariously experience the world and perspective of another, and to feel their distress” (Wilson & Brwynn, 2004).

**Methods**

The protocol for completing a scoping review by Tricco et al., (2018) was followed closely during this review (Tricco et al., 2018). Prior to the search process it was determined that to be included in the review, sources must be peer reviewed journal articles, feature new findings by source of participant
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data or results of literature review, be published in English, and contain the keywords “vicarious resilience” within the title of the article. Publications were excluded if they proposed research or ideas with no new findings, were in forms other than peer-reviewed articles, or in languages other than English. Since the first publication on VR was published by Hernández et al., (2007), search results published before 2007 were also excluded (Hernández et al., 2007).

Comprehensive searches were conducted utilizing the database Google Scholar and the Western Michigan University database library which hosts 573 databases including ProQuest and PubMed. Dates of access to both Google Scholar and the Western Michigan University database library were September 28, 2020, September 29, 2020, October 5, 2020, October 6, 2020, December 5, 2020, December 6, 2020 and December 7, 2020. The keywords utilized in the search were “vicarious resilience,” “secondary resilience,” “vicarious trauma resilience,” and “secondary traumatic stress resilience.” Upon identifying an includable source, the full text of the publication was obtained and data including authors, date of publication, participant population, methods utilized, results and recommendations from each source were inputted into a Summary of Findings table (see Table 1 in Appendix A). In accordance with the research question, the recommendations section of the summary of findings table refers to the researchers’ practical recommendations for how helping professionals may experience VR, rather than recommendations for future research.

Results

Database searches revealed tens of thousands of sources. A flow diagram of the search results of the keywords “vicarious resilience” is presented below in Figure 1. Includable publications located with other keywords resulted in only duplicates.
As is displayed in Figure 1, the keyword search of “vicarious resilience” on Google Scholar and the Western Michigan University database library yielded 24,851 publications. The most significant reduction in sources \((n=19,520)\) occurred when removing publications without “vicarious resilience” within the title. A total of 29 publications were screened and nine were excluded because they were not peer reviewed journal articles or they contained no new findings. Of these nine publications, five were book chapters, three were ideas or proposals for research, and one was a framework for a training...
designed to teach VR to trauma therapists (Hernández et al., 2010). The remaining 20 studies with a cumulative 988 participants provide the body of evidence supporting VR and present recommendations for how helping professionals may benefit from the phenomenon.

**Included Study Demographics**

Included in the scoping review are 14 qualitative studies (Acevedo & Hernandez-Wolfe, 2014, 2020; Edelkott et al., 2016; Engstrom et al., 2008; Hernández et al., 2007; Hernandez-Wolfe et al., 2015; Hernandez-Wolfe & Acevedo, 2020; Michalchuk & Martin, 2019; Pack, 2014; Pair, 2018; Puivimanasinghe et al., 2015; Silveira & Boyer, 2015; Velut, 2019; Welsh, 2014), three quantitative studies (Frey et al., 2017; Killian et al., 2017; Reynolds, 2020), one mixed methods study (Trivedi, 2017), one case study (Tassie, 2015) and one comprehensive review (Hernández-Wolfe, 2018). Within the body of evidence, helping professionals included therapists, psychologists, counselors, social workers, helpers of injured animals, sexual assault and domestic violence advocates, law enforcement officers, teachers and community mothers. Results of the 14 qualitative studies consisted of identification of common themes derived from participant interviews. Of the four studies with quantitative results, a multiple regression analysis (Frey et al., 2017), an exploratory factor analysis (Killian et al., 2017), and two correlational analyses were utilized (Reynolds, 2020; Trivedi, 2017). The case study provided a different perspective into VR by examining the effects of the intrapsychic worlds between client and therapist through three cases (Tassie, 2015). Finally, the comprehensive review synthesizes the findings of 10 studies on VR and offers a recommendation based on the compilation of findings (Hernández-Wolfe, 2018).

**Qualitative Results**

The qualitative studies and mixed methods study identified a cumulative 112 themes from interviews with helping professionals. Common themes across studies were identified and categorized (see Table 2 below). The themes were categorized into those associated with positive feelings or emotions, those associated with negative feelings or emotions, and those which are neutral or could be
associated with either positive or negative emotions. The frequency of theme occurrence was also included. Any theme identified in more than one publication was included. The common themes identified in the qualitative studies were most frequently positive \((n=36)\) or neutral \((n=19)\), with only 11 common negative themes identified (see Table 2).

**Table 2**

*Thematic results of qualitative studies*

<table>
<thead>
<tr>
<th>Negative Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist’s own adversities/problems</td>
<td>3</td>
</tr>
<tr>
<td>Vicarious trauma</td>
<td>3</td>
</tr>
<tr>
<td>Compassion fatigue</td>
<td>2</td>
</tr>
<tr>
<td>Challenges</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neutral Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perspective taking/alteration in perspective</td>
<td>5</td>
</tr>
<tr>
<td>Relational skills</td>
<td>2</td>
</tr>
<tr>
<td>Changes in interpersonal relationships</td>
<td>2</td>
</tr>
<tr>
<td>Personal &amp; professional identity</td>
<td>2</td>
</tr>
<tr>
<td>Shared experience or journey</td>
<td>2</td>
</tr>
<tr>
<td>Recognition Cultural considerations</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience of clients or selves</td>
<td>9</td>
</tr>
<tr>
<td>Hope</td>
<td>6</td>
</tr>
<tr>
<td>Inspiration</td>
<td>5</td>
</tr>
<tr>
<td>Spirituality/faith</td>
<td>3</td>
</tr>
<tr>
<td>Empathy</td>
<td>3</td>
</tr>
<tr>
<td>Flexibility</td>
<td>2</td>
</tr>
<tr>
<td>Coping</td>
<td>2</td>
</tr>
<tr>
<td>Strength</td>
<td>2</td>
</tr>
<tr>
<td>Learning</td>
<td>2</td>
</tr>
</tbody>
</table>

**Quantitative Results**

Though outnumbered by the qualitative studies, the quantitative research methods revealed important findings. Utilizing a multiple regression analysis, Frey et al. (2017) tested the prevalence of VR amongst a large sample of advocates for survivors of sexual assault and domestic violence \((n=222)\). Participants completed six surveys (see Table 1) to determine rates of vicarious posttraumatic growth,
compassion satisfaction, perceived organizational support, and other related factors. The analysis revealed that the experience of personal trauma and peer relational quality predicted increased VR. This supports the theory that one’s experiences of adversity may strengthen their ability to handle stressors later in life (Elder, 1975; Rutter, 2006; Southwick & Charney, 2012). After controlling for shared variance, researchers found that both organizational support and peer relationships were positive predictors of VR, with organizational support being the sole predictor of compassion satisfaction, and peer relational quality being the sole predictor of vicarious posttraumatic growth (Frey et al., 2017).

In 2017, Killian et al. published the first VR measurement, the Vicarious Resilience Scale (VRS) (Killian et al., 2017) (see Appendix B for the full VRS). Upon initial use of the scale, a Cronbach’s alpha reliability analysis of .92 demonstrated adequate to very good reliability of the 27-item scale. The VRS was administered to a sample of helping professionals working with survivors of severe trauma from around the world (n=190) along with the Posttraumatic Growth Inventory Short Form (Cann et al., 2010), the Professional Quality of Life scale (Stamm, 2003), the Olso Social Support Scale (Dalgard et al., 1995), a trauma history questionnaire (Killian, 2008) and a 6-item measure of work morale. As predicted, the VRS was positively correlated with posttraumatic growth and compassion satisfaction. The VRS was not correlated with compassion fatigue or burnout, which suggests that VR is “a unique construct that is not merely ‘the opposite’ of compassion fatigue or burnout” (Killian et al., 2017). An exploratory factor analysis was used to consolidate results into seven key factors: changes in life goals and perspective, client-inspired hope, increased recognition of clients’ spirituality as a therapeutic resource, increased capacity for resourcefulness, increased self-awareness and self-care practices, increased consciousness about power and privilege relative to clients’ social location, and increased capacity for remaining present while listening to trauma narratives (Killian et al., 2017). Interestingly, the first three factors listed (changes in life goals and perspective, client-inspired hope, increased recognition of clients’ spirituality as a therapeutic resource) were some of the most frequently reported
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themes amongst the qualitative studies (see Table 2): alteration in perspective (frequency of 5), hope (frequency of 6) and spirituality/faith (frequency of 3).

Social worker, Trivedi, utilized the VRS (Killian et al., 2017) in her mixed methods study along with the Professional Quality of Life Scale (Stamm, 2011), Vicarious Trauma Scale (Vrklevski & Franklin, 2008), and Empathy Assessment Index (Gerdes et al., 2011) to determine potential relationships between VR, vicarious trauma, and a number of other related factors amongst a sample of psychotherapists \( (n=77) \). Similar to the results by Killian et al. (2017), a correlational analysis suggested that VR was positively correlated with compassion satisfaction. The ability to remain present during trauma narratives (a subscale of the VRS) was negatively correlated with burnout, vicarious trauma and secondary traumatic stress. Surprisingly, the participant’s hours spent working with trauma survivors was positively correlated with VR and their years of experience working with trauma survivors was positively correlated with a subscale of the VRS, increased capacity for resourcefulness. This provides evidence that, as one’s experience grows, the effect of VR also increases. While there was no significant correlation found between VR and vicarious trauma, a Pearson correlation test run between vicarious trauma scores and the subscales of the VRS revealed that one subscale, “capacity to remain present during trauma narratives” was negatively correlated with burnout, vicarious trauma, and secondary traumatic stress. This finding challenges the hypothesis presented by Killian et al. (2017) and suggests that at least one piece of VR may be dependent on the adverse effects of trauma work (Trivedi, 2017).

A recent study by Reynolds (2020) also utilized the VRS (Killian et al., 2017) and the Professional Quality of Life Scale (Stamm, 2011) with a sample of 302 practitioners working with trauma survivors. The sample reported a mean score of 95.5 on the VRS, indicating a strong prevalence of VR. Again, a positive correlation between VR and compassion satisfaction was found. However, results of this sample showed that VR was negatively correlated with burnout and secondary traumatic stress. Finally, length
of practice and presence of trauma-informed supervision were found to be positively correlated with VR (Reynolds, 2020).

**Practical Recommendations**

All included research revealed significant results supporting the presence of VR amongst a variety of helping professions. This fosters hope that, not only may these workers be spared from the negative effects of their work, but they may even experience increased personal resilience from their interactions with patients or clients. Though, the question of “how?” still remains. How may a therapist, healthcare worker, law enforcement officer or other helping professional begin to experience VR if they wish to? A pie chart illustrating recommendations for the practical application of VR found in the literature is presented below (see Figure 2). Some publications offered multiple solutions yielding a cumulative 29 recommendations from the body of research. The frequency of each recommendation is also included.

**Figure 2**

*Recommendations for practical application of VR amongst helping professionals*

Increasing education as a way to promote VR was the most commonly referenced recommendation (*n*=12). One source specifically indicated that it is the employer’s duty to educate
employees (Pack, 2014), and two sources indicated that the national organization of each profession
should be responsible for educating professionals about VR (Frey et al., 2017; Pack, 2014). Increasing the
awareness of VR to boost its effects was recommended 10 times throughout the body of research.
Because increasing education will be an important way to increase awareness, these two most
frequently recommended ways to boost VR may be accomplished with a single intervention.

The implementation of clinical supervision (n=3), adjustment of practice (n=3) and specific
character traits of the therapist (n=2) were also recommended as contributors for increased VR. The
adjustment of practice category refers to adjustment of clinical practice, and the therapist’s own
selfcare practices. Two publications proposed specific aspects of clinical practice which may contribute
to VR. The first indicated that a strengths-based approach to treatment may positively impact the
therapists themselves (Edelkott et al., 2016). Another source indicated that remaining in contact with
clients after treatment concluded may benefit their sample of advocates for survivors of sexual assault
and domestic violence in order to witness the positive growth which occurs posttherapy (Frey et al.,
2017). The third source advocated for utilizing narrative-self-stories, or the practice of telling the
therapist’s own story, as a selfcare practice for improved VR (Acevedo & Hernández-Wolfe, 2020). While
more difficult to control, the therapist’s own character traits were identified as contributing factors for
VR in two studies. Social worker, Tassie, published a case study (2015) with findings that the therapist
must display self-awareness, and a close empathetic relationship with clients in order to benefit from VR
(Tassie, 2015). Additionally, Hernández-Wolfe (2018) mentioned the need for attentiveness and
professional conduct amongst therapists in order for VR to occur (Hernández-Wolfe, 2018).

The findings of the body of research suggest that it is possible for helping professionals to
experience their own resilience as a direct result of the work they do. The qualitative research identified
common positive themes such as “resilience,” “hope,” and “inspiration” at a higher rate than the
common negative themes. Evidence from the quantitative research found positive correlations between
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VR and posttraumatic growth (Killian et al., 2017), compassion satisfaction (Killian et al., 2017; Trivedi, 2017), presence of supervision (Reynolds, 2020), and experience in the field (Killian et al., 2017; Reynolds, 2020; Trivedi, 2017). In addition, personal trauma, peer support, and organizational support predicted increased VR (Frey et al., 2017). Out of the 20 publications, 19 included a recommendation for increased awareness and/or education of VR as way to allow helping professionals to benefit from it.

Discussion

The results clearly demonstrate that it is possible for helping professionals to be uplifted by their work and experience increased vicarious resilience as a result of working with patients and clients who have survived trauma or difficult life circumstances. Results of the qualitative research indicates that helping professionals were mostly optimistic when describing how they are impacted by their work throughout interviews. The research participants represent a diverse range of professionals including teachers, law enforcement officers, community mothers and helpers of injured animals. The overwhelming presence of positive themes identified by the participants in the VR studies contradicts previous research, which hypothesize that helping professionals will internalize the client’s trauma and experience negative personal outcomes (Cummings et al., 2018; McCann & Pearlman, 1990).

Some of the quantitative results are easy to explain, such as the finding that VR was positively correlated with compassion satisfaction. This indicates that participants who were naturally inclined to get gratification from helping others were also more likely to experience VR (Frey et al., 2017; Killian et al., 2017; Reynolds, 2020; Trivedi, 2017). VR was also positively correlated with posttraumatic growth, providing evidence that participants who had overcome their own traumatic experiences, were better able to experience VR (Frey et al., 2017; Killian et al., 2017). In addition, supervision was shown to contribute positively to VR, supporting the recommendation that healthcare providers have opportunities to talk through difficult work situations and receive guidance (Reynolds, 2020).

Interestingly, increased hours of weekly trauma work and increased years in the field of trauma
work was also positively correlated with VR across two studies (Reynolds, 2020; Trivedi, 2017). It would be easy to hypothesize the opposite effect, that as hours of trauma work and years of experience increase, vicarious trauma would escalate, making it more difficult to experience VR. A detail that is not explicitly mentioned in the literature, but may be assumed is that, in order for professionals to experience VR, they must observe resilience in their client in some way. So, the positive correlation between VR and time or experience with trauma work may be caused by an increased likelihood to encounter resilient clients. The more time spent working, the more likely someone is to come across exceedingly resilient individuals. It may also be true that the presence of VR does not equate to lower levels of vicarious trauma; so, while these seasoned professionals report high levels of VR, they may also be simultaneously experiencing vicarious trauma.

Research by Killian et al. (2017) found no correlation between VR and burnout or compassion fatigue amongst their sample. This suggests that VR is not simply the absence of the negative side effects of trauma work, but instead a unique construct, an idea which was hypothesized in earlier research (Engstrom et al., 2008; Hernández, 2010; Hernández et al., 2007; Hernández-Wolfe et al., 2015). Hernández-Wolfe et al. (2015) describes this stating, “We hypothesized that vicarious resilience is also a unique and common consequence of trauma work that may coexist with vicarious trauma” (Hernández-Wolfe et al., 2015, p. 157). However, a recent correlational analysis by Reynolds (2020) found that VR was negatively correlated with burnout and secondary traumatic stress (Reynolds, 2020). These new findings suggest that experiencing the negative side effects of trauma work may make it more difficult for professionals to feel the benefits of VR. The quantitative findings of the study by Trivedi et al. (2017) found that only one specific subscale, “capacity to remain present during trauma narratives,” of the VRS was negatively correlated with vicarious trauma. All three studies utilized professionals working with survivors of trauma as their participants. The sample of professionals in the research by Killian, et al. (2017) had a mean VRS score of 113 out of a possible total of 135, and the
sample in the research by Reynolds (2020) had a mean score of 95.5 out of 135. Both scores indicate high levels of vicarious resilience amongst participants. A mean score on the VRS was not reported by Trivedi (2017). While neither the Killian et al. (2017) or Trivedi (2017) articles reported their sample’s specific levels of burnout, compassion fatigue and secondary traumatic stress, the research by Reynolds (2020) reported high levels of secondary traumatic stress (mean score=61.59) amongst the sample (Reynolds, 2020). It is hypothesized that there may be a threshold for when the negative effects of trauma work begin to affect one’s ability to experience VR. High levels of burnout, compassion fatigue and secondary traumatic stress may directly impact levels of VR, while moderate to low levels have a sparing or nonsignificant effect. This may be explored further in future research.

Practical Application

Education and Awareness

Throughout the included research, two exceedingly frequent recommendations for how helping professionals can experience VR emerged: providing education and increasing awareness of VR. Considering the high significance levels and overwhelming positive responses from participants, it is hypothesized that simply participating in the research measures provided enough education and increased awareness to impact participants’ VR experience. In some of the studies, participants were introduced to the idea of VR by researchers. Acevedo and Hernández-Wolfe (2014) explained that “participants also understood the phenomenon of vicarious resilience in relationship to the professional, social, and political contexts from which it emerged” (Acevedo & Hernández-Wolfe, 2014). Even when the topic of VR was not openly shared, participants gained awareness of the idea through the interview or survey questions. This was exemplified in a question asked to a sample of law enforcement officers which asked, “Have there been times when a victim’s display of resilience has led you to reevaluate your own adversities?” (Pair, 2018). The original study on VR conducted by Hernández et al. (2007) included
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the interview topics: “thoughts about how interviewees may have been positively affected by clients’ ways of coping” and “thoughts on the concept of VR” (Hernández et al., 2007).

The VRS also cultivates awareness for VR in its seven section headings: “changes in life goals and objectives, increased capacity for resourcefulness, increased self-awareness and self-care practices, client-inspired hope, increased recognition of clients’ spirituality as a therapeutic resource, increased consciousness about power and privilege relative to clients’ social location, increased capacity for remaining present during clients’ trauma narratives” (Killian et al., 2017). Positivity within the framework of the interview questions and section headings of the VRS create awareness and encourage positive responses from participants. Attention to this positive lean within the measurement materials appears to be a purposeful installation by researchers and is not discussed to instill distrust of the results. Instead, it supports the recommendation that increased awareness will promote VR.

**The Helping Professional’s Character Traits**

The idea that a slight shift in the framework of interview questions could create a significantly more positive, hopeful response from helping professionals seems too simple of a solution, especially when considering evidence which highlights other contributing factors. The case study by Tassie (2015) describes the essential characteristics of self-awareness and empathy which are recommended for someone to experience VR (Tassie, 2015). Hernández-Wolfe (2018) discussed the necessity for therapists to be attentive and display professional conduct of three types, “being in the here and now”, “being open,” and “being with-and-for the client,” in order for VR to be experienced within her comprehensive review (Hernández-Wolfe, 2018). The idea of character traits as contributors of VR is supported by research on resilience. A study which tested individuals’ specific character strengths against resilience measures found that hope, zest, and bravery were largely correlated with resilience (Martínez-Martí & Ruch, 2017). Character strengths, though mainly inherent, may also be learned or improved upon if the aspiration is present. Founders of the field of positive psychology, Peterson and
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Seligman (2004) describe character strengths as, “trait-like in the sense of being individual differences with a degree of stability and generality, but they are not necessarily fixed or grounded in immutable biogenetic characteristics” (Martínez-Martí & Ruch, 2017, p. 111). As a possible contributing factor to VR, ways to build character strengths like hope, zest, and bravery along with ways to increase self-awareness, empathy and professional conduct may be included in the development of VR training.

The Client’s Impact

Peterson et al. (2004) explained that character strengths can be developed, however some influencers of VR may be completely out of the professional’s control. As previously mentioned, due to the namesake, “vicarious,” nature of VR, one must observe some form of resilience within their client in order for the professional to experience VR. Music therapist, Sato (2020), described her experience with a patient whose resilience helped her process her own grief. For a year after her brother’s unexpected death, Sato questioned her ability to be an effective hospice music therapist while also living through her own trauma. Meeting a client who had experienced trauma and displayed resiliency through it had a major impact on Sato. She concluded, “in the end, it was the work itself that helped me understand and work through my grief” (Sato, 2020, p. 17). At the time, Sato was the only music therapist working at the hospice organization serving over 700 patients. If she had not met this specific, resilient patient, would she have been able to experience VR with other patients, or would she still be struggling? It is clear that the factors which contribute to a professional’s ability to experience VR, occur both within and outside of the professional’s control. To cultivate an environment which gives staff the greatest opportunity to experience VR, there are steps that can be taken at an organizational level.

Implementation of Training

The research recommends creating training programs to teach about VR. While similar programs have been implemented to teach about vicarious trauma and burnout (Ashley-Binge & Cousins, 2020; Bell et al., 2003; Bober & Regehr, 2006), a VR training program would teach from a different perspective.
In accordance with Skinner’s theory of operant conditioning, teaching the new practice of VR, rather than ways to avoid the negative side effects of vicarious trauma, aligns with the evidence-based learning style of positive reinforcement (Skinner, 1948). Michalchuk and Martin (2019) support the positive approach to training, explaining, “Wise et al. (2012) found that when focused solely on surviving, individuals often fixate on the negative, whereas when focused on flourishing, a broader array of optimistic possibilities become available” (Michalchuk & Martin, 2019, p. 153). Due the history and substance of the literature supporting vicarious trauma, secondary traumatic stress, compassion fatigue and burnout, a training developed to teach about VR may be helping professionals first introduction to the possibility for positive personal benefit from their work. When creating such a training, there are important considerations to be made. Acevedo and Hernández-Wolfe (2020) warn about the proper way to educate about VR stating, “Those who conduct training, using as a frame the concept of vicarious resilience, must be careful to avoid minimizing the impact of working with complex traumatic stress and continued exposure to trauma” (Acevedo & Hernández-Wolfe, 2020, p. 379). As mentioned previously, the presence of VR does not necessarily mean the absence of vicarious trauma (Killian et al., 2017). It is important that this phenomenon of conflicting, yet simultaneous responses to trauma work be explained and validated.

An integrative training framework was created and designed by Hernández et. al. (2010) to provide education and raise awareness of VR amongst therapists working with trauma survivors, and their supervisors. The framework designed a five-hour course for a group of four to eight training therapists and one facilitator. Hernández et. al. (2010) explained:

The purpose of this exercise is to assist clinical supervisors and therapists working with trauma survivors in attending to the ways in which they are both positively and negatively affected by their clinical work. Although the leader acknowledges the stressful aspects of the work, the
emphasize is on developing and amplifying meaning that strengthens hope and reciprocity. (p. 75)

The framework details several structured times for reflection and discussion about trauma work, the personal effects of trauma work, and the benefits of trauma work. Opportunities for special attention to be directed towards the concepts of multiple identities, marginalization, and privilege are included (Hernández, 2010). Hernández describes implementing the training at least once, however no data was reported, nor were any other publications utilizing the training framework found. This framework may be useful to organizations looking to implement an expert-developed education program on VR.

**Resilience as a Learnable Trait**

With the abundance of recommendations centering on education and awareness, there are grounds for exploring whether resilience, and VR, are actually learnable traits. Fortunately, evidence supports the utilization of behavioral and cognitive strategies to increase resilient behaviors and trigger neuroplasticity through building and strengthening neural pathways which prompts resilient reactions (Tabibnia & Radecki, 2018). Behavioral strategies for resilience include getting healthy amounts of sleep and exercise, eating a healthy diet, positive social connections, and expressing gratitude. Cognitive strategies shown to improve resilience were emotional-regulation strategies, cognitive bias training, mindfulness training, and cognitive therapy. Researchers also explored the use of the “growth mindset” as a way to increase resilience. The growth mindset is described as, “people who believe or are taught that abilities are malleable (growth mind-set) rather than immutable (fixed mind-set) tend to learn better and improve more (De Castella et al., 2013; Dweck, 2008)” (Tabibnia & Radecki, 2018, p. 73). In a large, national study, the implementation of a growth mindset of intelligence intervention was shown to significantly improve the grades of lower-achieving ninth-grade students (n=6,320) and increase enrollment into advanced mathematics courses. The intervention was an online, hour-long course which taught students that intellectual abilities could be developed and were not fixed entities (Yeager et al.,
The success of this simple, low-cost intervention to instill a new way of thinking amongst students suggests that a similar intervention may be utilized to teach helping professionals about VR.

Other Recommendations for Practical Application

The evidence included also suggested utilizing clinical supervision (Reynolds, 2020; Welsh, 2014), providing a strengths-based approach to treatment (Edelkott et al., 2016), the continuation of contact between therapist and client after treatment (Frey et al., 2017), and the use of narrative self-stories (Acevedo & Hernández-Wolfe, 2020). Supervision, though shown to be effective, is not required by most national organizations or certifying agencies (Hearns, 2017; Reynolds, 2020). The recommendation of Acevedo and Hernández-Wolfe (2020) for the use of narrative self-stories would likely be included in a supervision experience, since its nature is to discuss work experiences. Employers may be hesitant to initiate clinical supervision because it pulls professionals away from clinical tasks and their clients, however as the research has shown, allowing burnout to kick in may impact the safety and clinical outcomes for clients in addition to its harmful effect on the professional (Bae et al., 2010; Blome & Safadi, 2016). If supervision is not provided at an organizational level, it is within the helping professional’s best interest to seek out supervision opportunities available through national or regional associations, online discussion boards, and social media groups.

Edelkott et al. (2016) mentions the style of therapy itself as a way to increase VR. She hypothesized that utilizing a strengths-based treatment style would also help the therapist to see themselves through a strength-based lens, promoting optimism and hope (Edelkott et al., 2016). Similarly, in the earliest study on VR, Hernández suggested discussing VR in treatment sessions with clients. Hernández explained, “because client’s often worry about the toxic effect of their traumas on their therapists, introducing the concept of VR to clients may facilitate the clinical work” (Hernández et al., 2007, p. 239). The inclusion of VR into therapy could possibly have a ripple effect, allowing the client to think of a resilient person in their life and be uplifted by their strength. Finally, Frey (2017) suggested
staying connected through infrequent contact with clients after treatment has ended, allows helping professionals to see the positive growth occurring in their clients (Frey et al., 2017). While this may be applicable in some settings, it should be implemented with caution due to the possibility that clients regress or remain stagnant after therapy and the detrimental impact this could have on the therapist.

**Evidence for Mindset Change within the Field of Positive Psychology**

The variety of suggestions from the research reflect the complex nature of the goal, which is to alter thought processes, change emotional responses, and reframe knowledge about how one may be personally impacted by helping work. In order to teach individuals to experience VR, we must change the way they think. While seemingly a formidable task, previously mentioned evidence on the growth mindset supports the possibility to shift one’s thinking (De Castella et al., 2013; Dweck, 2008; Yeager et al., 2019). Seligman’s “three blessings” intervention is another example of a simple, yet effective practice to positively change one’s thinking (Conway, 2012). The intervention consists of journaling three positive events that happened each day before going to sleep. In a randomized controlled trial, the intervention was shown to reduce reactions to daily stressors. It also significantly weakened the relationship between daily stress and overall well-being, suggesting that individuals who completed the intervention were less likely to let daily stressors affect their overall perception of their personal well-being (Krejtz et al., 2016). Similarly, a study of Chinese prisoners showed that simple practices of kindness and gratitude significantly improved their overall well-being. In this study, prisoners (n=144) were randomized into one of three groups: a kindness group which performed three acts of kindness each day and described them in a diary, a gratitude group, which recalled three events for which they were grateful each day and described them in a diary, and a “treatment as usual” or control group which received no intervention. After six weeks, both experimental groups’ scores significantly increased in well-being and decreased in negative affect, with the kindness group having the most significant results
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(Yang et al., 2018). This research proves that therapeutic interventions do not need to be complex or costly to have a significant and positive influence on one’s thinking and well-being.

**Proposed VR practices**

With the work of Seligman, Dweck and other positive psychology researchers in mind, two simple interventions to encourage VR amongst helping professionals are included (see Appendix C and Appendix D). The first intervention is a modification of Seligman’s “Three Blessings” intervention. The intervention prompts helping professionals to journal three moments of resilience observed in others and mention three opportunities for resilience within themselves in the presented format: If _____ can _____, then I can _____. The task is designed to bring conscious awareness to the resilience of others, which will eventually lead to an unconscious habit. Additionally, the second part of the phrase empowers the individual, by identifying and writing goals in a positive “I can” framework. Combining the observed moment of resilience with the “I can” phrase will encourage the individual to reconsider the problem they are facing as something that is attainable.

The next intervention is designed to be implemented on an organizational level. At the beginning of any type of a team gathering, whether it be a staff meeting, interdisciplinary rounds, morning huddle, or team retreat, the leader will call for two resilient moments to be shared, one by a client and one by a team member. The resilient client does not need to be treated by the resilient staff person, nor do the stories need to be connected in any way. Rather, this provides the opportunity to recognize two team members, the staff person working with the resilient client, and the staff person who displayed resilience. This is best practiced on a weekly, bi-weekly or monthly basis, to provide enough time for staff to identify new resilient moments, but also to limit gaps of time between acknowledgements. This prompts staff to look for resilient moments in their clients and coworkers, knowing there will be an opportunity to share them. Both of the previously mentioned VR practices are untested and should be implemented in combination with recommendations from the literature.
Limitations

A limitation of this scoping review is the inclusion criteria requiring the term “vicarious resilience” to be within the title of the publication. The inclusion criteria were decided upon due to time constraints and to avoid ambiguity within the selection process. It is unclear from the literature search whether other applicable publications would have been identified and contributed to the findings of this review. However, it is possible that studies about VR, utilizing the terms “secondary resilience” or “vicarious posttraumatic growth” may exist. In order to compile all of the available evidence on this topic, it is recommended that further research including these terms be conducted.

Conclusion

The relatively new concept of vicarious resilience brings light to the positive personal growth one may experience as a result of their work with individuals who have survived trauma or difficult life circumstances. Turnover rates of healthcare and other helping professionals continue to rise, making “resilience” a buzz word amongst healthcare administrators and a desirable trait amongst staff (Cheval et al., 2019; Han et al., 2019). Helping professionals such as music therapists, law enforcement officers, healthcare workers, teachers and childcare workers are essential to maintaining life as we know it and should be provided the support and protection necessary to continue doing their work. Research in the field of positive psychology shows that it is possible to learn new ways of thinking and develop new character traits, such as resilience (De Castella et al., 2013; Dweck, 2008; Seligman, 2012; Tabibnia & Radecki, 2018; Yeager et al., 2019). Studies included in this review call for a change at the organizational level. They recommend that academic and employing organizations of helper professionals cultivate awareness of VR by initiating training programs (Frey et al., 2017; Pack, 2014). Research has shown that these programs do not need to be complex, expensive or time consuming to be effective (Haimovitz & Dweck, 2017; Yeager et al., 2019). Organizations should consider implementing the already developed training program by Hernández (2010) as a way to support and retain staff (Hernández, 2010). Like
music therapist, Sato, found during her journey with grief, it turns out that “the work itself” offers a solution to build resilience amongst helping professionals (Sato, 2020). With support at an organizational level and the use of simple interventions, we can build a more hopeful outlook for the helping professionals of today and of the future.
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Table 1

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Note: The table continues with additional rows, each containing the same structure: Author(s) Date, Participants, Method, and Results. These rows are not listed here for brevity.
Table 1 (Continued)

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Notes: Additional notes on the research methods and findings.
Appendix A (continued)

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Table 1 (Continued)
Support [18, 19], with emphasis on the need for emotional support of healthcare professionals [18]. The surveys utilized in Frey et al., 2017: Vicarious Posttraumatic Growth Inventory (VPTGI), Compassion Satisfaction Questionnaire (CSQ), Resilience Health Indexes (RHI) and Practice of Resilience (PR) are recommended.

| Table 1 (Continued) |

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<td>Practice of Resilience (PR)</td>
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Suggestions made by Frey et al., 2017: Vicarious Resilience Inventory (VRI), Vicarious Posttraumatic Growth Inventory (VPTGI), Resilience Health Indexes (RHI) and Practice of Resilience (PR) are recommended.
Appendix B

The Vicarious Resilience Scale (VRS)

Please reflect on your experience working with persons who have survived severe traumas. Since you began this work, you may have undergone changes in how you view your clients, your approach to this work, and/or your own experience or world view. Please read each of the following statements about your attitudes, experiences, and how your view of life since you began this work, and indicate the degree to which you disagree or agree:

For each statement, respondent indicates if they: did not experience this (0), experienced this to a very small degree (1), experienced this to a small degree (2), experienced this to a moderate degree (3), experienced this to a great degree (4), experienced this to a very great degree (5).

(Changes in life goals and perspective)
1. I am better able to reassess dimensions of problems
2. I am better able to keep perspective
3. I see life as more manageable
4. I am better able to cope with uncertainties
5. I am more resourceful
6. I have learned how to deal with difficult situations

(increased capacity for resourcefulness)
7. I am more connected to people in life
8. My life goals and priorities have evolved
9. I have more compassion for people
10. I put more time and energy into relationships
Appendix B (continued)

11. My ideas about what is important have changed
12. I am more mindful and reflective
   (Increased self-awareness and self-care practices)
13. I am more in tune with my body
14. I make more time more meditative, mindful, or spiritual practices
15. I am better able to assess my level of stress
16. I am better at self-care
   (Client-inspired hope)
17. I am inspired by people’s capacity to persevere
18. I am hopeful about people’s capacity to heal and recover from trauma
19. I am more hopeful and engaged when focusing on strengths
   (Increased recognition of clients’ spirituality as a therapeutic resource)
20. I see my clients’ spiritual practices as a source of inspiration
21. I recognize spirituality as a component of clients’ survival
22. I highlight clients’ spiritual/religious beliefs to promote resilience
   (Increased consciousness about power and privilege relative to clients’ social location)
23. I am more aware of ethnicity, gender, sexual orientation and religion
24. Race, class, gender, sexual orientation and privilege, access, resources
   (Increased capacity for remaining present while listening to trauma narratives)
25. When I experience distressing thoughts I am able to just notice them
26. I am better able to remain present when hearing trauma narratives
27. I notice client trauma narratives without getting lost in them
Proposed VR practices

Practice 1:

Three Resilient Moments

(adapted from Martin E.P. Seligman’s “Three Blessings”)

This practice is meant to encourage conscious awareness of the resiliency around you and empower resiliency in yourself. The identification of a resilient moment of a client, coworker or friend, combined with an “I can” statement will help you to realize all that you are capable of.

Instructions: Every night before going to sleep document in a journal, digital form or on a scrap paper, three resilient moments. Use the template:

If ________ can ________, then I can ________.

If ________ can ________, then I can ________.

If ________ can ________, then I can ________.

For example: “If Molly can recover from knee replacement surgery, then I can complete my half marathon race.” “If Andrew can continue to come to work after losing his mom to Cancer, then I can continue working full time and finish my thesis project.” “If Ginny can be vulnerable and share her detailed trauma narrative, then I can apologize to my husband for losing my temper.”

Appendix D

Proposed VR practices

Practice 2:

Organizational Approach to Vicarious Resilience

This practice is an approach that organizations can implement to encourage vicarious resilience amongst staff. The acknowledgement of resilient moments of staff and clients will provide an opportunity for recognition and encourage staff to notice the resilient moments occurring around them.

Instructions: At the beginning of any team gathering including, staff meetings, morning huddles or team retreats, the leader will introduce a moment for staff to share two observed resilient moments, one by a client and one by a coworker. The resilient client does not need to be treated by the resilient coworker, rather the two moments can be completely unrelated.

For example: One staff member shares, “One of my clients has struggled with substance abuse for four years, and yesterday he told me he has been sober for three months.” Another staff member shares, “Our team member, Shauna, has been advocating for at home nursing care for a patient and encountering roadblock after roadblock. Today she finally received confirmation that her client will receive at home nursing care, and it will be fully covered by the patient’s insurance.”

Special considerations: This practice is best completed on a weekly, bi-weekly or monthly basis to provide enough time between practices for new resilient moments to occur, while also keeping the practice fresh in staff members’ minds.